The Evolution of Registered Psychiatric Nursing Education in British Columbia (1913-2012)

by

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Abstract

In British Columbia (BC) there are currently four legislated nursing groups: Registered Nurses (RN), Nurse Practitioners (NP), Registered Psychiatric Nurses (RPN) and Licensed Practice Nurses (LPN). The designation of RPN is unique to Western Canada. RPNs are legislated as a distinct profession with a separate education and code of ethics separate from other nurse designations. The purpose of this research was to compile a comprehensive history of RPN education in BC by focusing on the first school that opened in the province. This history of nursing education in BC sheds light on its contribution to the formation of RPNs as a distinct profession in Western Canada. Analysis of the persistence of the distinct education stream highlights the core facilitators that led to the perseverance of RPNs in overcoming threats and barriers to their existence. These include the integral relationship to the development of psychiatry, formation of Riverview as a large-scale mental institution that had workforce needs, and advocacy of Registered Psychiatric Nurses Association of British Columbia (RPNABC) in maintaining the distinction.

Preface

This thesis is an original work by Michelle Clementine Danda. The research project, of which this thesis is a part, received ethics approval from the University of Alberta Ethics Board, Project Name “Exploring the History of Registered Psychiatric Nursing Education in British Columbia from 1913 to 2012”, No. Pro00113662, October 13, 2021.

Dedication

This thesis is dedicated to my mother, Mercedes Danda. I would not have been able to make it through this five-year long process without her support and dedication to her beautiful grandkids. I also dedicated this research to my brother Klement Constantine Danda who died suddenly at the beginning my PhD journey, and my father Klement Danda Sr. who died shortly after I chose to embark on my nursing career. I know, wherever they are, that they are eternally proud of me.

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I am ever grateful for the love and support of my life partner, Kelly Davison, who's support and encouragement have been unwavering throughout my five year PhD journey. At the darkest times, and when I wanted to throw in the towel, he knew exactly what to say to motivate me. I would not have been able to persevere in this process without the love, patience, and encouragement of our four beautiful children, Deia, Kelly Jr., Gus, and Izzy.

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Abbreviations

ANA	American Nursing Association
APA	American Psychiatric Association
BC	British Columbia
BScN	Bachelor of Science in Nursing
BScPN	Bachelor of Science in Psychiatric Nursing
CCPN	Canadian Council of Psychiatric Nursing
CMHA	Canadian Mental Health Association
CNA	Canadian Nurses Association
CNCMH	Canadian National Committee for Mental Hygiene
GNAO	Graduate Nurses Association of Ontario
LPN	Licensed Practice Nurse
NDP	New Democratic Party
NP	Nurse Practitioner
PHI	Public Hospital for the Insane
PNAC	Psychiatric Nurses Association of Canada
RN	Registered Nurse
RNAO	Registered Nurses Association of Ontario
RPN	Registered Psychiatric Nurse
RPNRC	Registered Psychiatric Nurse Regulators of Canada
UBC	University of British Columbia

Pivotal Events

1850	First recorded case of insanity in BC at the Victoria Goal.
1871	BC entered Confederation on July 20, 1871.
1875	Insane Asylum Act passed.
1878	Victoria asylum closed. Patients were transferred to the newly constructed New Westminster Asylum.
1909	Construction began on the "Hospital for the Mind at Mount Coquitlam". The complex would be known as Essondale. The first building constructed was officially named the Male Chronic Building (it was later named West Lawn in 1950).
1913	On April 1, 1913, Essondale opened it's first building, the Male Chronic Building (later renamed West Lawn). It was home to 340 male patients transferred from the New Westminster Asylum.
1918	British Columbia Registered Nurses Act enacted.
1930	The Psychiatric Nurses Training School opened at Essondale. The new Chronic Female Building opened. The first Occupational Therapist was hired.
1932	The first psychiatric nurses graduated from the training school. Mentally defective patients were transferred to New Westminster Asylum. The first Child Guidance Clinic opened in Vancouver.
1940	Graduation of the first class of men from the BC School of Psychiatric Nursing. Mental Health Act amended to remove reference to "lunatic" and "insane".
1946	The first female physician was hired.
1948	Voluntary hospitalization became possible when the Clinics of Psychological Medicine Act was passed.
1949	Riverside building was opened at Colony Farm. It was the first new building since 1934.
1950	On January 3, 1950, the Block System of classes for the BC School of Psychiatric Nursing came into effect.
1951	Inaugural meeting of the three western associations of psychiatric nurses who formed the Canadian Council of Psychiatric Nursing (CCPN) was held in BC. British Columbia Psychiatric Nurses Act was enacted.
1953	School for Mental Defectives Act passed.
1955	A 230 bed TB Unit (North Lawn) opened on May 4, 1955. The Child Guidance Clinic opened in Burnaby.
1959	Mental Health Services transferred from the Provincial Secretary's Department to the Department of Health Services and Hospital Insurance. Tranquille School for the Retarded opened in Kamloops.
1960	Mental Health Centre opened in Victoria.
1963	Canadian Mental Health Association (CMHA) began an examination of mental health care.
1964	Forensic Home in Colquitz closed and all patients were transferred the to Riverside Unit at Essondale.
1966	Essondale renamed Riverview Hospital.

1967	Mental Health Branch Administrative Offices moved from Vancouver to Victoria.
1973	The last psychiatric nursing class graduated from the BC School of Psychiatric Nursing. Training was transferred to BCIT.
1976	Riverside Unit transferred to the Forensic Commission.
1983	West Lawn permanently closed. Colony Farm ceased operation as a farm.
1984	January 1984 BCIT received the final enrollment intake for their Psychiatric Nursing program. The program was transfer to Douglas College and implemented using a career laddering model with LPN and RN education.
1986	Riverview and Valleyview Hospitals amalgamated to form Riverview Hospital.
1988	Riverview Hospital Society reorganized under the BC Mental Health Society. A Supreme Court ruling determined that the mentally ill in psychiatric facilities had the right to vote in national elections.
1994	The Charter of Patient Rights, the first in Canada, was approved by Riverview Hospital. The Patient Sexuality Policy, also the first in Canada, was introduced. The Riverview Family Group, Mental Health Law Program, and Patient Empowerment Society began operation.
1996	Woodlands School closes.
1997	The 190-bed Forensic Psychiatric Hospital opened on the remaining Colony Farmland.
2001	The Registered Psychiatric Nurses Competency Profile for the Profession in Canada is released.
2006	The first Bachelor of Science in Psychiatric Nursing opened at both Douglas College and Kwantlen Polytechnic University. Two new psychiatric nursing programs are opened, the Bachelor of Psychiatric Nursing program at Kwantlen Polytechnic University and the Psychiatric Nursing Diploma program at Stenberg College.
2012	Riverview officially closes in July 2012.

Chapter One -Introduction

This study is a historical examination of the evolution of registered psychiatric nurse (RPN) education in British Columbia (BC), Canada from the years 1913 to 2012. The largest mental institution, Riverview Hospital, is connected to the evolution of psychiatric nursing in the province. Scholarly historical nursing research is valuable in building understanding of nursing. Registered psychiatric nursing in Canada emerged and expanded in the early 20th century, comprising a valuable yet little-known piece of nursing history in comparison to Registered Nursing (RN). Psychiatric nursing developed as a domain within Registered Nursing in Eastern Canada, while Western Canada has a separate profession of RPN. This research expands on previous psychiatric nursing research in Manitoba and Saskatchewan. In this research, the term registered psychiatric nurse (RPN) is used to refer to psychiatric nurses in Western Canada who received unique education which led to a separate designation from RNs. This began with the mental hospital schools of nursing. The scope of RPN practice in BC was closely tied to the patient care delivered in the mental hospital. The profession of RPNs developed formally because of a legislated definition as a distinct nursing designation in 1951. The legislation of psychiatric nursing as a self-regulated nursing profession solidified the position of RPNs.

Psychiatric nursing is the term used to refer to RNs working in mental health care without the RPN designation.

Positioning the Study

In BC there are currently four legislated nursing groups: Registered Nurses (RN), Nurse Practitioners (NP), Registered Psychiatric Nurses (RPN) and Licensed Practice Nurses (LPN). This research study is a historical examination of RPN education in BC. The full research

questions are presented later in this chapter. The central research questions that sparked this study were: when did the separate education of RPNs in BC begin, and what factors led to the persistence of the distinct nursing profession despite the demise of the provincial mental hospital? I attempt to answer these questions by exploring the emergence and evolution of RPNs as connected to the history of the major mental hospital in BC, Essondale Hospital (later named Riverview Hospital). The beginning of the asylum system sets the stage, but the story mainly centers around Essondale Hospital's lifetime. Archival sources are used in addition to oral interview to create a comprehensive story of RPN education in BC.

Riverview Hospital (originally called the Hospital for the Mind at Mount Coquitlam and then named Essondale Hospital) was constructed in the city of Coquitlam, BC. The Hospital was in service for nearly a century from 1913 to 2012. It was a key facility in the history and development of registered psychiatric nursing in Canada because it was the site of the BC School of Psychiatric Nursing (subsequently referred to as the School of Psychiatric Nursing) which operated from 1930 to 1973. The School of Psychiatric Nursing was central to many significant events that influenced the development of RPN education.

The designation of RPN is unique to Western Canada. RPNs are legislated as a distinct profession with a separate education and code of ethics from other nurse designations. In 2021, approximately 49% of the national RPN workforce was licensed to practice in BC, indicating a large proportion of this nursing designation in the province.[1] In BC, this has been a distinct nursing profession since 1951, and RPNs have made a significant contribution to the delivery of mental health care in the province. Yet historical research on nursing is silent on the development of the profession. In 2018, all regulated BC nurses joined the BC College of Nurses

[1] Canadian Institute for Health Information, 'Nursing in Canada, 2021 — Data Tables' (CIHI, 2022), https://www.cihi.ca/en/registered-psychiatric-nurses.

and Midwives. Each group kept their unique standards and practices. These significant changes to the regulation of nursing in BC and pursuit of strategic goals such as enhancing registrant mobility, developing regulatory leadership, and modernizing regulatory programs highlight the need for a comprehensive exploration of the unique history of RPNs. Such an exploration will help us understand how RPN education and practice began and evolved, and the unique contributions of RPNs to health care delivery in BC[2]

Historical Research

Researchers bring their perspectives, experiences, and the frame through which they view the world into the research process. The historical research method focuses on the past. Social or political institutions, events, persons, or ideas from the past may become the objects of historical study. Historical knowledge is constructed from past events that are recorded, available, and accessible, thus become the evidence that provides traces in the time in which researcher embarks on their journey.[3] Doing historical research involves engaging in a subjective process that involves the selection and rejection of evidence by present-day historians who collect and assemble it into a coherent and plausible narrative.[4] The narratives that the researcher creates and the way they structure them have changed throughout time, coinciding with changes in ontological perspectives.[5] The historical narratives of the 19th century were driven by notions of

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[2] British Columbia College of Nurses & Midwives, 'Strategic Plan 2023-2027', Strategic Plan (Vancouver, BC: British Columbia College of Nurses & Midwives, 2023), https://www.bccnm.ca/BCCNM/governance/Pages/Strategic_plan.aspx.

[3] Patricia D'Antonio, 'Conceptual and Methodological Issues in Historical Research', in *Capturing Nursing History: A Guide to Historical Methods in Research* (New York: Springer Publishing Company, 2007), 11–23, http://ebookcentral.proquest.com/lib/ualberta; Brigid Lusk, 'Historical Methodology for Nursing Research', *Image: Journal of Nursing Scholarship* 29, no. 4 (1997): 355–59, https://doi.org/10.1111/j.1547-5069.1997.tb01055.x.

[4] Geertje Boschma, Sonya J Grypma, and Florence Melchior, 'Reflections on Researcher Subjectivity and Identity in Nursing History', in *Capturing Nursing History: A Guide to Historical Methods in Research* (New York: Springer Publishing Company, 2007), 99–121, http://ebookcentral.proquest.com/lib/ualberta.

[5] Anna Green and Kathleen Troup, *The Houses of History* (Manchester, England: Manchester University Press, 2016), https://www.manchesterhive.com/view/9781526153708/9781526153708.xml.

objective facts that were revealed in historical factors, usually constructed by men, and presented as a picture of history from a progressivist perspective.[6] In the 20th century, historical research shifted to a scientific model based on positivist frameworks aligned with the evidence-based, objectivist sentiment of the time. Modernist and post-modernist approaches weakened the idea of discovering one true history through objective fact-finding.

Today historical inquiry within the discipline of nursing is understood by some as an interpretive approach in which the researcher applies a framework to organize, interpret and construct narratives of the past.[7] Prior to embarking on historical research, it is imperative for the researcher to understand their position, and their biases, to gain insight into how and why certain frameworks are constructed that guide their historical research process.[8] Reflection is necessary to understand personal biases, those influences that have shaped one's nursing work and understanding of nursing.

I will position myself in this study in the following sections of this chapter, and discuss how my perspective changed in Chapter 7. In the Discussion chapter (Chapter 7) I ground the ontological perspective guiding this historical research project, followed by a focused personal reflection of how I am situated in the context of uncovering the history of RPN education in BC. Explication of my biases focuses on my perspectives of RN and RPN education, scopes of practice, and the mental health system.

The work of a nurse historical researcher is to build the knowledge of the discipline. Additionally, an equally important goal of the researcher is the communication and

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[6] Green and Troup.
[7] Sandra B. Lewenson and Eleanor K. Herrmann, 'Why Do Historical Research?', in *Capturing Nursing History: A Guide to Historical Methods in Research* (New York: Springer Publishing Company, 2007), 1–10, http://ebookcentral.proquest.com/lib/ualberta.
[8] Boschma, Grypma, and Melchior, 'Reflections on Subjectivity'.

dissemination of that research to an audience broader than like-minded academics. According to D'Antonio nurse historians have an ethical obligation to construct a narrative from their research which can deepen understanding of a diverse audience. The researcher who constructs a narrative from research in psychiatric nursing has the ethical obligation of appealing to a broader audience. This deepens understanding and informs nursing, health care, and mental health knowledge. Consideration of the multiple audiences is revisited in returning to the initial, "so what" that was considered in the development of the research question.

In exploration of personal biases, a critical question that concerns the nurse historian is developing research questions that are substantiate more than embarking on a self-indulgent project to fulfil one's personal interest in a topic or to present a certain narrative. The historical researcher must reflect on overall contribution to nursing knowledge and the presentation of it while considering the value of the research within the greater field of history. In this sense, historical research can be conceptualized as having similarities to other types of scientific research. The historical research process has a subjective component like many types of research, seeking answers to questions that are of self-interest, but is also valuable to the greater discipline. This research knowledge adds to the history of women and work in BC. The objective components of historical research will be discussed in-depth in the methods section.

My Education Journey and Personal Biases

My interest in this area of study arose from my own nursing experience. I am a mental health nurse; I am an RN who has specialized education in mental health and have passed the Canadian Nurses Association (CNA) certification exam in Psychiatric and Mental Health

Nursing.[9] I did not know the difference between a mental health RN and an RPN until I worked in inpatient mental health.

Pursuit of a nursing degree was my second undergraduate university experience. Before I became an RN, I had completed undergraduate degrees in sociology and psychology. I "happened upon" nursing almost by accident in 2005, while volunteering at a Women's Day conference in Calgary, Alberta. The University of Calgary, Faculty of Nursing, had a booth to promote its new Accelerated Track nursing program. The most appealing feature of the program was the 20-month completion time. I had not considered a nursing career before that day. I had my own biases about nursing; multiple times I discouraged peers from returning to school to pursue a nursing degree. At that time my mother was a retired LPN who had work in long-term care (LTC). My personal bias stemmed from my knowledge of nursing gleaned from the little my mother disclosed about her work in a private LTC facility doing full-time night shifts, and media images I saw on television, books, and movies.

I did not believe that nursing was a good fit for me until my mental health rotation. My placement was on an acute psychiatric unit. My previous formal education in sociology informed the experience, and my knowledge from psychology was coupled with popular media portrayals. The pace, time for talking with patients, and care provided to stigmatized people appealed to me because nurses gained in-depth knowledge of the patient as a person. They intervened in a way that contrasted with my subjective observations and understanding of what appeared to be the task-focused physical interventions of medical-surgical care. My undergraduate psychology degree knowledge could apply to my nursing practice. My education in sociology was also a

[9] Canadian Nurses Association, 'CNA Certification Program - What Is Certification?', Canadian Nurses Association, 2023, https://cna-aiic.ca/en/certification/about-certification. In Canada the Canadian Nurses Association has nationally recognized nursing specialty credentialing that is obtained by passing a certification exam.

strength because it gave me an understanding of human behaviour from a societal lens, including foundational knowledge in social inequality and gender issues.

When I was a nursing student, I noticed the marked differences between nursing practice in inpatient mental health compared to medical/surgical areas. The nurses in inpatient mental health were slower paced than what I observed in medical-surgical inpatient care. I recall being told by a new graduate mental health RN, “you can be as busy or as not busy as you want, depending on how much work you want to do”. At the time, I thought it a curious statement to integrate into my then limited understanding of nursing. Until then I viewed nursing as an anxiety provoking, fast-paced, structured, and task-oriented practice as emphasized by our clinical instructors and the staff nurses. I remember tense discussions in mental health post-conference in which my student peers discussed the judgments they observed of some of the nurses towards certain patients, and what I interpreted as the negative attitude demonstrated by some of the staff. Up to that point, I did not realize another nursing profession existed that focused primarily on mental health, registered psychiatric nursing.

As I progressed into independent practice as an RN in BC, I heard remarks from the RPNs I worked with about their experiences of being subjected to stigma from the patients, families, and the public. For example, RPNs made self-deprecating jokes about the RN (colloquially referred to as the “real nurse”). I deduced in discussion with my RPN colleagues that their education was different, but observed that in practice our duties were seemingly identical. Many RPN colleagues shared stories about their clinical rotations, which sounded like mine; they told me that they completed placements in both medical-surgical and mental health. While day-to-day duties and tasks were identical, the underlying philosophies by which we enacted them may have differed.

My Clinical Experience

The first unit that I worked as an RN, in spring of 2008, was a concurrent disorder unit. People admitted to this unit were experiencing a mental health crisis and a co-occurring substance use issue. The unit was classified as acute level care located in a general hospital. Admissions were intended to be short-stay, meaning less than two weeks, for crisis stabilization. Staff were mainly RNs. As a new graduate RN, my mentor/preceptor was an RN, who shortly after mentoring me left the mental health unit to become an operating room (OR) nurse. I recall my mentor and many other RN/RPNs voicing frustrations about the mental health system, and that the specialized mental health hospitals and units were being shut down, re-configured, and downsized. For years, I assumed that the education of my RPN peers was starkly different from mine, although it remained unclear exactly how. It surprised me to learn that RPNs entry to practice was a diploma in contrast to RNs degree-level for entry to practice in BC.

Specialty education post-graduation and qualification as an RN were options to build my skills as a mental health nurse. In 2013 I earned a mental health nursing diploma from Mount Royal University in Calgary through distance learning. As I progressed through my career, I completed my first master's degree in nursing in 2012. I then became a nursing instructor in 2013 at a new hospital in Southern Alberta. I observed that many of my coworkers at the leadership level were RNs and many staff nurses who were RPNs were diploma-level nurses. Nursing skills utilized in RN/RPNs' day-to-day practice included both physical and mental health assessments. I saw no noticeable difference in the interventions carried out by both RNs and RPNs, with no observable difference between scopes of practice in terms of care delivery within mental health services. "RN/RPN" was used in job descriptions and policies, and I assumed they were interchangeable.

Personal Nursing Reflection

I discovered over the years of my career that I did not see myself as a psychiatric nurse. I always thought that only RPNs could be referred to as psychiatric nurses. I pursued a Master of Psychiatric Nursing (MPN) degree at Brandon University in 2014, to become a better mental health nurse, graduating in 2018. This led to my research in an acute care setting. It surprised me that the RPNs in my study sample did not have in-depth education in what I considered common mental health inpatient interventions such as chemical restraint.[10] I was even more surprised to learn that some of the RPNs I interviewed did not have an acute mental health clinical rotation in their education experience. It was not until my PhD program, when I thought more deeply about the underlying philosophical underpinnings of nursing, that I began to wonder about the fracture between RNs and RPNs in Western Canada.

Increasingly, I began to wonder how the separate nursing professions began and evolved, and about the key differences in their education that led to different professional designations while day-to-day practice was seemingly identical. I wondered how the RPN profession formed, why RPNs chose not to take a bridging program to obtain the RN designation, and if they could work in a clinical area beyond mental health. I began to wonder about the term "psychiatric nurse" and why I, as a new graduate RN with no specialty training in mental health, was deemed equally qualified for the same inpatient mental health positions as my RPN peers who graduated from a nursing program, however at the diploma level, focused on that specific clinical area. I began to question what the key differences were in scopes of practice at a regulatory policy level because they appeared to be the same at the practice level, including the day-to-day duties,

[10] Michelle Clementine Danda, 'Exploring Mental Health Nurses' Experience of Administering Chemical Restraint in an Acute Care Setting' (Master's Thesis, Brandon, Manitoba, Brandon University, 2017), https://core.ac.uk/download/pdf/236972592.pdf.

professional development opportunities, and ability for mid-level advancement (restricted to the area of mental health).

In terms of identity formation, I reflected on how I conceptualized my own identity as a mental health nurse, including how and why I distinguished myself from my RPN peers. Though my mental health identity was closely connected to the mental health clinical space, it was also closely connected to the patient population that I cared for, and my professional identity as an RN. I wondered, how did the mental health care space and education of RPNs shape the formation of their professional identity?

After working in both BC and Alberta, in inpatient and community-based mental health and substance use programs, I began to consider the influence the structure of different institutional systems, namely health care, hospitals, and education, had on shaping psychiatric nursing. In 2017, I returned to direct care nursing on an inpatient adolescent mental health unit and found that the burden of the mental health system weighed me down. I was critical of a system labelled as "mental health" yet driven by an illness-based medical model controlled by psychiatrists, in which certain mental health clinicians, predominantly social workers (SW), occupational therapists (OT), and psychologists seemed to hold more power and respect more than RNs and RPNs.

My critical lens was informed by the philosophical shift away from the dominant illness oriented medical model that has guided mental health practice and conceptualizes the client as inevitably and persistently impaired by their medical diagnosis.[11] Similarly, I observed system shifts over time that seem to broaden the integration of unregulated healthcare professionals. The

[11] Tom K.J. Craig, 'Recovery: Say What You Mean and Mean What You Say', *Journal of Mental Health* 17, no. 2 (2008): 125–28, https://doi.org/10.1080/09638230802003800; Margaret McAllister, 'Doing Practice Differently: Solution-Focused Nursing', *Journal of Advanced Nursing*, 2003, https://doi.org/10.1046/j.1365-2648.2003.02564.x.

organization frequently introduced these changes without any plan for evaluation or transparency about their impact on the roles of RNs and RPNs, how scopes of practice aligned, or how interprofessional models of care were integrated.

When I reflect on my experience working in psychiatric and mental health services, I feel frustration and moral distress arising from a system that has often left me feeling confused about how to best integrate my unique nursing perspective and expertise. I have become overwhelmed with experiences of being misunderstood, undervalued, and feeling unappreciated by other members of the health care team, with exposure to repeated messaging that unregulated staff do the same thing as mental health RNs and RPNs.

My lingering questions have drawn me to this research that emerged from my experience in mental health care spaces as a mental health nurse. I developed the research questions based on my experiences as a mental health nurse in health care spaces. I wanted to understand the formation of the designation of RPN in BC over time, how curriculum was determined, who taught in the educational programs, where the learning occurred, and how it shaped RPNs' identity and the stigma that persists for RPNs. The value of deeply understanding the formation of the education of RPNs in BC helps to answer questions about the origin of the separation of the Western Canada RPNs from the RNs in the 20th century, and how this has changed over time as RPNs transitioned into the 21st century.

Rationale for the Study

The discipline of nursing cannot begin to ask questions about how to clearly define the role of the psychiatric nurse if the nurses (e.g., RPNs, RNs) who work within this practice area remain divided yet fail to question why this is so, and how it came about. The story of nursing in Canada has largely excluded RPNs. Scholars of nursing history such as Mansell and McPherson

deliberately left out the story of psychiatric nursing because it developed differently from general nursing.[12] This research helps to fill the knowledge gap in the history of psychiatric nursing in Canada, beginning with the BC experience.

The RPN nursing designation is not recognized in Eastern Canada, yet it is integral to mental health service delivery in Western Canada. Most RPNs in Western Canada are educated in the three programs offered in BC, or are graduates of one of the other three psychiatric nursing programs in Western Canada.[13] In addition to the three programs located in Lower Mainland, BC, there is one in Edmonton (with a satellite in Ponoka), Alberta; one in Saskatoon, Saskatchewan; and one in Brandon, Manitoba. Manitoba is the only province that requires a degree-level program for RPNs entry to practice.[14]

The number of practicing RPNs, new graduates who complete their education in BC, and number of post-secondary RPN programs in BC indicates the influence of BC psychiatric nurse education in Canada. Chapter Two reviews the existing literature on the education and development of the RPN profession, with a focus on the provinces of Manitoba, Saskatchewan, and Alberta.[15] Prior to this work no historical research has focused on the formation and

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[12] Kathryn M. McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: University of Toronto Press, 2003); Diana Jean Mansell, *Forging the Future: A History of Nursing in Canada*, 1st. ed. (Ann Arbor, Mich: Thomas Press, 2004).

[13] Canadian Institute for Health Information, 'Nursing in Canada, 2019: A Lens on Supply and Workforce', 2020. In 2019, 47% of RPNs were registered in BC.

[14] Registered Psychiatric Nurse Regulators of Canada, 'RPN Education', Registered Psychiatric Regulators of Canada, 2023, http://www.rpnc.ca/rpn-education.

[15] Beverly Hicks, 'From Barnyards to Bedsides to Books and beyond: The Evolution and Professionalization of Registered Psychiatric Nursing in Manitoba, 1955-1980.' (Doctoral Dissertation, Winnipeg, Manitoba, University of Manitoba, 2008), http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=109853021&site=ehost-live; Veryl Margaret Tipliski, 'Parting at the Crossroads: The Development of Education For Psychiatric Nursing in Three Canadian Provinces, 1909-1955' (Doctoral Dissertation, Winnipeg, Manitoba, University of Manitoba, 2002), http://hdl.handle.net.login.ezproxy.library.ualberta.ca/1993/29612; Angela Yvonne Martin, 'Determinants of Destiny: The Professional Development of Psychiatric Nurses in Saskatchewan, 1914 to 2003.' (Master's Thesis, Regina, Saskatchewan, University of Regina, 2003), National Library of Canada = Biblioth??que nationale du Canada; Mary Smith and Nazilla Khanlou, 'An Analysis of Canadian Psychiatric Mental Health Nursing through the Junctures of History, Gender, Nursing Education, and Quality of Work Life in Ontario, Manitoba, Alberta, and Saskatchewan', *ISRN Nursing* 2013 (2013): 1–13, https://doi.org/10.1155/2013/184024.

education of RPNs in BC, which limits understanding of the development of the RPN role, education, place in the larger profession of nursing, and place in mental health care in Canada. To address these knowledge gaps, I have used a critical interpretive lens to examine the history of formal RPN education in BC, focusing primarily on one mental hospital, Riverview Hospital. I have examined the significant historical events, organizational changes, and trends which influenced RPN within the broader historical context of the mental hospital and mental health care. In the analysis process considerations were made about the impact of various social, political, and economic influences on the development of the profession over the past century.[16]

Study Purpose

The purpose of this research was to compile a comprehensive history of RPN education in BC by focusing on the first school opening in the province. To comprehend the current relationship between RNs and RPNs and the place of RPNs in the BC health care system, it is crucial to understand the historical factors that led to the development of RPN nursing education. This involves understanding the historical factors that contributed to the development of RPN nursing education as distinct from the history of other nursing professions (RN, NP, LPN).

The story begins with the development of the first mental institution in BC in 1872 which led to the first identified need for a separately trained group of nurses beginning with the 1913 opening of Essondale Hospital (later named Riverview Hospital), and evolved to become the home of BC's first training school for psychiatric nurses in 1930.[17] The distinction between training and education is made because traditionally nurse training focused on institution specific

[16] D. Brennan, '"Telling Stories about Ourselves": Historical Methodology and the Creation of Mental Health Nursing Narratives', *Journal of Psychiatric and Mental Health Nursing* 18, no. 8 (October 2011): 657–63, https://doi.org/10.1111/j.1365-2850.2011.01714.x.
[17] Karen Spiers, *Riverview Hospital: A Legacy of Care & Compassion* (Vancouver: British Columbia Mental Health and Addiction Services, 2010); Mike Laanela, 'Riverview Hospital: A Brief History', CBC News, 2014.

skills learned on the job to improve the functioning of the organization and fulfil the goals of the institution, whereas education refers to learning for development and to acquire more general knowledge.[18] This research will inform the profession of nursing about the unique contributions and position of RPNs amongst other health care professionals in mental health care. Use of a historical perspective to construct a narrative of the development and education of RPNs forms a foundation upon which additional questions can be asked. For example, the professionals in mental health care can entertain questions about the goals achieved by the separation of RN and RPN education, how it was supported by or influenced the development of the nursing profession in BC, and how it continued to support mental health services delivery until 2012. To understand the significance of the School of Psychiatric Nursing's opening, it is necessary to construct a picture of the broader context within which decisions and events occurred including the history of the mental hospital, psychiatry, women and work, and nursing education in Canada with a particular focus on how this shaped BC RPNs.

Significance of the Study

Today, RNs and RPNs work side by side in acute care hospitals and community mental health settings in BC, but animosity and role confusion persists. Ongoing debate about the specific education required to prepare a psychiatric or mental health nurse exists in both Great

[18] Peter Callery, 'Training and Education: An Analysis of Quality Assurance in Teaching and Nursing Education', *Nurse Education Today* 20, no. 5 (July 2000): 373–80, https://doi.org/10.1054/nedt.2000.0431; Jayne Elliott et al., *Canadian Nurses Association: One Hundred Years of Service* (Ottawa, Ontario: Canadian Nurses Association, 2013), www.cna-aiic.ca.

Britain[19] and in Australia.[20] This exploration helps increase understanding of the decisions made about their educational preparation and training, why it persisted through the 20th and into the 21st century, and changes over the century to clarify the role of psychiatric nurses in BC and in Canada. Registered Psychiatric Nurses (RPN) in BC are of particular significance because the province has the most education programs (3) and largest numbers of RPNs in Western Canada.[21] While the focus of this work was on RPNs in BC, the findings of this research have relevance across Western Canada.

Historical exploration of RPN education through an interpretive and critical lens can illuminate difficult questions including: why was separate education considered to be the best choice within certain historical contexts, what were the key pieces of RPN education that substantiated the separation of training and education, and how was RPN curriculum influenced by changes in the mental health system? This exploration requires background information on the development of nurse education in Canada and RPN as a distinct nurse designation in Canada.

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[19] John Cutcliffe, 'A Historical Overview of Psychiatric/Mental Health Nursing Education in the United Kingdom: Going around in Circles or on the Straight and Narrow?', *Nurse Education Today* 23, no. 5 (July 2003): 338–46, https://doi.org/10.1016/S0260-6917(03)00027-3; John Cutcliffe, Chris Stevenson, and Richard Lakeman, 'Oxymoronic or Synergistic: Deconstructing the Psychiatric and/or Mental Health Nurse', *International Journal of Mental Health Nursing* 22, no. 2 (April 2013): 125–34, https://doi.org/10.1111/j.1447-0349.2012.00850.x.

[20] Brenda Happell and Margaret Mcallister, 'Back to the Future? Views of Heads of Schools of Nursing about Undergraduate Specialization in Mental Health Nursing', *International Journal of Mental Health Nursing* 23, no. 6 (1 December 2014): 545–52, https://doi.org/10.1111/inm.12082; Timothy Wand, Suzanne Glover, and Diane Paul, 'What Should Be the Future Focus of Mental Health Nursing? Exploring the Perspectives of Mental Health Nurses, Consumers, and Allied Health Staff', *International Journal of Mental Health Nursing* 31, no. 1 (2022): 179–88, https://doi.org/10.1111/inm.12947.

[21] Canadian Institute for Health Information, 'Nursing in Canada, 2021 — Data Tables'.

Background - History of Psychiatric Nursing

British Columbia recognized registered psychiatric nursing as a profession by enacting an Act on April 18, 1951.[22] British Columbia (BC) was the first province to establish an Association of Psychiatric Nurses, and the second province to pass legislation professionalizing psychiatric nursing.[23] The province of Saskatchewan was the first to pass legislation governing RPNs in 1948.[24] Manitoba was the last province to pass legislation in 1960. However, the first training programs were established in Manitoba asylums.[25] This legislation was similar to that of regulated RNs, in that it protected the title of licenced psychiatric nurse, established a registrar and procedure for filing complaints against licensees, and posed a penalty to those violating the provisions of the Act. The Act did not affect RNs who provided care for the mentally ill.[26]

The background for this research comes from the few historical research studies that focused on psychiatric nurse education in Western Canada. The two significant studies about the history of RPN education in Canada are: 1) *Parting at the Crossroads: The Development of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955* in 2002 by Veryl Tipliski, and 2) *From Barnyard to Bedsides to Books and Beyond: The Evolution and Professionalization of Registered Psychiatric Nursing*, completed by Beverly Hicks in 2008,

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[22] Government of British Columbia, 'Chapter 59. An Act Respecting the Practice of Psychiatric Nursing', § Chapter 59 (1951), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/1264551512/search/CIVIX_DOCUMENT_ROOT_STEM:(An%20act%20Respecting%20the%20Practice%20of%20Psychiatric%20Nursing%20and%201951)?3#hit1; Beverly Hicks, *Politics, Personalities, & Persistence: One Hundred Years of Psychiatric Nursing Education in Manitoba*, 2020. This Act established the Council of Psychiatric Nurses within which a registrar was appointed to maintain a register of licensed psychiatric nurses.

[23] Author Unknown, *Dear Bill, Let's Start an Association...A Tribute to the Psychiatric Nurses Association of Canada On the Occasion of Its 25th Anniversary* (British Columbia: Registered Psychiatric Nurses Association of British Columbia, 1976).

[24] 'SS 1948, c 81 | An Act Respecting The Saskatchewan Psychiatric Nurses' Association' (1948), https://www.canlii.org/en/sk/laws/astat/ss-1948-c-81/latest/ss-1948-c-81.html.

[25] Hicks, 'From Barnyards to Bedsides'. The first was at Brandon in 1920 and then Selkirk hospital a year later.

[26] Government of British Columbia, Chapter 59. An Act Respecting the Practice of Psychiatric Nursing.

both at the University of Manitoba.[27] A third seminal study was a University of Manitoba masters-level thesis completed by Chris Dooley, who explored the development of intellectual and occupational identity of women psychiatric nurses at Brandon Mental Hospital from the years 1919 to 1946.[28] In this background I focus on the context of BC, followed by identity formation, and then give an overview of nursing education in Canada, RPNs in Canada, and end with a description of RPN education in Western Canada.

The Context of British Columbia

British Columbia (BC) is a western Canadian province that formed in 1866 and joined Canada in 1871.[29] Today the province has a total population of 5, 214, 805 people, the majority of which (2, 629, 950) live in the urbanized area in the Lower Mainland.[30] Population distribution by density in 2006 is displayed in Figure 1.1. Health care services in BC offer both physical and mental care, which is similar to the rest of Canada. To understand the development of health care services it is necessary to understand how the province developed in the 19th and 20th century.

Throughout the history of the province much of the population settled along the coastal areas of Vancouver Island and the southern coast in what is now known as the Lower Mainland (Figure 1.1). In the 19th and early 20th century BC was unique in the labour industries that developed, it's politics, and gender composition of the population. In this section I describe the

[27] Tipliski, 'Parting at the Crossroads PhD'; Hicks, 'From Barnyards to Bedsides'.
[28] Christopher Patrick Alan Dooley, '"When Love and Skill Work Together": Work, Skill and the Occupational Culture of Mental Nurses at the Brandon Hospital for Mental Diseases, 1919-1946' (Master's Thesis, Winnipeg, Manitoba, University of Manitoba, 1998), http://mspace.lib.umanitoba.ca/xmlui/handle/1993/1522.
[29] Jean Barman, *The West Beyond the West: A History of British Columbia*, ed. University of Toronto Press (Toronto: University of Toronto Press, 2007).
[30] BC Stats, '2021 Sub-Provincial Population Estimates Highlights', government, Population Estimates, 21 July 2021, https://www2.gov.bc.ca/assets/gov/data/statistics/people-population-community/population/pop_subprovincial_population_highlights.pdf.

relevance of the province's unique geography, politics and economy that influenced government policy, settlement of people, urban development and labour movements that impacted health care.

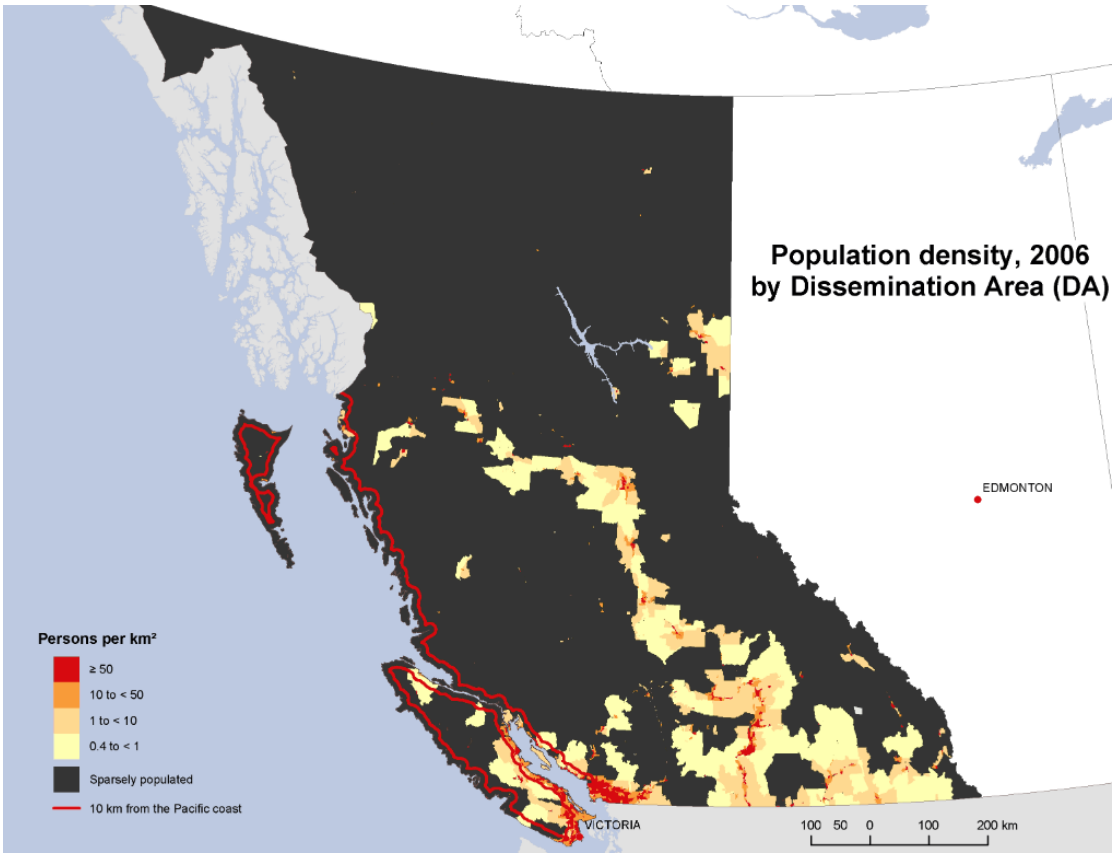

Figure 1.1- Map of BC [31]

Politics, geography and economy

Regional influences, such as geography, a resource-based economy with limited agriculture, a partially radicalized labor force, and idiosyncratic political leadership, shaped contemporary BC between the years 1850 and 1972.[32] A majority of white settlers (mostly British) held power and dominated BC politics ideologically until after World War II. One of the

[31] Statistics Canada, 'Population Density, British Columbia, 2006', accessed 19 June 2022, https://www12.statcan.gc.ca/census-recensement/2006/as-sa/97-550/vignettes/m1bc-eng.htm.
[32] Robert A.J. McDonald, *A Long Way to Paradise: A New History of British Columbia Politics* (Vancouver, Canada: UBC Press, 2021), http://ebookcentral.proquest.com/lib/ualberta/detail.action?docID=6749253.

prominent results was many pro-white anti-immigration policies which controlled immigration, limited work opportunities, and limited land ownership.[33] Policy such as stopping Chinese immigration was strongly supported by colonial-era political reformers including George Walkem, Amor De Cosmos, and Robert Beaven.[34]

Politics. British Columbia (BC) was the sixth province to join Canada on July 20, 1871.[35] Local governments were organized by geography rather than function. In contrast to the other provinces in the confederation, BC was governed by a Legislative Council composed of a mix of elected and appointed representatives, and by an appointed Executive Council responsible to the governor but not the elected legislature.[36] British-born men landholders held power in their positions as retired fur trade officers, and colonial administrators. They embraced Victorian liberalism that prioritized private ownership of land and resources, limited government, and the fundamental liberties of speech and assembly.[37] As a social group those in power embraced and normalized hierarchal social order, a structured system of classes in which fee-based education perpetuated class distinctions over generations.[38]

Many politicians in late 19th century and early 20th century BC promoted racist policies and social values. John Robson (a colonial-era political reformer who sat in the Legislative Assembly for Nanaimo from 1871 to 1875 and New Westminster from 1882) also articulated

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[33] Barman, *History of BC*. BC historian Jean Barman brought to light the unique circumstance in BC having a large proportion of Chinese immigrants and racist policies intended to limit their rights.
[34] McDonald, *A Long Way to Paradise*; H. Keith Ralston and Hamar Foster, 'Biography – Beaven, Robert – Volume XIV (1911-1920)', Dictionary of Canadian Biography, 1998, http://www.biographi.ca/en/bio.php?id_nbr=7196. Beaven, a politician and businessperson who moved to the province from Toronto, Ontario because of the gold rush, supported working-class views including labour's opposition to Chinese immigration.
[35] Barman, *History of BC*.
[36] BC maintained close political and economic ties to Britain after confederation.
[37] McDonald, *A Long Way to Paradise*.
[38] McDonald.

anti-Chinese views.[39] Propaganda publicized fears of mass immigration from China, threatening BC's still developing settler identity.[40] In 1885, a federal legislation was passed to make the Chinese Immigration Act more restrictive, limiting entrance of Chinese into Canada by charging a head tax of fifty dollars.[41] Such policy and propaganda were influential in medical assessments used to identify, exclude, and deport non-Canadians "born insane". Exclusionary laws were aimed at controlling who was accepted as the population of BC had almost doubled in the 1880s and increased by over 80 per cent in the 1890s from 49, 459 to 178, 657, with many more men than women.[42]

Geography. British Columbia (BC) is unique because of its large land mass and geographical topography that includes both mountains and ocean. Unlike the Prairie Provinces (Alberta, Saskatchewan, and Manitoba) very little land in BC is suitable for agriculture.[43] The main industry that attracted people to the province was natural resources, most prominently gold mining in the mid-1800s[44] followed by coal mining, fishing, and forestry.[45] Resource focused industry was largely privately owned, supported by capitalist ideals and primarily employed men.[46] Unlike the provinces of Ontario and Quebec, BC's population was concentrated in urban centres, with 43 percent of people living in cities, towns and villages of over 1000 people by

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[39] Elsbeth Heaman, '"The Whites Are Wild about It": Taxation and Racialization in Mid-Victorian British Columbia', *Journal of Policy History* 25, no. 3 (July 2013): 354–84, https://doi.org/10.1017/S0898030613000158. For example, politician Noah Shakespeare, a photographer and tax collector who was Victoria's MP in the 1870s and 1880s was committed to keeping BC white, and was vocal in his racist anti-immigration beliefs.
[40] McDonald, *A Long Way to Paradise*.
[41] McDonald.
[42] McDonald; Barman, *History of BC*. The population explosion was the result of the construction and completion of the Canadian Pacific Railway. The Chinese population doubled, and the white population tripled. In contrast the Indigenous population decreased. Barman also found the in the late 1800s and early 1900s the birthrate in BC was among the highest in Canada.
[43] Barman, *History of BC*.
[44] Robert Galois, 'Gold on Haida Gwaii', *BC Studies* 196 (2017): 15–42.
[45] Barman, *History of BC*.
[46] Barman.

1900.[47] The major cities emerging were in the southern region of the province and along the coast, including Vancouver, New Westminster and North Vancouver in the Lower Mainland and Victoria and Nanaimo on Vancouver Island.[48]

History of women and work. The history of women and work in Canada and BC is integral to understanding RPN, a profession comprised mainly of women. Creese and Strong-Boag identified that a history of BC must include research on women, integrating the influence of gender and how it shaped the experience of women in the province.[49] The significance of gender emerges from understanding the concept as a social construction, gender is not simply the result of a biological difference of women and men, girls and boys.[50] Gender differences arise from ascribed meaning of biological difference and the experiences attached to them, thus gender is not a constant, rather the meaning attached to it changes across cultures and over time.[51] These meanings also change over the life course of an individual because of the interactions between gender with age and family status.[52]

Nationally, more women moved into paid labour roles after 1850. Domestic service remained the most prominent type of paid employment for women until the late 1800s, but across the country, they gradually started to enter fields such as teaching, nursing, and clerical

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[47] Barman.
[48] Barman.
[49] Gillian Creese and Veronica Strong-Boag, 'Taking Gender Into Account In British Columbia: More Than Just Women's Studies', *BC Studies* 105/106 (1995): 9–26, https://doi-org.login.ezproxy.library.ualberta.ca/10.14288/bcs.v0i105/106.940.
[50] Canadian Institutes of Health Research Government of Canada, 'What Is Gender? What Is Sex? - CIHR', 10 January 2014, https://cihr-irsc.gc.ca/e/48642.html.
[51] Creese and Strong-Boag, 'Taking Gender Into Account In British Columbia: More Than Just Women's Studies'.
[52] Gillian Creese and Veronica Strong-Boag, 'Introduction - Taking Gender into Account in British Columbia', in *British Columbia Reconsidered: Essays on Women - . Centre for Research in Women's Studies and Gender Relations* (Vancouver, BC: Press Gang Publishers, 1992).

work.[53] The end of World War I in 1918 saw shifts of women from manufacturing to white-collar work.[54]

An exploration of the written history of BC reveals that the gendered work experience of women is most prominent in those cities and towns that relied on a single industry such as forestry, mining and fisheries.[55] As discussed in the previous section, the gender ratios were imbalanced in BC at the beginning of the 20th century, with a three to one ratio favouring men who were drawn to the province by resource industries such as gold mining, forestry and fishing.[56] Within these resource industries, job scarcity favoured men meaning that women working in those industries had less job security and were laid off first in times of economic hardship.[57] Gender and the experience of women is significant to the history of RPNs in BC because it was a profession largely composed of women (and largely governed by men) and it began in the municipality Essondale which heavily relied on the jobs provided by the mental hospital.[58]

The labour movement in BC has a long history extending back to the coal miners in the late 1800s.[59] Like the political context of that time the roots were grounded in exclusion based on

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[53] Alison L. Prentice, *Canadian Women: A History*, 2nd ed. (Nelson Thomson Learning, 1996).
[54] Prentice.
[55] Barman, *History of BC*.
[56] Barman.
[57] Eric W. Sager, 'Women in the Industrial Labour Force: Evidence for British Columbia, 1921-43', *BC Studies* 149 (2006): 39–62; Barman, *History of BC*.
[58] Catherine Mary Prebble, 'Ordinary Men and Uncommon Women: A History of Psychiatric Nursing in New Zealand Public Mental Hospitals, 1939-1972' (Dissertation, Auckland, New Zealand, The University of Auckland, 2007); Tipliski, 'Parting at the Crossroads PhD'. However, the presence of men in the history of RPN must also be considered in terms of the role of keepers and attendants in the asylum and later mental hospital. The prominent role of men in psychiatric work in New Zealand and Manitoba respectively was examined in the dissertation research of Prebble and Tipliski.
[59] Rod Mickleburgh, *On the Line: A History of the British Columbia Labour Movement* (Madeira Park: Harbour Publishing, 2018). Rod Mickleburgh, a former reporter for the *Globe and Mail*, published a comprehensive history of the labour movement in BC in 2018. Mickleburgh provides some insight into the labour disputes of BC nurses, but his focus was on the labour disputes of the Registered Nurses Association of BC (RNABC) with no mention of the Registered Psychiatric Nurses Association of BC (RPNABC) or the Union of Psychiatric Nurses (UPN).

race and gender.[60] For example, in the late 1800s and early 1900s, Chinese, Japanese and South Asian migrants who were the resource workers providing labour on the railroad, in the forestry and cannery industry were excluded because of the perceived threat to the jobs of white men.[61] In the early 1900s issues of labour gained prominence in BC as workers participated in eighty-seven strikes, primarily led by men.[62] In the 1900s strikes began with miners, then fishermen and Canadian Pacific Railway (CPR) workers.[63] Limited research exists on early labour action of working women in BC. Some major events were the closure of mental institutions that employed large numbers of RPN graduates, such as Tranquille and the Woodlands schools for the developmentally disabled (both facilities opened as mental health hospitals before services were centralized at Riverview), and eventually the remaining psychiatric hospital, Riverview Hospital.[64]

The gendered dominance of white men in the labour movement was also seen in the early years in which acts of violence were common. [65] It was not until the NDP government passed legislation to create a Labour Code and established the Labour Relations Board in the 1970s that unions became widely accepted and integrated into the fabric of BC. Decades earlier RPNs had

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[60] Janet Mary Nicol, '"Girl Strikers" and the 1918 Vancouver Steam Laundries Dispute', *BC Studies: The British Columbian Quarterly*, no. 203 (29 October 2019): 53–81, https://doi.org/10.14288/bcs.v203i203.190428. Nichol wrote about strike of women workers who worked in the Vancouver steam laundries. Unpaid laundry work was assigned to females in institutions of confinement, including Aboriginal students attending residential schools across Canada. This work was also performed by women in the mental institutions.

[61] Mickleburgh, *On the Line: A History of the British Columbia Labour Movement*.

[62] McDonald, *A Long Way to Paradise*. Labour unions more than doubled from 100 union locals in 1900 to 216 in 1903.

[63] Sager, 'Women in the Industrial Labour Force: Evidence for British Columbia, 1921-43'. An important primary source utilized by Sager to explore the history of employment of men and women in BC is the annual reports of the provincial Department of Labour which was established in 1917. The department was created to improve the relationships between employers and employees by administering laws relating to labour, to oversee boards and commissions, to collect statistics, and to monitor the employment of Asian immigrants. During this time there was increasing worker involvement in trade unions, and new provincial initiatives were introduced, including Workmen's Compensation. Information collected by the department included numbers of workers, wages, and nationality and race.

[64] Gary Steeves, *Tranquility Lost: The Occupation of Tranquille & Battle for Community Care in BC* (Gibsons: Nightwood Editions, 2020).

[65] Mickleburgh, *On the Line: A History of the British Columbia Labour Movement*.

sought unionization as provincial government employees, which will be discussed in Chapter 5.[66] Throughout the history of BC, the interest of unions has clashed with the capitalist and market driven ideals of the conservative governments that held power in the province. In the 1900s women played an increasingly prominent role in the unions and job actions. Union involvement was strong with the private sector in BC in the first half of the 1900s, but with the decrease in private-sector unions and the increase in the public sector, women became the majority members of BCs trade unions.[67] Relevant to the situation of RPNs is the history of the organization of labour of women in BC.[68]

Essondale - The City of Coquitlam. Coquitlam, the city in which Riverview Hospital (first known as Essondale) was built, was a major city located in the Lower Mainland of BC.[69] Coquitlam is located along the Coquitlam River. The land on which the Provincial Mental Hospital at Essondale (this hospital will be referred to as Essondale) stood was located on the Coquitlam Mountain hillside, and the work farm (Colony Farm) was situated below, on the Coquitlam River floodplain.[70]

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[66] Alan F. J. Artibise, '"A Worthy, If Unlikely, Enterprise": The Labour Relations Board and the Evolution of Labour Policy and Practice in British Columbia, 1973-1980', *BC Studies: The British Columbian Quarterly*, no. 56 (1982): 3–43, https://doi.org/10.14288/bcs.v0i56.1138.

[67] Mickleburgh, *On the Line: A History of the British Columbia Labour Movement*.

[68] Star Rosenthal, 'Union Maids: Organized Women Workers in Vancouver 1900-1915', *BC Studies* 41, no. Spring (1979): 36–55. Private industry in the province based on extraction and processing of natural resources was identified as the prominent focus of organized labour. Mickleburgh's examination highlighted that in many ways the reliance on resource heavy industries deeply seated in private corporations and capitalism kept unions illegal in BC long after legalization in other Canadian provinces. The first predominantly woman's labour movement in BC was the organization of Vancouver's telephone operators in 1902 as an auxiliary of the International Brotherhood of Electronical Workers. Their union action involved cutting off phone services. They were backed by business operators and the community. These women telephone operators won wage increases, paid sick leave, and signed a closed shop agreement (meaning that only those who were already members of the union could be hired). But, a few years later their union folded for reasons that were unclear due to lack of retained records.

[69] The Lower Mainland is the geographical area surrounding Vancouver and the Fraser Valley.

[70] Elaine Golds, Lori Austin, and Victoria Otton, 'The Riverview Hospital Site - Respecting Its Past, Realizing Its Future.' (Coquitlam, 2004), www.bmn.bc.ca.

The first inhabitants of the area were the Kwikwetlem First Nation of the Central Coast Salish. The name Coquitlam is derived from the name of the Indigenous people that were on the land and means "small red salmon".[71] The municipality of the District of Coquitlam was incorporated in 1891.[72] Originally the municipal boundaries included what is today the City of Port Coquitlam but excluded the Fraser Mills town-site.[73]

The 1857 Gold Rush brought men from the USA, China, European countries, and Eastern Canada to the area. Conflict often occurred between the different ethnic groups.[74] Settlement began in the area in the late 1800s, and was ignited by the lumber industry. The area grew following the opening of the Fraser Mills lumber mill located on the north bank of the Fraser River.[75] Originally most of the workers at the mill were of Chinese, Japanese and Indian descent but this changed dramatically following the 1907 anti-Asian race riots in Vancouver which exemplified racial exclusion that grew to include severe restrictions on Asian immigration.[76] The population demographics changed based on labour recruitment for the mill. The Fraser Mills company provided incentives to French-Canadians to relocate from Quebec to staff the mill, resulting in the formation of a large Western Canadian French community, Maillardville.[77]

Nursing Education in Canada

Canadian RN education in the first half of the 20th century was organized and delivered as an apprentice model where students were paid employees of hospitals, concentrating their

[71] 'Coquitlam | The Canadian Encyclopedia', accessed 25 June 2022, https://www.thecanadianencyclopedia.ca/en/article/coquitlam.
[72] 'Heritage & History, Coquitlam, BC', Municipal Website, Coquitlam, accessed 26 June 2022, https://www.coquitlam.ca/797/Heritage-History.
[73] 'History Coquitlam BC'.
[74] 'History of Coquitlam — Coquitlam Heritage at Mackin House', Coquitlam Heritage Society, accessed 26 June 2022, https://www.coquitlamheritage.ca/history-coquitlam.
[75] 'History Coquitlam BC'.
[76] 'History of Coquitlam'.
[77] 'History of Coquitlam'.

focus on providing their service to the hospital rather than meeting educational requirements.[78] Changes in RN education began in Canada with the release of the Weir Report in 1932, which highlighted the need to improve the standard of nurse education.[79] At the time, curriculum content and practice varied greatly amongst hospital-based nursing schools, sometimes limiting the experiences of nursing students because of the lack of variety in clinical experiences based on hospital size, and vested interest of the hospital catering to service to patients rather than delivering a consistent standard of education for nursing students.[80] This is explored in greater detail in the literature review chapter.

