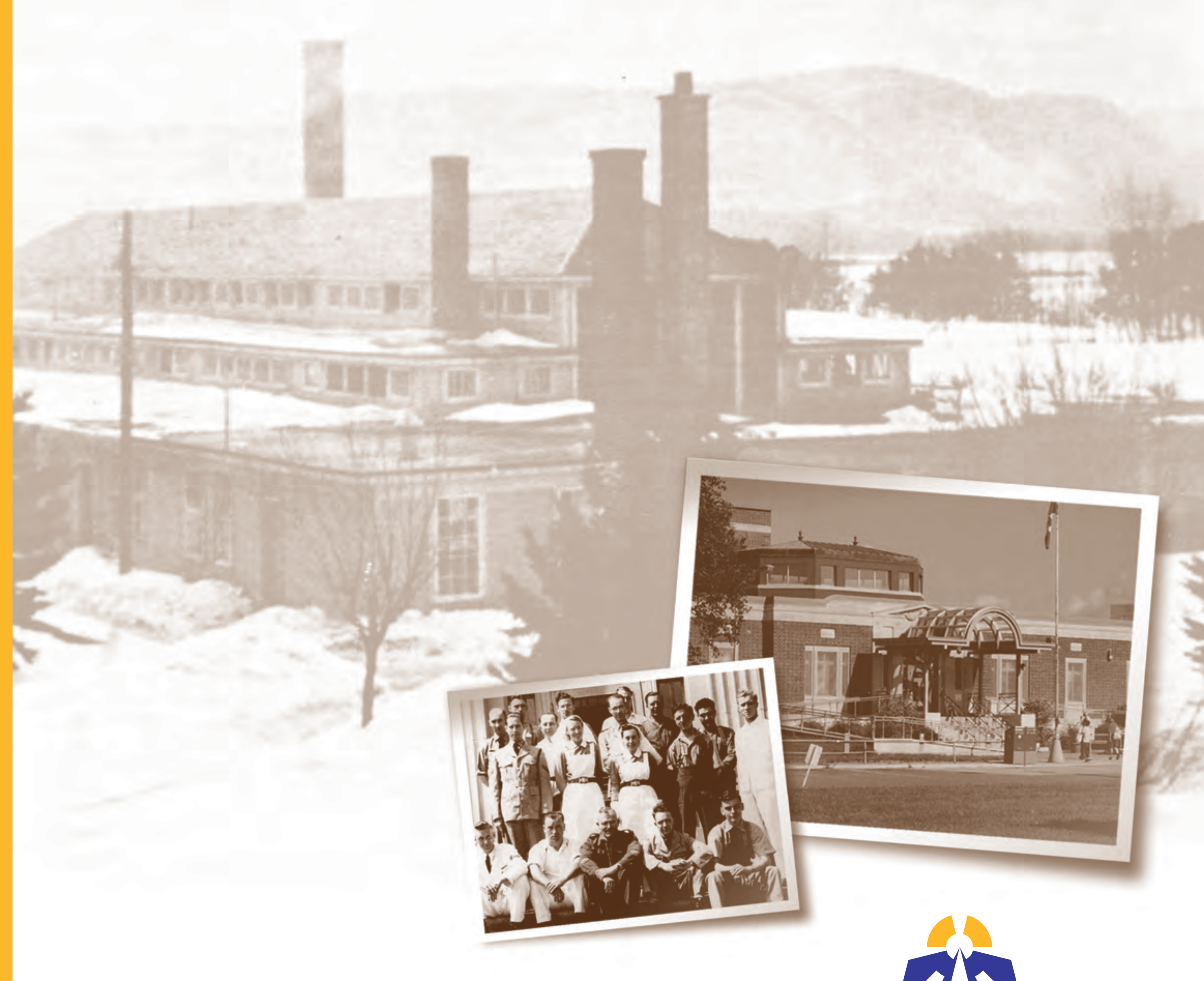
1934-2004

Lakehead Psychiatric Hospital

From Institution to Community

A Transformation of Psychiatric Hospital Services



Written by Peter Raffo

St. Joseph's Care Group

1934-2004 Lakehead Psychiatric Hospital

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Arial view of Lakehead Psychiatric Hospital, circa 1980

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Preface

In January, 2003, the Community Advisory Board of Lakehead Psychiatric Hospital (LPH) made a commitment to preserve the history of the hospital and the provision of mental health care in Northwestern Ontario. St. Joseph's Care Group assumed governance and management of Lakehead Psychiatric Hospital on June 23, 2003 and, shortly thereafter, agreed to continue this work and publish a commemorative history of the hospital. The publication would "tell the history of the hospital and outline the development of care provided over the course of its existence over a 70 year period, from the perspective of clients, family members and staff." It was also the intention of the Working Group, which was appointed to oversee the project, that it would serve as an educational tool, not only for the preservation of the record of the past, but also as a means of combating the stigma that continues to be attached to people who have mental illnesses, in our society.

I was fortunate to be chosen to write this book, and to fulfill the mandate that has been given to me by the members of the Working Group. I trust that I have been able to meet their expectations.

Some obstacles presented themselves from the start. Not the least was my own lack of anything but the most rudimentary knowledge of the nature and history of mental health care in Ontario. This was compounded by a schedule that was very tight. We began, optimistically as it turned out, with the hope that the research and writing could be completed in four months. Well, that became six months and more, but even then it was clear to me that the scale of my research was going to be severely compromised by the constraints of time.

I also came very rapidly to the conclusion that a true perspective on the experiences of the clients – those with mental illnesses living in our community – would not be possible. I was troubled by the problem of gaining meaningful access. Quite apart from issues of privacy, I had no confidence that I could gain the trust of a person with mental problems in the course of one brief interview, which was as much as I was likely to get, in the time available to me. To achieve a sympathetic and realistic understanding of the ways that the psychiatric hospital has affected the life of any individual within the system would, I came to believe, take far longer than that. In addition, I would have to talk to a significant number of clients and their families, and many of them would be reluctant to be identified for interview.

While I have tried, therefore, throughout the writing of this text, to "see" things from the point of view of the clients, I cannot hope to offer much more than second-hand impressions. This is not to say that I talked to no one who has been treated by the hospital over the years. But the numbers are few. Nevertheless, I hope I have been able to produce an accessible and lively account of an important local institution in the context of the ever-changing directions of provincial mental health policy over these years. From my point of view, I can honestly say that it has been a joy to write.

A few words are necessary, I believe, on the subject of "names". People with mental illnesses have been described in different ways at different times. In the past seventy years – the length of this study - the names have changed with bewildering rapidity. At one time, and not in the too-distant past, they would have been called "inmates", as if they were imprisoned persons. Then, more properly, they were "patients". By the late 1980s, they became "clients" and by the end of the narrative they are often, today, referred to as "consumer/survivors".

Similarly, the reader should be warned that the government agency that was responsible for policy and funding of the psychiatric hospitals changed its name on a regular basis: from "Department" to "Ministry" of Health, and from there to its latest manifestation in the "Ministry of Health and Long-Term Care".

There is a further potential confusion of nomenclature, in that there is a difference to be noted between the "mentally ill" and the "developmentally-handicapped". Those who are mentally ill are diagnosed with a specific psychiatric condition, such as paranoia or schizophrenia. Usually, they do not have a mental disability which makes it difficult for them to function fully in society. At the beginning of this narrative, and right into the 1960s, the distinction between these two groups of patients was hardly recognized in the psychiatric hospitals, both being treated together in the same wards of the institutions. Children who were, at that time, called "mentally retarded" were treated in separate Regional Centres, including the Northwest Regional

Preface

Children's Centre located at Lakehead Psychiatric Hospital. Adult patients with developmental disabilities were only separated from the mentally ill, in different wards and under a different regime of care, after the Mental Health Act of 1967 was passed. In 1974 they were transferred (to their great advantage) from Health to the Ministry of Community and Social Services. At Lakehead Psychiatric Hospital, they nonetheless remained under the same roof, although in a separate unit, until 1994.

Other names change during this brief period of time! The Ontario Hospital Fort William becomes the Ontario Hospital Port Arthur Annex and then Lakehead Psychiatric Hospital. It is now part of the St. Joseph's Care Group, which used to be two separate organizations, namely St. Joseph's General Hospital and St. Joseph's Heritage. Two of the three general hospitals in the city (Port Arthur General and McKellar General) transformed themselves into Thunder Bay Regional Hospital and thence to the Thunder Bay Regional Health Sciences Centre, in 2004. Even the cities of Port Arthur and Fort William, situated at "The Lakehead", evolved into the new city of Thunder Bay in 1970. I'm sure that I must have forgotten others, but, whatever the changes, my policy has been the same. I use the term most commonly used at the particular point in time of the narrative. I trust that the reader will be less confused by this stratagem than by the unhistorical device of always naming people and organizations by their modern equivalents.

At certain points in the text, I have inserted brief quotations from individuals whom I have interviewed during the course of the research for this book. Although these extracts accurately reflect what was said, I have, on occasion, edited them, for length and clarity.

One final note. This book is designed for a general readership, which, I am sure, is not greatly interested in academic "paraphernalia" such as footnotes. I do acknowledge, however, that I have an obligation to identify my sources, and I make a point of doing that at the end of the narrative. But I have not littered my account with citations. I have adopted what seems to me to be a common sense approach. When it is perfectly clear in the body of the text from where I am drawing my material, I have made no reference to it in an end-note. When I identify an interviewee by name, it is surely quite unnecessary to say the same thing in an end-note. The same principle applies when a newspaper is identified, and the date of the edition is perfectly clear from its context. Where there is any doubt, however, and when it is important to identify my sources, I have done so.

Peter Raffo. December, 2004

Acknowledgements

In writing this book I am grateful for much help. I could not have completed it without the guidance of the Working Group, who must be named individually. They are: Carole Faulkner, Carrie Gibbons, Brook Latimer, Margaret O'Flaherty, Sharron Owen, Barbara Parker, Erin Paul, Janet Sillman, Chad Tanner and Patricia Vasko. All of them helped to keep me honest, and not only corrected errors, but also offered thoughtful advice. Pat Paradis and Ingrid Britt, two long-serving members of the staff at the hospital, always made themselves available to correct me or to offer nuggets of information. Christina Snow, in the Northwestern Regional Mental Health Library, searched items for me and passed on vital texts.

I also wish to acknowledge, posthumously, Marg Raynard, one-time Public Relations Officer at the LPH, whose archive of material from the early years, which formed the basis for her 25th Anniversary booklet, As It Happened, proved to be an unexpected treasure trove for the early years of the Ontario Hospital Fort William.

Carolyn Forbes generously offered her memoir of the first summer at the Ontario Hospital Port Arthur. Alex Ross, City Archivist, guided me through the records of the cities of Port Arthur, Fort William and Thunder Bay. Tory Tronrud, Director/Curator of the Thunder Bay Historical Museum, gave me access to written and photographic material stored there. Joseph Solovitch at the Archives of Ontario, showed me, via the internet, how to find my way through the maze of material in the records of the Ministry of Health and Long-Term Care, from which some fascinating glimpses of the working of the Ontario psychiatric hospital system were caught. The former MPP for Port Arthur, Jim Foulds, helped me to understand the politics of Queen's Park. Wayne Lax, in Kenora, sent me much printed material about his far-from-happy, personal experiences with the mental health system in Ontario. The staff at the Thunder Bay Public Library helped me through the newspaper index and archive.

I am especially indebted to all those who allowed me to interview them about their experiences at the hospital and without whose memories there would have been very little to write about. They are individually listed in the bibliography.

The length of this list is testament to the amount of advice and assistance I needed. To all of you, my thanks. The faults that are detected in this script are none of them yours, but mine alone.

And to Donna G., who puts up with me, and to Leigh, Suzy, Adam and Emma, who, along with her, give me so much to love, a special dedication.

Lakehead Psychiatric Hospital Working Group. Back row: Margaret O'Flaherty, Carrie Gibbons, Janet Sillman, Brook Latimer and Chad Tanner. Front row: Erin Paul, Barbara Parker, Sharron Owen, Carole Faulkner, and Patricia Vasko, 2005

1934-1939

Twin City Rivalry

Homecoming

On March 1, 1936 a train drew into the Fort William station pulling a private coach in which sat a party of twenty-eight people. It was, as one of the passengers later described it, a "temporary miniature train coach hospital." The patients on board, and the staff that were assigned to accompany them, had been deliberately separated from the regular passengers. They were not considered normal. Twelve of their number were mentally ill - some of them may have been diagnosed in those days as "retarded", in popular parlance, "loonies". The other members of the group, who could be described as their custodians, were headed by a psychiatrist, Dr. John Senn. With him were two nurses, twelve male attendants and a cook. "Little did we realize", recalled that cook many years later, "that this … would grow into one of the most modern psychiatric hospitals in Ontario." Such an up-to-date facility was in nobody's mind in the winter of 1936.[1]

We spent many happy hours behind the farm buildings skiing down the only hill nearby on moon light (sic) evenings. We really never found out if the coyotes at the foot of the hill were friendly or not, each time we raced down the hill they would be running a short distance in front of us, and as we climbed the hill, they sneaked up behind us, with their sharp shrill yelps, in the stillness of the darkness.

Lorne Holditch, Cook

The party of pioneers, for in truth that is what they were, left Fort William in driving snow that same day to take possession of a collection of buildings sitting on over 1,300 acres of land that had, only a month before, been an industrial (prison) farm run by the Ontario Department of Reforms. Sited some sixteen kilometres out of town on the Scott Highway (today's Highway 61), this was to be the Ontario Hospital, Fort William, part of a complex of mental institutions across the province which were directly administered by the provincial government, through the Department of Health.

The beginnings of what was to become Lakehead Psychiatric Hospital (LPH) were entirely inauspicious. "I remember well the reception we got", wrote Dr. Senn, later: "There was snowing hard [sic] for several days both before and after we arrived, and I am afraid very little consideration had been given for our reception. Certainly at …the hospital we were not appreciated and things were in a terrible mess." The buildings had been vandalized, the toilets were unusable at first, and there was no meat in the ice box. Only two or three cords of wood had been left behind to heat several buildings, so that "we had to get a gang out the day after we arrived to cut wood and to buy 4ft lengths wherever we could."[2]

Ontario Hospital Fort William, 1936

Staff members transferred from eastern Ontario Hopitals in to Ontario Hospital Fort William in 1936. Left to right - Gilman Holditch, Dr. John N. Senn, Miss Agnes Baillie, Miss Hilda Kamstra and John Boyd.

It was incredibly dirty, poorly heated, not enough bathing facilities or hot water, poorly equipped kitchen & dining room. It took three months of cleaning, painting & renovating before we could admit any new patients.

Hilda (Kamstra) Green, Nurse

Only the two nurses of the original sixteen members of staff who accompanied the patients came originally from the city. Agnes Baillie and Hilda Kamstra had lived in Fort William before they went south, to train as registered nurses. All of the party had been recruited from Southern Ontario psychiatric hospitals, including Senn himself, who came from the Ontario Hospital in Whitby. This first taste of the Northwest for the uninitiated majority must have been grim indeed. Three of the attendants were soon to develop "symptoms of depression" and were sent back shortly after their arrival. One of their number exclaimed to Senn, after an unsuccessful expedition to the Kaministiquia River in search of ice: "Surely the Lord wouldn't let a man die in this place!"[3]

In one sense, the patients were better equipped than most of the staff for the harsh conditions on the Scott Highway, because they were all originally from the Northwest. Until this time the usual route for anyone in the whole region from the Manitoba border to White River who was diagnosed as "retarded", or with a severe mental illness, was to the local jail, where they stayed until a suitable train was available. Then, under the supervision of a constable, they would be sent to one of the mental institutions a thousand miles away in the south. For the twelve patients who arrived in Fort William that day, therefore, this was a kind of Homecoming.

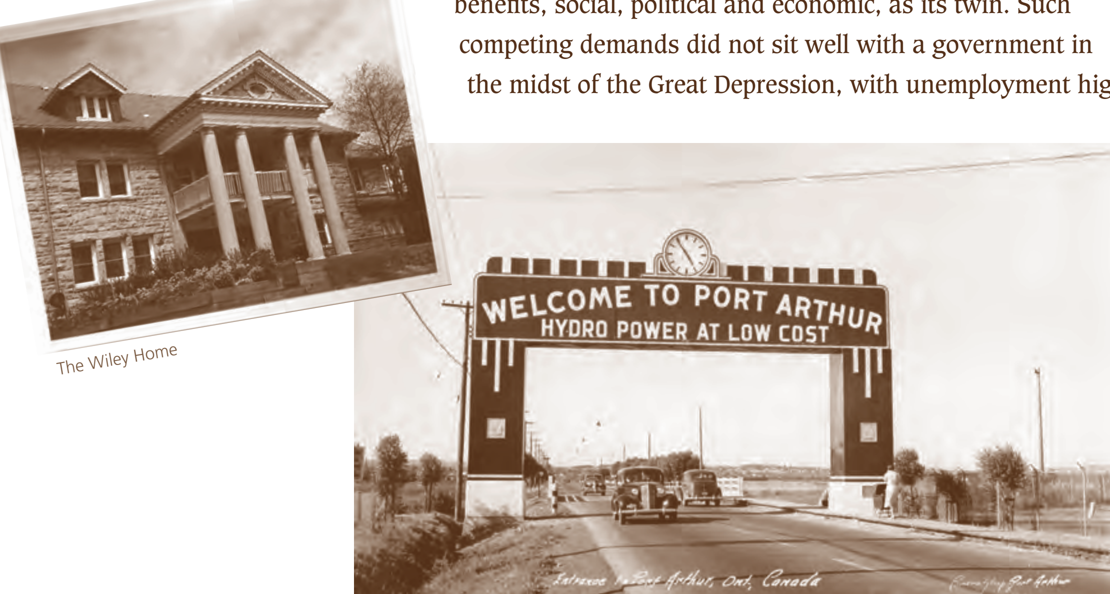
How had this change of government policy come about?

1934-1939 Twin City Rivalry

The Deal

The lack of a mental hospital for residents of Northwestern Ontario had long been a grievance of the people in the region. This huge slice of the province, the equivalent in size to the state of France, and with a population at that time of over one hundred thousand, lacked many of the medical support systems that had already come to be expected by the more populous, and politically influential, south. Until the mid-thirties, anybody diagnosed with tuberculosis could also look forward to a significant period of separation from family and friends. In the case of people, male or female, who were defined as mentally retarded the prospect was for permanent institutionalization far from the region of their birth. The same fate could await any person discovered to have a severe mental illness. The nature of institutional care in the mental hospitals was such that those who would today be considered capable of living fulfilling lives in the community, in those days rapidly became "institutionalized".

In 1934, this expectation of permanent separation, for both mental patients and those with tuberculosis, began to change. The nature of the change was a "deal" which seems, at that time, to have been struck between the two sitting Conservative members of the provincial legislature for Port Arthur and Fort William. The two cities had a tradition of rivalry. Standing together at "The Lakehead" each was fiercely determined to maintain its independence and to gain from the provincial government exactly the same benefits, social, political and economic, as its twin. Such competing demands did not sit well with a government in the midst of the Great Depression, with unemployment high and revenues from its taxes and its resource sectors in retreat. Nevertheless, the Conservative government of George Henry had an election in prospect and two of its members, D.M. Hogarth in Port Arthur and Frank Spence in Fort William, held seats that were by no means secure for the party. Legend has it that the two men agreed that they would cooperate to push for both a tuberculosis sanatorium and a mental hospital, the former to be sited in Fort William, the latter in Port Arthur. On February 21, 1934 the announcement to that effect came down from Queen's Park. The mental hospital would be situated, it was proposed, in the old Wiley home, a stone three-storey building sitting on eight and a half acres of land at the top of the hill in Port Arthur (today's St. Joseph's Manor). Hogarth, who had sent word of the deal from Toronto, said that work on both projects would begin immediately, and would be carried through to completion with "full steam ahead." The medical establishment of the twin cities applauded the decision enthusiastically, noting that in the previous year eighty-five mental patients, the largest number on record, had been sent to hospitals in the south.[4]

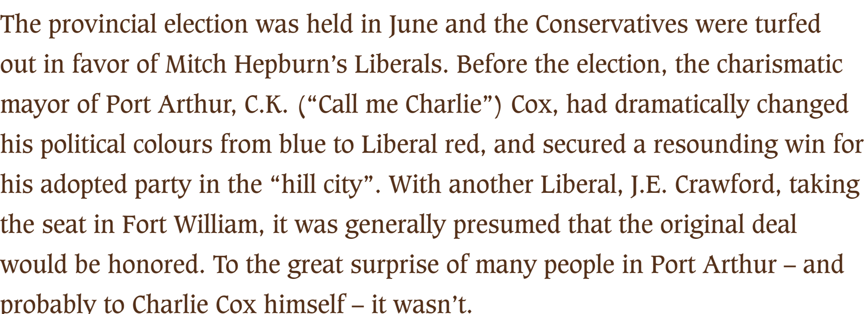


The Wiley Home

Port Arthur welcome arch, 1939

"Charlie" Cox

Charlie Cox, Mayor of Port Arthur, 1940



The provincial election was held in June and the Conservatives were turfed out in favor of Mitch Hepburn's Liberals. Before the election, the charismatic mayor of Port Arthur, C.K. ("Call me Charlie") Cox, had dramatically changed his political colours from blue to Liberal red, and secured a resounding win for his adopted party in the "hill city". With another Liberal, J.E. Crawford, taking the seat in Fort William, it was generally presumed that the original deal would be honored. To the great surprise of many people in Port Arthur – and probably to Charlie Cox himself – it wasn't.

Less than two years later, in February 1936, Crawford announced that the mental hospital for the Northwest was to be located in the township of Neebing. This was a rural area, adjacent to Fort William. The proposed site for what would be called the Ontario Hospital Fort William was the industrial farm, which would be transferred from the Department of Reforms to the

Some time ago I forwarded a set of upper dentures to you, for one of our patients. I am afraid I neglected to send a covering letter and, as the teeth have not been returned, I felt that they might have been mislayed (sic) owing to you not having sufficient information. The patient is continually asking about them and Iwould appreciate their early return.

John Senn to Ontario Hospital, Queen St, September 12, 1936.

Department of Health. "I have received a flood of comments on the plan", said Crawford, adding blandly "and have yet to hear a voice raised in opposition." No doubt he was situated on the south side of the Neebing River when he made that pronouncement. According to Port Arthur's The News-Chronicle: "Charles W. Cox… and L.J.B. Bolduc, president of the Liberal Association, stated they were without information on the matter." So Port Arthur had ended up with neither a psychiatric hospital nor a sanatorium (which had already been built in Fort William).[5]

Perhaps Cox had not yet found his feet in the legislative assembly of Ontario. Perhaps the bond between himself and Mitch Hepburn, based, it was often alleged at the time, on Cox's knowledge of some scurrilous activities of the mercurial premier, had not yet been forged. More likely, Cox had been forced to bow to reality. A psychiatric hospital may have been promised to the Lakehead – indeed to the Northwest – but the originally-proposed site in Port Arthur was simply unsuitable. It could hold no more than forty-four patients, was located on a piece of land far too small to sustain the kind of institution that was envisaged. In the south, such hospitals were being built for patient communities of up to two thousand. Except for those located in major urban areas such as Toronto and Hamilton, they were expected to be largely self-sufficient, with acreages that could supply them with much of their own food. They were often placed on farm land which could support herds of livestock, beef and dairy cattle, sheep, pigs and poultry, not to mention arable produce. The Wiley residence, albeit the largest private house in Port Arthur, met none of these criteria.

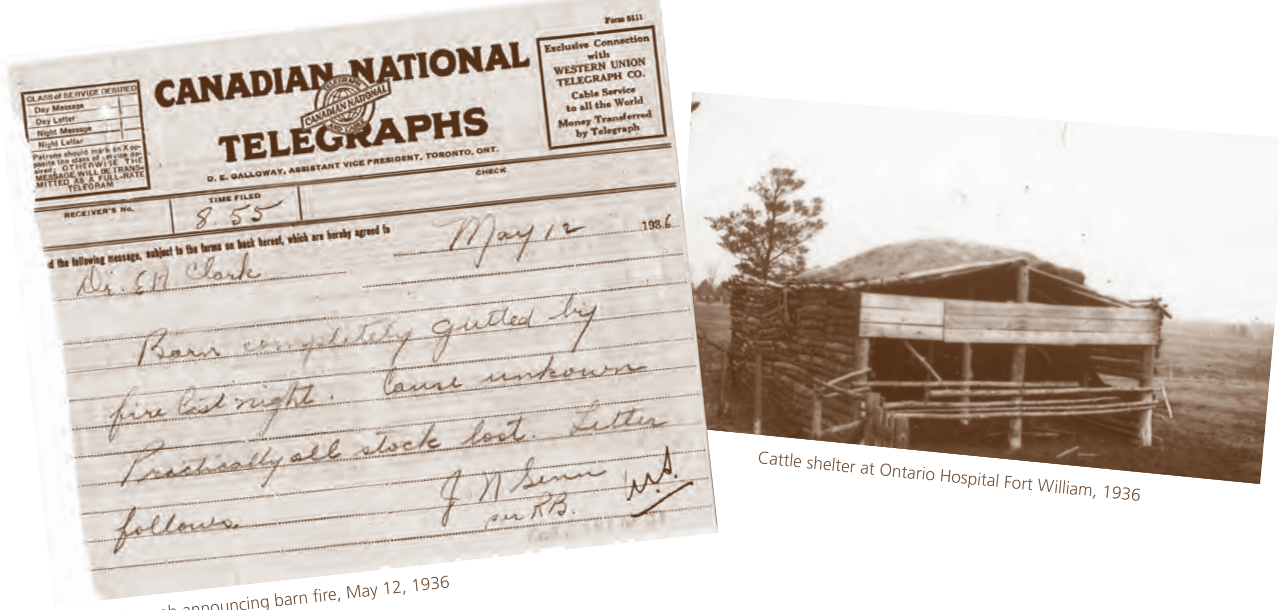
But time was on Cox's side in what was to become an ongoing struggle between the two cities for the permanent site of the Ontario Hospital. Even as Dr. Senn, the Superintendent, and his intrepid group were settling with such difficulty into their new quarters, the shortcomings of the Neebing location were becoming only too apparent.

Fire and Water

On May 12, 1936 John Senn sent a telegraph to Dr. C.A. Clark of the Department of Health in Toronto: "Barn completely gutted by fire last night. Cause unknown. Practically all stock lost. Letter follows." That letter told a tragic tale. Not only was the barn itself burned down, along with two other buildings, but all the livestock in the barn, including twenty-five cattle, nine horses and about twenty sheep, all of them ewes with young lambs, had perished.[6]

The herd of Holstein dairy cows would not be replaced. Instead, the farm thereafter began to raise beef cattle, which required less protection from the elements. Nonetheless, the persistent requests from Dr. Senn for the replacement of the barn were consistently refused by the Department of Health, usually on the advice of the Department of Public Works, which would have been responsible for the construction of such a building. Senn was discovering what the common local complaint, of the provincial government's "neglect of the north", meant. Astoundingly, the correspondence on this issue continued beyond the end of the Second World War. Senn's successor as superintendent, Dr. C.A. Cleland, was able only in 1947 to secure a replacement, and then it was for a much smaller barn.[7]

In the meantime, other problems with the site had become evident. It was too far out of town, and in the winter the highway was often closed. On more than one occasion, staff took to their skis to make the journey to or



CANADIAN NATIONAL TELEGRAPHS

Time filed 8.55

May 12 1936

Dr. C.A. Clark

Barn completely gutted by fire last night. Cause unknown. Practically all stock lost. Letter follows.

J N Senn per RB.

Telegraph announcing barn fire, May 12, 1936

Cattle shelter at Ontario Hospital Fort William, 1936

1934-1939 Twin City Rivalry

from Fort William. There was no public transport to the facility. Developing contacts between Neebing and the general hospitals in Fort William and Port Arthur was difficult, especially in the winter. There was also a continuing problem with the water quality. A high tower was the only source of a fresh, uncontaminated supply. It was supplemented by a pumping plant to a well that regularly failed. A year after occupation of the site had commenced, yet another fire destroyed the pumping plant. By 1938, Dr. Senn was sending desperate telegraphs to Toronto: "Water situation becoming acute here. Would advise immediate action if at all possible. McAllister has consulted local engineer of Northern Development who advises new well." Even after that well had finally been dug, and the water tower hauled down – and that did not take place until after the Second World War – another Superintendent, Dr. J.R. Howitt, was complaining: "The water supply still continues to be a problem.... It would be greatly appreciated if we could obtain some practical help from the Department of Public Works in meeting this difficulty. Surely there must be some solution to the problem." That plea was made in 1953. Whether the Departments of Health and Public Works were unconcerned about such issues, or whether, more charitably, they were simply ignorant of local conditions, it is hard to say.[8]

Letter from the Department of Health, August 24, 1936

ONTARIO
DEPARTMENT OF HEALTH
OFFICE OF
THE DEPUTY MINISTER

TORONTO, August 24th, 1936.

RECEIVED
AUG 27 1936
ONTARIO HOSPITAL
FORT WILLIAM

Dr. J. N. Senn,
Superintendent,
Ontario Hospital,
FORT WILLIAM .. Ont.

Re: Care of Stock,
Ontario Hospital,
Fort William.

Dear Doctor:

Confirming our conversation on August 21st with Dr. MacNabb, Mr. O'Connor and yourself, it is understood that you will obtain locally the necessary material to protect both your milking herd and the six horses in one end of the basement left of your large barn following the fire. You will also make arrangements to purchase steers and feeders to be housed in the beef barn for feeding during the coming winter, thus supplying the necessary beef to your patients during the coming winter.

If it is considered advisable to add to your flock of sheep, these also can be purchased from Winnipeg markets. Decision should be made re purchase of this stock at an early date as stock will be selling cheaply from the dried-out areas in Western Canada.

I will discuss with the Civil Service Commissioner today the question of whether you will hire local tradesmen by the month or hour to carry out the construction found to be necessary to properly house these animals.

With respect to swine, Dr. MacNabb will confirm certain information he obtained from the livestock branch which may enable you to cook garbage sufficiently to feed it to the hogs that you have and still keep within the regulations.

Yours very truly,

Deputy Minister.
(B. T. McGhie, M. D.)

Barnyard turkeys at Ontario Hospital Fort William, 1936

The News Chronicle
$2,000,000 HOSPITAL FOR PORT ARTHUR
Plans for Mental Institution Are Announced by Mayor Cox; Site Likely to be in North End

Election campaign for Charlie Cox, 1934

The News Chronicle, March 3, 1937

A Far Bigger Thing

Long before that time, however, a radical solution had been found for all the problems with the site at Neebing. In 1937, Queen's Park decided that the site of a permanent Ontario Hospital for Northwestern Ontario would be moved back to Port Arthur and that Neebing would serve only as a temporary refuge for the region's mentally ill population. It would also continue only to house male patients. The transfer home of female patients would have to await the construction of the brand new facility.

"I think it was understood when Health took over the premises of the Reform institution that it was a temporary solution", wrote Senn, many years later. There was only space for seventy-five beds. With the facility averaging eight admissions a month, many patients continued to be sent by train to mental hospitals down south. Problems with water supply and sewage, with telephone connections (which were frequently interrupted), and with the distance from town all conspired to give the initiative back to Port Arthur in the continuing inter-city competition for the prize of the mental hospital. "Unless I am in error", opined Senn on that matter, "politics entered into the picture."[9]

How could it not? Charlie Cox was the supreme politician. Caught flat-footed in the first round, this athlete of a man – who regularly took part in the annual ten-mile road race in Port Arthur – was nimble enough to re-group and renew the fight from the vantage point of Queen's Park, where he was now Minister Without Portfolio in Hepburn's regime. His corner was further enhanced by the fact that, not only had he the ear of the Premier, he continued to be Mayor of the city as well.

"$2,000,000 HOSPITAL FOR PORT ARTHUR", screamed the headline of the March 3, 1937 edition of The News-Chronicle. The story below included the

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triumphant declaration of the Mayor: "I have procured the definite assurances of the department and of Premier Hepburn that, if the conditions of site are complied with, this institution will be located in Port Arthur."

A few days later he prophesied, "It will be a far bigger thing than the people of Port Arthur could have any conception of." Before the end of the month, the Port Arthur city council had passed a resolution in a special meeting, which approved a grant of land of upwards of one hundred and sixty acres, property bounded by Lyon Boulevard and Algoma St. as far as Huron St., and alongside Boulevard Lake, deeded free of charge to the Ontario government. The resolution added, curiously, that the council made this grant "if within its power to do so." It would become apparent, many years later, that it had not been in its power to do so, but by that time the Ontario Hospital in Port Arthur was already under construction.

Charlie Cox and the hill city had won the bout by a knockout.[10]

Life on the Scott Highway

Unless the man mentioned has some experience in this district he would find it very hard to offer advice to settlers, as I assure you that farming in this district is not the same as farming in the east.

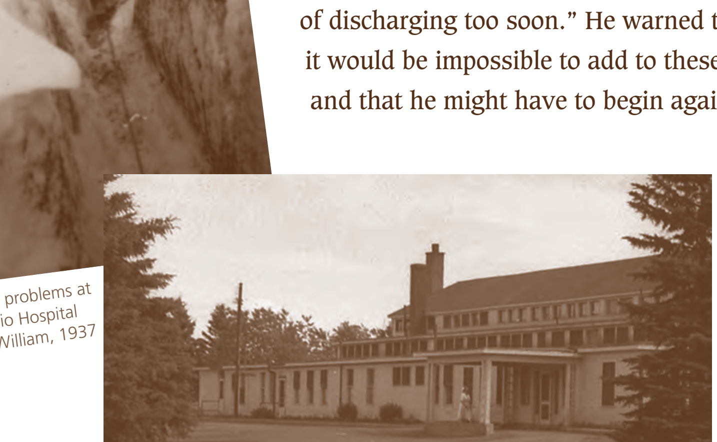
John Senn to Dr. B.T. McGhie, February 22, 1943 regarding the proposed appointment of a farm manager from Southern Ontario.