The 1932 Weir Report motivated significant changes to standardize nurse curriculum, but it was not until 1967 that the first diploma nursing program outside of a hospital was created.[81] The first diploma nursing program in BC was a joint venture between the British Columbia Institute of Technology (BCIT) and the Registered Nurses Association of British Columbia (RNABC).[82] The University of British Columbia (UBC) was the first educational institution to offer a Canadian nursing undergraduate degree (1919).[83] Initially, the UBC program was completed over five years. Students spent the first two years in university study, then two years at an approved hospital affiliated with UBC, finally returning to UBC for their last year of study.[84] As in the rest of Canada, other than in Ontario and Quebec, hospital-based nursing

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[78] Pauline Paul, 'The Origins and Development of Nursing Education in Canada', in *Ross-Kerr and Wood's Canadian Nursing Issues & Perspectives-E-Book.*, ed. Lynn McCleary and Tammie McParland (Toronto: Elsevier, 2020), 396–421.
[79] Pauline Paul and Janet C. Ross-Kerr, 'The Origins and Development of Nursing Education in Canada.', in *Canadian Nursing Issues & Perspectives*, ed. Janet C. Ross-Kerr and Marilyn J. Wood (Milton: Elsevier, 2014), 328–58.
[80] Paul and Ross-Kerr.
[81] Cynthia Baker et al., 'Ties That Bind: The Evolution of Education for Professional Nursing in Canada From the 17th to the 21st Century', 2012.
[82] Paul, 'The Origins and Development of Nursing Education in Canada'.
[83] Glennis Zilm and Ethel Warbinek, *Legacy: History of Nursing Education at the University of B.C. 1919-1994* (Vancouver, BC: UBC Press, 1994).
[84] Zilm and Warbinek.

programs in BC remained popular into the second half of the 20th century with the last one at Vancouver General Hospital (VGH) closing in 1998.[85] Western Canadian provinces were much slower in closing hospital programs than Eastern Canada. For example, Quebec and Ontario closed all hospital nursing programs in the early 1970s.[86] Registered Psychiatric Nursing education followed the trend of moving nurse education from hospitals to post-secondary education institutions in the 1970s, when they moved their education completely away from the Riverview hospital-based training school and into the post-secondary institution.[87]

Registered Psychiatric Nurses in BC emerged and was shaped within a specific historical, socio-political, legal, intellectual, and gender context influenced by RN education, and beliefs about mental illness. Philosophical and political ideologies shifted in between 1913-1974, the timeframe over which the need for an RPN school was identified, opened, and moved out of the hospital setting. During the lifetime of the RPN school the understanding of mental illness changed in response to researchers, academics, and emerging mental health professionals who challenged the societal norms of how to treat the mentally ill. In the 1970s the mentally ill were no longer something to be hidden away in large and isolated mental health institutions because community integration-based care became the norm, the aim of which was to increase access to mental health services, deliver the care regionally, and decrease stigma of mental illness.[88] The result was that development and delivery of their education shifted within specific timeframes in response to institutionalization and then deinstitutionalization. Mental institutions in BC became

[85] VGH School of Nursing Alumnae Association, 'History of the VGH School of Nursing', VGH School of Nursing Alumnae Association, accessed 22 July 2021, https://vghnursingschoolalumnae.com/archives/#.
[86] Baker et al., 'Ties That Bind: The Evolution of Education for Professional Nursing in Canada From the 17th to the 21st Century'.
[87] Dorothy M. (Dorothy May) Pringle et al., 'Nursing Education in Canada: Historical Review and Current Capacity' (Nursing Study Sector Corp, 2004).
[88] Geertje Boschma, 'Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950-1980', 2011, https://doi.org/10.1353/his.2011.0020. Changing conceptualization of mental illness was a global movement across Europe, Canada, the United States and Australia.

less important for delivery of mental health care, and mental health education was becoming more important to RN education as the profession embraced holistic care practices. This signalled a potential merging of the two nursing professions, registered nursing and registered psychiatric nursing, but this did not happen.

Registered Psychiatric Nurses in Canada

To understand the context of RPNs provincially, an explanation of the background and structure of RPNs in Canada is required. The RPN Regulators of Canada (RPNRC) is the overarching organization that connects the provincial regulating bodies of RPNs in BC, Alberta, Saskatchewan, Manitoba and the Yukon Territory.[89] In 2014, the RPN regulatory bodies in the four provincial jurisdictions came together and published national entry-level competencies.[90] The entry-level competencies helped ensure that students graduating from these programs have achieved an agreed standard of theoretical and practice knowledge upon their graduation.[91] However, the degree requirement for entry level to practice differs among provinces. Manitoba RPNs entry to practice is a baccalaureate degree, while Alberta, British Columbia, and Saskatchewan have a diploma entry to practice.

The mental health care system influenced the beginning of the separate nursing profession and historical analysis of RPNs education helps educators, regulators, academics, and the public understand this. RPNs have become an integral piece of health care delivery in the

[89] Registered Psychiatric Nurse Regulators of Canada, 'Registered Psychiatric Nurse Regulators of Canada', Registered Psychiatric Nursing in Canada, 2021, http://www.rpnc.ca/registered-psychiatric-nursing-canada.
[90] Laura Panteluk, 'Mobility and Assessment of Canadian and Internationally Educated Registered Psychiatric Nurses PROJECT REPORT', 2015. The Yukon Territory is the only territory to regulate RPNs. Regulation occurred in 1990 under the Yukon Health Professions Act but regulation is overseen by the government appointed Registered Psychiatric Nurses Advisory Committee and no RPN-specific education program is offered in the territory.
[91] Registered Psychiatric Nurse Regulators of Canada, 'Registered Psychiatric Nurse Entry-Level Competencies', 2014.

province of BC. The close connection between the planning, opening and closure of Riverview Hospital is central to the argument made in this research that RPN education was deeply influenced by the mental institution and medical psychiatry. Registered Psychiatric Nursing helped to shape development of mental health services in the province, and the profession maintained a unique entry to practice curriculum that influenced RPN scope of practice in BC health care services. Registered Psychiatric Nursing programs in Western Canada (British Columbia, Alberta, Manitoba, Saskatchewan, and the Yukon Territory) do not have a national accreditation body that guides education and curriculum development. This is different from the degree programs that prepare students to become RNs or NPs. Registered Nurses are accredited at the national level by the Canadian Association of Schools of Nursing (CASN).[92] Provinces have developed RPN education programs based on competencies published by the RPNRC but no national accreditation body exists to assess the meeting of those standards.[93]

Psychiatric Nurse Education in Western Canada

Currently, the province of BC has three psychiatric nursing programs, two baccalaureate and one diploma program. The programs were established within different historical contexts to serve different geographical areas in BC. The two baccalaureate programs are located respectively at Douglas College, Coquitlam campus (established 2006) and Kwantlen Polytechnic University, Surrey campus (established 2006)[94]. Stenberg College, home to the

[92] Canadian Association of Schools of Nursing, 'Accredited Canadian Baccalaureate Nursing Education Programs' (Canadian Association of Schools of Nursing, 2020), https://www.casn.ca/accreditation/accredited-canadian-nursing-education-programs/; Smith and Khanlou, 'An Analysis of Canadian Psychiatric Mental Health Nursing through the Junctures of History, Gender, Nursing Education, and Quality of Work Life in Ontario, Manitoba, Alberta, and Saskatchewan'.
[93] Registered Psychiatric Nurse Regulators of Canada, 'Registered Psychiatric Nurse Entry-Level Competencies'.
[94] Stenberg College, 'Psychiatric Nursing', 2021, https://stenbergcollege.com/program/psychiatric-nursing/. All three education institutions are based in the lower mainland. The on-line delivered diploma program at Stenberg College was established in 2006, to meet demand for educating RPNs in health services located outside of the Greater Vancouver area.

diploma program, is a private vocational college located in Surrey, that specializes in non-degree health care and human services education. Despite the separate education and designation, both RPNs and RNs work in mental health care and psychiatry, blurring the distinction between the two professions in terms of their standards of practice, nursing roles and how this translates into patient care.

The available literature that was explored in preparation for embarking on this study focused on RPNs in Alberta, Saskatchewan, and Manitoba, leaving a gap in knowledge about psychiatric nursing in BC. Tipliski and Hicks noted the diversity of RPN education across the Western Canadian provinces, highlighting the need for in-depth historical research on the development of psychiatric nursing education in BC. Additional studies were found that explored various aspects of psychiatric nursing in Western Canada including professionalization, identity formation, and the effects of deinstitutionalization.

Research Questions

The purpose of this research was to improve and advance collective knowledge about the social, political, and economic factors that influenced the nursing education of RPNs in BC by seeking answers to the following questions:

1. When and how did RPN training and education begin in BC?
2. How did the development of RPN education relate to trends in psychiatric nursing within the broader historical context of nursing education and various social, political, and economic influences in the development of the profession over the past century?
3. What socio-political factors of the early 20th century led to the formation of Essondale (later Riverview) Hospital and the BC Psychiatric Nursing School?

4. What role did the BC Psychiatric Nursing School at Riverview Hospital play in the development of Registered Psychiatric Nursing as a distinct nursing designation?
5. What provincial legislation influenced the formation, education, and professionalization of RPNs in BC?
6. What were the social, political, and economic influences on the development of the mental health nursing program structure and curriculum at the BC School for Psychiatric Nursing?
7. What was the role of Psychiatric Nursing in BC during institutionalization?
8. What were the impacts of the de-institutionalization movement on the role of RPNs in BC and subsequent impacts on program design and curriculum?

The scope of this research is limited to the findings related to the defined research questions. While relevant to this research and important in development of my research questions, the differentiation and distinction between the general nursing and psychiatric nursing education programs was beyond the scope of this research.

Notes on Terminology

The terms used to describe mental illness, the places in which persons living with mental health issues have been cared for, and the titles of those who provide care for them have changed over time. The changes reflect the changing attitudes towards mental illness and those living with these conditions. Terminology has changed over the last two centuries in accordance with the changing understanding of mental illness, and the medicalization of mental illness.[95] In

[95] Geoffrey Reaume, 'Lunatic to Patient to Person: Nomenclature in Psychiatric History and the Influence of Patients' Activism in North America', *International Journal of Law and Psychiatry* 25, no. 4 (2002): 405–26.

Europe during the 13th and 14th centuries, the term 'lunatic' became popular. However, the medicalization of mental illness in the mid-1800s led to the adoption of a more scientific-sounding term 'patient', and medical treatments became the focus of asylum care.[96] Insane was term popular in the 17th to 19th century that referred to a mental condition, it was both a legal and medical term.[97] The term asylum was used to name the institutions that the lunatic and insane patients were housed in. After the 1870s there was increased attention to the prison-like features of the insane and lunatic asylums. By the 1900s the institutions for people living with mental health issues in Canada and the USA were rebranded as hospitals.[98]

Those who took care of the people in the asylums were referred to as *keepers*.[99] The term *attendant* was also used to refer to those who cared for persons in the hospital when referring to male and female staff. The term *nurse* was used to refer to women who cared for patients. The word *nurse* gained popularity in the 1920s after the popularization of the medical model. However, the term *nurse* became more contentious when it was identified as reserved for those who were registered by a general nursing licensing body.[100] The acceptable and appropriate verbiage changed over time and in different contexts. Within this study the terminology used and documented in each era was used to reflect the accepted societal norms of the time. Terms such as feeblemindedness, idiocy, and mental deficiency were commonly used terms in the 1800s and

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[96] Reaume.
[97] Kenneth J. Weiss, Susan Hatters Friedman, and John P. Shand, 'Insanity: A Legal and Cinematic Diagnosis', *The Journal of Nervous and Mental Disease* 207, no. 9 (September 2019): 749, https://doi.org/10.1097/NMD.0000000000000979.
[98] Reaume, 'Lunatic to Patient'; Terry A. Bragg and Bruce M. Cohen, 'From Asylum to Hospital to Psychiatric Health Care System', *American Journal of Psychiatry* 164, no. 6 (June 2007): 883–883, https://doi.org/10.1176/ajp.2007.164.6.883.
[99] James E. Moran, 'Keepers of the Insane: The Role of Attendants at the Toronto Provincial Asylum, 1875-1905', *Histoire Sociale=Social History* 28 (1995): 51–75, https://islandscholar.ca/islandora/object/ir:ir-batch6-5198; L. D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800–60', *Social History of Medicine* 1, no. 3 (1988): 301–27, https://doi.org/10.1093/shm/1.3.301.
[100] Hicks, 'From Barnyards to Bedsides'.

first half of the 1900s to describe mental illness, but not limited to these conditions.[101] Such terms are now considered obsolete, harmful, and stigmatizing however it is imperative to understand that the terms used within this research are intended to reflect the time periods explored to provide context and demonstrate the changing terminology over time in accordance with societal changes. The contemporary terms mental illness, mental health, mental health issues, substance use issues, and intellectual disability are used with the purpose of writing to explain and discuss at points where it is not necessary to reflect the voice of the era being explored.

Chapters Breakdown

Following this introductory chapter there are six chapters. Chapter Two is a literature review. In Chapter Three, I present the method used for this research. Each of the findings and analysis chapters are divided by time intervals as boundaries for significant developments and events that impacted the development of RPN education in BC. Chapter Four focuses on the story of Riverview Hospital from its opening in 1913, through its expansion, downsizing and to its closure in 2012. I explore the major changes that occurred in the BC mental health system, subsequent changes within the mental hospitals, and the development, expansion, closure of the provincial mental hospital. In Chapter Five I focus on the education of nurses at the BC School of Psychiatric Nursing. Exploration begins with the planning of the school for RPNs, affiliation for RNs, and the evolution of RPN education following the school closure in 1974, until the Riverview Hospital closure in 2012. The primary focus is on the years 1930 to 1973, when the RPN school existed, and when the Psychiatric Nurse Association (PNA) was formed. The

[101] Reaume, 'Lunatic to Patient'.

chapter ends with the closure of the mental hospital-based BC School of Psychiatric Nursing. Registered Psychiatric Nursing education in the years 1974 to 2012 is explored beginning with the developments of post-secondary RPN education to explain the impacts of the rapid downsizing of Riverview Hospital. Chapter Six focuses on the development of treatment for psychiatric patients. The chapter includes an examination of changes to the provincial mental health strategy, program termination and impacts this had on the role of RPNs and other caregivers at Riverview Hospital until its closure in 2012. Chapter Seven summarizes my analysis, and discusses the extent to which the research questions were answered, and concludes with strengths and limitations, knowledge dissemination strategies, and suggestions for future research.

Chapter Two - Literature Review

In this literature review I aim to explore studies that shed light on the current scholarship about the history of mental hospitals, psychiatry, psychiatric nursing, and nursing education in BC. The review is divided into four parts: the evolution of mental hospitals and mental health care in Canada and abroad, the evolution of psychiatric treatment, psychiatric nursing abroad, and finally Canadian psychiatric nursing practice and education. The chapter closes by examining literature on relational practice as it relates to psychiatric nursing and psychiatric nurse education because Peplau's relational nursing practice model was identified as prominent in the development of psychiatric nurse education.

Historical research is often published as books which were found using the University of Alberta search of databases with the search terms: psychiatric nursing, mental health nursing, history of psychiatry, history of psychiatric nursing, asylum history, mental health history and combinations of those terms. I also found literature using the online databases Academic Search Complete, CINAHL, JSTOR, and PubMed.

The Evolution of Mental Hospitals and Mental Health Care in Canada and Abroad

Mental hospitals evolved from insane asylums. In this section the history of asylums is presented from an international, national, and provincial lens to identify influences that shaped formation of the BC asylums. The history of psychiatry is discussed, highlighting the relationship between the mental institution's development to the medical model demonstrating psychiatry's push for psychiatrically trained nurses.

History of Asylum Development

The mental hospital system in Canada developed from the European asylum system. The literature reviewed in this section was primarily from the United Kingdom (UK) because evidence indicates that the care provided there was influential in the development of the asylums and mental hospitals in 19th century English-speaking Canada and BC.[102] Literature supports that the asylum system developed in Canada after Great Britain and was directly influenced by it.[103] Much of the historical research on asylums was produced in the United States of America (USA).[104] Compared to the asylums in Europe and the USA, asylums in Eastern Canada before Confederation (that is in British North America) were much less developed into the 1850s.[105]

The treatments offered in asylums were limited, largely consisting of moral treatment.[106] Organization of specialized physicians in the asylums influenced the change of asylums into mental hospitals. In Europe, the USA and Canada the history of asylums was initially presented as a project in steady progress.[107] Much of the literature on the history of mental asylums has

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[102] Neil Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890–1910', *Journal of Advanced Nursing* 55, no. 6 (2006): 770–77, https://doi.org/10.1111/j.1365-2648.2006.03959.x; Sam Sussman, 'Mental Health Policy In Canada', *Mentalities* 18, no. 1 (1 January 2003): 6–9, https://www.proquest.com/docview/1474310028/citation/AC35DD325E934400PQ/1; Sam Sussman, 'The First Asylums in Canada: A Response to Neglectful Community Care and Current Trends', *Canadian Journal of Psychiatry* 43 (1998): 260–64. This may have been the result of Medical Superintendents immigrating from those countries. The work of Sussman explores early historical formation of the English-speaking British North America (pre-Confederation) asylum system as having strong British influence.

[103] Sussman, 'The First Asylums in Canada: A Response to Neglectful Community Care and Current Trends'; James E. Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (McGill-Queen's Press - MQUP, 2001).

[104] Hicks, 'From Barnyards to Bedsides'.

[105] Norman L. Nicholson, 'British North America', Encyclopedia, The Canadian Encyclopedia, 6 February 2006, https://www.thecanadianencyclopedia.ca/en/article/british-north-america. British North America (BNA) is the name of the British colonies and territories in North America following the 1783 independence of the USA until the Confederation of Canada in 1867. The BNA Act of 1867 united the five BNA Colonies. BNA originally consisted of the provinces of Quebec, Nova Scotia, St. John's Island, Newfoundland, the Hudson's Bay Company territories and the Northwestern Territory.

[106] Barry Edginton, 'Moral Treatment to Monolith: The Institutional Treatment of the Insane in Manitoba, 1871-1919', *Canadian Bulletin of Medical History* 5, no. 2 (December 1988): 167–88, https://doi.org/10.3138/cbmh.5.2.167; Annie Borthwick et al., 'The Relevance of Moral Treatment to Contemporary Mental Health Care', *Journal of Mental Health* 10, no. 4 (1 January 2001): 427–39, https://doi.org/10.1080/09638230124277.

[107] See Hurd's *The Institutional Care of the Insane in the United States and Canada* and

been written by scholars in Europe and the USA, focused on the role of asylums in containment, care, and treatment of the mentally ill under the leadership and supervision of administrative superintendents and medical superintendents.

In the first half of the 19th century the concept of the asylum was viewed positively as a curative tool for insanity.[108] In England, the numbers of patients rapidly increased from 10 000 to ten times that between the years 1800 to 1900.[109] In 1841, the English asylum physicians organized as the Association of Medical Officers of Asylums and Hospitals for the Insane,[110] while American physicians began to organize into the Association of Medical Superintendents for the Insane in 1844.[111] In Great Britain, specialized physicians who were experts in treating insanity, known as medical superintendents, were responsible for running the asylums.[112]

Initially, staff who performed the day-to-day work with patients were known as attendants. These attendants and other domestic staff who spent the most time with the asylum patients played a key role in the moral treatment delivered in the institutions.[113] Nurses were integrated into the early mental hospital when attendant roles shifted from performing duties focused on containing and controlling patients to acting as the instruments of the medical superintendents to cure the insane; their work became directed by medical orders and included a

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[108] Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890–1910'.
[109] Porter, Roy. Madness: A brief history. OUP Oxford, 2003.
[110] Shute, Hardwicke. "Association of medical officers attached to hospitals for the insane'. Provincial Medical and Surgical Journal vol. 3,57 (1841): 100–101.
[111] Association of Medical Superintendents of American Institutions for the Insane, *History of the Association of Medical Superintendents of American Institutions for the Insane, from 1844 to 1874, Inclusive: With a List of the Different Hospitals for the Insane, and the Names and Dates of Appointment and Resignation of the Medical Superintendents - Digital Collections - National Library of Medicine*, 1875, https://collections.nlm.nih.gov/catalog/nlm:nlmuid-66350420R-bk. The Association of Medical Superintendents of American Institutions for the Insane compiled a comprehensive history of the early history of medical superintendents of American mental institutions. The Association listed the different hospitals for the insane, and the names and dates of appointment and resignation of the medical superintendents.
[112] Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890–1910'.
[113] Peter W Nolan, 'A History of the Training of Asylum Nurses', *Journal of Advanced Nursing* 18, no. 8 (1993): 1193–1201, https://doi.org/10.1046/j.1365-2648.1993.18081193.x.

duty to act kindly towards patients.[114] By the end of the 19th century the early optimism towards the curative nature of the asylum faded as overcrowding and pessimism towards treatment rose.[115] Greater emphasis was placed on scientifically based explanations of insanity like hereditary causes.[116]

The late-nineteenth century symbolized a time of pessimism and decline in psychiatric services.[117] In the 1950s and 1960s alternative views were offered, prevalent in the works of scholars such as Sanbourne Bockoven,[118] Carlson and Dain, and Grob.[119] These psychiatrists and historians found that hospitals had moved through several periods of optimism and pessimism. Evidence emerged that supported a different understanding of the mental hospitals that contrasted optimistic notions their social benefit, and rejected the oversimplification of constant progress.

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[114] Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890–1910'.
[115] Brimblecombe; Sarah Hayley York, 'Suicide, Lunacy and the Asylum in Nineteenth-Century England' (PhD, University of Birmingham, 2010), https://etheses.bham.ac.uk/id/eprint/801/.
[116] Henry Mills Hurd and Ed 1843-1927, 'The Institutional Care of the Insane', n.d., 760; N. Dain, 'From Colonial America to Bicentennial America: Two Centuries of Vicissitudes in the Institutional Care of Mental Patients.', *Bulletin of the New York Academy of Medicine* 52, no. 10 (December 1976): 1179–96, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1807273/. In a historical overview of two centuries of institutional care of mental patients in the USA, Norman Dain highlighted the first integrated history of mental disorders in the USA written by Albert Deutsch in 1937, who agreed with early historians like Henry Mills Hurd on the steady development of knowledge and effective therapeutic services.
[117] Peter Bartlett, 'The Asylum and the Poor Law: The Productive Alliance', in *Insanity, Institutions and Society, 1800-1914* (Florence, United States: Taylor & Francis Group, 1999), 48, http://ebookcentral.proquest.com/lib/ualberta/detail.action?docID=178160; York, 'Asylum in 19th Century England'. For British historians the general conclusion is that the asylum model had come to its' lifespan as a useful model of care by the end of the 1890s.For example, historian Peter Bartlett identified that asylums were originally viewed as a humanitarian triumph, but that historians largely view asylums in the later 19th century, "as a failure, full of incurable cases and unable to fulfill the humanitarian promise of reformers".
[118] J. Sanbourne Bockoven, 'Moral Treatment in American Psychiatry', *The Journal of Nervous and Mental Disease* 124, no. 2 (August 1956): 167–94, http://journals.lww.com/jonmd/Citation/1956/08000/MORAL_TREATMENT_IN_AMERICAN_PSYCHIATRY_J_.8.aspx.
[119] Norman Dain and Eric T. Carlson, 'Social Class and Psychological Medicine in the United States, 1789-1824', *Bulletin of the History of Medicine* 33, no. 5 (1959): 454–65, http://www.jstor.org/stable/44446628; Gerald N. Grob, 'Origins of the State Mental Hospital', *Bulletin of the Menninger Clinic* 29, no. 2 (1 March 1965): 1–19, https://www.proquest.com/docview/1298143967/citation/A0C2979CDE9C425EPQ/1.

The regulatory nature of traditional asylums has long highlighted their use as 'total institutions' as described by Goffman, focusing on issues of power and social control exerted by medical professionals over their patients.[120] The shifts in spaces of treatment, along with shifts of treatment rather than containment helped to solidify the legitimacy of psychiatry as a profession. In BC, as with other provinces in English-speaking Canada, care of the mentally ill took place in large mental institutions until the mid-twentieth century.[121] Into the 1960s sociologist Erving Goffman critiqued the structure and coercive and controlling nature of the mental institutions[122], while anti-psychiatrist physician Thomas Szasz rejected the concept of mental illness and challenged the medical role in mental hospital.[123] In Canada the Canadian Mental Health Association (CMHA) began an examination of mental health care in 1963.[124]

The Canadian asylum

The Provincial Lunatic Asylums were established earlier in Eastern Canada compared to Western Canada. While the Ontario and Quebec provisional asylums for the insane were established around the same time (November 1, 1839, in Montreal and January 21, 1841, in Toronto) in BC an asylum was not established until thirty years later.[125] In Toronto the first asylum, originally housed in the public jail, opened as a public welfare institution. Many of the

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[120] Michael Ignatieff, 'Total Institutions and Working Classes: A Review Essay', *History Workshop Journal* 15, no. 1 (1 March 1983): 167–73, https://doi.org/10.1093/hwi/15.1.167.
[121] Alex Richman and Pamela Harris, 'Mental Hospital Deinstitutionalization in Canada: A National Perspective with Some Regional Examples', *Source: International Journal of Mental Health* 11, no. 4 (1982): 64–83, https://www.jstor.org/stable/41344299; Sam Sussman, 'The History of Mental Health Services in Canada', *Madridge Journal of Internal and Emergency Medicine* 1, no. 1 (6 September 2017): 7–13, https://doi.org/10.18689/mjiem-1000103.
[122] E Goffman, 'Asylum: Doubleday Gorden City New York', 1961.
[123] Thomas S Szasz, 'The Myth of Mental Illness', *American Psychologist* 15 (1960): 113–18.
[124] JS Tyhurst et al., *More for the Mind: A Study of Psychiatric Services in Canada* (Toronto: The Canadian Mental Health Association, 1963), https://ubc.summon.serialssolutions.com/#!/search?bookMark=eNrjYmDJy89L5WQQ9M0vSlVIyy9SKMlIVcjNzEvhYWApKSpN5YVQ3AySbq4hzh66pUnJ8cmJJYk5-enxhgYGFiYWRvjllDDlMvJzUjLz0ovjDY0MTM0tjQD-7ic_.
[125] Moran, *Committed to the State Asylum*.

social patterns that emerged in England at the beginning of the nineteenth century were replicated in British North America following immigration of British middle-class families. The colony's proximity to the USA also meant that American values influenced the thinking of some settlers, adding a threat to the securing of a traditionally ordered British society.[126]

Terbenche explored the medical superintendents in the asylum's first 25 years of operation to gain insight into the professional development of psychiatry.[127] Terbenche found that, in Canada, like in Britain, professional work was the primary means through which increased social status could be reached. The established professionals in colonial society imposed licensing restrictions and penalties to keep newcomers from threatening their status and authority. Professional men sought avenues of financial stability to confirm their identity as professional gentlemen and differentiate them from their colleagues. By 1850, insanity treatment and asylum management became a means through which a small number of Upper Canadian (English-speaking Canada) doctors sought professional distinction and social elevation.[128] Joseph Workman, Medical Superintendent of the Toronto Asylum from 1855 to 1865 made deliberate efforts to present himself as having expert knowledge and responsibilities not characteristic of other physicians.

Western Canadian asylums

The history of mental hospitals in western Canada has been studied to a much lesser extent compared to those in eastern Canada. Recent historical research has been published on provincial mental institutions in Western Canada including institutions located in Ponoka,

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[126] Moran. In the 1850s colonization of what would be Canada happened when European settlers primarily from Great Britain imposed a new style of Victorian liberalism with more flexible class structures and emphasizing moral character over predetermined status.

[127] Danielle Alana Terbenche, 'Public Servants or Professional Alienists?: Medical Superintendents and the Early Professionalization of Asylum Management and Insanity Treatment in Upper Canada, 1840-1865' (Dissertation, University of Waterloo, 2011).

[128] Upper Canada was the English-speaking part of Canada established by Great Britain in 1791.

Alberta,[129] and Weyburn, Saskatchewan.[130] The formalization and professionalization of RPNs was solidified in the twentieth century. The development of the asylum in Westernized countries is integral to understand, including how those developments influenced and paralleled those in eastern Canada. Wickham's comparative work of the Saskatchewan Hospital located in North Battleford to the Hospital for the Insane in Washington state sought to fill a knowledge gap about the persuasiveness of the asylum and the treatment of insanity in relation to the development of frontier societies.[131] Specialization and development of psychiatric specific treatments contributed to the professionalization of the asylum and the transformation into mental hospitals. Toward the end of the 1800s a spotlight was shone on the need for trained attendants' as medical superintendents in the mental hospitals. This bolstered their prominence, but later there was criticism of their treatment of inmates which lead to an identified need for a nurse role.[132]

The Changing Conceptualization of Mental Health Care

By the mid-20th century public attitudes towards mental illness in Canada were changing. Critical social theorists Erving Goffman and Michel Foucault published works that challenged the philosophical underpinnings of psychiatric and mental hospitals as institutions of help and progress.[133] Goffman offered an alternative view to the psychiatric literature of the time which

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[129] Jack Martin, *Hometown Asylum, A History and Memoir of Institutional Care* (Victoria: Friesen Press, 2020).
[130] Alex Deighton, 'The Last Asylum: Experiencing the Weyburn Mental Hospital 1921-1939' (Master's Thesis, Saskatoon, University of Saskatchewan, 2016); Erika Dyck and Alex Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada* (Univ. of Manitoba Press, 2017). Weyburn was the last asylum built in Canada, opening in 1921 it was met by criticism by reformers who argued that that large asylums had become places to warehouse people rather than cure them.
[131] Blaine Wickham, 'Into the Void: A Crossborder Comparison of the Mental Asylum on the American and Canadian Frontier' (Dissertation, Saskatoon, Saskatchewan, University of Saskatchewan, 2016), http://harvest.usask.ca/handle/10388/7648.
[132] Tipliski, 'Parting at the Crossroads PhD'.
[133] Goffman, 'Asylum: Doubleday Gorden City New York'; Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (Knopf Doubleday Publishing Group, 2013).

was written from the viewpoint of psychiatrists.[134] Foucault also offered an alternative view of psychiatry as contingent on the power of psychiatrist's which prioritized and positioned medical knowledge, above other forms of knowledge.[135] Psychiatrists Thomas Szasz and R.D. Laing were proponents of the anti-psychiatry movement, offering critical conceptualizations of psychiatry and constructions of psychiatric illness.[136] They conceptualized psychiatry and the mental hospitals ways to enforce social control, and challenged the philosophical assumptions of psychiatry as a project of compassion and benevolence.

The Evolution of Psychiatry

The development and evolution of mental hospitals were connected to the evolution of psychiatry as a medical profession. In many respects the position of psychiatry as a medical specialty was born in the asylum system. The medical profession of psychiatry did not begin to gain legitimacy until after 1900, because of the limitations of the treatment and therapies available.[137] However, the mental asylum was a vehicle for centralization and consolidation of medical men who would gain traction in developing medical treatments with the transition from asylum to mental hospital.[138]

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[134] Goffman, 'Asylum: Doubleday Gorden City New York'.
[135] Pat Bracken and Philip Thomas, 'From Szasz to Foucault: On the Role of Critical Psychiatry', *Philosophy, Psychiatry, & Psychology* 17, no. 3 (2010): 219–28, http://muse.jhu.edu/article/405314.
[136] Allan Beveridge, 'R. D. Laing Revisited', *Psychiatric Bulletin* 22, no. 7 (July 1998): 452–56, https://doi.org/10.1192/pb.22.7.452. Laing was a Scottish psychiatrist who rose to fame in the 1960s and 70s from his bold theories about schizophrenia because caused by the family. While many of his theories were later dismissed as nonsense and even dangerous Laing did bring psychiatric patients into the spotlight. He offered a different take on the medical psychiatry perspective. Laing hypothesized that schizophrenia was not a mental illness, instead being a result of distorted family communication. Szasz challenged medical explanations for mental illness, positing that that the lack of a biological basis for mental illness disqualified it from being a true disease.
[137] Edward Shorter, *A History of Psychiatry : From the Era of the Asylum to the Age of Prozac* (John Wiley & Sons, 1997).
[138] Terbenche, 'Public Servants or Professional Alienists?: Medical Superintendents and the Early Professionalization of Asylum Management and Insanity Treatment in Upper Canada, 1840-1865'.

The Evolution of Psychiatric Treatment

As previously discussed, scholars have generally rooted much historical analysis of mental hospitals in their early development as asylums.[139] Moral treatment was one of the first forms of intervention offered to the mentally ill in the asylum. Its underlying principles originated in Quakerism in the USA, based on principles of human rights, respect, occupation, and the healing powers of a healthy environment.[140] Moral treatment was developed during the same period independently in France and England by Pinel and Tuke respectively.[141] Religious motivations supported the development of moral treatment. In the USA the idea of self-control for the betterment of society was also popularized as influenced by Protestant theology, meaning rewards would be achieved in the afterlife only through hard work and moral self-discipline.[142] Unlike the religiously-based asylum treatments in the USA, the Western Canadian provinces, and Quebec and Ontario established an asylum system that was integrated into a complex pre-existing network of medical and therapeutic responses to insanity across the country. Thus, psychiatry in Canada became medicalized in the late 19th century with the moral treatment model. The mental hygiene movement further reinforced this in the early 20th century.

Mental Hygiene Movement

The Canadian Mental Hygiene Movement rose to popularity in the 1920s. It aimed at preventing and treating mental illness, and was first promoted by prominent advocates in

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[139] Shorter, *A History of Psychiatry*; Nolan, 'A History of the Training of Asylum Nurses'. Extensive writing has established the struggle between lunatic asylum reformers and physicians who were attempting to medicalize lunacy.
[140] Borthwick et al., 'Relevance of Moral Treatment'.
[141] Thomas Knowles and Serena Trowbridge, *Insanity and the Lunatic Asylum in the Nineteenth Century* (London, United Kingdom: Taylor & Francis Group, 2014), http://ebookcentral.proquest.com/lib/ualberta/detail.action?docID=1873402.
[142] Wickham, 'Into the Void'.

Ontario, including women.[143] The movement was initially led by physician Dr. Helen MacMurchy in Ontario who publicized many of the social problems the mental hygienists sought to address such as sexual deviance, and unwed mothers.[144] MacMurchy used the scientific tools valued by medicine to shape strategies to address social problems that were within the domain of public health problems, namely childbirth, maternal health, and infant mortality.[145] MacMurchy explained social problems as conditions of mental incompetence and moral degeneracy. Many people in the 1920s considered eugenics, that is practices aimed to improve humanity by intervening to select for desired heritable characteristics, as a treatment for feeble-mindedness, which was believed to be biologically caused and hereditary.[146]

For the mental hygiene movement to succeed in Canada it required a comprehensive provincial social policy to coordinate municipal authorities and charitably citizens. MacMurchy attempted to redefine social problems, such as sexual deviance and children born to unwed mothers, as public health problems, in turn encouraging the government to assume greater responsibility in public health, which then made them political problems as well. MacMurchy's view was that non-professional associations held responsibility in identifying the feebleminded in the community, and that the medical doctor diagnosed the condition, along with identifying physical or environmental factors that were the source.[147] The program placed the diagnostic

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[143] Dianne Dodd, 'Advice to Parents: The Blue Books, Helen MacMurchy, MD, and the Federal Department of Health, 1920–34', *Canadian Bulletin of Medical History* 8, no. 2 (October 1991): 203–30, https://doi.org/10.3138/cbmh.8.2.203. According to maternal feminists it was in motherhood that the best qualities of femininity were developed and expressed. Feminine qualities allowed children to grow up as morally, physically fit citizens. In contrast to the approach of maternal feminists who relied on ideal images of the family and the natural resources brought forth by a woman's gender. In the early days of the movement women who were referred to as "maternal feminists" held a prominent place in promoting the ideals against which social problems took shape.
[144] Dodd.
[145] Helen MacMurchy, *Sterilization? Birth Control? : A Book for Family Welfare and Safety* (Toronto : Macmillan, 1934), http://archive.org/details/b29809575; Dodd, 'Advice to Parents'.
[146] Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (University of Toronto Press, 1990).
[147] Dodd, 'Advice to Parents'. Terms such as feeblemindedness, idiocy, and mental deficiency were commonly used terms in the 1800s and first half of the 1900s to describe mental illness, but not limited to these conditions.

process in the domain of medical professionals leading to the psychiatric hospitals becoming a centralized place of institutionalization for the feebleminded patient rather the using public health or social strategies to address these issues in communities.

The work of two prominent Ontario physicians, Dr. C.K. Clarke and Dr. Clarence Hincks solidified the place of mental hygiene in the mental hospital.[148] In 1922, Hincks identified the role of post-secondary institutions in promoting mental hygiene research and laying the foundation for the scientific authority of the mental hygiene movement.[149] He asserted that psychiatry was dependent on expert social service more than other branches of medicine, identifying that many educational programs made provision for instruction of social workers, public health nurses, and medical students in mental hygiene. Clarke, in accordance with trends in the USA, sought to establish a psychopathic hospital in Toronto because of the role they played in establishing and enabling psychiatry to strengthen ties with general medicine.[150]

The opening of the Psychiatric Clinic at the new Toronto General Hospital in 1914 was pivotal in the mental hygiene movement.[151] At the Psychiatric Clinic, Clarke, Withrow and

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[148] 'Clarence Meredith Hincks | The Canadian Encyclopedia', accessed 4 July 2022, https://www.thecanadianencyclopedia.ca/en/article/clarence-meredith-hincks; 'Obituaries', *Canadian Medical Association Journal* 92, no. 6 (6 February 1965): 304–5, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1927919/. Hincks was an Ontario physician who received his medical degree from the University of Toronto in 1907. His interest in mental hygiene grew from his interest in the Binet-Simon intelligence test and his part-time position as a medical inspector for the Toronto schools where he was introduced to children who he believed had mental disorders.

[149] C. M. Hincks, 'The Function of the College in Promoting Mental Hygiene', *The Public Health Journal* 13, no. 9 (1922): 385–94, http://www.jstor.org/stable/41972901.

[150] Terbenche, 'Public Servants or Professional Alienists?: Medical Superintendents and the Early Professionalization of Asylum Management and Insanity Treatment in Upper Canada, 1840-1865'. Clarke left his position at the Toronto General Hospital in 1917 to work fulltime for the CNCMH, later returning to hospital work. He made many significant changes to the psychiatric training program upon his return in 1922. At Clarke's 1923 lecture in Britain to the Quarterly Meeting of the Medico-Psychological Association he purported the social value of psychiatry outside of the asylum. Hincks established the first mental health clinic in Canada with fellow physicians Dr. C.K. Clarke.

[151] David MacLennan, 'Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914–1928', *Canadian Bulletin of Medical History* 4, no. 1 (April 1987): 7–23, https://doi.org/10.3138/cbmh.4.1.7. Eugenics could only offer a short-term solution to heightened public awareness of social problems and helped instigate government action but was limited in building a sophisticated foundation for psychiatry. Though

Hincks (founder of the Canadian National Committee for Mental Hygiene (CNCMH)) merged the two worlds of social problems and scientific knowledge. Clarke promoted the Kraepelinian system, which suggested a diagnostic and classification system of causal factors to explain feeblemindedness.[152] Clarke attempted to invoke public fear of feeblemindedness and mental deficiency as public harm, while also purporting the scientific promise of eugenic explanations to solve such problems.

Hincks's work helped to solidify the mental hygiene movement, as coordinated by the Canadian National Committee for Mental Hygiene (CNCMH). He skillfully engaged the elite class in society to support his ideas.[153] Surveys of the existing provincial asylums conducted in the 1920s linked psychiatry of the past, in the mental asylum, to psychiatry of the future as an integral part of a range of social services. Surveys were done in Manitoba asylums to detect issues and he convinced the government to do national surveys as well.

The CNCMH urged the government to treat insanity as a disease and take appropriate medical measures to alleviate mental suffering. This perspective aligned with Hincks's approach and contrasted MacMurchy's public health approach. Hincks positioned mental illness as best addressed with the collective expert knowledge of the mental hygiene movement, a collective of

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MacMurchy first suggested the idea it was Drs. Clarke and Hincks who were instrumental in bringing mental hygiene into the psychiatric setting. This clinic was originally part of the Social Service Department of the Toronto General Hospital.

[152] Ian Dowbiggin, '"Keeping This Young Country Sane": C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890–1925', *Canadian Historical Review* 76, no. 4 (1 December 1995): 598–627, https://doi.org/10.3138/CHR-076-04-03.

[153] Dowbiggin. This elite group included the Governor General, the Duke of Devonshire, C.K. Clarke (dean of medicine at the University of Toronto), Charles F. Martin (Professor of Medicine at McGill), Sir Robert Falconer (President of the University of Toronto), Lord Shaughnessy (president of the Canadian Pacific Railway), E.W. Beatty (Vice President of the CPR), Sir Vincent Meredith (President of the Bank of Montreal), and E.F. Molson (President of Molson's Brewery). Another prominent figure who influenced the early success of the CNCMH was Clifford Beers, a Yale Graduate and ex-mental patient who formed the National Committee for Mental Hygiene in the United States in 1909. Beers spoke at an event two months before the official formation of the CNCMH, telling this story of mental illness a member of the elite, reinforcing the credibility of the American committee on the Canadian one which was in the making. Beers advanced the mental hygienists' perspective on questioning the efficacy and humanity of the existing asylum system.

medically focused and scientifically driven research-based evidence produced within Canadian universities.[154] The mental hygiene movement had a significant impact on nursing because it included a preventative component that was extended to the community by public health nurses while also acting as a vehicle of professionalization for psychiatrists and psychologists.

Mental Hospitals and the Medicalization of Psychiatry

The development of medically based psychiatric treatments, prominently psychosurgery and pharmacotherapy, played an essential role in solidifying the place of psychiatrists as leaders in mental hospitals across Canada. Recent research has explored the various treatments that were implemented in the early Canadian mental hospitals. For example, Collins' dissertation research on the history of psychosurgery in Western Canada focused on its use in British Columbia, Alberta, Saskatchewan, and Manitoba between the years 1935-1970.[155] While Collins examination of psychosurgery primarily focused on the role of physicians, the role of nurses was discussed in terms of their patient care duties before and after surgery. Exploration is needed to understand how various treatments, such as psychosurgery, influenced the development of the psychiatric nurse's role in the mental hospital, the types of knowledge and skills required, and how this shaped understanding of the place of psychiatric nurses within the institutional setting of mental hospitals in Canada. Pharmacological treatments emerged at the same time as

[154] MacLennan, 'Beyond the Asylum'.
[155] Brianne M Collins, 'Uncharted Territory: Psychosurgery in Western Canada, 1935-1970', 2020, http://hdl.handle.net/1880/111599. Findings highlighted the significant use of psychosurgery in the increasingly crowded mental hospital in the face of the challenge of inadequate funding and psychiatrists' goal to prove their position as medical specialists through demonstrating effectiveness of their treatments. Collins explored the role that psychosurgery played in meeting the larger social agenda of mental hospitals to manage, control and correct people who were viewed as a burden to society. This was not simply the production of expertise; it was creation of the facilities and production of experts within a professional training structure to strengthen the position of psychiatrists and psychiatry in the mental hospital.

psychosurgery but became the preferred treatment when scientific research demonstrated their effectiveness in alleviating illnesses such as epilepsy, syphilis and eventually psychosis.

The Rise of Pharmacotherapy

In the early 1930s, American neurologist and psychiatrist Dr. William Bleckwenn used sodium amytal to render catatonic patients responsive, enabling them to engage in talk therapy. This led to important discoveries and developments of medication-based treatments for catatonia.[156] While today's medications for treatment of psychiatric illness target specific symptoms and diagnoses, early medications were primarily used to sedate psychiatric patients.[157] The earliest medications used in psychiatry began in the mid to late 1800s, and included morphine, potassium bromide, hyoscine, and paraldehyde that were prescribed for sedation and to reduce epileptic seizures.[158] The increased development and application of barbiturates paralleled the increased use of psychoanalysis and talk therapy in psychiatry.[159] In the 1950s, when mental hospital admissions reached their peak, antipsychotic medication became commercially available in Europe and Canada.[160] The introduction of psychotropic drugs in Alberta in 1954 changed the public's perception of mental illness as incurable; the hope of more effective management and even elimination of symptoms along with a reduction in hospital farms led to a dramatic decrease in long-term mental hospital admissions.[161]

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[156] Shorter, *A History of Psychiatry*. This was an off-label use for the medication that was at that time indicated for anesthesia and as an anxiolytic.
[157] Shorter.
[158] Ariel Gershon and Edward Shorter, 'How Amytal Changed Psychopharmacy: Off-Label Uses of Sodium Amytal (1920–40)', *History of Psychiatry* 30, no. 3 (1 September 2019): 352–58, https://doi.org/10.1177/0957154X19847605. Use of barbiturates began in the early 1900s.
[159] Gershon and Shorter.
[160] Erika Dyck, 'Dismantling the Asylum and Charting New Pathways into the Community: Mental Health Care in Twentieth Century Canada', *Social History* 44, no. 2 (2011): 181–96, https://doi.org/10.1353/his.2011.0016.
[161] Geertje Boschma, Olive Yonge, and Lorraine Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75', *Nursing Inquiry* 12, no. 4 (2005): 243–55, https://doi.org/10.1111/j.1440-1800.2005.00287.x.

Psychiatric Nursing Abroad

Studying how psychiatric nurses use psychotropic medication sheds light on their role in BC mental hospitals. As early as 1900, RPN as a developing profession was influenced by developments in psychiatry and the institutions of the time.[162] A review of international research on psychiatric nursing offers insight into the evolution of the profession from asylums to mental hospitals and beyond. The evolution of RPN in BC began with untrained and unskilled staff in insane asylums, changing shape with shifts from the asylum to the mental hospital. In the first half of the 20th century, psychiatric nursing was changing in accordance with the evolution of mental hospitals across Canada, the USA, and the UK, in which patient populations were differentiated, hospital wards were unlocked, and genders were integrated. International research on psychiatric nursing was used to provide a context for Canadian psychiatric nursing development. The seminal research from a global perspective includes research from the USA, New Zealand, and The Netherlands. Like Canada, these countries share similar structures of institutionalized mental health care that shifted with the deinstitutionalization model as the 20th century progressed.

Psychiatric nursing's early history emerged from the largely untrained caregivers and attendants who worked in the asylum. Studies on early caregivers in the hospital explored the role and the attendant as part of the mental asylum. British and Australian historical research has contemplated the role of the attendant in the asylum as a role integral to the functioning of the institution.[163] Throughout the 19th century the term "nurse" as used in the asylum setting to

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[162] Anita Boling, 'The Professionalization of Psychiatric Nursing', *Journal of Psychosocial Nursing & Mental Health Services*, no. October (2004): 26–40.
[163] Claire Chatterton, '"Always Bear in Mind That You Are in Your Senses": Insanity and the Lunatic Asylum in the Nineteenth Century - from Keeper to Attendant to Nurse', in *Insanity and the Lunatic Asylum in the Nineteenth Century* (London, UNITED KINGDOM: Taylor & Francis Group, 2014), 85–97,

distinguish female and male attendants rather than an indication of formal nurse training. After 1950, psychiatric nursing again shifted in relation to the movement of care from the centralized institutional setting to the community.[164] No formal training was given to staff in the asylum to fulfil the vision the medical superintendent's moral treatment approach.

International studies on the development of psychiatric nursing clarify trends and influences that shaped psychiatric nurse education in Canada and in BC. Seminal psychiatric nursing research from the USA[165], Great Britain[166], New Zealand[167], and the Netherlands[168] demonstrates similar, though earlier, establishment of an asylum model of care for patients deemed insane. These countries developed a similar mental hospital structure for delivery of mental health care services in which a strict hierarchy was established, headed by psychiatrists, and staffed by attendants and nurses. Of note, today psychiatric nursing is not recognized as a separate professional designation in the previously named countries that have produced seminal research; it is considered a specialty nursing practice within the RN profession.

While there is a dearth of research on the education of psychiatric nurses in Canada, seminal research in the history of psychiatric nursing, as indicated earlier, is found in other

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http://ebookcentral.proquest.com/lib/ualberta/detail.action?docID=1873402; Lee-Ann Monk, 'Working in the Asylum: Attendants to the Insane', *Health and History* 11, no. 1 (2009): 83–101, http://www.jstor.org/stable/20534505.

[164] Chris Dooley, '"The Older Staff, Myself Included, We Were Pretty Institutionalized Ourselves": Authority and Insight in Practitioner Narratives of Psychiatric Deinstitutionalization in Prairie Canada', *Canadian Bulletin of Medical History = Bulletin Canadien d'histoire de La Médecine* 29, no. 1 (2012): 101–23; Geertje Boschma, 'Community Mental Health Nursing in Alberta, Canada: An Oral History', *Nursing History Review* 20 (2012): 103–35, https://doi.org/10.1891/1062-8061.20.103; Dyck, 'Dismantling the Asylum and Charting New Pathways into the Community: Mental Health Care in Twentieth Century Canada'.

[165] Kylie Smith, *Talking Therapy: Knowledge and Power in American Psychiatric Nursing* (Rutgers University Press, 2020).

[166] Niall McCrae and Peter Nolan, *The Story of Nursing in British Mental Hospitals*, 0 ed. (Routledge, 2016), https://www.taylorfrancis.com/books/9781317812395.

[167] Prebble, 'Psychiatric Nursing in New Zealand'.

[168] Geertje Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920* (Amsterdam: Amsterdam University Press, 2003).

countries including the USA[169], Great Britain[170], New Zealand[171], Australia[172] and the Netherlands[173]. While there are numerous histories of psychiatry, there are fewer published on the history of psychiatric nursing. I focus here on prominent works, from the USA, the UK, New Zealand, and the Netherlands. These were deemed most appropriate to explore because they were conducted in nations with similar structures of care in which mental health care was delivered in mental hospital or asylum settings and headed by psychiatrists and staffed by nurses.

United States of America

Asylums in the USA during the 1800s provided psychiatric nurse training.[174] For example, in the McLean Hospital in Belmont, Massachusetts the first class of psychiatric nurses graduated in 1882.[175] Substantial education did not begin until the 1930s when many mental hospitals received patients who were veterans from World War I.[176] Teaching responsibility remained the domain of psychiatrists, and included treatments such as cold packs, seclusion room practices, and habit training.[177] The skills were focused on the interpretation of behaviour

[169] Smith, *Talking Therapy: Knowledge and Power in American Psychiatric Nursing*.
[170] McCrae and Nolan, *The Story of Nursing in British Mental Hospitals*.
[171] Prebble, 'Psychiatric Nursing in New Zealand'.
[172] Brenda Happell, 'Appreciating the Importance of History: A Brief Historical Overview of Mental Health, Mental Health Nursing and Education in Australia', *The International Journal of Psychiatric Nursing Research* 12, no. 2 (January 2007): 1439–45.
[173] Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920*.
[174] Boling, 'The Professionalization of Psychiatric Nursing'; E. Jane Martin, 'A Specialty in Decline?: Psychiatric-Mental Health Nursing, Past, Present and Future', *Journal of Professional Nursing* 1, no. 1 (1 January 1985): 48–53, https://doi.org/10.1016/S8755-7223(85)80082-X. The first psychiatric nurse training school in the United States opened in 1882 at the McLean Psychiatric Asylum in Waverly, Massachusetts, 109 years after the first psychiatric hospital had been built in Williamsburg, Virginia. The school opened ten years after the first training school of nurses opened in Philadelphia at the New England Hospital for Women and Children.
[175] Boling, 'The Professionalization of Psychiatric Nursing'.
[176] Trudy Tappan Rosenthal, 'University Psychiatric Nursing Education in the United States: 1917–1956', *Issues in Mental Health Nursing* 6 (1984): 21–33, https://doi.org/10.3109/01612848409140879. In 1984 Trudy Tappan Rosenthal published one of the first histories of psychiatric nursing education focusing on the years 1917-1956. She focused on the university-based nursing programs delivery of psychiatric nursing curriculum between the years 1917-1956.
[177] Rosenthal.

as part of the psychiatric nurses' expanding skill-set.[178] Nurses were discouraged from having knowledge of the medications they were giving, thus when nurses gave medications, they did not know what they were dispensing.[179]

More recently Kylie Smith of Emory University in Atlanta, Georgia in the USA published a book on the history of psychiatric nursing in America.[180] The structure of psychiatric nursing in the USA is like that in Eastern Canada in which nurses first obtain an RN designation, and then specialize in post-graduate specialty training to work in psychiatry. Although her focus is not specifically on the education of psychiatric nurses, Smith touches upon some of the important educational developments that took place, such as the development of advanced practice nursing courses. The divide between general hospital nurses who were educated in post-secondary institutions in the post-World War II era, and the psychiatric nurses who were trained in the mental hospitals is highlighted as a key distinction between the two types of nursing. According to Smith, psychiatric nursing education was crucial in undergraduate and graduate levels due to its specialization and the support of nursing theorists such as Hildegard Peplau and Dorothy Mareness. However, as in Canada, American psychiatrists were reluctant to relinquish their control of the curriculum.

Smith described the ongoing stigma surrounding mental illness as resulting in parents' reluctance to send their daughters to the training schools in the mental hospitals. Societal barriers prevented women in the mental hospitals from providing care to male patients, largely due to perceptions about overtly sexual nature of some of the symptoms. Additional challenges

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[178] Rosenthal.
[179] Hildegard E Peplau, 'Some Reflections on Earlier Days in Psychiatric Nursing', *Journal of Psychosocial Nursing and Mental Health Services* 20, no. 8 (August 1982): 17–24, https://doi.org/10.3928/0279-3695-19820801-05. Habit training aimed at extinguishing patients of undesirable habits, such as spitting, hoarding, sloppy eating, and stealing.
[180] Smith, *Talking Therapy: Knowledge and Power in American Psychiatric Nursing*. Smith offers a historical analysis of the relationship between psychiatric nurses and other health care professionals between the years 1930 to the 1970s.

emerged in the differing opinions of nursing leaders about the education requirements for psychiatric nursing which ultimately moved into disagreeing about curriculum. Although some of the challenges faced by American psychiatric nurses were like those in Canada, they did not experience the fracture of nursing professions found in Western Canada. In contrast, the work by seminal mental health nurses of the day, including Peplau, ensured the inclusion of psychiatric nursing curriculum in RN programs.

Great Britain

Mental asylum nurses in late 19th century in Great Britain faced multiple hardships, including poor working conditions and stigma from their general hospital nurse counterparts.[181] In 1890, the Medico-Psychological Association (which later became the Royal College of Psychiatrists) instigated a training scheme that was relatively widespread, but was of little practical benefit to the asylum nurses. Shifts were long, often fourteen hours a day with only one day of leave a month.[182] During the 1890 to 1910 period, general hospital trained nurses were critical of asylum nurses, referring to them with derogatory terminology such as 'the scum of the earth'.[183] Their work was viewed as unskilled, largely involving keeping patients quiet, cheerful, clean, comfortable, facilitating meals, and helping them exercise. Asylum nurses at that time

[181] Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890–1910'. The term asylum nurse was used for women who were formally classified as nurses, but also included males who were classified as 'attendants of the insane' or 'lunatic attendants'. Brimblecombe explored how asylum nurses viewed themselves and how others viewed them between the years 1890 and 1910, compiling demographic characteristics of those who became asylum nurses and traced their patterns of employment. Asylum nurses reported the abuse and violence from patients that they had to endure which nurses in the general hospital did not experience.

[182] Brimblecombe. The typical patient to attendant ratio was ten to one. Recreation was also limited, with male attendants often having access to none. However, large-scale social events that included staff and patients were common. Written rules show that the social activities of attendants were restricted when outside the asylum walls, banning them from drinking in local pubs, with attendants fined for returning late from leave.

[183] Brimblecombe. Primary sources included medical superintendents writing their views of asylums nurses as inferior to other nurses.

were keenly aware that the medical superintendents were invested in shifting public perceptions of asylum nurses to improve the public view of physicians at the asylum.

The 19th century asylums in Great Britain had a high turnover rate among staff, nurses and attendants, was due to low salaries, low status, poor working conditions and lack of motivation and specialized knowledge among asylum nurses.[184] Asylum nurses were dismissed from their work at high rates for ambiguous reasons such as unsuitability which provides insight into the negative perception of asylum nurses.[185] Qualifications for asylum nurses were similar to those required for attendants. Key qualifications for being a good attendant included endurance, cheerfulness, firmness, self-control, honesty of purpose and altruism, strength of character, kindness and humanity.[186] While women and men could be attendants, only women could be asylum nurses. Evidence demonstrates that the British asylum offered a way for women to move from domestic service to a job that offered better earning potential and enabled them to develop a career, so long as they stayed unmarried.[187] Men who entered work as attendants in the asylum were ex-servicemen, musicians, clerks, gardeners, electricians, labourers, and some had previous asylum work. Ex-servicemen stayed in their asylum roles for a relatively short period compared to other male attendants. To ascertain whether there was a similar pattern in Canada it is necessary to understand the development of the asylum system in Canada.

New Zealand

In 2007 at the University of Auckland, Kate Prebble conducted PhD research on the history of psychiatric nursing in New Zealand, covering a similar period to that of Smith (1939-

[184] Brimblecombe; Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800–60'.
[185] Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890–1910'.
[186] Brimblecombe.
[187] Brimblecombe.

1972) in the USA.[188] Prebble's research offers a different perspective on psychiatric nursing from narratives framed from a gendered perspective of nursing as woman's work. Her analysis is informed by the labour movement, focused on a narratives of workers, and their attempt to maintain autonomy and identity within forces that were changing the work of psychiatric nurses. Psychiatric nursing in New Zealand was shaped by the institutionalized conditions of the mental asylum, and focused on custodial care that had a large proportion of men to support safety within a largely male patient population. Gender lines were drawn with men seen as most appropriate for the labour-intensive work of psychiatric care.

Prebble found dominant gender stereotypes of nursing as women's work (like mothering and nurturing) were not prevalent in service to patients in New Zealand mental institutions. Unlike Canada, men dominated the New Zealand psychiatric nursing field conceptualized as dangerous and requiring hard labour. The construction of psychiatric nursing as hard labour shifted in the second part of the 20th century with the influence of mental health reform.[189] Shifting understanding of mental illness and treatment brought a change in psychiatric nurse identity, with the development of the nurses' therapeutic role and nursing becoming a profession. With the changing face of nursing, those working in the psychiatric setting turned to labour action, seeking union organization to maintain working conditions and optimal patient care. Prebble focused on the intersection of gender, class, and professionalization in the shifting role of the psychiatric nurse. While parallels can be drawn with New Zealand, the unique situation of BC allowed for the retention of a distinct regulatory body of psychiatric-focused nurses while also maintaining space for psychiatric curriculum to become integrated into general nursing programs.

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[188] Prebble, 'Psychiatric Nursing in New Zealand'.
[189] Prebble.

The Netherlands

Boschma's work on mental health nursing in the Dutch asylum from the years 1890 to 1920 showed that psychiatrists used nurses as a means of raising the prominence of their profession.[190] The author highlighted the lack of attention to nursing in existing histories of the asylum system, in addition to a lack of the role that gender played in the structure of these systems. Analysis was conducted using gender, class and religion as key factors that played integral roles in the development of psychiatric nursing as an accepted profession. Like in English Canada, the origins of modern mental health care came from a structure of paternalism in the mental asylum.

Boschma utilized historical writing that foregrounds common experiences of men and women to understand the broader social changes of the time. Four institutions were selected to create a balanced picture of the trends and shifts in psychiatric care during the defined period. The work aimed to address the challenges of improving care quality through training and specialization in the face of limited resources. Constraints such as high turnover, instruction designed and delivered from a physician perspective, and minimal amounts of education resulted in a mismatch between the vision and actual practice. At the close of the 1910s, Dutch community-based alternatives grounded in the mental hygiene movement were identified as a means through which focus shifted from intensive resources placed on the asylum system to preventative and after-care services. The situation in Canada differed, in that the early 1900s were the beginning of large mental hospitals that grew in population until the mid-20th century. Factors such as gender and class warrant exploration in how they shaped psychiatric nursing as a

[190] Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920.*

distinct nursing profession. The review of international studies is followed by a review of Canadian studies.

Canadian Psychiatric Nursing Practice and Education

A comprehensive review of literature on the history of psychiatry in Canada provides a robust context of psychiatric nursing. However, few historical research studies have focused on RPN education in Western Canada. Discussion begins with focus on the history of the professionalization of psychiatric nursing in Western Canada, exploring literature on identity formation and deinstitutionalization. Canadian studies on nursing education are then explored as a means of gaining understanding into the changes in the model of nursing education delivery over the 20th century. The focus then shifts to nursing education beginning with research on RN education in Canada, followed by studies on RPNs and their education in Canada. The section ends with review of Canadian studies on psychiatric nursing. Psychiatric nursing history in Western Canada was studied, focusing on professionalization, identity formation, and deinstitutionalization effects. Research on RPN education includes a 2020, self-published book by Hicks on the history of RPNs in Manitoba. It focused on the struggle for psychiatric nursing to become a distinct, legally recognized nursing profession from the 1920s to the 1990s.

Psychiatric Nursing in Western Canada

In recent decades, there has been an increase in research on psychiatric care in Canada by scholars such as Dooley, Boschma, and Dyck.[191] As discussed earlier, the research on psychiatric

[191] Dooley, 'Mental Nurses at Brandon Hospital'; Chris Dooley, '"They Gave Their Care, but We Gave Loving Care": Defining and Defending the Boundaries of Skill and Craft in the Nursing Service of a Manitoba Mental Hospital during the Great Depression.', *Canadian Bulletin of Medical History = Bulletin Canadien d'histoire de La Médecine*, 2004, https://doi.org/10.3138/cbmh.21.2.229; Dooley, 'We Were Institutionalized'; Chris Dooley, 'The End of the Asylum (Town): Community Responses to the Depopulation and Closure of the Saskatchewan Hospital,

care in Canada is focused on asylum care[192], psychiatry[193], attendants[194], and patients and families[195]. Canadian studies on the development of psychiatric nursing in Canada have focused on the development of RPN as a distinct profession. The major Canadian works focused on for this study were the dissertation research of Tipliski (1909-1955)[196] which focused on Saskatchewan, Manitoba and Ontario, that of Hicks (1955-1980)[197] on Manitoba, and the masters research of Dooley (1919-1946)[198] on Manitoba, and Martin (1914-2003) on Saskatchewan.[199]

Psychiatric nurses in Western Canada were not always welcomed under the greater umbrella of nursing.[200] The separate professional designation of RPN was led by discontented male psychiatric attendants in Saskatchewan who resisted a new training program that would designate them as 'psychiatric workers.' In 1948, a group of unionized male attendants from the North Battleford Mental Hospital pursued the passing of The Psychiatric Nurses' Act.[201] Male

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Weyburn', *Histoire Sociale* 44, no. 88 (November 2011): 331–54, https://doi.org/10.1353/his.2011.0015; Boschma, 'Community Nursing in Alberta'; Boschma, Yonge, and Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75'; Geertje Boschma, '"You Had To Just Kind Of Rub Her Cheek": Memories and Emotions of Mental Deficiency Nurses in Alberta, Canada, 1945 - 1975', *Quality Advancement in Nursing Education - Avancées En Formation Infirmière* 6, no. 2 (17 September 2020), https://doi.org/10.17483/2368-6669.1247; Dyck and Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada*.

[192] Sussman, 'The First Asylums in Canada: A Response to Neglectful Community Care and Current Trends'.

[193] V.E. Appleton, 'Psychiatry in Canada a Century Ago', *Canadian Psychiatric Association Journal*, 1967, 345–61; Karen Saperson, 'Psychiatry Residency Education in Canada: Past, Present and Future', *Academic Psychiatry* 37, no. 4 (2013): 238–42, http://ap.psychiatryonline.org; Terbenche, 'Public Servants or Professional Alienists?: Medical Superintendents and the Early Professionalization of Asylum Management and Insanity Treatment in Upper Canada, 1840-1865'.

[194] Moran, 'Keepers of the Insane'.

[195] Geertje Boschma, 'A Family Point of View: Negotiating Asylum Care in Alberta, 1905–1930', *Canadian Bulletin of Medical History* 25, no. 2 (October 2008): 367–89, https://doi.org/10.3138/cbmh.25.2.367; Mary-Ellen Kelm, 'Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905-1915', *Journal of Family History* 19, no. 2 (June 1994): 177–93, https://doi.org/10.1177/036319909401900202.

[196] Tipliski, 'Parting at the Crossroads PhD'.

[197] Hicks, 'From Barnyards to Bedsides'.

[198] Dooley, 'Mental Nurses at Brandon Hospital'.

[199] Martin, 'Determinants of Destiny'.

[200] Hicks, 'From Barnyards to Bedsides'.

[201] Author Unknown, *Dear Bill, Let's Start an Association...A Tribute to the Psychiatric Nurses Association of Canada On the Occasion of Its 25th Anniversary*.

psychiatric attendants in Alberta soon followed in 1950, forming the Alberta Psychiatric Nurses Association (PNA).[202]

Hicks' research on the history psychiatric nursing in Manitoba highlights the rejection of psychiatric nurses in Saskatchewan by the greater Canadian Nurse Association (CNA) in the mid-20th century. Hicks' work focused on the developments of the 1950s, when the pivotal first meeting of the Canadian Council of Psychiatric Nursing (CCPN) occurred in BC, to 1980, when provincial legislation was enacted that gave control of psychiatric nursing education to the Registered Psychiatric Nursing Association (RPNA) of Manitoba. Hicks' historical analysis of the development of education of psychiatric nurses in Manitoba focuses on professionalization, meaning the changes that happened that led to RPNs being a self-regulating body that had control over their own education. The key components of the Manitoba RPN model were the relationships among male leaders of Western RPN associations, the influence of medical superintendents of provincial hospitals for a separate workforce, and the lack of interest of RNs employed in the provincial institutions to nurse mental patients.

The unique aspect of Hicks' work was a focus from the 1950s to the 1980s, advancing understanding of the development of the psychiatric nursing profession, bringing education front and centre in the argument. Hicks argued that Canadian Nurses Association (CNA) was unkind and unwelcoming of the psychiatric nurses of the time.[203] The large percentage of Manitoba RPN students and leaders (upwards of 50 per cent of all that existed in Canada in the 1960s) was attributed to the advancement of RPN as a distinct profession. The evidence points to the notion that psychiatrists sought to legitimize medical psychiatry and attempted to use nursing as a

[202] Boschma, Yonge, and Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75'.
[203] Hicks, 'From Barnyards to Bedsides'.

means of doing this. From an administrative perspective, men leaders at that time acknowledged that this was a workforce issue; mental hospitals required trained staff, and psychiatric nursing was not viewed as a prestigious choice in comparison to RN in that province. Gender, place of work, and the relationship with other health care staff were additional significant factors that influenced professionalization and identity of psychiatric nurses. British Columbian RPNs posed a unique situation because of the differing political climate and geography, the location of provincial psychiatric hospitals, and nursing schools in BC which are integral to understanding the development of psychiatric nurse education in Canada's western-most province. As well, the history of RPN education exists within the greater context of RN education.

Shaping the RPN role

Literature on the role of RPNs is explored to provide a thorough context of the ongoing struggle to define psychiatric nursing. The development of psychiatric nursing identity in the early to mid-1900s has been explored by scholars such as Boschma, Tipliski, Dooley, and Hicks in connection to mental health care, mental hospitals, and psychiatry. Studies found highlighted the importance of gender, location of work, and connection to and differentiation from other health care professionals.

The unique occupational identity of RPNs in Canada was shaped by their relationship to RNs, psychiatrist, and other care providers; location of their work in mental hospitals and services; the social understanding of mental illness; and the evolution of treatment of mental illness. Like RNs, RPNs were impacted by feminine gender norms that deeply influenced the work itself, the role that nurses played in mental hospitals, and the accessible work opportunities. Unlike RNs, NPs, and LPNs, RPNs worked almost solely in mental health specific services from the outset of their profession's development.

People outside psychiatric nursing, such as medical superintendents, psychiatrists, and RNs, influenced the position of RPNs in mental hospitals. Medical superintendents of the mental hospitals sought nurses to legitimize their role as leaders similar to that of physicians in the general hospitals. With the professionalization of RNs, the rise of hospital-based nursing schools, and university education of RNs in leadership roles, a power differential started to occur between RPNs and RNs. As early as the 1930s, nurses training at general hospitals had a professional advantage over RPNs because of access to RN credentialing that allowed mobility. Combined training programs were established in Alberta, Saskatchewan and Manitoba for mental hospital trained psychiatric nurses to complete additional general hospital training and obtain their RN license, thus enhancing the reputation of the mental hospital.[204]

Psychiatrists were also a powerful force in shaping the role of RPN. In 1963 the American medical journal "The Lancet" published an article in which a physician sought to answer the question: What is psychiatric nursing?[205] The author took a medical perspective to query whether psychiatric nurses were moving towards becoming co-therapists in the clinical setting, and how the medical/psychiatric nurse relationship in turn could be negotiated to support this. The segregation of education programs for RPNs and RNs in Western Canada was causing mental hospital educated nurses to be marginalized from general hospital nursing. While RPN has been an evolving profession because of the changes in the structure or the mental health care system and evolving understanding of mental illness, the practice of it has long been on the fringes of nursing in Canada. Even today, this designation exits only in the four Western provinces.

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[204] Boschma, Yonge, and Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75'; Tipliski, 'Parting at the Crossroads PhD'.
[205] Maxwell Jones, 'What Is Psychiatric Nursing?', *The Lancet*, 23 November 1963, 1108–10, https://doi.org/10.1016/S0140-6736(63)92874-5.

History of nurse education in Canada

The focus of this section is on the English-speaking nursing schools in Canada because they are most applicable to the development of nursing education in BC which followed a similar model to Ontario rather than that of Quebec. Formal nurse education in Canada began in the hospital-based training system of the 1800s in which young, white, unmarried women entered the vocation.[206] While the Nightingale model of nursing education was popular in Canada in the latter half of the 19th century, its slow development led many nurses to seek education in the USA.[207] In 1874 the Mack Training School for Nurses located in St. Catherine's Ontario opened and was the first hospital diploma-based nursing school in Canada.[208] Standards for admission were few, including moral character, speaking English and aligning with Christian religious values.[209] Soon, the rest of Canada followed suit in establishing hospital-based nursing schools.

The number of nursing schools in Canada rapidly increased in the early 20th century. In 1909 there were 200 hospitals in Canada and 70 schools of nursing.[210] Within the next two decades over 800 hospitals were in operation bringing the total number of nursing schools to 218 schools by 1930.[211] Lack of standards amongst the schools lead to great variability in preparation of nurses and their education being viewed as worthless.[212] The apprenticeship model became prominent because nurse training schools became the domain of the individual hospital through which nursing students became cheap labour; however, many did not continue working in the

[206] Baker et al., 'Ties That Bind: The Evolution of Education for Professional Nursing in Canada From the 17th to the 21st Century'.
[207] Ina J. Bramadat and Karen L Chalmers, 'Nursing Education in Canada: Historical 'Progress'-Contemporary Issues', *Journal of Advanced Nursing* 14 (1989): 719–26.
[208] Paul and Ross-Kerr, 'The Origins and Development of Nursing Education in Canada.'
[209] Paul and Ross-Kerr.
[210] Bramadat and Chalmers, 'Nurse Education in Canada'.
[211] George Moir Weir, *Survey of Nursing Education in Canada* (Toronto: University of Toronto Press, 1932).
[212] Bramadat and Chalmers, 'Nurse Education in Canada'.

hospital beyond their time as students.[213] In the early decades of nursing education, learning occurred mainly through observation and experience and did not include any type of formalized learning through lectures or courses.[214] Emphasis for nursing students was on patient care and not on the student's as individual learners. However, shifts were on the horizon because of the changing workplace of nurses following World War II.

The professional model of nursing which emphasized standardized education, formal professional organizations, and registration rose in prominence in the 1920s. However, nursing education remained mainly in hospitals and was delivered with varying quality. The 1932 Weir report described multiple issues with the education of nurses and recommended that it be moved from the hospital to the education system.[215] However, this did not happen for several decades. The immediate impact of the Weir Report was the publication of a curriculum guide by the CNA in 1937 with the intention of providing hospital schools direction for autonomy from the hospitals.

The emergence of scientific research in medicine and public health were two key factors that began the gradual move of nursing from the hospital-based training system into the university setting. However, it took decades for nurses to be educated in significant numbers in universities. Two key BC proponents of university-based education for nurses included Dr. Malcolm MacEachern, superintendent of Vancouver General Hospital (VGH,) and Dr. Henry Esson Young, the provincial medical officer of health.[216] Nursing education represented womanly virtue in which women were seen as inherently nurses and nurses were seen as

[213] Bramadat and Chalmers. This was because of reasons like marriage and having children.
[214] Bramadat and Chalmers.
[215] Paul, 'The Origins and Development of Nursing Education in Canada'.
[216] Zilm and Warbinek, *Legacy: History of Nursing Education at the University of B.C. 1919-1994*.

inherently women.[217] In the early 20th century, sexual stereotypes of women were promoted in efforts to present nursing as complimentary to the growing field of medicine. Meanwhile, the efforts of nurse leaders moved nurse education into the post-secondary system.

From 1920 to 1930 university enrollment of women increased significantly, but the following decade did not see the same growth.[218] Physicians increasingly embraced a scientific knowledge base for the development of their profession, but constrained nurses by deeming it unnecessary for them to use the same scientific knowledge base. Nursing fit into a category of gender stereotyped women's roles that upheld notions of motherhood, nurturing and domesticity. Nursing was competing with other women-friendly professional programs such as education, social work, and other social sciences.[219] Nurse leaders maintained their space within the university setting by presenting nursing as a profession complimentary to, not in competition with, medicine.

The first Canadian undergraduate nursing program was established at the University of British Columbia (UBC) in 1919.[220] Soon after, post-graduate programs in public health were established at the University of Toronto, McGill University, the University of Alberta, and Dalhousie University.[221] These university-based programs were seen as a means of educating nurse leaders, administrators and educators, and not considered the common path for all nurses in Canada.[222]

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[217] Alice J. Baumgart and Rondalyn Kirkwood, 'Social Reform Versus Education Reform: University Nursing Education in Canada, 1919-1960', *Journal of Advanced Nursing* 15 (1990): 510–16. Primary sources included medical superintendents writing their views of asylums nurses as inferior to other nurses.
[218] Baumgart and Kirkwood.
[219] Elliott et al., *CNA One Hundred Years*. The plan of early nursing leaders was to professionalize nursing as a means of gaining equal status to other health care professionals.
[220] Zilm and Warbinek, *Legacy: History of Nursing Education at the University of B.C. 1919-1994*.
[221] Baker et al., 'Ties That Bind: The Evolution of Education for Professional Nursing in Canada From the 17th to the 21st Century'.
[222] Lynn Kirkwood, 'Enough but Not Too Much: Nursing Education in English Language Canada (1874-2000)', 2005, https://www.ebsco.com/terms-of-use.

By the end of the 1940s, significant social, political and technological changes had led to increased funding for university-based nursing programs; however, enrollment in these programs remained relatively low into the 1960s.[223] The post-World War II era marked a new age of medical technology, leading to an increase in hospital construction and the centralization of services as a means of physicians using the latest technologies in a financially viable manner.[224] Federal government priorities emphasized the importance of higher education in general beginning in the post-World War II years; related to that national direction, government subsidies allowed the CNA to distribute a significant amount of money for nursing education.[225] In the 1940s, the result was that major universities across Canada, including the University of Manitoba, Queens University and McMaster University (both in Ontario) established nursing schools.[226] At the same time, nurse employment shifted to the hospital from community and private nursing settings. This centralization of nurses from communities to hospitals post-World War II led to a need for more nursing students to staff the proliferating hospitals.

A nurse controlled curriculum

The evolution of psychiatric nursing education in Canada was intertwined with the development of nursing education, particularly in English-speaking hospital nursing schools. The 1950s brought change to nursing education as curriculum development became the domain of individual schools and their faculty members.[227] With the increased number of hospitals after WWII and use of new medical technologies came a need for highly trained and better educated nurses. However, it was not until the 1970s that Canadian nursing schools organized curriculum

[223] McPherson, *Bedside Matters*.
[224] Baker et al., 'Ties That Bind: The Evolution of Education for Professional Nursing in Canada From the 17th to the 21st Century'.
[225] Paul, 'The Origins and Development of Nursing Education in Canada'.
[226] Paul.
[227] Bramadat and Chalmers, 'Nurse Education in Canada'.

within frameworks outside of the medical model.[228] The organization of nursing education as driven by a distinct body of nursing knowledge and occurring in universities, led to an identity split between technical nurses prepared in hospital schools of nursing and professional nurses receiving education in post-secondary institutions.

Through the 1970s and into the 1980s CNA solidified a position that all RNs should have a baccalaureate degree for entry to practice by the year 2000; this stand was endorsed by all provinces except Quebec.[229] From the CNA perspective, specialization including psychiatric nursing, is obtained at the post-graduate level.[230] In 1942, the Canadian Conference of University Schools of Nursing (CCUSN) was unwelcoming of psychiatric schools of nursing entering universities.[231] The history of RPN education in Canada, like the history of RPNs, is not well known. While authors of general nursing histories of Canada identify that RPN history is excluded because of the unique characteristics and development of the profession, it nonetheless leaves a gap in Canadian nursing and Canadian nursing education history.[232] This research builds on the historical Canadian nursing work of Tipliski, Hicks, and Dooley by integrating the three histories: mental institutions, psychiatric nursing schools, and the treatment provided by various caregivers in the care delivered in mental institutions.

Registered psychiatric nursing schools in Canada

Four significant studies have been conducted on the history of psychiatric nursing education in Canada. As previously introduced, the major doctoral dissertations are: 1) *Parting at the Crossroads: The Development of Education for Psychiatric Nursing in Three Canadian*

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[228] Bramadat and Chalmers.
[229] Baker et al., 'Ties That Bind: The Evolution of Education for Professional Nursing in Canada From the 17th to the 21st Century'.
[230] Baker et al.
[231] Hicks, *Politics, Personalities, & Persistence*.
[232] McPherson, *Bedside Matters*; Mansell, *Forging the Future*; Zilm and Warbinek, *Legacy: History of Nursing Education at the University of B.C. 1919-1994*.

Provinces, 1909-1955 in 2002 by Veryl Tipliski, and 2) *From Barnyard to Bedsides to Books and Beyond: The Evolution and Professionalization of Registered Psychiatric Nursing*, completed by Beverly Hicks in 2008, at the University of Manitoba.[233] Additional significant historical masters research on the development of psychiatric nursing education in Manitoba and Saskatchewan were completed by Dooley, and Wood respectively.[234] The Brandon Hospital for Mental Disease established the first mental hospital training school west of the Great Lakes in 1921, more than a decade after Ontario standardized mental nurse training, though the separate RPN profession never emerged there.[235] In the late 1930s mental hospitals and psychiatric nursing institutions did not have organized nursing staff but this would soon change to meet the staff needs of the growing mental hospitals. A component of this organization was development and implementation of organized nursing education. Dooley argued that while nurses in the Canadian general hospitals had control of nurse education it did not extend to mental hospital nurses in Manitoba. Brandon's Medical Superintendent, Dr. Arthur Baragar, with the support of his wife who was a graduate nurse, transformed all female civil servant attendant positions into pupil nurse positions. He hired RNs to serve as Head Nurses and modelled the school on the ideals of general hospital training, excluding male attendants from the school. Although mental hospital nursing education programs were developed, they maintained a relationship with general hospital that were educating RNs. For example, the affiliation program for mental hospital nursing students continued in Saskatchewan and Manitoba was created and continued to evolve

[233] Tipliski, 'Parting at the Crossroads PhD'; Hicks, 'From Barnyards to Bedsides'.
[234] Susan Taylor Wood, 'Changing Times: A Historical Review of Psychiatric Nursing Education in the Province of Saskatchewan' (Master's Thesis, Regina, Saskatchewan, University of Regina, 1998); Dooley, 'Mental Nurses at Brandon Hospital'.
[235] Dooley, 'Mental Nurses at Brandon Hospital'.

because it had the benefit of affiliating general hospitals that desperately needed students to fulfill the growing hospitals' workforce needs.

North Saskatchewan's North Battleford and Weyburn mental hospitals offered no organized education for RPNs until 1930.[236] North Battleford's medical superintendent, Dr. James MacNiell, and the Commissioner of Mental Hospital Services rejected the general hospital nurse training model for the mental hospitals in contrast to leaders in Manitoba and Ontario. RNs did not have a great presence in Saskatchewan's mental hospitals because McNeill did not want them working in his institutions.[237] The trend across Canada was that RNs chose not to work in mental hospitals, creating the conditions for medical superintendents who needed nursing staff to create hospital-based training programs.[238]

Ontario medical superintendents, like their American counterparts, developed and delivered provincial curriculum and examinations for mental nurse training in hospitals for the insane in Kingston, Toronto, Hamilton, London, and Brockville.[239] Students and graduates replaced the untrained female attendants only in the female part of the institution, but few general trained nurses worked in the medically controlled insane hospital. From its beginning the Graduate Nursing Association of Ontario (GNAO) decided as an organization that graduates would be eligible for registration following completion of an affiliate general hospital

[236] Tipliski, 'Parting at the Crossroads PhD'. Training led by lecturing medical superintendents evolved to a three-year, 100-hour lecture program by 1937. The Saskatchewan government had no direct involvement in the training.
[237] Tipliski. He required RNs to take his lectures and spend a year apprenticing as a nurse-attendant. The result was that few RNs chose to work at his hospital, and he expanded his attendant training to include nursing skills. At Weyburn the medical superintendent attempted recruiting RNs to administer insulin coma therapy.
[238] Veryl Margaret Tipliski, 'Parting at the Crossroads: The Emergence of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955.', *Canadian Bulletin of Medical History = Bulletin Canadien d'histoire de La Médecine* 21, no. 2 (2004): 253–79, https://doi.org/10.3138/cbmh.21.2.253. Tipliski found that at the end of WWII of the 33 338 practising RNs in Canada only 500 were employed at the 36 mental hospitals, a reflection of the shortage of nurses and amplified by difficult hospital working conditions
[239] Tipliski, 'Parting at the Crossroads PhD'.

component.[240] The decision was made to align with professional nursing standards and because American RN education included training for psychiatric hospital nurses. In Canada, RN schools began to include curriculum on nursing for the mentally ill in the 1930s.[241] The exception was the Winnipeg General Hospital in which nursing students had been receiving a psychiatric affiliation at the nearby Winnipeg Psychopathic Hospital since 1920.[242]

In the 1930s, Ontario nurse leaders, like their American colleagues, became aware of the need to include psychiatric nursing education within RN education.[243] This was in part due to the mental hygiene movement in Canada and the US. The mental hygiene movement led to psychiatrists emphasizing a public health approach to population mental health needs, bringing the scope of psychiatry out of the mental institution.[244] Nurse leaders began to support that psychiatric affiliation for RN students could improve overall patient care. Weir disagreed with specialized entry-level training for psychiatric care, rather supporting the inclusion of mental hygiene as part of all nursing education.[245] He recommended psychiatric affiliations should be integrated into all general hospital nursing education and thus this was incorporated into the CNA Proposed Curriculum for Schools of Nursing in Canada.

As previously stated, nursing education began to change after the publication of the Weir report. Tipliski found that the Registered Nurses Association of Ontario (RNAO) recommended the closing of mental hospital nurse training schools, and instead rotating RNs through mental hospitals as affiliation programs.[246] After WWII specialty schools saw decreasing enrolment,

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[240] Tipliski.
[241] Tipliski.
[242] Tipliski.
[243] Tipliski.
[244] C. G. Stogdill, 'Progress of Mental Hygiene Programs in Public Health in Canada', *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique* 40, no. 12 (1949): 497–507, http://www.jstor.org/stable/41979970.
[245] Weir, *The Weir Report*.
[246] Tipliski, 'Parting at the Crossroads PhD'.

leading to eventual closure of many mental hospital nursing schools by the 1950s. By that time psychiatric nursing education in Ontario was well accepted into mainstream nurse education. Her findings were limited to the history of Ontario, Manitoba, and Saskatchewan. Assumptions about the developments of RPN in BC cannot be generalized from the developments in other Western provinces because of the provincially delivered health care model in Canada where provinces each have distinct ministries of health. Factors such as the distance of BC from Ontario, Manitoba and Saskatchewan and the impact of historical developments in the USA may be of value to explore to paint a clearer understanding of the evolution of RPN education in BC.

Historical research on RPN education in Canada

In 2004, the Government of Canada funded a project entitled *Building the Future: An integrated strategy for nursing human resources in Canada.* The project output included a formal report entitled *Nursing Education in Canada: Historical Review and Current Capacity.*[247] The nursing education report described the historical context of nursing in Canada. At that time, only one RPN school (out of four) responded, resulting in no report for RPN education.[248] The reasons why three RPN schools chose not to respond is not reported, but it was clear that there was a gap in evidence about the current state and future planning for RPNs in Canada.

In the historical overview component of the study, the key RPN partners were from Manitoba and Saskatchewan. The lack of representation from BC may have resulted in a gap in knowledge about the unique situation of BC, especially in consideration of the historical research of Tipliski and Hicks, which emphasized the unique aspects of RPN professional development

[247] Pringle et al., 'History of Canadian Nurse Education'. The overall focus of the project was to create an informed, long-term strategy to ensure an adequate supply of skilled and knowledgeable nurses to meet the health care needs of all Canadians.
[248] Pringle et al. To protect anonymity of the one RPN school respondent, the survey results of that school were not included in the public report.

and education across each of the Western provinces.[249] Tipliski and Hicks noted the diversity of RPN education across the Western Canadian provinces, highlighting the need for in-depth historical research on the development of psychiatric nursing education in BC.

In reporting the history of RPN education in Canada, the authors acknowledge that despite an 85-year history of education programs, the first of which opened in Manitoba, at that time it had been largely undocumented. The report divides RPN education into 4 distinct categories: pre-nursing (1886-1920), the developmental phase (1920-1960), the transition phase (1960-2000), and the education option phase (2000-2004). The division of education eras provides a guideline that may be used to explore the history of psychiatric nursing education in BC based on the greater trends happening in psychiatric nurse education across Canada. The authors focused on the contexts of Manitoba and Saskatchewan. They highlighted the invisibility of RPN and RN input in the development of psychiatric nurse training at that time. Psychiatrists were described as having almost total control over what RPNs learned.

Registered Psychiatric Nursing education evolved at the same time in BC and Saskatchewan.[250]The first Canadian study focused on RPN education was a master's thesis completed by Susan Taylor Wood at the University of Regina.[251] Wood's study focused on the years 1930-1997, the initial lifetime of Saskatchewan's Psychiatric Nursing Training Program (PNTP). Wood was motivated to conduct the study to capture the history of RPN education in the province. At the time, the psychiatric nursing program had been discontinued and the last class had graduated from the Saskatchewan Institute of Applied Sciences & Technology (SIAST)

[249] Tipliski, 'Parting at the Crossroads PhD'; Hicks, 'From Barnyards to Bedsides'.
[250] Wood, 'Psychiatric Nursing Education in Saskatchewan'. The Saskatchewan Hospital in North Battleford (SHNB) was opened on February 4, 1914
[251] Wood.

Psychiatric Nursing Diploma program in 1997.[252] This coincided with the opening of the Nursing Education Program of Saskatchewan (NEPS) in 1996.[253]

At the Saskatchewan Hospital North Battleford (SHNB) staff working in nursing service in the 1920s were either called nurses or attendants, as determined by gender rather than distinct training or credentialing.[254] In 1929, the Saskatchewan Government appointed a commission to make recommendations on the future of mental health care in Saskatchewan.[255] It was led by Dr. Clarence M. Hincks, Director of the Canadian National Committee for Mental Hygiene (forerunner of the Canadian Mental Health Association), Dr. Sam R. Laycock (Professor of Educational Psychology at the University of Saskatchewan), and Dr. O.E. Rothwell, the first psychiatrist in the province. In 1930, the Commission released the Provincial Mental Hospitals and Mental Hygiene Conditions in the Province of Saskatchewan report that gave criticism to the lack of trained ward staff, and the custodial care provided with no active treatment. One of the 37 recommendations of the commission was to raise the standard of ward staff training that included instruction in the fundamentals of medicine, psychology, psychiatry, and mental hygiene.[256] The commission recommended that both genders of staff be judged by the same admission criteria, and receive the same training and be awarded the same diploma on graduation.[257] Saskatchewan was the second province in Canada to establish a Ward Attendant Training Program (WATP) in in 1921, the first being established at Brandon Provincial Hospital in 1921.[258] Ward staff training

[252] Wood's study focused on the years 1930-1997, the initial lifetime of the Psychiatric Nursing Training Program (PNTP). Wood.
[253] Wood; Margaret Elaine Olfert, 'The Life Cycle of a Collaborative Nursing Program: The History of the Nursing Education Program of Saskatchewan, 1996-2010' (Doctoral Dissertation, Calgary, University of Calgary, 2012), https://prism.ucalgary.ca/handle/1880/49874.
[254] Wood, 'Psychiatric Nursing Education in Saskatchewan'.
[255] Wood.
[256] Of note, nursing was not on this list. Wood.
[257] Wood.
[258] Wood.

began in Essondale in BC in 1930, and in Ponoka, Alberta in 1931.[259] In the 1940s Saskatchewan's Dr. D.G. Mckerracher, appointed Commissioner of Mental Health Services and Chief Psychiatrist of the province, rejected the idea of establishing a general nursing program in the mental hospitals because of the challenges Eastern Canada and the USA had in retaining RNs in the mental hospitals post-graduation.[260] This was an interesting statement from a psychiatrist because like the general hospitals, mental hospitals relied on the student workforce. Instead, McKerracher expanded the WATP professional group to provide therapeutic care consistent with the training program established at Manitoba's Brandon Mental Hospital in 1921.[261] Training was compulsory for all attendant ward staff by 1932.

Wood identified the changing standards for ward staff in the 1930s and 40s that coincided with development of psychiatrist driven treatments such as hydrotherapeutic shock, fever treatments and pharmacotherapy. Segregated care of men and women patients required training for both men and women staff in the WATP. The program ended in June 1997 with the opening of the Nurse Education Program of Saskatchewan (NEPS) in 1997.[262] The NEPS program took the place of the diploma based psychiatric nursing program. While the Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) initially approved NEPS graduates to write the RPNAS registration exam, they revoked it in 2001, following a formal assessment of the program.[263] The Nurse Education Program of Saskatchewan (NEPS) was a transitional collaborative program developed as a partnership between SIAST and the University of Saskatchewan.

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[259] Author Unknown, *Dear Bill, Let's Start an Association...A Tribute to the Psychiatric Nurses Association of Canada On the Occasion of Its 25th Anniversary*.
[260] Wood, 'Psychiatric Nursing Education in Saskatchewan'.
[261] The model is also consistent with model used in the United Kingdom in which mental nurses were recruited and trained. Wood.
[262] Wood; Olfert, 'The Life Cycle of a Collaborative Nursing Program'.
[263] Olfert, 'The Life Cycle of a Collaborative Nursing Program'.

In 2003, Martin stated that the relationship between RPNs and RNs is crucial for the professional development of RPNs in Saskatchewan.[264] Before the 1980s, their relationship was strained, but they started collaborating to improve the professional image of nurses.[265] The work of Saskatchewan RPNs from the 1970s to the 2000s was the most influential factor in solidifying the continued professional development of psychiatric nurses.[266]

In 2020, Hicks built on her 2008 dissertation on the history of professionalism of RPNs in Manitoba, self-publishing a book entitled *Politics, Personalities & Persistence: One Hundred Years of Psychiatric Nursing Education in Manitoba.* Hicks focused on the years 1920, to the 2000s, tracing the movement of psychiatric nurse education from the institutional asylum and mental hospital setting to the academic setting of Brandon University. Focus was on the policy and government legislation that changed over the 20th century and led to significant changes in education. Changes included the governing bodies who determined psychiatric nurse education curriculum development and delivery, the length of programs, the composition and training of educators, and the location of delivery. Hick's research did not focus on the content of the curriculum, rather she provided a historical narrative of who determined guidelines, standards, and credentialing.

Though Hicks highlights the lack of acceptance that RN organizations had for psychiatric nurses, including the Manitoba Association of Registered Nurses (MARN), CNA, and the Canadian Association of University Schools of Nursing (CAUSN), she does not go into detail about how education differed other than the location of psychiatric nurse education in mental

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[264] Martin, 'Determinants of Destiny'.
[265] Martin. Martin used a variety of sociological concepts of professionalization to identify five factors terms 'determinants of destiny' that influenced the professionalization process of psychiatric nursing having profoundly shaped the profession.
[266] Martin.

hospital settings. One can conclude that if all learning was done in a mental health hospital, graduates would have had limited opportunity to learn about other areas of nursing such as medical/surgical, obstetrics, pediatric and community health care. Understanding about the curriculum that guided psychiatric nurses' learning is of value in acquiring greater insight into what psychiatric nurses focused on in their education in the mental hospital, and ways that this evolved as mental health care shifted over the 20th century. To contextualize the situation of registered psychiatric nurse education at the BC School of Psychiatric Nursing it is necessary to have a clearer picture of the history of psychiatry in BC, an overview of Riverview Hospital, and to understand the changes on mental health care that took place over the 20th century.

The Rise of Psychiatric Nurses

I focused specifically on the research of Tipliski and Hicks regarding the development of RPN education. Their research explored factors that led to the adoption of a Western-Canadian psychiatric nursing model. Dooley focused on the development of occupational culture of RPNs at Brandon Hospital. Martin's research traced the professionalization of RPNs in Saskatchewan, focusing on legislation and development of the professional association of psychiatric nurses in that province. A common thread in all these documents was the connection of the formation of RPN education to the location of the work in the institutional mental hospitals that were rapidly filling with patients until the late 1950s. This separation of psychiatric nurses from general hospitals and their work with a stigmatized population led to a separate RPN identity.

Work location and identity

Psychiatric nurses were deeply connected to the mental hospital institution, and this only changed in the mid-20th century when new philosophies of care and deinstitutionalization of the patient population began to occur. Professional identity formation for psychiatric nurses

happened in Alberta in the1930s with the shift of mental asylums into mental hospitals.[267] The government of the time promoted the ideal of women as figures embodying compassion and bringing order to the mental hospital; this view shaped the formation of psychiatric nursing education that favoured women students over men. Boschma highlighted the ways that the rehabilitation movement shifted professional identity along with nursing practice in the Alberta mental hospitals.[268] The asylum attendants, who were both women and men, were subjected to a shift in their identity when the structure of mental asylums moved to being mental hospitals. The major change was that women could access two years of training at the mental hospital along with an additional eighteen months of training in the general hospital thus qualifying them to write the RN exam and become a licensed RN. Men were limited to a three-year program that led to a diploma in mental nursing, designating them as certified attendants. Exploration is necessary to understand the processes of professionalization of psychiatric nursing in BC along with understanding the connection between gender and differentials in access to credentialing and professional status.

Location of work significantly shaped psychiatric nursing identity. The changing delivery of care influenced the nurse role and professional identity. Boschma conducted historical research focused on psychiatric nurses in community mental health and in institutions for the developmentally disabled, finding that the patient population and nature of work influenced identity formation.[269] The expansion of RPNs from the mental hospital led to greater understanding of the changing role of the mental health or psychiatric nurse in the wake of

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[267] Boschma, Yonge, and Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75'.
[268] Boschma, Yonge, and Mychajlunow.
[269] Boschma, 'Community Nursing in Alberta'; Boschma, '"You Had To Just Kind Of Rub Her Cheek": Memories and Emotions of Mental Deficiency Nurses in Alberta, Canada, 1945 - 1975'.

deinstitutionalization in Alberta in the 1960s and 1970s.[270] Community mental health care was a shift in the location of services, but not a complete break from the institutional mental health hospital model.[271] Similarly, the role that RPNs fulfilled in institutions that housed people with developmental disability created a unique identity for those nurses.[272] It is of value to understand how the deinstitutionalization movement along with shifts of nurses to non-traditional mental asylum and hospital settings impacted the education received.

Deinstitutionalization and RPNs

Deinstitutionalization was a global trend that occurred primarily in Western Europe, North America, Australia and New Zealand beginning in the 1960s and continuing until the 2000s.[273] It was led by government efforts to scale down and close large institutions and increase community-based services.[274] The deinstitutionalization movement reflected the shifting social belief that people experiencing a mental illness should, where possible, receive care within their own family and community settings.[275] In Canada, deinstitutionalization was a complex process that involved shifting of funding from provincial and institutional settings to the community, a reduction of services from psychiatric hospitals, increasing capacity of general hospitals and

[270] K. Smith and Geertje Boschma, *Chapter 6: Toward Community-Based Practice: The Changing Role of the Registered Nurse in Psychiatry and Mental Health*, ed. Sandra Lewenson, Annemarie McAllister, and Kylie Smith (New York: Springer Publishing Company, 2017), https://www.ebsco.com/terms-of-use; Boschma, 'Community Nursing in Alberta'.
[271] Boschma, 'Community Nursing in Alberta'.
[272] Boschma, '"You Had To Just Kind Of Rub Her Cheek": Memories and Emotions of Mental Deficiency Nurses in Alberta, Canada, 1945 - 1975'.
[273] H. Richard Lamb and Leona L. Bachrach, 'Some Perspectives on Deinstitutionalization', *Psychiatric Services* 52, no. 8 (2001): 1039–45; Walid Fakhoury and Stefan Priebe, 'The Process of Deinstitutionalization: An International Overview', *Current Opinion in Psychiatry* 15, no. 2 (March 2002): 187–92, http://journals.lww.com/co-psychiatry/Fulltext/2002/03000/The_process_of_deinstitutionalization:an.11.aspx.
[274] Happell, 'Appreciating the Importance of History'; Trevor Turner, 'The History of Deinstitutionalization and Reinstitutionalization', *Psychiatry*, Community Psychiatry 1, 3, no. 9 (1 September 2004): 1–4, https://doi.org/10.1383/psyt.3.9.1.50257.
[275] Enric J. Novella, 'Mental Health Care in the Aftermath of Deinstitutionalization: A Retrospective and Prospective View', *Health Care Analysis* 18, no. 3 (1 September 2010): 222–38, https://doi.org/10.1007/s10728-009-0138-8.

other types of regionalized facilities to provide psychiatric care, and a reduction in reliance of long-term psychiatric care.[276] As in Canada, the Australian and Great Britain deinstitutionalization movements faced criticism mainly about limited funding to ensure suitable community support for people needing mental health care as well as for their families. There was also concern that community services were not sufficiently well resourced to provide an optimal level of care.[277]

The role of the RPNs in Canada changed as the mental health system and services changed over the course of the 20th century. The work of Boschma on psychiatric nurses in Alberta[278] and mental health care in BC, and that of Dooley in Saskatchewan[279] highlight the significant impact that deinstitutionalization had on the psychiatric nurse profession and its identity. Boschma focused on the changing role of the mental health nurse in the wake of deinstitutionalization in Alberta in the 1960s and 1970s.[280] Changes in the delivery of care fundamentally changed the nursing role and professional identity.

In Saskatchewan deinstitutionalization had a similar impact to nursing practice and the identity of psychiatric nurses. In the 1940s the government of Saskatchewan was the first to reject the model of psychiatric care that was prevalent in the provinces east of Manitoba which utilized an RN and psychiatric aide model to deliver custodial care.[281] Instead, a new type of

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[276] James D. Livingston, Tonia Nicholls, and Johann Brink, 'The Impact of Realigning a Tertiary Psychiatric Hospital in British Columbia on Other Institutional Sectors', *Psychiatric Services* 62, no. 2 (2011): 200–205; Yekeen A Aderibigbe, 'Deinstitutionalization and Criminalization: Tinkering in the Interstices', *Forensic Science International* 85, no. 2 (28 February 1997): 127–34, https://doi.org/10.1016/S0379-0738(96)02087-7.
[277] Happell, 'Appreciating the Importance of History'; Turner, 'The History of Deinstitutionalization and Reinstitutionalization'.
[278] Boschma, Yonge, and Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75'; Boschma, 'Community Nursing in Alberta'; Boschma, '"You Had To Just Kind Of Rub Her Cheek": Memories and Emotions of Mental Deficiency Nurses in Alberta, Canada, 1945 - 1975'.
[279] Dooley, 'We Were Institutionalized'; Dooley, 'End of the Asylum'.
[280] Boschma, 'Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950-1980'.
[281] Dooley, 'We Were Institutionalized'.

nursing education was developed that emphasized human relationships and social sciences rather than the medical content the heavily influenced general nurse training. Dooley found that as the 1960s approached, deinstitutionalization was changing the way that mental health care was delivered, moving it away from large mental health institutions and into decentralized general hospitals and community-based settings.[282]

Uncredentialed psychiatric nurses, trained within the hospital-based education system faced a challenge of limited mobility and a rapid erosion of their job security. Notably, staff who moved to the general hospital setting noted that a significant philosophical shift occurred in the 1970s towards increased reliance on a medical model that prioritized the compliant patient, and coercive control rather than the work-oriented and relationship-based models they knew from the mental institutions.[283] Registered Psychiatric Nurses identified that they themselves had been institutionalized, accustomed to the structure of institutionalized care, and were having a challenging time adapting to the changing model of care delivery in general hospitals and community settings. Dooley's research uncovers a gap in knowledge about the extent to which shifting models of mental health care impacted the curriculum for RPN students and nurses who were working in the institutional mental hospital setting. There is value in understanding the potential disparity between students who may have been learning models of care relevant to the changing face of mental health care, while the practice, philosophies and understanding of staff nurses who were training student nurses in the clinical setting may have stayed the same.

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[282] Dyck and Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada*. At that time Saskatchewan had one of the largest, and newest built institutions, the Weyburn Mental Hospital.
[283] Dooley, 'We Were Institutionalized'.

Psychiatric Nursing Theory Informing Psychiatric Nurse Education

Nursing theory that informed the curriculum of psychiatric nursing in general included Peplau's relational practice theory, was foundational in the development of nursing curriculum at the BC School of Nursing. Peplau's theory was integral to the development of the BC School of Psychiatric Nursing as evidenced in the preliminary search of archival documents. Peplau's Interpersonal Theory is about the process of the patient-nurse relationship. The nurse enters a relationship with the patient in which they are helping them with a process of transformative change.[284]

In 1989, Peplau identified many of the issues that have now come to fruition. She identified that "nursing needs to develop a comprehensive history of psychiatric nursing, showing the influence of changing social and professional contexts on its development; this can inform students, the profession, and the public".[285] Her hope that every nursing school should include a component of psychiatric nursing in their general nursing programs is a reality in Canadian nursing. An additional factor in this embracing of psychiatric nursing knowledge in undergraduate curriculum was to encourage nurses to pursue graduate work in mental health nursing areas. Her hopes manifested differently in the Canadian context. The role of nurse psychotherapist is not something that has come to fruition in Canada, though there are Advanced Practice Mental Health Nurses in some provinces.[286] Peplau called for nurse involvement in advocacy related to political actions and the role of nurses in ensuring proper resources meet

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[284] Anita Werner O'Toole and Sheila Rouslin Welt, *Hildegard E. Peplau Selected Works: Interpersonal Theory in Nursing* (Macmillan Education UK, 1994).
[285] Hildegard Peplau, 'Future Directions in Psychiatric Nursing From the Perspective of History', *Journal of Psychosocial Nursing & Mental Health Services*, vol. 27, 1989, 27.
[286] Brandon University, 'Curriculum - Master of Psychiatric Nursing', Master of Psychiatric Nursing - About the Program, 2023, https://www.brandonu.ca/mpn/about/curriculum/; McGill University, 'Mental Health Nurse Practitioner Concentration', Ingram School of Nursing, 2023, https://www.mcgill.ca/nursing/programs/masters-programs/npnnpc/np-concentrations/mental-health.

patients' needs. As the 1990s approached the de-institutionalization movement had already led to many mental health hospital downsizing care and shifting to psychiatric units within general hospitals.

The foundation of Interpersonal Relations Theory is the human connection and the nurses' therapeutic use of self. As psychopharmaceuticals were gaining popularity and becoming common practice in psychiatry Peplau cautioned against psychiatric nurses embracing a medical model because of the constraint that it places on the patient centered relationship necessary in psychiatric nursing. Conforming to a medical model built on ideas of control, observation, and monitoring rather than building a human relationship. Such a model created an oppressive context in which nurses were limited in their practice, and operating within it limited their understanding of patients.

Chapter Summary

This chapter provided a review of the current literature relevant to this study on the history of psychiatric nursing education in Canada. The chapter was divided into four main sections: review of literature on the evolution of the mental hospital and mental health care; an exploration of literature on the evolution of psychiatric treatment, literature on psychiatric nursing abroad, and research Canadian studies on nurse practice and education. By beginning more broadly and finally narrowing focus, I was able to gain an understanding of the changes in the model of nursing education delivery over the 20th century. Mental hospital and mental health care literature demonstrated that mental hospitals developed in late 18th and 19th century in English-speaking Canada and were influenced by those in the UK and the USA. The control and influence of psychiatrists in the mental hospitals had an impact on the need for attendants and domestic staff to shift to educated nurses. Due to the paucity of BC focused research, a focus was

on available Canadian and international literature on psychiatric nursing. I examined seminal research from a global perspective focusing on the USA, New Zealand, and the Netherlands which, like Canada, share similar structures of institutionalized mental health care that shifted with the deinstitutionalization model as the 20th century progressed. An overview of the history of nursing in Canada provided a general understanding of the major historical developments in RPN education over the 20th century. Canadian psychiatric nursing literature focused on Alberta, Saskatchewan, and Manitoba, leaving a gap in knowledge about psychiatric nursing in BC. I found additional studies that explored various aspects of psychiatric nursing in Western Canada including professionalization, identity formation, and the effects of deinstitutionalization. The chapter closed with an exploration of the foundational psychiatric nursing theory of Hildegard Peplau and its influence on shaping understanding of psychiatric nurse identity.

Chapter Three - Research Method and Design

In this chapter, I provide an overview of the historical research method and approach. This is followed by a description of my study design. I present an explanation of the primary and secondary sources used in this study to summarize where and what types of resources were used. Ethical considerations including risks and benefits are outlined. Issues related to rigour in historical research are also explored.

The Historical Method (Research Approach)

As addressed by Tipliski[287] and Hicks[288] in their doctoral research a historical perspective is imperative to understanding the story of nursing. Historical methods of research allow for a critical examination and analysis of records of the past to discover the unknown and explore questions of "how" and "why".[289] Researchers must not overlook the importance of using historical sources to contextualize the unique circumstances of psychiatric nursing. This powerful method of inquiry allows them to extend beyond what is contained in the here and now and explore questions of "how" and "why" by examining artifacts from the past.[290] Exploration of the history of psychiatric nursing in Canada enables the challenging of notions of nursing in Canada traditionally constructed in histories of registered nursing, allowing nurses to see where the intersections occur between the history of RPNs and RNs. In addition, this brings a different perspective to the history of mental health care and mental hospitals in Canada.

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[287] Tipliski, 'Parting at the Crossroads PhD'.
[288] Hicks, 'From Barnyards to Bedsides'.
[289] Laurie K. Glass, 'Historical Research', in *Advanced Design in Nursing Research* (2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc., 1998), 356–74, https://doi.org/10.4135/9781452204840.n14.
[290] Brennan, 'Historical Nursing Narratives'; Luke Molloy, Richard Lakeman, and Kim Walker, 'More Satisfying Than Factory Work: An Analysis of Mental Health Nursing Using a Print Media Archive', *Issues in Mental Health Nursing* 37, no. 8 (2 August 2016): 550–55, https://doi.org/10.1080/01612840.2016.1189634; Diane B Hamilton, 'The Idea of History and the History of Ideas', *The Journal of Nursing Scholarship* 25, no. 1 (1993): 45–48.

Historical sources can be used to help researchers reflect on the past to highlight the problems of current conditions, to question assumptions, and to propose alternative histories and analyses.[291] Smith discussed the necessity of the nursing profession to move beyond the discourses that divide it; for nursing to, "transcend its history, nurses must first more fully engage with that history, and in a much more complex analytical way than it currently does".[292] The value of understanding history is that it goes beyond simply relating progressive stories of success; it also reveals why failures occur, which is paramount in devising strategies to do better.[293]

Approach to Historical Writing

The work of Brennan guided my data analysis. Brennan's approach merges an interpretive historical approach and a critical perspective, enabling historians of mental health nursing to move beyond the notion of history as construction of a narrative of probing questions of who created the story and why.[294] The interpretive theoretical approach is rooted in the tradition of historical sociology, following in the tradition of seminal theories such as those of Max Weber, mainly rejecting positivist methodology and embracing an open-ended comparative process and analysis that foregrounds multiple causative factors and results in social change. The underlying assumption is that researchers are not value free, meaning the perspective of the researcher is integrated into the interpretive process. The critical perspective interrupts and

[291] Molloy, Lakeman, and Walker, 'More Satisfying Than Factory Work: An Analysis of Mental Health Nursing Using a Print Media Archive'.
[292] K. Smith, 'Facing History for the Future of Nursing', *Journal of Clinical Nursing* 29, no. 9–10 (1 May 2020): 1429, https://doi.org/10.1111/jocn.15065.
[293] Smith, 'Facing History for the Future of Nursing'.
[294] Brennan, 'Historical Nursing Narratives'.

interrogates existing narratives, both revisionist and progressive.[295] The approach allows the researcher to move beyond the notion of progressive historical perspectives, to critically analyze issues of the past. Such a critical analysis will result by asking questions such as: a) how did psychiatrists influence RPN education? b) what was the RPNs role in mental institutions? c) how was RPN identity shaped in relationship with RNs?, and d) what were the changes in the relationship between nurses and psychiatrists when education moved from the mental hospital to the post-secondary institution? Central to the approach described is understanding the contextualization of the historical phenomenon being explored.

The Historical Perspective

This section provides an overview of general historical practice and how scholars have adapted these practices to nursing history, discussing the shift from a positivist to post-postmodern perspective. As previously stated, an interpretive and critical approach informed by the work of Brennan was used to guide the data analysis process of this historical research. Historical research method focuses on the story of human beings through time with a focus on the past as a means of understanding the present, exploring processes and events that shaped the world in which we live.[296] Social or political institutions, events, persons, or ideas from the past may become the objects of historical study. Historical knowledge is constructed about past events or institutions from available and accessible traces of evidence.[297] Some evidence is

[295] Marnie Hughes-Warrington, *Revisionist Histories* (London: Routledge, 2013), https://doi-org.login.ezproxy.library.ualberta.ca/10.4324/9780203769805. Revisionist histories are concerned with the notion that historians revisit histories, challenging and providing diverse perspectives and alternative interpretations of narratives that contrast what has been written by historians in the past. This contrasted progressive histories that painted history as a forward moving process with positive change.
[296] Green and Troup, *Houses of History*.
[297] Glass, 'Historical Research'.

included, while some is rejected by present day historians who collect and assemble it into a coherent and plausible narrative.

The narratives historians create and the way they structure them have changed throughout time. Men physicians who held power in a patriarchal system usually constructed the progressive historical narratives of 19th century psychiatry, presenting a picture of history from a perspective of heroic storytelling.[298] In the 20th century, historical research shifted to a scientific model based on positivist frameworks in adherence with the evidence-based, objectivist sentiment of the time.[299] Novel questions were being asked by groups whose experiences did not resonate with the histories they read or heard. Certain groups such as women, people of colour, people of gender diversity, people of sexual diversity, blue-collar workers, rank-and-file nurses, and the mentally ill had been excluded in historical writing.[300] Ladened with the label of marginalized or oppressed, these groups, and those who supported them, mobilized and fought for a place in history. This included having their stories told and being included in the collective histories of work and education in mental institutions.

Positivist notions of objective history eroded as scholarly historical works deepened understanding of the histories we knew as written from a particular standpoint, that is from a frame of reference in which the individuals who wrote them perceived importance and value in telling certain stories.[301] Changing notions of history emerged because historians realized that

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[298] Kate Prebble and Linda Bryder, 'Gender and Class Tensions between Psychiatric Nurses and the General Nursing Profession in Mid-Twentieth Century New Zealand', *Contemporary Nurse* 30, no. 2 (2008): 181–95, https://doi.org/10.5172/conu.673.30.2.181; Beverly Hicks, 'Gender, Politics, and Regionalism: Factors in the Evolution of Registered Psychiatric Nursing in Manitoba, 1920 - 1960', *Nursing History Review* 19 (2011): 103–26, https://doi.org/10.1891/1062-8061.19.103.
[299] Marc Bloch, 'The Historian's Craft', in *The Modern Historiography Reader, Western Sources* (New York: Vintage Books, 1984); E. H. Carr, *What Is History?* (New York: Vintage Books, 1961).
[300] Ann E. Bradshaw, 'Gadamer's Two Horizons: Listening to the Voices in Nursing History', *Nursing Inquiry* 20, no. 1 (2013): 82–92, https://doi.org/10.1111/j.1440-1800.2011.00584.x.
[301] Carr, *What Is History?*

historical research included more than simply heroic stories of progress in the past. Histories became powerful tools to expose human frailties, to keep alive memories of the past neglect and social injustices, or to illuminate the accomplishments of forgotten or ignored groups not traditionally perceived as important.[302]

With this change in perspective came questions about how representations of people, places, groups, and events, were being constructed, by whom, and why particular representations of the past were privileged over others. Academics and scholars in history began to question the histories prevalent in the history books. These discussions were framed from a postmodernist perspective. Post modernism rejects epistemological assumptions and refutes methodological conventions.[303] This perspective challenges understandings of truth, the nature of knowledge and the stability of language. The impact of post-modernist perspectives on scholarship resulted in new positions and analytical frameworks. The emerging frameworks challenge established protocols and ask new questions. The postmodern perspective in historical research undermined the basic assumptions that the past could be recovered and represented as it happened. The crux of this change was the shift in writing about the past, to asking questions about how the past was written about.

Revisionist nostalgia, and the use of the past to justify present actions or behaviour are popular uses of history.[304] However, it is only by asking critical questions that new objectives, and new perspectives become unearthed. New perspectives offer opportunity for different voices to be heard and different perspectives to be offered. Historical research can offer new insights into understanding of past events and how processes have changed over time to inform the

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[302] Carr.
[303] Michael Peters, 'Derrida and the Tasks for the New Humanities: Postmodern Nursing and the Culture Wars', *Nursing Philosophy*, vol. 3, 2002, http://www.thepub.
[304] Brennan, 'Historical Nursing Narratives'.

present, but considerations must be made to who, how and why certain documents and artifacts are retained and preserved.[305] Data collection for historians is unique because in contrast with natural or social scientists, historians cannot gain data through conducting experiments because they cannot go back into the past. Thus, the biggest challenge of historical research is the reliance of the researcher on useful artifacts, documents, data being retained and accessible in the present. The historical researcher's evidence is the traces of the past.