While the political tug-of-war was being conducted in town, across the Kaministiquia River, at Neebing, staff and patients together struggled to make the best of things. The original twelve patients had been recruited with the expectation that they would work alongside the attendants and nurses, first to get the buildings up to scratch, and then to maintain and develop the considerable acreage of farmland that was the legacy of the Department of Reforms. Despite the trauma of the lost livestock and barn, and the continuing problems of water supply, a viable mental institution was rapidly taking shape. By mid-summer 1936, new patients began to be admitted to a hospital which now boasted a main building, dormitories, kitchen, dispensary, dining room, recreation room and several staff residences. Most of the troupe of nurses, attendants and administrative personnel found it more convenient to live in the hospital, rather than to find lodgings in town. Several of those who have left reminiscences of those early days mention the closeness of the relationships that developed in that isolated community. Nurses and attendants worked twelve-hour shifts, up to six days a week. Constantly on call, the staff would find it hard to make much of a social life, except amongst themselves. They write of roller-skating down the Scott Highway in the summer, of skiing in the winter. They would swim in the nearby river and hold picnics on its banks.[11]

Farmhands were recruited locally, as were attendants and other service personnel, to replace those who left. In the "dirty thirties" it was not difficult to find non-medical staff. Professionals were less easy to recruit or to replace. For instance, when the Business Steward, who looked after the finances, left for service with the armed forces after the war began, Ruth Black, who was first hired in 1936 as a typist, took his place. Dr. Senn noted, in retrospect, that it was because they were so far from Toronto, and "left to themselves" so much, that they had a certain freedom of action in those early years.

Trained psychiatric staff were always at a premium, which was to be one of the continuing problems of the psychiatric hospital at the Lakehead from that time onwards. Throughout his tenure as Superintendent, Senn was the only psychiatrist on staff, as would be the case with his successor, Dr. Charles Cleland. The number of Registered Nurses remained no more than the original two for quite some time.[12]

On the other hand, it was not long before the hospital had reached its capacity in patients. By January 1937, Senn was reporting that the seventy-five beds in the facility were no longer enough. "We have put in extra beds wherever 85 patients can be accommodated.... We are discharging every possible patient and I am afraid erring on the side of discharging too soon." He warned the Department of Health that it would be impossible to add to these numbers for much longer, and that he might have to begin again sending patients down to the south, "where, I presume, overcrowding is not noticed so severely."[13]



Water problems at Ontario Hospital Fort William, 1937

Ontario Hospital Fort William, 1937

1934-1939 Twin City Rivalry

Custodial Care

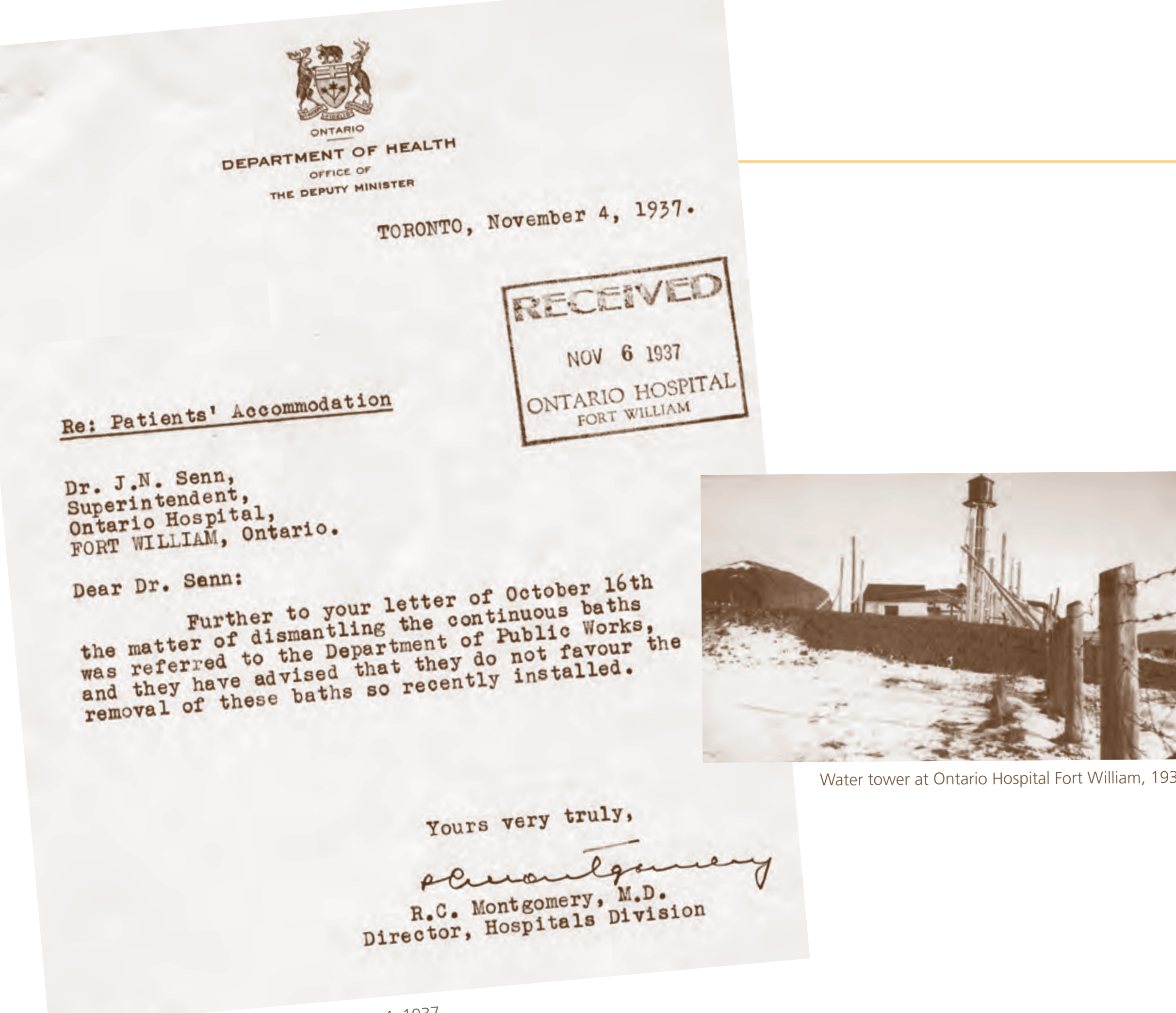
… the superintendent may direct the treatment of any patient by such methods as in his opinion are in the best interests of the patient.… If the superintendent feels that the proper treatment … is insulin or metrazol shock treatment, it is proper for him to direct that the patient be treated in that manner. The superintendent is not required to obtain the consent of any member of the patient's family before ordering such treatment.

The superintendent as "feudal lord'": F.T. Egener to Dr. R.C. Montgomery, Director, Hospital Division, March 11, 1941.

Treatments available for psychiatric patients in the 1930s were primitive indeed. The care that was offered, albeit with the best of intentions, was essentially custodial. The era of the 19th century "lunatic asylum" was not that far behind. Public attitude and much medical practice preferred that people with mental illnesses be put away and kept out of sight. At the Fort William Hospital, Senn noted that: "Voluntary admissions were practically unknown …. Prior to the war years we had opened up treatment by insulin shock and electro shock with the usual results – good and bad." Injection of patients with large doses of insulin always induced a profound, though brief, coma before, in many cases, leaving patients calmer than before. Electro-convulsive therapy (ECT) was administered routinely, applied without any tranquilizing agent and, although often successful in calming the more agitated patients, occasionally left a person with fractures, due to the intensity of the charge.[14]

One of the original group of sixteen staff members, nurse Hilda Green (Kamstra), remembers treating bush workers suffering from depression with "mild sedatives and hospital routine", which may have been an adequate therapy for short-term patients. A more usual treatment, all in the hope of "calming" the patient who had become agitated, was the "continuous water bath" system. The patient would be placed in a full bath of warm water with a strip of rubber covering all but his neck, in order to maintain the temperature as long as possible, and to prevent any chance of drowning. The theory was that, if the water was run through the bath continuously, it would create a sensation similar to lying in the amniotic fluid of the womb. These were devices rather than therapies, it is true, but there were few enough other means available for improving the condition of those who were severely ill.[15]

As long as such limited treatments were the best available, the emphasis in all the mental hospitals in the Ontario system was bound to be more custodial than curative. Even the one outstanding characteristic of the Neebing site, its natural beauty, lying as it did below the hump-back hills of the Nor'westers and a considerable distance from the city, lent an element of custody to its care. After all, it had begun life as a prison farm (and would eventually return



ONTARIO
DEPARTMENT OF HEALTH
OFFICE OF
THE DEPUTY MINISTER

TORONTO, November 4, 1937.

RECEIVED
NOV 6 1937
ONTARIO HOSPITAL
FORT WILLIAM

Re: Patients' Accommodation

Dr. J.N. Senn,
Superintendent,
Ontario Hospital,
FORT WILLIAM, Ontario.

Dear Dr. Senn:

Further to your letter of October 16th the matter of dismantling the continuous baths was referred to the Department of Public Works, and they have advised that they do not favour the removal of these baths so recently installed.

Yours very truly,

R.C. Montgomery, M.D.
Director, Hospitals Division

Letter from Department of Health, November 4, 1937

Water tower at Ontario Hospital Fort William, 1937

to that role in the 1950s).

According to such accounts as we have, Dr. Senn's administration was an enlightened one, by the standard of the time. There is even a hint of dissatisfaction with the continuous bath regimen in his plea to the Department, in October, 1937: "I would appreciate if you would take up with the Public Works Department the possibility of us removing the battery of three continuous baths now installed here and utilizing room for dormitory accommodation." On the other hand, the pressure of space requirements, already mentioned in his correspondence with Toronto, was reason enough for him to make such a suggestion. Another reason for his proposal would have been the sheer difficulty at that site of getting a decent and continuous supply of water for all operations, let alone continuous baths. As with so many of his struggles with the Departments of Health and Public Works – over water supply, physical improvements to the buildings, the replacement of the barn - the response was in the negative.[16]

A Critical Inspection

Enlightened or not, the physical deficiencies of the Fort William Hospital, together with the lack of trained medical staff, made for a damning report from Dr. J.E. Sharpe, when he conducted an inspection of the premises for the Department of Health, in March, 1938. If his report did anything, it must have convinced Queen's Park of the urgent need for the new hospital which, by then, was about to be constructed in Port Arthur. Sharpe noted that the patients at Neebing were largely unoccupied (work on the farm would have been halted for the winter, of course). He wrote that the hospital urgently required an occupational therapist. There were few books available in the library and the kitchen was unclean. Worse than this, he reported, what few medical personnel there were had not maintained accurate medical records, and he wanted to see more extensive use of continuous baths. He did admit that the hospital "differ[ed] markedly from our other Ontario Hospitals, due to the limited number of patients, and the fact that the Superintendent is the only Medical Officer on the staff." To this critique Dr. Senn dispatched a stout reply: "We of course appreciate Dr. Sharpe's inspection both from the standpoint of the suggestions he has given and because he will now appreciate probably better our problems when we write to head office regarding them." As to the issue of the baths, Senn's

Letter from Department of Health, June 7, 1938

DEPARTMENT OF HEALTH

File No.

Date June 7th, 1938.

Memorandum to
Dr. J. N. Senn
Superintendent
Ontario Hospital
FORT WILLIAM .. Ont.

From
Dr. R. C. Montgomery
Director, Hospitals Division

Re Inspection Report - Fort William

I wish to acknowledge receipt of your letter of May 30th with reference to the Inspection Report of the Ontario Hospital, Fort William. In view of the fact that Dr. Wilson will be reporting to you in the near future, I would suggest that he can carry out the blood counts which you had suggested referring to a nurse. It would also seem advisable that complete immunization procedure should be carried out on all your patients and this will be more readily done with the additional doctor on your staff.

At present it is not possible to transfer to you an attendant who is trained in occupational therapy but this matter will be kept in mind.

Requisitions for library, books, rubber mats for bathroom, electric razors have been approved.

It should also be possible to have notes regarding patients in keeping with the instructions laid down in the Physicians' Handbook in view of the fact that you will have a second doctor on your staff.

RCM.EBR

Inspection,
O. H. Fort William.

March, 1938.
Sheet No. 4.

The supply is insufficient, but with the number of patients, it probably does not amount to such a marked handicap.

In the attendant's office, which appeared to be a general store-room or catch-all, I observed a straight blade razor, and was informed that they are used entirely. I would recommend that their use be discontinued, and that some type of a guarded razor should be used, such as a safety razor, Gillette or auto-strop, or the Durham duplex type. With the small number of patients, it might be advisable to try out one of the electric razors, as to their durability, and whether they would be considered satisfactory.

Utility room space is by means of a small room, with no ventilation except by the door.

There is considerable plastering needed and some painting. In one place, the roof is apparently leaking, and the plaster is off to the lath. In the isolation dormitory, the plaster was also off. The roof also needs repair, as evidenced by its leaking in one or two places at least.

The second large dormitory accommodates 48 patients, and they are very crowded. The patients here are of the quieter type, the majority working on the farm. Lavatory and wash room accommodation, as above mentioned, are available.

The rooms are divided only by clapboard partitions, which makes it quite difficult to nurse noisy, destructive, disturbed patients, and one such patient could disturb all the others.

There are three continuous baths on suite, and these are used very little for the purpose of such therapy. I would recommend that consideration be given to their more extensive use. These baths are along the corridor, and separated by the corridor from the wards. Along this corridor also, are the head nurse's office, the chief supervisor's office, and the dispensary. There are no drugs kept on the ward at all, and as medication is prescribed or required, it is brought directly from the main dispensary. With the small hospital, the small number of patients, and the regular accessibility of the dispensary, this procedure works out quite well.

I would suggest that there should be kept on the Wards a file on every patient, in other words, each patient should be considered an active treatment patient. This file might contain the treatment sheet, clothing card, weight record and clinical chart, with clinical notes to be written by the Supervisor of the Ward at least every month, on every patient. These are not notes which are incorporated with the physician's records, but are notes available for the information of new members of staff, and so that each member of staff can be acquainted with the individual patients.

There are no radios in the dormitories, or in the present sitting room. A small radio of the mantel type might be appreciated.

Inspection Report, March 1938 sheet No. 4

response was both guarded and ambiguous: “We are using continuous baths in practically every case where patients are present that can benefit by this form of treatment.”[17]

One Step Forward, One Step Back

Work began on the construction of the new Ontario Hospital in Port Arthur in 1938, as soon as the frost was out of the ground. By the end of the year the first structure, an administration building, was complete. Early in 1939, the Minister of Health, while on a tour of the new building, announced that in the following year a further group of buildings would be erected. By late August, the plans for the full development of the hospital were made public, and an impressive complex it sounded. There would be four main buildings, including the one already completed. The three now planned would be grouped in line behind, and at 90 degrees to, the administration unit. These ‘pavilions’ would consist of separate wards for male and for female patients plus a central reception and kitchen building, attached to the administration block by a long sidewalk. Further away on the property, and to the south, would be the power house and beside it a “radial brick chimney 15 feet across at the base and 114 feet high.” Each of the patients’ pavilions would be 273 feet by 60 feet, with two stories plus a basement. On each floor there would be eight wards with ten beds in each, and a series of other rooms, some for patients, some for nursing staff and attendants. The kitchen and reception building would include, not only the main kitchen, but a pastry bakery, a chef’s room, a dietician’s room, an executive dining room, and a huge storage capacity for refrigerators, to keep a wide variety of fresh and frozen foods. There would be examining rooms, doctors’ quarters, a storekeeper’s office and stores, dispatching rooms, a transformer room, a “truck wash room” and an ice-making room. The Daily Times-Journal, in Fort William reported, in addition:

> Plans for the layout of the hospital show that ten more buildings are projected for the future. These include three

CANADA

Department of National Defence
"Air Force"

IN REPLY PLEASE QUOTE
NO. 36-3

Fort William, Ontario, November 10th 1940

Dr. J.N. Senn,
Superintendant,
Ontario Hospital,
Fort William, Ontario.

Dear Dr. Senn:

I have to thank you for your extreme courtesy in stating that it would be a privilege for this School to use your field.

I have to tell you that, should any of our aircraft behave in such a manner as to constitute a nuisance in any way, I should be glad to investigate the matter in order that such behavior may be prevented further.

Should you, at any time, feel such action is necessary, by taking the number of the aircraft painted on the underneath side of the wings and sides of the fuselage and telephoning this Unit, the matter will receive instant attention.

Yours faithfully,

(H.C. Johnson), Flight Lieutenant,
Chief Supervisory Officer,
No.2 E.F.T.S., R.C.A.F.,
Fort William, Ontario.

Letter from the Department of National Defence, November 10, 1940

more pavilions for male and three more for female patients;
a disturbed patients' building, assembly hall, nurses'
residence, and laundry.[18]

Truly Charlie Cox's prophecy was about to be fulfilled: this was indeed bigger than anyone "could ever have had conception of." Accommodation for three hundred and fifty patients was envisaged for the first phase, before any expansion beyond the projected three pavilions. The end-capacity could be as many as thirteen hundred beds. John Senn and his tiny staff at Neebing, treating close to one hundred patients by this time, in conditions that were clearly unsatisfactory, must have been salivating at the prospect of moving, in the near future, into such palatial surroundings.

It was not to be. Before even the sod could be turned on any new construction at the Port Arthur site, and before the new administration building itself could be occupied, Adolf Hitler intervened. On September 1, 1939 the Second World War broke out. The diversion of all national energy to the war effort in Canada meant that nearly all civil construction projects were put on hold. By August, 1940 the administration unit on Algoma St. had been formally taken over by the Department of National Defence, "for military purposes." It would be used during most of the war years as a military hospital for army personnel who were overseeing German prisoners-of-war in the camps located in Northwestern Ontario. Port Arthur would have to wait, it seemed, until the end of the war to get its new psychiatric hospital. In fact, it would wait until 1954.[19]

LEND TO DEFEND THE RIGHT TO BE FREE

The Minister of Finance of the Dominion of Canada
offers for public subscription

$600,000,000

VICTORY LOAN

1941

Dated and bearing interest from 15th June 1941, and offered in two maturities, the choice of which is optional with the subscriber, as follows:

Ten-year
3% BONDS, DUE 15th JUNE 1951
PAYABLE AT MATURITY AT 101%
Callable at 101 in or after 1950
Interest payable 15th June and December
Denominations,
$50, $100, $500, $1,000, $5,000, $25,000
ISSUE PRICE: 100%,
yielding 3.09% to maturity

Five and one-half year
2% BONDS, DUE 15th DECEMBER 1946
PAYABLE AT MATURITY AT 100%
Non-callable to maturity
Interest payable 15th June and December
Denominations,
$1,000, $5,000, $25,000
ISSUE PRICE: 99%,
yielding 2.19% to maturity

Principal and interest will be payable in lawful money of Canada; the principal at any agency of the Bank of Canada and the interest semi-annually, without charge, at any branch in Canada of any Chartered Bank.

Bonds may be registered as to principal or as to principal and interest.

CASH SUBSCRIPTIONS

Cash subscriptions for either or both maturities of the loan may be paid in full at the time of application at the issue price in each case *without* accrued interest. Bearer bonds with coupons will be available for prompt delivery. Cash subscriptions may also be made payable by instalments, plus accrued interest, as follows—
10% on application; 15% on 15th July 1941; 15% on 15th August 1941;
20% on 15th September 1941; 20% on 15th October 1941;
20.71% on the 3% bonds or 19.52% on the 2% bonds, on 15th November 1941.

The last payment on 15th November 1941, covers the final payment of principal, plus .71 of 1% in the case of the 3% bonds and .52 of 1% in the case of the 2% bonds representing accrued interest from 15th June 1941, to the due dates of the respective instalments.

CONVERSION SUBSCRIPTIONS

Holders of Dominion of Canada 5% National Service Loan Bonds due 15th November 1941, may, for the period during which the subscription lists are open, tender their bonds *with final coupon attached*, in lieu of cash, on subscriptions for a like or greater par value of bonds of one or both maturities of this loan. The surrender value of the National Service Loan 5% Bonds will be 102.15% of their par value, inclusive of accrued interest; the resulting adjustment to be paid in cash.

The Minister of Finance reserves the right to accept or to allot the whole or any part of the amount of this loan subscribed for cash for either or both maturities if total subscriptions are in excess of $600,000,000.

The proceeds of this loan will be used by the Government to finance expenditures for war purposes.

The lists will open on 2nd June 1941, and will close not later than 21st June 1941, with or without notice, at the discretion of the Minister of Finance.

SAFETY • INCOME • SALEABILITY

Victory Loan Advertisement, 1941

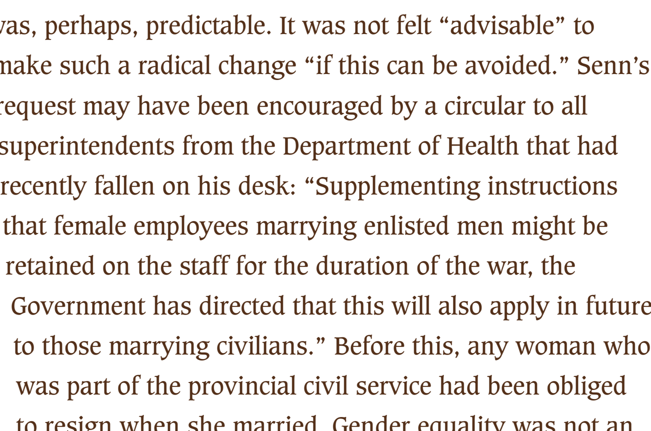
1939–1954

The Long Wait

Wartime Shortages

The coming of the war changed all expectations. The most obvious disappointment for the staff and patients at Neebing was the postponement of the completion of the Port Arthur hospital. But the demands of the war effort also interfered with recruitment of support staff for the first time, while the rising number of those in care began to put a real strain on resources. A facility originally designed for seventy-five beds was housing over a hundred patients before the war's end. Women patients in distress continued to be sent to Toronto, to the Lakeshore Hospital, for example. Some German prisoners-of-war, held in camps along the north shore of Lake Superior, such as at Neys Provincial Park, were even referred to the mental hospital, adding further to its numbers. According to Senn, that experience was by no means a happy one: "I recall 3 of them dying. Elderly men that never should have been sent to Canada, one a Luftwaffe officer who died in spite of all we could do – just wore himself out with his 'Heil Hitlers'."[1]

Desperate to meet the manpower shortage, Dr. Senn petitioned the Department in 1942 to replace a male driver, who had recently gone into the armed forces, "with a girl who, I think, would do the work." The response from Toronto was, perhaps, predictable. It was not felt "advisable" to make such a radical change "if this can be avoided." Senn's request may have been encouraged by a circular to all superintendents from the Department of Health that had recently fallen on his desk: "Supplementing instructions that female employees marrying enlisted men might be retained on the staff for the duration of the war, the Government has directed that this will also apply in future to those marrying civilians." Before this, any woman who was part of the provincial civil service had been obliged to resign when she married. Gender equality was not an issue in those days. All the more surprising, therefore, that Ruth Black should have been appointed from the rank of secretary to that of Acting Bursar, when H.V. Western left for the war, in 1940. She would remain on staff for over thirty-three years, rising to the position of Assistant Administrator, before her retirement in 1974.[2]



Dr. Senn, 1942

Senn's tenure came to an end in October, 1943. He did not even see the return, by the Department of Defence, of the administration building in Port Arthur to his own ministry. He went back to Toronto and the Department of Health to supervise the Ontario Hospital system, and thence to become Superintendent of the Ontario Hospital Hamilton. His had been a quite extraordinary period as Superintendent. The tasks before him and his team, when they arrived at the Scott Highway, had been almost as much physical as they were medical or administrative. They had watched, powerless to intervene, a traditional dogfight between the twin cities over the bone that was the future, modern Ontario Hospital. Whilst that struggle was played out, the Department of Health was evidently unwilling to invest sufficient funds to enable them to run an efficient hospital on the model of the facilities in the south. Time and again one reads, in his correspondence with the Ministry, that the conditions in Northwestern Ontario were fundamentally different from those in the south. If care of the patients was in any way lacking at Neebing, it was not for want of effort on the part of Dr. Senn and his small staff.

Mental Health Bulletin, May 1940

MENTAL HEALTH BULLETIN

The National Committee for Mental Hygiene (Canada)

Number 1 — May, 1940

Conserving Mental Health During The War Period

The importance of conserving mental health at this period in Canada's history was fully appreciated by Lord Tweedsmuir who, in September, 1939, expressed himself as follows:

"I think that the work of the National Committee was never more needed than in time of war, and it is, therefore, worthy of the support of every public spirited Canadian. It is most important to prevent men enlisting who have a precarious mental balance, and will soon become only liabilities . . . At all costs, we must prevent the existing services in Canadian mental institutions from breaking down."

Lord Tweedsmuir had in mind Canadian experiences during the World War, 1914-18. At that time, 12% of invalided men who were returned to Canada from overseas were afflicted with nervous and mental disabilities—disabilities that had tended to spread among the armed forces, involving serious curtailment of morale and efficiency. And Lord Tweedsmuir realized that, with the advance of scientific knowledge since 1918, much could be done to obviate a repetition of this unfortunate history. He believed that the National Committee in particular could make a significant contribution because of the experiences gained by this organization during the last world conflict and because of the intimate knowledge possessed by its staff concerning recent progress in mental hygiene.

An epitomization is presented in this Bulletin of the activities of the National Committee since the declaration of war in September, 1939. There are outlined, not only the war efforts of the organization, but also program that is designed to conserve mental health on the home front.

1939-1954 The Long Wait

Two Hospitals

John Senn was succeeded at the Ontario Hospital Fort William by Dr. Charles A. Cleland. Almost immediately, it became his primary responsibility to oversee the takeover of the Port Arthur building, which had been awaiting the occupancy of mental patients and staff since 1938. The detachment of the militia occupying it as a military hospital moved out of the premises in the spring of 1944. In anticipation of the move, Cleland made an assessment of the use that could be made of this "hospital". There were, he could see, severe limitations to it. The first, and most obvious, was that it had not been designed as a hospital, but as the first, non-medical, phase of the much larger institution which had been anticipated in 1939. As such, it was quite inadequate as a solution to the needs of mental patients in the Northwest. In a letter to Senn, soon after taking charge, he wrote, "the great need at the present time in this district is for the care of female patients…. It would be unwise to open a unit… until further accommodation can be provided." But if Cleland believed that such a prospect was imminent, even immediately after the war was over, he was going to be disappointed.[3]

Dr. Charles A. Cleland with unidentified public works employee, 1940

The Port Arthur site offered accommodations for no more than forty-five males. Half of that number, Cleland thought, could be maintained in "continuous bed care." Two nurses would be needed, and a minimum of five attendants. By the time the transfer of some of the patients from Neebing had been completed, these staff numbers were increasing. A maid, a mechanic, a clerk-stenographer and a cook were added, as well as new appointments to the attendant and nursing staff who continued at Neebing. Cleland, who preferred to remain at the original site, was now in effect Superintendent of two facilities, and the new premises became known officially as the Port Arthur Annex of the Ontario Hospital Fort William. Nobody doubted that this situation would soon change. After all, plans for a large facility had been laid in the 1930s and the land for it now awaited its construction.

Attendant Ernie Rollason, nursing supervisor Agnes Baillie and nurse Isobel Wilson, 1944

The first patients were moved from Fort William to Port Arthur on April 17, 1944. Ernie Rollason, who had become an attendant in 1939, was put in charge of the transfer, and remembers it proceeding without major mishap. Dr. Cleland himself reported to the Ministry his satisfaction with the transfer, later that month. But forty-five patients moved from one hospital, which was itself over-crowded, into a building that was never designed for psychiatric beds did not come close to a remedy for the situation in Northwestern Ontario at that time. A brand new mental institution had been promised in 1937. It did not seem much closer to reality in 1944.[4]

Times Journal, May 4, 1944

Civilian Use

Times Journal – May 4/44

Mayor Charles W. Cox announced today that the Ontario hospital building on Algoma street, Port Arthur, had been taken over from the military authorities and now was being operated as a civilian mental hospital.

There are 15 patients now accommodated in the building and this total will be increased to 45, which is the capacity of this unit. When the larger figure has been reached the hospital will have a staff of 12. Dr. C. A. Cleland is superintendent of the hospital.

Mayor Cox added that the hospital eventually will be expanded, with new buildings to be erected, so as to accommodate 1,000 mental patients, and will provide facilities for all of northwestern Ontario.

—oOo—

More Promises

In May, 1944 Mayor Charlie Cox was still announcing confidently his expectation that the new hospital was just around the corner and that it would have up to one thousand beds. A couple of weeks after that, the Minister of Health himself assured a meeting of the Port Arthur Progressive Conservative Association that a new unit for the Port Arthur site would be under construction "within the next year." Reginald Vivian, the Minister of Health, made his forecast in the light of an official assessment that the number of mentally ill people in the province was now 15,000, and rising. There was indeed a general perception in medical, psychiatric and government circles, even before the war, of an impending crisis in the delivery of mental health services across Canada. The Department of Health in Ontario was much concerned by these forecasts. In 1937, it had received the report of the Mental Health Survey Committee, which stated that the province's existing mental institutions were over-crowded and under-funded. During the course of its investigations, the committee had visited the Fort William Hospital and described it as "a framed structure which is not very suitable for a hospital service." More than that, its authors, Drs. Hamilton and Kempf, two psychiatrists, had estimated that the bed capacity of Ontario mental hospitals, which was established at the time at 9,920, was already oversubscribed by 30%. They painted a grim picture of the reality behind such numbers.

1939-1954 The Long Wait

Mental Hospital Promised Here

The Ontario Government is definitely under commitment to build a mental hospital in Port Arthur and will build it, Dr. R. P. Vivian, Ontario Minister of Health and Public Welfare, said at a luncheon today tendered him by the Port Arthur Progressive Conservative Association.

The minister said he hoped the first unit, apart from the administration building which is now on the site, will be under construction within the next year.

Most certainly, he declared, the hospital was required here since the increase of mentally ill patients in Ontario was rapid. There were now, he added, 15,000 such people in the province.

He intimated the mental hospital here would have no less than 400 beds. Dr. Vivian told those at the luncheon, including several members of the women's Progressive Conservative Association, that this section of Ontario, or Northern Ontario as he was pleased to call it, had been sadly neglected in the past. Steps were being taken to remedy that deplorable fact, he said, and in future the Government would pay more attention to the problems and needs of this area.

The minister reviewed legislation brought up at the recent session of the Legislature and said the opposition of the Co-operative Commonwealth Federation members was the weakest of any opposition the Ontario house had had in many years.

He ventured the opinion that on its record of the recent session the Drew Government could go to the people today in a provincial election and be returned with a clear majority.

He said a federal election in Canada shortly was possible. He expected Premier King to return from England ready to take advantage of an imagined wave of public approval and so manipulate things that he would call an election on the assumption that he could win back Parliament for the Liberal Party.

Port Arthur News-Chronicle, May 18, 1944

> The patients must spend their time in turmoil, so thrown together that peace is impossible, when an able-bodied patient must spend months in bed because of the danger of combat if he is up in narrow quarters, when there is not space for eating together because the beds have supplanted all other accommodations, then it must be time for radical action in the field of construction.[5]

Reports such as these, which emphasized not only the present crisis of space, but also the likelihood of increasing demand from people seeking mental health care, had spurred the Ontario government into the projected building program of the late 1930s. Port Arthur had been one of the principal beneficiaries, or so it had seemed at the time. A new hospital at St. Thomas in Southern Ontario, for example, had been started before the war, and by 1939 had already admitted 1,054 patients. St. Thomas was in the riding of the Premier, Mitch Hepburn, which went to illustrate the other, essentially political, dimension to such massive building projects. They spelled jobs and tax revenues to the communities in which they were constructed.

In Port Arthur, Charlie Cox's sympathy for the underdog was legendary, if somewhat exaggerated, but he had used it to good effect in his advocacy for the Port Arthur site. He was surely well aware of the political kudos attached to such a potential economic generator as an institution that would house over 1,000 patients and employ between six and seven hundred staff. So, with a government apparently committed to a program of institutional construction, and the new hospital in Port Arthur already promised, and indeed begun, there would have seemed to be no obstacle in the way of its emergence into reality immediately after the end of the war.[6]

ONTARIO

PARLIAMENT BUILDINGS, TORONTO

TO THE SUPERINTENDENT:

This day is a symbol. It is not the end of the war, but it *is* the end of the German war. As such, it is a symbol of gigantic achievement.

To each of us personally, it represents a goal long dreamed of--an achievement long and bitterly fought for. It is natural and proper that our first thoughts should be personal; that we should think first of our own sons and daughters, husbands, relatives, and friends; and that we should remember with a deep sense of pride the courage, the endurance, and the sacrifice which has made this day possible. Each of us has had a personal stake in a vast human enterprise. We honour those who will not return. We honour those who have returned, or will return, bearing scars of war. We honour those who will return only when their full duty is done--when the task has been completed.

But this day is more than a personal symbol. To each of us, as Canadians, it represents a tremendous national achievement. In this world struggle, Canada has, in a sense, grown up. She has found her strength. She has mightily matured. With this growth come heavy responsibilities and a great new challenge. Having developed and exerted her strength in war, Canada must shortly learn how to use that strength effectively in peace. Having fought so well to defend her right to a world worth living in, she must now begin to play her full part in building and preserving that sort of world.