Context in Historical Research

Historian Mark Bloch wrote about the importance of contextualizing historical research in terms of time, and about the idea that a historical phenomenon cannot be understood outside of its timebound context.[306]. Historical context encompasses the details of the time and place in which a situation occurs. In exploring the historical context of when historical artifacts were created, the researcher gains a greater understanding and appreciation of the narrative that unfolds. The context is the environment in which the events occur, and understanding the historical context becomes imperative in interpreting historical artifacts and events.

Writing Nursing History – A Reflexive Process

The outcome of historical research is most often a written narrative. In embarking on an exploration of historical literature it is essential to acknowledge that most early historians of nursing did not have formal education about historical methods and were writing as amateurs which likely influenced the shifting historical frameworks that have shaped historical writing about nursing history. Scholars such as Celia Davis in Great Britain began to challenge the

[305] Bloch, 'The Use of History'.
[306] Bloch.

professionalization focused progressive narratives of women nursing leaders in history which focused only on their accomplishments.[307] In 1980, Davis assembled a book of ten essays, each of which challenged the self-congratulatory, chronological, nursing history as progress approaches which masked power, gender, and class discourses.[308] Davis challenges nurse historians to continuously engage in a process of rewriting history, reflecting on how a nurse in a particular period is affected by their identity, subjective position and the contextualized discourse of the where and when they are writing.

Research Design

I explored the research questions guiding this study using a historical research design. In my writing of the history of RPN education in BC it was necessary to understand the context in which it developed. Historical contexts that were explored include the Canadian health care system, the mental health system, the evolution of psychiatry, the history of the rights of women, work conditions, the political climate, geography, and the RN education system as they were all necessary to create the foundation of this work. The unique context of BC was explored including European and non-European settlement, creation of the hospital system, development of provincial health services, economy, the place of women, and politics. The local history of the municipality where the hospital was built, the City of Coquitlam, was also integral to this work. New contexts emerged from the data, through the intensive and extensive data collection and analysis of archived evidence. I discovered how particular contexts intersected to impact the development of psychiatric nurse education in BC.

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[307] Celia Davies, *Rewriting Nursing History* (London: Cambridge University Press, 1980).
[308] Davies. Each author offered alternative perspectives, questioning why nurses should accept one particular account of their history over another.

The narrative of RPN education developed in the data analysis phase, and the context supports comprehensive understanding of why certain decisions were made at junctures in time. The narrative focuses primarily on the development of the British Columbia School of Psychiatric Nursing and the development of college education for RPNs, and eventually, the university-based degree program for psychiatric nurses in BC.

Conducting Nursing History (Data Sources and Data Collection)

In this section the data collection and analysis process are discussed, along with the limitations of data-gathering and analysis. In historical research identification of source material is necessary to determine if there is enough existing material to embark on a research project that will answer the research questions. Data collection for this project came from three main sources: primary sources, secondary sources, and oral history interview data. I primarily featured the oral histories in Chapter Six about caregivers in the mental hospitals. Both primary and secondary sources are identified and described below. A full list of sources identified is provided in the references section of this dissertation.

Primary Sources

Primary sources are essential in historical research. Glass defined primary sources as those that provide a first witness account of an event or a first written recorder such as meeting minutes, diaries, and correspondence.[309] Primary source collection is part of the data collection phase of historical research.[310] The purpose of locating primary sources is to position the

[309] Glass, 'Historical Research'.
[310] Lusk, 'Historical Nursing Method'.

researcher as close to the historical event as possible. Different types of primary sources can be used to locate and resolve any potential discrepancies as part of the analysis phase.[311]

Inclusion criteria for primary sources was guided by Boschma, Grypma, and Melchior who recommended four criteria for primary sources in data collection: a) relevant socio-political event in the historical period under study, b) first-hand accounts of people living through the period, c) recollections of experiences after the period of study has passed, and d) sources that help in understanding the values, beliefs, and assumptions of subjects.[312] Data collection from various sources allowed for construction of a foundation that supports creation of a narrative for the time period from various sources.

Primary sources of data were those accessed through BC provincial archives, including government reports, government correspondence, curricula, newsletters, committee meeting minutes, maps, pictures, and publications of the BC School of Nursing. The publicly accessible major reports include BC Government Annual Reports of Mental Health Services. Archives of BC Government reports were accessed primarily through the UBC Open Archive. Reports reviewed include those from the 1870s to the 1990s. Sources highlight the social, cultural, political, medical, and economic factors that led to the evolution of psychiatric nursing in BC. Annual reports revealed the opinion of the superintendent and communicate an official history of the mental health hospitals and services. These reports provided insight into the trends and changes. Examination of newspaper reports helped gauge public opinion toward mental illness, the mental hospitals, and psychiatric nursing.

The first step in the research process was completing an extensive preliminary survey of sources to substantiate that enough evidence existed to conduct a thorough research project. In

[311] Bloch, 'The Use of History'.
[312] Boschma, Grypma, and Melchior, 'Reflections on Subjectivity'.

this stage I found as many primary sources as possible to ensure that multiple avenues of data collection were exhausted before interpreting the data. In addition to primary sources, secondary sources were used to contextualize the primary sources and gain a greater understanding of the extant literature on the topic of interest.

Secondary Sources of Data

An initial step in the historical research process was reading the existing literature on the topic. Secondary sources are those written about the topic of interest, including for example books and journal articles written by individuals who were not present when events occurred.[313] They were collected both prior to and after the collection of primary data. Glass identified that secondary sources can be used to support explanations and arguments that emerge from primary data sources.[314] They were also used to make the context clearer. Secondary sources that were accessed included journal articles, books, student theses and dissertations. I accessed both primary and secondary sources in person and online including hospital, nursing school, and association meeting minutes, correspondence, annual reports, historical newspapers, journal articles, and books.

Use of Digital Archives to Locate Primary and Secondary Sources

Technological advances coupled with the constraints of access resulting from the COVID-19 pandemic led to extensive searching in digital archives. The digital archives accessed were BC historical newspapers, student dissertations and theses, and government reports accessed through the UBC Open Collections. Newspaper resources were an important source of

[313] Glass, 'Historical Research'.
[314] Glass.

data. *The Coast News*, *The New Westminster News*, *Times –Colonist*, and *The Vancouver Sun* were examined. Newspapers are considered as both primary and secondary sources depending on the nature of the articles. Newspaper articles were used as a primary source when they included information as a firsthand account about a specific event written immediately after the occurrence of the event.[315] Consideration was given to the article author, why it was written, and when it was published. Newspaper articles were treated as a secondary source if the content was an analysis of an event, or an account of someone who did not directly witness an event. Newspapers were treated as a primary source if it was an account or opinion of an event.

Other primary sources from digital archives included relevant records located in the BC Provincial Archives in Victoria, BC and the Coquitlam City Archive located in Coquitlam, BC. The BC Archives are the official repository of BC government records. In September 2020, extensive historical records were transferred and catalogued in the BC Archive. The City of Coquitlam archive contains historical documents from the Riverview Hospital Historical Society, including some meeting minutes of the Psychiatric Nurses Association (PNA) and The Psychiatric Nurse Journal (a partnership between the psychiatric nurse Council of Saskatchewan and the British Columbia Psychiatric Nurses Association (BCPNA)). Digital copies of meeting minutes and official correspondence of the move of the psychiatric nursing program from BCIT to Douglas College were also obtained. Archived documents from the former Psychiatric Nurses Association of British Columbia (PNABC) were reviewed for analysis, focusing on the years 1960 to 1980. Records related to program approvals, course curriculum and school calendars

[315] Keith C Mages and Julie A Fairman, 'Chapter Nine: Working With Primary Sources: An Overview', in *Capturing Nursing History: A Guide to Historical Methods in Research*, ed. Sandra B. Lewenson and Eleanor Krohn Herrmann (New York: Springer Publishing Company, 2007), 129–48, http://ebookcentral.proquest.com/lib/ualberta.

were also reviewed around the years 2003-2008 when the RPN undergraduate nursing programs in BC were developed at Douglas College and Kwantlen Polytechnic University.

Oral History

In addition to archival research, eleven oral history interviews were conducted with nurses who either attended the BC School of Psychiatric Nursing or worked at Riverview Hospital. No honoraria were given. Locating participants for interview involved identifying a key contact in the BC History of Nursing Society to find names of RPN nursing figures in BC who are known to still be alive. Oral data was a valuable component in this research to bring context to the archival data. Unlike other qualitative research, oral histories are not anonymous nor is the information that the interviewer chooses to share confidential.[316]

The aim of conducting oral interviews was to explore participants' experiences of their own education and training as psychiatric nurses in BC. An interview guide was developed (see Appendix A). The guide was provided to participants beforehand via email to offer them the opportunity to reflect and recall their experiences at Riverview Hospital. Participants were given the opportunity to review and refine the transcripts of their interviews. Field notes were taken electronically immediately after each interview and are included as part of the data for analysis.

It was essential to explain the interview process to participants along with option to deposit their data in an archive to ensure accessibility for future researchers.[317] Lewenson cautioned that although oral histories can be a rich source of data, it is important to cross-reference the material for accuracy, as memory of events can vary.[318] This is done by examining

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[316] Geertje Boschma, Olive Yonge, and Lorraine Mychajlunow, 'Consent in Oral History Interviews: Unique Challenges', *Qualitative Health Research* 13, no. 1 (2003): 129–35, https://doi.org/10.1177/1049732302239415.
[317] Boschma, Yonge, and Mychajlunow.
[318] Sandra B Lewenson, 'Chapter Three: Doing Historical Research', 2007, http://ebookcentral.proquest.com/lib/ualberta.

the extent to which participant recollections are in line with archival documents, and with statements made by other interviewees. Ethical issues can arise when using sensitive material from primary sources. For example, Einwohner experienced some unexpected ethical dilemmas when using archived oral testimonies of survivors of the Holocaust to conduct historical research.[319] Similarly, in this project sensitive material shared by participants has been excluded from the archived recordings. All participants consented to their interviews existing in the public section of the BC Provincial Archives located in Victoria.

Transcription

The audio recordings were transcribed by the researcher verbatim using voice transcription computer software on the teleconferencing software Zoom. Notes were made during transcription and analysis was supplemented using Microsoft Word comments in the margins of the printed interview transcripts. Completed transcripts were uploaded to the data analysis software Atlas Ti to facilitate analysis.

Access and Recruitment of Participants

Interview participants were recruited using purposive snowball sampling as recommended by Boschma et al.[320] All participants interviewed were required to have had experience either working at Riverview Hospital or as a student in the BC School of Psychiatric Nursing. Snowball sampling was deemed appropriate because of the limited number of nurses who met the inclusion criteria, making it necessary for participants to identify additional nurses who met the criteria to participate. Contact happened with the BC History of Nursing Society at their 2021 Annual General Meeting (AGM). Initial contact was made to potential participants by

[319] Rachel L Einwohner, 'Ethical Considerations on the Use of Archived Testimonies in Holocaust Research: Beyond the IRB Exemption', *Qualitative Sociology* 34, no. 3 (2011): 415–30.
[320] Boschma, Yonge, and Mychajlunow, 'Consent in Oral History Interviews: Unique Challenges'.

the organization, and those who were willing to participate were provided with my contact information. Letters of Invitation (Appendix B) were distributed to those who met the criteria for the study. The participants who met the study criteria were contacted through email, and the researcher confirmed their eligibility through a screening process.[321] The goal in using oral history was to generate data related to the lived experience of RPNs who worked and/or attended the BC School of Psychiatric Nursing in addition to collecting archive data. Eleven RPNs were interviewed, ten of which attend the School of Psychiatric Nursing and graduating between the years 1958 and 1972. Responses are primarily integrated into Chapter Six on Caregivers in the BC Provincial Mental Hospital because of the years of their attendance and recollections of their experiences.

Informed Consent

Informed consent was obtained from all participants prior to their research involvement, with clear instruction that the opportunity not to answer any question or to withdraw from the study was possible at any time prior to the publication of the research data (Appendix C). The principle of informed consent was utilized to uphold the ethical principle of autonomy, meaning the participant has the ability and right to independently decide whether they want to participate in the study.[322] The fundamental differences of oral history research versus other types of research are the disclosure of personal narratives by study participants in which subjective stories of their lives are shared surrounding a historical event.[323] The Standard Oral History Association

[321] The screening process included confirming via email that the interview participant was a psychiatric nurse, and that they attended the BC School of Psychiatric Nursing and/or that they worked at Essondale (later Riverview) Hospital.
[322] HJ Streubert and DR Carpenter, 'Designing Data Generation and Management Strategies', in *Qualitative Research in Nursing:Advancing The Humanistic Imperative*, 2011.
[323] Boschma, Yonge, and Mychajlunow, 'Consent in Oral History Interviews: Unique Challenges'.

guidelines exist for the storage and future use of recorded interviews because preservation of the data is a strategy to increase credibility of the data collected.[324] The subjective nature of the interview and connection to known events prevents maintenance of confidentiality and anonymity, thus interview participants must be informed and close attention must be given to documenting consent.[325]

Ethical Considerations

Ethics approval was obtained on October 12, 2021 (Appendix D). Ethical considerations are appropriately made for any research study that involves human participants. Ethical principles must be upheld at every stage of the research process.[326] Ethical considerations include discussion of informed consent, confidentiality, and anonymity, as well as benefits and risks for study participants. Research Ethics Review Board (REB) approval was obtained from The University of Alberta Research Ethics Review Board Study ID Pro00113662. Ethical approval was not required for accessing archives as archival documents are part of the public domain. A research agreement was signed for accessing BC Archive data and BCCNM archived files (Appendix E).

Benefits and Risks

Potential benefits to the participants were that the interviews provided an opportunity to share their stories, as well as share concerns and feelings about their experiences in an unrestricted manner. Potential risks to participants may occur if participants choose to disclose memories of emotionally difficult, traumatic, or distressing experiences. Participants were

[324] Boschma, Yonge, and Mychajlunow.
[325] Boschma, Yonge, and Mychajlunow.
[326] Streubert and Carpenter, 'Designing Data Generation and Management Strategies'.

informed of their right to pause or terminate the interview, with opportunity to resume later if they became upset. In the event of participants becoming distressed they were informed of the opportunity to debrief with the researcher immediately after the interview and offered a written list of resources for counselling support if requested or deemed useful. The benefits and potential risks were made clear to the study participants both in the Consent Form (Appendix C) and the Letter of Invitation (Appendix B).

Data Analysis

Unlike other types of research, the analysis process in historical research begins in the researcher's mind; the researcher organizes the collected facts into a plausible narrative to communicate results. According to Glass, the process happens in the head of the researcher, who puts the ideas on paper in the form of a report.[327] This analysis involved an iterative process in which the back-and-forth writing and viewing of data resulted in new questions as sources were examined, leading to seeking additional primary and secondary sources. The collection of data was completed when enough data was generated to provide a thorough description of the development of the BC School of Nursing and the development of psychiatric nursing education in BC, and/or when no data could be found on a particular topic of interest. In the following chapters, the findings and the analysis are presented together to insert findings in the broader context and to avoid repetition.

[327] Glass, 'Historical Research'.

Issues Related to Rigour

Data collection, interpretation and analysis of research data is subject to potential issues of reliability and validity.[328] External and internal criticism is used in historical research to maintain validity and reliability. External criticism is the initial lens that is used to determine authenticity of the source. Criteria include determining who authored the document, identifying dates, and identifying the original form. The second step of internal criticism is to assesses the reliability of the source. Reliability was determined by assessing the type of evidence found, and if there was an adequate amount to support the interpretation. In addition, when statements are made by more than one source there is a greater likelihood that it reflects reality. In the interpretation stage, reliability is reinforced when the researcher clearly identifies their biases and the potential impacts. Reliability of interpretation was substantiated by an appraisal about competence of analysis based on the explanation of types of evidence, and if the amount was enough to support any claims made.[329]

[328] Glass.
[329] Glass.

Chapter Four – The Evolution of Riverview Hospital

Riverview Hospital was the major mental institution that operated in BC for nearly a century (1913-2012). This chapter is focused on the history of this hospital. It was the main health care facility where BC RPNs worked until additional education was developed in 1967, which allowed them to move out of the mental hospital and into community-based mental health services. The chapter is divided into three sections based on chronological events beginning with the development, opening, and expansion (1912-1950), then progressing into the years of reorganization and deinstitutionalization (1951-1992), and lastly the downsizing and closure of the hospital (1993-2012). The first era was marked by the development of a School of Psychiatric Nursing which is explored in detail in Chapter 5. Riverview Hospital's closure came with the transfer of tertiary care mental health patients across the province to smaller more home-like facilities. Deinstitutionalization was aligned with what was happening across Canada and the USA. Despite the hospitals closure, RPN's role in the delivery of health care in mental health settings persisted.

Riverview Hospital was known by several different names over its lifetime based on changes in funding, care delivery, and the organizational structure. When initially conceived the hospital was known as the Hospital for the Mind at Mount Coquitlam. When it opened in 1913 it was named Essondale Hospital for Dr. Henry Esson Young, using this name until 1965.[330] From 1965 to 2012 the hospital was known as Riverview Hospital. In this dissertation the hospital name used corresponds with the name of the institution used within that time period.

[330] Henry Esson Young was a physician and political figure who held office in the BC Legislative Assembly from 1903-1915.

Development, Opening and Expansion (1912-1950)

The years 1912 to 1950 were a pivotal era in which the role of the Essondale Hospital was solidified as the major mental hospital in BC. During this period, the hospital rapidly expanded by constructing many buildings to house various mental health care programs and services for patients, students, staff, and the families of staff. The hospital was central to Essondale, as it was known, a relatively rural, fully functioning community until the 1930s. This section of the chapter is divided into three parts; the first provides an overview of the development of mental hospitals in BC (1872-1912), the second describes the opening of the hospital (1913-1941), and the third is focused on the expansion (1942-1950). To situate the context in which the hospital was constructed I first provide a brief overview of the development of mental hospitals in BC.

Development of the Mental Hospitals in BC (1872-1912)

Several mental institutions were opened and closed in BC from 1872 to 1914, prior to the opening of Essondale Mental Hospital on April 1, 1913. The first mental asylum in BC opened in the coastal island city of Victoria in 1872, and was moved to the mainland city of New Westminster in 1878 because of overcrowding.[331] From 1906 to 1909 the patient population at the New Westminster mental hospital increased rapidly reaching capacity.[332] Under the leadership of Medical Superintendent Dr. C.E. Doherty and a

[331] K. Scott, 'Society, Place, Work: The BC Public Hospital for the Insane 1872-1902', *BC Studies* 171, no. Autumn (2011): 93–110, https://doi-org.login.ezproxy.library.ualberta.ca/10.14288/bcs.v0i171.336. For an extensive history of the BC Public Hospital for the Insane read the 2011 work of Ken Scott. Scott's analysis focused on the difference in treatment of the Chinese population and the late implementation of moral therapy in the BC asylum.
[332] Henry Esson, 'Annual Report on the Public Hospital for the Insane of the Province of British Columbia for the Year 1906' (Victoria, B.C.: British Columbia. Legislative Assembly, February 1907); Henry Esson Young, 'Annual Report of the Public Hospital for the Insane of the Province of British Columbia for the Year 1909', Sessional Papers of the Province of British Columbia (Victoria, B.C.: British Columbia. Legislative Assembly, 1910),

Conservative Government led by Richard McBride the decision was made to begin construction on a new institution that would become Essondale Hospital. The property, previously known as Colony Farm, was situated in the Valley where the Fraser River and Coquitlam River joined, comprising virgin forest, and low swamp land. The choice of a relatively rural area with transportation access was common for new mental hospital construction in Canada at the time because of the beliefs about the benefit of quiet, natural surroundings and lack of significant curing treatments.[333]

Patient labour was used to begin construction, when twenty patients from the New Westminster Hospital lived in tents while they cleared land for temporary quarters.[334] Use of patient labour was common in mental hospitals because as previously discussed in my literature review patients were ambulatory in contrast to patients in general hospitals.[335] The land was located uphill from the Canadian Pacific Railway (CPR) line giving the property easy access to waterways, railway, and wagon roads. Plans were made to use the new hospital for treatment of adults only, and to construct a building for better care of people with tuberculosis.[336] The first building that was opened was the Male Chronic Building, known as the West Lawn building (Figure 4.1).[337]

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http://resolve.library.ubc.ca/cgi-bin/catsearch?bid=1198198. From 1906 to 1909, the total population increased from 348 to 507. Attempts were made to expand the site, but it was clear from the annual mental hospital reports that any type of expansion was limited, and resources were focused on preparing land in the nearby city of Coquitlam. By the spring of 1909, 80 acres were cleared by 40 patients in the Coquitlam-located Colony Farm. In winter of 1909, temporary quarters were enlarged to accommodate 65 patients to clear 500 acres of land.

[333] Shorter, *A History of Psychiatry*.

[334] Fred J. Fulton, 'Annual Report of the Public Hospital for the Insane of the Province of British Columbia for the Year 1904', Sessional Papers of the Province of British Columbia (Victoria: British Columbia. Legislative Assembly, March 1905), UBC Open Archive.

[335] Moran, *Committed to the State Asylum*.

[336] Henry Esson Young, 'Annual Report of the Public Hospital for the Insane of the Province of British Columbia for the Year 1910', Sessional Papers of the Province of British Columbia (Victoria, B.C.: British Columbia. Legislative Assembly, 1911), UBC Open Archive, http://resolve.library.ubc.ca/cgi-bin/catsearch?bid=1198198.

[337] Letter of permission for all pictures from Coquitlam Archive is listed in Appendix F.

Figure 4.1– Photo of the Male Chronic Building 1914 [338]

The grounds included significant features that were thought to exemplify it as a modern institution including a botanical garden, and a work farm.[339] At this time a new mental hospital was under construction in Brandon, Manitoba which was also publicly heralded as a modern mental facility, and the geographically closest mental institution in the Western provinces.[340]

Opening Essondale Mental Hospital (1913-1941)

Between the years 1913 and 1929, Essondale was established as a modern mental hospital within the province. Changes within the 1910s and 1920s substantiated the need for establishing a nursing school within the hospital, like those already established across the province in general hospitals.[341] The medical superintendent at Essondale, Charles E. Doherty, M.D., held the position until his death on August 14, 1920. Doherty recognized the need for nurses to maintain the "happiness and welfare" of patients.[342] This aligned with the efforts of

[338] *Essondale's West Lawn - Straight-on View ca. 1914*, 1914, Photograph, 1914, City of Coquitlam Archive, https://searcharchives.coquitlam.ca/index.php/essondales-west-lawn-straight-on-view-ca-1914.
[339] Henry Esson Young, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the Year of 1913', Annual Report, Sessional Papers of the Province of British Columbia (Victoria: The Government of British Columbia, 1914), UBC Open Archive, http://resolve.library.ubc.ca/cgi-bin/catsearch?bid=1198198.
[340] Edginton, 'Moral Treatment to Monolith'.
[341] Helen Vandenberg and Geertje Boschma, 'The Evolution of Early Hospitals in British Columbia, 1855-1918', *BC Studies* 208 (2021): 73–118. For a comprehensive history of early hospitals in BC see the work of Vandenberg and Boshma.
[342] J D Maclean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the Year 1918', Government Report, Sessional Papers of the Province of British Columbia (Victoria: British Columbia. Legislative

medical superintendents at the Brandon and Selkirk Manitoba mental hospitals that opened psychiatric nursing schools in 1920 and 1921 respectively.[343] During Doherty's tenure, hospital expansion included creation of a building for acute patients, a convalescent home, occupational therapy, and a social services department and a place to house nursing staff.

Development and Expansion

The first ward opened was the Male Chronic Building (later known as West Lawn). When the Essondale site opened in 1913, only men were transferred; 340 in total.[344] Thus, women remained in the chronically under-funded mental hospital in New Westminster, BC.[345] Until 1930, the patient care at Essondale was primarily delivered by male psychiatric attendants because patient care was gender segregated. Gender segregated care of patients in mental hospitals was common across Canada until the 1950s.[346] Treatment of women in the mental hospital will be addressed in Chapter 6. The Male Chronic building was planned as the first of many buildings, originally constructed to house 480 patients.[347] As the decade progressed both the New Westminster and Essondale Mental Hospitals had estimated increased spending for the

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Assembly, 1919), V9, http://resolve.library.ubc.ca/cgi-bin/catsearch?bid=1198198; 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1921', Legislative Proceedings, Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1922), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0226027. Doherty was the Medical Superintendent for the hospitals at New Westminster, and Essondale and Colony Farm until his death.

[343] Hicks, *Politics, Personalities, & Persistence*.

[344] Young, 'Annual Mental Hospital Report 1913'.

[345] M.E Kelm, 'A Life Apart: The Experience of Women and the Asylum Practice of Charles Doherty at British Columbia's Provincial Hospital for the Insane, 1905–15', *Canadian Bulletin of Medical History* 11, no. 2 (October 1994): 335–55, https://doi.org/10.3138/cbmh.11.2.335; Kelm, 'Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905-1915'.

[346] Boschma, Yonge, and Mychajlunow, 'Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-75'; Dooley, 'Mental Nurses at Brandon Hospital'; Hicks, 'From Barnyards to Bedsides'.

[347] British Columbia Mental Health Branch, 'A Summary of the Growth and Development of Mental Health Facilities and Services in British Columbia 1850-1970' (Mental Health Branch Department of Health Services and Hospital Insurance, June 1970), Legislative Library of British Columbia, http://www.llbc.leg.bc.ca/public/pubdocs/bcdocs2014_2/378642/summary.pdf.

upcoming fiscal years.[348] Essondale Hospital quickly filled and was holding a greater number of patients than it was designed for, requiring a plan to accommodate the increase in population.[349] Problems arose in housing all patients in a single building because the Male Chronic building was constructed for the care of long-term patients only, and not adapted for treating patients with acute conditions. Mental hospital crowding was a long-standing issue across Canada because of the lack of substantial treatments to cure patients of their illness and thus enable discharge.[350]

The lack of proper space for patients and staff had to be addressed. Dr. J.G. McKay, Acting Medical Superintendent,[351] strongly requested and received funding from the provincial government to move forward with constructing an acute building with a capacity of 150 beds.[352] The new building was described as the admitting unit for all male patients at Essondale, thus converting the New Westminster institution to the care of female patients only. The rationale for the plan was to minimize maintenance costs and end the constant transfer of male patients to and from Essondale. Few other requests for funding were made between 1913-1919 except for the cost of constructing a new laundry facility that was included in the 1916 annual budget.[353] The Acute Building, known as Centre Lawn, opened on November 1, 1924.[354] With the opening of

[348] J D Maclean, 'Annual Report of the Mental Health Hospitals of the Province of British Columbia for the Year 1916', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia. Legislative Assembly, 1917), UBC Open Archive, http://dx.doi.org/10.14288/1.0059882.
[349] Annual Report of BC Mental Hospitals, 1917
[350] Moran, *Committed to the State Asylum*; Shorter, *A History of Psychiatry*.
[351] McKay was taking over for Medical Superintendent Dr. C.M. Doherty who had left to fight in World War I.
[352] Maclean, 'Mental Hospitals Report 1915-16'.
[353] Maclean; J D Maclean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the Year 1917', 1918; Maclean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the Year 1918'.
[354] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC, 1925), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0225894.

this building for the treatment of acute psychopathic cases came the hiring of the first RN, Florence Van Wyck as the first female superintendent (see Figure 4.2).[355]

Figure 4.2 – Photo of Superintendents, including Florence Wyck, RN, 1924.[356]

In the 1920s RNs were utilized in Western Canada mental hospitals to deliver care for patient's physical health needs, and to assume leadership positions such as head nurse which did not change until critical RN shortages post-World War II (WWII) occurred.[357] The same nurse leader structure was used at Essondale.

Colony Farm, used to produce food for both Essondale and New Westminster mental hospitals, was an integral part of patient treatment through occupation and for financial

[355] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925'.
[356] *Staff Photo with Dr. Arthur L. Crease and Florence Van Wyck*, 1924, Photograph, 1924, City of Coquitlam Archive, https://searcharchives.coquitlam.ca/index.php/staff-photo-with-dr-arthur-l-crease-and-florence-van-wyck. Van Wyck was the Mental Health Hospital's first woman Superintendent
[357] Dooley, 'Mental Nurses at Brandon Hospital'.

benefit.[358] The value of Colony Farm was evident in its description by Medical Superintendent Doherty as a, "very necessary part of the institution, not only from a standpoint of supplying proper milk and vegetables, but it places us in a position whereby we can find outdoor occupation for the patients, which in mental cases is an essential part of the treatment". He further suggested, "the whole vote for maintenance of the farm be incorporated with that of the Mental Hospital, but segregate the accounts on our books".[359] Other mental hospitals across Canada established working farms for the same purpose.[360]

Through the 1920s the goal for constructing a mental hospital aligned with the medical focus of the general hospital was maintained. The efforts of medical superintendents to provide equivalent services to the general hospital was again demonstrated with the 1929 opening of a Male Infirmary Ward for the sick and infirm in the Acute Hospital Wing. Under the leadership of RN Matron B. Willingress, a graduate nurse oversaw experienced female RNs and male orderlies who provided care for physical illness to infirm mental patients.[361] The structure of this ward was aligned with the general hospitals, but staff would care for both the patient's physical and mental conditions.[362]

There is brief mention of nurses in the annual mental hospital reports published between 1913 and 1928, indicating their insignificance to the medical superintendents who wrote the

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[358] J.D. MacLean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the 15 Months Ending March 31st, 1920', Sessional Papers of the Province of British Columbia (British Columbia. Legislative Assembly, 1920), UBC Open Archive.
[359] Maclean, 'Mental Hospitals Report 1915-16', I 10. In 1916 the segregation of accounts allowed for clear determination of the revenue accrued by the unpaid patient labour.
[360] Moran, *Committed to the State Asylum*; Dooley, 'Mental Nurses at Brandon Hospital'.
[361] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1929', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1930), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0300617. The Annual Report for 1929 was the only report that used the term "orderlies" and referred exclusively to male workers. This term is equated with the male staff in the general hospitals that provided patient care.
[362] 'Mental Hospitals Report, 1928-29'.

reports. However, nurses were integral to the functioning of the hospital and delivery of patient care as indicated by the opening of the BC School of Psychiatric Nursing in 1930, to support the specialized training for mental hospital nurses. The school provided education to a variety of nurses and nursing support staff, including RNs who participated in an affiliate program that opened in the general hospital schools of nursing. An in-depth history of the nursing school is provided in Chapter 5.

Gender played a significant role in who held the power in the BC mental hospital which shifted from general superintendents in the early days of the mental asylums to medical superintendents as the hospital structure crystallized. Male physician control within the mental hospitals was common across Canada as found by Tipliski, and they had a significant impact on the creation of a separate training school for RPNs in Western Canada.[363] Consistent messaging by the Medical Superintendent of BC Mental Hospitals to the Provincial Secretary is noted in which emphasis was placed on the medical need for the mental hospital, and the development of medical procedures and testing on par with the general hospitals to substantiate the need for expansion under the control of men physicians. This narrative solidified the positioning of psychiatry in the 1910s and 1920s as a necessary medical profession to address the problem of mental illness. The returning soldiers from World War I and II helped to build a rationale for additional government funding to expand mental hospitals.

Returned soldiers post World War I

The First World War (1914-1918) enlisted over 600 000 Canadian soldiers, with 59 544 fatal casualties and 172 950 non-fatal casualties.[364] A need for a separate building for the

[363] Tipliski, 'Parting at the Crossroads PhD'.
[364] Kandace Bogaert, '"Due to His Abnormal Mental State": Exploring Accounts of Suicide among First World War Veterans Treated at the Ontario Military Hospital at Cobourg, 1919-1946', *Histoire Sociale / Social History* 51, no. 103 (2018): 99–123, https://doi.org/10.1353/his.2018.0004.

returning soldiers of war was an identified requirement after the end of WWI in 1918. The unit for the long-term care of soldiers was not built until the 1934-35 fiscal year and remained open until 1950.[365] The building was comprised of a separate three stories used for living quarters with a lower floor for recreation kept separate from a dining-room.[366] The World War II years (1939-1945) resulted in chronic understaffing of adequately trained nurses which will be discussed in Chapter 5.

Medical superintendents identified a need for specialized care of acute patients, returning soldiers, and children. Plans were made to classify and segregate different patient populations at Essondale Hospital based on age, gender, and acuity of illness. The first segregated group occurred when the Home for the Feeble-minded was opened in a small building at Essondale in September 1919.[367] The Subnormal Boys' School was then planned in 1920 in a separate building away from the main Essondale Hospital to prevent contact between mental patients and the subnormal.[368] The effort proved inadequate; in 1921 the home was full with 34 patients, and thus unable to receive more.[369] The growing mental hygiene movement and efforts in prevention led to creation of services aimed at segregating and removing the feeble minded (through deportation), early treatment and prevention (including sterilization).[370]

Care of the feebleminded

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[365] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1935', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, B.C.: British Columbia Legislative Assembly, 1936), http://resolve.library.ubc.ca/cgi-bin/catsearch?bid=1198198, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0306435. The building was known as the Veteran's Wing.

[366] 'Mental Hospitals Report 1934-35'.

[367] MacLean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the 15 Months Ending March 31st, 1920'.

[368] MacLean. The home was constructed in the former carpenter's shop.

[369] 'Mental Hospitals Superintendent's Report'.

[370] Angus Mclaren, 'The Creation of a Haven for "Human Thoroughbreds": The Sterilization of the Feeble-Minded and the Mentally Ill in British Columbia', *Canadian Historical Review* 67, no. 2 (1 June 1986): 127–50, https://doi.org/10.3138/CHR-067-02-01. To read more about sterilization the feeble-minded and mentally ill in BC see the work of Angus Mclaren.

In 1925, the BC Royal Commission on Mental Hygiene report was published.[371] A provincial government requested inspection was conducted to evaluate the provincially run mental hospitals and their branches. A survey was conducted of all patients admitted during the previous decade. Evidence was given and recommendations were made by the medical profession, public officials, representatives of various welfare organizations, and other interested persons.

The 6 recommendations were:

1. Creation of a Provincial Board of Control.[372]
2. Establishing a "psychopathic hospital" to be operated by the province as a unit of the mental institution system.[373]
3. Removal of mental deficient, described as "idiots and imbeciles" to other appropriate quarters.
4. Sterilization recommendations for those following treatment and their return to community life to prevent procreation.
5. Devising a mechanism of repatriation when patients were from different provinces.
6. Exclusion of immigrants deemed "mentally unfit and those liable to insanity".[374]

In the report the Royal Commission stated that, "Growth of public enlightenment on the subject in nearly all civilized communities has forced radical changes in the attitude and sense of

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[371] E.J. Rothwell et al., 'Report on the Royal Commission on Mental Hygiene (Appointed under the Public Inquires Act by Order in Council Dated December 30th, 1925)', British Columbia. Legislative Assembly (Victoria: Victoria, BC : Government Printer, 28 February 1927), https://doi.org/10.14288/1.0228017. Public hearings were held in both Victoria and Vancouver.

[372] No remuneration was given to members who were already members of public service. They were given the authority to act in coordinating and supervising the work of Provincial Mental Institutions.

[373] The psychopathic hospital was to be equipped to provide outpatient service and travelling clinics across the province, and operated in close connection with a leading general hospital.

[374] Rothwell et al., 'Report on the Royal Commission on Mental Hygiene (Appointed under the Public Inquires Act by Order in Council Dated December 30th, 1925)'.

responsibility of society and the State towards the mentally afflicted. The result has been something in a revolution in methods of care and treatment in recent years," and that "preventative measures," were beginning to be thought about. [375] This substantiated the need for ongoing financial government support of these services.

Momentum in BC had increased for a centralized modern mental hospital system on the Essondale grounds. The out-of-date design of the buildings at New Westminster were seen as a hindrance, obsolete and unsuited to the type of care models being practiced in the 1920s.[376] The pivotal Royal Commission on Mental Hygiene Report identified the need to separate psychiatry, a scientifically-based branch of medicine, from the incurable mental deficiency which required training schools.[377] To streamline the organization and reduce duplication of services Medical Superintendent Dr. H.C. Steeves proposed centralizing care at one site. He re-iterated previous concerns of medical superintendents that the building constructed for the care of feeble-minded children was already overcrowded leading to children being admitted to the general wards of the mental hospital. He proposed that the outdated buildings at the New Westminster mental hospital become a separate institution solely for the feeble-minded.[378] In both Alberta and BC the 1920s saw government efforts to both segregate and sterilize those deemed mental-defectives or feeble-minded under the recommendations of the Royal Commission on Mental Hygiene.[379] In BC the

[375] Rothwell et al., 7. Identification of a key person in this report, Helen Davidson. Davidson was a resident of New Westminster, formerly a teacher in special classes for subnormal children, and obtained education from the Department of Psychology at Stanford University. It appears that this report was written by Miss Davidson. Her fee was $1001.90 and the total cost of the report was identified as $4663.74.
[376] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1922', Sessional Papers of the Province of British Columbia (Victoria, BC, 1923), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0226029.
[377] Rothwell et al., 'Report on the Royal Commission on Mental Hygiene (Appointed under the Public Inquires Act by Order in Council Dated December 30th, 1925)'.
[378] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1922'.
[379] Jana Grekul, Arvey Krahn, and Dave Odynak, 'Sterilizing the "Feeble-Minded": Eugenics in Alberta, Canada, 1929–1972', *Journal of Historical Sociology* 17, no. 4 (2004): 358–84, https://doi.org/10.1111/j.1467-

Sexual Sterilization Act came into effect on July 1, 1933 but was not put into operation until 1935 when the members of the Board of Eugenics was appointed. This will be discussed more in Chapter 6.

Nurses and mental hygiene

In accordance with the mental hygiene movement came a need to provide early identification and treatment for children in the community to prevent them from requiring mental hospital care. Registered Nurses in Canada were becoming aware of the mental hygiene movement that began in 1908 in Connecticut with the push of Beers and uptake of his book "A Mind that Found Itself". The field of mental hygiene appeared in the April 1914 issue of *The Canadian Nurse*.[380] For RNs mental hygiene required additional training to ensure its success.

The value and recommendations of the Canadian National Committee for Mental Hygiene (CNCMH) influenced the decision-making and planning of the provincial mental hospitals in BC.[381] With the committee's recommendation the province began to develop Child-Guidance clinics to study the personality of the problem child, a key strategy to decrease the development of psychosis and hopefully decrease the 8000 to 9000 patients who were admitted to mental hospitals across Canada each year. This growth took place within the context of the

6443.2004.00237.x; Mclaren, 'The Creation of a Haven for "Human Thoroughbreds"'; Gail van Heeswijk, '"An Act Respecting Sexual Sterilization" : Reasons for Enacting and Repealing the Act' (Master's Thesis, Vancouver, BC, University of British Columbia, 1994), UBC Open Archive, https://doi.org/10.14288/1.0087539.

[380] V.M. MacDonald, 'The Field of Mental Hygiene', *The Canadian Nurse* 10, no. 4 (April 1914): 210–12, https://www.cna-aiic.ca/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=acaaff11-0614-6c47-c303-d27d937b10fa&forceDialog=0. In the nationally distributed Canadian Nurse journal mental health was becoming more prominent however, the challenge remained of how to properly and adequately train the number of RNs required to work in the mental hospital especially with the increasing specialized knowledge.

[381] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1933', Legislative Proceedings, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1934), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0308238.

Great Depression, a time in which everyone in BC suffered economically, and wages of almost all hospital staff were cut.

The Government of Canada, through the Department of National Health and Welfare, developed the Mental Health Grant.[382] The purpose of the grant was to improve mental health services in each province. At the expense of a provincially funded committee a social-service worker trained in psychiatry was sent to BC for one year. The role of the social-service worker included contacting the patient's relatives, aiding patient discharge, and helping to establish the child-guidance clinic.[383] In 1932, the CNCMH funded a one-year salary for a social-service worker, Josephine Kilburn, to Essondale marking a philosophical shift in care and prevention of the mentally ill in the province.[384] Kilburn, an RN, and social worker, was an instrumental figure in the connection between the mental hygiene movement and public health nursing.[385]

Women at Essondale – patients and staff

A modern facility for treatment of female patients was needed. By 1925 the capacity of the New Westminster mental hospital swelled. An urgent need arose for a permanent Chronic

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[382] Stogdill, 'Progress of Mental Hygiene Programs in Public Health in Canada'.

[383] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1932.', Legislative Proceedings, Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1933), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0305087. The 1933 Annual Report also included the first Social Service Report which included information about the new Child-Guidance Clinic which opened on July 15, 1932, in Vancouver. The Social Services Department assumed the responsibility of obtaining patient history and mental conditions, allowing for attaining information about precipitating cause of mental issues to address such issues prior to the patient returning home. The Social Service Department also began the process of follow up treatment. The opening of the Child Guidance Clinics and Social Services Department were intended to prevent patients from needing mental hospital care, aligning with a goal to alleviate the hospital overcrowding.

[384]'Mental Hospitals Report 1932-33'; Richard James Clark, 'Care of the Mentally Ill in British Columbia' (Master's Thesis, Vancouver, B.C., University of British Columbia, 1947), UBC Open Archive, https://doi.org/10.14288/1.0107005. Kilburn's work led to the 1932, opening of the provincially run, Essondale staffed Child Guidance Clinic located in downtown Vancouver. Kilburn and the Social Service Department became a permanent part of Essondale in 1934.

[385] Melissa Suzuki, 'The Kilburn Connection: Public Health Nursing Education and the Child Guidance Clinics in British Columbia 1932-1950' (Master's Thesis, British Columbia, Trinity Western University, 2013). Suzuki's masters work discussed the invisibility of nurses in the functioning of the Child Guidance clinics. Kilburn herself contributed to the invisibility of nurses in this, using the RN title only once in a 1934 annual mental hospital report.

Building for female patients at Essondale, although construction was not completed until 1930.[386] The Essondale Hospital expenditure was increasing, in part because of the development of the BC School of Psychiatric Nursing for RPNs, and construction of additional patient care buildings on the Essondale Hospital grounds. The patient population at New Westminster Mental Hospital changed significantly to focus on child patients when the Essondale Female Chronic building opened in 1930.[387] To support nursing staff in the transfer of women patients to Essondale infrastructure changes were required including a new Nurses' Home which was constructed and opened in November 1929.[388] This enabled nurses who previously lived in the same building where patients were housed in, to live in a separate building from the patients. The opening of the Female Chronic Building enabled the expansion of occupational therapy, resulting in cost savings because patients manufactured nurses' uniforms, patient clothing, and repaired clothing for all hospital staff and patients.[389]

Aging population – the homes for the aged

Between 1932 to 1949, the population of Canadians over the age of 70 (considered older adult patients) was increasing; the greatest increase was in BC.[390] The number of mental hospital

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[386] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925'. Women patients continued to be housed at the New Westminster site despite the building being out of date and in disrepair.

[387] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1930', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1931), J110.L5 S7; 1931_V02_17_BB1_BB67, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0300518.

[388] 'Mental Hospitals Report, 1929-30'.

[389] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1931', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1932), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0300626; Isabelle Gordon, 'The Development of Occupational Therapy in British Columbia', *Canadian Journal of Occupational Therapy* 2, no. 3 (1 March 1935): 80–82, https://doi.org/10.1177/000841743500200305. In 1931 the first Occupational Therapist (OT), a graduate from the University of Toronto, joined the staff at Essondale.

[390] J. W. Fisher and C. A. Roberts, 'The Mental-Hospital Aspect of an Ageing Population: First Admissions of the Aged to Canadian Mental Institutions, 1932-1949', *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique* 44, no. 6 (1953): 200–203, http://www.jstor.org/stable/41980440. In Ontario the average increased from 156 200 to 215 700 (38%). In BC the increase was from 26 400 to 54 600, an increase of more than 100%.

admissions of those aged 70 and older increased across Canada, with a particularly marked increase in BC between the years 1934 to 1940.[391] Additional beds were needed at Essondale to accommodate the aging population. It was proposed to remove 400 older adult patients and relocate them into a different service.[392] In 1935, the Provincial Home for the Aged Act was enacted after which the Homes for the Aged were constructed from cottages made available on Essondale grounds. The Boys' Industrial School became the first Home for the Aged, occupied on May 14, 1936.[393]. The segregation allowed for older adult patients to be transferred away from the general mental hospital population benefiting patients and their families because it increased safety by separating them from potentially violent and unpredictable patients.[394] Despite these efforts, overcrowding continued into the 1940s, with the hope that the new unit planned for the elderly which would accommodate 100 would help alleviate this. Ongoing construction to accommodate an aging population included a new building for the aged at Essondale. The new 100-bed unit was specially constructed and occupied on June 27, 1946.[395]

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[391] Fisher and Roberts.

[392] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1941', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1942), J110.L5 S7; 1941_1942_V02_03_N1_N80, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0314263.

[393] 'Chapter 230. An Act to Provide for the Establishment and Maintenance of a Provinicial Home for Aged Persons.', 1935, c. 66, s. 1. § (1935), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/649415303/search/CIVIX_DOCUMENT_ROOT_STEM:(home%20for%20the%20aged)?4#hit1.

[394] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1938', Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1938), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0307542.

[395] 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31ST 1948' (Victoria, BC : Government Printer, 1949), http://open.library.ubc.ca/collections/bcsessional/items/1.0340584. A second unit for 100 patients was occupied on June 11, 1947. Further care for elderly patients over the age of 70 was planned when the Mental Hospital Department took over the military hospital in Vernon, BC. On July 7, 1948, the Home for the Aged unit at Vernon. The unit accommodated 160 patients. An additional 40 patients were transferred in March, 1949, to increase the total to 200. Two additional buildings were planned for the aged on the Essondale site in response to the lifespan increasing from 48 to 64 years (and increasing).

While the feebleminded were segregated and sterilized, those who were identified as immigrants were deported.

Deportation of immigrants

Immigrants were a population of patients that could be segregated at Essondale and then removed via legal deportation. From Confederation (1867) until 1939 more than 5000 people were deported to European countries, the USA and China, classified as 'insane' or 'feebleminded' under the provision of the Federal Immigration Act.[396] In BC, 750 mental hospital patients were officially removed or informally repatriated to their countries of origin through the 1920s and 1930s.[397] The eugenics movement, prevalent in both BC and Alberta, contributed further to this, by increasing public fears about unregulated immigration and understanding of mental illness. Psychiatric officials used deportation as a convenient and effective mechanism for ridding hospitals of their least wanted inmates.[398]

On February 9, 1935, the province effected a mass deportation of 65 Chinese male patients who were collected from the province's three mental hospitals and repatriated to the

[396] Robert Menzies, 'Governing Mentalities: The Deportation of Insane and Feebleminded Immigrants out of British Columbia from Confederation to World War II', *Canadian Journal of Law and Society* 13, no. 2 (1998): 135–76, https://heinonline.org/HOL/P?h=hein.journals/cjls13&i=373. The 1887 Immigration Act amendment gave the Canadian government authority to repatriate ineligible immigrants to their place of origin, although before 1900, there was no formal procedure for removing foreigners to the country of origin. Medical doctors became integral to the implementation of the Act when a 1902, revision in the Act gave them the power to establish medical procedures to screen those seeking entry to Canada. In 1910, the federal government's power in the Act increased to exclude and regulate the flow of immigrants into the country. These changes profoundly impacted BC due to the large immigrant population, particularly Chinese immigrants who were disproportionately deemed insane and feebleminded. This new criterion disallowed their entry. Menzies wrote about the Canadian strategy employed in the late 19th and 20th century to banish the mentally disordered. Medical superintendents who were motivated by hospital overcrowding, wanting to expand their influence and enforce control over the quality of patients admitted to their institutions became allies with provincial bureaucrats, federal immigration authorities, and a variety of nativist and restrictionist groups to assemble a powerful and efficient system to deport Canadian migrants who did not meet the standards for Canadian citizenship.

[397] Menzies.

[398] In 1932 it was noted that the deportations of those who were not born in Canada resulted in considerable savings of provincial government money. The Immigration Department was named as doing a "wonderful" job in identifying those mental patients eligible for deportation. Menzies.

Honam Mental Asylum in Canton.[399] This was the final collective deportation of immigrants from BC mental hospitals because identification and deportation of those attempting to enter the country prevented them from reaching the point of mental hospitalization.[400] Provincial Secretary G.M. Weir, his Deputy, P.D. Walker, and Provincial Psychiatrist A.L. Crease couched their efforts to deport non-Canada born mental hospital patients in the discourse of institutional economy and fiscal restraint.[401] The conversation changed from a problem of the insane immigrants polluting the population's genetic pool to them occupying beds needed for Canadian citizens.[402] The annual reports of the mental hospitals stopped publishing statistics on deportations in 1938.[403] The issue of unwanted immigrants in the mental hospital seemed to subside by 1940 when it was noted that 50 per cent of admissions to the BC mental hospitals were Canadians compared to 33 percent in previous years.[404]

Expansion (1942-1950)

As the 1940s progressed the patient population was rapidly increasing at an untenable rate with few new buildings constructed to accommodate them. Diagnostic categorization became prominent in the 1940s. For example, the term "schizophrenia" was used for the first time in the 1941 Annual Report perhaps indicating acceptance of the classification system popularized by Kraepelin, which connected a diagnosis to a specific treatment, namely insulin

[399] The total increase in annual admissions at Essondale in 1935 was 120 exclusive of the reported 65 Chinese patients. 'Mental Hospitals Report 1934-35'.
[400] 'Mental Hospitals Report 1934-35'.
[401] Similar plans for mass deportation of patients were proposed for Japanese, 'Hindoo' [sic], Italian, and Jewish patients but this never came to fruition because the eugenics movement fell out of favour with the rise of Nazism in World War II. Menzies, 'Governing Mentalities'.
[402] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1940', Sessional Papers of the Province of British Columbia (Victoria, BC, 1940), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0314089.
[403] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1938'.
[404] 'Mental Hospitals Report, 1940-41'.

shock treatment.[405] The opening of the Acute Main Building and the Psychopathic Ward for both male and female patients opened more than a decade earlier in 1928, positioned as optimizing treatment of patients with use of modern equipment and the latest treatment methods, but these methods remained limited due to overcrowding and little scientific evidence leading to cures.[406] Similar trends were happening in mental hospitals across Canada until more medical treatments were introduced in the 1940s.[407] The impact of these treatments are explored in Chapter 6.

Services were needed for early treatment, before requiring hospital-level care as prevention. Requests were increasingly made for care of young children and geriatric patients beyond what could be offered.[408] By 1942, overcrowding was becoming dangerous to patients and staff and costly. Three strategies identified to address overcrowding were:

1. build more accommodation
2. remove those patients whose condition permits their accommodation elsewhere
3. increase discharges.[409]

In 1947, Medical Superintendent Dr. A.L. Crease (General Superintendent and Provincial Psychiatrist from 1926 to 1950) introduced the idea of constructing a new institution for mental

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[405] 'Mental Hospitals Report, 1940-41', N 10. Influential psychiatrist Emile Kraepelin's notion that mental suffering was the result of biological or organic causes led physicians (namely the emerging psychiatrist) to modify the terminology used to describe mental patients. Insulin shock therapy and Metrazol shock were two treatments that increased the level of skill required in the mental hospital nurses. A noticeable shift happened in the annual mental hospital reports in the late 1930s, with focus on reporting medical treatments (e.g. insulin shock therapy and Metrazol).

[406] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1928', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1929), J110.L5 S7; 1929_V02_12_X1_X77, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0368903.

[407] Federico Allodi and Henry B Kedward, 'The Evolution of the Mental Hospital in Canada', *Canadian Journal of Public Health* 68 (1977): 219–24.

[408] 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31ST 1947' (British Columbia. Legislative Assembly, 1948), http://open.library.ubc.ca/collections/bcsessional/items/1.0340001.

[409] 'Mental Hospitals Report, 1940-41'.

illness because Essondale was growing beyond what had originally been planned for.[410] The building would become The Crease Clinic. Patients who were living in the Veterans unit at Essondale were transferred to the new 220-bed Riverside building opened at Colony Farm on August 31, 1949.[411] The Veterans Block was then expanded and reopened as the Crease Clinic of Psychological Medicine on November 16, 1949.[412] The decades following the World Wars saw expansion and growth of mental health services coupled with unsustainable increases in inpatient populations.

Changing legislation

Amendments were made to the Mental Hospitals Act in 1940, increasing patient's rights, giving them the ability to have their committal reviewed by a review panel consisting of two physicians who were not the two who originally committed the patient. This change was influenced by complaints about patients being forced into the institution and held longer than they should, thus the amendment entitled the patient to ask for re-examination by two qualified physicians after at least three months of hospitalization.[413] Increased scrutiny was placed on language used within the act. In 1941, the Mental Hospitals Act was redrafted with the words "lunatic" and "hospital for the insane" deleted and substituted with different words representative of changing understanding of mental illness.[414] The definition of "patient" changed removing the descriptor "insane," and the verbiage "a mentally ill person who is suffering from such a disorder

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[410] 'Mental Hospitals Report, 1946-47.'
[411] 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31st 1950', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1951), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0342770.
[412] 'Mental Hospitals Report, 1949-50'.
[413] The amendment also gave the Medical Superintendent the power to request further examination of a patient. 'Chapter 207. An Act Relating to Mental Hospitals.', 1940, c. 27, s. 1. § (1940), 207, https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/549053833/search/CIVIX_DOCUMENT_ROOT_STEM:(review%20panel%20and%201940)?3#hit1.
[414] 'Mental Hospitals Report, 1940-41'.

of the mind as to require care, supervision, and control for his own protection or welfare or for the protection of others".[415] British Columbia mental health law were changed in similar ways as global changes in Western industrialized countries which gave more power to psychiatrists who treated a broader range of patients using new scientifically researched treatments.[416]

Voluntary hospitalization became possible in the late 1940s, when the Clinics of Psychological Medicine Act, was passed in 1948.[417] This act permitted admission upon the voluntary application of the patient, or by the medical certification of two physicians upon the application of a relative or other interested responsible person. The Act restricted admission to the Crease Clinic (the admitting centre) to four months. Dr. A.L. Crease described the new Act as "bringing mental illness directly into the field of medicine".[418] The new Crease Clinic required three essentials as part of the plan: 1) intensive treatment and rehabilitation, 2) education, 3) research.[419] This transition to a treatment driven, medically focused mental hospital system required adequately trained staff. To support intensive treatment and rehabilitation the same provisions were required as those in a general hospital plus the specialty of psychiatry and neurology.

Legislation aligned with changes that were happening to specialization and removal of services within the mental health hospital to provide better care, but also to decrease the number

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[415] Chapter 207. An Act relating to Mental Hospitals., 2839.
Gene Fraser, 'Governing Madness: Coercion, Resistance and Agency in British Columbia's Mental Health Law Regime' (Doctoral Dissertation, Victoria, University of Victoria, 2015). [416] Gene Fraser wrote a comprehensive analysis of the history of mental health legislation in BC in his doctoral dissertation.
[417] 'Chapter 6. An Act Relating to Clinics of Psychological Medicine.' (1948), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/2136654007/search/CIVIX_DOCUMENT_ROOT_STEM:(psychological%20medicine%20act)?6#hit1.
[418] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1949', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, British Columbia: Legislative Assembly of British Columbia, 1950), HH 12, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0340943.
[419] 'Mental Hospitals Report 1948-49'.

of admissions. Changed legislation required financial support from the provincial government to fund different hospital professionals and clinicians, to train staff, open new programs, and create education resources such as a librarian and a library for patients and staff.[420] The new legislation likely shaped public and professional understanding of mental health patients because it further defined who qualified as a mental health patient in terms of qualification of mental illness, and treatment needs.[421] The next decade brought significant change in conceptualizing of mental illness, mental patients and best practice in treatment delivery.