And so, while this day is a symbol of great achievement in the past, it is also a symbol of the tremendous challenge in the future. If we want healthy people in a healthy Canada, if we want a healthy Canada in a healthy world, then we must work for it. The task ahead of us in peace is no less difficult than the one we have achieved in war. It will take much the same qualities we have had to use in war. It is one that we may now undertake with fresh confidence because of the strength we have found in war.

R. P. Vivian M.D.

Minister of Health.

TORONTO, V-E Day, 1945.

Letter from the Minister of Health announcing V-E Day, 1945

1939-1954 The Long Wait

Two Critical Reports

An inspection of the two sites at the Lakehead, made by Dr. H.D. Mitchell for the Department of Health in the mid-summer of 1945, seemed well-enough satisfied with the general running of the Fort William Hospital. On the other hand, it did note the continuing problems. The farm, Mitchell wrote, was not operating as efficiently as it might, there was a lack of fresh in-season vegetables in the daily diet and the problems of water supply continued, which meant that even when both the water tower and the water pump were operating, there would be inadequate fire protection in an emergency. He thought there was little opportunity for "organized recreational activity" in the winter months, which was "regrettable." He noted also that Dr.Cleland was

> the only physician and is responsible for the care and treatment of all patients as well as his administrative duties. Besides his hospital duties which include electro-shock therapy he is frequently called in consultation by practising physicians and sees a fair number of prisoners at the county jail in regard to their mental status.

The only medical staff available to him at that time were three registered nurses and one nurse attendant.[7]

Grand Jury report, September 27, 1948

OFFICE OF
LOCAL REGISTRAR, S.C.O.
DISTRICT COURT CLERK
AND
SURROGATE REGISTRAR
DISTRICT OF THUNDER BAY

ONTARIO

File

PORT ARTHUR, ONTARIO September 27, 1948.

Superintendent Mental Institution,
FORT WILLIAM, Ontario.

Dear Sir:

Pursuant to direction of His Lordship The Honourable Mr. Justice E.R.E. Chevrier, I am enclosing, herewith, extract taken from the Grand Jury Presentment submitted to His Lordship at the Jury Assize of the Supreme Court of Ontario, on Friday, September 10, A.D., 1948.

Yours truly,

Local Registrar, S.C.O.

JCC/CH
ENCLS.

A year and a half later, another body inspecting the two units was even less satisfied with what it saw. Now, two years after the ministerial promise of new construction, and with no detectable movement on that front, a local grand jury, charged with the authority to inspect fourteen public buildings in the two cities, found many of them unsatisfactory, mainly because of overcrowding.

LAKEHEAD CITIES
The News Chronicle
PORT ARTHUR, ONTARIO, MONDAY EVENING, DECEMBER 2, 1946
$6,000,000 FOR HEALTH HERE
Mental Hospital Will Be Completed, McKellar Helped
Gov't Urged to Distribute Milk
Jap Deportation Order Upheld By Privy Council
Judge At Poultry Show Here
Milk Commission Starts Sessions Here
Garage, Equipment Burned At Hurkett With $28,000 Loss

Headline from The News Chronicle, December 2, 1946

According to a report in The Fort William Times-Journal, the jury did not think the Fort William structure adequate for the number of patients in its care, and made a similar judgement on the Port Arthur site. Its strong recommendation for the "immediate completion" of the new hospital was heartily endorsed by The News-Chronicle. Its comment reflected the growing impatience with the lack of movement on the construction of the promised facility.

> It is nine years since the corner stone of a new institution was laid, but that institution has yet to come into being. The war, of course, delayed it, but the need has grown meanwhile. The grand jury which brought the matter to attention again this week may have done something to hurry it along. It is to be hoped so.[8]

Less than three weeks later, in December, 1946 came the government response, an answer to all its critics, it seemed. "$6,000,000 FOR HEALTH HERE", proclaimed The News-Chronicle headline: "Mental Hospital will be completed." The Minister of Health, Russell Kelley, had come to the city to make the announcement that, not only would a 700-bed mental hospital be built in Port Arthur, but also a government building and a technical institute, in addition to financial assistance for both the Fort William Sanatorium and McKellar Hospital. He stressed the need for a large institution for the mentally ill, on the grounds that the numbers of those needing care were on the rise, and that "about 400 women from Northern and Northwestern Ontario are in hospital elsewhere in Ontario." Kelley suggested that the project might begin in 1947, but added that "a shortage of building materials and also a dearth of nurses and doctors had governed such schemes in the past and would govern them in the future."[9]

1939-1954 The Long Wait

Politics Again?

But nothing happened. What was going on? Speculation is perhaps called for here. The issue of the location of the proposed hospital had always been enmeshed in politics, and specifically the politics of both twin-city rivalry and party affiliations at the Lakehead. Cox, who had defected to the Liberals to seize the provincial seat from the Conservatives, had apparently won the mental hospital for the hill city in 1937. But in 1943 the Progressive Conservatives came back to power in Ontario as a minority government. To compound the situation further, in both Port Arthur and Fort William, candidates of the fledgling left-wing CCF (the predecessor of the New Democratic Party) won the seats. Cox was out, but the Conservatives were not in. When the next election, in 1945, gave the Tories a majority, Fred Robinson, for the CCF, retained his seat in Port Arthur. Cox continued as Mayor of the city through all these changes. In other words, and despite Kelley's promises, there were some telling non-medical reasons why the resurgent Conservatives might be unwilling to reward those who were their political enemies. Perhaps the people of Port Arthur needed to be taught a lesson for their political infidelity.

So the long delay continued, through 1947 and 1948, with no clear indication from Queen's Park that an end was in sight. The hospital at Neebing and its satellite unit in Port Arthur, struggled on, offering care to only a fraction of those male patients from Northwestern Ontario who were in need, and none at all to women. Even a scathing denunciation of the conditions of care at both Neebing and Port Arthur from another grand jury seemed to fall on deaf ears down south. In September, 1948 this body reported the discovery of eighty-five "inmates" (a telling choice of word) at Fort William where "in our estimation a maximum of thirty patients at most is all that should be accommodated." The grand jury stated:

> It would require considerable expenditure to rehabilitate this structure but due to its age and being totally unsuited for its present purpose, we consider it a wanton waste of public funds to do more than spend sufficient to keep it operating until replaced by one in which female patients can also be treated. Why this condition has been permitted to exist until now is beyond our comprehension.[10]

The jury "strongly condemn[ed]" all those responsible for this state of affairs. In response, The News-Chronicle deplored the eleven-year delay since the first sod for the new hospital had been turned.

> A great war has intervened but the war did not occupy half of those 11 years. Yet today all that exists of the proposed big institution, planned because it was much needed, is what is known as the administration building. It has served a small purpose… but it is not in any sense a fulfillment of the plans of more than a decade ago.[11]

Hubert Badanai, Mayor of Fort William, circa 1950's

Fred Robinson, Mayor of Port Arthur, circa 1950's

Instead of a rejoinder from the provincial government, there came, from Fort William a last-ditch attempt to frustrate Port Arthur's grand project. Bill Spicer, President of the Fort William Chamber of Commerce, pointed out that some psychiatric hospitals in Southern Ontario were being re-located outside areas of urban growth. He therefore suggested that the Port Arthur site was unsuitable, due to "growth of the city in that direction and the development of Boulevard Lake." On the other hand, he claimed, the water problems at Neebing could be overcome, and the site itself was ideal, because it was so far out of town. Then he came to the heart of the matter.

> We feel, considering the fact that the original site was taken from the Fort William constituency through political moves, and due to the fact that Port Arthur has received more than an ample share of government capital expenditures, it would be very unfair on the part of the Provincial Government to take action against retaining the institution in its present location or within the Fort William constituency.[12]

The battle was on again, and both cities deployed their heavy artillery. A flurry of exchanges ensued between the two city councils. Fred Robinson, now Mayor of Port Arthur, suggested that there had always been an agreement that the hill city would get the mental hospital and Fort William the sanatorium; Mayor Badanai of Fort William denied the allegation. A Fort

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Staff residence at Neebing site, late 1940's

William alderman charged that the only reason Port Arthur got the prize was "strictly a political move of one individual." The city on the south side passed a resolution urging the Minister to consider seriously the claims of Neebing; the city to the north, not surprisingly, declined to endorse such a motion. Alderman Anten in Port Arthur stated that to renovate the Neebing site

"would be like building a mansion around a garage."[13]

Meanwhile, Back on the Highway

A guy was here [Port Arthur] from the old mental hospital ,Fort William. He was a washer-man. He remembered eighty beds in one room. Full moon, there was about three or four staff on all night. They'd [patients] start jumping on the beds. Full moon, you had to watch. He said, one time a couple of big Finlanders came up to him, they said "we're leaving here, give us the keys." He said "I gave them the keys and they went! What are y'going to do?"

Cliff Eyjolfsson, Manager of the Laundry at Port Arthur

While the politics of the Port Arthur site were reprised one more time, the people most directly affected by the issue continued their daily routines. By this time conditions of work for the staff were definitely improving. The eight-hour day had been introduced in the provincial civil service at the end of the war, which necessitated a significant increase in staff numbers. Opening the Port Arthur building to patients certainly relieved some of the pressures on the Neebing site, which never again had to look after the immediate post-war high of one hundred and seven patients.

The situation of the patients themselves was not greatly improved, however. Treatments had not changed significantly from the pre-war era, and would not change until the development of a new regimen of drugs, and their introduction, in the 1950s. Electro-shock continued to be the standard therapy for the most disturbed patients, and it was used extensively across the whole Ontario Hospital system. Dr Cleland would make rounds to the medical hospitals at the Lakehead three times a week, carrying a portable ECT machine with him. Most of those admitted to the hospital were diagnosed as suffering from schizophrenia, "mania" or depression. According to Dr. Morley Smith, Medical Director of the Lakehead Psychiatric Hospital in 1979, in these early days "personality disorders were not prominent in the diagnostic groups admitted." But, he added, fatalities occurred sometimes "simply because patients exhausted themselves without effective treatment." Nick Ochanek, who became an attendant at Fort William in 1946, recalls that patients were overseen in three shifts through the day with three or four attendants on each shift. They were responsible for housekeeping, bed-making, clothing and bathing the patients and charting their daily progress. Apart from ECT, continuous baths were still in use, as were "cold packs." This treatment involved wrapping a patient in wet sheets and then adding a further swaddling of blankets to prevent excessive shivering. Justified at the time as a method similar to that of calming an agitated child, it nonetheless can hardly be described as curative. Ochanek remembered the limited drug therapies that were available before the 1950s:

Thelma Charlton and Ruth Black in front of staff residence, early 1950's

> For disturbed patients sedatives were used such as Pedraldahyde [he meant Paraldehyde]… and morphine. We had two large wards but no single rooms, therefore one patient could disturb the whole ward. We were all looking forward when a new hospital would be built with better facilities, but in the meantime we had to do with what we had.[14]

Thelma Charlton, a nurse, said that the staff and patients were very close: "we were like one large family." Patients, however, were looked upon with a good deal of discomfort by the general public when they were escorted beyond the bounds of the hospital. Ernie Rollason recalled: "City residents would become angered the moment they saw a patient outside the hospital, and they would telephone the hospital demanding 'something be done.' They sometimes harassed the patients. It was easier, by far, for the patient to stay on the grounds."[15]

And so, for the most part, they did. But the grounds were huge, and the opportunity for "occupational therapy" in the shape of work on the farm was great and probably quite fulfilling for most patients. In the late 1940s, some of the water problems were partially (though never completely) overcome by the drilling of a new well, and eventually the water tower was removed. But if anything convinced the authorities that the Neebing site was not adaptable to a 1,000-bed institution, it remained the lack of an adequate, safe and consistent supply of water. The south end site remained the senior facility, and the Superintendents worked from there until the grand opening of the Ontario Hospital in Port Arthur, when that day finally arrived.

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Dr. Charles Cleland, 1949

Dr. Charles Cleland moved on in September 1949. He became Superintendent of the Ontario Hospital St. Thomas. His task had been a difficult one, trying to simultaneously run two sites separated by over twenty-five kilometres. Nothing much in the way of a document trail has been left behind by him, and few have recalled in any detail the kind of man he was. Dr Ruth Kajander, one of the first psychiatrists to set up a private practice in Port Arthur, remembers him thus:

> [He] was a very socially engaged person. He was the first psychiatrist who ever became president of the Thunder Bay Medical Society, and... he was the only medical superintendent who completely integrated with the medical community.... Cleland played bridge, knew everyone, a very genial and, at the same time, a highly capable person.

Those photographs that exist portray him in raincoat, trilby, pipe and moustache, the very picture of an English gentleman farmer.[16]

Department of Health memo, October 27, 1949

DEPARTMENT OF HEALTH

File No.

Date TORONTO, Oct. 27, 1949.

Memorandum to Superintendent, Ontario Hospital,
FORT WILLIAM, Ont.

From
R. C. Montgomery, M.B.
Director, Hospitals Division.

Re. Landscaping - Ontario Hospital, Port Arthur

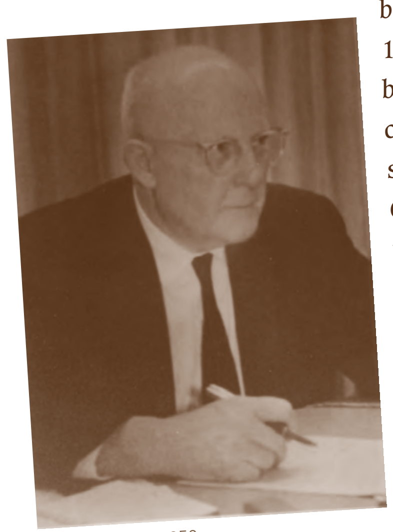
Further to your letter of September 7th regarding landscaping the property of the Port Arthur hospital, the Honourable Mr. Kelley wrote to the Minister of Reform Institutions regarding this matter, and has received a letter in reply under date of October 19th. This states:

"Just yesterday I signed an application to the Lieutenant-Governor in Council for permission to use prison labour in connection with the removal of gravel and shale from the Ontario Hospital property, and I am sure this same Order will permit the use of prisoners for landscaping purposes."

In due time I believe the Sheriff will be notified when the Order-in-Council is passed, and you can expect that they will assist you with the landscaping.

Promise Finally Becomes Reality

Cleland's replacement was Dr. J.R. Howitt. It would be his honour to become the first Superintendent of the Ontario Hospital Port Arthur in its new buildings on the site which had been designated for it since 1937. But it would be nearly five years after his appointment before that day finally arrived. However, the project was definitely online by the time he took over. The crucial decision was made some time in 1949. It may have been as early as February, when George Wardrope, a prominent Conservative, ex-alderman and unsuccessful candidate for Port Arthur in the election of 1945, announced that he had been informed by the Minister of Health that "definite steps will be taken on the mental hospital as soon as the present session of the legislature is over." In October the Premier, Leslie Frost, announced plans for a significant increase in the number of beds for psychiatric patients across the province. In the same month, Howitt was informed by R.C. Montgomery, Director of the Hospitals Division of the Department of Health, that the Ministry would have no objection to the use of prison labour from the Port Arthur jail, just down the road, to landscape the Algoma St. site. On July 2, 1950 contracts for the construction of three pavilions, similar in size, dimension and capacity to those described by the local newspaper in 1939, were awarded. And so construction finally began - just as the Korean War broke out![17]



Dr. J. R. Howitt, 1950

Everything came to a halt, while steel, cement and other building materials were re-allocated to the new war effort. It was only in September, 1951 that Howitt could actually report to his fellow Superintendents that "three buildings are going up" and that the chimney on the new power house was standing tall. A 466-bed unit would be open by Christmas 1952, he forecast. Like all previous prophecies, this, too, would prove to be over-optimistic, but the project was heading towards completion at last.[18]

In an ironic twist to this tale of inter-city rivalry, it was now discovered that there had, indeed, always been a question of legality hanging over the award of the hospital to the city of Port Arthur. That carefully-phrased disclaimer

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in the original resolution of the Port Arthur council, when it granted the land at Algoma St. to the province, had been put there for a reason. In fact, and as early as 1942, the solicitor to the Department of Public Works had raised the issue, which was a complex one, whether the city had the right to have transferred the property on Algoma St. to the province. When, in 1952, the city desired to negotiate for a further acquisition of land for the hospital, and one of the property owners resisted, it became clear that a legal battle might ensue out of which, in the words of the city's solicitor,

"the whole transaction may be called into question."

One can only imagine the state of consternation in the corridors of the Port Arthur city administration when this was discovered. In order to avoid the prospect of deep embarrassment to the city and the government of Ontario, it was finally decided that the original grant of land and subsequent actions of the Port Arthur council would be validated by an Act of the Legislature. No doubt to the relief of many in the know, the Ontario Hospital Port Arthur Act was passed in 1954, just in time for the official opening.[19]

In the meantime, extensions to the existing plans had been approved. New contracts were awarded in 1952, providing for two additional pavilions for the patients and a laundry building. All too predictably, a subsequent series of anticipated dates for the opening of the new facility were frustrated by the short building season in the Northwest and then by labour disputes on the site. Dr. Howitt himself projected the opening for the end of April 1953, before settling finally for a correct forecast only one month before the event actually took place. It would be May 26, 1954. There would be 460 beds now, in addition to the seventy-five remaining at Fort William. But that was only the beginning. By the end of the year, he announced to his fellow Superintendents, there would be accommodations for 800 patients.[20]

Arial Photo of original Port Arthur Site, May 26, 1954

The Grand Opening

With great fanfare, the Ministers of Health and of Public Works together led the ceremonies that marked the official opening of the Ontario Hospital Port Arthur on that Wednesday in May. An estimated crowd of 8,000 attended the event. Dignitaries and representatives from the region came by special invitation, some two hundred of them. Charlie Cox, although in attendance, was not officially invited, nor indeed, was any acknowledgement granted to him for his efforts in securing the hospital for his city. He would die of a heart attack a couple of years later, a janitor looking after the furnace of a downtown commercial block, which he had once, in his heyday, owned.[21]

"antiquated idea that there is some form of shame attached to mental illness."

The day before the opening, *The News-Chronicle*, in its leading editorial, praised the establishment of the mental hospital, while regretting its necessity. It noted that "its primary and sole purpose is to minister to the sick", but nevertheless made much of the economic benefits that an institution of such a size would bring, "confirming this as the administrative centre, the Northwestern capital of Ontario." By that, of course, the newspaper meant the city of Port Arthur, not Fort William. It went on to attest that the hospital marked an end to the "antiquated idea that there is some form of shame attached to mental illness."

> One of the new conceptions is to provide patients with conveniences, comforts and home-like conditions. The one-time shuffle between iron cots and wooden benches has been replaced by living in modern rooms, lounges with chairs, radios, magazines, flowering plants and other comforts of home.

The anticipated final size of the hospital was now predicted to be over 1200 beds, with five pavilions at the back and a central structure that would link

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the administration building to them. A wide variety of service functions would be set up for what was envisaged to be an almost self-supporting facility. At the rear of the pavilions would be laid down a large garden of vegetables, although no livestock would be retained on the new site. The power house would produce more than enough energy for running the hospital. The laundry would be huge. The staff numbers were expected to rise to at least 400, as the usual ratio of staff to patients in the Ontario system was one to three. It would be a village, a community. It was a gleaming modern building of brick, steel, tiles and cement.[22]

It had been exactly twenty years in the planning, since that date in 1934 when the Order-in-Council of the Ontario government adopted the goal of a mental hospital for Port Arthur. But, for all the optimism of the newspaper editorials, for all the declarations that this was the herald of a new age in the treatment of the mentally ill in Ontario, the fact was that the institution itself – the buildings and the philosophy of custodial care that was enshrined within them – was of a kind that was about to become outdated.

Grand Opening of Ontario Hospital Port Arthur, May 26, 1954

Member of Legislative Assembly, George Wardrope, Minister of Public Works, W. Griesinger, and Minister of Health, Dr. M. Phillips, Grand Opening Ceremony, May 26, 1954

Department of Health

File No.

Date May 3rd, 1954.

Memorandum to

Mr. G.N. Williams,
Deputy Minister of Public Works.

From

R.C. Montgomery, M.B.,
Director, Mental Health Division.

COPY FOR ONTARIO HOSPITAL AT Fort William

Re Opening Ceremonies – Ontario Hospital, Port Arthur.

I am attaching herewith a copy of Dr. Howitt's memo regarding the above.

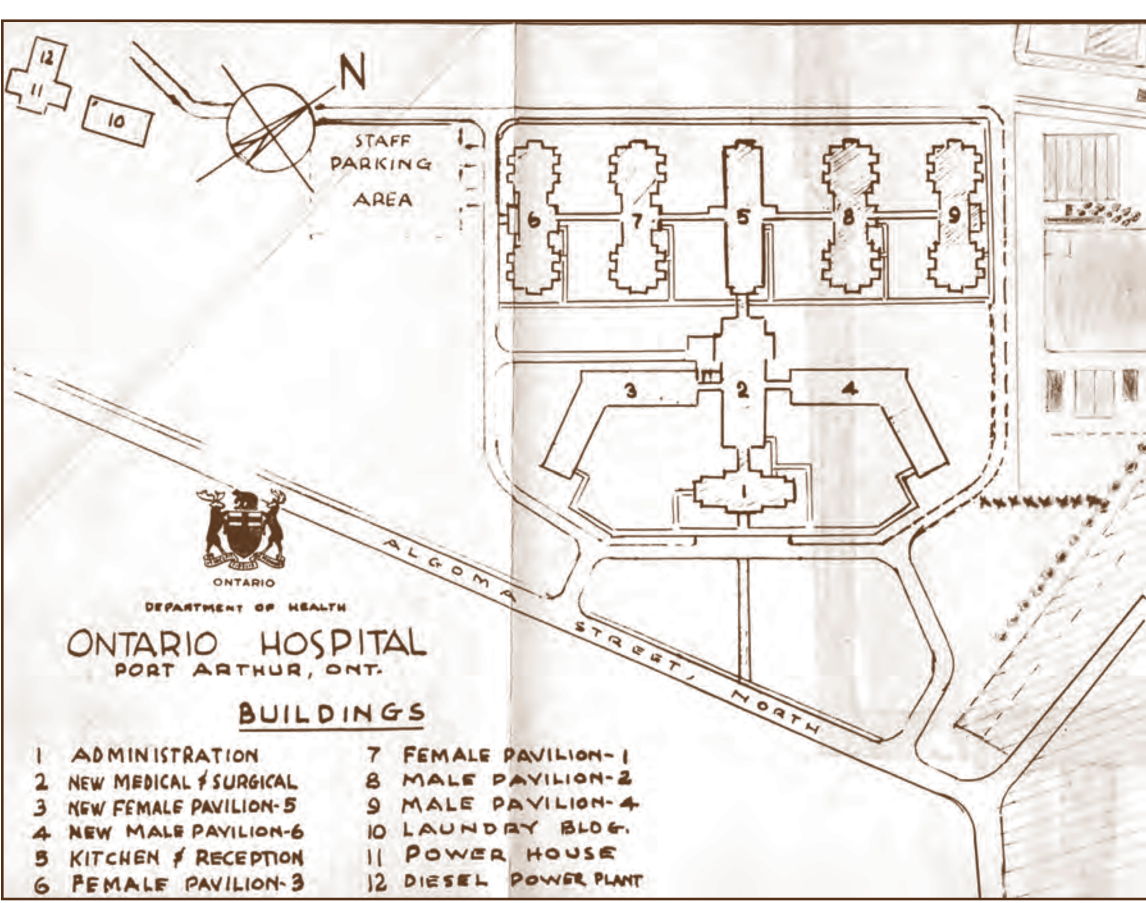
The opening of the Port Arthur hospital is slated for May 26th. Could arrangements be made to have the buildings all cleaned and in good order for that date as there will be a large attendance at the official opening and visitors will be shown through all the buildings which are ready for occupancy.

R.C. Montgomery

RCM:MC
Att:

Form 86.

Department of Health memo, May 3, 1954



Drawing of Ontario Hospital Port Arthur site

1954-1969

Up & Running

First Impressions

In the summer of 1954, Carolyn Forbes got a job as a nurse's aide at the new hospital. She was fifteen years of age, a schoolgirl with no nursing experience. "At fifteen, I looked much older than my age, not only because I was five foot eight inches in height, but also because I had an air of confidence that made me appear much older. "Carolyn's recollections of the first days of the institution provide a vivid picture of how psychiatric hospitals were run as little as fifty years ago.

I was pregnant and a few people were concerned about a pregnant woman on the male ward, but the men, mentally disturbed or not, they treated me like a queen. Those men were perfect gentlemen.

Vel Roininen

Nurse's aides were the equivalent of the male attendants who looked after the patients at the all-male facility at Neebing. Now, at last, women would be coming back to the Lakehead from institutions such as Lakeshore or Whitby in the south. At Algoma St., almost from the first day of admissions, there would be roughly equal numbers of male and female patients, and the nurse's aides would be an integral part of the program of custodial care that was so characteristic of mental hospitals across the country. When those who were being brought back "home" arrived, they would be segregated by sex, and the care of each would be entrusted to equally-segregated male and female staff. The only time a nurse would appear in a male pavilion would be when it was necessary to administer injections, the prerogative of the registered nurses. A male attendant would come onto a female ward only when there was a dangerous situation arising between staff and patients, which could happen quite often.

The fact that a young schoolgirl could get a summer job in a mental hospital, with virtually no training and no questions asked, speaks more to a different age than it does to a lack of care in the appointment of staff (although it remains astonishing). As Forbes points out, in those days,

> no one had to provide documents of any kind to get a job. There was no unemployment insurance, no workers' safety and insurance board, no reason to have all those documents on file. A person applied for a job… showed up to be checked out, and then put to work…. The society of the mid-20th century, and in this case the 1950s, did not operate on documents, records … or other verifications. You just gave your word.[1]

Times Journal, May 28, 1954

Patients Moved Into New Ontario Hospital

About 100 patients will be moved into the new pavilion at the Ontario Hospital, Port Arthur, this week, said Dr. J. R. Howitt, superintendent, last evening. Seventy were moved from the administration building into new quarters yesterday and 30 are to be brought over from the Fort William mental hospital this week. Sixty more are to be moved from Fort William to the new hospital in the near future.

"As we have the accommodation and staff to take care of them," said Dr. Howitt, "262 men and 286 women residents of this area who are now patients in New Toronto institutions will be brought to Port Arthur."

Dr. George Ferrier, of Toronto, will be assistant to Dr. Howitt and ultimately the medical staff will number about six, said Dr. Howitt.

Other key personnel include:

Miss Isobel Wilson, assistant supervisor of nurses who will be in charge of the nurses and ward aids until a supervisor is appointed.

Andrew Currie, chief attendant of male patients and Ernest Rollison, assistant chief.

Gilman Holditch, chef, with an initial cooking staff of six.

M. McGuire, chief engineer in charge of the power plant.

A dietitian is to be appointed in the near future.

When the 1,200-bed institution is completed a staff of about 400 will be required Dr. Howitt said.

Parking lot at Ontario Hospital Port Arthur, May 1960

Carolyn started work at the hospital before the first contingent of women from the south arrived. But the transfer of some thirty patients from the Neebing site was effected immediately. Together with the patients brought into the new pavilions from the administration block, they formed the first group of residents of the Ontario Hospital Port Arthur, as it was now called (some locals referred to it as the "Boulevard Hilton"). By early June, Dr. Howitt could record that only thirty-four patients remained behind at Neebing, but that the hospital on the Scott Highway would remain in operation for some time to come. Indeed it would not be until March 1955 that the last patient would be transferred from Neebing and those buildings returned to the Department of Reforms, to re-incarnate themselves as a prison farm for young offenders.[2]

Before large numbers of patients began to be repatriated from Southern Ontario, Aides such as Forbes, alongside the male Attendants and even the Registered Nurses, were all working in the hospital, preparing it for an influx of residents that was expected to reach well over four hundred by the end of the year. The wards had to be cleaned in the wake of the construction teams, and the furniture installed and prepared. All the furnishings were designed to be too heavy to lift, in order to avoid the danger of them being used, in frustration or in anger, by patients when they were particularly disturbed. As Forbes remembers it, there was a strange and ghostly atmosphere to those pavilions in the early days of summer, before they were filled with life.

> Walking through the vacant wards was a peculiar experience. One almost expected to turn a corner and meet patients. I was assigned to clean one of the wards, and was alone in the large and empty ward waiting to be occupied. The sun shone through the dusty windows which I had been assigned to clean, creating long, dust-filled rays of sunshine that lit up the silent and somewhat eerie ward.

It would not remain silent for long.

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Busloads by Night

Carolyn Forbes was working on the night shift when the first busload of psychiatric patients from the south arrived. She could look down from the second storey of one of the pavilions as the passengers checked into the reception area of the hospital, which was in the centre building, behind the administration block.

> Moving very slowly, people disembarked, walking as if dazed, stumbling in the dark, having no idea where they were or why they were there. In single file, they slowly stumbled into the reception area where they were processed.... Every few nights, more buses arrived, more tired and confused patients straggled off the buses to be accounted for, then taken to their designated ward and put to bed.[3]

It would have been no accident that they all came by night. The Ontario Hospital Port Arthur already had a stigma attached to it, as did anybody with a mental illness or, even more frighteningly to some, a mental disability. Such people may have been coming home, and the care that they were to be given may have been the best that was on offer at the time, but it would not be unfair to suggest that it was assumed they would remain largely out of sight, out of mind. That was the way it had been since provincial governments began to take responsibility for the care of the mentally ill and "mentally retarded" in Canadian society.

Front of Hospital Port Arthur, 1945

"Everything was Lock and Keyed"

When the hospital opened its doors, three of the five projected pavilions were already in operation and two more were under construction. By the end of 1955, that part of the building program was complete and, in addition to the main structure, a power house and laundry had been built at the south end of the grounds. A trades building was completed by 1958 and eventually, in 1960, contracts were awarded for a centre block attaching the administration to the back pavilions which would include a surgical unit, plus two additional wings which would attach to that and run parallel to, and then reach round, the administration building itself.

By the time these extensions were standing, the "rated bed capacity" of the Ontario Hospital Port Arthur was 1100. Despite occasional suggestions that it might grow even larger (and such forecasts usually came from the Conservative party's most-favoured spokesman and member of the legislature for Port Arthur, George Wardrope), the hospital had reached its limit. The in-patient population would peak in 1966 at an average for that year of 970. At any time during that year it may well have topped 1,000 and more. A further small number of patients were "in residence" at the hospital in private rooms by that time, ostensibly in preparation for return into the community. This meant that they were counted as out-patients, so slightly distorting the official bed-count.[4]

Carole Faulkner came to the hospital in 1955 as a young Registered Nurse, and her memories of those early years are similar to those of Carolyn Forbes. She remembers that there was little or no "orientation" to her duties. She was first placed on the ten-bed reception ward, then within the month sent to the "infirmary" which was a dormitory for the bed-ridden and elderly. Alongside four nurse's aides she found herself responsible on each shift for forty-five patients. She "worked like a dog."

All the pavilions were organized on the same pattern. On each of the two stories of a pavilion would be two units, divided into four "dorms" with a total of forty-five patients. This would make for a rated bed capacity, when the first phase of building was complete, of 720. There were a few single rooms on each floor for patients whose condition was regarded as so serious that they had to be segregated from the rest. These were sometimes called "seclusion rooms". Thus, in December 1955, Dr. Howitt could report to Toronto that Port Arthur had a rated bed capacity of 740, and that at that time there were 318 women and 343 men on the units.[5]

A unit consisted of a nursing station at one end, four dormitories separated

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Connection between administration buildings to pavilions under construction, early 1960's

down the centre by a corridor (with open panels that allowed for continuous observation), and a recreation room at the far end. Meals were served in each pavilion in a cafeteria located in the basement. "Everything was lock and keyed", recalls Flo Varrin-Campbell, who started work at the hospital in 1954 as a Registered Nurse. Carolyn Forbes remembers "two locked doors before the stairway landing was reached and four locked doors between the staff of each unit on the particular ward." Custodial care could hardly go further than that. A decade after the hospital opened, Pauline Vranesich, a Registered Nurse, recalls no pictures on the walls, no "nice drapes", it was "quite barren."

When a patient was admitted to the hospital, says Varrin-Campbell, "everything would be taken from them", including all jewelry: "you'd even take their dentures." Wedding rings would be cut off, if they proved too tight to remove conventionally. Such personal belongings would be tagged and stored away for safe-keeping. Nurse's aides and attendants were responsible for washing, dressing and the general personal care of the patients. The more disabled the person the more personal the task. Patients were accompanied to the canteens and similarly escorted on their return to their units. Looking back some fifty years, Vel Roininen, who began as a Registered Nurse at the hospital in 1958, feels some discomfort at the regimentation of it all.

A patient would be admitted. EVERYTHING would be taken from them. You'd even take their dentures.

Flo Varrin-Campbell

> Some of our procedures… the way we used to line patients up for meds, the way we lined them up to go for showers. Shower days were specified, you know, Tuesdays and Thursdays, and it was [only] gradually over the years that we started becoming a little more humane in our methods.