Rethinking the mental hospital

In the 1950s the ongoing overcrowding and treatment focus to improve mental patients' quality of life led to a reconceptualizing of the idea that mental hospitals were a place for long-term refuge and care. Changing social understanding of mental illness, developments in universal health care, and economic constraints fueled plans to scale down the large mental institutions across the country. The care of older adults in and as part of the mental hospital were also quickly becoming a problem to address because this population required more financial and health care resource allocation due to increased life expectancy following World War II.[422] In BC this meant that beginning in the 1950s plans were made to reorganize, regionalize and

[420] 'Mental Hospitals Report 1948-49'. The New England Journal of Medicine (1949) said of a library that there were two important factors to distinguish man from animals, the ability to reason, and speech. The library was located on the ground floor to provide easy access to patients and staff. The Clinical Director and Director of Education arranged for an educational program for psychiatrists, psychiatric nurses, psychologists, social service workers, and other staff. UBC was becoming involved, related to contemplation of a medical school and related to contributing to the field of psychological medicine.
[421] A. G. Armstrong, 'Mental Health Legislation in British Columbia', *The University of Toronto Law Journal* 15, no. 1 (1963): 221–24, https://doi.org/10.2307/824920; Chapter 207. An Act relating to Mental Hospitals.
[422] Megan Jean Davies, *Into the House of Old: A History of Residential Care in British Columbia* (McGill-Queen's Press - MQUP, 2003).

eventual close the provincially centralized mental institution. Similar downsizing happened in the provincial mental institutions in Alberta, Saskatchewan, and Manitoba.[423]

Specialized Programs in the Mental Hospital

In the late 1940s, Dr. A.L. Crease identified that psychiatry had become a "real medical specialty" in part as a response to the public criticism about the mental hospitals in previous years.[424] He commended the provincial government for valuing education and raising the standard for staff, increasing funding, building recreation, occupation, and treatment of patients, and funding prevention, encouraging research, stating that these were "basic needs on which better mental hygiene is actually founded".[425] Crease sought more funding and expansion of services, treatment and education and training of staff, appealing to the Provincial Government in 1949 to take into consideration three essential components for creating a new clinic, intensive treatment and rehabilitation, education, and research.[426] He wanted to support the Canadian and American Mental Hygiene Commission standards of education and support the use of the classification system popularized by Kraepelin which had become a tool for psychiatrists.[427] Patients treatments will be explored in greater depth in Chapter 6 but the impact of TB cases is provided here to give context to the impacts it's treatment had on organization of the mental hospital services.

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[423] Martin, *Hometown Asylum, A History and Memoir of Institutional Care*; Dyck and Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada*; Rachel Carr, 'The Closure of Brandon Mental Health Centre: A Case Study and Ten-Year Follow-Up of Individuals Discharged from 1990-1998' (Master's Thesis, Winnipeg, Manitoba, University of Winnipeg, 2012).
[424] Crease identified the lack of resources allocated to prevention and research. 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31st 1946', Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia. Legislative Assembly, 1947), HH 10, http://resolve.library.ubc.ca/cgi-bin/catsearch?bid=1198198, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0339795.
[425] 'Mental Hospitals Report, 1945-46', HH 10.
[426] 'Mental Hospitals Report 1948-49'.
[427] 'Mental Hospitals Report, 1940-41', N 10.

Tuberculosis

Tuberculosis (TB) was a major concern across Canada, most prominently in mental hospitals in which it accounted for the largest cause of death in the 1930s.[428] A proper space was made for segregating tuberculosis patients. Patients with TB continued to be treated on separate units, but hospital overcrowding limited the ability to properly isolate them. Tuberculosis patients were treated on separate wards with diagnostic testing done, mainly x-ray, to identify the illness.[429] The practice at Essondale followed the medical recommendations of the 1940s to contain the spread of TB.[430] Separate facilities to address the care needs of the ongoing tuberculosis cases were not planned until the next decade with construction of the 230-bed North Lawn Building not completed until 1955.[431]

Leadership changes

After World War II health care delivery was becoming centralized in hospitals across Canada. The number of beds in general hospital increased by 35 percent, and admission increased by 110 percent, doubling by 1970.[432] In BC, the Vancouver General Hospital (VGH) drastically decreased the length of hospital stay beginning in 1940, with some post-surgical

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[428] G. J. Wherrett, 'The Tuberculosis Problem in Canada', *Canadian Medical Association Journal* 44, no. 3 (March 1941): 295–99, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1826737/.

[429] 'Mental Hospitals Report, 1945-46'. The x-ray department was increasing in volume. A new x-ray machine was received in 1944 but not yet installed. By 1946 x-rays were being done on every patient at admission and annually as a means of early identification of TB under the supervision of Dr. Gee.

[430] John K. Deegan, J. E. Culp, and F. Beck, 'Epidemiology of Tuberculosis in a Mental Hospital', *American Journal of Public Health and the Nations Health* 32, no. 4 (April 1942): 345–51, https://doi.org/10.2105/AJPH.32.4.345; Wherrett, 'The Tuberculosis Problem in Canada'; Bertram T. Mann, 'Tuberculosis in Mental Hospitals', *British Medical Journal* 1, no. 4770 (7 June 1952): 1228–29, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2023607/.

[431] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1953', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1954), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0348641.

[432] David Gagan and Rosemary R. Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950*, McGill-Queen's/Associated Medical Services (Hannah Institute) Studies in the History of Medicine, Health, and Society; 13 (Montreal ; Ithaca: McGill-Queen's Press - MQUP, 2002).

patients having next-day discharges instead of the previous three to five day stay.[433] Such changes magnified the resources used by the mental hospitals because of the lengthy hospital stays that took care of all patients' needs. The first major reorganization of Mental Health Services (MHS) took place following a leadership change on March 31, 1950, when Dr. A.L. Crease retired from the position of Director of Mental Hygiene and Psychiatry. [434] This ended his 35-year career with the BC mental hospital. [435] As of April 1, 1950, the various Provincial Mental Health activities were amalgamated into the Provincial Mental Health Services (PMHS). The internal organization was strengthened by the formation of a Hospital Council comprised of senior administrative heads of the various divisions with secondary membership comprised of the various departmental heads invited to participate in meetings involving their different departments.[436] The role of nurses in the hospital (RN and RPN) rose in prominence following WWII like that of the general hospitals.

A need for nurses

During the World War II period, Essondale would become BC's largest mental hospital solidifying its position as a major mental health institution in Western Canada. Psychiatry gained prominence with the development and expansion of mental hospitals, facilitating its development

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[433] Gagan and Gagan.

[434] WMT Straith and Department of Provincial Secretary, 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1951', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1952), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0343147. Crease obtained his medical training at McGill University, graduating in 1910. He completed four years of postgraduate study in medicine and pathology in hospitals in the US state of Rhode Island. He joined the staff as a pathologist and physician at the Provincial Mental Hospital located in New Westminster, BC in 1914. He was appointed to Medical Superintendent after the death of Dr. Steeves in 1926.

[435] 'Mental Hospitals Report, 1949-50'. Crease was promoted to General Superintendent and Provincial Psychiatrist in 1934. Under his leadership the role was redesignated in 1946, to Director of Mental Hygiene and Psychiatry.

[436] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'. Administrative management was expanded by appointing a Medical Superintendent and Deputy Superintendent to The Woodlands School, a Medical Superintendent to the Colquitz branch of the Mental Hospitals (the branch that provided care for the criminally insane), and a Medical Superintendent in charge of the three branches of the Homes for the Aged.

as a hospital-based medical specialty. The restricted budgets of the World Wars and the Great Depression prevented making significant expansion at Essondale beyond the existing buildings. Adaptations and reorganization occurred in response to limited budgets and an exponentially increasing patient population. Nursing shortages were an issue across Canada in general hospitals before, during, and after WWII in part because many nurses joined the armed forces resulting in lowered qualification standards, and supporting physicians and administrators to maintain the status quo.[437] Mental hospitals faced the same challenges. In Saskatchewan and Manitoba, the WWII years became contentious as medical superintendents advocated for separate RPN training programs that catered to their needs and ideas about mental patient care.[438] The growing mental hospital system facilitated the rise of psychiatric attendant staff and RNs who became more prominent in their patient care role.

The key factors that influenced the development of the RPN role and the need for formal education in the post WWII years included changes in the development of psychiatry as a medical specialty, changes in understanding of mental illness, and changes in provincial legislation. These changes supported the proliferation of RPNs as integral to the functioning of Essondale. The establishment of a formal education program for RPNs (in 1930, for women and 1940 for men) played a significant role in their development as distinct from RNs, achieving their own legal title in 1951.[439] Similar shortages of nursing students and graduates were happening at the Brandon, Manitoba mental and general hospitals post World War II which lead to ward closures.[440] Strategies to address the ongoing nursing shortages and the standardization

[437] Merlyn Ledgister, 'The Nursing Shortage Crisis: A Familiar Problem Dressed in New Clothes: Part I', *Leadership in Health Services* 16, no. 1 (1 January 2003): 11–18, https://doi.org/10.1108/13660750310458407.
[438] Tipliski, 'Parting at the Crossroads PhD'.
[439] Tipliski.
[440] Tipliski.

of the RPN role is explored in greater detail in Chapter 5. By the 1950s, the changing understanding of mental illness, development of evidence-based treatments, and economic constraints changed the need for the centralized institutional care delivered as Essondale Hospital.

Reorganization and Deinstitutionalization (1951-1992)

Beginning in the 1950s, major structural changes were made to the organization of mental health services in BC. Essondale reached its peak patient population in 1951, with 4630 admitted patients; to reduce admission, policies were developed to increase early active treatment to prevent long-term mental hospitals stays, and to address the already overcrowded hospital.[441] This marked the beginning of the decline of the institutional model of mental health care delivery in the large-scale provincial mental hospital. The institutional era ended with the identification of human rights, and financial constraints leading to deinstitutionalization.[442] Deinstitutionalization from 1951 to 1992, saw major changes in the structure of hospital, leadership change, the creation of specialized programs, and the closure of the BC School of Psychiatric Nursing. Changes related to the school will be presented in the next chapter. Significant changes and ambiguity about the future of Essondale continued until the decision was made in the 1990s to close the hospital completely.[443] This section is divided into three parts,

[441] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'.
[442] Charlene Ronquillo, 'Deinstitutionalization of Mental Health Care in British Columbia: A Critical Examination of the Role of Riverview Hospital from 1950 to 2000', in *The Proceedings of the 18th Annual History of Medicine Days*, 2009, http://hdl.handle.net/1880/48968. Ronquillo has written about deinstitutionalization in BC that began in the 1960s, but rapidly increased with government plans to decentralize mental health care in community settings and close Riverview Hospital.
[443] Ministry of Health, 'Riverview Hospital Pilots Mental Health Prototype', *BC Government News*, 19 October 2000, https://archive.news.gov.bc.ca/releases/archive/pre2001/2000/317.asp; 'Riverview Hospital to Be Upgraded', 27 August 1999, https://archive.news.gov.bc.ca/releases/archive/pre2001/1999/315.asp.

growing a mental hospital community (1951-1959), decentralization and regionalization (1960-1983), and a plan for rapid downsizing (1984-1992).

Growing a Mental Hospital Community (1951-1959)

In 1951, Dr. A.M. Gee became the Director of Mental Health Services. [444] He remained in the position until his retirement on August 31, 1958.[445] In 1952, Gee changed the leadership structure at Essondale to include a range of physician directors, including a Clinical Director (Dr. A.E. Davidson) and two Assistant Clinical Directors (Dr. B.F. Bryson for men, and Dr. F.E. McNair for women) were appointed to supervise all treatment activities. Diagnostic testing and research were becoming an important part of patient treatment with physician directors appointed to each of the new departments for Radiology, Pathology and Neurology.[446] After Gee's retirement in 1958, Dr. A.E. Davidson, who previously held the position of Deputy Director of Mental Health Services took over as Mental Health Services Director.[447] Under Davidson's leadership many organizational changes happened including the major name change of Essondale Mental Hospital to Riverview Hospital.

Reorganization of mental health services in BC

In the late 1950s, significant reorganization of health services led to consolidation of departments and a shift in mental health care delivery to regional general hospitals along with

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[444] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'; 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925'. He would serve an integral role in solidifying the power of physicians in the mental hospital, and the development of RPNs as a separate nursing profession in BC and across Western Canada. Gee had first been hired by BC Mental Health in 1924.

[445] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1960), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0356288.

[446] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'.
'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'. [447] Davidson left his role as Deputy Minister of Mental Health in 1967 to take a position in the Department of National Health and Welfare in Ottawa.

reclassification of mental health institutions to social services. I am providing many details about this as they are necessary to understand what happened at the institution I am studying. Reorganisation in BC began in the 1959 Session of the Legislature that resulted in the transfer of the MHS from the Provincial Secretary's Department to the newly created Department of Health Services and Hospital Insurance.[448] The Mental Health Services Branch (MHSB) became one of three along with the Health Branch and the Branch of Hospital Insurance. The MHSB was represented by its Deputy Minister, responsible to the Minister of Health Services and Hospital Insurance. The reorganization bought the service closer to the other agencies in the health field, which facilitated the development of the service. The representation by the Deputy Minister also provided a more direct approach of access and communication to the Provincial Government.[449] The hope was that the new organizational structure would promote adequate service development. The buildings at Essondale were renamed to keep up with modern nomenclature. The Male Building was renamed "West Lawn," the Acute Building "Centre Lawn," and the Women's Building "East Lawn".[450] Focus became adult patients with mental illness excluding youth who were previously classified as feebleminded.

Youth - schools for mental defectives

The care of youth with mental retardation and disabilities was no longer deemed appropriate for hospital care with the provincial legislation changing accordingly. In February 1951, permission was granted for the Provincial Mental Hospital located in New Westminster, to be renamed The Woodlands School.[451] The long-term plan was to directly admit patients to the

[448] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'.
[449] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'.
[450] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'.
[451] Straith and Department of Provincial Secretary. The name change was reflective of the shift of the facility from a mental hospital to a training school for the mentally retarded.

Woodlands School, taking pressure off the Mental Hospital at Essondale by eliminating initial intake to the admitting unit. The 100-bed unit was opened and occupied on April 1, 1950.[452] In January 1951, plans were underway for construction of three additional 100-bed units contained within a new building.[453]

The opening of the facility required appropriate legislation governing operation of a school to allow for direct admission as students, subverting the need for admission to begin in the Mental Hospitals at Essondale.[454] The School for Mental Defectives Act came into effect on October 1, 1953.[455] The Act separated the Woodlands School as a specialized facility within the MHS specifically for the care and training of the mentally defective rather than treatment of mental illness.[456] After that date all mentally defective patients were admitted directly to the Woodlands School. The short-term outcome was a decrease in mental hospital admissions, but the school would soon experience the same overcrowding as the mental hospital. Criticism of the lack of discharges and strategy of bringing people into large, centralized institutions sometimes for decades would soon be scrutinized both for fiscal reasons and within the lens of a human rights focus.

Psychiatric services in general hospitals

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[452]. Straith and Department of Provincial Secretary. The lower floor of the building was devoted to small children and infants requiring crib care. The upper floor was occupied by older children.
[453] Shannon McConnell, 'The Woodlands School, 1950-1980' (Master's Thesis, Saskatoon, University of Saskatchewan, 2020), UBC Open Archive, http://hdl.handle.net/10388/12888. For a comprehensive history of The Woodlands School see the masters thesis of Shannon McConnell from the from University of Saskatchewan. Her work explores the factors and problems that emerged in the transition from mental institution to a custodial training school.
[454] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'.
[455] 'Schools for Mental Defectives Act', 1953, c. 26, s. 1. § Chapter 347 (1953), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/1533330362/search/CIVIX_DOCUMENT_ROOT_STEM:(School%20for%20Mental%20Defectives)?3#hit1.
[456] 'Mental Hospitals Report, 1952-53'.

Mental health care was increasingly delivered outside of Essondale Hospital. Many program changes happened to address the changing branches of mental health care in accordance with provincial legislation and research evidence about treatment of mental illnesses. For example, in the 1960s psychiatric services were expanding within the general hospitals across BC.[457] Psychiatric services were shifted across Canada to general hospital delivery as a strategy to enable earlier access to treatment in a facility that could adequately address a range of acute care needs in a centralized timely manner with quicker discharge back to the community.[458] General hospital psychiatric care required training of RNs in psychiatry to meet these needs, and RN educations programs increased the content in mental health.[459]

The criminally insane

While forensic psychiatric services were yet to be developed, they would soon find a home on the grounds of the Essondale Hospital and become one of the primary areas of RPN practice in the province. The Provincial Mental Home at Colquitz which originally housed forensic psychiatric patients closed on January 29th of 1964.[460] With the population of the criminally insane moved to Riverview, plans were made for the expansion of the Mental Health

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[457] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1963', Sessional Papers of the Province of British Columbia (Victoria, B.C.: British Columbia Legislative Assembly, 1964), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0363468. Knowledge exchanges were happening with Mitchell, Director of Nursing Services, and general hospitals seeking to expand their psychiatric units including Kelowna General Hospital, Royal Jubilee (located in Victoria), and Lions Gate Hospital (located in North Vancouver).

[458] C. A. Roberts, 'Psychiatric Treatment and the Future of Mental Hospitals in Canada', *Canadian Medical Association Journal* 90, no. 12 (21 March 1964): 731–35, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1922529/.

[459] Zilm and Warbinek, *Legacy: History of Nursing Education at the University of B.C. 1919-1994*. In response to the 1933 Weir report the nursing program at UBC began including more psychiatric and preventative content in the RN program which increased in the 1940s and again in the 1960s.

[460] George Randolph Pearkes and Eric Martin, 'Mental Health Services Branch Province of British Columbia 1964' (Victoria: Department of Health Services and Hospital Insurance, 15 December 1965). With the decreasing population at the Essondale Mental Hospital a gradual closure of the Colquitz forensic mental institution was planned and implemented. The institution had long been considered unsuitable for the treatment of psychiatric patients, but its abandonment was presented by the provincial government as an accomplishment. It was originally opened as a provincial gaol in 1913, then transferred to the Provincial Mental Health Services in 1919 to be operated as a mental hospital serving the patient population of the criminally insane.

Center in Victoria.[461] Construction began on a comprehensive mental health facility aimed to bring more and improved psychiatric care to the people of Vancouver Island.

Staff shortages (1950s-60s)

During and after World War II hospitals struggled with staff shortages; the provincial mental hospitals were especially impacted with many resignations from RNs.[462] During the war men enrolled to fight and nurses enrolled to provide care to wounded soldiers. After the war, many nurses married as men were coming back and they focused on having children. Of note, until well into the 1960s, nurses who married were no longer permitted to continue to work in hospitals. This contributed to the shortage of nurses. Despite staff shortages, hospital administrators were aware of the increasing patient population. The buildings for administration, intensive treatment, and acute mental phases of psychoses on the female side were planned but not yet built.[463] It was identified that "the reason for existence of a mental hospital is to give the patients the environment for treatment better than that of the environment where the psychosis occurred," meaning the completion of the buildings was necessary for better treatment.[464] Expansion met the exploding patient population which had doubled (from 2000 to 4000) in the

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[461] 'Mental Health Branch Province of British Columbia Annual Report 1974', Sessional Papers of the Province of British Columbia (Legislative Assembly of British Columbia, 1975), http://open.library.ubc.ca/collections/bcsessional/items/1.0376305. In 1974 with legislation that established the Forensic Psychiatric Commission the Riverside Unit (formerly for Veterans) was convered into forensic psychiatric services.

[462] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1940'; 'Mental Hospitals Report, 1940-41'; 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1942', Legislative Proceedings, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1943), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0314378. Between 1939 to 1942 RN resignations were reported at 9 per year. In the 1942 annual report the RN shortage was identified as leading to RPN graduates holding hospital positions previously held by RNs. Subsequent annual reports nurse resignations were presented as a single total, with no differentiation between nursing personnel roles.

[463] 'Mental Hospitals Report, 1940-41'.

[464] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia For 12 Months Ended March 31ST 1943', Sessional Papers of the Province of British Columbia, Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1944), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0319045.

first 20 years of hospital operation with an anticipation of 8000 patients in the following ten years.[465] As previously discussed, in 1944, progress was made with the completion of the admission centre at Essondale. Crease hoped that the new admission centre would support more scientific and modern treatment for those newly admitted.[466] Efforts were made for the hospital to meet the higher standards of the Mental Hygiene Commission, but the limiting factor was the ongoing staffing shortages.

By the 1950s, hundreds of staff were living on the hospital grounds in addition to the thousands of patients on the hospital wards. However, the patients care needs were not being met due to high attrition rate of both nurses and physicians. These ongoing staff shortages that continued into the 1950s and 1960s were a hindrance to delivering adequate patient treatment. The shortage of medical staff was especially pronounced in the summer months, July and August, when many staff members would move on to other and better appointments in terms of financial compensation, or continue their education in the specialty of psychiatry to obtain their certification.[467] In the 1954-55, fiscal year Medical Superintendent T.G. Caunt appealed to the provincial government to increase senior medical-staff salaries to both attract new staff and retain current medical doctors.[468] The recruitment and retention of physicians was necessary to solidify psychiatrist's position within the mental hospital to ensure that administration and

[465] It was not only patient care areas that required expansion. A new bakery had been completed in 1943 to meet the food demand with the increase in patients and staff.
[466] 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31st 1944', Sessional Papers of the Province of British Columbia, 1945, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0319187.
[467] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1956), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0348913.
[468] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.

research could happen with bourgeoning procedures like insulin coma therapy, electroconvulsive therapy, lobotomies and psychotropic medications.[469]

Nurses at Essondale – recruitment and retention

The 1960s were a time of nursing staff shortages across Canada.[470] The impact of RPN shortages on hospital operations is introduced here, although nursing shortages will be discussed in greater detail in Chapter Five. At the beginning of the decade the MSHB tried several recruitment activities to entice more nurses to apply. These strategies included staff engagement and advertising placed with the Civil Service Commission and conducting interviews with nurses who requested for information about the Mental Health Services. Action was taken for the Civil Service Commission to place RPNs who worked with in the Mental Health Services by taking into account their individualized employment preference, but also the priority needs for the nurses in different units.[471] Shortages of RPNs led to a nursing care model change to become more inclusive of RNs. A new psychiatric ward was established where RNs interested in psychiatric nursing could be employed. RNs became increasingly interested in work at Essondale in the late 1960s.[472] This was in contrast with the mental hospitals in both Saskatchewan and Manitoba that had few RNs and primarily RPNs.[473]

Strategies were developed across the inpatient hospitals and facilities to improve nursing recruitment and retention. For example, flexible schedules were the result of unending nursing shortages. The nursing department received permission to employ part-time and short-term

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[469] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.
[470] 'The Nursing Shortage', *The Globe and Mail (1936-)*, 9 April 1963, https://www.proquest.com/news/docview/1282753058/abstract/FAE25938BED747D3PQ/3.
[471] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1963'.
[472] 'Mental Health Services Minutes of Branch Staff Meeting' (Mental Health Services Branch, 19 April 1966).
[473] Hicks, 'From Barnyards to Bedsides'; Tipliski, 'Parting at the Crossroads PhD'.

nursing staff which helped to improve standards of care.[474] A trend began in supervisory staff seeking improved qualifications for those nurses in leadership positions and to improve nursing care.[475] The practice of seeking further education was beginning to influence raising the nursing standards, and thus was encouraged by superintendents.[476]

Decentralization and Regionalization (1960-1983)

In Canada, between 1960 to 1980, all provinces were implementing some form of deinstitutionalization of their mental health services with varying degrees of success.[477] Arrangements were previously made for the American Psychiatric Association (APA) to conduct a survey into the mental-health needs and resources of the province. Led by Dr. Matthew Ross, the medical director of the APA, the hope was that the study would assist the MHSB in future planning of the mental health program.[478] The research of Kylie Smith, a historian of USA psychiatric nursing, argued that psychiatric nurses were (and still are) implicated in social processes such as social control and normalization that helped to form the classifications systems that led to institutionalization, treatment and understanding of what was and was not a psychiatric patient.[479] The influence of the standards set by the APA were repeatedly mentioned

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[474] George Randolph Pearkes and Eric Martin, 'Mental Health Services Branch Province of British Columbia 1960' (Victoria: Department of Health Services and Hospital Insurance, 12 January 1961). Psychiatric nursing staff continued to have high turnover while RN attrition rates had stabilized. The mostly RN leadership began consultation with senior nursing personnel at Valleyview, Crease and Mental Hospital, The Woodlands School, and the Mental Health Centre. A decision was made by the Superintendents of Nurses and Chief Psychiatric Nurses that a conference should be held every three months to discuss mutual problems and share information. Plans were made to create representative nursing committees, standing and task oriented.

[475] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1963'. In the annual report four members were identified as going on leave to attend the teaching and supervision course offered by the UBC School of Nursing.

[476] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1960'.

[477] Patricia Sealy and Paul C Whitehead, 'Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment', *The Canadian Journal of Psychiatry* 49, no. 4 (1 April 2004): 249–57, https://doi.org/10.1177/070674370404900405.

[478] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1960'.

[479] Smith, *Talking Therapy: Knowledge and Power in American Psychiatric Nursing*.

in annual reports of the MHB throughout the formation of the mental hospitals and into the second half of the 20th century indicating it's importance to the medical superintendents.

Pieces of the hospital campus once considered integral to mental health care were no longer viable, nor considered part of mental health care including the Colony Farm. In the 1960-61 fiscal year the therapeutic and economic roles of the institutional farms were studied.[480] Effective April 1, 1961, the farms were transferred to the jurisdiction of the BC Department of Agriculture, to be used for experimental and demonstration purposes. Resources were shifting to the community with the awareness of the importance of community delivered services to support those patients discharged from the hospital. For example, the Rehabilitation and After Care Clinic was opened in Vancouver in December 1961.[481] In April 1967, the provincial government appointed a committee to review the organization and future role of the Mental Health Branch (MHB) and made a statement indicating that the reorganization of the MHB was necessary to meet the changing patterns of care for the mentally ill and retarded in the province. The focus of the MHB was to assist in developing community-based psychiatric programs, facilities, and services.

Decentralization and regionalization of mental health programs within BC shifted the Mental Health Services organization from being strictly service oriented to assuming responsibility for all aspects of mental health planning. Buildings at Essondale were reorganized

[480] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1961', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1962), http://open.library.ubc.ca/collections/bcsessional/items/1.0363083.

[481] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1962', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, B.C.: British Columbia Legislative Assembly, 1963), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0363349. It was located at the Venture halfway house at 445 West Thirteenth Avenue, Vancouver. It served patients discharged to the metropolitan Vancouver region.

and repurposed with philosophical and care delivery changes focused on patient treatment.[482] Essondale Hospital provided one piece of an increasingly comprehensive continuum of mental health care delivered across the province, with specialized services divided by patient classification, primarily diagnosis and age. The populations to be included were the mentally retarded, emotionally disturbed children, the aged mentally ill, and the forensic population. The continuum of care included acute care, intermediate care, and extended and chronic care. To streamline administration, in 1967, the Deputy Minister and his administrative staff moved from Vancouver to Victoria to be in closer proximity to the office of the Minister of Health Services and Hospital Insurance and to the Deputy Ministers and administrative staff of the other two branches of the department.[483]

As the 1970s progressed across Canada, the speed at which deinstitutionalization was happening increased. In BC, during this time period the provincial government began a significant reorganization of provincial health services that resulted in the sole responsibility of mental health programs falling within the domain of community level mental health services.[484] The increased use of the regionally run community mental health teams appeared to reduce pressure of admission to government operated mental hospitals.[485] In the late 1950s, the Canadian federal government stopped funding large mental hospitals, supporting inpatient mental health units in general hospitals in which outpatient services were opened to support the

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[482] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1965' (Victoria, B.C., 1966), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0364028. For example, in 1965 the North Lawn Building that was originally opened for treatment of TB patients was renovated and reorganized to treat patients with physical illnesses who were too infirm to be treated on the general mental hospital wards.

[483] George Randolph Pearkes and W D Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967' (Victoria: Department of Health Services and Hospital Insurance, 31 March 1968).

[484] Walter S Owen and R H Mcclelland, 'Department of Health Annual Report 1975' (Victoria: Ministry of Health, 1976), UBC Open Archive.

[485] 'Department of Health Annual Report 1976', Annual Report (Victoria, B.C.: Department of Health, 1977), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0377926.

transition of patients from hospital back to the community.[486] Increased caseloads in the community mental health services and the demands for these services necessitated an increased need for appropriately educated clinical staff.

Psychiatric nurses in the community

In both Canada and the USA the patient population in the mental hospital was rapidly decreasing along with a decline in the length of hospital stay.[487] In the USA the plight of the poor and homeless people living with mental illness drew more and more attention to the shortcomings in government planning and the provision of community services.[488] While government social programs and health services in Canada differed, patients similarly began falling through the cracks of inadequate post-discharge programs. In response, the provincial government allocated resources to building community-based services to help with the transition.[489] For example, in the 1973/74 fiscal year 20 mental health nurses in BC were added to the community mental health services programs.[490] These positions marked the first time that the Public Service Commission opened the hiring competition in the community Mental Health Centres to RPNs to meet the workforce needs.[491] Although community-based mental health

[486] Dyck, 'Dismantling the Asylum and Charting New Pathways into the Community: Mental Health Care in Twentieth Century Canada'.
[487] Gordon E. Barnes and John Toews, 'Deinstitutionalization of Chronic Mental Patients in the Canadian Context.', *Canadian Psychology / Psychologie Canadienne* 24, no. 1 (January 1983): 22–36, https://doi.org/10.1037/h0080681.
[488] Leona L. Bachrach, 'General Hospital Psychiatry and Deinstitutionalization: A Systems View', *General Hospital Psychiatry* 7, no. 3 (July 1985): 239–48, https://doi.org/10.1016/0163-8343(85)90076-3; Lamb and Bachrach, 'Some Perspectives on Deinstitutionalization'.
[489] 'Mental Health Branch Province of British Columbia Annual Report 1973', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1974), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0376290; 'Mental Health Branch Province of British Columbia Annual Report 1974'.
[490] 'Mental Health Branch Province of British Columbia Annual Report 1974'.
[491] 'Twenty Community Positions Opened', *This Month*, June 1974, Box - 520353485, Folder- This Month 1974 Volume 6, British Columbia College of Nurses and Midwives Archive.

programs were developed outside of the provincial mental hospital setting the majority of RPNs continued to work on the inpatient units of Riverview Hospital for the next two decades.

Reorganization of mental health services

Canadian federal statistics were maintained on mental hospital utilization between 1955 and 1978.[492] A system was put in place to monitor inpatient admissions and discharges to track demographic changes and clinical characteristics of long-term mental hospital patients and mental hospital usage. The data supported a decreased rate of long-stay patients. Bed capacity in mental hospitals concurrently decreased between 1960 and 1976, with over 90% of short-stay admission in Victoria on a general hospital psychiatric unit.[493]

Deinstitutionalization, patient care, and professional role

The role of the RPNs evolved as the mental health system and services changed over the course of the 20th century. Although the School of Psychiatric Nursing stayed in the mental health hospital setting until 1973, deinstitutionalization in BC began in the 1960s; more about this is presented in Chapter 5.[494] The connections between mental health workplaces and other health care professionals help to illuminate the value of maintaining the profession but also clarify future transitions of mental health nursing. Dooley's work on RPNs in Saskatchewan highlights the significant impact that deinstitutionalization had on the professional identity of psychiatric nurses beginning in the 1940s.[495] In Saskatchewan deinstitutionalization had similar impacts on nursing practice and identity of psychiatric nurses. In the 1940s, the government of Saskatchewan was the first to reject the model of psychiatric care that was prevalent in the provinces east of Manitoba which utilized an RN and psychiatric aide model to deliver custodial

[492] Richman and Harris, 'Mental Hospital Deinstitutionalization'.
[493] Richman and Harris.
[494] Boschma, 'Community Nursing in Alberta'.
[495] Dooley, 'We Were Institutionalized'.

care.[496] Instead, a new type of nursing education was developed that emphasized human relationships and social sciences rather than the medical content that heavily influenced general nurse training. Dooley found that as the 1960s approached, deinstitutionalization was changing the way that mental health care was delivered, moving it away from large mental health institutions into decentralized general hospitals and community-based settings. At that time Saskatchewan had one of the largest, and newest built institutions, the Weyburn Mental Hospital.[497] The uncredentialed psychiatric nurse, trained within the hospital-based education system faced a challenge of limited mobility and erosion of their job security.[498]

In BC the provincial government began closing facilities that were in disrepair and not in line with the new standards of mental health facility design.[499] Notably, interview participants who moved to the generalized hospital setting noted that a significant philosophical shift occurred in the 1970s towards increased reliance on a medical model that prioritized risk aversion and patient control rather than the work-oriented and relationship-based models they knew from the mental institutions. Dooley's research uncovered RPNs knowledge gaps that highlighted the magnitude the shifting models of mental health care had on changing RPN education curriculum, impacting the future of nurses in the institutional mental hospital setting. Interview participants in this research, like those RPNs interviewed by Dooley, identified that they themselves has been institutionalized, accustomed to the structure of institutionalized care. These BC nurses, like those in the Manitoba mental hospitals, learned to adapt to the changing model of care being delivered in generalized hospitals and community settings.[500] There is value

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[496] Dooley.
[497] Dyck and Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada*.
[498] Tipliski, 'Parting at the Crossroads PhD'; Dyck and Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada*.
[499] In 1964 Colquitz forensic psychiatric hospital closed.
[500] Dooley, 'We Were Institutionalized'.

in understanding the potential disparity between the curriculum delivered to RPN students who were learning models of care reflective of new trends and changes in mental health care models and philosophies, and the day-to-day practice, personal philosophies, and beliefs about psychiatric nursing of the staff nurses who delivered the mentorship and training to student in the clinical setting. Similarly, Boschma's research on Alberta and BC psychiatric nurses, explored the nurse's changing role in the wake of deinstitutionalization in Alberta in the 1960s and 1970s and found that the strategy for delivery of care in the community changed the nursing role and professional identity.[501]

A new service-rehabilitation and Riverview Hospital

In the 1960s health care had become a recognized human right and federal and provincial governments continued to invest surplus revenue in the health system.[502] The two key pieces of legislation that influenced the development of mental health care and mental health nursing in BC were the federal Medical Act, and the provincial Mental Health Act.[503] Rehabilitation became an important focus of treatment in the 1960s which led to the development of new programs and restructuring of existing ones. With the implementation of the 1964 Mental Health Act, the Crease Clinic of Psychological Medicine, and the Provincial Mental Health Hospital, Essondale, were combined to function as one mental health facility. This facility was formally named the Riverview Hospital, Essondale.[504] The Crease Centre (formerly Crease Clinic and the Centre Lawn unit), were designated Admitting and Active Treatment Units. Due to the heavy

[501] Boschma, 'Community Nursing in Alberta'.
[502] Health Canada, 'Canada Health Act', Annual Report (Ottawa, Ontario: Government of Canada, 2015), https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/hcs-sss/alt_formats/pdf/pubs/cha-ics/2015-cha-lcs-ar-ra-eng.pdf.
[503] 'An Act Relating to Mental Health', § Chapter 29 (1964), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/1656512767/search/CIVIX_DOCUMENT_ROOT_STEM:(mental%20health%20act)?3#hit1.
[504] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1964'; An Act Relating to Mental Health.

admission load, and with plans to develop regionally delivered community-oriented program, admissions to the two units of Riverview Hospital were geographically divided. Residents of the Vancouver metropolitan area were designated as requiring admission to the Crease unit, whereas persons from the remainder of the province were admitted to the Centre Lawn unit. The two units were approximately the same size with identical standards of care and treatment. The geographical division of service was thought to be satisfactory as slightly more than 50% of all admissions came from the Vancouver metropolitan area.[505]

In 1965, more than 90 non-forensic patients were transferred within Riverview following the conversion of the Riverside building at Colony Farm to an area for patient requiring maximum-security.[506] Riverview adopted a new rehabilitation focus which led to the opening of an Activities of Daily Living Unit. The new Hillside Building opened in January 1966, and contained a 60-bed rehabilitation focused unit was constructed at a cost of $241 296.[507] The unit was for longer-term patients for rehabilitation and return to the community in a less structured, relaxed atmosphere with fewer institutional rules.[508]

Decentralization and regionalization

The Mental Health Services Branch (MHSB) continued to undergo major reorganization in the latter half of the 1960s to meet the changing patterns of care for the mentally ill and retarded. It was no longer going to be primarily service oriented and would assume increased responsibility for the over-all aspects of mental health planning to facilitate the decentralization

[505] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1966', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1967), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0364184.
[506] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1965'.
[507] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'.
[508] Pearkes and Black.

and regionalization of mental health programs throughout the province.[509] The separation of the positions of Deputy Minister and Director would help to support a differentiation of centralized inpatient services from regionalized community-based ones. The Director of Mental Health Services was thus located in Vancouver and held the responsibility of the management of all mental hospitals and institutions providing inpatient care, and the Mental Health Centre located in Burnaby.[510] The Deputy Minister was relocated to Victoria, overseeing a staff of professional consultants tasked with cooperating with local authorities, mental health professionals, universities, public and private agencies, and with other government departments in the development of community programs.[511]

Additional changes included emphasis on a wide range of new programs to meet local needs. The hope was that the division between care of physical and mental illness would lessen and eventually disappear, supporting a grander vision of comprehensive health care for the population of the province as first envisioned by Superintendent A.L. Crease in the 1940s and further developed by Superintendent A.M Gee in the 1950s.[512] The recruitment and training of new professional staff was to receive high priority because of the anticipated continued shortage of mental health professionals. In-service training and retraining would be advanced and special programs were developed to meet staffing requirements. The added focus of the Mental Health Services would be prevention, requiring more precise problem identification and definitive

[509] R.R. Loffmark, 'Mental Health Branch Province of British Columbia Annual Report 1968', Sessional Papers of the Province of British Columbia (Victoria, B.C.: Department of Health Services and Hospital Insurance, 23 January 1969), UBC Open Archive, http://dx.doi.org/10.14288/1.0365685.
[510] Loffmark.
[511] Loffmark.
[512] 'Mental Hospitals Report, 1949-50'.

planning.[513] Improvement and evaluation of treatment methods were organizational goals, but would require clinically driven research. [514]

A comprehensive regional mental health program was going to have broad categories of care that included:

1. Acute care- The acute care would include the general hospitals psychiatric wards.
2. Intermediate care–day and night hospitals, group-living homes, nursing homes, foster homes, patient, and emergency services.
3. Extended care- For individuals with physical disabilities and additional mental illness or retardation. Placement would be in expanded extended care facilities within their own communities. Larger centralized units would be reserved for only those requiring highly specialized care.
4. Chronic care– Also known as the boarding home programme. Expansion was planned for areas outside of major metropolitan areas to bring patients in closer proximity to their family and friends.[515]

Implementation of the plan to move the Riverview patients from an institutional setting into community-based programs like boarding homes posed significant challenges, one of which was related to the stigma of mental patients who had been living at the hospital for sometimes decades. The other challenge was lack of adequate funding to build community mental health services. These challenges were not unique to Riverview, but had been anticipated by mental health academics and psychiatric researchers who questioned whether adequate resources were

[513] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1958), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0354201.
[514] Loffmark, 'Mental Health Branch Report, 1967/68'.
[515] Loffmark.

in place and the lack of a fulsome understanding of chronic mental illness that was perhaps not best served by short-term treatment in a general hospital setting.[516]

Structural changes were required to mental health services delivery across the province to support the changed composition of patient demographics and philosophical changes in mental health care. Multiple reorganization of the MHB and the Department of Health Services in the 1970s and 1980s led to the eventual amalgamation of health services in the province. The first major reorganization happened in 1975, when the MHB was reorganized and renamed as Mental Health Programs as part of the reorganization of the BC Department of Health.[517] Riverview Hospital was placed under the jurisdiction of Hospital Programs, and combined with the older adult hospitals Valleyview, Pearson and Dellview.[518] The branch transferred the operation of the various mental health institutions to the Division of Government Health Institutions, thus reducing its responsibility solely to the development of mental health services at the community level.[519]

Downsizing Riverview Hospital. It was no longer economically feasible to deliver the wide range of health care services once necessary because of the large patient population and isolated location of Riverview Hospital site. The Crease Unit was designated as the acute admitted unit, and the Centre Lawn unit offered special programs such as Organic Brain

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[516] Richman and Harris, 'Mental Hospital Deinstitutionalization'.
[517] 'Department of Health Annual Report 1976'; Owen and Mcclelland, 'Department of Health Annual Report 1975'.
[518] Owen and Mcclelland, 'Department of Health Annual Report 1975'. Valleyview hospital was the geriatric facility located on Riverview grounds. It opened in 1959 with 328 beds for geriatric patients with mental illness. It was the first facility in Canada that was built to deliver mental health care to geriatric patients.
[519] Owen and Mcclelland; Muriel Helen Colls, 'Role of the Mental Hospital in the Provision of Service to the Adult Psychotic Patient by the Government of British Columbia' (Master's Thesis, Vancouver, BC, University of British Columbia, 1976), UBC Open Archive, https://doi.org/10.14288/1.0093818. In September 1975 the Riverside Unit was placed under the administrative control of the Executive Director of the Forensic Psychiatric Service, and in December operational responsibility was formally assigned to the Commission.

Syndrome, Behaviour Modification, and Young Adults.[520] Development, evaluation, and organization of community-based mental health services was the new focus of the provincial MHB in 1975, its final year of operation.[521]

In the early 1980s, BC's ruling fiscally conservative Social Credit government developed a plan to fully close Riverview Hospital, with a goal of integrating patients into the community though these plans were not fully communicated to nursing staff. Interview participant Angie Kirk recalled the downsizing happening just before she stopped working at Riverview in 1982:

> Just before I left, we were certainly getting…updates of what was going on but in the early years no. Maybe it was because I wasn't really in the upper echelons or in management…that information…wasn't widespread and we…didn't have the use of it until later… You can see certain things downsizing and you could see…Just before I left, we were certainly involved, hearing a lot more about trying to get people out into the communities and, and downsizing Riverview a bit with the eventual plan to close Riverview Hospital and put those services into the community. Many people felt badly about it…they didn't really trust that these services would be put into community so…everybody has a bit of skepticism, is it really going to be followed through. It sounds very good in theory, but will it really happen?

The plan for downsizing rapidly increased as the 1980s progressed when the population of Riverview dropped down to 1100 a substantial decrease from the peak population of 3517 in 1955.[522] In 1983 West Lawn, the first building opened in 1913, was permanently closed. Pieces of Riverview Hospital lands were sold to private developers as buildings were no longer used for health care purposes and the Colony Farm had ceased operation as a working farm.[523]

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[520] 'Department of Health Annual Report 1976'. Organizational changes to these programs were underway during the second half of 1976 including arrangements with other hospitals to provide surgical services which could no longer be provided safely and economically at Riverview because of the reduced surgical volume.
[521] 'Mental Health Branch Province of British Columbia Annual Report 1974', 19; Owen and Mcclelland, 'Department of Health Annual Report 1975'.
[522] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'. The daily average population for all patients in Mental Health Services institutions for the discal year ending March 31, 1955 was 6301.
[523] Andrew Merrill, 'Riverview Heritage Inventory' (Project, Vancouver, B.C., University of British Columbia, 2009), https://doi.org/10.14288/1.0107188.

Approximately 69 hectares of the upper hillside was developed as the Riverview Heights housing subdivision. Riverview Forest was acquired by the municipality.[524]

A Plan for Rapid Downsizing (1984-1992)

While the downsizing plan had varying success in terms of seamless transition of patients into community placements the 1980s and 1990s continued to see a steady shutdown of most of the Riverview Hospital site. The primary factors influencing closure were the increasing financial pressures to decrease lengthy mental hospital admissions and the changing mental health care trends away from long-term hospital stays in centralized institutions.

The first major change happened in 1985, when changes in the hospital operations led to cutbacks in the use of patient labour. The immediate result was that the grounds previously maintained with assistance of patient labour were now filled by paid gardening staff.[525] To decrease administrative costs and streamline operations in 1986, Riverview and Valleyview Hospitals were amalgamated under one operational umbrella and administratively referred to as "Riverview Hospital".

Impact of the Mental Health Consultation Report (1987)

As the 1980s progressed the BC government began to review and restructure the entire mental health system, including the gradual reduction of size and replacement of Riverview Hospital. The 1987 *Mental Health Consultation Report* called for the replacement of Riverview

[524] Donald Luxton & Associates, 'Statement of Significance - Riverview' (City of Coquitlam, 2008), https://www.coquitlam.ca/DocumentCenter/; '1983 Legislative Session: 1st Session, 33rd Parliament Hansard', Debates of the Legislative Assembly (Victoria, B.C.: Hasnard Services, 20 October 1983), https://www.leg.bc.ca/content/hansard/33rd1st/33p_01s_831020p.htm.
[525] Donald Luxton & Associates, 'Statement of Significance'.

Hospital.[526] Several key elements of the mental health reform initiative were identified which included:

1. The formal downsizing of Riverview Hospital from 1026 beds to 550 beds
2. The development of these 550 tertiary beds in four regional clusters
3. The annual reallocation of dollars from the Riverview Hospital budget to replace services in the community for transferred patients
4. The provision of $3 million annually in transitional funding

Optimal mental health care services were redefined within the community in bed-based rehabilitation programs. Staff support managed those patients living with chronic mental illness to reduce pressure on hospital psychiatric beds and optimize patient outcomes in terms of better quality of life and social adjustment.[527] The basic philosophical underpinnings of the new provincial mental health plan were human rights based, individualized, dignity focused, collaborative and consultative with patients, communities, and families to develop "as normal a lifestyle as possible".[528] Similar reforms were happening across Canada to restructure mental health services delivery with limited funding. In Ontario, a 1987, report from the Liberal Government appointed working committee published the Graham report which highlighted the discrepancy in mental health service spending in comparison to other areas of government spending.[529] The Ontario reforms came at the same time as Mental Health Act amendments

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[526] Adult Mental Health Divisions Ministry of Health and Ministry Responsible for Seniors, 'Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital' (Victoria, 1987). The target population of the report was adults and elderly people living with acute and/or chronic mental illness. The assumption was that this was the population being served by Riverview Hospital services at the time of the report. The BC *Mental Health Consultation Report* acknowledged that the target population had changed from the early stages of deinstitutionalization in the1960s.

[527] Ministry of Health and Ministry Responsible for Seniors.

[528] Ministry of Health and Ministry Responsible for Seniors, 2.

[529] Kathleen Hartford et al., 'Report: Four Decades of Mental Health Policy in Ontario, Canada', *Administration and Policy in Mental Health and Mental Health Services Research* 31, no. 1 (1 September 2003): 65–73,

changing the language for involuntary committal to ""serious bodily harm" (to the patient or others) or "imminent and serious physical impairment of the person"."[530] Ontario, like BC was grappling with strategies to ensure access to care for people with mental health needs while also balancing human rights.

The trend of drastic mental hospital downsizing was prevalent across Canada in the 1980s.[531] In BC the composition of the care team was expanded beyond paid staff. Roles were envisioned for volunteers and family involvement in care of the mentally ill. The central principles of this model included comprehensiveness, coordination of care, continuity of care, available and accessibility, and accountability.[532] By 1987, it was identified that 18-35 year olds were overrepresented in outpatient mental health services; they were described as "difficult and multi-system users," who had had little to no hospitalization, were "non-compliant with traditional office-based treatment," and had problems with personal care, social skills, and job skills.[533] Community delivered rehabilitation became the focus of treatment.

Inpatient care delivery was swiftly moving to the regional general hospitals which accounted for 27 psychiatric units with 627 inpatient beds around the province, including specialized treatment and assessment.[534] Riverview Hospital retained a relatively large number of

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https://doi.org/10.1023/A:1026000423918. The Ontario government Ministry of Health established a committee to implement regionally delivered mental health services that reallocated care to community supports, integration of mental health with other non-health care services, and psychiatric hospital beds as a last resort.

[530] Hartford et al., 68.

[531] K. Leila Sinnen, 'The Head Nurses' Perceptions of the Impact of Deinstitutionalization on the Chronically Mentally Ill' (Master's Thesis, Vancouver, University of British Columbia, 1993), https://doi.library.ubc.ca/10.14288/1.0086161.

[532] Ministry of Health and Ministry Responsible for Seniors, 'Draft Plan to Replace Riverview'.

[533] Ministry of Health and Ministry Responsible for Seniors, 3. Substance use was becoming an issue with this population who were identified as using proportionally more services thus costing more mental health dollars.

[534] Ministry of Health and Ministry Responsible for Seniors, 'Draft Plan to Replace Riverview'. Specialized extended care for the elderly mentally ill accounted for 153 beds.

inpatient beds, 1306 (400 geriatric and 906 for adult patients).[535] Interview participant Noella Pertch recalled that the direct result of rapidly getting rid of older staff to facilitate the downsizing plan resulted in short-term nursing shortages at the hospital.

> I resigned in '89 and told them I wouldn't be back because I didn't live locally anymore. At that time, they had given Riverview staff early retirement if they wanted it and they gave them some big packages for, for resignations and retirement and that because they knew they were going to start shutting it down. And they got a little carried away and they laid off too many people. So, they decided that they would let some people come back on a temporary basis with all the benefits and, and I hadn't actually been there since 1984, but we were building a boat at the time, and we never got the boat built in time. So, I went out to Riverview and said, "hey I can come back to work for a couple of months if you want me," so I did actually go back to Riverview for four months in 1990.

Following her final stint at Riverview Hospital she shifted to working in Long Term Care on Vancouver Island, becoming a Director of Care in 2000 until her retirement in 2021. The 1990s were the decade when final plans were released for the final closure of Riverview Hospital.

The final transition

In response to public and hospital staff pushback about impending hospital closure and tenuous mental health resources in the community the BC government announced in 1990 that Riverview would downsize to a 300-bed tertiary care facility by the year 2000, serving only the BC Lower Mainland Region.[536] The downsizing plan required transitions in governance, a reduction in the operation budget (including a plan to reduce staff), and a transitional plan for moving patients to community-based services. Since it's inception Riverview Hospital had been directly operated by the BC Government. This changed in 1988 when the provincial Government

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[535] Ministry of Health and Ministry Responsible for Seniors. A ten-year reform plan began in the 1992/93 fiscal year with a planned end in the 2001/02 fiscal year. The details included further downsizing, the development of new clinical programs for Riverview Hospital, and the relocation of tertiary mental health beds to three regions outside of the lower mainland.

[536] Province of BC Ombudsman, 'Listening: A Review of Riverview Hospital' (British Columbia: British Columbia Ombudsman, 1994), https://bcombudsperson.ca/investigative_report/listening-a-review-of-riverview-hospital/. The definition of tertiary care in the Ombudsman report was to provide in-patient care to those persons whose mental health cannot be stabilized or restored at the primary or secondary care levels.

created a non-profit society, the BC Mental Health Society (BCMHS), that would run Riverview pursuant to the Mental Health Act and the Hospital Act.[537] In 1992, the Minister of Health fulfilled a policy commitment by appointing a community-based board that included six consumers of mental health services and family members. The original mandate of BCMHS extended beyond Riverview Hospital to the community mental health programs, including one that served patients with dual diagnoses (mental illness and mental handicap). However, responsibility for those community operations were returned to the Mental Health Services Division of the Ministry of Health leaving the BCMHS's sole role of overseeing Riverview Hospital.[538]

A decreased operating budget

The operating budget of Riverview Hospital rapidly decreased in the 1990s.[539] The Ministry of Health made transitional funding available to Riverview Hospital to support patients moving into the community as part of the downsizing. Riverview Hospital returned funds associated with each year's bed closures to the Ministry, which were supposed to be allocated to community services. At that time there was concern that the funds would not be allocated in a way that directly benefitted those in the community. Despite the downsizing Riverview Hospital remained one of the largest employers in the City of Port Coquitlam in 1994, with a staff of approximately 1800. Most staff who were employed in key patient areas were RNs (132) and

[537] Province of BC Ombudsman. The Minister of Health appointed the Board of Trustees of BCMHS. The first Boards were comprised of senior provincial civil servants in the health field.
[538] Province of BC Ombudsman.
[539] In 1993-94, $3.75 million was returned for 50 closures and discharges. Province of BC Ombudsman. In the 1991-92 fiscal year the operating budget was approximately $112 000 000 decreasing to $104 336 639 in 1993-94. In the 1992-93 fiscal year, the Hospital returned approximately $6 million to the Ministry for 105 bed closures and 67 discharged patients.

RPNs (555) out of a total of 1143 clinical staff.[540] Transitional funding allowed nurses from Riverview Hospital to follow patients for several days in their new community placements, and to make follow-visits for up to six months. As of March 31, 1993, Riverview Hospital had 819 patients admitted, 527 men (64%) and 292 women (36%).[541] Changes to patient care programs were needed to reflect the remaining patient population, and to focus on transitions in care and a rehabilitation focus.

Restructuring patient care programs

Patient care programs were divided into three divisions: adult, community psychiatry and geriatric. The adult division was the largest and continued to occupy Centre Lawn, East Lawn, and North Lawn buildings. Admissions were based on referral from general hospitals across BC. The three adult programs were Acute Assessment and Treatment Program (AATP), Continuing Treatment Program (CTP), and Organic Brain Syndrome.[542] Admission to Riverview Hospital was restricted to patients with a primary diagnosis of a "classic psychiatric disorder" which included schizophrenia, mood disorder, or bipolar disorder.[543] The primary purpose of the

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[540] Province of BC Ombudsman. Clinical staff included in this total were Social Workers, Health Care Workers, RNs, RPNs, Psychologists and Activity Workers. Medical staff included psychiatrists (23) and general practitioners (32) who were hired on a sessional basis.

[541] Province of BC Ombudsman. Approximately 62% of patients were involuntarily detained under the Mental Health Act.

[542] Province of BC Ombudsman. The AATP program was for acute patients. It consisted of 120 beds on five wards including one locked Intensive Care (ICU) unit. The ICU was 20 beds for patients requiring stabilization or exhibiting disturbed behaviour. Ten beds were for referred general hospital patients who would be repatriated to their referring hospital after stabilization. The other ten beds were for patients transferred from Riverview wards. The CTP was for patients requiring longer treatment. It was delivered across 11 wards of 25 beds each. Rooms contained five to seven beds. Five of the 11 wards were locked. Patients had been Riverview for many years. The Organic Brain Syndrome ward had 85 beds on three wards located in the North Lawn building. Patients were diagnosed with conditions related to brain trauma or chronic disease. The CPD provided intensive rehabilitative and social learning skills for patients with the goal to return to the community. CPD had 90 beds across two wards with single or double rooms. The CPD had a bridging program with Coastal Foundation, a non-profit society that operated housing and vocational services in Vancouver. The Geriatric Division offered services to patients aged sixty-give and older who required psychiatric treatment and/or behaviour management that could not be managed in another service. Referrals were made from the community and general hospitals. The Geriatric Division contained 10 wards containing 20 to 31 beds (total of 300 beds) in the former Valleyview Hospital.

[543] Primary diagnosis of mental handicap or personality disorder did not support admission. Province of BC Ombudsman, 5–3.

hospital was to engage patients in active psychiatric treatment, which by the 1990s was largely pharmacological in nature.[544] Admission focused on people with diagnosed psychiatric illness that could effectively be treated with medication with no intensive behavioural programs run at Riverview Hospital. It made sense that the focus and role of the RPNs narrowed and was largely for pharmacotherapy and medication support. Consequently, RPNs who remained at Riverview Hospital recalled that they would not use the range of skills learned in school despite learning them in the post-secondary RPN program delivered at Douglas College. This sentiment was expressed by interview participants who recalled that their RPN skills were best utilized when they moved into community-based, regionalized mental health programs and services.

At that time, referring agents in general hospitals were complaining about the restrictive admission criteria. The only program that took direct admissions was the Geriatric Program. The newness of illnesses such as personality disorders were large umbrella diagnoses under which to classify many patients with behaviours labelled as troublesome; aggressiveness and manipulation behaviours, for example, were used to exclude admissions.[545] The rationale for restricting direct admissions was to encourage the development of acute psychiatric care in general hospitals. The discharge process was lengthy, with patients followed closely for weeks in the event that they required readmission.[546]The perceived success of those discharged fueled abbreviation of the plan for closure.

Speeding up the plan – abbreviating the deinstitutionalization timeline

[544] Shorter, *A History of Psychiatry*.
[545] Province of BC Ombudsman, 'Review of Riverview Hospital'.
[546] Province of BC Ombudsman. The discharge process in 1993 involved a two-week home visit leave, in which the patient remained a patient for their first two weeks away from the hospital which allowed for time to return to the hospital if their mental health deteriorated, meaning they would not have to first be admitted to the general hospital and re-referred. The exception to this was the CTP which held the patient's bed for six-months after discharge.

The 1990s saw a rapid decrease in mental hospitals beds, with a downsizing phase to be completed by the year 2000. The original plan was for the completed phase to retain a 500-bed provincial hospital for psychiatric patients.[547] In Canada between 1987-1988, 22 518 (11.6%) of patients discharged from psychiatric and acute care hospitals were in BC.[548] The Mental Health Initiative of 1990, and the 1991 Report of the Royal Commission on Health Care and Costs (Closer to Home) addressed the need to shift hospital-based health services to the community.[549] The plan was to downsize to a 300-bed facility serving the Lower Mainland, along with three other provincial tertiary psychiatric care hospitals.[550] The plan required a nuanced understanding of the nature of care and treatment delivery in a smaller inpatient setting, ensuring the relocation of other programs and trained staff, with adjustments made to regionalized programs. The overall goal was to provide patient-centered, individualized care rather than the traditional institutionalized custodial care delivered in large mental hospitals.[551] In the next two decades plans for significant downsizing and the closure of Riverview Hospital brought an end to the institutional mental hospital era in BC.