In the summer months, the less seriously-ill patients would be encouraged to go outside into the grounds and, until it was abandoned in the seventies, many would work on the vegetable garden which was located beyond the pavilions. All such activities took place under close supervision, and out of sight of the general public. There was a constant (and well-justified) fear that patients would try to escape. Once inside the institution, on the other hand, there was very little to keep a patient occupied. Most of the time, Forbes says,

Vegetable garden at Hospital Port Arthur, early 1960's

> the ladies would just hang about the ward. They were discouraged from lying on their beds, and had to be up and dressed. And dressed meant just that. They wore dresses, … stockings and shoes and looked very nice each day, with their hair freshly combed, some with barettes. There was virtually no interaction among the ladies themselves as they walked up and down the halls, or stood against a wall, or sat in the lounge room at the end of the unit.

Many of these women had been in institutions in the south for most of their adult lives. Many of them were elderly. They had been in the system so long that they had become, in effect, "institutionalized". There was little opportunity in the early years for occupational therapy or for programs of rehabilitation, even for those who were not mentally disabled. And the distinction between the mentally ill and the mentally disabled patient was by no means made clear, either in the units or in the therapies adopted in most Ontario mental hospitals, well into the 1960s.

The "Drug Revolution" Begins

Drs. Senn and Cleland had been the only psychiatrists at the Neebing hospital. Dr. Howitt was more fortunate. His Assistant Superintendent, Dr. George Ferrier, was also a psychiatrist. They were joined, in 1957, by another colleague, Dr. Ruth Kajander. She was a pioneer in the use of drug therapy for disturbed patients. In 1953, she had begun to use the drug Largactil, or Chlorpromazine, as a medication for patients with severe mental disorders, when she was on the staff of the Ontario Hospital London (for appropriate recognition of this work she would have to wait until 1999.) The fact that she was a woman in the psychiatric field would have made her remarkable in the first place, let alone that she was originally from Germany, a refugee from Nazism and a post-war immigrant to Canada. Later, at the Ontario Hospital (Toronto), which had a poor reputation, she had not been happy. So she had

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taken the opportunity to come to Port Arthur to set up a mental health clinic, which at first operated out of the psychiatric hospital. [6]

Eventually, in 1957, Kajander would go into private practice, but not before she had the opportunity to observe the regimen at Port Arthur, and to note that, in general, the treatment of patients there, as in the rest of Ontario, was not as humane as she had observed it in her native Germany. Continuous baths were still in use, as were cold packs. "Isolation/seclusion" of patients was a not-unusual form of response to problems on the ward, nor indeed for those who were believed to be at risk to themselves at any time. Electro-shock was used as the most common method of treatment and for calming patients.

We sometimes had to use this ancient old treatment, the wet-packs, wrapping patients in cold sheets when they were acutely disturbed and trying to harm themselves.

Vel Roininen on 'treatments'

On the other hand, new drug-related therapies were coming into use by this time. According to one account of the changes in mental health delivery, there was a veritable "drug revolution" from the fifties onwards, which was to allow far more sophisticated methods of treating patients in the mental institutions. Under the influence of such "meds" as Chlorpromazine and Reserpin, the agitation of patients could be better controlled in order to allow participation in various recovery programs. Such new regimes, however, were still in their infancy at Port Arthur, and, according to one account, may have been administered somewhat indiscriminately there. Flo Varrin-Campbell remembers "we were feeding massive doses of Chlorpromazine to schizophrenics."[7]

It must be remembered that treatments such as these were standard for the time and that they were, for the most part, administered with humane sentiments, if not with completely successful results. Patients would be lined up in the corridors of their units for ECT treatments, it is true, but electro-convulsive therapy remains a common practice in mental health to this day, and its benefits, although it is not fully understood why, are evident in many cases.

Nurses aides and attendants, early 1960's

Nurses aides and attendants, early 1960's

Education

I can remember giving my first lecture, which was the History of Psychiatric Nursing. It was supposed to be an hour long. Would you believe I finished in ten minutes? And I was supposed to ask if there were any questions, but I neglected to do that, I just dashed out of the room.

Vel Roininen on teaching the nurses

The four most important fields of activity at the hospital were: Care and Treatment, Rehabilitation, Research and Education. Clearly, the first two of these were the priorities of all psychiatric institutions. At Port Arthur, research opportunities for the clinical staff would be limited by the continuing difficulty of recruiting specialists, although links with the Department of Psychology and, later, the Social Work program of Lakehead University were firmly established after 1965. The development of an education program in Psychiatric Nursing was, however, something of an opportunity for an institution placed so far away from the rest of the province. From the beginning, the nurse's aides and attendants were trained in-house. From 1957-70 nurses in the three general hospitals were given three-month secondments to the psychiatric hospital. Vel Roininen was one of the earliest teachers in the program, as was Carole Faulkner. Before this time, student nurses would have had to go to the mental hospitals in London, Brockville or Whitby for such training. Later, as nursing programs were developed at Confederation College and at Lakehead University, student nurses came in on a regular basis, usually during the summer months, for training in psychiatric care. It made for a point of contact for the staff at the Ontario Hospital with the world of general medicine, by which all those in the psychiatric fields at this time felt themselves to be, if not excluded, certainly rebuffed. The fact that the mental hospitals were directly administered by the Department of Health made their separation from the mainstream of the medical health establishment all the more obvious.[8]

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"A short little happy little fella"

Dr. Ruth Kajander was one of many who felt inhibited under Dr. Howitt's regime: "We did not see eye to eye. I smoked …. I did not eschew alcohol…. He had some odd ideas about teaching homosexuals with the appropriate bible chapter." Dr. Bert Coates, a psychiatrist who worked at the hospital in the early sixties, remembers him as "straight-laced." Others talk of a man who was a strict Baptist, who insisted on God-fearing behaviour on Sundays, from staff as well as from patients. Nothing could be allowed that "smacked of the devil", says Carole Faulkner. No trivial pursuits. No recreational activities. Attendance at church services, while not obligatory, was preferred. The radio was tuned in only to religious broadcasts or the afternoon CBC broadcast of the New York Metropolitan Opera. All fairly acceptable demands, perhaps, if one's job depended upon meeting Howitt's expectations. But doctors, nurses, aides and attendants knew that, for many patients, the lack of any kind of distraction meant they became, according to Varrin-Campbell, "bored, disgruntled, agitated, noisy, aggressive." So, what usually happened was that, no sooner had Dr. Howitt completed his morning round on a Sunday (after the church service), then staff on the wards broke out the cards and tried as best they could to engage the patients in activities. This is not to suggest that Howitt was universally disliked, on the contrary. Mary O'Rourke, who came as a nurse teacher in 1960, saw him first when she was a nurse at the Port Arthur General Hospital, where he would give lectures on psychiatry to the staff. She has a somewhat more flattering recollection of a "short little happy little fella going along."

Ministry of Health officials with Dr. Howitt (second from right) and Dr. Dymond (far right), early 1960's

J.R. Howitt's regime came to an end with his retirement in 1962. He had overseen a smooth transition from one facility (perhaps it would be more accurate to say one-and-half), to another. He inherited a complex of buildings which were still growing in number as he left, albeit the final phase of construction was nearing its end. In this sense he could be regarded as a pioneer of the new. But the "new" in concept and in design, came from a blueprint laid down in the 1930s. And he had done little to change the expectations that such a ground-plan assumed. The Ontario Hospital that he left behind was, for all its gleaming tiles and waxed floors, something of a grim institution once one got behind the gloss. It seemed more of a penitentiary than a hospital.

Royal watchers, 1959

Queen Elizabeth's visit to Lakehead Psychiatric Hospital, 1959

He had, however, and from the beginning, adopted an "open-door" policy, encouraging visits to the patients from those members of their families who wished to retain contact with them. Despite a claim in earlier recollections of these years, that this was not the practice in the rest of the Ontario hospitals, it was not unknown, and some of them were as relaxed about it as Dr. Howitt. But it was a step in the right direction. After all, the patients, nearly 550 of them since 1954 having returned from the south, had been brought back to the Lakehead so that they could be closer to their homes and families. The opportunity for daily visits was a natural and humane response to that need.[9]

In addition, by 1962 psychotropic drugs, a whole regimen of them, had been increasingly introduced to the mental health field, and had replaced such practices as warm baths and cold packs. The increasing use of drug therapy was reaping significant rewards in the control of patients' erratic and sometimes dangerous behaviours, and although this might be described as "custodial care" in a new disguise, it was allowing for the development of occupational and behavioural therapies from which many residents could take real benefit. As a result, an increasing number of patients were gaining off-ward "privileges", as the still-paternalistic language of the institution described it.

But the numbers in the beds at night were still rising. Institutional care was still the order of the day. J.R. Howitt's tenure as Superintendent had done very little to change that.

"A Benevolent Alien"

Dr. George Ferrier, 1963

The man who had served as Howitt's Assistant Superintendent, Dr. George Ferrier, now took over the administration of the hospital. The contrast between the two men could hardly have been greater. Where Howitt is described by one witness as "short, roly-poly, very rigid", Bert Coates rather wickedly paints Ferrier as looking "like a benevolent alien … tall, bald, blue-eyed…" He further describes him as being "asocial", a man who would drive across the border to Grand Marais on his own, for lunch on Sundays. He was a bachelor who lived a solitary life in the Superintendent's apartment on the third floor of the hospital's central wing. Dr. Kajander remembers him as "retiring, but fair." He seems to have been accessible enough, but perhaps was not entirely comfortable in the role of Superintendent. That, at least, is the testimony of one who worked for him and admired him.[10]

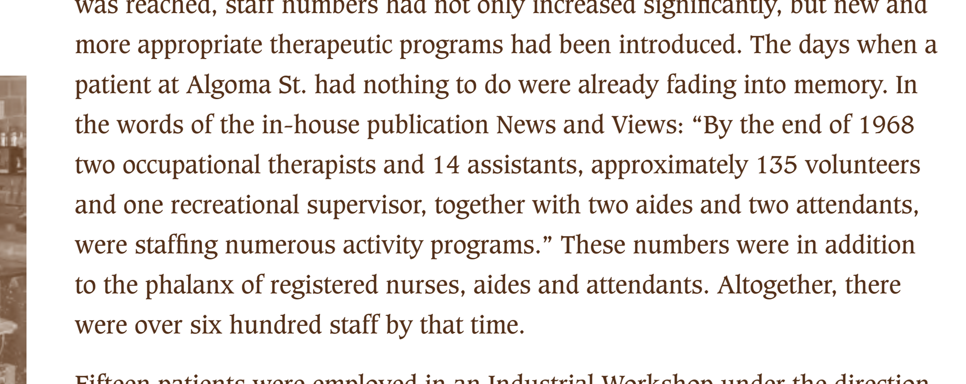
Other, more telling, differences between the two regimes would quite soon become apparent. A process of change was under way. By 1963, the building program was complete. As part of the final phase a surgical unit had been added as part of the central section joining the administration building to the back pavilions. Such a unit was a normal part of the old model of mental health institutions going back as far as the 1930s and beyond. It would have been used to perform lobotomies on patients with severe problems and who were non-responsive to the kinds of treatment available to the hospitals of that age. The surgical unit at Port Arthur was never used for that purpose. Lobotomy was falling out of favour, indeed it was coming under increased scrutiny and criticism, from the 1950s onwards. In Canada, fewer and fewer such operations were carried out by that time.

In addition, although the patient numbers at Port Arthur were still rising when Ferrier came to the helm, they were already beginning to drop quite markedly across the whole of the Ontario system: from close to 21,000 in 1960 down already to just over 18,000 by 1963. It would be a long, and sometimes painful, transition, but the movement in mental health from a custodial mentality to one of "community care" was, with faltering steps, beginning.[11]

The Industrial Workshop, early 1960's

New Arrivals, New Directions

This downward trend in bed-patients did not begin to show at the Ontario Hospital Port Arthur until 1968, but that was in part due to the fact that there were still a number of persons in hospitals in the south as yet unreturned to their home region. These were, in the medical language of the time, "mentally retarded" patients, many of them children. They had, up until this time, been sent from the Northwest down to Smith Falls Regional Centre. Some of these children first appeared at Port Arthur in March, 1965. By the following year a full "Mental Retardation Unit" had been established at the hospital and the numbers rose significantly, reaching one hundred and forty children by 1969. This was the beginning of what would become, in 1974, the Northwestern Regional Centre (NRC). In the meantime, the advent of a group of children with mental disabilities into the population of the hospital did not come without its problems. As one attendant who was placed in charge of them was to remark, many of the older staff of the hospital "did not know what kids were." According to the official chronicle of the life of the NRC: "The kids were blamed for everything" that went wrong: "The venerable institution just wasn't equipped for kids and it was 'pure hell' the first few years."[12]



By 1964, 80% of patients at the hospital were on "open" wards, which meant that they were no longer locked away, although remaining under close supervision. A further twenty-eight were in "self-care units" as a forerunner to their return to the community. By the time the peak population was reached, staff numbers had not only increased significantly, but new and more appropriate therapeutic programs had been introduced. The days when a patient at Algoma St. had nothing to do were already fading into memory. In the words of the in-house publication News and Views: "By the end of 1968 two occupational therapists and 14 assistants, approximately 135 volunteers and one recreational supervisor, together with two aides and two attendants, were staffing numerous activity programs." These numbers were in addition to the phalanx of registered nurses, aides and attendants. Altogether, there were over six hundred staff by that time.

Fifteen patients were employed in an Industrial Workshop under the direction of Rehabilitation Officer, Jack Varrin, and were constructing picnic tables as

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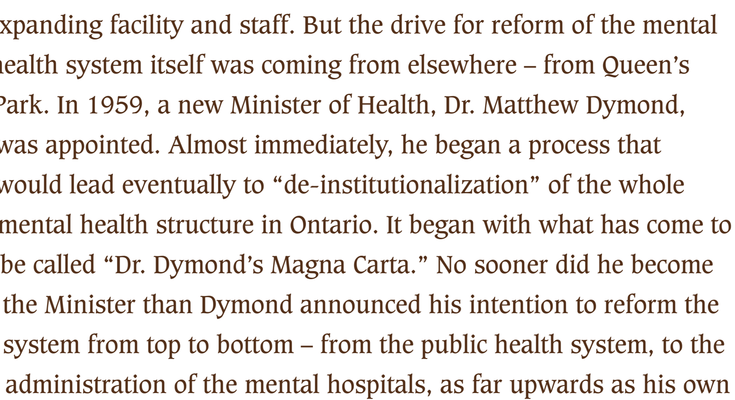
well as making Christmas toys for sale to the public. The hospital garden employed over 200 patients and a further 160 worked on the wards alongside the attendants and aides. An edition of News and Views, published to mark what it described as "1967-1977: The Demanding Decade", made the following judgment on the progress that the hospital had made by the end of the 1960s.

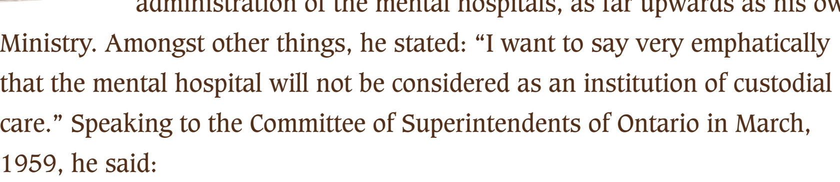
> Treatment programs of those days may seem crude when judged by today's standards; indeed all areas seem to be lacking the comparatively modern-day sophisticated approach. But the staff did a fine job – the best they could, considering the handicaps they had to work under.[13]

It is difficult to disagree with that.

Dr. Dymond's Magna Carta

Some of the changes that were taking place in the hospital during these years rose out of the personal initiative of individuals within the institution and, even more so, through the greater diversity of effort that came with a rapidly-expanding facility and staff. But the drive for reform of the mental health system itself was coming from elsewhere – from Queen's Park. In 1959, a new Minister of Health, Dr. Matthew Dymond, was appointed. Almost immediately, he began a process that would lead eventually to "de-institutionalization" of the whole mental health structure in Ontario. It began with what has come to be called "Dr. Dymond's Magna Carta." No sooner did he become the Minister than Dymond announced his intention to reform the system from top to bottom – from the public health system, to the administration of the mental hospitals, as far upwards as his own Ministry. Amongst other things, he stated: "I want to say very emphatically that the mental hospital will not be considered as an institution of custodial care." Speaking to the Committee of Superintendents of Ontario in March, 1959, he said:





Dr. Matthew Dymond observes construction at Lakehead Psychiatric Hospital, November 18, 1960

Dr. Ferrier's retirement, 1969

> Society is awaking to the need for intelligent understanding of the impact that mental health has on all strata. It is no respecter of persons. [He} stressed the need to remove the idea of stigma or blame in connection with mental illness and the attitude that once a patient was committed, he was more or less lost to society. The idea should be developed that the patient should remain part of the family and community.[14]

The road to the Mental Health Act of 1967 had been laid down.

That Act changed the face of psychiatric care in Ontario and led, not without some questionable deviations along the way, towards the elimination of the Ontario Hospital system as it had existed since the establishment of the Department of Health in 1924. The Act took the first step towards limiting the almost-dictatorial control over the patients in the system that was wielded by the hospital administration. It brought to an end the role of the all-powerful Superintendent, a "feudal lord", as one critic had described the breed. The role of leadership would, in the future, be divided between an Administrator and a Medical Director. The Administrator would be a person with management training and experience, and no longer a psychiatrist. The psychiatric profession, in other words, would no longer be the sole directing force within the institutions. The Medical Director would be able to concentrate on the provision of psychiatric therapies for the patients. "Patients' Rights" would be recognized for the first time in the mental health world, just as such rights were being increasingly acknowledged in the public health system. Only persons certified as a danger to themselves or others would be admitted in future as "involuntary" patients. Short-term stays were to be emphasized within the institutions, and provision would be made for regular reviews of patients' records. The emphasis would move from in-patient towards out-patient care.

Dr. Ferrier's administration, a fair and humane one by all accounts, would mark, when it ended in 1969, the end of an era.[15]

1969–1979

Agents of Change

A Man in a Hurry

The Mental Health Act of 1967 had been in operation for two years when Milton J. Fisher came to the helm of what was now called Lakehead Psychiatric Hospital (LPH), under the direction of the new Ministry of Health (MOH). Fisher, as almost everybody who remembers him never fails to point out, was an American, from Minnesota. He must have been surprised, perhaps even shocked, by the lack of movement towards the goals established in the new legislation. Many of the provisions in the Act had been based upon more enlightened policies which had already been adopted by psychiatric hospitals in the United States, and in Europe as well. Dr. Brian Frost, a psychiatrist who hailed from Ireland and who had arrived just before Fisher in 1969, says of LPH at that time: “Architecturally it looked good, but from the point of view of psychiatry, it looked more back towards the forties and fifties than forward.”

MILTON J. FISHER

New Hospital Administrator From Minn.

The Lakehead Psychiatric Hospital has a new administrator.

Milton J. Fisher arrived in the Lakehead from Rochester, Minn. Sept. 15, to take over his new post. Mr Fisher was previously administrator of Rochester State Hospital.

The post was left open due to the retirement of the former administrator and medical superintendent, Dr G. C. Ferrier, who has served in that position for the past seven years.

Dr. D. C. Panday takes over the duties of medical director at the hospital. Dr. Pandy has been a resident psychiatrist at the hospital for the past eight months. His position is effective Oct. 20.

The policy of the department of Health is to delete the hospital superintendent classification and replace it with both hospital administrator and medical director.

Prior to his service at the Rochester State Hospital, Mr. Fisher had experience at Allentown State Hospital and the Utah State Hospital.

Mr. Fisher has an undergraduate degree from the University of Washington, Seattle and a degree from the University of Puget Sound, Tacoma, Wash. He also holds a Masters Degree in Hospital Administration from Cornell University, Ithaca, New York.

He is married, and he and his wife, Louise, have five children, all boys, ranging in age from 11 to 24 years. The three elder sons left home, one presently training in Hawai, for service in the Peace Corps in Western Samoa.

Chronicle Journal October 8, 1969

It seems that, even after the Mental Health Act was passed, some of the methods used by the attendants to control difficult patients for example, remained pretty primitive. Jorma Halonen, a student at Lakehead University, was employed at the hospital during the summer of 1967. He remembers with embarrassment, being unwittingly the cause of the disciplining of a patient who was giving him some trouble in the canteen. The man was taken to a shower room by a couple of attendants, made to adopt a prayerful position naked on his knees, and hosed down with cold water. This kind of treatment may have been infrequent, but it was not unusual, Halonen recalls. It would not survive the new broom that swept through LPH with the arrival of Mr. Fisher. He was a man in a hurry.

Fisher was the Administrator, not the Superintendent. Neither was he a psychiatrist, for he had been trained as an occupational therapist. Appointed now to the position of Medical Director was Dr. D.C. Panday, who came from Guyana. Bert Hopkins, Ph.D. came in as Chief Psychologist, and department chiefs in Occupational Therapy, Social Work and Vocational Recreational Services were added. Father John Rice was placed in charge of the Mental Retardation Unit, which at that time was the home to some 140 children.. The re-organization included the creation of departments for purchasing, personnel and business affairs. Ruth Black, by now one of the few survivors of the Neebing days, became the only female Assistant Administrator in the Ontario mental health system.[1]

Mr. Fisher was different He was an American. They have a softer approach to things. He was ready for change. When somebody new comes in they bring the broom and they sweep.

Mary O’Rourke

The changes that would now take place were long overdue. Bert Hopkins came to the LPH from the south, and was struck by how slowly the adaptation to new ways of treatment had progressed. It seemed to him, on his arrival, that the hospital was “using the old model … almost pre-war.” For him, and no doubt for many of the staff – and surely for almost all of the patients – the Fisher era would be like a breath of fresh air. Fisher was no aloof “feudal lord”. He mixed readily with the staff, took a direct interest in their lives. One of the first of his innovations was to hold regular meetings with the whole staff of the facility, to acquaint them with new policies and to obtain feedback directly from them in open debate. The message he brought was clear and, in its own way, revolutionary: LPH was to “humanize” its relations with its patients, the doors of the institution were to be opened and the keys thrown away. And the goal of the hospital in the future would be to rehabilitate as many of its residents as possible into the community.

Milton Fisher, Dr. George Ferrier and Ruth Black, 1970

1967 Statistics

Number of Admissions	787
Number of Separations	783
Beds set up	840
Number of Patients in Hospital as of December, 31, 1967:	788

News and Views, 1967

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Barred Windows Outmoded

Workmen at Lakehead Psychiatric Hospital, Tuesday began removing iron bars from windows of all areas where patients reside.

Hospital administrator Milton Fisher, said the action is symbolic of the change in philosophy of the care and treatment of the troubled people with problems of living.

"Although symbolic of our new approach it is carrying out the intent of the Mental Health Act of 1967 which requires that provincial psychiatric hospitals be administered like general hospitals. This means that as many patients as possible be admitted on an informal or voluntary basis. Only those certified by their own physicians as being a danger to themselves or others are now being admitted in an involuntary or compulsory manner," he said.

He added that the hospital is no longer a place where society puts away persons with problems, but is a link between the person and his family and community.

Times Journal June 10, 1970

Humanizing the Hospital

This "Humanization Program", was designed to eliminate practices which tended to regiment or "institutionalize" the patient. This meant that now they would work on wards or in the gardens, including the farm fields, only by choice. A far broader variety of merchandise was to be available from the stores department, including items for personal use. Full-length doors were placed on washrooms and toilet cubicles were given greater privacy. Panels were inserted between the dorms and the unit corridors where once there had been large gaps in the walls for observation of patients, even at night-time. The bars came off the windows, in 1970. They had suggested, only too obviously, the prison-like nature of the hospital of old. It must be admitted, however, that the replacement of the iron bars by "security screens" did mean that there were occasional successful "escapes", before the screens were more securely attached.[2]

New programs were introduced, emphasizing rehabilitation rather than permanent residence. The Industrial Workshop flourished, occupational therapy became more community-based, and the beginnings of the separation of the patients with mental illnesses from those with severe mental disabilities was established, with the relocation of the Mental Retardation Unit under Father Rice to the back pavilions, so that the special needs of such residents could be directly addressed. Re-named the Mentally Retarded Unit, it brought together 160 adults and 120 children. The Regional Children's Centre (RCC), which looked after children with mental health problems on an out-patient basis, instituted a summer program for kids, taking them on an expedition to Loon Lake. In June, 1971 six boys from LPH competed in the annual Canadian Association Olympics for Mentally Retarded Children, returning proudly from Toronto with six gold, silver and bronze medals. [3]

A Rehabilitation Unit was established at the hospital, and a Psycho-geriatric program introduced. Milton Fisher also set as a goal the gradual reduction in the numbers of "involuntary" patients within the institution. Where practical, he announced, the consent of the individual and family would be sought before a patient was admitted. The days when the Superintendent had sole power to "commit" a person to permanent residency were over. "We have so

The bars come down from the Lakehead Psychiatric Hospital windows, June 1970

1969-1979 Agents of Change

many patients who shouldn't be here", he told the local newspaper: "Without them we could provide more and better services for patients who need us. Now we're filled with patients and grossly short of trained staff."[4]

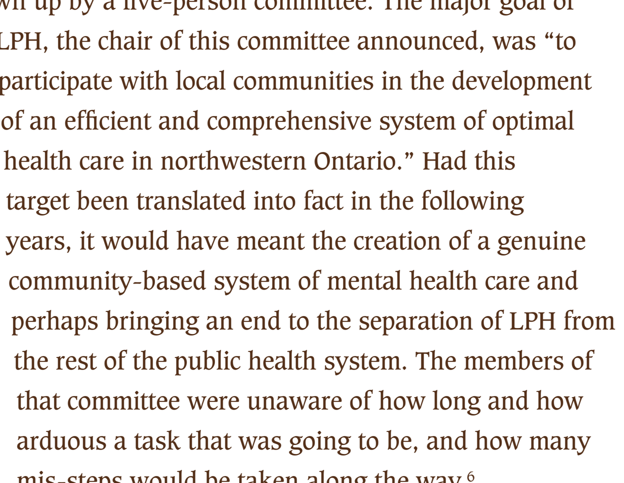
A series of articles in *The News-Chronicle* in 1970 made clear the changing dynamics at LPH. The reporter noted the effect of the new regime on the life of one of the in-patients, whom he called "Harry".

> Harry's life in hospital has changed sharply since Mr. Fisher sent a blast of fresh air blowing through the dark, stuffy wards and gloomy corridors..... "We're no longer looking at a hospital as a place to put away troubled people so that the community can forget about them, knowing they are securely locked up," said the administrator emphatically.[5]

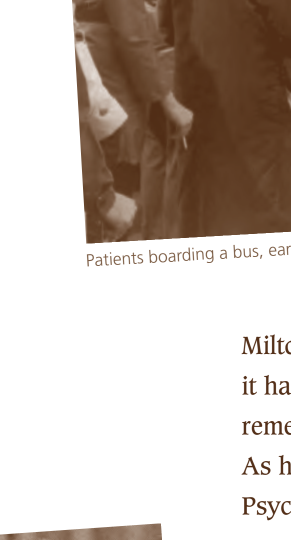
There can be no question that such changes were not only in tune with the legislation, but were long overdue at LPH. They seem to have been adopted with enthusiasm by most, if not all, of the staff. According to Bert Hopkins, if there was opposition, it came mainly from "the non-therapy people", those involved in running the basic services of the facility.

Before Fisher left, in 1971, a Master Plan for the next five years of the hospital had been drawn up by a five-person committee. The major goal of LPH, the chair of this committee announced, was "to participate with local communities in the development of an efficient and comprehensive system of optimal health care in northwestern Ontario." Had this target been translated into fact in the following years, it would have meant the creation of a genuine community-based system of mental health care and perhaps bringing an end to the separation of LPH from the rest of the public health system. The members of that committee were unaware of how long and how arduous a task that was going to be, and how many mis-steps would be taken along the way.[6]

Patients playing hockey, early 1970's



Patients enjoy a tour onboard the Welcome Ship, early 1970's



Patients boarding a bus, early 1970's

Mini Putt at Boulevard Lake, early 1970's

Milton Fisher's administration came to an end in 1971, just two years after it had begun. He seems to have been a popular leader. Most of those who remember him speak with affection of his tenure and of his personality. As he prepared to take responsibility for the administration of the Whitby Psychiatric Hospital, News and Views, the newly-created in-house monthly magazine, printed a "Farewell to Milton J. Fisher" in its columns. It spoke of the "deep regret" of those at the institution at his departure: "His liberalizing philosophy led many of our patients out of comparative darkness and to quote Winston Churchill led them to 'the broad sunlit uplands'." There remains a doubt, however, as to how universal this feeling was. In a sense, Dr. Frost asserts, "his style was not a Canadian style." This may speak solely to a national perspective. It may also conceal certain reservations. Frost liked him a lot, but felt he could be "impatient" with the slow pace of change. Fisher brought great change to LPH in a very short space of time. In a facility of this size it is unlikely that this would have received universal approval. Not only patients can become "institutionalized".[7]

Milton Fisher, 1970

Nonetheless, in two years LPH had experienced what in modern terms might be called "a complete makeover". Exciting innovations had been made, at top speed, as if to catch up with developments in the rest of the world of psychiatric care. In psychologist Bert Hopkins' memory, "it was arduous, but [a] very exciting, very interesting, time to be in the mental health field." Perhaps Fisher pushed a little too hard, and perhaps that is the reason for his surprisingly brief term of office.

The "Colonel"

Charles (Ken) Temple, "The Colonel", 1971

I felt that Ken Temple wanted to be sure that his superiors at the Ministry of Health would approve of what he did.

Vel Roininen

Charles (Ken) Temple came to LPH from the Whitby Psychiatric Hospital in 1971, in an exchange of positions with Fisher that was described at the time as "ministerial policy." If that was the case, it was one that was not pursued with much vigour thereafter, for Temple was to remain at LPH for the next fifteen years. He would oversee the implementation in much of their details of the broad goals and specific directions set out under Fisher's administration. A native of Saskatoon, Temple was, despite a long association with medical and teaching hospitals, a man who had quite obviously been shaped by his four years in army service during the Second World War. There is not one person who remembers Ken Temple who does not remark that he was a "military" man. His nickname, inevitably, became "The Colonel". The contrast between him and his predecessor was only too obvious. Unlike Fisher who, according to Vel Roininen, tended to ask the question "why not?" When faced with an objection to a new line of action, Temple went by the book. Today, he puts it this way:

> The thing is that Change should be brought about gradually. You confer with your superior officers, you consult with your department heads and then you create manuals of administration and procedures, so that everybody knows what is going on.

According to this managerial philosophy, any institutional problem was resolvable because there would always be a regulation to cover it and a chain of command to execute it:

> There's the Mental Health Act, there's the regulations under the Act, there's circular memoranda that are issued by the psychiatric hospitals branch, there's a standardized method of purchasing, then you in turn at the local level create your own operating procedures....

"Follow the manual", Temple asserted. This is not a sophisticated theory of governance, but for most of the years of his administration, it seems to have worked, admirably.

Homes for Special Care

Carole Faulkner, February 2003

The community was not prepared to take them back. We used to say, you know, whose going to follow up on this patient?

Carole Faulkner

The pace of change did indeed slow down after 1971, when the whirlwind of the Fisher years subsided. But it did not cease. At the end of his first year, Temple wrote to the staff of LPH:

> This year 1972 has been a year of re-organization within the Ministry of Health. Under the new organization, health is considered as a broad concept of well-being, embracing all aspects of an individual's physical and mental state. Thus the health program including mental health is focused on development of community resources.[8]

The emphasis on the development of community-based care would be something of a mantra among mental health providers from the 1970s onwards, but its implementation as practice as well as policy would be much less easily achieved. Many persons who worked at LPH during these years admit that the process of "de-institutionalization" by this time under way, was very imperfectly executed. A case in point would be a provincial program adopted by LPH in October, 1972. Entitled "Homes for Special Care", it sought to place former patients who were in need of a measure of supervision outside the institution, in nursing homes and in private residences, under the indirect supervision of the mental hospitals from which they were discharged. One of the coordinators of the initiative at LPH, Ron Johnson, said of it at the time: "The programme (sic) represents a new and dynamic approach to the concept of accommodation for these chronic patients. We hope the homes will be treatment oriented and that the hostesses will integrate the patient into their home life while receiving support from hospital staff." The goal of the LPH program was to place 36 patients into such homes, which indeed was the figure eventually achieved.[9]

Michelle Salterelli, Fleurette LeClair & Ron Johnson, 1972

It is testimony to the work of Ernie Rollason, who came to head Homes for Special Care at LPH, that Don Gandier remembers the benefits his personal

efforts brought to the life of his father. Charles Gandier would otherwise have remained pretty-well "institutionalized" had he not been brought into the program. And Pat Mitchell, now living in her own apartment, began her "escape" from LPH through the same program, and remains deeply attached to the family who took her into their home, in the early 1970s.[10]

But, admirable though the concept of Homes for Special Care was, it would prove to be highly controversial. Criticisms arose, especially in the Ontario Provincial Legislature. It was noted that patients in the program were supported at a lower cost than those who remained in the psychiatric hospitals. The Department of Health, when it introduced the program in 1964, had claimed that it was designed to move patients back into the community and into "a homelike atmosphere." But many of the homes chosen across the province were inappropriate or placed so far out of town that the patients remained isolated, far from transportation or shopping facilities. Homes for Special Care achieved no lasting success in the province as a whole, although its record in Thunder Bay has been admirable. A study commissioned by the Ministry of Health in 1984, noted its organizational weaknesses.

> … the administrative responsibility for the Program has changed on six different occasions. These frequent changes and lack of consistent management have resulted in a program with a wide range of resident types and an unclear role in the continuum of mental health services in the province.[11]

Programs such as these, implemented to fulfill the stated goal of increased community involvement in mental health care, were often either ill-conceived, under-funded, or both. Few experts in the field, and few of those who have been associated with LPH over the years since then, fail to acknowledge the general lack of success of these first attempts at "community care" for mental patients.

De-segregating the Wards

A giant step was taken towards the further 'humanization' of the hospital in 1973. In October, the wards in the psychiatric units were de-segregated. The integration of males and females onto common wards was viewed with much trepidation by some members of the staff. Bert Hopkins remembers how some staff "painted pictures of people copulating behind every tree … or doorway." Pat Paradis, who came to LPH as a Registered Nurse in 1972, remembers some "interesting moments" that followed in the wake of this innovation, but agrees in general with Hopkins' assertion that "absolutely nothing happened." The transition was, in the end, a smooth and a natural one.

Ken Temple's regime, then, did not hold back the movement for change. Faltering steps towards greater involvement in the community were coupled with a broadening of the hospital's programs for patients. Dr. Panday expressed the new intent clearly, when he wrote:

> These changes have forced the regional psychiatric hospitals… to recognize that their roles have been changing. They are no longer the chief primary care centres - the front line troops so to speak – but have evolved more into a secondary or even a tertiary type of back-up facility providing special programs as necessary, but mainly consulting and coordinating with other community agencies.[12]

In practice, however, such statements remained more wish than reality. The numbers of patients in residence was certainly going down by 1972 and programs for rehabilitation and occupational therapy were on the rise. But, according to its official rated bed capacity of 604, the hospital was overcrowded by over 10%. During that year, 939 persons were admitted to LPH and 989 were discharged. The average daily census was 688, while a total of 252,008 "in-patient days of care" were recorded. Staff complement by this time had risen to 622, which was a small increase of six over the previous year. In other words, LPH was still, overwhelmingly, a residential hospital.[13]

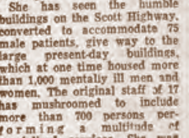
1969-1979 Agents of Change

"Energetic and Equestrian"

In December, 1973 Ruth Black retired. She was the longest-serving member of staff, and the only female Assistant Administrator in the entire Ontario mental health system. Her influence at the Fort William Hospital and at Algoma St. had been considerable. She may have had little to do directly with policy, but she had her hands on the purse-strings throughout her tenure. In her own words: "From 1940 the job consisted of managing all non-medical departments, and while the titles changed – from steward to bursar to business administrator and finally to assistant administrator – the responsibility remained essentially the same."[14]

She ran the place like a sergeant-major, but if you wanted something, she would get it done for you.

Ruth Kajander describes Black as "an incredible woman … courageous", who "as long as she worked ran the place." Carole Faulkner says that she wielded a lot of power "behind the scenes…. She kept a very tight purse-string, a very tight ship as far as finances go." What this meant in practice was that the food budget was always restricted and the food quality (for the patients) was, in Faulkner's words, "minimal." Most of those who remember these years say that the staff was fed better than the patients. Bert Hopkins says that Black was "hard-working, vigorous, bright, ambitious." Dr. Coates remembers her as "energetic and equestrian", a reference to the days when she used to organize the "cattle drives" down the Scott Highway to the railway sidings at Fort William. Whatever the personal testimony, it all adds up to an extraordinary career in a field that was not normally ready to give a woman such authority. There is probably the bare bones of a novel about Northwestern Ontario during the mid-century in the story of her life.



Hospital Administrator Concludes Brilliant Career

CHRONICLE JOURNAL SATURDAY, DECEMBER 15, 1973

BACK IN 1936 Ruth Black, then a secretary at the newly-opened Ontario Hospital farm, was far too busy absorbing myriad details of a new job to contemplate either future or career. Today, as she prepares to retire as Lakehead Psychiatric Hospital's assistant administrator, Miss Black remains too intent on her present workload to give serious consideration to the future. "I have a commitment not to become committed," is her standard reply to any query regarding the days following December 31.

Occasionally she will pause to appraise her almost 38 year career as an Ontario Civil servant. And it's when she recalls cattle drives and harvesting vegetable crops at the 1,252 acre Scott Highway farm, forerunner of today's North Algoma Street structure, that listeners realize Miss Black has seen more than a career unfold. She has seen history in the making.

She has seen the humble buildings on the Scott Highway, converted to accommodate 75 male patients, give way to the large present-day buildings, which at one time housed more than 1,000 mentally ill men and women. The original staff of 17 has mushroomed to include more than 700 persons performing a multitude of specialized services. She was present when revolutionary

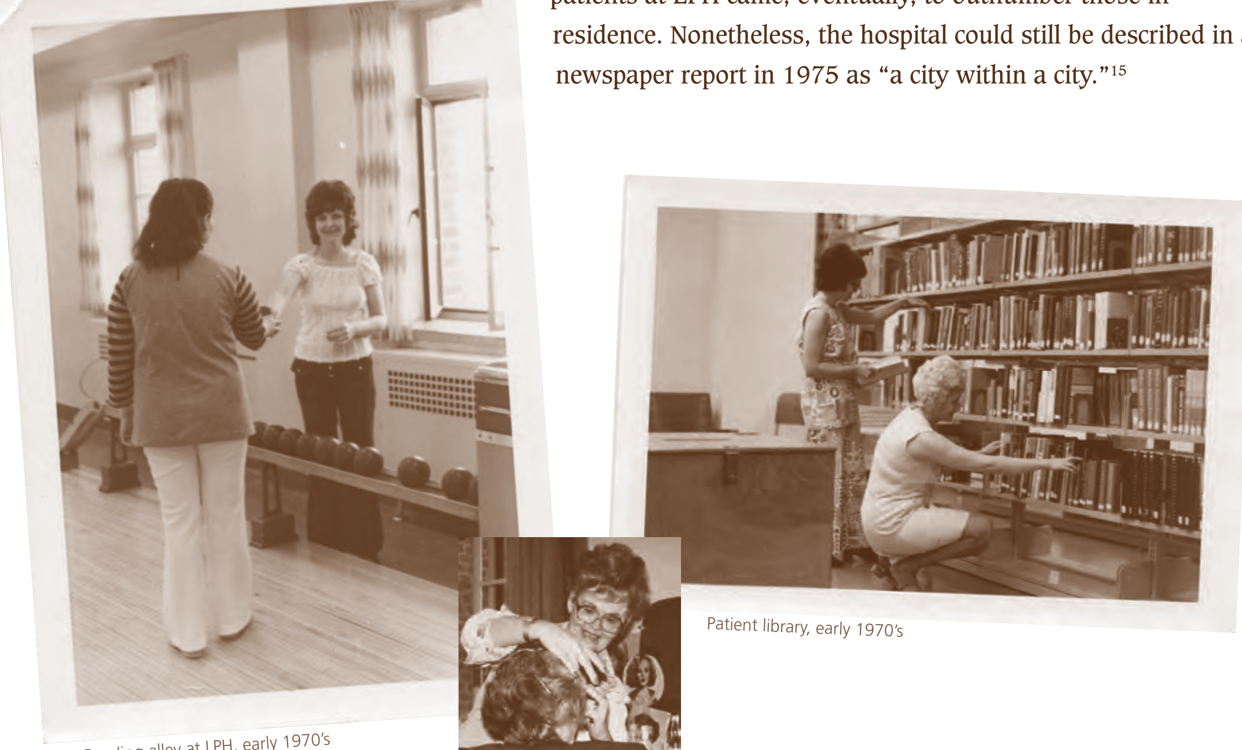
MISS RUTH BLACK
. . . doing a great job

Chronicle Journal, December 15, 1973

With Ruth Black's retirement, and the departure soon afterwards of Ernie Rollason into his family flower business, the last connections to the early days on the Scott Highway were severed.

"A City Within a City"

By 1975 the number of in-patients was falling, the yearly average having reached 574. This had been accomplished by a number of means, in addition to Homes for Special Care. Approved Boarding Homes, Group Homes, in addition to the development of mental health clinics attached to the general hospitals, had been part of this movement. As early as 1970, Beacon Hill Lodge had been opened for a limited number of ex-patients from the hospital. In 1974, as previously noted, the Mental Retardation Unit had been separated from LPH altogether, when it was taken under the direction of the Ministry of Community and Social Services and renamed the Northwestern Regional Centre. It continued to operate in a separate wing of the hospital under Father Rice, but its budget now came from a different (and much more generous) source. It was, in fact, a separate institution, although, being under the same roof, it shared many of the resources of LPH. The NRC took with it over a hundred staff in addition to the nearly three hundred developmentally handicapped patients. By such means the numbers of out-patients at LPH came, eventually, to outnumber those in residence. Nonetheless, the hospital could still be described in a newspaper report in 1975 as "a city within a city."[15]



Bowling alley at LPH, early 1970's

Hair salon, early 1970's

Patient library, early 1970's

1969-1979 Agents of Change

Many past members of the staff of LPH have described the institution of those, and earlier days, in similar terms, with a certain amount of regret for a world that has been lost. Indeed the phrase most often used in such reminiscences is "we were a community, staff and patients together." Whether the patients themselves would speak in such terms has to be questioned, but there can be no doubt that the old institution-like structure of the Ontario Hospital system offered a kind of security and solidarity to all within it. Despite its loss of residential beds, LPH in the mid-1970s could boast of a bowling alley, a beauty parlour, a barber shop and a chapel, a library, a variety of activity rooms and recreational areas, a large canteen, a storeroom containing a number of quite fashionable articles of clothing for distribution to the less-fortunate as well as to its own clientele. Its power house could produce enough energy to service many other large institutional buildings (had they been able to hook into it), its laundry could deal with well over a million pounds of bedding and personal clothing in any given year. The canteen served nearly 200,000 meals a year for an average cost of 78 cents.[16]

By the mid-1970s, however, out-patient service was increasingly the order of the day. Programs continued to be introduced. From 1974 onwards, a Continuing Care Program was geared to patients who had been in institutional care for over twenty years, and who might still get a chance to move back into the community in Approved Homes or Homes for Special Care. An Out-Patient Day Care Centre had been established in 1974 to allow former patients back into everyday life, with the goal of an eventual complete break from the hospital. By 1977, it was treating 284 out-patients and 87 "day-care" persons, who spent no more than four hours a day in the confines of LPH. New kinds of care were being delivered for in-patients as well, most of them involving only relatively short stays in the hospital. There was, for example a five-week Alcohol and Drug Rehabilitation Program, developed with the cooperation of Alcoholics Anonymous.[17]

LPH entrance sign, 1970's

The Accreditation Marathon

Meanwhile, the mental health establishment was being drawn closer to the mainstream health system. For years those who worked in mental health had felt the same kind of stigma that was attached to their patients. As Vel Roininen puts it: "If you told anyone I work at the Ontario Hospital… oh … then they'd kind of move over." Government funding for mental health was always less "voter-friendly" than that for the medical needs of the general public. Staff at psychiatric hospitals across the province were less well-paid than those in the public health services. Even psychiatrists, and especially those working in psychiatric institutions, felt themselves to be treated as less than equals by medical professionals in the general hospitals. This, too, was changing.

By the second half of the 1970s, psychiatric hospitals such as LPH were seeking acceptance on an equal footing with medical hospitals, from the Canadian Council on Health Accreditation (CCHA). To become "accredited" meant that a hospital had been judged to have met a defined national standard of patient care. It also meant that its other services and its general maintenance were at an accepted, measurable, level. The survey that was conducted by a team of experts from the council included assessment of qualified staff, medical records, fire and safety precautions and the like. The general hospitals at the Lakehead were all accredited. In 1973, it became Ken Temple's goal to get that accolade for LPH. Thus began something of a tortured path towards "Accreditation".

The first try failed. The report from the CCHA, following an inspection in 1975, did not give the hospital a passing grade. The assessment seems to have been pretty brutal. Temple responded by announcing that "the hospital is working to rectify some of the problem areas" identified by the report:

> For example, the occupational therapy department is expanding its staff; medical records are being improved; plans are underway to have a practice drill of the external disaster plan; post-graduate programs in psychiatric nursing are in the works and proposals made to have the kitchen renovated.[18]

An accreditation team returned to LPH in October 1976, and this time the result was more satisfactory. The January, 1977 issue of News and Views headlined the reaction of the administrator and staff in general: "We've Earned it!" But the jubilation was tempered by the fact that the period of acceptance was only for two years, and that the hospital would have to go through another review in June, the following year. When that came, the news was not so good. Reporting the results of the inspection, Temple noted that the two representatives of the CCHA had come at an unfortunate time, when "staffing patterns were being adversely affected by seasonal turnover and unavoidable long term leaves of absence", but he could not hide the disappointment in his announcement that, although "the hospital did not lose its accredited status", it had only been awarded a one-year certificate. The long haul continued into the next year, when, finally, on November 29, 1979 the coveted three-year accreditation was achieved. "We're the tops!" News and Views trumpeted, with justifiable (but perhaps exhausted) pride. The Colonel called it "The Good Housekeeping Seal of Approval."[19]

Chronicle Journal 20/5/75

LPH To Try Again For Accreditation

Lakehead Psychiatric Hospital's first attempt at obtaining accreditation from the Canadian Council on Hospital Accreditation has not been successful.

Hospital administrator, C. K. Temple said the council's survey team "hit us at a bad time." When the survey took place in January the hospital was in the middle of a medical shortage.

Psychiatrists from Toronto and local doctors were holding the fort, while the ministry of health was advertising widely for new doctors.

"But there are better days ahead," the administrator said. "Three psychiatrists will be joining the staff in July."

BONUS OFFERED

Mr. Temple explained the ministry is trying to make working at the LPH financially attractive to doctors and is offering a generous pay bonus. The bonus works out to be 20 per cent of the doctor's salary, no matter where he stands on the salary grid.

The hospital can offer both psychiatrists and general practitioners bonuses.

Mr. Temple sees the hospital's initial failure to receive accreditation as a challenge. "I was disappointed. The hospital staff worked hard as a team, but now we're going back to the drawing board."

He noted that "attainment of the accreditation certificate does not come easy. That is exactly why it is considered to be so valuable."

In defining what accreditation means the administrator said it's similar to the Good Housekeeping Seal of Approval.

INDEPENDENT BODY

The Canadian Council on Hospital Accreditation is an independent corporation which drew up a set of basic principles and standards for patient care. If a hospital wishes to become a part of the accreditation program, it has to volunteer.

The council won't go to the hospital, the hospital has to come to it.

The accreditation work-up is essentially interested in the quality of patient care. The survey team the council sends is looking for qualified staff, organized medical staff and administration, complete medical records, fire and safety precautions and hospital goals and objectives.

In the survey report on the LPH many areas were singled out for commendations. Mr. Temple said the hospital was commended for its goal statements, objectives, evaluation and target dates.

TO RECTIFY

On the other hand, the administrator said the hosital is working to rectify some of the problem areas in the report.

For example, the occupational therapy department is expanding its staff; medical records are being improved; plans are underway to have a practice drill of the external disaster plan; post-graduate programs in psychiatric nursing are in the works and proposals have been made to have the kitchen renovated.

"We will keep knocking the things off the council's list," Mr. Temple said, "but what the accreditors are looking for is progress. By their next visit we will have carried out their recommendations, but they're bound to have others."

Lakehead Psychiatric Hospital has been working towards applying for accrediation for three years and has every intention of reapplying next year, he said.

One of the biggest beneficial results of working towards accreditation, Mr. Temple said, is the great unifying effect it has on the hospital. It stimulates co-operation within departments and between departments.

He concluded that although all the general hospitals in Thunder Bay have accreditation certificates, there are many hospitals in Northwestern Ontario that are not accredited.

Chronicle Journal, May 20, 1975

Canadian Council on Hospital Accreditation
Conseil Canadien D'Agrément Des Hôpitaux
A.L. SWANSON, M.D., F.A.C.H.A., Executive Director

MEMBER ORGANIZATIONS
CANADIAN HOSPITAL ASSOCIATION
THE CANADIAN MEDICAL ASSOCIATION
THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
L'ASSOCIATION DES MÉDECINS DE LANGUE FRANÇAISE DU CANADA
CANADIAN NURSES ASSOCIATION

25 IMPERIAL STREET, TORONTO, ONTARIO M5P 1C1
TELEPHONE (416) 487-8175

January 7, 1977.

Mr. C.K. Temple,
Hospital Administrator,
Lakehead Psychiatric Hospital,
580 N. Algoma Street, Box 2930,
Thunder Bay, Ontario.
P7B 5G4

Dear Mr. Temple:

The Board of Directors of Council has assessed the reports of survey submitted after the recent Accreditation visit to your hospital.

We are pleased to advise that Council has awarded Accreditation status to your hospital for a period of two years.

A certificate of Accreditation will be issued on which the name and address of your hospital will be hand lettered. If an additional copy of the certificate is desired for display in a second location in your hospital, it may be obtained at a cost of fifteen dollars.

Please let us know by return mail whether or not the name and address of your hospital, as they appear above, are correct.

To assist in your efforts for continuous improvement of the quality of patient care, recommendations approved by Council are appended. These should be implemented as soon as feasible and, in any event, before the next survey, because evidence of a hospital having implemented recommendations made after a previous survey is influential in deciding Accreditation status on the successive survey.

Yours sincerely,

A.L. Swanson, M.D.,
Executive Director.

ALS:rc
encl.

c.c. Mr. William C. Jappy
Dr. L.M. Smith
Dr. L.C. Ash
Dr. C.H. Cahn
Mrs. I. Shaw

LAKEHEAD PSYCHIATRIC HOSPITAL
THUNDER BAY
JAN 13 1977
ADMINISTRATOR'S OFFICE

Notice of Accreditation, January 7, 1977

1969-1979 Agents of Change

A Shortage of Professionals

The accreditation marathon had revealed one of the hospital's continuing problems, which was the lack of a sufficient number of qualified psychiatric and other professional staff. However hard Temple might try to attract psychiatrists and psychologists to full-time appointments to LPH, it was an uphill struggle. For every psychiatrist like Bert Coates (who thought the city was a nice size in which to raise his kids), or psychologist such as Bert Hopkins (who came to the Lakehead because he and his wife wanted an outdoor life) there were those who simply could not be persuaded to make the break to the Northwest from more sophisticated surroundings. From the later 1970s onwards, this problem of recruitment would be compounded by the tightening purse-strings of the provincial government. What this meant in practice was that, despite the fact that, by 1978 the rated bed capacity was down to 212, overcrowding was a continuing fact of life and the demands on hospital medical staff were serious indeed. News and Views reported in that year: "Since early in 1976, when wards were re-allocated and the two active treatment wards amalgamated … staff has had to cope with continually crowded conditions." A small number of staff cuts in 1978, in response to the government's restrictions aimed at balancing the provincial budget by 1981, did not help matters. In fact, one could mark the beginnings of staff dissatisfaction at LPH from this period of growing uncertainty.[20]

Vel Roininen at recruitment booth, late 1970's

Question marks over the future, even of the whole psychiatric hospital system in Ontario, were evident by the end of the 1970s. Although the actual number of patients under some form of treatment was not diminishing, the balance between in-patient and out-patient care had obviously been reversed. At what low level would the rated bed capacity finally settle? What implications did such changes carry? If governments were encouraging de-institutionalization, what impact would that have on the number of permanent staff at Algoma St.? At what stage would the maintenance of such a huge "city within a city" become economically unrealistic? Such questions increasingly weighed on the minds of the staff, and perhaps even the patients, at LPH.

In February, 1978 Dr. P. Lynnes, a psychiatric consultant with the Ministry of Health assured the staff at LPH that "there will always be a hospital… they will not be phased out." Yet the very fact that such a possibility had to be officially denied spoke volumes as to what was on some official minds. Some might argue, indeed, as one authority put it, that the movement away from the large mental hospital model,

> resulted from a fortuitous linkage between the forces of fiscal conservatism anxious to save money by closing large mental hospitals and returning patients to the community, and the pressure groups and other humanitarian forces which saw the large mental hospital as the symbol of everything that was wrong with mental health policy.[21]

Change was being compounded by, as well as helping to cause, increasing fears about the future.

It was still possible, however, for those working within LPH to remain optimistic. Dr. L.M. (Morley) Smith, the Medical Director who succeeded Dr. Panday in 1976, announced in May, 1979: "Looking at the present in the perspective of the last 25 years… I think we can see that the present is a relatively stable time."[22]

How wrong that prophecy would prove to be!

1978-1986

"A Whole Lot of Turmoil"

An Anniversary

In 1979, LPH celebrated twenty-five years of full-time service from its site on Algoma St. A commemorative issue of *News and Views* noted the great changes that had occurred over that time. The buildings were now shared with the Northwestern Regional Centre and the Regional Children's Centre. The former assisted developmentally handicapped persons from across the region, the latter assessed and treated children and adolescents with mental health problems, as out-patients. There was increasing communication and sharing of services with agencies within the city and in the region. LPH had twenty-three departments, including all the service units that were necessary to run an institution of its size and capacity. In terms of the psychiatric and therapeutic services which it now offered to the region, huge advances had been made since the days of Dr. Howitt. There was an Active Treatment Unit, which provided acute care to those in immediate crisis and offered a multi-disciplinary assessment and treatment program to those in need. The Alcohol and Drug Rehabilitation Program continued to offer its five-week courses and individual counselling. A Psycho-geriatric Unit cared for the elderly with mental illnesses. A Behaviour Modification Program was designed, amongst other things, to "offset effects of long-term hospitalization" on patients. A Continuing Care Program offered support to those out-patients who were having difficulties adjusting to life in the community. Other out-patient programs included a Crisis Intervention Service and an Out-Patient Day Care, which featured "follow-up and medication reviews for discharged patients and therapy sessions for community residents." In addition, there was a Community Placement Service which sought accommodations for patients in the community and in Approved Homes or Homes for Special Care. The Regional Children's Centre had satellite units in Fort Frances, Dryden, Terrace Bay and Geraldton. *News and Views* proclaimed, proudly:

News and Views, 1979

The Way We Are

individuals in all population centres served by the LPH.

A Community Educational Service provides a wide range of educational and training workshops to all areas served by the hospital and our library provides specialized information regarding the mental health field to hospital staff as well as to interested persons living within the region. A travelling psychiatric service presently provides consultative services to medical staff in Kenora and Fort Frances. And, our Psychogeriatric Unit provides a broad range of consultative services to local and area nursing homes, homes for the aged and physicians.

We're no longer just a hospital. We've become a community resource.

Cathy Heighton, Public Health Liaison Nurse, 1974

"We're no longer a hospital. We've become a community resource."[1]

News and Views, 1978

Revisions to Mental Health Act designed to enhance patients' rights

Future historians may someday recall that in November of 1978 the Province of Ontario revised the Mental Health Act. They will probably note that the revised portions of the act were primarily designed to further safeguard patients' rights. They'll no doubt make mention of the fact that the revised act placed greater emphasis on all aspects of confidentiality of patients' records.

And, they will no doubt completely overlook the contribution made by many hospital employees as they attempted to interpret the Act for fellow employees and for both local and district physicians, health agencies and hospitals.

"Explaining the Act to those persons affected by it has been a time-consuming business during the past few months", says Vicki Polischuk, director of the LPH Medical Records Department. "We've been spending a lot of our time writing letters and supplying those concerned with the new forms."

The portion of the Act dealing with patients' records states that, with certain exceptions, no person shall disclose, transmit or examine the clinical records of psychiatric patients. In fact, under the revised Act the issue of confidentiality has been moved from regulations dealing with hospital administration to primary legislation affecting the care of psychiatric patients. "In most situations disclosure may be made only with the consent of the patient or his nearest relative", says Polischuk. "And, this means that before we can send out discharge summaries to the referring physicians or agencies we must receive appropriate consents."

Appropriate consents must also be obtained before required information can be released to agencies such as the Children's Aid Society or the Unemployment Insurance Commission. "It becomes more time-consuming for the agencies", she says, "but on urgent matters--such as when pensions or other types of benefits are at stake--we do everything we can to speed the process."

Polischuk has also worked closely with the hospital's Public Health Liaison Nurses to ensure that district health personnel affected by the revisions received appropriate forms and information packages.

Supplying persons with information has also been a major task for J.J. Young, the hospital's Social Services Department chief. In addition to organizing workshops for LPH staff, Young has also taken advantage of every opportunity to explain the revisions to local agency and hospital staff.

In addition to letting these people know about the increased emphasis on confidentiality of patients' records, the chief Social Worker also outlines the revised criteria for involuntary admissions to the LPH.

The revised Act makes it clear that being detained in hospital for assessment is not the same as becoming an involuntary patient. In the past even persons detained in hospital for assessments were considered to be involuntary patients. Today, involuntary admissions occur only if the hospital's attending physician believes the person is in need of the specialized services available in a psychiatric facility. Such assessments must now be made within five days after the person has been admitted to the facility.

The revised Act tightened the criteria for involuntary admissions to that of Mental Illness of a nature that would likely result in serious bodily harm to the person; serious bodily harm to another person or imminent and serious physical impairment of the person.

Regional Review Boards are another important item that Young brings up in his information sessions. "The three-to-five member boards include at least one lawyer and a psychiatrist and has been established to provide hearings for involuntary patients who believe they are ready for discharge", he explains. Under the old Act involuntary patients were informed that they could apply to have their cases heard by the Regional Review Board only after waiting one month. Today, under the Revised Act, they are informed that they or a person acting on their behalf can apply immediately for a hearing. And, now the hospital is required to automatically request such hearings for patients who have been in the facility, on an involuntary basis, for a period of six months plus two weeks. In addition, persons declared to be unable to handle their own financial affairs may now apply to have the Board review the physician's decision. Such application may now be filed once every six months, rather than the 12-month period as set out under the old Act.

The revisions have meant that many staff members must now cope with an additional workload--particularly those assigned to Medical Records. "More involuntary patients now appear before Review Boards", says Polischuk, "and this puts increased pressure on our paperwork. In addition we're monitoring such things as what happens to patients who come in for assessments and, of course, we closely check all documentation to ensure all forms are completed properly."

But, she adds, it's a responsibility that her department quite willingly accepts. "The revisions have made us much more conscientious regarding all aspects of patient confidentiality and that's extremely positive. It's meant more work for us but I'm glad to see that revisions have been made. It's far better for the patients."

That, indeed, seems to be the general reaction of all hospital employees affected by the revisions. It's meant more work. But, it's also meant increased privacy and increased recognition of the rights of past, present and future LPH patients.

In-Patients Moving Out

The Medical Director, Dr. Smith, noted in this same edition of *News and Views* that one of the most significant developments at LPH since 1954 was the change in the ratio of in-patients to out-patients. "The in-patient population peaked at about 1,000 and declined to its present 200 in-patients. Major treatment advances ranging from biological, social, psychological, have been introduced." By this time, the average number of out-patients under treatment at LPH was 281, while the RCC registered, in Thunder Bay and the region, an active case load of 578. According to Ken Temple's review of the hospital's first twenty-five years, admissions in the previous year had decreased by 5.6%. A review of clinical data from 1978 revealed that some patients required inpatient services for less than one month, while other patients required many years of inpatient care.

New Legislation and Patients' Rights

News and Views also contained an item on the Mental Health Act of 1978, which had made substantial revisions to the 1967 legislation. While noting that "future historians" would recall that the act was designed "to further safeguard patients' rights", the article somewhat sourly added: "And, they will no doubt completely overlook the contribution made by many hospital employees as they attempted to interpret the Act for fellow employees and for both local and district physicians, health agencies and hospitals." No mention of the patients!

This guarded, even suspicious-sounding, response to the new legislation reflected, to some degree, problems in interpretation of the new law. It also

1978-1986 "A Whole Lot of Turmoil"

probably reflected a sense of unease about the extension of patients' rights, which was the main burden of the Act. The legislation provided that patients' records could no longer be exchanged between agencies or even doctors, without their consent. The power of the medical directorate of the hospital to commit patients into care "involuntarily" was now substantially limited, and regional review boards were to be set up to assess any patient's application for discharge. Involuntary admissions would have to be ordered within five days of entry into the system, and they could only occur if the psychiatrist could show that there was a danger of "serious bodily harm" to the patient or to another person.[2]

Vicki Polischuk, who was (and remains) in charge of the medical records at LPH, noted the "increased pressure on our paperwork" which these changes had wrought, but said that it was a responsibility her department willingly accepted. The revisions, she wrote, "made us much more conscientious regarding all aspects of patient confidentiality and that's extremely positive.... It's far better for the patients." This was the typical reaction within the psychiatric community: general support for the principle and the definition of patients' rights, coupled with a realization that it was going to increase their workloads even as government economic restraints were beginning to put additional pressures on resources.

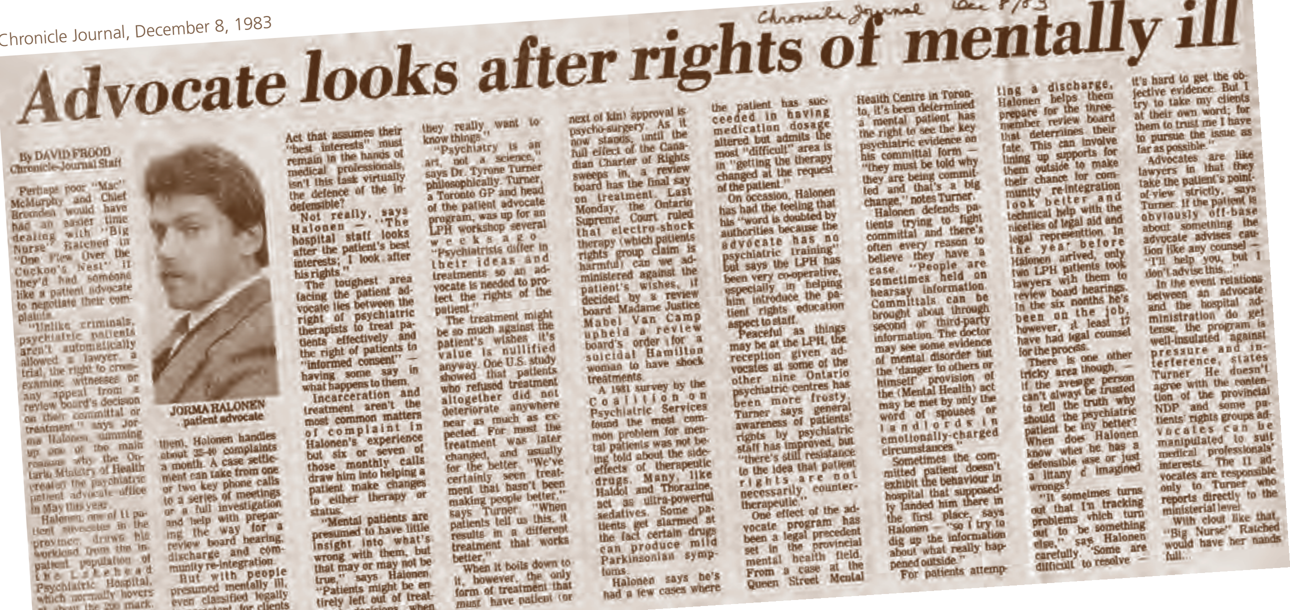
By the late 1970s, the issue of patients' rights could not be ducked. Some of the revisions incorporated into the legislation in 1978 raised enough of a storm among psychiatrists that they were not at first proclaimed into law. Sections 66 and 67 of the Act had given specific rights to a patient to gain access to legal advice and representation in certain circumstances. Patients in mental hospitals would be able to challenge a decision of the hospital to commit them against their will, and to do so before a formal review board. They could also demand access to all documents produced in such a hearing, including those by the medical professionals. Decisions of a review board could be appealed in the courts. Although these two sections of the 1978 Act were not at first passed into law, they were so proclaimed in 1984. The main reason for this was the imminent coming into force of the Canadian Charter of Rights and Freedoms.[3]

Together with the establishment, in 1981, of the Psychiatric Patient Advocate Office at Queen's Park, these legislative initiatives mark the response of government to growing public concern about equality rights in general and the rights of patients in the mental health system, in particular. To its credit, LPH had already begun to move in this direction when, in 1977, a small committee was established to investigate patients' complaints. Chief Psychologist Bert Hopkins became the chair of this body. It proved to be, at first anyway, pretty controversial. He remembers that, on the day the committee published its plans, a senior "mental health person" at LPH flew into his office "in an absolute rage. 'What do you think you're doing, telling these people what their rights are? Don't we have enough problems as it is?'" But more rational counsels prevailed. One of the first changes that the committee introduced was to abandon the practice of taking (sometimes even cutting) the rings off the fingers of all patients when they were admitted. Taking away all personal belongings had been a practice of the past, inspired by fear of self-injury. The committee was also concerned to ensure that any research activities at the hospital would only be developed with the consent of the patients who were under study. The patients' rights movement of the 1980s would, however, take much larger issues than these under its wing.[4]

"The Burr in the Saddle"

The extension of the right of appeal by a patient to the five-person review boards would lead to a substantial change in the "balance of power" between the psychiatric profession and its clients. The introduction of the patient advocate gave even more strength to the previously mute voice of those in the community of the mentally ill. In May, 1983 Jorma Halonen, who had worked briefly as an attendant in the early years, took up his position at LPH as one of eleven advocates in the province. He had an office within the hospital, and direct access to the patients. He was answerable, not to the hospital administration, but to a provincial coordinator in the Ministry of Health. By the end of 1983, Halonen would be dealing with between 35 and 40 complaints a month, some trivial, some serious. In many of these cases, the issue was the drug therapy that had been prescribed by the attending

Chronicle Journal, December 8, 1983



Chronicle Journal Dec 8/83

Advocate looks after rights of mentally ill

By DAVID FROOD
Chronicle-Journal Staff

Perhaps poor "Mac" McMurphy and Chief Bromden would have had an easier time dealing with "Big Nurse" Ratched in "One Flew Over the Cuckoo's Nest" if they'd had someone like a patient advocate to negotiate their complaints.