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[547] However, with future iterations of refocused plans there would be a new goal of the eventual closure of the provincial mental hospital.
[548] Sinnen, 'The Head Nurses' Perceptions of the Impact of Deinstitutionalization on the Chronically Mentally Ill'. The total number was 194 306.
[549] British Columbia Royal Commission on Health Care and Costs, ed., *Closer to Home - Summary of the Report of the British Columbia Royal Commission on Health Care and Costs*, vol. 1, 3 vols (Victoria, B.C.: Province of British Columbia, 1991), http://www.llbc.leg.bc.ca/public/Pubdocs/bcdocs/53108/CloserToHomeVol1.pdf. In 1989 Valleyview 300 was renamed Valleyview Pavilion.
[550] Province of BC Ombudsman, 'Review of Riverview Hospital'. The other three facilities would be located on Vancouver Island, the Interior and in the North.
[551] Province of BC Ombudsman. The patient-centered approach was not unique to mental health services. Within the Ombudsman report it was acknowledged that a patient-centered philosophy was a philosophical shift happening nationally across all health care services.

Downsizing and Closure of the Hospital (1993-2012)

The final years of Riverview Hospital took place from 1993 to 2012. During these years the BC government released refined plans to transfer buildings on the site to regionally run Health Authorities, and to relocate all the provincially run services to Regional Health Authorities. This section is divided into two parts: plans for downsizing (1993-2000) and plans for hospital closure (2001-2012). In the 1990s, mental health services were mainly moved to smaller, regionally located facilities. In October 2000, the government announced the construction of a new 20-bed facility to care for patients who were difficult to place in the community. This was the first new construction since the 1950s.[552] At the time only 750-800 patients remained across all programs at Riverview. The full closure of Riverview came under the leadership of the BC Liberals, aligning with fiscally conservative goals to decrease mental health care costs while also delivering regionalized community-based services.

Plans for Downsizing (1993-2000)

The number of patients in BC mental hospital institutions was drastically reduced from its peak in the 1960s to only 900 patients by 1993. Policy and organizational changes led to a decrease in hospital beds and an increase in community mental health services. Concerns were voiced by the public, the government of official opposition, and community health care providers about the delays in adequate funding for development of the necessary community services.[553] The 1990 Mental Health Initiative proposed the development of additional acute psychiatric care

[552] Ministry of Health, 'Pilot Mental Health Prototype'.
[553] Richard A. Watson, 'The Road to Respect - People with Disabilities Are Slowly Gaining Ground in Their Struggle to Become a Functioning Part of Society. Where Do They Go in the '90s.', *The Province*, 27 October 1991, sec. A, https://www.proquest.com/news/docview/2380618961/D94DE2E2127B4D7EPQ/2?accountid=14474; Dawn Hanna, 'Mental Health Called Election Issue for First Time', *The Vancouver Sun*, 9 October 1991, ProQuest Historical Newspapers, https://www.proquest.com/news/docview/2241878417/D94DE2E2127B4D7EPQ/1?accountid=14474.

and emergency residential program capacity to compensate for the reduction in Riverview Hospital capacity.[554] The pace did not match the rapid downsizing, negatively impacting the general hospitals that were reliant on referrals of mental health patients to Riverview Hospital.

Despite these problems, the organizational partner reports supported that the transfer of suitable patients from Riverview Hospital to the community was a success. Disconnection occurred between what patients and nursing staff were reporting about the rapid downsizing and that which was publicly reported.[555] The Minister of Health suspended the downsizing of Riverview Hospital on February 21, 1996.[556] At that time the Minister of Health indicated that the downsizing process would resume when mental health collaborative partners were satisfied that the necessary services were in place to support patients in the community. Downsizing resumed following a report published later that year as directed by the Provincial Mental Health Advisory Council (PMHAC) in collaboration with the BC Mental Health Society (BCMHS) recommendations from the Working Group.[557] Across Canada mental hospitals were being downsized and closed.[558] The mid-1990s marked 50 years since construction of any new

[554] PMHAC/BCMHS Working Group to the Minister of Health, 'Working Group to Identify the Regional Resources Necessary to Resume the Downsizing of Riverview Hospital', June 1996.
[555] Sinnen, 'The Head Nurses' Perceptions of the Impact of Deinstitutionalization on the Chronically Mentally Ill'; Ian Clayton, 'Ward Closure Frustrates Riverview Nursing Staff', *The Vancouver Sun (1986-2016)*, 10 July 2000, https://login.ezproxy.library.ualberta.ca/login?url=https://www.proquest.com/historical-newspapers/july-10-2000-page-13-44/docview/2318434084/se-2?accountid=14474.
[556] PMHAC/BCMHS Working Group to the Minister of Health, 'Working Group to Identify the Regional Resources Necessary to Resume the Downsizing of Riverview Hospital'. Between the 1992/93 and 1994/95 fiscal years 162 patients were placed with funding allocated as $191/day per patient transferred for this purpose. However, downsizing patients comprised less than 10% of the people discharged from Riverview Hospital.
[557] PMHAC/BCMHS Working Group to the Minister of Health. The working group was composed of selected consumer, family, and caregiver representatives across BC. The released report was unanimously endorsed by PMHAC and BCMHS.
[558] Patricia A. Sealy, 'The Impact of the Process of Deinstitutionalization of Mental Health Services in Canada: An Increase in Accessing of Health Professionals for Mental Health Concerns', *Social Work in Public Health* 27, no. 3 (29 March 2012): 229–37, https://doi.org/10.1080/19371911003748786; Fakhoury and Priebe, 'The Process of Deinstitutionalization'; Sealy and Whitehead, 'Forty Years of Deinstitutionalization of Psychiatric Services in Canada'.

psychiatric hospital in Canada except for the Whitby Psychiatric Hospital in Ontario.[559] Some examples of change occurring prior to the release of the 1996, *Position Paper on Riverview Land Use* were a shift from institutionalized care to tertiary care, segregation to integration, provider focus to patient focus, regimented to consultative care, containment to an open environment, loss of rights to creation of a Charter of Patient Rights, and indefinite stays to shorter lengths of stay with earlier discharge.[560] The future of Riverview Hospital seemed uncertain as the BC Government continued to promote the tentative planning for the opening of a new Riverview Hospital perhaps to appease public outcries of perceived failures of deinstitutionalization.

Reconfiguring a downsizing plan (1997-2000)

In 1997, Riverview Hospital was BC's last and Canada's largest remaining provincial psychiatric hospital.[561] One year later, the provincial government published a new Mental Health plan stating, "Riverview Hospital will continue to play a critical role in the mental health system of the Province of British Columbia for the foreseeable future," with a proposed closing for Riverview Hospital in 2005, its remaining 663 beds replaced by those relocated to a number of smaller facilities.[562] The BC government's vision for the future of Riverview Hospital was unclear because government funding continued for upgrading until the end of the decade.[563] While the end of the hospital was nearing a continued public outcry called for the preservation of

[559] British Columbia Mental Health Society, 'Position Paper on Riverview Land Use' (Riverview Hospital, May 1996), Legislative Library of British Columbia.
[560] Design was a key factor considered to support service delivery in a collaborative, consumer-driven way. Province of BC Ombudsman, 'Review of Riverview Hospital'; British Columbia Mental Health Society, 'Position Paper on Riverview Land Use'.
[561] Dianne Macfarlane et al., 'Clinical and Human Resource Planning for the Downsizing of Psychiatric Hospitals: The British Columbia Experience', *Psychiatric Quarterly* 68, no. 1 (1997): 25–42, https://doi.org/10.1023/A:1025405121176.
[562] One of which would be located on the Riverview grounds. Merrill, 'Riverview Heritage Inventory', 18.
[563] 'Riverview Hospital to Be Upgraded'.

Riverview Land as a horticultural and tourist space.[564] The sentiment of the failures of deinstitutionalization were rising across Canada, highlighting negative consequences such as increased homelessness.[565] Big ideas were proposed for the future of Riverview lands, but these plans would not come to fruition. The future of the Riverview lands did not include plans for health care development. In the 1999, Spring Convention, the BC Liberal Party passed a motion that encouraged the government to preserve the remaining Riverview Lands as park land, Colony Farm as a regional greenspace, and the remainder of the site to be preserved as a means of promoting economic development of the horticultural industry and tourism.[566]

Plans for Hospital Closure (2001-2012)

The period from 2001-2012 marked the final years of the large provincial mental health institution in BC. The 2001 provincial election resulted in a change of government from the NDP to the BC Liberals.[567] Fiscally conservative goals led to the final decade of Riverview filled with unactualized plans and budget cuts.

The 2001-02 fiscal year was a transition year for the provincial government that was sworn in on June 5, 2001.[568] An extensive reorganization of ministries took place with each given a significant new policy direction and tasked with the responsibility for implementing the

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[564] Donald Luxton & Associates, 'Statement of Significance'; Golds, Austin, and Otton, 'The Riverview Hospital Site - Respecting Its Past, Realizing Its Future.'

[565] Michael McCubbin, 'Deinstitutionalization: The Illusion of Disillusion', *The Journal of Mind and Behavior* 15, no. 1/2 (1994): 35–53, https://www.jstor.org/stable/43853631; Sealy, 'The Impact of the Process of Deinstitutionalization of Mental Health Services in Canada: An Increase in Accessing of Health Professionals for Mental Health Concerns'.

[566]Merrill, 'Riverview Heritage Inventory'. In 2000 the BC government established regional health authorities and patients were gradually transferred to regional facilities. A petition with 22 000 signatures calling for the preservation of the Riverview Lands was presented in the provincial legislature.

[567] 'Premiers of British Columbia', The Canadian Encyclopedia, 2023, https://www.thecanadianencyclopedia.ca/en/article/premiers-of-bc.

[568] 'Ministry of Health Services 2002/02 Annual Report - A New Era Update', Annual Report (Victoria, British Columbia: Ministry of Health Services, 2002), http://www.gov.bc.ca. The 2001-02 report described the progress made in the first year of the provincial government's New Era commitments. The end date to fulfill these commitments was May 17, 2005. The Minister of State and Mental Health was Gulzar Cheema.

government's New Era commitments.[569] To improve efficiency and accountability of health service operations, the fifty-two regional health authorities were drastically reduced to six (five geographic authorities responsible for managing services across 15 health services delivery areas and one provincial health services authority).[570] The Provincial Health Services Authority (PHSA) coordinated delivery of provincial programs and highly specialized health services which included Riverview Hospital.[571]

A Gradual Transfer

The 2001/02 Ministry of Health Services Report was titled "A New Era," indicating the numerous changes that the newly elected BC Liberal government planned for the next six years. The new Mental Health Plan called for a cultural shift away from traditional models of care to one centered on patient involvement and outcomes intended to be responsive to both patient needs and accountable to the public.[572] Despite the BC government's publicly promoted best intentions to preserve and care for Riverview ground the following year they announced approval of budget cuts that made it challenging to properly maintain the grounds. The 2002, the patient population of 800 was expected to decrease to 125 within the next three years.[573] In March 2002, Connolly Lodge, a twenty-bed residential care facility opened on Riverview grounds for a cost of $1.6 million.[574] The Fraser Health Authority (FHA) run tertiary mental health facilities were the only new buildings that would open on Riverview grounds before the official hospital closure in 2012.

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[569] 'Ministry of Health Services 2002/02 Annual Report - A New Era Update'.
[570] 'Ministry of Health Services 2002/02 Annual Report - A New Era Update'.
[571] British Columbia Ministry of Health Services, 'Ministry of Health Services - A New Era Update 2001/02 Annual Report', Annual Report (Ministry of Health Services, 2002), http://www.llbc.leg.bc.ca/public/PubDocs/bcdocs/355218/355218_bchs_ar_2001_02.pdf.
[572] British Columbia Ministry of Health Services.
[573] 'Ministry of Health Services 2002/02 Annual Report - A New Era Update'.
[574] British Columbia Ministry of Health Services, 'Ministry of Health Services - A New Era Update 2001/02 Annual Report'.

A new focus – community and home-like mental health care

A new focus was placed on mental health and home and community care by expanding choices and providing more appropriate care to patients.[575] The annual budget dramatically increased in the 2001-02 fiscal year, from $1.1 billion to $9.5 billion.[576] Construction of new home-like facilities were planned across the province to bring patients closer to their communities and loved ones, and to support individualized care needs.[577] In the 2001-2 fiscal year, health care professionals and support workers were described as the "highest paid in the country at a time when there were worldwide shortages in health care professionals," a concern because this accounted for 80% of the health care budget for both hospital and community delivered programs.[578] By the 2005-06 fiscal year, approximately $1.02 billion was spent on mental health and addictions services operating across BC, an increase of twenty per cent from the 2001-02 fiscal year with little funding allocated to Riverview.[579] Research programs that were located at Riverview Hospital were moved in 2008 into the portfolio of the BC Mental Health and Addiction Research Institute located at the Provincial Health Services Authority (PHSA) run BC Children's and BC Women's Hospitals.[580] The move was a positive step forward in integrating mental health and addictions research and knowledge translation.[581] Instead of building a new Riverview Hospital a total of 915 beds (500 in Vancouver and 415

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[575] 'Ministry of Health Services 2002/02 Annual Report - A New Era Update'.
'Ministry of Health Services 2002/02 Annual Report - A New Era Update'. [576] The previous decade saw an increase from 33 percent to 39 percent of the total provincial budget, an unsustainable strategy in the long-term, indicating the need to change the management of health care resources. A government commitment was made to fully fund and implement the new Mental Health Plan with a $263 million investment between 2001-2007.
[577] 'Ministry of Health Services 2002/02 Annual Report - A New Era Update'. At the end of the six years the plan was to direct $125 million to improve community mental health services, with $138 million in capital funding for the Riverview Hospital redeployment and increased provincial tertiary capacity across the province.
[578] British Columbia Ministry of Health Services, 'Ministry of Health Services - A New Era Update 2001/02 Annual Report', 2.
[579] Ministry of Health, '2005/06 Annual Service Plan Report' (Victoria, British Columbia: British Columbia Ministry of Health, 2006), http://www.gov.bc.ca/health/.
[580] Spiers, *Riverview Hospital*.
[581] Spiers.

located throughout the province) were created to replace the outdated Riverview facilities aligning with the plan of caring for patients closer to home.[582] The new provincial 10-year plan for Mental Health and Substance Use released in 2011 emphasized the regionally located tertiary mental health bed strategy was aligned with international standards for community-based mental health treatment.[583]

A major teaching hospital

The BC School of Psychiatric Nursing closed in 1974, but Riverview Hospital remained a major teaching hospital until the 2000s, continuing to take RN and RPN practicum students and allied health students. Relationships remained strong between Riverview Hospital and the post-secondary institutions in the Lower Mainland that delivered health care professional education.[584] The hospital continued to provide clinical experiences to students in RN, RPN, medicine, social work, pharmacy, psychology, dietetics, physiotherapy, occupational therapy and recreational therapy programs.[585] Provincial interdisciplinary mental health conferences in the areas of schizophrenia, psycho-geriatrics, and mood disorders continued to be planned and delivered at the hospital.[586]

By the end of 2010, Riverview Hospital had fewer than 200 remaining beds with a plan for complete closure in 2012. Riverview Hospital's life ended with the 2012, transfer of its last provincially run adult inpatient service, the BC Psychosis Program to the second floor of the University of British Columbia Hospital. The institution that was the biggest provincially run

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[582] Spiers.
[583] Ministry of Health Services and Ministry of Children and Family Development, 'Healthy Minds, Healthy People: A 10-Year Plan to Address Mental Health and Substance Use in British Columbia' (Victoria: Government of British Columbia, 2011), https://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf.
[584] 'Reaching Out to the Community - Riverview Hospital Annual Report 2000-01', 2001.
[585] 'Reaching Out to the Community - Riverview Hospital Annual Report 2000-01'. A total of 47 000 hours of clinical instruction was given in the 2000-01 fiscal year, an increase of three percent over the previous year despite no increase in funding. In-service training in the amount of 35, 000 was also provided to staff.
[586] 'Reaching Out to the Community - Riverview Hospital Annual Report 2000-01'.

mental institution in Western Canada had shifted all its services to regionally run facilities. The full closing of Riverview Hospital marked the end of an era distinguished by the proliferation of a large-scale centralized government run mental institution in the province.[587] BC provincially controlled operation of specialized mental hospitals with the closure of Riverview Hospital.[588]

The primary delivery of mental health services had shifted to acute general hospitals and community-based settings that included some longer-term inpatient services for the purpose of psychosocial rehabilitation. No evidence was found to indicate that the BC Government attempted to keep Riverview Hospital open, instead focusing on regionally delivered mental health care services that were closer to where patients and their families resided. Regionally operated tertiary mental health programs remained guided by a recovery focused model of care in which staffing models were not specified.[589] Registered Psychiatric Nurses remained prevalent in community-based programs, tertiary inpatient mental health programs.

Chapter Summary

This chapter was divided into three sections, beginning with development, opening, and expansion (1912-1950), then focusing on reorganization and deinstitutionalization (1951-1992), and lastly exploring the downsizing and closure of the hospital (1993-2012). While the hospital was initially opened with great fanfare, aligning with the mental health care delivery across Western Canada, it eventually became overcrowded and downsized, as did many mental

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[587] 'Closure of Riverview Hospital Marks End of Era in Mental Health Treatment', *Vancouver Sun*, 19 July 2012, https://vancouversun.com/news/closure-of-riverview-hospital-marks-end-of-era-in-mental-health-treatment.
[588] Martin, *Hometown Asylum, A History and Memoir of Institutional Care*; 'History - Selkirk Mental Health Centre', Government, Province of Manitoba - Mental Health and Community Wellness, accessed 5 February 2023, https://www.gov.mb.ca/mh/smhc/history.html; 'Saskatchewan Hospital North Battleford Officially Opens | News and Media', Government of Saskatchewan, accessed 5 February 2023, https://www.saskatchewan.ca/government/news-and-media/2019/march/08/shnb-opens. The Forensic Psychiatric Hospital, also located in Coquitlam, BC across the highway from Riverview Hospital remains in operation.
[589] 'Building Opportunities - Strategic Plan for Vancouver Coastal Health Tertiary Mental Health Services' (Vancouver, B.C.: Vancouver Coastal Health, 2003).

hospitals across Canada and the USA with the deinstitutionalization movement. Registered Psychiatric Nurses were an integral part of the patient care delivered, necessitating the opening of the BC School of Psychiatric Nursing within the hospital. Although Riverview Hospital closed in 2012, RPNs persisted, transitioning into mental health care that was regionally delivered in general hospitals and community-based programs.

Chapter Five – The Evolution of RPN Education

This chapter is about the evolution of RPN education at Essondale Hospital, later known as Riverview Hospital, with a focus on the hospital nursing school, the BC School of Psychiatric Nursing (1930-1973). The school was instrumental in solidifying the position of RPNs in the delivery of patient care in mental hospitals in BC, and supported the education of RNs in mental health in the province. Hospital-based nursing education for RPNs ended in 1973, when the program was moved to the British Columbia Institute of Technology (BCIT). The RPN degree program was established during the closure era of the provincial mental hospital system (1996-2006).

This chapter is divided into three sections based on the beginning years of the psychiatric nursing school (1913-1950), the professionalization of psychiatric nursing (1951-1973), and the move of the RPN program to a post-secondary institution (1974-2006). The final section includes the transition of RPN education beyond the closure of the school in 1973, and the evolution of RPN education in the post-secondary educational institution, exemplifying RPNs transition to a broader role in provincial mental health care. The major factors that influenced the education development within each period are explored including relevant legislation, changes in understanding of mental illness, and the influence of other health care disciplines. Throughout this chapter the term “RPN” will be used to describe those registered psychiatric nursing students who attended and received an education at the BC School of Psychiatric Nursing. The term “RN” will be used to describe registered nursing (RN) students who completed rotations at the Riverview Hospital for the mental health component of their programs.

The Beginning Years (1913-1950)

In the previous chapter the construction and expansion of Essondale Hospital in the 1910s and 1920s were explored to describe the foundational role of the institution in solidifying psychiatry as a medical specialty. In these years medical-based modern psychiatric treatments were implemented as Medical Superintendents learned about them, directly influencing the need for educated nurses. This section is divided into three parts, the need for a nursing school (1913-1929), educating psychiatric nurses (1930-1940), and developing nurse education (1941-1950). As seen in the previous chapters, in Canada the modernization of medical psychiatric treatments, World War I, and the mental hygiene movement were critical contributors in the formation of mental hospitals. The annual mental hospital reports of BC in these beginning years touted the successes of the existing treatments, substantiating the need for nurses. This was similar to the process seen in general hospitals.[590] Treatments used in mental hospitals will be explored in detail in Chapter 6, but they are introduced here to illuminate and connect nurses, particularly RPNs, to the development of mental health care.

The Need for a Nursing School (1913-1929)

The years 1913-1929, were the beginning years of Essondale Hospital. During this period of time the need to open a school of psychiatric nursing at Essondale was considered multiple times and finally planned. This need was driven by the growth of psychiatry as a medical profession, the development of mental health diagnoses, changed social understanding of the mentally ill, and legislative changes. For brevity throughout this chapter the BC School of Psychiatric Nursing will be referred to as the RPN School.

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[590] Paul, 'The Origins and Development of Nursing Education in Canada'. To read more about the history of hospital nurse education in Canada see the work of Paul.

The path to the provision of nursing care

In the 1910s and 1920s the need for trained nurses in the Provincial Mental Hospitals was becoming more apparent with the rapid increase in patient population coupled with developments in medical psychiatry. In BC, psychiatrists were influential as they sought to legitimize psychiatry as a medical specialty and used nurses to accomplish this goal. The archival evidence supports that the motivations of psychiatrists in Western Canada during the post- World War 1 era were to advance their role by seeking to place RPNs on par with RNs. Thus, psychiatrists worked in their own self-interest to staff the mental hospitals with nurses who catered to their medical direction.[591] In the post-World War I era the mental hospitals were also in desperate need of staff. Registered Psychiatric Nurses were not viewed prestigiously and the men administrative leaders at that time acknowledged that the production of competent nurses was a workforce issue. The political climate and geographical differences in the location of BC psychiatric hospitals and nursing schools are integral to understanding the development of RPN education in Canada's western-most province.

In the 1930s, separate education for RPNs in Western Canada gained traction, setting a standard for the proliferation of RPNs in BC. The BC split of RNs and RPNs helped support the staffing needs at the mental hospitals. During the 1930s, the perspective of the CNA was that psychiatric nursing was a nursing specialty that involved valuable therapeutic skills that would not be fully developed within the custodial care model that was used to deliver most mental hospital care.[592] Tipliski identified that the Graduate Nurses' Association of Ontario (GNAO) decided from the organization's inception that nursing schools would only recognize mental

[591] Hicks, 'From Barnyards to Bedsides'.
[592] Tipliski, 'Parting at the Crossroads: The Emergence of Education'.

hospital nurses when they completed mandatory general hospital training.[593] Western Canada took a different route in the 1930s; separate education for RPNs gained traction in the Western provinces, setting a standard for the proliferation of RPNs in BC.

Educating Psychiatric Nurses – Opening a BC School (1930 – 1940)

In this section links are made between pivotal federal and provincial legislation, the evolution of psychiatry, it's influence on psychiatric nurse education, and the influence of the evolving understanding of mental illness and definitions of the mental patient. Connections are drawn to the influential role of nurses in the mental hospital and the need for standard training of RPNs. The first nursing program at Essondale Hospital was offered in October 1930, coinciding with the opening of the first unit for female patients, East Lawn. The leadership structure of the nursing school included a Superintendent, Assistant Superintendent, and Instructress.[594] Women nurse leaders in the mental hospital services who held supervisory and instructor positions were RNs who received support to pursue higher education and professional development on leadership and teaching.[595]

The initial format of the program was clinical practice accompanied by lectures and a first aid course for nurses and attendants at the New Westminster mental hospital and, like the

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[593] Tipliski, 'Parting at the Crossroads PhD'. Tipliski described the affiliation that mental institution hospital nurses completed in which they moved out of the mental hospital into the general hospital as moving them away from psychiatrist-controlled mental hospital work, thereby enhancing their professional status. GNAO's perspective was aligned with nurse leaders across North America who shared the view that generalist nursing training was the standard.

[594] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1937' (Victoria, BC: British Columbia Legislative Assembly, 1937), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0307363; 'Mental Hospitals Report, 1931-32'; 'Mental Hospitals Report 1934-35'. The name of the Nurse Instructor was first reported in 1932, M. Marlatt, RN. The Superintendent of Nurses Training School Report was included in annual reports starting in 1936 by C.A. Hicks, RN.

[595] 'First Annual of the School for Nurses of Essondale Mental Hospital 1938', Riverview Hospital Historical Society Collection - Subseries 2 - Nursing Annuals and Reunion Books (Coquitlam, B.C.: Riverview Hospital, 1938), C5 - Box 41, C5 - S08 - SS1 - F01, City of Coquitlam Archive; 'Second Annual of the School for Nurses of Essondale Mental Hospital', 1939, Folder C5-S08-SS2, City of Coquitlam Archive.

schools established in Manitoba, the instructors and nursing leaders within the nursing schools were RNs.[596] Two programs were offered, a three-year program for mental nursing and a six-month post-graduate program for nursing graduates from the general hospitals.[597] A shorter program was delivered to students who graduated in spring of 1932 to address an immediate need for trained nurses to take charge positions on the hospital wards with those graduates supporting the second group of nurses through a subsequent two-year program.[598]

The original program structure of the mental nursing program was three years in length. In 1933 new students were enrolled in a three-year program structure that remained in effect until 1951.[599] Courses included pathology, gynecology, obstetrics, biology, and physiology and surprisingly, no course in psychiatry or mental health. The lecture program was 100 hours for first year students, 90 hours for second year, and 80 hours for third year students.[600] Similarly the Brandon Mental Hospital program increased from a two-year to three-year program in 1930 with the first graduates completing the program in 1931.[601] By 1935 the RPN School at Essondale was experiencing great success in terms of the numbers of students graduating the program which supported the treatment advancements of the time, exceeding the medical superintendent's

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[596] 'Mental Hospitals Report 1932-33'. Tipliski, 'Parting at the Crossroads PhD'. Hicks, RN, began as an Instructor of Nursing. While classes began for nursing students under the supervision of Miss Leonard they were not fully organized until 1931, when C.A. Hicks was named as the Superintendent of Nurses in 1933. In the spring of 1930, post-graduate nurses (practicing general hospital RNs) also began taking courses. Upon completion of the 6-month course these post-graduate RNs assumed supervisory positions within the hospital.
[597] 'Mental Hospitals Report 1932-33'.
[598] The course curriculum was not specified in Annual Reports nor were curriculum documents found. 'Mental Hospitals Report, 1931-32'. The first class of psychiatric nurses graduated in June 1932.
[599] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1934', Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1935), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0305805.
[600] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1939', Sessional Papers of the Province of British Columbia (Victoria, BC, 1939), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0314044.
[601] The requirement of the additional year was imposed on nurses who were already in the program. Dooley, 'Mental Nurses at Brandon Hospital'.

expectations.[602] At the end of the 1936, fiscal year the total number of nursing staff at Essondale was 146, including 31 RNs, 40 RPN graduates, 57 nursing students (all female RPN students), and 18 male attendants.[603] In 1938, Superintendent Crease identified the operational challenges at Essondale to maintain a school of nursing because of the dependence on student nurses for a large portion of nursing care to patients.[604] Nursing staffing issues at the BC mental hospitals were similar to those in general hospitals that were dependent on nursing students as cheap labour.[605] The dependence on nursing students for a large portion of the nursing care posed a significant problem to achieve the goal of properly educating students because students carried heavy class schedules in addition to having to care for patients .[606] In addition, while students were in class it led to staffing problems. Finally, students had very little time left for recreation.

Ultimately, medical leadership and operational needs drove the design and delivery of nursing care, and thus education. Across Canada the 1930s saw nursing students educated within centralized hospitals under the power of physicians.[607] The *Weir Report* on nursing education confirmed the poor working conditions and disparity in education of nurses in the hospital-based nursing schools.[608]

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[602] 'Mental Hospitals Report 1934-35'; 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1936', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, BC: British Columbia Legislative Assembly, 1936), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0308246.

[603] 'Mental Hospitals Annual Report 1935-36'. A second group of post-graduates received diplomas.

[604] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1938'; Em Pijl-Zieber, Sonya Grypma, and Sylvia Barton, 'Baccalaureate Nursing Education: Has It Delivered? A Retrospective Critique', *Canadian Journal of Nursing Leadership* 27, no. 2 (26 June 2014): 27–34, https://doi.org/10.12927/cjnl.2014.23839. The new Nurses' Home was finally completed in 1938 which provided accommodation for 68 nurses, making it possible to establish an affiliate program for general hospital nurses.

[605] Gagan and Gagan, *For Patients of Moderate Means*.

[606] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1938'.

[607] D. Coburn, 'The Development of Canadian Nursing: Professionalization and Proletarianization.', *International Journal of Health Services : Planning, Administration, Evaluation* 18, no. 3 (1988): 437–56, https://doi.org/10.2190/1BDV-P7FN-9NWF-VKVR.

[608] Weir found that the prevailing hospital-based model of nurse education relied on nursing students to carry out most of the hospital work with minimal amount of formal education. Weir, *The Weir Report*.

Opening a Nursing School

In 1901, recommendations of Dr. C.K. Clarke (Superintendent of the Rockwood Asylum) for implementing attendant and nurse training in the BC mental hospital.[609] Despite such recommendations there is brief mention of nurse education prior to the 1930 Annual Mental Hospital Report perhaps indicating its low priority until more medicalized treatments were developed that required a specialized skill-set to support physicians.[610] The first BC RPN School opened in 1930 at Essondale Mental Hospital; the first class graduated in 1932.[611] Similar drivers for RPN education happened in Manitoba at the Brandon Hospital for Mental Diseases in which Superintendent Baragar implemented a diploma mental nursing program to improve the hospital status, increase the standard of medical care, and implement newly developed therapies.[612] The Brandon Asylum was the site of the first school of psychiatric nursing in Canada, opened in 1921, to train asylum staff.[613] Beginning in 1922, the school offered a two-year Mental Nurses Diploma Program that included courses in anatomy and physiology, nervous and mental

[609] British Columbia Legislative Assembly, 'Report Of C. K. Clarke, M. D., Superintendent of the Rockwood Asylum for the Insane, Kingston, Ontario, Appointed a Commissioner to Inquire into and Concerning All Matters Connected with the General Administration of the Hospital for the Insane at New Westminster.', Sessional Papers of the Province of British Columbia (Victoria, BC, 1901), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0064053.

[610]. British Columbia Legislative Assembly; MacLean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the 15 Months Ending March 31st, 1920'. Substantial mention in the BC Annual Reports coincided when the Essondale Mental Hospital School of Nursing opened in 1930. In the 1920 Annual Report the Lab Report makes brief mention that specimens were prepared from patients on whom autopsies were performed to facilitate teaching of the nursing staff, perhaps indicating the lack of deliberate thought put into establishing curriculum for BC mental hospital nurses.

[611] 'Mental Hospitals Report, 1931-32'.

[612] Dooley, 'Mental Nurses at Brandon Hospital'.

[613] Dooley. As found by Dooley efforts were made by administrators to present an image of nursing consistent with general hospital nurses, for example with a standard uniform. However, like their RNs counterpart female students in the Brandon Asylum nursing school spent most of their time in on-the-job training and not in classroom lectures or coursework. The first diploma class graduated in 1925. An optional shorter program was available for male attendants that included instruction in Anatomy and Physiology and Mental Diseases.

diseases, psychology, bacteriology, sanitation and hygiene, elementary pathology, materia medica and toxicology, nursing of mental diseases, and general nursing.[614]

Education of RPNs was integral to professionalization but the graduates lacked future employability and mobility because they were limited to their training hospital for employment. In Saskatchewan attendants at the North Battleford and Weyburn institutions received rudimentary training beginning in 1930, which later became a three-year program in 1937.[615] Like many of the early RN hospital-based schools the mental hospital programs had inconsistent curriculum and teaching, were controlled by medical superintendents, and were only recognized within the training hospital.[616]

The rise of medical psychiatry treatments

The need for properly educated mental hospital nurses rose out of a need to bolster psychiatry as a medical specialty, coinciding with the rise of treatments that included seizure therapy and pharmacotherapy. The 1930s were an important decade in new and innovative medical treatments for people with mental illness.[617] When the effectiveness of medication in treating mental illness symptoms increased so did the nurse's role in carrying out medical interventions. Insulin shock therapy and Metrazol shock were two treatments that increased the level of skill required for the mental hospital nurses. A noticeable shift happened in the annual mental hospital reports in the late 1930s, with focus on reporting medical treatments (e.g., insulin shock therapy and Metrazol).[618] The increase of medical treatments was identified as the cause of

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[614] Dooley.
[615] Hicks, 'Gender, Politics, and Regionalism'.
[616] Elliott et al., *CNA One Hundred Years*. This differed in the Roman Catholic hospitals in which the sisters were in control.
[617] Shorter, *A History of Psychiatry*.
[618] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1938'; 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1939'. Insulin shock treatment for

the increased discharge rate.[619] With these shifts, understanding of mental illness changed with increased hope for cures. These new medical treatments also led to a need for increased education of male attendants to support physicians in providing this care.

Educating RNs - affiliate program (1937)

An RN affiliation program was organized and opened in 1937.[620] The aim of the program was to give RN students of general hospitals a course in psychiatry.[621] Affiliation programs with general hospitals were already running in Manitoba beginning with Neepawa General Hospital in 1929, and included graduated nurses from the public health service in 1930.[622] In the 1930s questions were arising about the underlying nature of psychiatric nursing compared to RN care. For example, Dooley argued mental nurses laid claim to a specific skill-set that differentiated them from RNs, one that prioritized caring without an expectation for curing the patient.[623] This contrasted the goals of psychiatrists to progress newly emerging scientific research to cure mental illness. In the same period RNs were also distinguishing their work from medicine by balancing the art of caring with the scientifically-based curative interventions of physicians.[624]

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treatment of dementia praecox was first introduced by Dr. Manfred Sakel, of Vienna in 1938. The physiological effects were widely studied, with findings that it caused anoxemia of the brain. The treatment was increasing in use because dementia praecox was the largest population in the mental hospital. Led by research of Dr. Von Meduna in Budapest, who used camphor, then Metrazol to produce seizures, with the best results for patients with six months or less of symptoms. The 1939 Mental Hospitals annual report included an explanation of the physiological theory of how insulin helped reroute neural pathways. Of the 89 patients treated almost 50% went into remission. The number of hydrotherapy treatments also increased.

[619] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1939'.

[620] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1937'.

[621] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1938'. This was advantageous because it broadened RNs view to include a perspective that a sick person was not merely a case to be treated well, but that emotional needs should be addressed during illness, and that all nurses should optimally possess confidence to help the sick to feel more secure, and foster sense of belonging for patients.

[622] Dooley, 'Mental Nurses at Brandon Hospital'.

[623] Dooley.

[624] Dianne Elizabeth Dodd and Deborah Gorham, *Caring and Curing: Historical Perspectives on Women and Healing in Canada* (Canada: University of Ottawa Press, 1994).

Nurses in the mental hospital faced unique challenges, including patient violence, and administering medical treatments to patients who were experiencing mental illness symptoms such as paranoia, which also necessitated a different skillset of adaptability and rapid decision making.[625]

Developing Nurse Education - Organizing as Psychiatric Nursing (1941-1950)

In the 1930s the nurse leaders at the RPN School and Essondale were mainly RNs but this began to change in the 1940s.[626] There was an ongoing shortage of RNs with mental graduates of Essondale holding positions ordinarily held by RNs, overtaxing the medical and teaching staff and the senior nurses.[627] Additional training was required and funded for the nurse instructors, who were RNs, to teach in the school but this also took time.[628] Introduction of ward aides (both male and female) was implemented to help maintain service operations of the hospital.[629] In 1942, female aides were hired to supplement the nursing staff. The RPN School

[625] Dooley, 'Mental Nurses at Brandon Hospital'. The mental nurses from Brandon Hospital for Mental Diseases took objection to being viewed as providing custodial care because they upheld values of care and love for the patients which they viewed as different than the care nurses in the general hospital provided. The mental nurses that Dooley interviewed used terms like "thinking on your feet" and "ability to think on the situation rather than the illness" to describe the unique situation faced by nurses in the mental hospital who provided care for often unpredictable patients.
[626] 'First Annual of the School for Nurses of Essondale Mental Hospital 1938'; 'PMH Annual 1939'.
[627] 'Mental Hospitals Report, 1941-42'. Assumptions were made in the 1941-42 Annual Report that the quality of patient care would decrease from the lack of RNs. The nurse staff ratio was three RPN students to one RPN graduate; the ratio prior to World War II was two RNs and one RPN graduate nurse (meaning 3 graduate nurses) to one RPN student. In 1941-42 no nurses were in the post-graduate program nor any male attendants in the RPN program.
[628] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1938'. In the 1937 Annual Report General Superintendent Crease wrote that "some time ago it was decided that to keep up with advances in treatment and study of the mentally ill that doctors and senior nursing staff should go away for postgraduate study. Two RN nursing staff went to Butler Hospital in Rhode Island for education on nurse instruction.
[629] 'Mental Hospitals Report, 1941-42'.

accomplished extensive work including delivering education to attendant staff and students from the RN affiliate programs.[630]

The WWII era continued to negatively impact the RPN Nursing School, and it was anticipated that staff shortages would increase. Nursing staff reported leaving to join the armed services, to pursue better paid work, and for marriage.[631] The large number of resignations was also attributed to the opening of new fields of work to women following the war.[632] There were reported changes to lecture material from the ongoing nursing shortages, but the specific content of the change was not found in archived materials.[633] Across Canada, the best strategy to educate nurses on the care of psychiatric patients was debated using the two models, RN education with post-graduate specialization in psychiatry or separate education for a separate designation of RPN.[634] In a survey taken of nursing in mental hospitals in the USA and Ontario there were only three hospitals offering postgraduate psychiatric nursing courses, with a total enrolment of only 3 students.[635] Ongoing staff shortages affected entry requirement standards. In 1944, the education

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630 'Mental Hospitals Report, 1941-42'. In March 1942, a resolution was approved by the Registered Nurses' Association of British Columbia (RNABC):
"That for the present, the allowance of time for those who hold a certificate in Psychiatric Nursing acceptable to the Council, and who wish to take a general nursing course, shall be six months, provided such application is made within five years following the completion of their Psychiatric Course. Such regulation shall be applicable to any student who has entered a general school of nursing since January 1st, 1942". In 1942 RNABC outlined a plan for a four-year program; two years at Essondale Hospital and two years at any one of the seven general hospital RN schools of nursing within the province. Superintendent of Nurses, Linea Blomberg, RN, was questioned if the need for an affiliate program at that time warranted the expenses of setting it up, the thus the plan was deferred.

631 'Mental Hospitals Report, 1943-44.' In 1943, there were 188 resignations and 193 replacements.

632 'Mental Hospitals Report, 1942-43'. In 1944, experienced women nurse staff were resigning, leaving only newer nurses. Most nurses identified "change of occupation" as the reason for resignation. In further questioning nurses who resigned reported that they enjoyed the work but were dissatisfied with living in residence on the property, with staff as their only contacts. More recreation on the Essondale grounds was necessary to boost satisfaction of nurses.

633 'Mental Hospitals Report, 1943-44.'

634 Tipliski, 'Parting at the Crossroads PhD'.

635 'Mental Hospitals Report, 1943-44.'; Laura W. Fitzsimmons, 'Facts and Trends in Psychiatric Nursing', *The American Journal of Nursing* 44, no. 8 (1944): 732–35, https://doi.org/10.2307/3416648. Laura Wood Fitzsimmons was the inaugural nurse consultant appointed by the APA in July 1942. Fitzsimmons recommended that affiliation enriched the background of RNs hospital work but did not lead to pursuit of psychiatric nursing after graduation. Duke (Superintendent of Nurses) agreed that two months was not sufficient to prepare RN students for working in the psychiatric hospital.

requirement for applicants to the RPN School was reduced from Junior Matriculation (Grade 12) to Grade Ten.[636]

As the decade progressed the RPN School faced ongoing hardships. The attrition of experienced nurses was increasing, a trend not expected to resolve until after WWII. To improve retention and support better patient treatment in 1945, General Superintendent Crease recommended building a new Nurses' Home and reviewed shift length.[637] By the late 1940s it was clear that resources were required to develop better strategies to recruit and retain new nursing students. For example, they identified the lack of recreation as a significant barrier to attracting new nursing students.[638] Sports and recreation were an integral part of hospital life for staff because of the close community in which they both worked and lived, which was common to mental hospitals because of their location.[639] A business operations review indicated a need to optimize education delivery, leading to a hospital led review of the length and timing of nursing shifts. All staff were previously scheduled for twelve-hour shifts in which students attended lectures one to two hours a day for six months of the year. In 1946, the education delivery model

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[636] British Columbia Psychiatric Nurses Association, 'Brief Submitted to The American Psychiatric Association Survey of Mental Health Services in BC', Brief (New Westminster, BC: BC Psychiatric Nurses Association, 14 August 1959), Box 40, Folder - C5-S1-SS1-F9 Professional Association (Folder 1 of 6), City of Coquitlam Archive; 'Correspondence Sent between Dr. A.L. Crease, Instructor Jack Lowndes, and Instructor W.L. Pritchard', Letters, 1949, Box - GR 0133 British Columbia Mental Health Branch Box 16 69-716 , Folder 1-10.02 Department of Nursing Education, 1945-1959 - , Corres. closed, British Columbia Archives. Some exceptions were made to this requirement because aides who were already employed at the Hospital were admitted to the program. Some of the male attendants had grade seven and eight education.

[637] Pearson, Geo. S., 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31st 1945', Annual Report, Sessional Papers of the Province of British Columbia, 1946, https://open.library.ubc.ca/collections/bcsessional/items/1.0332431. It would allow nurses to staff the new treatment unit. The plan was for it to include a sick bay of at least 10 beds and a recreation room for nurses in the building basement. Further recommendation was made to build a theatre and other amusements to improve staff satisfaction.

[638] 'Mental Hospitals Report, 1945-46'. Nursing students were required to live in residence at the hospital. To involve and engage nurses in recreation and entertainment Nurse Instructors Pullan and Blythe formed an Arts and Crafts Club that was offered one evening a week. Mr. Brown, the Recreational Director, planned additional recreation in swimming, badminton, and movies.

[639] Dooley, 'Mental Nurses at Brandon Hospital'. Dooley also found that nurses at the Brandon Mental Hospital recalled the important role of sports and recreation with students, their senior nurse staff, and psychiatrists. Recreation was identified as flattening the rigid hierarchy experienced in hospital work.

changed to two sets of classes to accommodate students on night duty, so they did not have to extend their shift to attend lectures. At that time. intake and starting dates were not set, meaning nursing students began working and were scheduled into courses when they were hired. The following year shift length shortened to eight hours.[640]

Re-thinking married women and work

Most nurses and nursing students in the RPN School were young women. It is known that the wages of women in BC stayed steadily low in the 1920s and 1930s[641], which coincided with the time of the mental hospital opening. Women in BC were involved in various labour movements in the early part of the 20th century. In contrast to the unionization happening with men in the trades, women workers were largely low wages earners, limited by gender, trapped in jobs with inferior working conditions, and faced sexual harassment.[642] In 1921, women's wages were sixty per cent of men's wages, increased slightly to sixty-two per cent in 1933, but then decreased to fifty-four per cent in the 1940s because lay offs following the end of World War II at a higher rate than men.[643] Once men returned from the war women were sent back home, and men took positions occupied by women during the war.

In 1945, WWII ended and those staff in service could return to their jobs.[644] Nurses were needed because between 1943 and 1953, the number of hospital beds in Canada increased by twenty-six percent, and hospital admissions increased by seventy-four percent.[645] Across Canada

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[640] British Columbia Psychiatric Nurses Association, 'Brief Submitted to The American Psychiatric Association Survey of Mental Health Services in BC'. The men's division implemented the eight-hour day first in 1947, and the women's division followed in 1949.
[641] Sager, 'Women in the Industrial Labour Force: Evidence for British Columbia, 1921-43'.
[642] Nicol, 'Vancouver Steam Laundries'.
[643] Sager, 'Women in the Industrial Labour Force: Evidence for British Columbia, 1921-43'. At this time it was socially expected that men were the primary wage earner.
[644] 'Mental Hospitals Report, 1945-46'.
[645] Peter L. Twohig, '"We Shall Arrive at the 'Utopia' of Nursing": Reconceptualizing Nursing Labour in British Columbia, 1945-1965', *BC Studies: The British Columbian Quarterly*, no. 206 (18 June 2020): 9–30, https://doi.org/10.14288/bcs.v0i206.192263.

so-called rank-and-file nurses left their jobs because of the long hours, low wages, and poor working conditions.[646] Essondale experienced this trend, and in 1944 the organizational leaders' response was a significant policy change that allowed married women to return to duty; both RPN and RNs returned to the hospital following the change.[647] This was not unique to Essondale. By January 1943, married women accounted for fifty percent of the VGH nurse staff.[648] After WWII hospital administrators at Vancouver General Hospital (VGH), the largest hospital in the province, encouraged married women to return to practice.[649] BC was unique this way. In contrast, in most of Canada, it is common knowledge, that it was not until the 1960s that nurses who were married could continue to work. The post WWII years also brought a baby boom, and the societal norm was that mothers stayed at home at least until children began school. This exacerbated nursing shortages too.

Men in psychiatric nursing

Men played an important role in nursing the mentally ill throughout the global history of the asylums and mental hospitals.[650] As in Manitoba and Saskatchewan, men in the BC mental hospitals were first employed as attendants and then as nurses. The Essondale school in BC opened the first male attendants' course in 1937, and it provided training on par with other mental hospitals. The course had steady student enrollment.[651] Men were reluctantly accepted

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[646] Twohig.
[647] The return of RNs was described as a "definite aid in the endeavour to keep up a desirable standard of patient-care". 'Mental Hospitals Report, 1943-44.', GG 20.
[648] Twohig, '"We Shall Arrive at the 'Utopia' of Nursing"'. It was in the interest of nursing organizations to support the return of trained nurses to the BC hospital workforce which led to the RNABC sponsoring refresher courses. Another strategy used to build the nursing workforce was an accelerated RN course offered between 1942 and 1946.
[649] Twohig.
[650] Hicks, *Politics, Personalities, & Persistence*; Prebble, 'Psychiatric Nursing in New Zealand'; Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920*; Monk, 'Working in the Asylum'.
[651] 'PMH Annual 1939'; 'First Annual of the School for Nurses of Essondale Mental Hospital 1938'. In 1938 six male students were accepted into the three-year course of training in psychiatric nursing, and in 1939 five more male students entered the program with five continuing to their second year.

into the profession of RPN, and did not have access to nursing instruction until 1940, when the imminent need for better patient care pressured change to the constraint of exclusion of men.[652] With the end of WWII men were also returning to BC to find work. Discrepancies existed between trained male attendants who delivered care to male patients, and female nurses, who completed psychiatric nursing care duties only for women because women were not permitted to work with male patients.[653] In 1945, on the insistence of Deputy Provincial Secretary P. Walker, Superintendent Crease sanctioned a proposed plan for a male training course guided by the direction of the American Psychiatric Association (APA) on psychiatric teaching for nurses and attendants.[654]

After a three year lapse the classes for male-attendants resumed in 1946, consisting of a three-year course in psychiatric nursing. In 1946, sixty charge and deputy charge attendants received a short program, and twenty-six men received 100 hours of instruction.[655] It was not until 1948, that sufficient new senior qualified staff allowed for those with less experience to receive the training of the equivalency to those that women RPNs had since 1931. Parity was reached in 1949, when both men and women students were delivered the same courses and curriculum.[656] Two male RPN instructors from Essondale, Wilfred Pritchard and Richard Strong took the lead in the late 1940s when they arranged meetings to discuss the formation of a professional association for RPNs.

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[652] 'Mental Hospitals Report, 1943-44.'; 'Mental Hospitals Report, 1940-41'.
[653] British Columbia Psychiatric Nurses Association, 'Brief Submitted to The American Psychiatric Association Survey of Mental Health Services in BC'. It was not until 1945 that men Charge Attendants received 14 hours of instruction to assume the role.
[654] 'Correspondence on a Male Psychiatric Nursing Program February - September 1945', Letters and Memorandums, 1945, Box - GR 0133 British Columbia Mental Health Branch Box 16 69-716, Folder - 1-10.02 Department of Nursing Education 1945-1959 - Corres. closed, British Columbia Archives.
[655] 'Mental Hospitals Report, 1945-46'. At the New Westminster branch 19 men were instructed in the short course, and 34 in the 100-hour course.
[656] 'Mental Hospitals Report 1948-49'. Education was delivered by male instructors, Mr. Pritchard, and his assistants R. Strong and R. Palm. Mr. Palm was responsible for the New Westminster branch employees.

Forming an association

In 1947, the BC Psychiatric Nurses Association (BCPNA) was formed with the hope that the organization would raise the standard of nursing personnel through self-regulation and credentialing akin to that attained by BC RNs.[657] This did not happen because the 1951 Psychiatric Nurses Act failed to give the Association the authority. The development of RPN-specific curriculum and affiliation with RNs were integral to professionalization in terms of advancing specialized knowledge. Significant changes that contributed to the professionalization of psychiatric nursing across the Western Provinces were the opening RPN education to men mental hospital attendants, the removal of the restriction of married women to continue in their career as psychiatric nurses, and addition of other nursing classifications.[658] To attract men to the RPN profession it became necessary to professionalize the field within a societal context that was patriarchal. The evidence in BC aligns with Tipliski's perspective of the Manitoba and Saskatchewan mental hospitals in which the motivations of psychiatrists in the early 19th century and the post-world war era were to help to advance the role of psychiatrists and psychiatry as a specialty branch of medicine rather than advancing the role of women and nursing. Like the findings of Boschma in the Dutch asylums in the BC, psychiatrists sought to legitimize psychiatry as a medical profession and nurses were part of strategy to accomplish this goal.[659]

With the rapidly increasing patient population the provincial mental hospitals desperately needed more nursing staff, and psychiatric nursing was not viewed as a prestigious choice especially after WW II when more career options were available to women. The political climate

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[657] Zilm and Warbinek, *Legacy: History of Nursing Education at the University of B.C. 1919-1994*.
[658] Tipliski, 'Parting at the Crossroads PhD'; Dooley, 'Mental Nurses at Brandon Hospital'; Hicks, 'From Barnyards to Bedsides'. Hicks main argument was that the CNA was unkind and unwelcoming of the psychiatric nurses of the time. This perspective differed from Tipliski's because it focused on the benefit of men psychiatrists and psychiatric attendants in the creation of the separate RPN designation.
[659] Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920*.

and geographical differences in the location of provincial psychiatric hospitals and nursing schools in BC are integral to understanding the development of psychiatric nurse education in Canada's Western-most province. Gender, along with place of work, and the relationship with other health care staff were an additional significant factor that influenced the professionalization and identity of psychiatric nurses.

Curriculum

Course content changed in 1944, to focus on courses determined as essential for the preparation of staff performing psychiatric nursing. Prior to the change pathology, gynecology, obstetrics, and anatomy and physiology were included.[660] Few documents were found that describe the content of the original nursing program other than the names of the courses. The 1948-49 syllabus included an hour breakdown of the qualifying program for RPN graduates. Courses included nursing arts, pharmacology, medical nursing and communicable diseases, psychiatric nursing, psychology, and special therapies totaling 110 hours.[661] Curriculum for nursing students and educational opportunities for staff nurses did not significantly change until the 1950s, coinciding with the increase in therapeutic modalities for patient care and the profession of psychology gaining prominence in the mental hospital.[662]

Lectures in the 1950s were based on recommendations of the APA, and theory of American psychiatric nurse scholars and educators.[663] In 1954, there was an increase in the

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[660] British Columbia Psychiatric Nurses Association, 'Brief Submitted to The American Psychiatric Association Survey of Mental Health Services in BC'.
[661] School of Nursing, Provincial Mental Hospital, 'Syllabus 1948-49', 1949, Folder C5-508-SSI-F08 - School of Psychiatric Nursing photocopied policies, photographs, and other material (Part 1), City of Coquitlam Archive.
[662] 'Mental Health Services Province of British Columbia Annual Report For Twelve Months Ended March 31st 1954', 1955, UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0367809. RPNs knowledge base was increased with new therapeutic modalities gaining prominence in the mental hospital setting. In the 1954 Annual Report the value of milieu therapy is introduced.
[663] Dorothy Gregg, 'Reassurance', *AJN The American Journal of Nursing* 55, no. 2 (February 1955): 171, https://journals.lww.com/ajnonline/Citation/1955/02000/Reassurance_.25.aspx; Eleanor Lewis, 'Identifying Some

involvement of psychology in the field of nursing education. The rationale for the change was that a more meaningful view of basic psychology could be given in a longer session than in the former split sessions.[664] The education delivered to RPNs was based on the needs of the different psychiatric inpatient services. For example, in 1954, a consideration was raised about providing more preparation and assignment of nurses to caring for mentally retarded patients.[665]

The block system

The change to the eight-hour day and forty-four-hour workweek for all nurses supported a new structure of education delivery.[666] On January 3, 1950, the Block System of classes came into effect. The system improved the delivery of nursing education by addressing the problems of continuous students hires as vacancies appeared. The high attrition rate was fifty percent within the first year, allowing only small groups of students released to take the block of lectures at one time. Teaching for both male and female RPNs was centralized at the Essondale site, which was new for the New Westminster mental hospital staff. The block system freed students from ward-service responsibilities during their block of lectures.[667]

Concepts Nursing Personnel Need to Understand in Relation to the Nature of Therapeutic Functions', vol. 1 (Aspects of Psychiatric Nursing Considered at the 1956 Regional Conferences of the National League for Nursing, National League for Nursing, Mental Health and Psychiatric Nursing Advisory …, 1957); Melvin Sabshin, 'Nurse-Doctor-Patient Relationships in Psychiatry', *The American Journal of Nursing* 57, no. 2 (1957): 188–92, https://doi.org/10.2307/3461218.

[664] 'Mental Hospitals Report, 1953-54'. Sixty hours of basic psychology lectures were given. A series of fifteen consecutive lectures was organized for all second-term psychiatric nursing students instead of two short sessions in first and third years.

[665] 'Mental Hospitals Report, 1953-54'.

[666] Pearson, Geo. S., 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31st 1945'.

[667] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'. The curriculum was structured in a block system in which lectures were provided before students were assigned to ward duty. It was perceived as a major improvement with controlled rotations that gave students exposure to different clinical areas. The system required more work for teaching personnel and increased repetition of class work. The system continued into the 1950s as 447 students received instruction at various levels of the Psychiatric Nursing Diploma Course (257 women and 190 men), of these 54 were women and 43 were men from Woodlands School.

The RPN School gained prominence as the structure was a perceived success based on the numbers of graduates and continued into the early 1950s.[668] In 1951, a senior instructor was designated as Head of the whole Nursing Education Department.[669] That year the Provincial Government passed an Order-in-Council declaring that applicants to a two-year RPN course were classified as Students of the School of Psychiatric Nursing, and not employed as Civil Servants until successful completion of the program.[670] This was a first step in the separation of RPN students from hospital control to fulfill its workforce needs and towards standardized education to prepare graduates for work in diverse mental health settings. However, the change decreased job security because students were not guaranteed a job following graduation, and allowed for RPN students to receive a stipend rather than a salary.

Nursing job action - organizing labour unions

The expanding hospital system was grappling with increasing costs of labour, which accounted for sixty to seventy per cent of hospital budgets by the mid-1950s.[671] In BC, temporary permits were issued to nurses educated in other provinces, while training opportunities for nurses across Canada increased in addition to recruitment efforts to attract women to nursing.[672] The severe shortage opened the door for men to access RN education in addition to international recruitment efforts.[673] In the post-WWII era RN nurse leaders began to strongly advocate for nursing education in the educational institution rather than as part of

[668] Straith and Department of Provincial Secretary. Medical staff, including Superintendent L.E. Sauriol gave twenty hours of lectures and demonstrations on mental deficiency in an accelerated course for the psychiatric nurses and also to nursing students.
[669] British Columbia Psychiatric Nurses Association, 'Brief Submitted to The American Psychiatric Association Survey of Mental Health Services in BC'.
[670] British Columbia Psychiatric Nurses Association.
[671] Twohig, '"We Shall Arrive at the 'Utopia' of Nursing"'.
[672] Twohig.
[673] Twohig.

service to the hospital.[674] Additional workload from administration of penicillin along with the changing situation of women with home responsibilities, opportunities for further education, marriage, inadequate salaries, and poor working conditions led RNs to permanently leave nursing positions for opportunities elsewhere. Registered Nurses in BC were organizing to get better working conditions. In 1946, 150 RNs unionized by enrolling in the City Hall Employees Association.[675] In 1947, the psychiatric workers at Essondale formed the first legal association of psychiatric nurses in the world.[676]

The Rise and Fall of the BC School of Psychiatric Nursing (1950-1973)

In the 1950s, the education program changed because of the professionalization of RPNs, beginning with the passing of the Psychiatric Nursing Act, the expansion of the psychiatric nurse education program with speciality courses, and the demand of RPN professional association for RPNs to have a transferable education like that of RNs. This section is divided into three parts: changing RPN Legislation and professionalization (1951-1959), expansion of the RPN school (1960-1969), and the school closure and transfer (1970-1973). The first section explores the development of mental health nursing including the birth of the BC Psychiatric Nurse Association (BCPNA), followed by the second section on structural changes in the developing and expanding RPN education, and the third section on the eventual closure of the school and transfer to the post-secondary institution.

Changing Psychiatric Nurse Legislation – The BCPNA (1951-1959)

[674] Elliott et al., *CNA One Hundred Years*.
[675] The following decade saw nineteen more locals formed at BC hospitals. Mickleburgh, *On the Line: A History of the British Columbia Labour Movement*.
[676] McDonald, *A Long Way to Paradise*.

The 1950s marked an important decade for psychiatric nursing.[677] Of note, it was not until 1951, that a legislation creating a RPN professional association was enacted for RPNs despite their prevalence within the provincial mental hospitals. This change was combined with ongoing need for psychiatric nurses solidified RPN education.

Dr. A.M. Gee, Director of Mental Health Services, purported that the formation of the professional association, the British Columbia Psychiatric Nurses' Association (BCPNA), would cause an increase in standards for personnel and training.[678] While Gee strongly supported the separate psychiatric nursing program in Western Canada work was underway in Eastern Canada following the recommendation of the CNA to create a one year psychiatric nursing aide program to cost effectively replace the two and three-year psychiatric nursing programs developed in BC and Saskatchewan.[679]

As stated earlier the BC Government enacted the Psychiatric Nurses Act in 1951.[680] The Act provided protection to the public from unqualified persons practicing psychiatric nursing and mandated the creation of a Council of Psychiatric Nurses (CPN), for the purpose of overseeing the regulation of the profession.[681] With this legislation it became mandatory for practicing RPNs

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[677] 'Chapter 185. An Act Respecting the Practice of Nursing.', c.64, s. 1. § (1918), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/840286/search/CIVIX_DOCUMENT_ROOT_STEM:(registered%20nurses%20act%201918)?3#hit1; Chapter 185. An Act respecting the Practice of Nursing. Provincial laws were already enacted to determine who could use the title of registered nurse and establish the legislation that mandated the early nursing associations across Canada. The British Columbia Registered Nurses Act was proclaimed in 1918. RNs were organized as members within the Graduate Nurses' Association of British Columbia (GNABC), governed by an elected Council. The mental hospital was increasingly becoming an integral site for RN education, fulfilled with the development of affiliation programs creating partnerships between general hospital schools of nursing and that of the mental hospital. When the legislation was passed "Registered Nurse" became a protected title, only to be used by those nurses registered with the Association.

[678] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'.

[679] Tipliski, 'Parting at the Crossroads PhD'.

[680] Government of British Columbia, Chapter 59. An Act Respecting the Practice of Psychiatric Nursing.

[681] British Columbia Health Professions Council, 'Safe Choices: A New Model for Regulating Health Professions in British Columbia.' (Victoria: Ministry of Health, 2001), British Columbia Government Publications Search Portal, https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/safe-choices-a-new-model-for-regulating-health-professions-in-british-columbia.pdf. At the date of enactment 400 graduates from the School of Psychiatric Nursing and 300 graduates who were members of the BC Psychiatric Nurses Association.

to hold an active license and accordingly to use the title "Licensed Psychiatric Nurse" or the abbreviation "Psych. N".[682] Of note the Act included the mention that RNs could continue to work in psychiatry and were therefore not affected by this change.

Within this Act the CPN was defined to be composed of:

- The Deputy Provincial Secretary
- The Director of Mental Health Services (ex officio Chairman of the Council)
- Five members appointment by the Hospital Council of the BC Mental Health Service, of whom at least one shall be a member of the College of Physicians and Surgeons of BC
- Four members appointed by the BC Psychiatric Nurses Association

The formation of the BCPNA was attributed as a piece of an ongoing endeavour to increase the calibre of education of staff engaged in treatment of the mentally ill. The 1951 Psychiatric Nurses Act was described as "of great future benefit in elevating psychiatric nursing care".[683] Progress in regulation happened when the committee on nursing (chaired by the Senior Medical Superintendent) was created to deal with matters of promotion, appointment, and discipline.[684] It was a point of pride that the term "attendant" was deleted from the Civil Service staff structure and replaced with "psychiatric nurse, male and female".[685] The separate training route for RPNs in BC raised the professionalization and image of mental hospital nurses. But the mental hospitals continued to have nursing shortages in the 1950s, as was happening across Canada, leading the overworked and underpaid nursing staff to leave the profession.[686] In response a new

[682] Government of British Columbia, Chapter 59. An Act Respecting the Practice of Psychiatric Nursing.
[683] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'.
[684] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1952', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1953), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0348089.
[685] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51', O 64.
[686] McPherson, *Bedside Matters*. J.G. Elliot, Chief Psychiatric Male Nurse proudly reported in the 1951 Annual Report that the title of staff at The Woodlands School was changed from "attendant" to "psychiatric male nurse," a

role of psychiatric aide was created in the BC mental hospital, framed as beneficial in releasing nurse staff from activities unrelated to nursing.[687] A plan for mental hospital care delivery by RNs and psychiatric aides was recommended by the CNA but the structure did not serve the interests of MHS Director Gee.[688]

The Council of Psychiatric Nurses

A key distinction of professionalization was maintenance of a list of all RPNs licensed in the province. These changes were intended to raise the standards of nursing personnel and training, and increased the level of patient care delivery. As previously introduced the Council of Psychiatric Nurses (CPN) was the appointed legally mandated body responsible for the registering and licensing of psychiatric nurses. The Psychiatric Nurses Act made provision of the CPN, stating that the Council shall "govern, control, and administer the affairs of licensed psychiatric nurses".

The CPN had its first meeting at the Crease Clinic in Essondale, July 4, 1951. It was composed of eleven members (only three were women). The major business of the first meeting was to draft regulations related to:

1. Definition of psychiatric nurse
2. Conduct of examinations
3. Duties of licensed psychiatric nurse
4. Issuing, suspension, and cancellation of licenses
5. Feed and dues.

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change that he acknowledged may have seemed insignificant but fostered a morale boost and a desire of staff to further their education in caring for and training the mentally deficient child. The new role of "psychiatric aide" was created.

[687] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'. Superintendent Gee stated that "radical changes" were "contemplated in our nursing educational system," with a new position created called "psychiatric aide".

[688] Tipliski, 'Parting at the Crossroads PhD'.

6. Renewal of licenses
7. Investigation of complaints
8. Meeting of the council

The major topic of discussion was the acceptance of graduates of the Schools of Psychiatric Nursing of the Mental Health Services of Alberta, Saskatchewan, and Manitoba, and from the Royal Medico-Psychological Association in the UK as eligible for licensing in BC.[689] At the end of the fiscal year 356 RPNs were granted a license to practice in BC. The new Order-in-Council changed the compliment of staff and hiring practices. Prior to the order passing on September 1, 1951, when replacements or additional staff were required, the hospital was forced to hire untrained staff under the classification of psychiatric nurse-in-training. With the new order there was a formal mechanism for ensuring that students in the RPN program received classroom instruction before beginning work in the hospital and providing nursing care (service).

Registration provided a reliable source that showed the number of RPNs slowly increasing in the 1950s. At the 1954, annual meeting the BCPNA requested their representation on the Council be increased. The government introduced a bill to amend the Psychiatric Nurses Act to provide an additional member to the council as appointed by the BCPNA.[690] In 1955, this amendment was passed, but disappointingly while the numbers of RPNs steadily increased concurrently registrants were also leaving practice.[691] Table 5.1 shows the increase in total numbers of registrants between 1951-1959. Registrations increased substantially until 1953, and

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[689]. 'Mental Health Services Report, 1951-52'. The process recognized these nurses as equal to BC School of Psychiatric Nursing graduates Discussion continued in the two subsequent meetings that were held during the fiscal year, on November 30, 1951, and February 18,1952

[690] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.

[691] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1957), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0349124.

then levelled off such that they were not keeping pace with attrition.[692] Table 5.2 shows the number of resignations between 1951-1960.

	1951-52	1952-53	1953-54	1954-55	1955-56	1956-57	1957-58	1958-59
Licensed Psychiatric Nurses	356	668	936	941	1006	1051	1064	1064
Mental Deficiency Nurses	-	-	-	-	-	-	11	11

Table 5.1 - Numbers of Licensed Psychiatric Nurses[693]

	1951-52		1952-53		1953-54		1954-55	
Gender	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Resignations	296	29	281	31	351	37	311	57

Table 5.2 - Numbers of Nurse Resignations from Essondale 1951-1955[694]

Strategies like recruitment from other provinces and countries were implemented to address the psychiatric nursing shortage.[695] Overseas and out of province recruitment was an important

[692] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'.

[693] 'Mental Health Services Report, 1951-52'; 'Mental Hospitals Report, 1952-53'; 'Mental Hospitals Report, 1953-54'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1959), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0355438; 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'; 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1960', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1961), UBC Open Archive, https://open.library.ubc.ca/collections/bcsessional/items/1.0362896.

[694] 'Mental Health Services Report, 1951-52'; 'Mental Hospitals Report, 1952-53'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'; 'Mental Hospitals Report, 1953-54'.

[695] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'. At the annual CPN meeting held on April 27, 1956, the BCPNA reported that its education committee conducted a thorough study of the syllabus in mental nursing of the General Nursing Council of England and Wales. At the second meeting held December 19, 1956, BCPNA reported they reviewed courses in psychiatric nursing prescribed for Manitoba, Alberta, Saskatchewan, England, Scotland, Wales, and Northern Ireland finding them all acceptable for licensing in BC without need for further examination. Approval was received to use the revenue surplus accrued in the administration of the Act to advance the education of RPNs (at that time RPNs were referred to as Licensed Psychiatric Nurses). They concluded that graduates of the English RPN program had attained an acceptable standard of proficiency in psychiatric nursing and recommended their licensing to practice in BC without further examination. Although this was conceived as a temporary strategy it remained a key strategy to attain adequate numbers of nurses to meet the health care workforce need in BC until the 2000s

strategy to build the RPN workforce in the mental hospitals and services in BC but internal strategies were also required leading to the expansion of the BC School of Psychiatric Nursing.

Expanding psychiatric nurse education

In the early 1950s, the BC government continued exploring ways to reorganize nursing labour, establishing a special committee.[696] This led to the 1951, amalgamation of the students placed at the New Westminster and Essondale mental hospitals into a centralized course delivery model within the renamed "Department of Nursing Education".[697] The Department of Nursing Education structured the program with each educational program as the responsibility of a senior instructor. An increase of funding allocated in the 1959-60 fiscal year budget made it possible to plan for the expansion and improvement of existing programs and for the initiation of others. However, this plan could only be implemented with adequate numbers of instructors. Efforts were made to capitalize on the increased interest of nurses in the psychiatric field, six instructors and an Associate Director of Nursing Education (Miss M. Lonergan, RN BScN Ed) were recruited.[698] When the RPN program was developed and defined, an affiliation program in psychiatric nursing opened, students and nurses to the Mental Health Services (MHS) were oriented, in-services programs delivered, a post-basic program for senior RPNs opened, and a psychiatric aide training program began.

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[696] 'Committee on Nursing Services in B.C.', 27 November 1950, Folder - Nursing Department - Psychiatric Nurses Association - 1947-1967 1-20-38 Volume 1, B.C. Archive. The committee included the Faculty of Medicine at UBC, high level provincial officials, representatives from the RNABC and hospital and medical associations, the inspector of nursing, the director of Public Health Nursing, and substantial representation from the mental health areas including the head male nursing instructor from the PMH, the director of Mental Health Services from PMH, and a representative from the BCPNA.

[697] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1960'.

[698] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1964', 1965, UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0371058. With the new hires came opportunities to reorganize according to their interests. Margaret Lonergan was appointed to the position, but was enrolled in graduate studies at the University of Washington until April 1960. After completion of her Master's degree she resumed her administrative responsibilities in the Department of Nursing Educator in October 1963.

The number of applicants for the two-year course grew. Entrance requirements included an academic standing greater than Grade ten, and an aptitude for psychiatric nursing.[699] In comparison, the 1935 Nurses (Registered) Act set the minimum age of nursing student at nineteen and required junior matriculation (grade twelve) as the minimum education requirement for entry to a BC nursing education program.[700] Beginning in August 1959, a long-awaited clinical teaching program was introduced for both the RPN students and affiliating RN students. This coordination of the theoretical and practical aspects of the curriculum was further emphasized the following year.

Of note, the school offered education to more than RPNs because training for all staff was deemed beneficial to patient care. Beginning in 1953, psychiatric aides were given a one-week course in their first week of employment.[701] A study and reorganization of the School of Psychiatric Nursing began in April 1959. By December of that year several changes were implemented, and many were in the process of finalization. The Department of Nursing Education–Mental Health Services was organized into three programs.[702]

1. Two-Year Psychiatric Nursing Program – Enrollment November 20th, 1959, was 177 women and 72 men.

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[699] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1960'. The Psychiatric Nursing Course graduated sixty-three students (49 women and 14 men) who received their diplomas on April 16, 1959, at the Vincent Massey Junior High School auditorium. Each month over 100 people requested and received information and application forms for the course. It was possible to enroll large classes in the spring and fall of the year (for example, 64 women and 23 men in August, and 57 women and 28 men in February). In November 1959, a survey of 253 students enrolled in the course shows that 24.9 percent had University Entrance (Grade 13) and 31.2 percent had Grade 12.

[700] College of Registered Nurses of British Columbia, '100 Years of Nursing Regulation 1912-2012' (College of Registered Nurses of British Columbia, 2012), https://www.bccnm.ca/Documents/z_centennial/download/CRNBC-Centennial.pdf.

[701] 'Mental Hospitals Report, 1952-53'. The Psychiatric Aide Training Program was developed under the premise that all members of the nursing staff required instruction to provide the best nursing care for patients. Plans were made to develop an aide-training program course for men and women psychiatric aides.

[702] 'Appendix #1 - Department of Nursing Education Mental Health Services', 15 December 1959, GR 0133 British Columbia. Mental Health Branch. Box 15 Folder - Committees - Mental Health Services Nursing Council Minutes, Dec. 1959- Marc. 1962, B.C. Archive.

2. Two-Month Affiliation Program in Psychiatric Nursing – for general nursing students from Schools of Nursing across BC. Plans were to renew the program for an increase to Twelve-week length starting March 7, 1960.
3. Psychiatric Aide Training Program –. Planned for men and women psychiatric aides in Provincial Mental Hospitals, Crease Clinic and Homes for the Aged (Port Coquitlam).

Clinical Instructors were hired with the expectation that they would teach across all three programs, in the wards and in the classroom. The Department of Nursing became responsible for the administration of the nursing student residences.[703] A Basic Rotation Plan (dated December 15, 1959) provided a comparison of the old and new plan for RPN Students. The following tables use the same verbiage as found in the archival documents.

Old Rotation	**New Rotation**
Three Fields of Learning: 1. Open Wards 2. Closed Wards 3. Bed Ward	Two Fields of Learning: 1. Bedside Nursing 2. Junior Psychiatric Nursing
Students divided into six groups, two for each experience to cover AM and PM shifts.	Students remain in one area (up to sixteen weeks on psychiatric wards)
All students served a portion of time on relief or ward coverage.	Minimum amount of relief or ward coverage to be asked by nursing services.

Table 5.3 - First Term Clinical Experience (6 months)

[703] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'. This included Nurses' Homes 1, 2 and 6 (men students), 7 (affiliates), and 11 (contained the Nurses Infirmary which also became the responsibility of the Department of Nursing).

Old Rotation	New Rotation
Three Fields of Learning: 1. Admitting 2. The Woodlands School 3. North Lawn	Two Fields of Learning: 1. The Woodlands School 2. Intermediate Psychiatric Nursing
Students divided into six groups and rotated similar to first experience	Men and women students divided in half.
Minimum number allowed for night duty as required by nursing services (male students were seldom required on nights).	First half in second term lectures went to Woodlands School to receive orientation and seven days of lectures followed by planned rotation.
	After 12 weeks, returned to Essondale and switch with the other half.
	Essondale group placed on suitable wards for intermediate experience in Psychiatric Nursing for 12 weeks.
	Very minimum relief and night duty required.

Table 5.4 - Second Term Clinical Experience (Six months)

Old Rotation	New Rotation
Three Fields of Learning: 1. Psychiatric Nursing (active treatment) 2. Medical Surgical 3. Discharge	Two Fields of Learning: 1. Senior Psychiatric Nursing 2. Medical-Surgical Nursing
Students divided into groups for rotation with allowances for ward coverage, relief, and some night duty as required.	Students divided into convenient number of groups (differing male and female areas due to difference in nursing of students and number of wards used).
	Groups rotate with longer stay in one area.

Table 5.5 - Third Term Clinical Experience (Eight months)[704]

A contract for the construction of a new nurses' home and RPN School was granted on April 12, 1956, at a cost of $985 667. The building was completed in November 1957.[705] It was hoped that the provision of improved nursing accommodation would lead to increased applicants and nursing students, an increased number of faculty, and improve nurse retention because of the

[704] Of note geriatric care experiences were planned for first and third term.
[705] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'.

single room living for 100 nursing students. The RPN School moved into the new building in June, 1958, and the Nurses' Home was occupied by female nursing students in March, 1959.[706] The large classrooms and demonstration-rooms made it possible to increase the size of the classes.

Expansion of the RPN School (1960-1969)

Into the 1960s the RPN program, RN affiliate and specialty education, and other staff training was expanded; it peaked in the late 1960s and then rapidly declined until the school closed in 1973. A well attended In-Service Educational Program was an integral part of ongoing education organized by nursing services.[707] The psychiatric aide program began offering a five-day course for the staff entering Service or becoming staff at Dellview, Riverview, Skeenaview, and Valleyview Hospitals, The Tranquille and Woodlands School, and Vista and Venture.[708] The psychiatric aide program took up a majority of instructors' time, with only forty percent of their time assigned to teaching in the RPN program.[709] Psychiatric Aides were used to supplement the nursing shortages. In 1966, a new policy was established that all psychiatric aides required a five-day training which encompassed 735 hours of instruction for 274 aides entering the Mental Health Services Branch.[710]

Registered nurse education on care of mental health patients

[706] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'. Men students moved from the attic of the West Lawn building to the old nurses' home.
[707] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1960'. For example, several instructors participated in the in-service education program arranged by the nursing services in the Crease Clinic and Mental Hospital. Miss W. Van Est gave eight lectures to Occupational Therapy staff. Mrs. I Smith, senior instructor of the affiliate program, held eleven lecture-discussions with the nursing staff in the North Lawn Building.
[708] 'MHSB Annual Report 1966'.
[709] 'MHSB Annual Report 1966'. A four-month time study conducted in the 1965-66 fiscal year was conducted on instructor time spent teaching.
[710] 'MHSB Annual Report 1966'.

A close relationship was maintained between the RNABC and the BC School of Psychiatric Nursing. In BC RN education in mental hospitals had become an integral part of nursing education as evidenced by the expansion of the affiliate program following its inception in 1935. A second instructor at the RPN School was added to accommodate this by increasing the hours of lecture, class projects, and clinical supervision on the wards. The affiliate students were not hospital employees meaning they did not have a requirement to fulfil hospital service, so unlike the RPN program, their three-month psychiatric foundation was focused on education. There was an identified need to strengthen the supervision of the students.[711] The availability and optimal utilization of MHS for educational purposes prompted formal and informal discussions with representatives of the RNABC, the Health Branch, and the UBC.[712] The Nurse Consultant, a position created in connection with reorganization plans in nursing departments throughout the MHSB, was tasked to meet with medical and nursing administrators, and executive officers of the Branch along with participating in recruitment activities.[713]

Developing Standards in Psychiatric Nurse Education

In 1960, the rotation plan for the clinical experience of students was reviewed by a committee composed of nursing service and nursing educational personnel. Several changes were introduced for the mutual benefit of students and the three hospitals where students gained experience and were employed. This included a three-month program of instruction and nursing practice planned and conducted by the staff of The Woodlands School for the RPN students

[711] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'.
[712] 'MHSB Annual Report 1966'.
[713] 'MHSB Annual Report 1966'.

following their second-term classes.[714] In January 1960, the planning for the post-basic program for senior psychiatric nurses began, with eighteen students selected by nursing services from the thirty-five applicants starting on March 28, 1960. The purpose of the program was to give additional education to RPNs in supervisory and charge nurse positions. The format was lecture, discussions, and tours that were held three afternoons a week for three months with the hope to make it available for senior psychiatric nurses in other units.[715]

A Combined Program

Considerations were being made about how to best move forward with education for the care of mental health patients. The National Advisory Committee on Mental Health had appointed a special sub-committee a decade earlier, in 1955, to carry out a complete study with reference to the training of mental hospital nurses. The sub-committee was asked to explore a curriculum and study the operational requirements necessary to establish a combined program with the expected outcome to initiate a pilot training project in BC. It was hoped that a satisfactory standard might evolve for the dual training of RNs and RPNs which would be acceptable to all provinces.[716] The separate RPN profession was developing across the Western provinces but since it was not in Eastern Canada one wonders why they did not realize that this goal would be unmet. In BC input was sought from RNABC for recommendations about moving forward with RPN education in the province. In the December 1966 report for nursing, M.M Lonergan, Director of Nursing Education and Nursing Consultant for the Education Centre at

[714] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1960'. A clinical instructor at The Woodlands School hired to maintain and expand this program.
[715] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1960'.
[716] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957'. Evelyn Mallory, Director of the UBC School of Nursing chaired the committee. Also on this committee were Dr. Gee (Superintendent), R.H. Strong (Chief Male Psychiatric Nurse) and Edith Pullan (Director of Nursing for the Mental Health Services).

Essondale, stated that the RNABC Committee on Nursing Education had reviewed the PNA's draft syllabus and the Psychiatric Nurses Act. Their recommendation was for a unified general nursing basic-education with mental health specialization rather than a separate RPN entry to practice program.[717] This report was obviously ignored.

A study on psychiatric nurse education

In October 1960, the MHSB, with the assistance of a federal mental health grant, began a feasibility study to explore establishing a combined program (experimental in nature) to educate RPNs and RNs in BC, and, if feasible, set the objectives and the means through which this would be achieved. In the late 1960s there was a shift in the goals of the nursing consultation for the MHB toward changing standards of nursing and nursing education because questions were rising about the best way to move forward with education of nurses in mental health.[718] The Nurse Consultant, Lonergan, RN, began discussions with the Vancouver City College and the RNABC for the purpose of exploring education opportunities for RPNs in 1967.[719] None of these proposals proved successful and I found no archival evidence to support the reasons why.

Aligning coursework and clinical experience

In the 1960s the RPN program faculty at the school improved the connection between classroom content and clinical experiences. The curriculum committee used its meetings to prepare material for the revision of the curriculum, to create course objectives, and to identify required learning experiences.[720] The student experience in intensive-treatment areas emphasized

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[717] Margaret M. Lonergan, 'Report for the Month of December, 1966 - Nursing', 17 January 1967, Box 16 69-716 Folder - 1.10.02 Department of Nursing Education - Monthly Report 1964-1966, BC Archive.
[718] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'; Lonergan, 'Nursing Report December 1966', 17 January 1967. In the monthly reports prepared by Lonergan criticisms were made about the syllabus submitted by RPNABC.
[719] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'.
[720] Five thousand two hundred and eight hours of formal academic-clinical teaching was recorded for this program, indicating an average of 372 hours of planned structure teaching by each instructor Pearkes and Black.

learning about interpersonal relationships, the use of therapeutic milieu, rehabilitation methods, and participation in team nursing and the student experience continued to be about treatment focused on the development of skills in group work.[721]Courses were developed to support experienced RPN student clinical rotations with "mentally retarded,"[722] (at Woodlands School) and older adult patients. Courses in the care of the "mentally retarded" also provided educational experience in psychiatric and pediatric nursing, to connect the academic and clinical content, and an instructor was appointed for geriatric nursing, in which experience focused on learning bedside nursing care.[723] These changes coincided with the early stages of deinstitutionalization. Boschma found that in the Alberta mental institutions a change in emphasis from institutional custodial care to rehabilitation and discharge affected RPNs education and practice.[724] The same happened in BC, with RPN school curriculum changes to support psychiatric nurses in fulfilling these changing roles.

Changing needs – educating nurses for the community

Specialty education was developed for RPNs to work in community mental health settings. These changes helped RPNs adapt to the changing mental health care in the province that was shifting away from delivery in the large-scale mental institutions to regionally delivered services. Nurses from community mental health centres met in conferences for the first time in November 1967. Regular meetings continued for the purpose of education, communication, consultation, and cooperation. Groundwork began in preparation for a study of the role of the nurse in a community mental health centre.[725] Unfortunately nursing shortages persisted despite

[721] 'MHSB Annual Report 1966'. Efforts were made to communicate to the staff nursing service the objectives of student learning experiences.
[722] Mentally retarded was the term used in the documents of that time.
[723] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'.
[724] Boschma, 'Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950-1980'; Boschma, 'Community Nursing in Alberta'.
[725] Loffmark, 'Mental Health Branch Report, 1967/68'.

the numerous organizational changes and strategies implemented to build the nursing workforce within the MHSB.

Qualification exam - professionalization stalled

In the mid-1960s steps to advance RPN as a distinct nursing profession moved forward but challenges included salary discrepancy between RNs and RPNs, poor working conditions, and stalling of a new Psychiatric Nurses Act. Association members were frustrated with the inaction of the provincial government following the submission of a new program syllabus in 1966.[726] In 1968, the legislature passed a bill establishing the Registered Psychiatric Nurses' Association of BC (RPNABC), which gave psychiatric nurses a greater voice in their basic education and increased their professional status.[727] The new RPN Act set a new standard requirement of passing a written qualifying exam, ensuring tighter controls over members education levels.

The affiliate program

The affiliate program was developed to increase the RN student's understanding of people and their emotional needs, and to help them develop some skills in providing nursing care for psychiatric patients in addition to helping inform them about mental health, mental illness, and mental hospitals so they could become potential resources in the community.[728] The purpose of the affiliation course was to enable the RN students to increase their knowledge and skill in psychiatric nursing, to accept their role and function effectively in the psychiatric setting, and in

[726] Leslie Peterson, 'A Fight for Survival', *The Vancouver Sun*, 27 May 1971.
[727] 'An Act Respecting the Registered Psychiatric Nurses Association of British Columbia' (1968), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/1065001811. However, this act had still not been proclaimed in 1971 leaving association members working under the old Act.
[728] 'Mental Health Services Report, 1961/62'.

the field of mental health. The affiliate program was created in cooperation with RNABC, six general hospital nursing schools, and the School of Nursing at the UBC.[729]

Beginning in July 1960, a class of twenty-five RN affiliate program nursing students arrived at Essondale every six weeks year-round.[730] The affiliate program was temporarily discontinued in October 1964. When the program resumed in April 1965, an agreement was made between the MHS and each of the three participating schools of nursing on each party's responsibilities.[731] A major change to allow more accountability for the sending nursing school was that the Department of Nursing Education appointed a coordinator responsible for the administration of the program, teaching designated curriculum content, conducting courses for public health nurses, and arranging tours for visiting students.[732] Curriculum was designed to have a body of fundamental content, with each instructor able to modify this to ensure that the affiliation was relevant to the students' home school of nursing curriculum.

Post graduate program

The post-graduate Registered Nursing program was expanded in the 1960s because of the shift in mental health services to community programs and construction of acute psychiatric wards in general hospitals. The format was a short two-to-three-month program in basic

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[729] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1960'. The affiliation program was revised and expanded from eight to twelve commencing March 7, 1960.
[730] This marked the first time that women nursing students had been placed on wards for men patients. The nursing students from the UBC School of Nursing were enrolled in the May and June program, and with the leadership and guidance of Margaret Neyland, their lecturer in psychiatric nursing, they spent half of their clinical experience on four wards in the Men's Division, with plans to continue the placement in May.
[731] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1965'; 'Correspondence Affiliate Program in Psychiatric Nursing', Memo, 1967, Box 16 69-716 Folder - 1-10.02 Department of Nursing Education - Affiliate Program, BC Archive. This was formalized by an exchange of letters. Each school of nursing assigned one of its faculty for the clinical teaching and supervision of its students.
[732] 'MHSB Annual Report 1966'. The program was structured with each School of Nursing assigning one of its faculty for the clinical teaching and supervision of its students. Curriculum was designed with a fundamental base body of knowledge with each instructor able to modify it to align it as an integral part of the students' home school of nursing curriculum. Ongoing issues with knowledge transfer continued with the general hospital schools sending students. To improve these instructors participated in faculty and in-service programs for nursing staff from their home school.

psychiatric nursing. The purpose of the course was for RNs to increase their knowledge in psychiatric nursing. [733] The focus was first on nurse-patient relationship therapy, rehabilitation, and then on group and community relationships.[734] RN programs were embracing the inclusion of psychiatry in nurse education. The last group of students (baccalaureate degree) from the UBC School of Nursing completed its affiliation at the Riverview Hospital in April 1970, because plans were made for them to have their clinical experience in psychiatric nursing at the Health Sciences Centre located in Vancouver General Hospital (VGH).[735]

By the late 1960s the BC School of Psychiatric Nursing turned inward placing priority on the need for staff education in each department via in-services and to support nurses to attend educational events sponsored by other agencies in courses like supervision, psychiatric and geriatric nursing, and methods of teaching.[736]. Interdisciplinary education was developed to shared knowledge amongst the different health care disciplines who worked at Essondale.

Educating male psychiatric nurses

Gender segregation of patients and staff at mental hospitals was discussed in Chapter Four. Like many mental hospitals in Western Canada, until the 1950s, patient care for male patients was delivered by male attendants who did not have access to the same opportunity for

[733] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1960'. The six-month post-graduate course started in October 1960 with eight nurses enrolled in the first class.
[734] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1965'. Instructions of structured teaching and related activities totaled 850 hours. In 1965 the post-graduate program curriculum included 170 academic hours of clinical experience in intensive and continued-treatment wards of Riverview Hospital.
[735] F.G. Tucker, 'Mental Health Branch Province of British Columbia Annual Report 1970' (Victoria: Department of Health Services and Hospital Insurance, 21 January 1971).
[736] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'.

nursing education.[737] The result was a lower standard of care for men patients.[738] To resolve this, in 1937, the BC School of Nursing offered male attendants voluntarily admission to the three-year program alongside female students.[739] However, the start of WWII in 1939, led to discontinuation of this program with only nine men completing it.[740] The majority of nurses were women (including nursing students), but the school provided training for a range of staff who provided clinical care to the mental hospital patients, including RNs. The education of male attendants to become RPNs led to changes in clinical staff composition because previously female RNs had been placed in supervisory positions in the male wards, as Dooley found of the Brandon Mental Hospital.[741]

In the 1950s, hospital care and staffing remained gender segregated. Male psychiatric nurses were an integral part of patient care in the mental health hospitals. Under the leadership of W.L. Pritchard (Psych Nurse and Head Male Nursing Instructor for the RPN program) thirty-two male nurses, the largest class to complete the three-year course of instruction, received their diplomas in the 1950 Annual Graduate Exercise.[742] Pritchard noted that the training and recognition that male nurses received as part of completing the psychiatric nursing program had a positive impact on the position of male nursing personnel within the mental hospitals,

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[737] Hicks, 'Gender, Politics, and Regionalism'; Tipliski, 'Parting at the Crossroads PhD'; Dooley, 'Mental Nurses at Brandon Hospital'. Hicks, Tipliski and Dooley have written about the exclusion of male nurses from psychiatric nursing education in the early years of the distinction in Western Canada with explanations including conforming to feminized nursing care in the general hospitals and using it as a strategy to keep salaries low.

[738] Tipliski, 'Parting at the Crossroads PhD'; Dooley, 'Mental Nurses at Brandon Hospital'; Hicks, 'From Barnyards to Bedsides'. To read more about the history of gender segregated RPN education in the early years of RPN education see the works of Tipliski and Dooley.

[739] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1937'.

[740] 'Male Psychiatric Nurse Program', 1945.

[741] Dooley, 'Mental Nurses at Brandon Hospital'. Dooley found that female nurses in the Brandon Mental Hospitals, likely RPN, were required to perform skilled nursing duties because male nurses received less training yet held the same nurse title.

[742] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'; 'Mental Health Services Report, 1951-52'. Pritchard would later become part of the Council of Psychiatric Nurses established as part of the Psychiatric Nurses Act as appointed by the BCPNA.

increased interest in the profession, and positively changed the attitude of male nursing personnel because they felt they were an essential part of the treatment program.[743] Three male instructors were on staff to both deliver courses and to supervise the students and graduates on the wards.

Hick's analysis of psychiatric nurses in Manitoba points to the influence of gender on the separation of psychiatric nurse education because men leaders of the Western provinces psychiatric nurse association (namely in BC and Saskatchewan) developed a collegial relationship with the male attendants of Manitoba who were seeking RPN status.[744] Hicks concluded that through bringing male attendants into the realm of RPN they increased their strength and power. This differs from the focus of Tipliski's research in which she concluded that female nurses in the province of Manitoba were submissive to the medical authority seeking to control the profession and thus the fracture was solidified.[745]

In BC, many male attendants sought reclassification as RPNs to elevate their status within the mental institutions. Generally nursing was a solidly women-centred profession. Hicks found that during the beginning years of the Brandon Mental Hospital in Manitoba when the focus was on work as therapy many male RPNs served a dual role as a nurse supporting patients and within the hospital functioning with expertise in a masculine skill such as farming.[746] The dependence on patient work decreased significantly toward the end of the 1950s. This decrease in patient population was a desired result of the deinstitutionalization process that gained momentum in the 1960s and 1970s and dramatically changed delivery of mental patient care in BC and the role of psychiatric nurses in the delivery of it. An unintended consequence of the

[743] 'Mental Hospitals Report, 1949-50'.
[744] Hicks, 'From Barnyards to Bedsides'.
[745] Tipliski, 'Parting at the Crossroads PhD'.
[746] Hicks, 'From Barnyards to Bedsides'.

increased discharge rate of long-term patients was the reduction of the population of "working-class" patients whose labour was necessary to the hospital for business operations.[747]

Recruitment of male students in psychiatric nursing. In Saskatchewan, the large numbers of men attendants colluding with men legislators and mental hospital administrators played a crucial role in the development of the profession and the education of psychiatric nurses.[748] In BC there was a smaller ratio of men psychiatric nurses, yet the introduction of male students played a role in the creation of the first RPN act indicating patriarchal influences on the separation of RPN from RN. The number of men students peaked in the 1963-64 fiscal year.[749] Interview participant Heather Horgan (class of 1962) recalled her surprise about the larger than expected number of male students in the program stating, "I think there was more male nurses than I…expected there would be, but…they mainly worked on the male wards".[750] In the final enrollment for the February 1973, graduating class there was a slight increase with seven out of the thirty-seven students being men.[751] To address shortages of RPNs in the mental health services, repeated attempts were made to increase male enrollments, with little success.[752] Male RPN students in BC faced barriers such as the lack of full pay while training and limitations on promotion compared to their prairie province counterparts.[753] In BC many of the men psychiatric nurses were recruited from Saskatchewan and England, contributing to the highest ratio of nurse

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[747] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957', Q 25.
[748] Tipliski, 'Parting at the Crossroads: The Emergence of Education'.
[749] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1965'.
[750] Heather Horgan, Participant Interview - Heather Horgan, audio recording, 12 December 2021. At the time patient care was gender segregated except for The Woodlands School.
[751] 'New Students Enter Class Block', *This Month*, February 1971, Box - 520353486, Folder - This Month 1971, British Columbia College of Nurses and Midwives Archive.
[752] Nikki Moir, 'Psychiatric Field Needs Men Nurses', *The Province*, 15 September 1966, ProQuest Historical Newspapers. In Alberta and Saskatchewan in the 1960s approximately one third of psychiatric nurses were men. This was not so in BC. Only five percent of psychiatric nurses were men in 1966.
[753] Moir.

to patients in the country.[754] While younger men were more apt to embrace the title of nurse, some older staff in the mental hospitals were reluctant to identify with the nurse title.[755]

Professionalization and nurse education

By the end of the 1960s across the Western provinces RPNs sought professionalization in tandem with RNs across Canada. The hospital-based schools of nursing designed to meet the operational staffing needs no longer met the educational needs of the nursing profession. In 1966, the CNA released a report authored by Dr. Helen K. Mussallem (an RN with doctoral education) based on Canada's 170 RN hospital schools of nursing, 16 university schools, 79 nursing assistant programs, an unspecified number of psychiatric nursing programs, operating room technician programs, and midwifery programs.[756] Mussallem strongly critiqued the structure of hospital schools of nursing in which administrators had control and prevented instructors from achieving education goals in preference for service to the hospital.[757] The outcome of this report was the closure of hospital-based schools of nursing in Ontario and Quebec; however in BC hospital-based nursing schools remained open with the last one closing at VGH in 1998.[758]

The 1970s were a time when nurses sought education as a means of professionalization rather than being employees indebted for service to the hospital. The demise of the large-scale

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[754] Moir. The respective ratios across the country were 1 to 6.3 in BC, Saskatchewan second at 1 to 6.9, Manitoba at 1 to 10.0 and Alberta at 1 to 15.2. New Brunswick had the lowest ratio at 1 to 83.3. BC continued to rely on recruitment of foreign trained nurses and nurses from other provinces to meet nursing workforce needs until the 2000s.

[755] Moir.

[756] Elliott et al., *CNA One Hundred Years*.

[757] Susan M Duncan, Margaret R Scaia, and Geertje Boschma, '"100 Years of University Nursing Education": The Significance of a Baccalaureate Nursing Degree and Its Public Health Origins for Nursing Now', *Quality Advancement in Nursing Education - Avancées En Formation Infirmière* 6, no. 2 (17 September 2020), https://doi.org/10.17483/2368-6669.1248.

[758] 'History of the VGH School of Nursing VGH School of Nursing Alumnae Association > About Your Alumnae Association: History of the VGH School of Nursing', VGH School of Nursing Alumnae Association, accessed 30 June 2021, https://vghnursingschoolalumnae.com/about-your-alumnae-association/our-history/.

mental institution posed challenges to the future of RPNs as a separate stream of nursing, raising questions about the need with 1) the move away from institutions into community and general hospitals and 2) inclusion of more mental health curriculum in RN programs. PNABC increased its efforts to organize RPNs and create an image of professionalism akin to that of RNs; pushing to increase the standard of education and align with the goals of RNs to move to the post-secondary educational institution. Beginning in the early 1970s, a major shift occurred in the Western provinces when education programs were transferred from the psychiatric hospitals to colleges and universities.[759] This marked the end of the Riverview Hospital psychiatrists controlling the RPN curriculum. In fact, RPN education in BC was entirely transferred to educational institutions faster than RN education, likely because there were more RN programs and that general hospital boards wanted to maintain their schools of nursing.

School closure and transfer

The first transfer of the RPN program was in 1971, from Riverview Hospital to British Columbia Institute of Technology (BCIT), with the last class graduating from the BC School of Psychiatric Nursing in 1973. The program was launched in 1972, and two-years in length with the first year as foundational, meaning the same at the RN program.[760] The closure of the RPN School appeared to happen suddenly from the perspective of information released to PNABC members.[761] Initially, the plan was to maintain the School of Psychiatric Nursing in the Nursing

[759] Pringle et al., 'History of Canadian Nurse Education'.
[760] Pringle et al. When the training program was transferred to BCIT, there was a concurrent transfer of the authority for the program from the Ministry of Health to the Ministry of Education.
[761] Edith M Paulson, 'Letter to Dr. H.W. Bridge Informing Him of Removal of Student Psychiatric Nurses from the Staffing at Riverview Hospital', Letter, 20 April 1971, Box 16 69-716 Folder- 1-10.02 Department of Nursing Education - General Correspondence 1970, BC Archive; 'Canadian News - Alberta', *This Month*, June 1970, Box - 520353486, Folder - This Month 1970, British Columbia College of Nurses and Midwives Archive. In the PNABC monthly newsletter published June 1970 it was mentioned that A. Porteous, Assistant to the Deputy Minister, on behalf of the MHB reassured the Association that there was no plan to phasing out or shut down the RPN school, however by 1973 a transition plan was in place to move the program to BCIT. As early as 1971 correspondence was

Education Centre on Riverview Hospital grounds but this fell through, under pressure from the Deputy Minister of Mental Health.[762] This was a misdirection because as early as 1971, Victoria MHB meeting notes indicated that confidential meetings were attended by M.N. Lonergan, Nursing Consultant, about the transfer.[763] The final two classes graduated from the school in 1973, ending with the 43rd ceremony as the final one.[764] Plans were made for the continued use of the Education Centre facilities by the BCIT and its RPN and RN programs and arrangements for BCIT to assume responsibility for providing a qualifying examination service for RPNs not eligible for registration.[765]

Adaptability and Perseverance of RPNs in BC (1974-2006)

The last BC School of Psychiatric Nursing class graduated from the Riverview Hospital program in 1973 but RPN education persisted. This section is divided into two sections, the separation of psychiatric nurse education from service to the hospital (1974-1995) and the pursuit of a degree program (1996-2006).

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exchanged from Edith Paulson, Acting Director of Nursing Education, to Dr. H.W. Bridge, Director of Mental Health Services, Department of Health Services and Hospital Insurance informing him of the removal of RPN students from the staff compliment at Riverview Hospital.

[762] George C. Wooton, 'Letter to R.A. Stewart, President of the Psychiatric Nurses Association of British Columbia about the Location Change of the Psychiatric Nursing Training Program.', Letter, 28 February 1972, Douglas College Archives. In correspondence between R.A. Stewart, President of the PNABC and leaders of two local colleges (Douglas Regional College and BCIT) it seemed that preparation was made to move to post-secondary, with Douglas College as the frontrunner. An apologetic letter from Stewart was sent to Wootton, explaining that in a special meeting of the Provincial Council held on February 17, 1972, the Council members voted to involve the PNABC in the proposal presented to the Deputy Minister. A decision was required that evening which resulted in leaving the program in a service-based hospital school of nursing. The full circumstances of the decision were not explained in the letter.

[763] 'Victoria Mental Health Branch Staff Meeting Notes' (Mental Health Branch, 6 December 1971), B.C. Archive; 'Victoria Mental Health Branch Staff Meeting Notes' (Mental Health Branch, 29 November 1971), B.C. Archive; 'Mental Health Branch Headquarters Staff Meeting Notes' (Mental Health Branch, 13 March 1972), B.C. Archive. Dr. F.G. Tucker, Deputy Minister of Mental Health Chairman of the MHB had already reported at the March 13, 1972 meeting that the Treasury Branch approved for the transfer of the nursing education program to BCIT.

[764] 'Annual 1973', 1973. There were twenty-eight graduates in that class.

[765] 'Mental Health Branch Report 1973'. These arrangements were made with the RPBABC which assumed responsibility for the registration of psychiatric nurses on the proclamation of the RPN Act in June 1973.

From Service to Student (1974-1995)

Douglas College, in New Westminster, BC played a pivotal role in the education of RPNs from its inception in 1970. The college was involved with nursing through its service to nursing groups, primarily via the Psychiatric Nurses' Association.[766] Douglas College was involved in the programming for professional upgrading courses for graduate RPNs beginning in the summer of 1970.[767] Such a goal was accomplished in cooperation with the RPNABC, individual nurses, directors of major provincial mental health care facilities, and the provincial MHB.[768] Education faculty at Douglas College were keenly aware of the increased need to focus on care delivery at the community level while decreasing emphasis on the institutional approaches. This strategy involved striking a fine balance of preparing RPNs to meet the current demand of the mental institutions while also maintaining awareness of future trends.

Douglas College brought together an advisory committee to resolve the conflict between the systems.[769] Prior to this no educational institution was engaged in the preparation of RPNs at the basic or post-basic level to work in the community system.[770] The need for the program was apparent as evidenced by the MHB's decision in 1974, to develop a curriculum for a condensed

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[766] 'Douglas College Nursing Programs - Submission to the Registered Psychiatric Nurses' Association of British Columbia For Continued Approval of the Psychiatric Nursing Program', April 1979, Douglas College Archives. In the first four years of operation Douglas College provided courses to RNs, RPNs, and LPNs.

[767] Prepared by Douglas College, 'A Presentation to The Department of Education and The Department of Health and Hospital Insurance Regarding A Post-Basic Certificate Programme in Psychiatric Nursing', 15 May 1974, Douglas College Library Archives.

[768] Prepared by Douglas College. RPNABC and individual psychiatric nurses funded this. In 1974 Douglas College offered eight non-credit courses and a wide variety of credit courses. RPNABC and individual nurses identified that ongoing professional development was necessary for upward mobility within the civil service system, and to provide new skills and concepts to improve patient care. Approximately 1000 students had been served with a total of 27 200 student hours.

[769] Prepared by Douglas College. The original advisory committee membership was created in March 1972. It consisted of eleven members from RPNABC, Riverview, The Woodlands School, Douglas College, and Valleyview Hospital.

[770] Prepared by Douglas College. In September of 1974 partial funding from the Department of Education enabled the college to hire a Programmer in health services. With the Programmer in consultation with the expanded advisory committee a revision of the original draft of the post-basic curriculum was in the final stages of preparation.

program for nurses employed in community facilities. While the short program met the emergent need, it ineffectively met long term goals, necessitating the development of a comprehensive community psychiatric nursing education program.[771]. This aligned with senior nursing administrators, the RPNABC, RNABC, RPNs, and the Department of Mental Health need for post-basic preparation of RPNs with clinical expertise in the community settings.[772] The expected outcome of the program was to effectively prepare RPNs to deliver care and be resources in future leadership roles, act as a mechanism to disseminate new concepts in health care, and to change social policy.[773]

Basic psychiatric nursing education

The first RPN basic education program to open in BC was at BCIT, followed by a second program opening at Douglas College in 1975. The BCIT program was structured with two intakes per year, one starting in January and the other in August.[774] The program was considered a success because of low attrition.[775] Demand seemed high for RPNs, with the Douglas College

[771] Prepared by Douglas College. The structure of the program was a two-semester Post-Basic Certificate Program in Psychiatric Nursing to begin in September 1974. Maximum enrollment was 70 students in the first year. The total proposed budget was $71 250 including staff, teaching supplies, and rental space to deliver the course. The course structure was deliberately designed such that nurses could challenge certain courses. The program focused on clinical expertise in community psychiatric nursing. The objective was to encourage development of skills, attitudes, and knowledge congruent with the needs of a changing mental health care system. Prerequisites to the program included completion of a foundational course in psychology and sociology, and a minimum of one year of practice within a clinical setting. The program offered a mix of theory and practical courses including a course on Principles of Teaching and Leaning which examined learning theories and teaching methods in adult education. It was noted that the Principles of Teaching and Learning course could be included in the main core nursing course because much of the nurse's role involved assessment of health knowledge.

[772] Prepared by Douglas College. Douglas College was the institution chosen to provide the program because of their past commitment to psychiatric nursing, and continued responsibility for community services and education leadership to support such a program.

[773] Prepared by Douglas College.

[774] 'Proposal for the Gradual Transfer of the BCIT Psych Nursing Program to Douglas College - Commencing with 60 Students in September, 1984', January 1984. The length of the program was 5 semesters delivered over 2 years and 4 months with a 2 month break each year from mid-June to mid-August.

[775] 'Proposal for the Gradual Transfer of the BCIT Psych Nursing Program to Douglas College - Commencing with 60 Students in September, 1984'. Sixty students started at each intake, with approximately 55 entering the second year of the program and 45 graduating from each class.

RPN program set to open in September 1975.[776] The Douglas College program structure differed from BCIT because all students like at BCIT completed a foundation year; however, they could choose to take the RN route or the RPN route after completion of that first year.[777]. Despite high hopes that the program would meet provincial mental hospital needs, Douglas College announced dropping the basic RPN course for fall of 1976, because of a shortage of applicants.[778] Student autonomy of program choice resulted in only four students selecting the RPN route. Registered Psychiatric Nursing students in the first basic program had expressed their belief that their program was geared to RN and not RPN goals.[779] Faculty concerns arose regarding emphasis on psychological components of nursing care.[780] Changes were also necessary to clearly define RPN practice and curriculum.

Meeting workforce demands - changing needs of psychiatric nurses

The shift from inpatient, institutional-style nursing to specialized practice (namely forensic and community mental health services) directly impacted the continuing education that practicing psychiatric nurses pursued and demanded. Registered Psychiatric Nurses faced constraints in the workplace such as lack of flexibility with only a full-time shift rotation option that was not suited to women nurses who had children. Marleine Wagner who graduated in 1959,

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[776] 'Second Program to Open at Douglas', *This Month*, February 1975, Box 520353485 Folder - This Month 1975 Volume 7, British Columbia College of Nurses and Midwives Archive, https://onedrive.live.com/?cid=470B2949FE17011C&id=470B2949FE17011C%215698&parId=470B2949FE17011C%215207&o=OneUp.

[777] 'Douglas Cancels Basic Program for Now', *This Month*, August 1976, Box 520353485 Folder - THIS MONTH 1976 Vol 8 No 6 - 10, British Columbia College of Nurses and Midwives Archive, https://onedrive.live.com/?cid=470B2949FE17011C&id=470B2949FE17011C%215708&parId=470B2949FE17011C%215207&o=OneUp.

[778] 'Douglas Cancels Basic Program for Now'. The College had already enrolled its 1976 class using the same criteria. However, they were considering changing the 1977 plan for enrollment to instead directly enrolling into the Psychiatric Nursing program.

[779] 'Faculty Meeting - Minutes' (Douglas College - Health Services Division, 21 November 1977), Douglas College Archives.

[780] 'Faculty Meeting - Minutes'. To remedy this an orientation workshop was scheduled for the RPNs on January 18, 1978. Faculty were encouraged to attend the workshop.

recalled that after taking seven years off from 1966 to 1973, to raise her children, she was only able to return briefly, again quitting her full-time position because of the lack of part-time and casual options. Her manager informed her that there was a new unit opening for patients who were nearing discharge to provide support before their transition to the community. The new unit hired on-call staff. Before part-time and on-call options were available, women RNs and RPNs put their nursing career on hold, or left nursing altogether after having children.[781] At that time there were limited options for childcare and social norms relegated women as the primary caregiver of children. However, those nurses who returned to the workforce sometimes faced a culture shock as Marleine Wagner recalled:

> I hadn't been there for seven years, and I went back in '73. I couldn't believe the difference. It was like going onto another planet. Honest to God…the number one rule you starched your uniforms, it took a half a day to get dressed, by the time you got your clothes on and then your bib on, and your hat and all the rest of it. All of a sudden everybody was buying their own uniforms. And you called Head Nurses by their first name and, you sat, you just stayed in your chair if the doctor came in…and even the patients, by that time [I went back] the patients, they had men and women on the same wards…. There were different things that were…big changes, really big changes. A lot more medications. And for having been away for seven years, and then coming back to that. It was quite the quite the shock, believe me.

Noella Pertch recalled that after leaving Riverview in 1974, she went to work with her husband, a commercial fisherman until 1975, when the fishermen went on strike.[782] At that time "there was a hiring freeze on at Riverview," but she was able to gain employment at the rehabilitation unit, Hillside, because it was considered a separate hospital.

The Douglas College model – blending nursing and psychiatry

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[781] A decade later forty-seven percent of female nurses were married. McPherson, *Bedside Matters*. In McPherson's history of Canadian nurses, she found that in 1951 only twenty-five percent of female practitioners were married.
[782] 'Fish Talks Halt, Strike Today', *The Province*, 25 July 1975, The Province (1956-2010), ProQuest Historical Newspapers, http://www.proquest.com/hnptheprovince/docview/2380143250/C334DBB8C7574888PQ/27?accountid=14474.

By 1977, Douglas College had developed a comprehensive program with the intent of maximizing graduate's vertical and horizontal career mobility. It emphasized commonalities among the various categories of nursing, provided independent study and self-learning, and provided an opportunity for students to progress at their own pace when possible.[783] The intention of the two-part program was to prepare graduates to provide safe nursing care in a variety of settings at different levels of competence, and pursue eligibility to apply for registration as RPNs or RNs. Students could leave school after completing Phase One (first year) and could return later to continue their training in Phase Two.[784] The curriculum consisted of nursing theory, practice laboratory and clinical experience. Courses were taught by faculty in biology, psychology, sociology, English and counselling. Students who successfully completed their registration requirements with RNABC were eligible to apply for entry into the third year of the baccalaureate degree program at UBC (and other Canadian universities).[785] The numbers of students who graduated from the RPN program at Douglas College remained low until the program at BCIT closed in 1984 (see Table 5.6).

[783] 'Nursing Programs Information Sheet - Effective April 1, 1977' (Douglas College Health Services Division, 1977), Douglas College Archives.
[784] 'Nursing Programs Information Sheet - Effective April 1, 1977'. The program was divided into 2 phases, three semesters in length. A career laddering model was used. Completion of Phase 1 prepared students to the level of a Practice Nurse (LPN). RN and RPN students completed the same first year courses. The LPN would be able to organize and implement nursing care for individuals whose physical and psychological equilibrium was relatively stable, but who required assistance primarily with activities of daily living. Phase 2 was divided into two streams, one designed to prepare graduates to the level of RPN, and the other to the level of RN. Experience in clinical choice was planned in the sixth semester of both streams to provide opportunity to integrate theory and practice, and to develop beginning leadership skills in a specialized setting. Completion of Phase 2 led to eligibility to apply for registration in their field of training (either RN or RPN).
[785] 'Nursing Programs Information Sheet - Effective April 1, 1977'.

	1978	1979	1980	1981	1982	1983	1984
BCIT (RPN)	152	158	100	180	180	200	220
Douglas (RPN)	110	12	0	15	15	15	15
BCIT (RN)	121	103	60	120	120	120	120
Douglas (RN)	12	84	220	175	175	120	120

Table 5.6 - Psychiatric Nursing Enrollment 1978 - 1984

Advancing Professionalization - establishing Practice Standards (1974-76)

In 1974, the Psychiatric Nurses Association of Canada (PNAC) and its member associations approved a recommendation which established a national committee to develop Standards of Practice for RPNs. Each provincial association established a Standards Committee, composed of representatives from the professional psychiatric nurses association, the provincial registering or licensing body, the educational facilities, and the employers.[786] The process of establishing practice standards began with formalized documentation of entry to practice competencies which were solidified with creation of refresher courses for those psychiatric nurses who ceased practice for various reasons such as marriage and having children. Standards of practice solidified the RPN scope, including their growth in forensic and community mental health nursing. Consultation services were necessary to understand the scope of psychiatric nursing beyond the tertiary inpatient psychiatric institution, namely community mental health and general hospitals. Clear articulation of the objectives of RPNABC is necessary to understand the scope and future planning of the organization with respect to developing the profession of RPN and subsequently the appropriate education.

[786] Psychiatric Nurses Association, '"Working Paper on Standards of Practice for the Psychiatric Nurse" (Revised)', *This Month*, April 1978, Box 520353485 Folder - This Month 1978 Vol 10, British Columbia College of Nurses and Midwives Archive.

The constitutional objective of the RPNABC was to "promote and maintain an enlightened and progressive standard of RPN education and practice, and to foster means and opportunities to enable members to maintain and increase their competence in the practice of their profession".[787] The Association's prime responsibility was to develop and maintain those activities which enabled it to meet its objective and obligation to govern the RPN Act.[788] The Standards formed the base of inter-provincial reciprocity agreements, and performance evaluation. They also guided disciplinary action, the development and evaluation of continuing education programs, peer reviews as required in accredited hospitals, and members as they planned for their continuing education needs.