"Unlike criminals, psychiatric patients aren't automatically allowed a lawyer, a trial, the right to cross-examine witnesses or any appeal from a review board's decision on their committal or treatment," says Jorma Halonen summing up one of the main reasons why the Ontario Ministry of Health created the psychiatric patient advocate office in May this year.

Halonen, one of 11 patient advocates in the province, draws his workload from the in-patient population of the Lakehead Psychiatric Hospital, which normally hovers at about the 200 mark.

Acting as the next best thing to a lawyer for them, Halonen handles about 35-40 complaints a month. A case settlement can take from one or two key phone calls to a series of meetings or a full investigation and help with preparing the way for a review board hearing, discharge and community re-integration.

JORMA HALONEN
patient advocate

But with people presumed mentally ill, even classified legally incompetent, for clients and a Mental Health Act that assumes their "best interests" must remain in the hands of medical professionals, isn't this task virtually the defence of the indefensible?

Not really, says Halonen — "The hospital staff looks after the patient's best interests; I look after his rights."

The toughest area facing the patient advocate lies between the right of psychiatric therapists to treat patients effectively and the right of patients to "informed consent" — having some say in what happens to them.

Incarceration and treatment aren't the most common matters of complaint in Halonen's experience but six or seven of those monthly calls draw him into helping a patient make changes to either therapy or status.

"Mental patients are presumed to have little insight into what's wrong with them, but that may or may not be true," says Halonen. "Patients might be entirely left out of treatment decisions when they really want to know things."

"Psychiatry is an art, not a science," says Dr. Tyrone Turner philosophically. Turner, a Toronto GP and head of the patient advocate program, was up for an LPH workshop several weeks ago. "Psychiatrists differ in their ideas and treatments so an advocate is needed to protect the rights of the patient."

The treatment might be so much against the patient's wishes it's value is nullified anyway. One U.S. study showed that patients who refused treatment altogether did not deteriorate anywhere near as much as expected. For most the treatment was later changed, and usually for the better. "We've certainly seen treatment that hasn't been making people better," says Turner. "When patients tell us this, it results in a different treatment that works better."

When it boils down to it, however, the only form of treatment that must have patient (or next of kin) approval is psycho-surgery. As it now stands, until the full effect of the Canadian Charter of Rights sweeps in, a review board has the final say on treatment. Last Monday, the Ontario Supreme Court ruled that electro-shock therapy (which patients rights group claim is harmful) can we administered against the patient's wishes, if decided by a review board. Madame Justice Mabel Van Camp upheld a review board's order (for a suicidal Hamilton woman to have shock treatments.

A 1981 survey by the Coalition on Psychiatric Services found the most common problem for mental patients was not being told about the side-effects of therapeutic drugs. Many, like Haldol and Thorazine, act as ultra-powerful sedatives. Some patients get alarmed at the fact certain drugs can produce mild Parkinsonian symptoms.

Halonen says he's had a few cases where the patient has succeeded in having medication dosage altered but admits the most "difficult" area is in "getting the therapy changed at the request of the patient."

On occasion, Halonen has had the feeling that his "word is doubted by authorities because the advocate has no psychiatric training" but says the LPH has been very co-operative, especially in helping him introduce the patient rights education aspect to staff.

Peaceful as things may be at the LPH, the reception given advocates at some of the other nine Ontario psychiatric centres has been more frosty. Turner says general awareness of patients' rights by psychiatric staff has improved, but "there's still resistance to the idea that patient rights are not necessarily counter-therapeutic."

One effect of the advocate program has been a legal precedent set in the provincial mental health field. From a case at the Queen Street Mental Health Centre in Toronto, it's been determined a mental patient has the right to see the key psychiatric evidence on his committal form — "they must be told why they are being committed and that's a big change," notes Turner.

Halonen defends patients trying to fight committal and there's often every reason to believe they have a case. "People are sometimes held on hearsay information. Committals can be brought about through second or third-party information. The doctor may see some evidence of mental disorder but the 'danger to others or himself' provision of the (Mental Health) act may be met by only the word of spouses or landlords in emotionally-charged circumstances."

Sometimes the committed patient doesn't exhibit the behaviour in hospital that supposedly landed him there in the first place, says Halonen — "so I try to dig up the information about what really happened outside."

For patients attempting a discharge, Halonen helps them prepare for the three-member review board that determines their fate. This can involve lining up supports for them outside to make their chance for community re-integration look better and technical help with the niceties of legal aid and legal representtion. In the year before Halonen arrived, only two LPH patients took lawyers with them to review board hearings. In the six months he's been on the job, however, at least 17 have had legal counsel for the process.

There is one other tricky area though, — if the average person can't always be trusted to tell the truth why should the psychiatric patient be any better? When does Halonen know when he has a defensible case or just a litany of imagined wrongs?

"It sometimes turns out that I'm tracking problems which turn out to be something else," says Halonen carefully. "Some are difficult to resolve — it's hard to get the objective evidence. But I try to take my clients at their own word; for them to trust me I have to pursue the issue as far as possible."

Advocates are like lawyers in that they take the patient's point-of-view strictly, says Turner. If the patient is obviously off-base about something the advocate advises caution like any counsel — "I'll help you, but I don't advise this…"

In the event relations between an advocate and the hospital administration do get tense, the program is well-insulated against pressure and interference, states Turner. He doesn't agree with the contention of the provincial NDP and some patients' rights groups advocates can be manipulated to suit medical professionals' interests. The 11 advocates are responsible only to Turner who reports directly to the ministerial level.

With clout like that, "Big Nurse" Ratched would have her hands full…

doctor. It is little wonder that, despite the report in the local newspaper that "the LPH has been very cooperative, especially in helping him introduce the patient rights education aspect to staff", he had the feeling that "his word was doubted by authorities because the advocate has no psychiatric training."[5]

Looking back on his three years on the job, Halonen remembers being "the burr in the saddle" of an institution which was certainly struggling a little with the new demands that were being placed upon it. Ken Temple, he says, was a "decent man" who cooperated willingly with him. He remembers the nursing staff also being "pretty good" when it came to accepting his role in the hospital. But there was some opposition from the doctors, who no doubt felt that he was treading on turf that was part of the domain of their profession. He remembers also that, in the early days, the literature he posted on staff notice boards was sometimes defaced with symbols which suggested that he was an agent of the Central Intelligence Agency of the United States! A light-hearted riposte, no doubt, but the suggestion that he was a spy reflected some genuine, if exaggerated, fears within the hospital community.

Halonen says that he was able to acquaint patients with their right to legal counsel and that this made a significant difference to the operation of the review boards. They became much more formal. Yet, he also admits that he was unable to secure the best legal representation for his clients. Lawyers were largely unacquainted with the mental health system and were "not all that skilled." He also suggests that "there used to be a tradition to send more troublesome patients to Penetanguishene" (a maximum security provincial psychiatric hospital in Southern Ontario) and that on one occasion he had been able to secure the return of four of them to LPH. On another occasion, his intervention in a case of alleged assault established that the patient who had been accused, and who might otherwise have been charged, was acting under extreme personal distress. None of these cases suggests that at LPH there were any flagrant denials of a patient's rights.

The view from the other side of the fence was rather different, of course. It is quite arguable that the psychiatric profession was feeling pretty battered by this time. Psychiatric doctors already felt they were regarded as somewhat less than the equals of doctors in the general hospitals and the public health system. In addition to this, since the 1960s radical critiques of their profession, often from within its own ranks, had resulted in a veritable "decline in psychiatric authority." In the early 1970s, the writings of R.D. Laing in Britain and Thomas Szasz in Austria, had even suggested that there was a "myth of mental illness", arguing instead that it was society itself that was "mad". As if this was not enough, by the end of that decade the patients' rights movement was becoming more political, even radical.

> In addition, self-help pressure groups composed of former psychiatric patients, or, as some called themselves, 'ex-inmates' or 'ex-prisoners' sprang up… and began to criticize government and psychiatrists alike for their authoritarian treatment of mentally ill people and their unwillingness to provide community mental health care services.[6]

The profession, therefore, was hardly in the mood for more criticism. Yet, at LPH, for the most part, the transition into the world of patients' rights was pretty smooth. Ken Temple made a point of lending his authority to the proceedings of the review boards by being a constant presence at all hearings, however burdensome they could become. Psychiatrists had never imagined that they would have to defend their decisions in front of committees whose

1978-1986 "A Whole Lot of Turmoil"

memberships were drawn from the general public. Temple, on the other hand, says that the legislation offered no problems to the hospital staff. It was all very clear, he recalls: "There were procedures and regulations … In my opinion, everything fell into place … for the best." But, in truth, these developments did not come without their tensions. All of the psychiatric staff felt that the review boards "made life more difficult", as one of their number, Dr. Lois Hutchinson, puts it. It was not so much that professional judgements were being challenged by patients (although they were, of course), but that an increasing amount of time was being taken away from attention to the needs of those whom it was their vocation to serve.

Dawn Eccles, late 1980's

Dawn Eccles, who came to LPH as a Registered Nurse at this time, and who would eventually attend the hearings of the review boards in the place of the administrator, was witness to some most embarrassing moments. She remembers a psychiatrist who was quite unable to present a coherent case for a perfectly sincere decision about a treatment that had been prescribed for a patient. The fact is that the psychiatrists and psychologists were not trained to be lawyers and, as Dr.Brian Frost remarks, "Doctors don't like making an argument, they prefer to make a diagnosis."

So the mental health legislation, and the Charter of Rights as well, ushered in a new awareness of the responsibilities and legal obligations that LPH had towards its patients. For the patient population it must have felt like a breath of fresh air, to be given such clearly defined rights prescribed by law, and the means by which they could assert them.

They're learning all they can to help native residents...

News and Views, 1978

Aboriginal Issues

The region that LPH served spread not only east and west, but also to the north (although not the far north). Patients from aboriginal or First Nations communities, particularly the Ojibway peoples, were always represented in the hospital community. From the 1980s onwards, the number of the in-town aboriginal populations was growing and this was reflected in admissions to LPH. Carole Faulkner recalls a growing awareness of the need to find "appropriate care for aboriginal peoples." Increasing awareness of patients' rights, when coupled with the recognition of aboriginal rights in the Charter, served only to highlight earlier failures of communication. There was also, of course, a language barrier between the professionals and many First Nations patients who came from the reserves. "We didn't understand them well", says Faulkner, "we had not been acclimatized … our Indian patients tended to congregate with themselves…. Sometimes there was a mixed diagnosis." Issues of substance abuse were often accompanied with psychiatric troubles, and frequently there were cultural factors that were not well understood. Even after treatment had been successful enough to allow for a return to their communities, there were barriers of distance to any kind of effective follow-up care for First Nations patients. But a greater sensitivity to the special needs of these populations was in evidence from the early 1980s. Dawn Eccles speaks of an instance when a particularly difficult case came before one of the review boards, and a conflict arose when requests for traditional native healing practices from one branch of the patient's family clashed with demands for modern psychiatric treatment from another branch. It took the involvement of a Medicine Man brought in from the west to reach a solution. On other occasions, the services of an aboriginal lawyer at the North Bay Psychiatric Hospital were utilized to help resolve cases involving First Nations and Metis patients.[7]

Picnic Tables 1979

Workshop 1979

Loom weaving 1979

Jack Varrin making picnic tables and Christmas toys, 1979

Picnic Tables and Christmas Toys

The advocacy program also brought to public attention a controversial issue. An Advocate in Southern Ontario charged that patients, who worked in the "assembly line shops" at the hospitals for "wages" as low as 25 cents an hour, were being exploited. Such patients, she said, were not only paid far below the minimum wage, but they were ineligible for such benefits as paid leave. At that time, LPH had 22 patients in its Industrial Workshop who were

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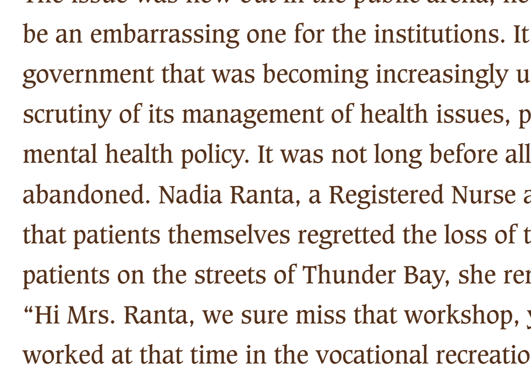
paid between 28 and 65 cents an hour. They made a variety of items, from picnic tables to Christmas toys. Grant Southon, the Supervisor of Vocational Rehabilitation at LPH, responded to questions from the press by asserting that "there's no employer-employee relationship here." Generally speaking, the workshops in the psychiatric hospitals were seen as vocational training and as a means of giving a sense of achievement to the patients who worked in them. Jorma Halonen, although he ventured to doubt that the hospital offered enough vocational opportunities to its clientele, did not directly criticize the practice at LPH, and he admitted that there had been "no direct complaints" about it, when quizzed by a local newspaper reporter.[8]

Nadia Ranta, RN, 1980



The issue was now out in the public arena, however, and it would prove to be an embarrassing one for the institutions. It had its effect on a provincial government that was becoming increasingly uncomfortable with media scrutiny of its management of health issues, particularly those related to mental health policy. It was not long before all such "shop" activities were abandoned. Nadia Ranta, a Registered Nurse at LPH for many years, claims that patients themselves regretted the loss of the program. Meeting ex-patients on the streets of Thunder Bay, she remembers they would call out: "Hi Mrs. Ranta, we sure miss that workshop, you know." Marion Clark, who worked at that time in the vocational recreation department, today states sadly,

"Who lost? Who lost in that? The patients did. Did anybody ask them? No."

Conflict and Confusion

Carole Faulkner sees the 1980s as "a very heady time in psychiatry because so much was changing, and some changes were being embraced and others were being resisted and there was a whole lot of turmoil in the psychiatric community." Pressures on the staff at LPH were more in evidence during these years. Government restraints were beginning to place limits on funding even as the demands on professional time were stretching human resources.

Community Advisory Board (CAB), 1987

Public criticism seemed to be growing, amidst doubts as to the suitability of institution-based care. Staff losses had taken place, first in 1974, when the NRC was established, and took a large number of clinical staff with it. In 1978, new cuts had been made, small in number, but enough for a sense of insecurity to arrive at LPH. After all, if the majority of patients being treated were, by this time, no longer in residence, what was the future of an institution that consisted of five huge pavilions sitting on over one hundred and sixty acres of land and designed for a resident population of 1100?

In 1983, a report to the Ontario government entitled Blueprint for Change raised, for the first time, the suggestion that Ministry of Health should "divest" itself of its control of psychiatric hospitals to locally-appointed boards of management who would separately set goals and objectives that responded to their particular local needs. The report's author, Dr. Gilbert Heseltine,

> admitted that central government control ensured the provision of basic, minimum psychiatric hospital services throughout the province, but there were 'considerable grounds for dissatisfaction with their performance to date.' Moreover 'some reasons for this dissatisfaction' derived from the fact that the Ministry exercised central control over the hospitals. Heseltine set forth detailed criteria which hospitals would have to meet in order to qualify for divestment, including the development of clear objectives for the individual hospital, improvement in training programs of hospital personnel… and, finally, giving the community advisory boards an increased role in influencing government policy towards the hospitals.[9]

Divestment would not become part of the political landscape for thirteen years, but here, in Heseltine's report, was the formula for the future of mental health provision in Ontario. For someone such as Ken Temple, who believed so strongly in the benefits of a centralized system of management and supply

Many activities propel patients towards community

Social Worker Naomi Farber and Psychologist Jamie Arthur ....conducting group therapy session

A newly-introduced Lifeskills Program and patient participation in the hospital's Fit Five physical fitness promotion are just two of the latest features to be added to the LPH Community Readiness Program.

The program, which was introduced in November of last year and moved to its present 2S location in January of this year, now has a capacity for 14 patients and features all manner of activity geared to help participants successfully rejoin community life. Interpersonal skills are emphasized, group therapy sessions are now featured and home skills, such as management of time and money, are soon to be taught. The hospital's Assistant Food Services Administrator Marg Holm is regularly scheduled to lead lessons regarding nutrition while Dr. D. Perenack, LPH dentist, offers sessions on proper dental hygiene. Patients regularly take part in individual psychotherapy sessions, in psychodrama or any number of other highly-individualized and sometimes customized treatment programs.

The program is designed for patients who do not require acute psychiatric care, says Co-ordinator Hanusia Romaniuk. "It's for patients who have specific problems which prevent them from joining community life," she says. "A lot of people involved in this program cannot seem to find effective ways in which they can deal with life in the community. Their community-based lives seem to be destructive to themselves. Some have been in and out of hospital. They're fine when discharged but soon find themselves unable to cope in the community. We're hoping we can break that out-again, in-again cycle." She admits to being a "little amazed" at the progress some of these patients have made during the past few months. "Some," she says, "have done a complete turnaround. Some have amazed both our staff and staff from other areas of the hospital."

The program encourages patients to become self-determining individuals by offering weekly staff-patients meetings. Patients are asked to voice their complaints regarding hospital life, to help plan solutions and to offer suggested program changes. They're asked to help plan community-oriented activities or outings. And they're offered an opportunity to either voice their approval or disapproval of suggested activity changes.

At the present time most participants have been referred to the program from other areas of the LPH. Romaniuk expects that once the program re-locates to its 4A site and is able to accept six additional patients it will begin accepting referrals from external agencies.

That, she adds, is somewhere in the future. Right now her biggest headache is attempting to get people to call the program by its right, proper name. "Many people still refer to us as being the Behavior Modification Program. We do use some behavior modification in the program but the token economy system is gone. We are definitely what our name implies -- a Community Readiness Program. We are preparing our patients to become successful members of the community."

...new faces...

..........Nursing
Mrs. D. Weatherby..........Nursing
Ms. V. Peel..........Nursing
Mrs. J. Shumka..........Nursing
Mrs. H. Kaarela..........Nursing
Mrs. W. Walmark..........Nursing
H. McGuire..........Nursing
Mrs. T. Owchar..........Nursing
Mrs. J. Leppanen..........Nursing
Mrs. K. Merrifield..........Nursing
Mrs. G. McNabb..........Nursing
P. Cormier..........Occupational Therapy
Dr. A. Lower..........Maintenance
Miss J. Rosenthal..........Stores
W. Donnelly..........
D. Smith..........

Part Time

..........Nursing
Mrs. R. Meyer..........Nursing
Mrs. L. Winters..........Dietary Services
Mrs. S. Hall..........Dietary Services
Mrs. L. Gibbs..........Dietary Services
Mrs. L. Roland..........Voc, Rec.-Vol. Services
Mrs. M. Onski..........Laundry and Linen
Mrs. I. Guthrie..........

News and Views, 1981

(rather as the army had been commanded and provisioned), it may have been a relief that Heseltine's proposals were largely ignored at that time.

One small, but significant, step towards a more responsive attitude to local concerns was taken by the province, however. In 1983, Community Advisory Boards (CAB) were established in the mental hospitals of Ontario. The CAB at LPH had representatives appointed from the city and the region that the hospital served, including the First Nations communities in the north. It was not a governing body, nor did it directly intervene in the administration of LPH. It could only bring to the attention of the Ministry issues that were special to Thunder Bay and the region, and it could advocate for change and for funding, directly to the Minister. The Administrator of the hospital reported to the advisory board on a regular basis, and, according to Lynn Pylypiw, who was a member of the board at LPH for seven years, it concerned itself largely with advocacy issues related to funding and to shortages of psychiatric staff. "Our hospital was under-funded....the government gave lots of money to the south.... When it came to Thunder Bay, all of a sudden there was no money available."

The Garden Party, an annual event at LPH invites residents from senior homes in the community onto the grounds for a special celebration in the summer. 2001

In 1982 and 1984, two "operational reviews" carried out by external consultants failed to find solutions to the issues surrounding future directions and staffing for the institution. The truth was that uncertainty was contributing to a lowering of morale across the Ontario mental health system. It manifested itself in frustration at cuts in hospital budgets and increasingly tense rounds of negotiations when contract talks were opened between the government and its civil service staff. The Ontario Public Service Employees Union (OPSEU) brought to light what it called the fears of its members when it went public on the issue of "increasing violence" at mental residences and hospitals, in January 1982. Two staff members of the Northwestern Regional Centre represented the employees at LPH, as well as NRC, at a union press conference held in Toronto. Speaking to a local reporter, one of them asserted that the increase in staff abuse "is basically attributable to staff cuts in the past five years at the institutions." No doubt such complaints could be dismissed as part of the politics of negotiating a new contract, but the issue

1978-1986 "A Whole Lot of Turmoil"

had not been given such prominence before, as part of collective bargaining, and it arose out of the desire to protect jobs by insisting on a minimum number of staff on each shift.[10]

Netta Calvert with the Community Support Program assists a client in purchasing groceries, 1981

Within six months, psychiatrists across the province were beginning a work slowdown to protest the lack of movement in salary negotiations with the Ministry. Dr. James Hignell at LPH, President of the Medical Staff Association, stated that the doctors would not attend administrative meetings, nor sign medical records, as part of the protest. It didn't come to much and, according to Brian Frost, such actions were not taken all that seriously at the local level. Psychiatrists at hospitals in Southern Ontario, however, had gone so far as to refuse to admit new patients during the month of slowdowns. Albeit the salary issue was settled, the problems within the system and the lack of a clear direction for the hospitals themselves, were wearing people down.[11]

In Northwestern Ontario, the particular problem of attracting doctors to LPH had never been completely resolved. A government incentive program that offered doctors an additional $20,000 on their salaries had, according to Temple, improved the situation, so that in 1982 he could claim that the staffing problem was no longer "that bad." But further unrest became evident a few years later, in 1986, when the doctors in Ontario threatened to go on strike if a series of staged 'Study Days' across the province did not result in their pay negotiations being taken to arbitration.[12]

Community Care?

Such developments, even when the issues were resolved (and they were), could not have been good for the system as a whole. They certainly would not have benefitted the patients. De-institutionalization had been taking place in Ontario since the early 1970s. Increasingly, programs had been developed at LPH to treat the mentally ill as out-patients. On the whole, however, community-based care for such persons had been neglected by governments, so that there was less than adequate provision for housing, either in group homes or other forms of special-need shelter. Many nurses and doctors remember, with much discomfort, coming across people whom they had treated as residents, addressing them from the streets, or wandering the city malls, living in poor housing, even spending nights in the Emergency Shelter House. In retrospect, it is probably true to say that, as long as the separation of the psychiatric hospitals from the rest of the provincial health system continued, it would always be difficult to place patients back into the community with adequate access to decent homes and a secure living. Experience had already shown that Homes for Special Care, Approved Homes and other forms of supported accommodation, were insufficient to meet their needs.

In addition, the stigma of fear and suspicion that had always been attached to those with mental illnesses or disabilities, remained. In 1978, a survey conducted by LPH staff had revealed that the "community is hesitant to work with, become personally involved with, ex-psychiatric patients." The hospital's Volunteer Coordinator at that time, Ken Wasky, reported that,

> the greatest problem ex-patients have in re-adjusting to community living is proving to others they have recovered from their illnesses, are able to obtain and continue to be

CHRONICLE JOURNAL, FRIDAY, MARCH 22, 1974

Town Talk

Hospital Emphasizes More Out-Patient Care

A progress report on activities at Lakehead Psychiatric Hospital indicates a greater emphasis on out-patient care than ever before.

In the hospital's annual report, administrator C. K. Temple outlined success of A Crisis Intervention Team established in January of this year as an alternative to institutional care. Staff for the team was drawn from the existing ward staff and their task was to assist a person presenting himself for psychiatric help whether or not he was admitted to the hospital. Although 57 per cent of admissions were re-admissions, there was a reduction in the inpatient population.

Patient follow-up included an increase in out-patient prescriptions and clinical staff assistance. During 1973, 58 per cent of admissions were informal as compared with 37 per cent for the previous year. Over-all admissions for the year were 794 with the average daily census at 574 patients.

Outpatient Day Care information booth, 1983

Chronicle Journal, March 22, 1974

involved in a work situation and are ready to develop and maintain friendships with other community residents.[13]

Few would suggest that, by the mid-1980s, this situation had improved to any significant degree.

For real change to come to the lives of the increasing number of out-patients still seeking services from LPH, a complex of well-funded community resources would be necessary. Appropriate housing, geared to the varying needs of the patient population, was required. Long-, medium- and short-term supports for those who were unable to manage entirely on their own, were still at a premium. Above all, ex-patients would need assistance in finding a way back into the labour force, in jobs which suited them. These would be the pre-requisites if "community care" was going to have any real meaning for them. The failures of the de-institutionalizing wave of the 1970s had already demonstrated these basic truths. How long would it be before "community care" would actually replace the long-abandoned "custodial care"?

"The Colonel" Retires

Ken Temple's management of the hospital came to an end in 1986. "The Colonel" had been in charge for fifteen years. He had been, in many ways, an ideal successor to the brief but tumultuous rule of Milton J. Fisher. His sense of order, his reliance on the "chain of command", his rigid adherence to policy directives and his complete loyalty to the system had undoubtedly brought stability to LPH during a long period of change. His dictum - "Follow the Manual" - had worked, for most of those years. But it is arguable that, by the mid-eighties, such nostrums were losing their potency. Humane and supportive as had been his role, both with patients and with staff, there is a sense that, by the end of his period in office, it was time for a change. The road ahead would require a more subtle, nuanced, style of leadership at LPH.

But Nobody Came Out Tops

Before any baseball game can begin, a decision has to be made — which team is up to bat first. And that's what Mayor Walter Assef of the City Council Team and C. K. Temple, administrator of the Lakehead Psychiatric Hospital are doing here through the time-honored methods of "tops". The game — between the city and hospital staff and residents — was played Wednesday and came out without a winner or a loser. It ended in an 18-18 tie. City Council was not satisfied with the outcome though and has requested a re-match. . . . next year.

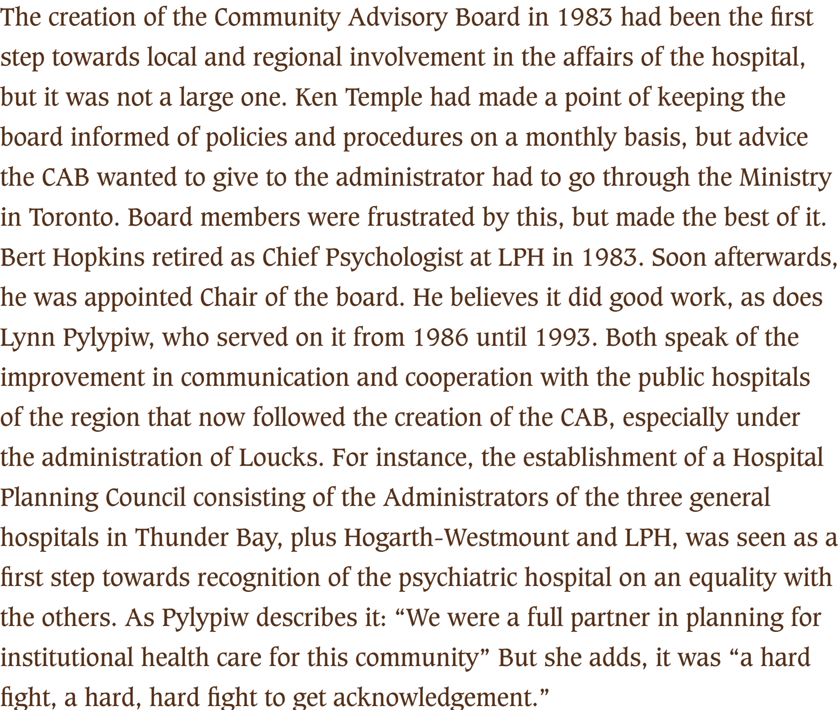
Chronicle Journal, September 12, 1973

1986-2003 The Rocky Road to Divestment

Connecting to the Community

The man who succeeded Ken Temple in 1986 was a different kind of manager. Foster Loucks had come to Thunder Bay four years before as Executive Director of the Thunder Bay District Health Council. He possessed credentials in hospital administration, and his years at the council had fully acquainted him with the politics of public health in the region. This would stand him in good stead as LPH began to move closer to full integration into the broader health system during his nine years at the helm. Nevertheless, he would feel, throughout those years – and probably because of that previous experience – the constraints placed upon him as the servant, not of a local governing or management board, but of the Ministry of Health.

The creation of the Community Advisory Board in 1983 had been the first step towards local and regional involvement in the affairs of the hospital, but it was not a large one. Ken Temple had made a point of keeping the board informed of policies and procedures on a monthly basis, but advice the CAB wanted to give to the administrator had to go through the Ministry in Toronto. Board members were frustrated by this, but made the best of it. Bert Hopkins retired as Chief Psychologist at LPH in 1983. Soon afterwards, he was appointed Chair of the board. He believes it did good work, as does Lynn Pylypiw, who served on it from 1986 until 1993. Both speak of the improvement in communication and cooperation with the public hospitals of the region that now followed the creation of the CAB, especially under the administration of Loucks. For instance, the establishment of a Hospital Planning Council consisting of the Administrators of the three general hospitals in Thunder Bay, plus Hogarth-Westmount and LPH, was seen as a first step towards recognition of the psychiatric hospital on an equality with the others. As Pylypiw describes it: "We were a full partner in planning for institutional health care for this community" But she adds, it was "a hard fight, a hard, hard fight to get acknowledgement."



Foster Loucks, 1986

Loucks felt himself to be continually frustrated in his relationship with the Ministry of Health. Unlike Temple, he baulked at the limitations that this placed on his administration of the hospital. Staff at LPH were public service employees, either members of a union or a staff association whose provincial offices negotiated directly with Management Board Secretariat of the Government of Ontario for wages, salaries and terms and conditions of employment. Unlike their counterparts in public hospitals, they had the right to strike. Where his predecessor had felt comfortable within such a province-wide structure of governance, Loucks did not. "Even though a thousand miles away, I felt they [the Ministry officials] were over my shoulder", he says, and "you didn't feel you were all that well supported." Above all, Loucks reflects, government "didn't want issues to get into the newspapers." He remembers always being aware that political considerations governed mental health policy and that, if he ever allowed LPH to become the centre of controversy, he would be "on the carpet." But he acknowledges that, for example in 1989, there was a significant infusion of new money into the system, from Queen's Park.

The Graham Report

The trigger for this unexpected governmental largesse was almost certainly the Graham Report, which was commissioned by the Ministry of Health, and published in 1988. Entitled Building Community Support for People, this document, unlike so many that had gone before it, was to have a major impact upon the delivery of mental health services to those in need, throughout the province. The report reiterated what had already been said numerous times in the past – that de-institutionalization of psychiatric hospital patients must be accompanied by a community-based mental health system, which linked directly to the needs of the "clients" (as, by this time and increasingly, they were called) in the different regions of the province. It recommended much more direct cooperation between the province's psychiatric hospitals and the various agencies involved in public health. A contemporary study of the history of mental health care in Ontario assessed the Graham Report as follows:

Graham Report, July 28, 1988

> It places priority on providing services to those with serious or prolonged mental illness; it suggests diverting

funds from inpatient services to community services; and it attempts to sketch an organizational framework within which planning will take place. It recommends the establishment of a provincial advisory committee on mental health care to monitor planning and to serve educational and advocacy functions. And it raises the question of whether provincial hospitals should be divested to community boards.[1]

Loucks was impressed by the direction that the report recommended, which was at first pursued with some intent by the government. The report clearly stated "where dollars were needed for the severely mentally ill." Such patients are usually defined as those with disorders such as schizophrenia or paranoia, which are chronic in nature and which interfere with the person's capacity to function normally. Loucks gives credit to the Ministry for accepting the principle that financial and social supports would be in place for clients as they moved into the community. In other words, money would follow them and directly fund supports for housing and medical services that would be needed to make "community living" a reality. As Dawn Eccles, who by this time had become Loucks' assistant puts it: "When they did it in the seventies, they didn't do it right." Now there seemed to be a determination to correct the errors of the past.

Eventually, "divestment" would prove to be the key to the transformation of services for psychiatric clients, from the hospitals to a wide range of community agencies and support systems. It would mean that the Ministry of Health would get out of the business of management and control of the provision of mental health services, including the psychiatric hospitals. The Ministry would eventually cede such powers to local and regional health organizations, and concern itself mainly with directing funds into specific programs of support. However, the publication of The Graham Report, would not lead directly to divestment. The provincial government did not adopt it as policy. It was merely on the horizon of government planning. At LPH, divestment would not take place for a further fifteen years.

Dr. Lois Hutchinson, 2002

The Development of Community Services

Community care, however, was at last becoming a priority. It was heartily endorsed by Loucks and a new Medical Director (now called Psychiatrist-in-Chief), Dr. Lois Hutchinson who, in 1990, returned to LPH after several years in British Columbia.

Jan Inkster, Director of the Occupational Therapy Department at LPH since 1980, felt there was a "huge void" in the provision of adequate services for ex-patients. In 1989, she became Assistant Administrator of Clinical Services. In this role, she was able to collaborate with Dr. Hutchinson in the development of housing initiatives with adequate support programs that were geared to the real needs of their clients.

A new LPH program, called the Community Support Program, was developed in 1992. The program was designed to provide clinical care and support for individuals who were discharged from the hospital. With appropriate levels of community-based services, clients would not need to rely solely on inpatient services during their recovery.

It was quickly recognized that access to safe and affordable housing was a key ingredient to successful community integration. Staff members, Reg Wilson and Val Picard, played pivotal roles in finding housing for clients and advocating for the establishment of a formal housing program.

With their support, Northern Linkage Community Housing was established with a local Board of Directors. The mission of this organization was to find suitable housing for people with a serious mental illness and to work in partnership with Lakehead Psychiatric Hospital to ensure necessary clinical and support services were provided.

A medium support residence, called Pioneer Court, was opened in 1994. This was a complex of twelve apartments that was built in collaboration with Lutheran Community Housing. People who were discharged from Lakehead Psychiatric Hospital were accepted into this residential setting and received clinical and support services from the staff of the Community Support Program.

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Another supportive housing development, Franklin Manor, followed in 1996. This was a small residential home, located outside the city, for a group of individuals with "high support" needs. Inkster saw remarkable improvements in the condition of those who lived at this dwelling: "within six months, they presented very differently." She observed them responding positively to life in semi-independent communities outside the hospital setting. In her view, this was proof-positive that community living worked.

Alpha Court grand opening, 1992

This was the psychiatric hospital's first venture into moving people into the community along with the supports that they required. Community Support Assistants provided, and continue to provide, care and support for the residents twenty-four hours a day. The staff offered a variety of services to clients who now needed to learn new skills in order to live independently. The services were not just clinical in nature. Many of the clients had lived at LPH for years, and were unfamiliar with the new landscape of the city and the complexities of living in it. Even to go shopping and to handle changes in the stores were experiences that had to be relearned.

The Canadian Mental Health Association building located on 200 Van Norman Street, Thunder Bay

A number of new community mental health agencies were established in Thunder Bay. Their development reflected the shift from hospital services to community care and the need for more community-based services. The Canadian Mental Health Association was incorporated in 1975, Alpha Court was created in 1989 and PACE (People Advocating for Change through Empowerment) was formally established in 1993, although it's predecessor Ontario Psychiatric Survivor Alliance – Thunder Bay Chapter began in 1990. These are just three of many agencies and programs that were established throughout Northwestern Ontario in the late 1980s and 1990s with the goal to provide ongoing care and support for people with mental illnesses who were ready to live in the community.

"Rae Days"

In the meantime, the economy of Ontario hit a brick wall. In 1990 the New Democrats had come to power. At first, the new government seemed to promise a different approach on all social policy fronts. Within a couple of years, however, the province's annual deficit had become hot politics. The premier, Bob Rae, at first tried to steer the government and the unions into a "social contract" by which cuts in wages or hours of work would be made by agreement, in return for the maintenance of job protections. This having failed, the New Democrats imposed "Rae Days" upon all staff, union and non-union, in government-funded agencies. What that meant, effectively, was that staff had to take time off without pay. The policy would hit all hospital and health care services in Ontario, including mental health care.

Government cut-backs thus coincided almost exactly with the changes in the provision of mental health care that were taking place across the system. Naturally, these cut-backs made it all the more difficult to put reforms into place. The response to belt-tightening at LPH was to try, as far as possible, to maintain the clinical staff by cutting back on replacing vacancies that occurred on the administrative side. A somewhat top-heavy system of Assistant Administrators was gradually reduced in size by collapsing positions and asking the remaining staff to take on additional responsibilities. But cuts in support service staff were inevitable under such circumstances, especially when the number of patients in residence was continuing to slowly decline.[4]

Staff Reductions Begin

At the beginning of 1993, Loucks announced the lay-off of forty-two staff at LPH: "Unfortunately, the hospital has faced the consequences of reduced resources and the imminent closure of the Northwestern Regional Centre, our neighbour facility." The NRC had been rehabilitating developmentally handicapped clients since its establishment in 1974. Its very success in placing its people into decent housing stood in contrast to the record of LPH itself, albeit the funding support from the Ministry of Community and Social Services had always been more generous than that of the Ministry of Health.[5]

Forty-two job losses for LPH at this time sounded a warning for the future. Now, in the following years, "expenditure reduction plans" would proliferate

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and the Community Advisory Board would develop "strategic planning", all in the context of a growing sense of malaise within LPH and deep uncertainty as to its future. Vel Roininen, by this time Regional Personnel Administrator, remembers the changing atmosphere at the hospital well.

"I know that many of the staff were having a tough time because there had been so many changes … in the policy and procedures. No sooner did you read a memorandum and know this was something you had to do from now on, the next week something else came out and said ignore that and do something else."

Little wonder that, according to Jan Inkster, the Community Support Program ran into opposition from some nurses at LPH, from whose ranks it took its staff, at the expense of existing units at the hospital.

Putting People First, 1993

PUTTING PEOPLE FIRST

Office of the Minister / Bureau du Ministre

Ministry of Health / Ministère de la Santé

Queen's Park, Toronto, Ontario M7A 2C4 — 416/965-2421

Message from the Minister

Putting People First is a policy framework for the transformation of mental health services across Ontario. As a government, we are committed to establishing a mental health system that will recognize the unique needs of every person with a mental illness.

The framework reflects the tremendous efforts of many individuals and groups over the past several years. In particular, the Graham report of 1988, **Building Community Support for People: a Plan for Mental Health in Ontario**, provided a central focus for development of this policy.

To create a balanced and integrated system of services to care for all persons with mental illness, our first priority must be to respond effectively to the special needs of the seriously mentally ill. Whenever possible, we will work to provide assistance and services for them in their own communities.

We face a significant challenge, one that will require a high level of co-operation and co-ordination, among those who use mental health services, those who work in the mental health field, and friends, families and communities. I am confident the outstanding efforts that shaped this framework will also help us move forward in the difficult task of building a co-ordinated system of mental health services that put people first.

Ruth Grier
Minister of Health

"Putting People First"

In 1993, the Ministry of Health produced a policy document on the reform of mental health services in Ontario. Although it spoke in general terms, rather than putting forward specific proposals, its intent can be summed up by its title, "Putting People First". It proposed a ten-year strategy to improve a system that, it admitted, was "not well-coordinated."

> … consumer/survivors may be shifted from one place to another, assessed again and again, and still not receive appropriate services. At the same time, the people who provide mental health services feel frustrated by the gaps and lack of coordination in the system.

The document went on to sketch out a series of principles upon which future reforms would be based. These included a re-allocation of funds within the system, to better meet the needs of the client community, the development of stronger local and regional planning initiatives and a further reduction in the number of clients in the psychiatric hospitals. It proposed that the District Health Councils take the lead in the implementation of such reforms, at the local and regional levels.[6]

The following year, the Ministry of Health published Implementation Planning Guidelines for Mental Health Reform, which laid great stress on the responsibility of the health councils to develop regional plans that promoted

> equity of access to specialized services and longer-term treatment, rehabilitation and reintegration services for consumers/survivors and families throughout the region.[7]

The provincial government's intention to reform the system was clear and unequivocal, as was the general direction it expected that reform to take. One way or another, even in hard financial times, most 'consumer/survivors' were on their way back to the community, probably with adequate funding for the first time, and the downsizing of the psychiatric hospitals was to continue. How it would actually happen was still unclear, and it is interesting to note that, even as late as 1993-4, the word "divestment" did not figure in either of these documents.

PACE Building located at 329 Waverly Steet, 1993

PACE and Patient Issues

In this atmosphere of increasing uncertainty, clients were often the first to be affected. Advocacy groups were now emerging in Thunder Bay which drew attention to some of the more obvious failings in the system of mental health care. In 1992, a very critical publication by a group called PACE (People Advocating for Change through Empowerment) gave voice to a number of

Despite uncertain times, LPH staff have always been leaders in the community by participating in charitable events, i.e. United Way. The support given to charities in the community is indicative of the caring and compassionate nature of the staff. 2001

Lakehead Psychiatric Hospital

LPH logo, 1987

complaints about the lack of effective community care for the mentally ill in the region. Entitled Surviving in Thunder Bay: An Examination of Mental Health Issues, it allowed people in the community of the mentally ill to explain, in their own words, how under-serviced they felt themselves to have been. One of their most persistent complaints was about the lack of decent housing: "Respondents felt a limited income restricted their housing choices and they often had to settle for sub-standard living conditions." Jan Inkster recalls going to a meeting of another group of ex-patients at this time where she was astonished to discover how negative had been their experiences under the care of LPH: "I was quite appalled to hear the patients' perspective of the way they were treated. I was quite shocked."[8]

Loucks certainly felt the pressures from advocacy groups. "When I was there", he remembers, "the consumer/survivor groups" were growing in influence. He believed that they had a "perception … that psychiatry and the psychiatric hospital was a menace."

Whilst acknowledging the natural and legal rights of the client, he felt that all too often the belief of some was that mental illness was no different from diabetes or heart disease. Some of their number, he says, seemed to believe that if the developmentally disabled could be rehabilitated into the community, it was no small step to do the same for the "severely mentally ill" who were the clients of LPH, and who he thought did, in fact, require the kind of twenty-four hour care that the hospital still offered. Whether Loucks was right or wrong, it cannot be denied that his concerns were shared by some in the psychiatric professions at that time.

Within the hospital itself, the number and the intensity of Review Board hearings were increasing. By this time they were called "Consent and Capacity Boards", but they were changing in nature as well as title. Dawn Eccles recollects one such board that sat for three to four days on one case alone.

Soldiering On

Despite the uncertainties, the programs that were the commitment of LPH to deliver to its clients were not substantially compromised. A Forensic Unit had been established in the hospital by this time. Previously, such patients had been in beds throughout the hospital. Now, in one unit, they were looked after by a specialized team of clinical staff. The unit made assessments of the mental condition of people brought before the courts, as well as taking charge of those who were found "not criminally responsible" for their crimes.

Acute Care still had two wards up and running in 1993 and the numbers of patients in the Psycho-geriatric units was close to capacity. In-patient numbers continued to decline. In 1992/3 the average number of beds in use at LPH was 148; the rated bed capacity 157. Two years, later the corresponding numbers were 138 and 141.[9]

Developing in-patient care was now less and less the priority of governments of any stripe in Ontario (and from the late 1980s the stripes were changing with extraordinary rapidity!) But government cutbacks, across the board, were not changing. In August, 1994 the hospital's own plan to meet the circumstances of financial constraint was pre-empted by brutal cuts in practically all government ministries, including the Ministry of Health. At the local level it was charged that, in the cutback process, LPH had taken the hardest hit of all the hospitals in the city: "A Cynical Move", headlined The Chronicle-Journal. In November, 1994 the same newspaper reported "LPH, Hogarth Hospitals remain in Limbo", which was the gist of a report from the District Health Council on health care in the region. The future of these two hospitals was now, said the newspaper, "Up in the Air."[10]

Morale Takes a Fall

In a sense, all of these developments in the first half of the 1990s, gathered together, created something of a self-fulfilling prophecy. The longer the future of such institutions remained in doubt, the less chance they had of re-invigorating themselves. Their clients would become increasingly disturbed

by the prospect of being de-institutionalized when, despite the admirable developments that were in train by this time, it was not clear where they would be re-housed. They could hardly be blamed if they feared a repeat of the scenario of the 1970s. Cutbacks in support service staff only made that concern dig deeper. As for the clinical staff, their own futures were also full of uncertainty. The temptation would be for them to move on to more secure settings, which would only make for a more acute shortage of psychiatrists, psychologists, nurses, occupational therapists and other professionals in the field.

Just as serious was the fact that, if such people left, it would be desperately difficult to replace them. This weighed increasingly on the minds of people such as Lois Hutchinson, who recalls that, by the mid-1990s, "everybody expected the place to close down." Loucks had had difficulty enough, he remembers, trying to "pry" psychiatrists out of Toronto and Southern Ontario to Thunder Bay in the days when the going was much more promising. Now it would be almost impossible.

Morale and recruitment were lost, and so, inevitably, was a sense of direction from within the institution. The Community Advisory Board, which had begun its work with some enthusiasm in the 1980s, was losing its drive during these later years. Lynn Pylypiw recalls, sadly: "In the long run the boards, our board here, locally, simply disintegrated and the government lost all interest in the purpose of the boards, any interest whatever. It was just an exercise in futility, I think, in the end."

Foster Loucks says, when he left LPH in 1995, some accused him of leaving a sinking ship. Yet, his administration had been a successful one in many ways. He had certainly brought LPH closer to the general public of the city and region. He had pioneered the development of the Northwestern Ontario Mental Health Network, which tried to link the various mental health agencies in the region to the three general hospitals and to promote cooperative programs for their clients. He was, in the words of one of his admirers, "a master of planning", who had, in many ways, paved the way for the changes that would very soon overtake the mental health system in Ontario. But he would not be satisfied that his efforts had matched his hopes when he took the job. The constraints that had been laid upon him by the Ministry of Health frustrated him. Even in 1995, while he had no doubt that there was "clearly an intent to downsize the hospitals", he says that the actual intentions of the Ministry were still vague.[11]

Ron Saddington, Hospital Administrator LPH 1995-1998

Administrators Come and Go

When Foster Loucks moved on, the problem of recruitment took on another dimension. Now the question was what potential Administrator would be interested in a position at an institution that seemed to have no future? It took six months to find a replacement for him, in the shape of Ron Saddington, who had been the administrative head of McKellar Hospital. While that decision was pending, Dr. Hutchinson took over the temporary duties of administration, even as she remained the head of the psychiatric team. This was to revert to a leadership system that had been abandoned in 1969! It could not have been satisfactory, and certainly placed a great burden on Hutchinson's shoulders. When Saddington left in 1998, to become the Administrator of the newly-created Thunder Bay Regional Hospital (TBRH), Hutchinson again, bravely, took on the role of Administrator at LPH for a further year and a half. Even as she did that, she became Chief of Psychiatry at the Thunder Bay Regional Hospital. The one advantage of this arrangement was that she now could begin to integrate the services at LPH with the general hospital's psychiatric unit. The workload must have been daunting. But such a rapid turnover of leaders in such a short period of time spoke volumes to the administrative state of mental health care in Thunder Bay, by the last half of the 1990s.[12]

The Health Services Restructuring Commission

All the question marks around the future of, not only LPH, but all the general hospitals in the region would finally be answered in 1996. In the previous year, the Conservative government of Mike Harris had come to power. Their

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Janet Sillman and Helen Tucker unveil accreditation plaque, 2003

"Common Sense Revolution", which envisaged a re-alignment of government funding and services across the board, called for reform of the entire hospital care system in Ontario, including mental health. A Health Services Restructuring Commission was established to make recommendations on the downsizing, renewal or amalgamation of all hospitals in the larger cities of the province, including Thunder Bay. Now, indeed and at last, divestment would become a reality, and "community care" its necessary complement.

In 1996, the Commission submitted its report. As Carl White, President of St. Joseph's Care Group (SJCG), explains it, the recommendations "changed the face of hospital care in this city forever." The Commission directed St. Joseph's Hospital (as it was then called) to assume the governance and management of LPH. All of the programs, though not the buildings and its grounds, would be divested from government to SJCG. The newly-named Ministry of Health and Long-Term Care would now be essentially a funding agent and a policy-maker. The Health Services Restructuring Commission directions focused primarily on hospital-based services, with very little mention on the provision of necessary community-based programs and services. Divestment itself, and the closure of the buildings on Algoma St., was scheduled for March 31, 1997.[13]

Carl White, President,
St. Joseph's Care Group, 2002

There was an immediate outcry of dismay from every quarter! That such a radical re-ordering of all the hospital services as well as the mental health system in Thunder Bay could happen within less than a year, stretched the boundaries of "common sense", let alone the ability of the various agencies to deliver it all on time. Radical restructuring involved the integration of existing hospitals with historically-separate local health "cultures". It involved the delicate issue of fully integrating mental health supports into the mainstream health system. Although this had been going on at the theoretical level since the 1970s, it had only just begun to get into gear a few years before. Thus, very rapidly, the due date for divestment and closure of the psychiatric hospital was put back, first until March, 1999 and finally until June, 2003.[14]

Strikes

Until 1996, the future of LPH had been unclear. The increasing commitment to the development of community-based mental health care served, inevitably, to sow seeds of doubt in the minds of clients and health care servers alike. For those who worked at LPH in the non-clinical service departments, the possibility that the institution might close was a real threat to their livelihoods, for if it was possible for clinical staff to follow clients out into the community, they could not. They had very good reason to fear that, once the buildings were gone, so would they. Even before the end of the Temple regime, and through much of Loucks' administration, labour unrest was manifesting itself, and not only at LPH, but across the province. In March, 1996 and in the light of all the uncertainty, the Ontario Public Service Employees Union (OPSEU) called its membership out on strike. They remained out for five weeks.[15]

For those who went on strike in 1996, and who came close to another work stoppage in 1999, divestment meant more than a transfer of governance to a local agency such as SJCG. Hospital re-structuring and the integration of mental health into the public sector meant that those who worked in future for St. Joseph's Care Group would no longer be public servants, and so, like other employees in the general hospitals, would be without the right to strike. From this point until divestment came about, labour issues would affect many decisions, culminating in another, and much more serious, strike in 2002.

Divestment Delayed

Carl White himself finds it difficult to explain why divestment, announced in 1996, took seven years to be delivered. There were no fundamental differences of philosophy between the Ministry of Health and Long-Term Care and SJCG on the issue, but there were certainly many points of detail to be ironed out. Transfer of the building and lands was not necessary, because they had always belonged to the Ontario Realty Corporation, and would remain so. On the other hand, SJCG did not want to occupy buildings

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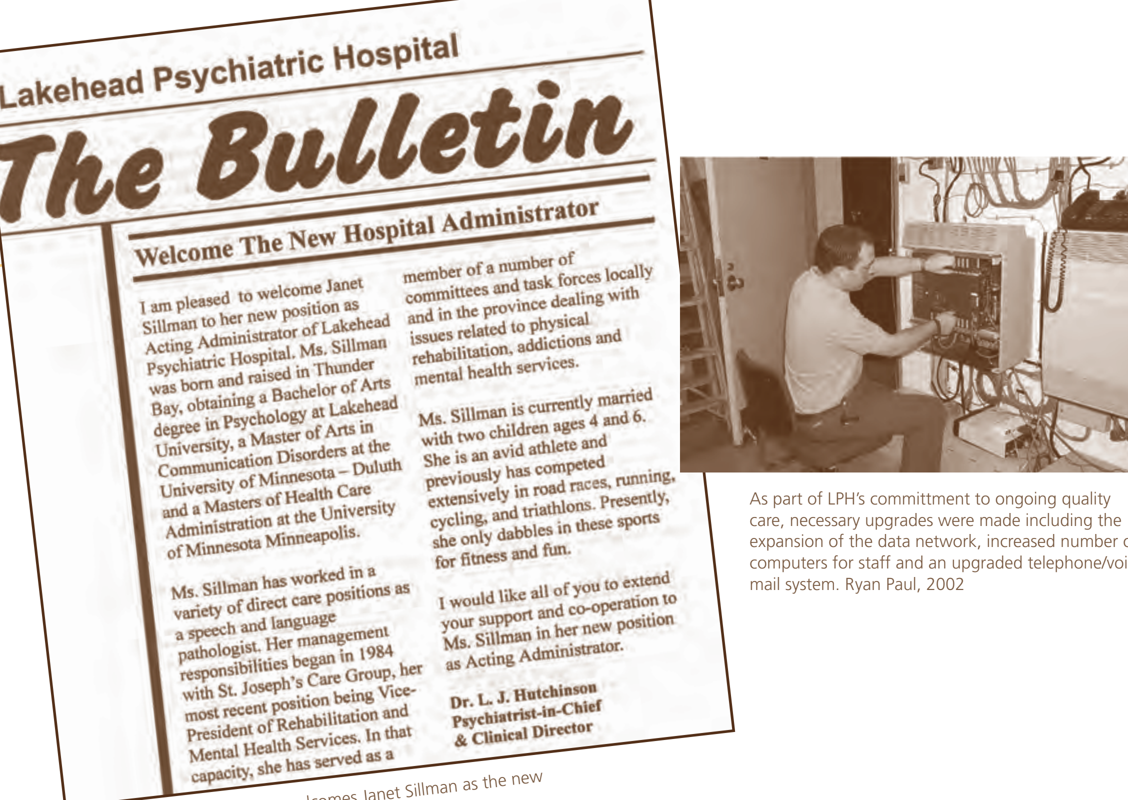
at Algoma St. that were in poor condition, and the history of the site since at least 1994 had been one of neglect, with funding for renovations and repairs having dried up. Negotiations dragged on and on. In the end, White puts the responsibility for the long delays on the bureaucracy of government: “When you’ve run something for years and you’ve worked with it for years, when the time comes to let it go, that’s difficult to do.” However, “there’s no way you should negotiate from 1997 to 2003!”

In February, 2000 Janet Sillman was seconded by the Ministry of Health and Long-Term Care to LPH as Hospital Administrator, with the confident expectation that her main task would be to oversee a rapid transition into the SJCG organization. She expected it to take no more than six months. She discovered a situation “chaotic and compromised for many, many reasons.” A number of the management staff had left by this time, as well as some of the psychiatrists. The maintenance of the buildings had been neglected from the mid-1990s. Leaks in the ceiling were caught by buckets in the corridors. She found beds in the wards that had been purchased decades before. There were few computers in the offices, and many of the vehicles used to transport clients to appointments, were not roadworthy. No increase in funding had been received by the institution since 1994. She discovered that the clients who remained expected that “St. Joseph’s Care Group was going to close the hospital and kick people onto the streets.” There was, she remembers, “not a whole lot of forward thinking” around the possibilities the future could bring. She describes the picture that presented itself to all who remained at LPH as “the Big Unknown.”

The huge question-marks that hung over divestment were as yet unanswered. What would be the shape and staffing needs of services for their clients in a re-organized mental health care system? What, in particular, were the plans of SJCG to meet those needs? After years of uncertainty, would clients have faith in the ability of a new kind of administration to find solutions? Would it be possible to move forward whilst this atmosphere of uncertainty lingered, especially when any changes that might be proposed were bound to affect the job security of the existing staff, both clinical and service personnel?

Divestment was a province-wide development. If SJCG was finding it difficult to negotiate with the Ministry of Health (and the successive postponements of



Lakehead Psychiatric Hospital

The Bulletin

Welcome The New Hospital Administrator

I am pleased to welcome Janet Sillman to her new position as Acting Administrator of Lakehead Psychiatric Hospital. Ms. Sillman was born and raised in Thunder Bay, obtaining a Bachelor of Arts degree in Psychology at Lakehead University, a Master of Arts in Communication Disorders at the University of Minnesota – Duluth and a Masters of Health Care Administration at the University of Minnesota Minneapolis.

Ms. Sillman has worked in a variety of direct care positions as a speech and language pathologist. Her management responsibilities began in 1984 with St. Joseph's Care Group, her most recent position being Vice-President of Rehabilitation and Mental Health Services. In that capacity, she has served as a member of a number of committees and task forces locally and in the province dealing with issues related to physical rehabilitation, addictions and mental health services.

Ms. Sillman is currently married with two children ages 4 and 6. She is an avid athlete and previously has competed extensively in road races, running, cycling, and triathlons. Presently, she only dabbles in these sports for fitness and fun.

I would like all of you to extend your support and co-operation to Ms. Sillman in her new position as Acting Administrator.

Dr. L. J. Hutchinson
Psychiatrist-in-Chief
& Clinical Director

The Bulletin, LPH Newsletter, welcomes Janet Sillman as the new Hospital Administrator, February 2000

As part of LPH’s committment to ongoing quality care, necessary upgrades were made including the expansion of the data network, increased number of computers for staff and an upgraded telephone/voice mail system. Ryan Paul, 2002

Janet Sillman, Vice President, Mental Health and Addiction Services, 2000 to present

the date of divestment made that only too obvious), so were all the hospitals in the province. Between November 2000 and April 2001, five provincial psychiatric hospitals were transferred to public hospitals. Although SJCG was the first in the province to receive Commission directions to accept governance and management of a provincial psychiatric hospital, it was not the first to carry out those directions.

Labour unrest amongst provincial employees complicated the situation and caused a further delay in the divestment. Provincial employees came out on strike again, on March 13, 2002. During this work stoppage at LPH, twenty-five managerial staff manned the hospital and provided basic services, alongside those members of staff who had been designated as “essential”, to about one hundred clients inside the hospital, and delivered medications to a further one hundred people living in the community. One psychiatrist in Thunder Bay described it as a reversion to “1950s psychiatric care.”[16]

The strike lasted for eight weeks. It would surely have been as hard on the clients in and outside the hospital as it was on staff and management. Yet, when it was over, there was every reason to hope that the clouds of uncertainty over the future of LPH were finally being blown away. Furthermore, that care for the community of the mentally ill in Thunder Bay was intact, with every prospect of improvement. During the course of the strike, very few of the people who worked at the hospital had actually left it. The atmosphere on the picket lines had been tense, but never aggressive. There were no large demonstrations against the management of LPH, such as had taken place at some mental institutions in the south. Dr. Brian Frost,

who had been medical director during much of the 1980s, has referred to an indefinable "spirit of the LPH", which, in his view, never deserted the staff members of the hospital, even in difficult times. It seems to have prevailed in the worst of times as well.

When the strike was over, decent relations prevailed between staff and management, amidst a general willingness to move forward. For Janet Sillman, this was a positive sign.

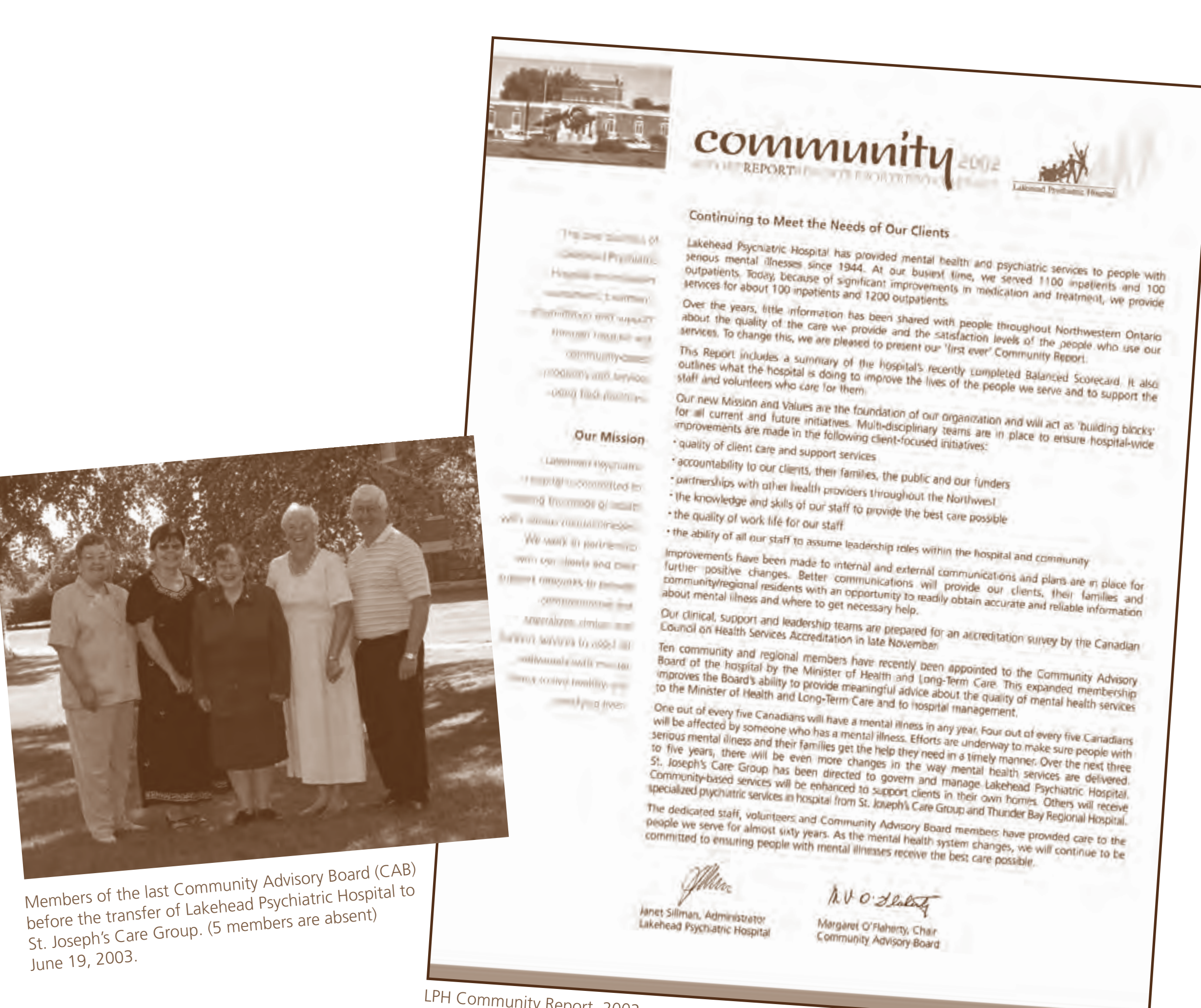
> People here get paid less than [at] other facilities, the building is falling down and clients are the most challenging to deal with…[yet] the part that warms my heart the most is that people stay here."

Soon they would have something to stay for.

A Delicate Balance

It is all too easy to see these last years of the old LPH administrative structure in a negative light. Certainly one crisis seemed to follow another as a general malaise engulfed the institution. The buildings were neglected, staff were demoralized, clients confused about the future. But a fair assessment of its continuing role in the community of the mentally ill requires a more delicately-balanced judgement. The truth is that, not only were existing programs maintained during these difficult times, but exciting and new ones were being developed. The path towards "community integration" for their clients was being laid down with increasing enthusiasm by the staff, as the obvious benefits of this kind of care demonstrated. If the buildings were failing, the programs were not. Decent housing at last was being provided, and for more clients. Support staff lived with those who were in high need, or were within ready reach of those who could, largely, manage on their own. This was no mean achievement.

In the last years of LPH, with the encouragement of Sillman, the Community Advisory Board was revitalized. It had, indeed, fallen into disuse since the heady days of the late-eighties and early-nineties. The Ministry had quite clearly lost all interest in the idea. When CAB members at LPH reached the end of their terms of office, they had not been replaced. When the new Administrator decided to re-institute the advisory board at LPH there were only three members left on it. A vigorous drive was begun to recruit new members, and the Ministry was petitioned to sanction their appointments, which it did, virtually without dissent. Once re-established, the CAB lent its support to Janet Sillman's determination to upgrade the furniture and equipment at LPH and to improve the maintenance of the facility. All of these goals were pursued despite the continuing financial constraints that were laid upon the organization.



community 2002 REPORT

Lakehead Psychiatric Hospital

Continuing to Meet the Needs of Our Clients

Lakehead Psychiatric Hospital has provided mental health and psychiatric services to people with serious mental illnesses since 1944. At our busiest time, we served 1100 inpatients and 100 outpatients. Today, because of significant improvements in medication and treatment, we provide services for about 100 inpatients and 1200 outpatients.

Over the years, little information has been shared with people throughout Northwestern Ontario about the quality of the care we provide and the satisfaction levels of the people who use our services. To change this, we are pleased to present our 'first ever' Community Report.

This Report includes a summary of the hospital's recently completed Balanced Scorecard. It also outlines what the hospital is doing to improve the lives of the people we serve and to support the staff and volunteers who care for them.

Our new Mission and Values are the foundation of our organization and will act as 'building blocks' for all current and future initiatives. Multi-disciplinary teams are in place to ensure hospital-wide improvements are made in the following client-focused initiatives:

- quality of client care and support services
- accountability to our clients, their families, the public and our funders
- partnerships with other health providers throughout the Northwest
- the knowledge and skills of our staff to provide the best care possible
- the quality of work life for our staff
- the ability of all our staff to assume leadership roles within the hospital and community

Improvements have been made to internal and external communications and plans are in place for further positive changes. Better communications will provide our clients, their families and community/regional residents with an opportunity to readily obtain accurate and reliable information about mental illness and where to get necessary help.

Our clinical, support and leadership teams are prepared for an accreditation survey by the Canadian Council on Health Services Accreditation in late November.

Ten community and regional members have recently been appointed to the Community Advisory Board of the hospital by the Minister of Health and Long-Term Care. This expanded membership improves the Board's ability to provide meaningful advice about the quality of mental health services to the Minister of Health and Long-Term Care and to hospital management.

One out of every five Canadians will have a mental illness in any year. Four out of every five Canadians will be affected by someone who has a mental illness. Efforts are underway to make sure people with serious mental illness and their families get the help they need in a timely manner. Over the next three to five years, there will be even more changes in the way mental health services are delivered. St. Joseph's Care Group has been directed to govern and manage Lakehead Psychiatric Hospital. Community-based services will be enhanced to support clients in their own homes. Others will receive specialized psychiatric services in hospital from St. Joseph's Care Group and Thunder Bay Regional Hospital.

The dedicated staff, volunteers and Community Advisory Board members have provided care to the people we serve for almost sixty years. As the mental health system changes, we will continue to be committed to ensuring people with mental illnesses receive the best care possible.

Our Mission

Janet Sillman, Administrator
Lakehead Psychiatric Hospital

Margaret O'Flaherty, Chair
Community Advisory Board

Members of the last Community Advisory Board (CAB) before the transfer of Lakehead Psychiatric Hospital to St. Joseph's Care Group. (5 members are absent) June 19, 2003.

LPH Community Report, 2002

1986-2003 The Rocky Road to Divestment

The Community Advisory Board developed Mission, Vision and Values Statements for the hospital. They emphasized, above all, the commitment to meeting the needs of adults with serious mental illness.

> "We work in partnership with our clients and their support networks to provide comprehensive and specialized clinical and support services to assist all individuals with mental illness to live healthy and satisfying lives."

The "core business" of LPH was described as "hospital and community-based programs and services using best practices."

The re-invigoration of the CAB reaped its benefits during the strike of 2002. As it lingered on, meetings were held off-site (out of respect for both sides in the dispute), in order to find ways of exerting pressure upon the Ministry and the union through local government representatives and the media. The CAB also had a role to play in the final act of the drama, the transition of LPH from the control of the Ministry to that of SJCG.[17]

Margaret O'Flaherty (CAB Chair) and Janet Sillman (Hospital Administrator) planitng a tree at closing ceremony celebration. June 19, 2003.

A New Beginning

For all concerned, divestment, which came in June 2003, marked a turning point of great importance. As if to signal the new beginning, the Ontario budget for 2004 promised an additional $65m in that year for mental health services, and $185m in all, over the next five years. This commitment was made at a time when the stigma of mental illness had by no means been overcome, and the political benefits for the government were probably negligible. It was a sign, for Janet Sillman, of a new beginning for psychiatric care for the whole of the Northwest, as well as for the province. At the very heart of this change was, finally, a whole-hearted commitment to the provision of supports at all levels in the community itself, for those clients who are mentally ill and in need of psychiatric care.

Quality Mental Health Services Continue

The divestment of Lakehead Psychiatric Hospital to St. Joseph's Care Group

As of June 23, 2003, St. Joseph's Care Group assumes governance and management of Lakehead Psychiatric Hospital. During and following the divestment process, quality mental health services will continue to be provided to Lakehead Psychiatric Hospital clients and their families.

Understanding Divestment

In 1996 the Health Services Restructuring Commission made many significant changes to the hospital-based health care system in Ontario. At that time, Thunder Bay had five separate hospital corporations which the Commission narrowed to two: Thunder Bay Regional Hospital, dealing with acute care, and St. Joseph's Care Group, dealing with complex care, mental health, addictions and rehabilitation.

As part of restructuring, the governance and management of Lakehead Psychiatric Hospital will be turned over or divested to St. Joseph's Care Group on June 23. Prior to this date, LPH has been managed and governed by the Ministry of Health and Long-Term Care (MOHLTC).

Carl White, President, St. Joseph's Care Group, sees many advantages to this transfer. "First of all," he points out, "the government's role is funding and setting standards in health care, not delivering health care."

He continues, "It is significant that mental health services in Northwestern Ontario will be delivered under the direction of a volunteer Board of Directors, and a local organization will be planning and setting the course for these services."

Carl explains that, as government employees, it was difficult for the previous administration to disagree with government policies and direction. This conflict will no longer exist, allowing changes to be made and advocacy for expansion of services when needed.

Moving forward with divestment and the transfer of services to the community provides an opportunity to relocate some services where they are most needed in Northwestern Ontario. Space will be acquired to handle community-based and outpatient programs.

As a member of the Northwest Mental Health Implementation Task Force, Carl is committed to their findings. "The recommendations of the report to the Ministry are supportive of good mental health planning and good principles of service delivery to people with mentally illness. I am so convinced of this that we will be using that document as a guiding principle in our own planning, whether or not it is fully endorsed by the Ministry."

Plans are in place for joint corporate services and joint administration. Janet Sillman, Vice President, Mental Health and Addictions for St. Joseph's Care Group, has been seconded to LPH for over three years and will continue to oversee and manage the facility.

Carl sums it up, "There will be no difference in client care when divestment takes place on June 23. St. Joseph's Care Group will experience a significant increase in the mental health programs we deliver. We are focused on developing plans for delivery of these programs in ways that support mental health reform. We are well prepared to do this."

Anyone with Doubts About Mental Health Recovery Should Talk to John McFarlane!

John is able to tell you of early signs that his world was not what it should be. His home situation was difficult and unstable. He suffered from attention deficit disorder. He couldn't sit still, couldn't concentrate.

John quit school at the age of seventeen. He was in and out of jobs, relationships, friendships. He was treated for depression and anxiety, but never for the illness from which he suffered – schizophrenia. And life was spiraling downward.

In his early 30's, John was admitted to Lakehead Psychiatric Hospital. He refers to this as his "first real break. The doctors knew what they were doing and I haven't looked back since."

Finally diagnosed, he was prescribed medications that were effective for about ten years before they had to be changed. He's been on a new medication for the past six years. "I've been just fine since then. Life is good and I'm very, very happy," he states emphatically.

"Schizophrenia is a completely different reality," he explains. "Everything is black or white, there are no grays. You have no awareness of self, no understanding of abilities or disabilities. When you are sick, there is no tomorrow, no next day – there is just the moment. The future is non-existent."

John speaks passionately of the readjustment he went through when the medications started to

*It's nice to **feel** like a part of my **community***

work. "It's very scary," he says. "When you begin to learn how most people think, you finally realize your thinking is so different. You gradually develop a little awareness here, a little perception there, and each little piece is a building block-something to add to and build on

"I'm living a full life now. I live on my own, cook, clean, budget and handle my own money. I have friends, do volunteer work, sit on the volunteer Advisory Board at LPH, and work part-time in the LPH canteen."

Having lived in the same apartment for 12 years, John feels very much a part of his neighbourhood. "The neighbours know my medical background, but they talk to me, their kids talk to me. They're not afraid of me and they care about me. It's nice to feel a part of my community," he says. "It does something for your sense of self-worth."

He has nothing but praise for the mental health care professionals who helped him when he needed it, and who take pleasure in his ongoing recovery. He feels confident that medical treatment will continue to be available for those who need it. "Administration is bound and determined to put us on the map as a place that is helpful in the treatment of mentally ill people. I respect that."

John has a message for us all. "One thing I want to say to the community is you don't have to be afraid of people who are out-patients. They may talk your ear off, look disheveled and have poor hygiene, but they won't do you any harm. If they're out there, they're okay!"

John has schizophrenia. He is also a valued and active member of the community. Unintentionally, he pays himself the ultimate compliment, "As far as I'm concerned, I'm as close to average as anyone can get!"

Our Mission St. Joseph's Care Group is a Catholic Organization committed to provide compassionate and holistic care and services to the people of Northwestern Ontario.

Our Vision St. Joseph's Care Group will identify and respond to the unmet needs of our region as a way of continuing the healing mission of Jesus in the tradition of the Sisters of St. Joseph of Sault Ste. Marie

Divestment Newsletter - 2003

the future

Looking Forward

St. Joseph's Care Group is a Catholic Organization committed to provide compassionate and holistic care and services to the people of Northwestern Ontario.

St. Joseph's Care Group will identify and respond to the unmet needs of our region as a way of continuing the healing mission of Jesus in the tradition of the Sisters of St. Joseph of Sault Ste. Marie.

St. Joseph's Care Group

St. Joseph's Care Group assumed the governance and management of LPH on June 23, 2003. By this time the integration of mental health services into the community was well under way. According to Maurice Fortin, the executive director of the Thunder Bay branch of the Canadian Mental Health Association (CMHA), probably less than 20% of those clients who come to his agency for support are today directly linked to the LPH site. CMHA is a service provider for those people with psychiatric problems who live in the community, and require assistance in finding work and decent housing. The days when the psychiatric hospital on Algoma St. was the main source of support, and its residential wards the main destination of people with mental health problems, are surely over.

SJCG, today, manages a wide range of services in the field of health care. St. Joseph's General Hospital has become a Rehabilitation/Complex Care Hospital which provides continuing care and a number of out-patient services to the community. St. Joseph's Heritage is a complex which includes Bethammi Nursing Home, a Community Centre, the Alzheimer Day Program (which is run from the old Manor House) and P.R. Cook Apartments, which provide support services to its tenants. If mental health care is truly to be integrated into the health system, its attachment to St. Joseph's Care Group is a natural one.

There is a remarkable irony here, in that SJCG is so closely identified with St. Joseph's Manor, which is the old Wiley residence, the site that had been originally designated, in 1934, as the first psychiatric hospital in Northwestern Ontario. An Alzheimer Day Program and Community Outreach Services for geriatric clients with mental illness are located at St. Joseph's Manor. Charlie Cox would smile at that.

LPH entrance sign, 2003

A Task Force for Mental Health

The process of divestment had been a difficult time for all concerned, but it was also a dynamic event. According to Janet Sillman:

> It was a time of high anxiety for clients, their families and staff. Many believed SJCG was to close the doors of the hospital, to reduce staff and abandon clients. Extensive work was done to prepare all stakeholders for the transfer. In June [2003], there was a celebration at LPH for everyone… to celebrate all that had been accomplished, to say goodbye and to move on.[1]

Indeed, before divestment actually took place, plans for the new administration of mental health care in the whole of Northwestern Ontario were being laid. In response to a recommendation of the Health Services Restructuring Commission, the Ministry established the Northwest Mental Health Implementation Task Force. It was charged with drawing up a 'regional mental health system" for Northwestern Ontario. Created in 2000, this body reported back in December, 2002, just a few months before divestment occurred.

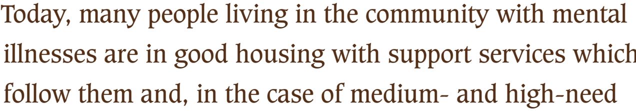
The task force defined eight principles upon which the delivery of mental health services would be based. Amongst these were:

> Establish the Northwest Region Mental Health Board and the Consumer and Family Supports Board to co-ordinate and integrate the mental health system in Northwestern Ontario. Establish a community mental health centre in the city of Thunder Bay. Establish a continuum of services and supports [across the region]. Establish appropriate safe and affordable housing for individuals with a serious mental illness that is tailored for [mental patients] in Northwestern Ontario.[2]

Such principles now guide the movement towards community reintegration for its clients, which is the goal of the new management at LPH.

"A Decent Place to Live, a Friend and a Job"

"We design our systems based on peoples' needs.... We don't say, 'here's the service, you fit into it'." These are the words of Marion Clark, who remains at LPH as Coordinator of Learning and Professional Practice, and they sum up the change that has occurred, largely over the past ten years, as the road to divestment has been taken. Dawn Eccles puts it in a nutshell when she says that what mental health clients want above all is "the same as we all need. A decent place to live, a friend and a job. Of course that's what they want. Who doesn't?" In other words, a mental illness should no longer define who, or what, a person is.



Video conferencing at LPH, 2003

Today, many people living in the community with mental illnesses are in good housing with support services which follow them and, in the case of medium- and high-need clients, this means that there are resident health providers available to them most of the time. Such housing projects as Alpha Court, Lutheran Community Housing, Pioneer Court, Franklin Manor and Wilson Place contribute together to give what Carl White describes as "a sense of pride" to those who now live independently in an apartment, where before they once "lived in a hospital room with three or more other people." These housing developments join some remaining Approved Homes and Homes for Special Care.

Less than one hundred inpatients remain at the old hospital. Some of them are seriously ill, and are, one way or another, likely to remain in need of twenty-four hour care. Some are in the Forensic Unit, some are in the Geriatric Psychiatry program. Over time, but only if appropriate accommodation and supports are available to them, many of these clients will live in the community. SJCG is planning to add thirty-eight long-term mental health beds at the St. Joseph's Hospital site. The Forensic Program will be transferred to Thunder Bay Regional Health Sciences Centre (TBRHSC), along with six adult mental health beds.[3] TBRHSC will then operate a 30-bed Adult Mental Health Program and a 20-bed Forensic Program, as directed by the Health Services Restructuring Commission. Some individuals and groups have voiced their concerns about establishing forensic services within an

A game of crib, 2003

Clients enjoy LPH gymnasium, 2003

acute care hospital. It will be a ground-breaking event for Ontario and other jurisdictions. But it can also be seen as another step in the plan to integrate mental health care into the broader health care continuum.

> Summing up the new directions that are now in train, Sillman says: The plan is to use acute and long stay mental health beds for people who are at risk for harming themselves or others. The key to achieving this is to establish safe, affordable housing with clinical services and supports in place.... Without enough supportive housing options, ... we will not be able to reduce the bed numbers to those directed by the Commission and we will never fully achieve the principles of mental health reform, as set out by the Ministry.[4]

Clients and staff in kitchen, 2003

Continuing Concerns

Some issues related to specific client populations remain to be resolved. The future of the psychiatric hospital on Algoma St. is not yet clear, for until the last client leaves, the buildings will stand. Dr. Hutchinson says that psycho-geriatric clients will be "difficult to provide services to", which is a concern echoed by Maurice Fortin. He believes that illnesses related to Alzheimer's

will grow in number over the years. Such is the reality of a country with an aging population. Fortin also suggests that instances of mental illness related to stress in the general population are going to rise significantly over the next twenty years. The client who is mentally ill, for whatever cause, is not going to go away.

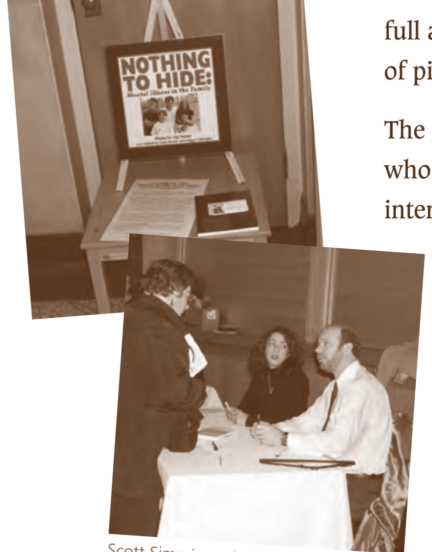
"There will always be people who require twenty-four hour care", says Marion Clark. Will enough beds be available for them at the hospitals or in supported housing, or perhaps the homes for the aged? "I worry about this", says Carl White, for it is difficult to forecast the exact need for such beds. "What's the right number? I hope it's small", he adds. One promise he does make, however: "St. Joseph's Care Group will not go down as the [agency which] began the slum living for people living with a mental illness in this community."

Staffing Problems

At no time in its history did LPH feel secure in the number of clinical staff on its books. Psychiatrists and psychologists, in particular, were always in short supply. Integration of health services, the building of TBRHSC, the development of the Northern Ontario School of Medicine at Lakehead and Laurentian Universities, may together herald an end to that problem. Recent bursts of new funding from the federal government to the provinces, specifically for health care, may offer other ways for agencies such as SJCG to access special funds for psychiatric staff and community-based mental health services. But it will not necessarily be doctors alone who are needed in the future. "Most people worry about the doctor shortage", says White, "but wait till the nursing shortage hits us full board." In recent years this has become a new trend in the provision of health care across Canada, and it is already having an impact on the delivery of services.

Staff and clients making crafts, 2003

Anti-Stigma campaign, 1999



Scott Simmie and Julia Nunes, authors of The Last Taboo: A Survival Guide to Mental Health Care in Canada, educate community about mental illness, 2001

The Stigma Remains

People who remember the days of the Ontario Hospital Port Arthur will recall the fear amongst the general public of the "inmates", and the dark whispers about life behind its walls. The stigma of mental illness was all too apparent in those early days. Even today the most optimistic of people in mental health care do not suggest that it has been substantially overcome. Opposition to the location of group homes or housing units in residential areas of the city continues to express itself, from time to time. It is all very well to say that mental illness is just another disease. Because of a general ignorance about its nature, and also of the wide variety of drug and rehabilitative treatments that are now available, the stigma remains.

Mental illnesses are different. They do not present themselves physically. Improvements in a person's condition are not necessarily visible for all to see. Mental illness affects that which continues to be something of a mystery – the human mind. People who behave differently from us for no apparent physical cause have always been treated with suspicion, fear, and sometimes rage. Will "community living" help destroy the fear that has so often surrounded those who have psychotic illnesses, are manic-depressive, or are so filled with despair that their behaviour seems erratic to those who meet them on the street corner, or in their neighbourhoods? How far, in truth, have we come to full acceptance of the equality rights of the mentally ill, since that small party of pioneers arrived at Fort William station in 1936?

The only persons who can answer that question with certainty are those who themselves struggle with such problems on a daily basis. One of the interviewees for this book, an ex-patient, was unequivocal in her answer. No, she says, the stigma has not gone away. Well-known and respected in the community, she nonetheless does not feel able to tell people of her own short period of mental distress, many years ago in another town far from here. Of the psychologists and the psychiatrists who were interviewed, each of them accepted that, if the taint of mental illness is less today than it was, it has not disappeared with the return of their clients back into the community. Dr. Brian Frost, for example, states: "It's been there for thousands of years.... It's still substantially there." Neither does a person in the nursing profession, such as Carole

Photo merge from LPH Community Report, 2002

Faulkner, expect attitudes to change very quickly.

> I am not that much of a Pollyanna. I think there will always be people who make negative comments, whether it is a psychiatric patient or a physically disabled person, or a mentally challenged person, there is always going to be a small nucleus who are threatened by somebody who's different. That's going to happen forever, that's human nature.

Janet Sillman, who is now Vice-President, Mental Health and Addiction Services, at SJCG, is more upbeat about the future. She puts her faith in the education of the general public to the real nature of mental illness. Others have said that education of public attitudes will not work on its own, that sometimes it even tends to harden existing prejudices. Jan Inkster suggests, on the other hand, that only full integration of the mentally ill into the community of the well is the key to unlocking fear and ignorance: "Getting to know someone with a mental illness can be very enlightening, and they can be very good friends, too."

One thing can be said with certainty. Institutional care, if it did anything, fostered the stigma. Community integration offers cause for hope that it can eventually be overcome.

From Custodial to Community Care

This short study has traced the history of LPH and its predecessors, from the mid-thirties to the present day. In the course of those years, huge changes in the administration and the nature of mental health care in the province of Ontario have taken place. When the story began, the client was forced to fit into an institutional framework that already existed, first at Neebing, then at the Ontario Hospital Port Arthur. Today, the ideal is to frame the therapy and the physical circumstances of mental health supports to the needs of the individual client. We have progressed from 1100 beds and over-crowded "dorms" at LPH, to individual and group homes for most of the clients, living in the general population of the city and region.

The path away from custodial care has been marked by some particular changes in attitude and therapies. The "drug revolution" of the 1950s undoubtedly allowed the psychiatric professions to use more humane and effective treatments for their patients. Critics of the use of drugs to 'calm' those who are mentally ill remain, but the movement back into the community is unthinkable without them. The introduction of skilled nurses, psychologists, occupational therapists, social workers, and other rehabilitation services has led away from the individual power of the psychiatrist and towards a team approach to the provision of care to those with mental health problems.

Changing attitudes to psychiatric care have been signaled also by legislation. The Mental Health Act of 1967, the amendments that were made to that Act in 1978, and again in 2000 (Brian's Law), the Charter of Rights and Freedoms, proclaimed in 1985, have fundamentally affected the way that those with mental health problems have been treated. The increased emphasis on patients' rights that was heralded by such legislation has had its own effect upon the movement towards community care.

The first steps in that direction at LPH were taken in the early 1970s. Before that the regimes of care offered variously at Neebing, the administration building on Algoma St., and even the new facility that finally arose in 1954, exactly mirrored the architectural designs of those places. It was custodial. De-institutionalization, when it began at LPH, was not a great success, as it was never a success in those days anywhere in Ontario. Far too many of those who were discharged must have felt the real pain of loss, as the bosom of the "city within the city" that had been their home at LPH was exchanged for life in poor housing, or even the Shelter House and the Salvation Army hostels.

The problems of delivering real community supports for the mentally ill were compounded, from the early 1980s, by diminishing government funding and increasing confusion about the role and the future of LPH. Under these circumstances it is quite remarkable that the hospital was able so radically to adapt its programs during these years of uncertainty, and to continue

The Future Looking Forward

to deliver real care to its clientele. The dedication to their calling of the community of LPH over the years, despite all the failings of the old system, must not be under-estimated. Those who work in the field of mental health are special people.

The movement away from the institutional model of mental health care continued unabated into the 1990s. By that time, real progress had been made, especially in the delivery of decent, safe and affordable housing for the clients. At the same time, the separation of the administration of the psychiatric hospitals from the rest of the public health sector was breaking down. When the Health Services Restructuring Commission issued its directions for the integration of hospital services in Thunder Bay and the divestment of LPH to SJCG, its proposals fell on willing ears. From that point onwards, and despite the organizational and labour troubles that followed, the commitment to a community care system for the mentally ill was firmly made.

The End in Sight

During the course of preparing this book, almost all those who were interviewed were asked the question "Will you regret the passing of LPH?" To be fair, answers varied. There were some who used to work there who look back on life within the hospital with a good deal of nostalgia. They remember the camaraderie, the sense that they were, along with the patients, part of a "community". Today that word has a new meaning, and particularly for the clients in the system. Unfortunately, it has not been possible to interview many of them, partly because of issues related to their right to privacy. In the end, only four current or former patients plus one family member offered their memories of LPH and of the changing life of a mental patient in the Ontario system. This was hardly enough to get anything close to a full perspective on the clients' experience over the years.[5]

One former patient, Wayne Lax from Kenora, who describes himself as a "survivor", sent newspaper clippings that told of his harrowing experiences of electro-shock therapy at various mental institutions, including LPH. He claims

Front entrance of LPH, 2004

LPH, 2004

to have lost much of his memory of twenty-five years of his life. In addition, he says, "I had more pills pumped into me than Elvis Presley." In sharp contrast to his experience is that of Lucienne Sisco. She was first admitted to the Ontario Hospital Port Arthur in 1963, and underwent ECT, as well as being prescribed a variety of drugs, having been diagnosed as schizophrenic. After three and a half months she was discharged and lived a normal healthy life for thirty years before experiencing another bout of her illness, in 2004. She has nothing but praise for the treatments she received on both occasions.[6]

Pat Paradis has worked at LPH since the early 1970s. She has seen the change that has come over the way that the clients themselves respond to the hospital. In the early days, she says, "they looked at LPH as their home and viewed short periods of living in the community… as an interruption in their treatment, viewing it as punishment because of the lack of supports available [to them]." More often than not, they were happy to return to the "safety" of the hospital. Today's clients, she argues, have an almost opposite point of view.

> [They] feel that coming to hospital is an interruption in their life, as they view their home [as] in the community and never in the hospital. Quality of life for clients has continued to improve with the addition of supports in the community. We always tell clients we start planning for their discharge on the day they arrive.[7]

Here, surely, is measured the distance between custodial care and community integration.

EPILOGUE

Pat Mitchell lived from her youth, first at the Ontario Hospital Port Arthur, and then at LPH. In recent years she has returned to the community of Thunder Bay, to a shared apartment in the south ward of the city. It is clean and brightly decorated. It has modern appliances, comfortable furniture and is fully carpeted. The apartment block itself is located on a busy main road, amidst a variety of housing units. It is within reach of a park and other social and commercial amenities. Pat has direct access to a resident nurse, on the premises.

Pat volunteered readily to be interviewed for this book. She talked at some length about her long experience of a variety of forms of mental health care. When she came to describe her present circumstances, she beamed with pride. Pat Mitchell loves her new way of life, away from LPH. Nothing made her attitude to that old institution more clear than the moment when she was asked to sign a waiver that released the contents of the interview for possible quotation in the final text. Perhaps remembering the consequences of signing other documents during her long stay at LPH, she looked up sharply at me and said, with a note of alarm in her voice: "You're not going to send me back there, are you?"

PHOTO CREDITS

Many of the photos, documents, and records for this book were created by the Ontario Hospital and subsequent, Lakehead Psychiatric Hospital (LPH) in Thunder Bay, Ontario. Post divestment of the Lakehead Psychiatric Hospital - June 23, 2003 these records were transferred to the Archives of Ontario. They are used with permission of the Archives of Ontario.

Cover Photos

Cover: (inset) Photo of the Ontario Hospital, Fort William, 1936. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Cover: (inset) Photo of the Lakehead Psychiatric Hospital (Front Entrance), St. Joseph's Care Group, June 24, 2003. Used with permission of Korkola Design Communications.

Cover: Photo of Army Nursing Sisters, Ontario Hospital Port Arthur (OHPA) Division, circa 1940. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 1: Arial Photo of the Lakehead Psychiatric Hospital, circa 1980. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Preface

Page 7: Photo of Peter Raffo, Writer. 2002. Used with his permission.

Acknowledgments

Page 9: Photo of the History Book Steering Committee, April 12, 2005. Used with permission of Korkola Design.

Chapter 1 – Twin City Rivalry 1934-1939

Page 11: Photo of Staff Members transferred from Eastern Ontario Hospitals, 1936. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 11: (inset) Photo of the Ontario Hospital, Fort William, 1936. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 12: Photo of the Wiley Home, circa 1935. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 12: (inset) Photo of the Welcome Arch, Port Arthur, 1939. Used with permission of the Thunder Bay Historical Museum Society. Reference code: 984.53.550-5F

Page 13: Photo of Charlie Cox, circa 1940. Used with permission of the Thunder Bay Historical Museum Society. Reference code: 985.1.18

Page 15: Telegraph Announcing Fire, Canadian National Telegraphs, May 12, 1936. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 15: (inset) Photo of the Cattle Shelter, circa 1936. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 16: (inset) Letter from the Department of Health, August 24, 1936. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 21: Photo of the Water Tower, circa 1937. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 30: Photo of Attendant Ernie Rollason, nursing supervisor Agnes Baillie and nurse Isobel Wilson, 1944. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 34: Grand Jury Report, September 27, 1948. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 35: Headline from the News Chronicle, "$6,000,000 for Health Here," December 2, 1946.

Page 37: Photo of Mayor Hubert Badanai, circa 1950's. Used with permission of the Thunder Bay Historical Museum Society. Reference code: 982.1.37H

Page 37: Photo of Mayor Fred Robinson, circa 1950's. Used with permission of the Thunder Bay Historical Museum Society. Reference code: 990.56.10

Page 39: Photo of Thelma Charlton and Ruth Black in front of staff residence, circa early 1950's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 39: Photo of Staff residence at Neebing Site, circa late 1940's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 40: Department of Health Memo, October 27, 1949. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 40: Photo of Dr. Charles Cleland, circa 1949. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 41: Photo of Dr. J.R. Howitt, circa 1950. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 43: Arial Photo of original Port Arthur Site, May 26, 1954. Used with permission of the Thunder Bay Historical Museum Society. Reference code: 990.56.510A

Page 44: (inset) Photo of Grand Opening of Ontario Hospital, Port Arthur, May 26, 1954 Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 44: Member of Legislative Assembly, George Wardrope, Minister of Public Works, W. Griesinger, and Minister of Health, Dr. M. Phillips, Grand Opening Ceremony, May 26, 1954. Used with permission of the Thunder Bay Historical Museum Society. Reference code: 990.56.510C

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Page 45: Drawing of the Ontario Hospital Buildings, Port Arthur ON, June 14, 1962. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 47: (inset) Times Journal, " Patients Moved Into New Ontario Hospital," May 28, 1954.

Page 47: Photo of parking lot at the Ontario Hospital, May 1960. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 48: Photo of the front of the Ontario Hospital, 1954. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 50: Photo of the Construction connecting Administration buildings to pavilions, circa early 1960's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 50: Photo of the Vegetable Garden, circa early 1960's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 53: (inset) Photo of Nurses Aides and Attendants, circa early 1960's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 53: Photo of Nurses Aids and Attendants, circa early 1960's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 54: Photo of Minister of Health Officials with Dr. Howitt and Dr. Dymond, circa early 1960's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 55: (inset) Photo of Queen Elizabeth's visit to the Lakehead Psychiatric Hospital, 1959. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 55: Photo of Royal watchers, 1959. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 56: Photo of Dr. George Ferrier, circa 1963. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 57: Photo of Employee working in the Industrial Workshop, circa early 1960's Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 58: Photo of Construction, Dr. Dymond, Novembner 18, 1960. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 61: Photo of Milton Fisher, Dr. George Ferrier and Ruth Black, circa 1970. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 62: (inset) Times Journal, "Barred Windows Outmoded," June 10, 1970.

Page 63: Photo of Bars come down, June 1970. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 64: (inset) Photo of patients and employees participating in a hockey game, circa early 1970's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 64: Photo of Patients enjoy a tour onboard the Welcome Ship, circa early 1970's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 65: Photo of Patients boarding a bus, circa early 1970's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 65: Photo of Mini Putt at Boulevard Lake, circa early 1970's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 65: Photo of Milton Fisher, circa 1970. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 66: Photo of Charles (Ken) Temple, 1971. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 67: Photo of Carole Faulkner, February 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 67: Photo of Michelle Salterelli, Fleurette LeClair & Ron Johnson, 1972. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 71: Photo of Hair Salon, circa early 1970's, Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 71: (inset) Photo of the Library, circa early 1970's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 72: Photo of Lakehead Psychiatric Hospital Sign, circa 1970's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 76: Photo of Vel Roininen at recruitment booth, circa late 1970's. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 78: News and Views Newsletter, "The Way We Are," 1979. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 78: Photo of Cathy Heighton, Public Health Liaison Nurse, 1974. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 85: 3 x Photos of the Industrial Shop and loom weaving, 1979. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 85: Photo of Jack Varrin Making Picnic Tables and Christmas Toys, 1979. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 86: Photo of Nadia Ranta, RN, circa 1980. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 87: Photo of the Community Advisory Board (CAB), 1987. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 88: News and Views Newsletter, "Many Activities propel patients towards community," 1981. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 89: Photo of the Garden Party, 2001. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 90: Photo of Netta Calvert, circa 1981. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 91: (inset) Photo of Outpatient Daycare Information Booth, 1983. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 91: Chronicle Journal, "Hospital Emphasized More Out-Patient Care," March 22, 1974.

Page 93: Chronicle Journal, "But Nobody Came Out Tops," September 12, 1973.

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Page 94: Photo of Foster Loucks, 1986. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 95: "Graham Report" (Front Cover), July 28, 1988. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 97: Photo of Dr. Lois Hutchinson, 2002. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 98: Photo of Canadian Mental Health Association (CMHA) local Thunder Bay Office, 2003. Used with permission of Canadian Mental Health Association (CMHA) local.

Page 98: Photo of Alpha Court Building, 1992. Used with permission of Alpha Court.

Page 100: (inset) "Putting People First: The Reform of Mental Health Services in Ontario" (Front Cover), 1993. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 101: Photo of PACE (People Advocating for Change through Empowerment) Building, 2005. Used with permission of PACE

Page 103: (inset) Photo of LPH staff with United Way Donation Cheque, 2001. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 103: Lakehead Psychiatric Hospital Logo, 1987. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 105: Photo of Ron Saddington, President and CEO of Thunder Bay Regional Health Sciences Centre, 2004. Used with permission of Thunder Bay Regional Health Sciences Centre.

Page 106: Photo of Janet Sillman and Helen Tucker, Accreditation, 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 106: Photo of Carl White, President, St. Joseph's Care Group, 2002. Used with permission of Alan Dickson Photography.

Page 109: (inset) The Bulletin, LPH Newsletter, "Welcomes the New Hospital Administrator," 2000. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 109: Photo of Ryan Paul, 2002. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 109: Photo of Janet Sillman, Vice President, Mental Health and Addiction Services, 2002. Used with Permission of Alan Dickson Photography.

Page 111: (inset) Lakehead Psychiatric Hospital Community Report, 2002. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 111: Photo of Members of the Community Advisory Board (CAB), June 19, 2003. Used with Permission of Alan Dickson Photography.

Page 112: Photo of Margaret O'Flaherty and Janet Sillman planting a tree, LPH Closing Ceremony, June 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 113: Divestment Newsletter, "Quality Mental Health Services Continue," 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

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Page 114: Photo of Lakehead Psychiatric Hospital sign, 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 116: Photo of Teleconference, 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 117: (inset) Photo of crib game with a client, 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 117: Photo of the gymnasium, 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 117: Photo of clients and staff in a kitchen, 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 118: Photo of staff and clients, 2003. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 119: (inset) Photo of Anti Stigma Campaign, 1999. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 119: Photo of Scott Simmie and Julia Nunes, authors. A Survival Guide to Mental Health in Care in Canada. 1999. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 121: 4 photos merged from LPH Community Report, 2002. Archives of Ontario. RG 10-356. Lakehead Psychiatric Hospital historical records.

Page 123: (inset) Photo of Lakehead Psychiatric Hospital, St. Joseph's Care Group, 2004. Used with permission of St. Joseph's Care Group.

Page 123: Photo of Front Entrance, Lakehead Psychiatric Hospital, St. Joseph's Care Group, 2004. Used with permission of St. Joseph's Care Group.

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1. Notes of Lorne Hilditch, in *LPH Archive* (hereafter *LPH*), "Archives" file.
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3. *Senn Letter*; see also M. Raynard, *As It Happened*, (*LPH*, Thunder Bay, 1979).
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L*akehead Psychiatric Hospital 1934-2004, From Institution to Community - A Transformation of Psychiatric Hospital Services,* tells the story of the origins and development of psychiatric care for the people of Northwestern Ontario, from 1934 to the present day. It is a narrative of change, of a remarkable transformation. In the 1930s, people with mental illness were, more likely than not, shut away in huge psychiatric institutions. Care for patients was custodial because of the lack of effective intervention. Today, they are increasingly integrated into the community, in decent housing, and with appropriate support systems, medial and social, available to them.

In Northwestern Ontario, this transformation has been mirrored through the history of what was once called the Ontario Hospital Fort William (later Port Arthur), then Lakehead Psychiatric Hospital, which is now a part of St. Joseph's Care Group.

The huge complex on Algoma St. once housed over one thousand patients. Its staff numbered nearly seven hundred. It was a 'village' that protected its residents from the outside world. Today, most of those who once would have lived within its walls are to be found out in the community, no less cared-for, but no longer shut away.

Tracing the history of this transformation, and relating it to politics of the Lakehead, as well as to changes in medical and psychiatric practice, Peter Raffo tells a story, not only of a local institution, but also of the provision of mental health care to the people of Ontario as a whole.

Peter Raffo received his Ph.D in History from Liverpool University in England. He came to Thunder Bay in 1967. Since then he has been a university professor, an actor and theatre director, and a radio producer and broadcaster with the CBC. He has written for the theatre, radio and film. He has also written articles on local history, and for international journals.

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