The Registered Psychiatric Nurses Association of British Columbia (RNABC) was connected to the PNAC as the overarching body bringing RPNs together in the Western Canadian provinces. The primary aim of the PNAC in developing Standards of Practice was to assure that its membership continued to provide therapeutically safe, competent, and ethical psychiatric nursing care to patients.[789] The RPNAM, SPNA, PNAA, RPNABC, and the Psychiatric Nurses Association of Nova Scotia (PNANS) appointed provincial committees to develop standards of practice.[790] The PNANS was composed of RNs working in psychiatry as there were no RPNS in that province. The purpose of the standards of practice, as those

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[787] Psychiatric Nurses Association, 31.
[788] 'Members Approve New Policy on Labour', *This Month*, June 1975, Box 520353485 Folder - This Month 1975 Volume 7. To carry out these responsibilities the Association articulated the need to have validated knowledge on what, specifically, a RPN should be able to do, and be able to identify distinguishing characteristics of RPN practice from that of other disciplines. The Standards were utilized to guide the professional functions of the Association in meeting its objects and governing the Act. The separation between the Association and Union was on the horizon when RPNABC members approved a new policy on the functions of the labour relations function of the organization on May 23, 1975.
[789] Psychiatric Nurses Association, '"Working Paper on Standards of Practice for the Psychiatric Nurse" (Revised)'.
[790] The "Working Paper" was reviewed by the Psychiatric Nurses Association of Ontario (PNAO). Psychiatric Nurses Association. In accordance with a resolution approved in October 1975 a committee was appointed to develop standards of practice for RPNs in Canada.

developed by the CNA for RNs, was to describe in general terms behaviours expected for an RPN.[791]

RPNs in BC were seeking autonomy from the dominance of RNs who continued to hold nursing positions of authority and leadership in the mental hospital because of their ability to access university-level credentialing.[792] The limitations on RPNs holding supervisory positions were seen by the BCPNA as a move for RNs to retain power rather than a strategy to improve patient care. BCPNA sought to solidify the professional role of psychiatric nursing as self-sufficient and self-supervisory. The proposed strategies were creation of a *Syllabus for Psychiatric Nursing* to direct curriculum, increased entrance requirements to grade 12, inclusion of courses in psychology, psychiatry, sociology, anatomy, physiology, and anthropology to raise the standard of psychiatric nurses, and access to clinical programs in team nursing, therapeutic communication, and counselling.[793]

Entry to practice competencies - rethinking curriculum and structure

The RPN Act was passed in 1973, and this advanced professionalization. Two components of professionalization were the creation of standard entry to practice competencies reflective of modern RPN practice, and the creation of a licensing exam.[794] An important

[791] Psychiatric Nurses Association. The standards were prefaced with the expectation that RPNs required information and orientation to the requirements of the employing agency and the specific programs operating within the agency. RPNs were also responsible for individually maintaining their continuing education. PNAC's position was that Standards of Practice were essential to give direction for professional psychiatric nursing care and encourage professional judgement and creativity, while recognizing that implementation in various practice settings would differ from province to province.
[792] The Psychiatric Nurses Association of British Columbia, 'A Brief to the Committee on the Re-Organization of the Mental Health Services of the Province of British Columbia', 20 June 1967, Folder - Psychiatric Department - Psychiatric Nurses Association - 1947-1967, 1-20-38 Volume 1, British Columbia Archives.
[793] The Psychiatric Nurses Association of British Columbia.
[794] 'Registration Exams Set', *This Month*, November 1976, Box 520353485, British Columbia College of Nurses and Midwives Archive; Psychiatric Nurses Association, '"Working Paper on Standards of Practice for the Psychiatric Nurse" (Revised)'. These two milestones were repeatedly referred to in the RPNABC newsletter. The RONABC sought self-regulation by setting standards of practice and designing and administering a standard licensing exam.

component of professionalization was the establishment of a unique knowledge base and standard credentialing which registrants obtained by meeting a set of requirements such as completion of academic requirements, completion of clinical hours, and passing an exam.[795]. A standard requirement of licensing for entry to practice was the writing of a registration exam to assess safety to practice. As had already been done with the RNs, passing a universal exam was determined as a requirement after initial registration.[796] RPNABC had one year to develop the examination, in time for the BCIT class graduating in 1974. Unlike the RPN associations in Alberta, Manitoba and Saskatchewan, BC did not have a government appointed council or university to develop its licensing exam.[797] At the time RPNABC framed this as a disadvantage, but the advantage was that unlike the other RPN provinces the BC association retained the autonomy to create its own exam rather than having it created by an external body of non-nurses.

Barriers that RPNABC faced included financial and human resource limitations because the organization was required to develop and pay for its own exam. Unlike the CNA established national exam for RNs, the RPN exam could not be borrowed or shared between provinces because each tested for different competencies. RPNABC appointed a Board of Examiners made up of nursing practitioners, RPNs and RNs with knowledge and a background in psychiatric nursing practice.[798] Twenty nurses, mostly RPNs, learned what type of items (questions) were

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[795] Bernard M. C. Yam, 'From Vocation to Profession: The Quest for Professionalization of Nursing', *British Journal of Nursing* 13, no. 16 (9 September 2004): 978–82, https://doi.org/10.12968/bjon.2004.13.16.15974.
[796] Elliott et al., *CNA One Hundred Years*; Canadian Nurses Association, *The Seventh Decade 1969-1980* (Ottawa, Ontario: Canadian Nurses Association, 1981), https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/The_Seventh_Decade_e.pdf.
[797] Hicks, 'From Barnyards to Bedsides'.
[798] 'Background #2 - Registration Examinations', *This Month*, December 1976, Box 520353485, British Columbia College of Nurses and Midwives Archive. The board was initially chaired by Ross Steward and then by Art Caza. Art Caza was President of RPNABC in 1977. One of the functions of the Board was to contract for item writers' workshops each year.

appropriate for examination, and how to write exams.[799] The first exam was set for March 15 and 16 in 1977.[800]

In 1978, RPNABC began to review the RPN entry to practice competencies. They acknowledged that the curriculum originally established in 1969, was created somewhat at random, frequently based on what members indicated they wanted and what was readily available.[801] Changes in the emphasis on therapeutic mental health care and the transfer of the RPN programs to the community colleges created the need for refresher courses for those nurses who were out of the workforce. The RNABC hoped to move forward with designing future refresher courses based on members' identified needs. The post-secondary institutions communicated a need for specific input about the competencies and skills required by nurses returning to practice after an absence of several years and by nurses changing practice areas. In the RPNABC report on the *Minimal Level of Competencies Expected of Graduate RPN Entry to Practice Skills Survey*, respondents suggested general competencies.[802]

Until the late 1970s the nursing program at BCIT was structured with a foundational first year for all nursing students similar to the nursing program at Douglas College. Perhaps in

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[799] 'Background #2 - Registration Examinations', 2. The process involved writing an item to test registrants safety to practice, requiring standardized exam questions, with only one correct answer. The total number of items needed to cover all aspect to be tested. Item writers were paid for items written. A total of four exams were written, each containing 100 items. The Board of Examiners would then assess the items submitted and select 100 for each exam. The percentage of the other items were changed from exam to exam to ensure that in five years exams could not be memorized. Most of the work was done by volunteers to keep within the $5000 budget.

[800] 'RPNABC Registration Examination Project 1979 Completed', *This Month*, October 1979, Box 520353485 Folder - This Month 1979 Vol 11, British Columbia College of Nurses and Midwives Archive; 'Registration Exams Set'. Exam development was financially supported into 1979 by a provincial government youth employment grant led by UBC Master of Nursing candidate Pat Porterfield.

[801] Committee on Nursing Education and Practice, RPNABC, 'Report on Minimal Level of Competencies Expected of the Graduate Psychiatric Nurse' (Registered Psychiatric Nurses Association of British Columbia, 1978). Refresher course is defined as a course intended to bring the student up to date on previously learned knowledge and skills. An upgrading course was defined as a course intended to teach new knowledge and skills to the student.

[802] Committee on Nursing Education and Practice, RPNABC. Suggested competencies for addition include staff evaluation, leadership ability, legal status, new therapies, medications, transfer and admission, mental retardation, work efficiency, community agency information, first aide, harms caused by restraints, role of family and stress caused by decentralization and deinstitutionalization, report writing, labour relations, dealing with workplace issues, interviewing techniques, techniques related to social learning, reality therapy and psychotherapy.

anticipation of moving the program BCIT began to develop a new RPN program curriculum.[803] Part of the curriculum development focused the final term as a designated preceptorship to provide each student with an individualized intensive interval of practice on the twenty-four-hour clock, and under the supervision of the practicing nurse with general oversight of an instructor.[804] Preceptorships in nursing were a relatively new strategy for nurse education in the late 1970s.[805] While the program seemed successful at BCIT, with ample enrollment, the program would soon move from BCIT to Douglas College, leaving only the RN program. [806]

RPN response to the nursing education study report

The Health Education Advisory Committee (HEABC) was established by the Minister of Education in 1976. In November 1977, the Nursing Subcommittee of HEABC was formed to study nursing programs in BC.[807] The Nursing Education Study Report publicly released in April

[803] 'New Curriculum for BCIT', *This Month*, November 1977, Box 520353485 Folder - This Month 1977 Vol 9, British Columbia College of Nurses and Midwives Archive, https://onedrive.live.com/?cid=470B2949FE17011C&id=470B2949FE17011C%215711&parId=470B2949FE17011C%215207&o=OneUp. A separate department of Psychiatric Nursing was established on July 1, 1977. To support the change the March 1978 class was cancelled, allowing staff to devote time to curriculum development.
[804] 'Preceptorships in the Education of Psychiatric Nurses at BCIT', *This Month*, February 1979, Box 520353485 Folder - This Month 1979 Vol 11, British Columbia College of Nurses and Midwives Archive. In health education the term preceptor was used to describe a practicing professional who agrees to assist a senior student to make the transition from a student to a practitioner by arranging for the student to have clinical experience in close association with and under direct supervision of their preceptor. The preceptorship format was expected to ease transition from student to staff, improving the graduate's ability to assume a full workload more rapidly, increasing their understanding of the administrative aspects of the staff role, and increasing their self-confidence.
[805] Judith Shamian and Rosalind Inhaber, 'The Concept and Practice of Preceptorship in Contemporary Nursing: A Review of Pertinent Literature', *International Journal of Nursing Studies* 22, no. 2 (January 1985): 79–88, https://doi.org/10.1016/0020-7489(85)90018-5.
[806] 'New Curriculum for BCIT'. The Department had its Psychiatric Nursing Program review by RPNABC in 1978. At that time enrollment was 109 first year students and 78 second year students. There were 24 faculty members.
[807] 'Association Reacts to Kermacks' Report', *This Month*, October 1979, Box 520353485 Folder - This Month 1979 Vol 11, British Columbia College of Nurses and Midwives Archive. They selected a research team consisting of a fulltime consultant and a research assistant. The project began on March 1, 1978, with a nine-month timeline and a budget of $39 000.

1979 (commonly referred to as the *Kermacks Report*) was presented to the Minister of Education on December 1, 1978.[808] The second recommendation of the report stated:

> "That the Registered Psychiatric Nurses Act be repealed; and that currently registered psychiatric nurses be eligible to become registered nurses by means of a "grandfather" clause under the Registered Nurses Act."[809]

The recommendation to eliminate RPNs indicated a lack of fulsome understanding of the nuances of their day-to-day practice, as their scope of practice was determined as not different enough from RNs.

The 1970s were a pivotal time for RPNs in Western Canada to solidify its position as a distinct profession. In Manitoba the MARN published a report in 1966, named *Challenge and Change* that called for the elimination of RPNs and LPNs in that province.[810] The recommendations of the report called for a model similar to that used in the USA beginning in the 1960s in which two types of RNs were educated in a two-year diploma (technical nurse) or a four-year degree (professional nurse).[811] The underlying assumption was the planned obsolescence of RPNs who's role was mainly to staff the large-scale provincial mental institutions slated for closure as part of deinstitutionalization.[812] The common belief was that the skills of institutional RPNs were non-transferable to community settings which lacked the structure and rigidity integral to mental hospitals. However, as in BC, RPNs in Manitoba had

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[808] 'Kermack Report Reaction'; Claire Kermacks, 'Nursing Education Study : A Report to the Health Education Advisory Council / by Claire Kermacks. --', Discussion Paper (Province of British Columbia. Ministry of Education, Science and Technology), 1978, https://llbc.ent.sirsidynix.net/client/en_GB/main/search/detailnonmodal/ent:$002f$002fSD_ILS$002f0$002fSD_ILS:342283/ada?qu=kermack&d=ent%3A%2F%2FSD_ILS%2F0%2FSD_ILS%3A342283%7EILS%7E1&h=8.

[809] Kermacks, 'Nursing Education Study Report, April 1979 - Kermacks Report.', viii.

[810] Hicks, 'From Barnyards to Bedsides'. The origin of this report began with the Manitoba Health Minister's Committee on the Supply of Nurses who published a report in 1966.

[811] Norma E. Anderson, 'The Historical Development of American Nursing Education', *JNE. Journal of Nursing Education* 20, no. 1 (January 1981): 18–36, http://www.proquest.com/docview/1026698423/citation/32DF6ADE574E4C37PQ/1.

[812] Hicks, 'From Barnyards to Bedsides'.

been working in the community since the early 1970s.[813] Minister of Health Larry Desjardins did not endorse the recommendations of the report, securing the existence of RPNs in Manitoba.[814]

In BC, the RPNABC responded to the *Kermacks Report* by appointing a task committee to critique the report. The critique was approved by the RPNABC Council on September 19, 1979.[815] The Association's 269-page reaction to the *Kermacks Report* was submitted to the Minister of Health, Education, and Human Resources on September 23, 1979. The RPNABC reaction to the *Kermacks Report* was broadly communicated to members via the association newsletter.[816] The critique was organized in response to the three stages of education presented in the report.[817] The purpose and terms of reference of the project were to identify the nursing care objectives of the BC Ministry of Health, the foundation on which the study was built.[818] The second stage of the project was to develop a profile of nursing skills, a Competency Analysis Profile Systems (CAP). The CAP failed to separate classes of workers in terms of the types of patient problems they encountered, and it did not distinguish the groups of workers whose roles were different in practice, making them appear similar on paper. This led to the flawed conclusion that there was no significant difference between RPNs and RNs. The third stage was to develop a new classification system for nurses. The strategy used was to develop a new

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[813] Hicks.
[814] Hicks.
[815] 'Kermack Report Reaction'.
[816] 'Kermack Report Reaction'; Lorea Amolea Ytterberg, 'Aspects of Nurse Manpower Planning in British Columbia' (Master's Thesis, Vancouver, University of British Columbia, 1980), UBC Open Archive. RNABC also criticized the report.
[817] 'Kermack Report Reaction'. Claire Kermacks was a project consultant who conducted the education study with a research assistant and a summer assistant.
[818] 'Kermack Report Reaction'. The beginning of the project involved developing a profile of required nursing skills, developing a new classification system, and surveying the range of nursing care workers (RN, RPN, LPN, care aide). Five key areas of focus were health promotion, illness/disability prevention, environmental concerns, effective service deliver, and public education and participation. RPNABC endorsed that these were important areas that had been supported by nursing professions for decades but failed to probe local objectives of the provincial ministry and future planning like the future of the large mental institution, patients' implications, and implications for nursing human resources. In the opinion of RNABC there was danger that the skills that most markedly separated RPNs from RNs were omitted.

classification system that organized nursing jobs into five distinct levels.[819] The RPNABC's main critique was that RPN skills were not specifically included in the profile of nursing skills (psychiatry, mental retardation and gerontology specialization were also not included), and psychiatric nursing manpower was excluded leaving them to question any recommendations made for the future of RPNs.[820]

The RPNBAC held the view that the recommendation to transition existing RPNs into RNs would not cause better opportunities or career mobility for existing RPNs.[821] The Association further criticized the report's suggestion that the two existing RPN programs amalgamate with the RN programs because no direction was provided on how this was to happen.[822] The RPNABC did support one recommendation, the increase in RPN baccalaureate programs. The organization held a strong position of advocacy for RPN members to have opportunities and facilitated access to baccalaureate education to meet the need for senior nursing supervisors, managers, educators, and community mental health nurses.[823] On November 22, 1979, Bob McClelland, the former provincial Minister of Health, was described as assuring

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[819] 'Kermack Report Reaction'. The five levels were aide, assistant, nurse I, nurse II, and nurse II. Each level was assigned nursing skills in accordance to the complexity of the skill. This structured failed to include lateral or specialized categories. The strategy to organize the current multi-level classification system that existed in non-standard ways in different services (for example hospital nurses and community health nurses) was not provided.
[820] 'Kermack Report Reaction'. RPNABC hired a consultant who created an inventory of existing positions using position descriptions.
[821] 'Kermack Report Reaction'. RPNABC held their position that it was unreasonable to assume that current employers would simply accommodate these changes. The RPNABC's position stood that ceasing to educate a separate designation of RPNs would leave a staffing gap in existing mental health services, one that was unaddressed by the Kermacks Report.
[822] University of British Columbia. Health Manpower Research Unit., 'Rollcall 77 - A Status Report of Health Personnel in the Province of British Columbia' (Vancouver: Division of Health Services Research and Development, University of British Columbia, 25 January 1979), UBC Open Archive, doi:http://dx.doi.org/10.14288/1.0075985. Curiously, it was identified that roughly 2500 RPNs would need to be made RNs, but according to manpower inventories only 1754 members were active while 601 had inactive status.
[823] 'Kermacks' Report Being Reviewed', *This Month*, July 1979, 4, Box 520353485 Folder - This Month 1979 Vol 11, British Columbia College of Nurses and Midwives Archive. In a subsequent meeting with former Minister of Health, Bob McClelland, the RPNABC was assured that the Kermacks' Report was "just another one of dozens of reports done up, and was not government policy," and that "the Association would certainly be involved in any future plans which would affect RPNs."

the RNABC that there were no formal plans to repeal the RPN Act at the next session of the legislature.[824]

RPNABC concerns about relocation to Douglas College

In the fall of 1982, the Assistant Deputy Minister of Education and his Executive Director of Program Services raised questions with the Vice President of Education at BCIT about the feasibility of shifting RPN education to Douglas College due to Douglas' excess space, and the overcrowding at BCIT. The RPN program was set for transfer to Douglas College despite RPNABC concerns about the future of the program.[825] The associations recommendations were that the RPN program continue as a separate entity, based on the existing BCIT curriculum. The January 1984, RPN enrollment at BCIT was the final program intake.[826] With the transfer to Douglas College there was also a commitment to a full review of the RPN curriculum in consultation with the existing faculty at BCIT.[827]

The concerns of the RPNABC were recognized and the RPN designation persisted. However, the fears and anxieties surrounding the uncertain future of RPNs resulted in decreased enrollment in the two RPN programs in the province (BCIT and Douglas College).[828] Students

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[824] Rafe Mair was named the new Minister of Health November 23, 1979. 'Kermacks Report Discussed with Health Minister', *This Month*, December 1979, Box 520353485 Folder - This Month 1979 Vol 11, British Columbia College of Nurses and Midwives Archive.

[825] 'BCIT Psychiatric Program to Close Move to Douglas Is Definite', *RPNABC Intercom*, March 1984, British Columbia College of Nurses and Midwives Archive. Ongoing changes to the current curriculum consistent with RPNABC accreditation were expected. The Psychiatric Nursing Department would continue was a unit, retaining the faculty and Department Head structure. Basic Health Science and English courses remained taught at BCIT until the final decision was made. The January 1984 intake (60 seats) would be through BCIT, and under BCIT's control, however the physical location would be made to Douglas College.

[826] Gordon Gilgan, 'Letter to William R. Emerton, Chairman Board of Governors, Douglas College', Memorandum, 17 February 1984, Douglas College Archives. BCIT's objective was to ensure continuation of a high quality, viable Psychiatric Nursing program in BC. Douglas College emphasized their belief that changes in responsibility and control could successfully take place, and a viable program maintained if the process suggested was accepted by the Ministry of Education, Douglas College, BCIT, RPNABC, future students, and the Psychiatric Nursing employers of BC.

[827] G.T. Trorise, 'Letter to The Honorable Jack Heinrich, Minister of Education', Memorandum, 29 February 1984, Douglas College Archives.

[828] 'Recruitment Help Needed', *This Month*, February 1980, Box 520353485, British Columbia College of Nurses and Midwives Archive.

considering RPN expressed concerns about the lack of job mobility and lack of jobs outside of the large government hospitals.[829] The RPNABC addressed concerns by explaining that the majority of mental health care was provided in the large, government operated psychiatric, mental retardation, and psychogeriatric settings thus education supported this.[830] Concerns about the lack of mobility were addressed by describing evolution of the RPN resulting from the increase of psychiatric care outside of large institutions.[831] For example, RPNs were increasingly hired in the acute psychiatric wards opened in general hospitals. As of September 1980, RPNs were employed at twenty-five psychiatric units in general hospitals while four general hospitals refused to employ RPNs.[832]

At that time RPNs understood the closure of Riverview was on the horizon. Heather Horgan (class of 1962) described her move to community nursing practice,

> "…in 1980 but then I left Riverview because…that's when the patients were all getting discharged in the community and I decided I didn't want to be an institutionalized nurse forever. You know, [I] took some courses in psychology and left and started working in the community at that time. So, I'm sure Riverview changed quite a bit after that, but…I wasn't there to, to see the changes… I went to Burnaby Mental Health, which was really, the best place that I've ever worked actually. And at first, I went to the… inpatient unit that was not connected to a General Hospital. It was the only…unit in BC at that time that that did that. But it was…a very good steppingstone to then get into the community care teams. You did have a lot more autonomy. They had Team Nursing there where you'd actually…develop the care plans for your patients…And they had meetings every shift that all patients were expected to come to. You kind of develop more counselling skills, I would say, and but you did still do shift work. But then I became a Team Leader there…it was Team Nursing, so you always worked with your same team. And if a person- lot of the referrals came from Burnaby General Hospital from the Emergency

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[829] 'More RPNs in General Hospitals', *This Month*, October 1980, British Columbia College of Nurses and Midwives Archive, https://onedrive.live.com/?cid=470B2949FE17011C&id=470B2949FE17011C%215729&parId=470B2949FE17011C%215207&o=OneUp.

[830] 'More RPNs in General Hospitals'.

[831] 'More RPNs in General Hospitals'.

[832] 'More RPNs in General Hospitals'. Lion's Gate Hospital (LGH) located in North Vancouver was the first general hospital to employ psychiatric nurses. The four hospitals that refused to hire RPNs were the largest general hospitals in the province including Health Sciences (UBC), Vancouver General Hospital (VGH), Royal Columbia Hospital (RCH), and Surrey Memorial Hospital (SMH). The numbers of nurses working in general hospitals increased from 182 in 1978 to 182 in 1980.

> Department…They had two really good Day Programs there at the time but because of all the budget cuts, well quite a few years ago, those Day Programs got cut. But one…was for…chronically ill patients. You know teaching them things like assertiveness training and…the other Day Program first of all was for the higher functioning patients. You know, some of them worked [paid jobs]. And they'd learn things like stress management, and assertiveness training too. And they were just very good programs…the nurses…spoke with the doctor all the time. You were much more involved with the planning and treatment…I went to one of the community teams in Burnaby, in…1989.

Similarly, Lorraine Lyons (class of 1969) who left Riverview in 1982 spoke about the impacts she saw with respect to the downsizing,

> "…there were some aspects…where you'd see. Of course…I wasn't there when they really were closing Riverview…people were kind of having plans to…put patients out in the community or clients out in the community with supports. But I could see the downsizing of Riverview. I definitely saw that, and the wards were being made much smaller and a lot more of the acute care…they had Crease Clinic and Center Lawn, but many more of the acute care admissions went to community hospitals or [patients] were seen by the Mental Health Teams…that was good in many ways, but I think it had a little bit of a negative effect on morale as people kept seeing Riverview kind of downsizing…like they used to have their own laundry, but that everything was, you know, given to other areas….certain services were cut back. I didn't see the real active things in Penn Hall like you used to, and not as much involvement as some of the other disciplines, of course because numbers were cut back and so were certain services".

The downsizing increased when the 1983, ruling Social Credit government began more aggressive cuts to public services.[833] With these cuts the BC government increased the pace at which it originally planned to close facilities that housed mental patients, older adults and the mentally retarded as with decisions such as abbreviating the ten-year plan to close Tranquille School by 1991, to one year.[834]

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[833] 'Hansard — Thursday, July 7, 1983 — Afternoon Sitting', Official Report of Debates of the Legislative Assembly (Hansard) (Victoria, BC: Government of British Columbia, 7 July 1983), 165, https://www.leg.bc.ca/content/Hansard/33rd1st/33p_01s_830707p.htm. On July 7, 1983, finance minister Hugh Curtis of the ruling Social Credit government announced the provincial budget stating, "In every Ministry, in every government office, in every crown corporation and in every public body, restraint measures will be taken".

[834]. Steeves, *Tranquility Lost*; Diane Purvey, 'Thrown Out Into the Community: The Closure of Tranquille', in *Small Cities, Big Issues*, ed. Christopher Walmsley and Terry Kading (Edmonton: AU Press, 2018), 125–46, https://doi.org/10.15215/aupress/9781771991636.01. A major union event that happened was the occupation of Tranquille School in response to its rapid and unexpected closure

Changes to psychiatric nurse education

The 1985, closure of Tranquille School for the mentally retarded triggered action by the RPNABC to retrain the displaced RPNs. The LPN/RPN RN Access Program was an example of a college response to a community need. The RN Access Program responded to both the RN shortage and the displacement of RPNs by offering laid off RPNs a fast-track RN completion program.[835] However by 1991, the majority of RPNs continued to work in psychiatric hospitals (63.3%), and few (only 23 nurses) worked in educational institutions.[836] The major finding of the 1993, nursing workforce study was that all nursing programs in the province, including basic and post-basic programs, expanded or contracted dependent on funding, course demands, and student demand.[837]

The contrast of the level of RPN skills was described by interview participants. Yves Chinnapen, who practiced as an RPN in the UK before moving to BC in 1975, described the difference between his practice in the UK and Riverview stating, "the care was more custodial, you know, than individualized care…and the other thing is, I felt my nursing skills were not fully utilized," further stating, "when I went to community it was a totally different thing altogether". He described the contrast between Riverview Hospital, where he worked as a head nurse from 1978 until 1993, before moving to community work,

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[835] Office of Institutional Research & Planning and Evaluation, 'Program Review Report on the Licensed Practical Nurse/Registered Psychiatric Nurse RN Access Program', Program Review (Kamloops, B.C.: The University College of the Cariboo, 1993), https://tru.arcabc.ca/islandora/object/tru:4941; Cariboo College, 'News Release # 1987/3.3 For Immediate Release' (Cariboo College, 26 March 1987), https://tru.arcabc.ca/islandora/object/tru%3A4383/datastream/PDF/view. In 1991 and 1992 the program expanded to accommodate LPNs and RPNs who were encouraged to upgrade to RNs.

[836] Arminée Kazanjian and Laura Wood, 'Nursing Resources in British Columbia : Trends, Tensions and Tentative Solutions', February 1993, https://open.library.ubc.ca/soa/cIRcle/collections/facultyresearchandpublications/52383/items/1.0048418. In 1991 both RPNs and LPNs could enroll in nursing access programs located in five community colleges in the province to become RNs. Access programs gave RPNs and LPNs the education required in 12-16 months of study and prepared them to write the RN exam.

[837] Kazanjian and Wood.

> "…in the hospital…I mostly was giving out medications, and you know, sometimes you will interact with the patient, not on the big scale. But things like, you know, we have a social worker [who] will do the social work. We have…the doctors and psychiatrists, and they would take the medical and the psychiatric part. We have the…occupational therapists…So, [the] role was more or less, like I say, more custodial… [You] make sure they are fed, you know they get their medication, and a big thing was, seclusion…those were the things that we did. But that changed when I went to the community…we did have some challenges because when we went to the community, some of us had difficulties, being accepted in the community. We were seen as coming from Riverview, from an institution as quote, "institutional nurses". So, as if we don't know anything. But we made a big difference in the community. That's where I started doing my assessments. I started doing my nursing care plan. I was…a case manager….I was it….I was the only person…that was a big change…for me. I remember my first two weeks in the community, I went to the manager and said, "do you have a social worker?" "Oh yes," they said, "Yves, you're it"…you were a case manager…you were the primary therapist. And you're also the clinical case manager. Oh, and you have all those resources around you. And so, you know, the clients are yours…"

By 1993, RPNs were solely educated in a two-year program offered at Douglas College that allowed them to practice in psychiatric settings. In Kazajian's 1993, report the entry to practice level was described as "in a manner equivalent to RNs after their psychiatric nursing preparation".[838] Those RPNs who were trained at the basic level were limited to the jobs at Riverview Hospital and at the general hospitals that had become the sites that delivered acute psychiatric care. Registered Psychiatric Nurses worked alongside RNs in these inpatient services, but both nursing designations required post-basic education to work in areas considered specialties: community, child and adolescent, geriatric, and forensic mental health.

To ensure the level of post-basic education was available to working nurses an Advanced Diploma Program was opened at Douglas College in the 1991/92 academic year.[839] The program was open to RPNs and RNs to prepare them for working in specialty areas that included community child and adolescent, forensic, gerontology, and services for the mentally

[838] Kazanjian and Wood, 16.
[839] Douglas College, 'Douglas College Calendar 1991-1992': (Douglas College, 1991), ARCABC, https://arcabc.ca/islandora/object/dc:4716.

handicapped. The theoretical nursing model guiding the program for the Advanced Diploma stream was the Neuman Systems Model.[840] Use of this model framed primary, secondary, and tertiary nursing prevention interventions for retention, attainment, and maintenance of optimal client system wellness.[841] The care model at the existing programs at Riverview Hospital was changed to focus on rehabilitation aimed at maximizing quality of life and retaining independence, which was consistent with the standard of care prevalent in the community mental health care in BC and across Canada and the USA.[842] The model of curriculum development for RPN education aligned with the trends in care models of mental health care.

A new curriculum

The Baccalaureate of Health Sciences (Psychiatric Nursing) Program, developed by Douglas College, was accepted by the Open Learning Agency in late October 1992.[843] This change came ahead of the 1993 recommendation of the PNAC that RPNs needed to enhance their entry-level diploma education to complete in the changing world of work.[844] Douglas

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[840] Betty Neuman, 'The Neuman Systems Model in Research and Practice', *Nursing Science Quarterly* 9, no. 2 (1 April 1996): 67–70, https://doi.org/10.1177/089431849600900207; Karen S. Reed, 'Adapting the Neuman Systems Model for Family Nursing', *Nursing Science Quarterly* 6, no. 2 (1 April 1993): 93–97, https://doi.org/10.1177/089431849300600209; Douglas College, 'Douglas College Calendar 1991-1992'. The Neuman Systems Model is a comprehensive, flexible, and holistic model based on a systems perspective that focused on response of a client system to actual or potential environmental stressors. The Neuman Systems Model became the guiding model for the psychiatric nursing program as evidence by its use in the basic psychiatric nursing program curriculum guides starting in 2004 when many of the advanced diploma programs became part of the basic nursing program. It remained the guiding model for curriculum development in documents examined for this project until the 2012/2013 academic year.

[841] Douglas College, 'Douglas College Calendar 1991-1992'; Douglas College (), 'Douglas College Calendar 1994-1995': (Douglas College, 1994), ARCABC, https://arcabc.ca/islandora/object/dc:5957; Douglas College (), 'Douglas College Calendar 2003-2005': (Douglas College, 2003), 200, ARCABC, https://arcabc.ca/islandora/object/dc:12031. Neuman's model is not psychiatric nursing specific model but was applied to developing curriculum for the family nursing, and health assessment courses.

[842] Robert E. Drake and Eric Latimer, 'Lessons Learned in Developing Community Mental Health Care in North America', *World Psychiatry* 11, no. 1 (2012): 47–51, https://doi.org/10.1016/j.wpsyc.2012.01.007.

[843] Brigid Ting, 'Douglas College - Developing a Caring Curriculum', *The RPNABC Profile*, Winter 1992, British Columbia College of Nurses and Midwives Archive. The program was forwarded to the Ministry of Advanced Education, Training and Technology for review, approval and granting of degree status.

[844] Brian Douglas Larson, 'The Future of Psychiatric Nursing Education in Canada', *The RPNABC Profile*, Winter 1993, Box 520353485, British Columbia College of Nurses and Midwives Archive. PNAC developed a position

College faculty in the RPN Diploma Program grappled with issues of designing a new curriculum at the start of September 1993.[845] Faculty were looking ahead to shape a curriculum to support that image and identity of RPNs within the context of practice for the year 2000 and beyond.[846] Collaboration between RPNABC, partners in clinical practice, students, and faculty were identified as integral to successfully developing the curriculum with caring as the central nursing value. While acknowledging the focus on scientific education and technical skills helped RPNs evolve its professional image and improve standards of practice through systematic assessment, nursing diagnosis and standard care plans sometimes led to complains of confusing jargon, and treatment delivered in a cold, mechanical and impersonal manner.[847]

A review of basic RPN education

Leaders in the RPNABC recognized that mental health care was growing and changing, thus education also required change. In 1988, a revised curriculum was implemented for the 22-month diploma program that led to a Diploma of Associate in Psychiatric Nursing and eligibility to write the RPNABC registration Exams,[848] Conversations were happening between the RPNABC and the regulatory college about the approach for basic education of diploma-level

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statement on baccalaureate education for RPNs. Comparison was made to the RNs entry-to-practice level which had changed the entry to practice level of baccalaureate degree planned for the year 2000. Recommendations included increasing program flexibility to accommodate those 5500 RPNs already practicing in Western Canada. It was thought that a baccalaureate psychiatric/mental health nursing program could also bridge diploma prepared RNs working in mental health.

[845] Ting, 'Douglas College - Developing a Caring Curriculum'.

[846] Ting.

[847] Ting. They looked to nurse scholar Em Bevis and the concept of the Caring Curriculum to highlight the tendency of modern society to prioritize technology and devalue the traditional caring role of nurses. Four curriculum workshops were scheduled for 1993, with an additional four planned.

[848] Ross Stewart, 'Education for the Future: The RPN and the Changing Practice World', *RPNABC Intercom*, October 1989, British Columbia College of Nurses and Midwives Archive; Elinor Carol Macpherson, 'Manpower Substitution in Mental Health Service Delivery' (Master's Thesis, Vancouver, BC, University of British Columbia, 1988), UBC Open Archive, https://doi.org/10.14288/1.0097652. The program was intended to produce entry-level practitioners for inpatient care in psychiatric, mental handicap, and gerontology settings. While some graduates gained initial employment in forensic, child/adolescent, substance abuse or other specialty settings there was not specialized training in these areas.

psychiatric nurses. RPNABC along with many RPNs across the province recognized that without a degree-level entry-to-practice like that of their RN counterparts they would fall behind in terms of ability to pursue health care leadership opportunities and develop RPN specific post-secondary education. A degree RPN program was not established in BC until 2006. The first RPN degree program opened in the fall of 1996, in Manitoba at Brandon University.[849] Though small, it marked an important step forward in the pursuit of a psychiatric nursing specific degree program for RPNs in Western Canada.

Pursuit of a Degree (1996-2006)

Registered Psychiatric Nurses persisted even with rapid downsizing of Riverview. This was a future that was not anticipated when initial planning for the process of deinstitutionalization began in the 1960s. In this period education of RPNs moved from the hospital-based education system to an exclusively post-secondary model of education. Three psychiatric nursing programs were running in the BC Lower Mainland by 2006, two baccalaureate degree programs and one diploma program.

Remedy for nursing shortages - increasing education funding for BC nurses

In 1997 the CNA predicted national and global nursing shortages of RNs becoming a reality in 1999 when the number of RNs and RPNs in the workforce were nearing 1/3 over the age of 55 (2/3 were over the age of 40), with BC relying on net immigration and inter-provincial migration for approximately half of its nursing workforce.[850] The BC Government strategy for addressing nursing shortages that began surfacing in the latter half of the 1990s included funding

[849] Hicks, *Politics, Personalities, & Persistence*.
[850] Ministry of Health, 'Assess and Intervene - Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia' (Victoria, B.C.: Crown Publications Queen's Printer for British Columbia, 2000), https://www.crownpub.bc.ca/Product/Details/7665003973_S. 860 vacant positions were unable to be filled in 1999 despite active recruitment.

focused on retention of new graduates, increased funding for education, and increasing the number of seats for nursing students by expanding existing nursing programs and creating new programs across the province. These strategies impacted RPNs differently than RNs.

The provincial government had provided $146 million between 2001-2007 to help educate, retain, and recruit the best qualified nurses in BC.[851] In December 2002, $21.5 million of this funding was made available, including $10.7 million from the Ministry of Advanced Education.[852] The funding was used for multiple initiatives, including new nursing education seats, grants for approximately 200 nurses to return to the nursing profession by taking upgrading or refresher courses, and specialty or continuing education opportunities for more than 1000 nurses. This translated into the BC government increasing the number of nursing education seats by 3347 (82%) between 2001-2006, and graduating of over 7500 new nurses. [853].

In the 2006/07 fiscal year the provincial government invested an additional $26 million on a formalized Nursing Strategy, increasing this amount to $28 million in the 2007/08 fiscal year.[854] The impact of these funding increases was limited on the RPN workforce because Douglas College was the only post-secondary institution offering psychiatric nurse education until 2006. In comparison to expanding RN programs the enrollments in the RPN program at Douglas College declined in the 1990s, with only 66 new graduates registered with the CRPNBC

[851] '2006/07 Annual Service Plan Report' (Victoria, British Columbia: British Columbia Ministry of Health, 2007), http://www.gov.bc.ca/health.
[852] Ministry of Health Services, '2002/03 Annual Service Plan Report' (Victoria, British Columbia: Ministry of Health Services, 2003), www.gov.bc.ca/healthservices/.
[853] '2006/07 Annual Service Plan Report'.
[854] '2006/07 Annual Service Plan Report'; Ministry of Health, '2007/08 Annual Service Plan Report' (Victoria, BC: Ministry of Health, 2008). The breakdown was 4909 RNs, 2286 LPNs and 344 RPNs. More than 1200 nurses were supported through various education upgrades and 1100 nurses were re-educated through the Return to Nursing Program. Additional strategies were implemented to address primary care shortages.

in 1998.[855] The reasons for the declining numbers are not definitively known, but it was likely because students chose to enrol in RN programs as opposed to RPN programs. Programs with an excess of applicants receive funding for nursing education from provinces instead of those with decreasing student enrolment.

The future of undergraduate programs in psychiatric nursing

By 2000, there were no longer hospital-based nursing program in Canada.[856] Registered Nurses and RPNs across Canada were educated in the post-secondary educational institutions predominantly in community colleges, and increasingly in universities or university-colleges (defined as community colleges with degree granting privileges). While baccalaureate degrees for RNs were available, it was not required for registration in any province but would soon become a requirement for most provinces. The diploma remained the entry-level to practice education for BC RPNs. Two provinces offered the opportunity for psychiatric nurses to complete a degree program, Manitoba, and Saskatchewan.[857] The Nursing Education Program of the Saskatchewan Institute of Applied Science and Technology (SIAST) offered a collaborative program between the University of Saskatchewan the Nursing Education Program (NEPS).[858] The first entry to the program opened in 1996, and the first degrees granted were in 2000. In BC until 2006, the only option for RPNs to obtain a degree was by completing the Bachelor of Health Science (Psychiatric Nursing) program at the Open Learning Institute.[859]

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[855] Ministry of Health, 'Assess and Intervene - Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia'. The trend for general nursing was rapid increase of applications from 1735 in 1995, to 2622 in 1998 (a 50% increase). In 1998, RPNABC registered 659 new graduates.

[856] Arminée Kazanjian et al., 'Nursing Workforce Study - Volume III An Inventory of Nursing Program Enrolments and Graduates in Canada by Province/Territory, 1998' (Vancouver: University of British Columbia, April 2000).

[857] Hicks, *Politics, Personalities, & Persistence*.

[858] Olfert, 'The Life Cycle of a Collaborative Nursing Program'.

[859] Kazanjian et al., 'Nursing Workforce Study - Volume III An Inventory of Nursing Program Enrolments and Graduates in Canada by Province/Territory, 1998'. Students in the program took 30 academic credits through

Change happened slowly in the development of the baccalaureate psychiatric nursing program in BC. In 2006, Douglas College opened an undergraduate psychiatric nursing degree in addition to keeping the diploma program.[860] That year two additional RPN programs opened, a degree program at Kwantlen Polytechnic University (KPU), and the other in a vocational college, Stenberg College.[861] The push to achieve a baccalaureate-level of entry to practice was advantageous in terms of aligning with the standard of RNs, but additional challenges were faced with the lack of options for an RPN-specific path to attain a graduate-level degree to prepare faculty. Neither of the post-secondary institutions (Douglas College and Kwantlen Polytechnic University) offered graduate programs, limiting the opportunities for graduates of these undergraduate programs to pursue graduate degrees. The immediate result was a shortage of potential faculty for these programs which was similarly experienced in Alberta and Manitoba.[862] The lack of interest in RPNs pursuit of graduate degrees was a similar trend in Australia, a country that had discontinued the separate entry to practice designation of psychiatric nurse in the 1990s.[863]

To address the current and ongoing shortage of faculty a Western Canada-based master's program was created in psychiatric nursing at Brandon University.[864] The theoretical best-case scenario was that RPNs with baccalaureate degrees would complete the program, develop an

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distance education following their completion of the Advanced Diploma in Psychiatric Nursing at Douglas College (there were 57 students enrolled in the 1998/99 year).

[860] Douglas College, 'Douglas College: Psychiatric Nursing (Bachelor of Science)', 2021, https://www.douglascollege.ca/program/bspnur.

[861] Stenberg College, 'Psychiatric Nursing'; Kwantlen University, 'Bachelor of Psychiatric Nursing', Bachelor of Psychiatric Nursing, 2007, https://www.kpu.ca/calendar/archive/calendar05-06/calendar/programs/bpn.html.

[862] Patrick J. Morrissette, 'Navigating the Labyrinth of Canadian Undergraduate Psychiatric Nurse Education', *International Journal of Mental Health Nursing* 19, no. 6 (December 2010): 371–76, https://doi.org/10.1111/j.1447-0349.2010.00687.x.

[863] Felicity Humble and Wendy Cross, 'Being Different: A Phenomenological Exploration of a Group of Veteran Psychiatric Nurses', *International Journal of Mental Health Nursing* 19, no. 2 (2010): 128–36, https://doi.org/10.1111/j.1447-0349.2009.00651.x. In response to low numbers of graduate nurses entering the field of psychiatry Australia psychiatric nurse academics began researching why nurses enter and remain in the field.

[864] Hicks, *Politics, Personalities, & Persistence*.

interest in teaching, and become psychiatric nursing faculty at the post-secondary institutions that offered baccalaureate education. However, limitations existed related to title disparity, nursing association affiliation, professional identity, societal perception, and regulatory restrictions.[865]

Psychiatric nurse education in Western Canada changed in the 2000s due to changes in mental health and nursing. The closure of specialized inpatient psychiatric programs in BC left many psychiatric nurses working in general hospital acute psychiatric units and in the forensic hospital. The narrow work opportunities continued to limit enrollment in RPN programs. The future of RPN education in the province was solidified by the opening of two additional nursing programs located at Kwantlen Polytechnique University and Stenberg College, along with the new baccalaureate program at Douglas College. Psychiatric nurses in the BC workforce increased between 2006 and 2012, from 2051 to 2281.[866]

Chapter Summary

This chapter explored the history of RPN education in BC with the primary focus on the BC School of Psychiatric Nursing. The interconnection between the evolution of RPN education and professionalization was explored to illuminate the social, political, and economic factors that led to the development of curriculum, practice standards, and education delivery in BC with particular attention to the links with the evolving mental health care system. This chapter was divided into three sections based on the beginning years of the psychiatric nursing school (1913-1949), the professionalization of psychiatric nursing (1951-1973), and the move of the RPN

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[865] P. J. Morrissette, 'Recruitment and Retention of Canadian Undergraduate Psychiatric Nursing Faculty: Challenges and Recommendations', *Journal of Psychiatric and Mental Health Nursing* 18, no. 7 (September 2011): 595–601, https://doi.org/10.1111/j.1365-2850.2011.01708.x. It was understood that lack of a doctoral degree required looking outside of their discipline.

[866] Canadian Institute for Health Information, 'Registered Psychiatric Nurses | CIHI', 2021, https://www.cihi.ca/en/registered-psychiatric-nurses; 'Regulated Nurses: Canadian Trends, 2005 to 2009', 2010.

program to the post-secondary institution (1974-2006). Registered Psychiatric Nursing programs were created to meet the staffing needs of psychiatric hospitals. Mobility of graduates was not an obvious concern for those who led and advocated for the separate distinction. However, mobility did become an issue with the move from the hospital-based school to the post-secondary institution. Moving RPN education to post-secondary institutions was a pivotal moment in RPNs' transition to broad mental health care delivery beyond the mental institution.

The final BC School of Psychiatric Nursing class graduated from the Riverview Hospital program in 1973, but psychiatric nursing students continued to have clinical placement at Riverview Hospital. RPNs continued to flourish in BC culminating with the opening of two-degree programs and a diploma program in 2006. RNs played a key role in the inception of baccalaureate-level options because of the earlier establishment of the degree entry-level to practice. This was a future that was not anticipated when initial planning for the process of deinstitutionalization began in the 1970s. Throughout this period the future of RPNs in the province was repeatedly threatened. Ultimately psychiatric nursing as a distinct profession persisted and thrived. Changes in politics, health care funding, education, and nursing affected psychiatric nurse education in BC.

Chapter Six – Caregivers in the BC Provincial Mental Hospital

This final analysis chapter focuses on the evolution of the roles of caregivers in mental health care in BC, as shaped by the development, expansion, and demise of the provincial mental hospital system. The narrative is situated within the greater philosophical shifts of mental illness when treatment moved from the large-scale centralized institutional provincial hospital to regionalized community delivered care in the deinstitutionalization era. The role of RPNs changed in relation to changes in the system. This chapter builds on Chapters Four and Five, in which I constructed arguments about the emergence, development, and persistence of RPN education as a separate nursing profession that was inextricably linked to the mental hospital and care of mental patients to meet hospital and health care workforce needs. It also advanced psychiatry as a medical profession at an opportune time that supported a cohesive transition of RPN education to post-secondary institutions.

The changing social understanding of mental health, medicalization of mental illness, and the increasing classification of mental health patients have led to the evolution of the RPNs' role. The changes in the philosophy of the nursing school, modifications in the curriculum, and alterations in the delivery methods and timings were all part of how RPN education was shaped. The distinct nursing profession, and thus what was considered psychiatric nursing knowledge, was also impacted by psychiatry and the emerging health care professions of occupational therapy (OT), social work (SW), psychology, and non-professional psychiatric aide caregivers. Mental health care in the hospital was influenced by the legal definition of mental patient, caregiving duties of the different staff, needs of the mental health patient, and changing philosophies of care. Caregiving roles are then explored within the context of deinstitutionalization and the move of care delivery to regionalized general hospital-based acute

treatment and community-based services. This chapter is divided into four parts of patient care in the mental hospital that mirror the different eras introduced in chapter 4: the opening and expansion of the mental hospital (1913-1950), growth of hospital-based treatment (1951-1964), deinstitutionalization (1965-1990), and downsizing and closure of the provincial mental hospital (1991-2012).

Birth of the Mental Hospital – Defining Mental Health Patients (1913-1950)

Mental health services in BC were borne in the mental hospital beginning at the end of the 1800s, and were institutionally based across Canada until the mid-1900s.[867] Globally physicians were moving psychiatry forward as a medical profession. Most prominently Sigmund Freud (1856-1939), believed that mental disorders resulted from problems with personality development, sexuality, and the subconscious.[868] Influential physician Emil Kraepelin's approach differed from Freud's. His development of a diagnostic classification system was based on symptoms of mental illness aimed to improve treatment.[869] In BC under the leadership of Medical Superintendent G.H. Manchester, the direction of the provincial mental hospital followed similar direction of treatment to other mental institutions in Canada and the US.[870] Manchester identified Kraepelin as a leader in methods for treating the insane in the mental institutions in the US, setting the standard for the BC Hospital for the Insane to meet to advance

[867] Sussman, 'The History of Mental Health Services in Canada'. Four major changes happened in quick succession from 1913-1949, the collapse of moral therapy, development of an organic neuro-pathological orientation which offered psychiatrists an opportunity to move closer to mainstream medicine, the beginning of a voluntary/involuntary movement, and World War I.
[868] Shorter, Edward. A History of Psychiatry : From the Era of the Asylum to the Age of Prozac. John Wiley & Sons, 1997.
[869] Shorter, *A History of Psychiatry*.
[870] Richard McBride, 'Annual Report on the Public Hospital for the Insane of the Province of British Columbia, for the Year 1903', Sessional Papers of the Province of British Columbia (Victoria: British Columbia. Legislative Assembly, 1904).

patient treatments.[871] Manchester's decisions aligned with the evidence at the time that supported the best designed mental hospital ward should resemble the general hospital. However, this was not possible at the Public Hospital for the Insane (PHI) because of the overcrowding attributed to chronic cases of dementia.

As discussed in the literature review, the overarching treatment of people in the asylum was influenced by the institution architecture, hospital location, and the plans of politicians and superintendents. Chapter Four revealed that the early BC asylum and mental hospitals defined people confined to the mental institution as inmates. An overview of the significant legislation that changed the definitions of mental health patients is provided with an explanation of the impact those laws had in shaping the developing mental hospital and treatment of mental patients. This is followed by explanation of the role of psychiatry which gained legitimacy and prominence as a medical specialty as the provincial mental hospitals in Canada developed and expanded. The same was true for BC. In the 1910s, the growing mental hospital system led by physicians facilitated the rise of mental hospital attendant staff and RNs who gained prominence in their patient care role.

Mental Illness Legislation - Changing Perceptions and Definitions

In the early 1900s an intersecting relationship existed between laws that reinforced the image of desirable Canadians citizens and laws that defined the mental health patient and mental hospital care. The same year that the Essondale Hospital opened (1913) the British Parliament passed the Mental Deficiency Act, from which the government of BC established a special

[871] Fulton, 'Annual Report of the Public Hospital for the Insane of the Province of British Columbia for the Year 1904'.

Mental Deficiency Act in accordance with other Canadian provinces.[872] The mental hygiene movement was growing across Canada (steadily gaining in popularity between 1910-1919).[873] The mental hygiene movement focused on the early detection and prevention of mental disorders in children and influenced the creation of laws defining mental defectives. In BC at the beginning of the 1900s, social attitudes about the feeble-minded changed, fuelled by increased immigration and urbanization. At the time public health nurses who worked in the community played an instrumental role in the implementation of mental hygiene to prevent and treat mental disorders.[874] Mental hygiene dramatically impacted social understanding of mental illness and mental deficiency, positioning them as problems to be addressed and treated by the medical community.

In the 20th century the definition of mental patient shifted significantly between WWI (1914-1918) and WWII (1939-1945) because of the returning soldiers from war, the advances of medical psychiatry and psychiatric treatments, and institutionalization. In the 1920s a complex relationship developed between federal and provincial laws that were used to define desirable citizens and outcasts in terms of country of origin and ethnicity, and in terms of mental deficiency. Federal legislation that was passed in the 1920s influenced the gatekeeping of immigrants defined as mentally defective, specifically Chinese immigrants. Provincially the Lunacy Act was passed in 1924, and it determined the path of patients entering the mental hospital, initially giving judges the power to determine who was deemed fit for admission to the

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[872] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1927', Annual Report, Sessional Papers of the Province of British Columbia (Victoria, B.C.: British Columbia. Legislative Assembly, 1928), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0300550; Rothwell et al., 'Report on the Royal Commission on Mental Hygiene (Appointed under the Public Inquires Act by Order in Council Dated December 30th, 1925)'.

[873] MacLennan, 'Beyond the Asylum'. The movement was initially led by physician Helen MacMurchy in Ontario who publicized many of the social problems the mental hygienists sought to address.

[874] MacLennan; Stogdill, 'Progress of Mental Hygiene Programs in Public Health in Canada'.

mental asylum.[875] The Act gave power to judges to determine the lunacy of a person as "of unsound mind and incapable of managing himself and his affairs."[876] The mental hospital medical superintendent's role was limited to sending the Chief Justice of the Supreme Court a report of the mental and physical conditions of the patient certifying that the patient should remain detained under care and treatment of the mental hospital.[877] The absence of clear physician roles and mental hospital care references shows mental illness was a legal, not medical, issue. Laws shifted in the 1930s to focus on condoning sexual sterilization. Legislation was passed to define the roles and responsibilities of the professions that provided care for those deemed lunatics.[878]

On April 7, 1933, the Legislative Assembly of BC passed legislation named Act Respecting Sexual Sterilization.[879] BC was the second province in Canada to legalize the sterilization of mentally ill and intellectually disabled individuals.[880] The Act specified that those individuals who could be sterilized were patients in custody of institutions defined within the Mental Hospitals Act, Industrial Home for Girls, or the Industrial School Act.[881] Within the school system, feebleminded children were classified as having a medical issue with medical

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[875] 'An Act Respective the Care and Commitment of the Persons and Estates of Lunatics', Pub. L. No. R.S. 1924, c. 149, s. 1., § Chapter 162, 2323 (1924), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/524126576/search/CIVIX_DOCUMENT_ROOT_STEM:(lunacy%20AND%20act%20AND%201924)?3#hit1.

[876] An Act respective the Care and Commitment of the Persons and Estates of Lunatics, 2324.

[877] The report was required annually on the first day of January. An Act respective the Care and Commitment of the Persons and Estates of Lunatics.

[878] 'Chapter 59. An Act Respecting Sexual Sterilization.' (1933), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/1887728313/search/CIVIX_DOCUMENT_ROOT_STEM:(sterilization)?4#hit1.

[879] Chapter 59. An Act respecting Sexual Sterilization.

[880] Mclaren, 'The Creation of a Haven for "Human Thoroughbreds"'; Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (University of Toronto Press, 2013). Alberta was the first province to pass sterilization legislation. The province maintained the longest and strongest eugenics laws.

[881] McLaren, *Our Own Master Race*. The Sexual Sterilization act supported the ongoing medicalization of the school system that began in 1907 when school medical inspection was first instituted throughout the City of Vancouver.

solutions.[882] The Industrial Home for Girls Act, in Vancouver, defined the population covered by the act as females aged sixteen and under who were found guilty of incorrigible conduct, running away or other offences.[883] The purpose of the home was for custody and detention to educate, provide industrial training, and moral reclamation. The grouping of mental patients (which at the time included the feebleminded) and girls in the industrial school shows the broad application of sterilization legislation to control people deemed abnormal using a medical classification, and incarcerated youth. Nurses and attendants provided the care to those patients institutionalized in the mental hospitals primarily in the form of occupation.

From Occupation to Medication - Changing Treatments (1913-1930)

When Essondale first opened in 1913, patient occupation with work was the prominent form of treatment. Using moral therapy designed to occupy patients was prevalent beginning in the mid to late 1800s, but OT (occupational therapy) was not referred to as a formal treatment modality until the 1918.[884] Occupational therapy (OT) was the popular treatment until the late 1920s because of limitations in scientific treatments akin to those found in general medicine. Patients were encouraged to work in the shops, gardens, lawns and in various departments on the farm. The latest evidence in mental hospital reports from 1913 to 1930, revealed that agricultural colonies were important for treating the insane. Italian psychiatrist Dr. Eugenio Tanzi's work on mental diseases at the time was described by Medical Superintendent Charles Doherty as,

[882] Mclaren, 'The Creation of a Haven for "Human Thoroughbreds"'.
[883] 'Chapter 11. An Act for Establishing an Industrial Home for Girls' (1912), 39, https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/2106050001/search/CIVIX_DOCUMENT_ROOT_STEM:(industrial%20school%20for%20girls)?5#hit1. The individuals identified in those acts were classified as inmates indicating that they were prisoners rather than patients.
[884] Maclean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the Year 1918'.

"probably the greatest work ever compiled and issues in the science of psychiatry."[885] Tanzi's work emphasized the necessity of treatment including regular occupation outdoors and living in large communal-style homes with open doors. He identified that the productivity on a farm brought patients happiness and health which became the cure for their insanity.

The creation of Colony Farm was presented as innovative and leading in both occupational treatment and fiscal responsibility, however most mental hospitals across Canada had functioning farms at that time.[886] Throughout the 1910s and 1920s Medical Superintendent Charles Doherty emphasized the numerous patient benefits of work at Colony Farm such as distraction from delusions, refocusing patients on a productive interest, and helping with sleep.[887] Throughout his tenure Doherty repeatedly highlighted these benefits and application of farming skills to patients post discharge in the published annual reports despite the fact that agriculture was a relatively small industry in BC compared to mining, manufacturing, forestry, and fishing.[888] The importance of patient labour was underscored by the idea that mental patients did not necessarily have to be the same burden or drain on society and taxpayers as were the physically ill patients who filled the general hospitals. The mental hospitals were thus self-sustaining.

The Evolution of Nursing Care in the BC Mental Hospital

Nurses (at the time there were only RNs) were integral to the treatment of the insane within the BC mental hospitals. Superintendent Doherty praised the good work of nurses,

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[885] Henry Esson Young, 'Annual Report of the Public Hospital for the Insane of the Province of British Columbia for the Year 1912', Sessional Papers of the Province of British Columbia, 1913, G8, UBC Open Archive, https://dx.doi.org/10.14288/1.0059526.
[886] Edginton, 'Moral Treatment to Monolith'; Moran, *Committed to the State Asylum*.
[887] Men patients were the primary beneficiary of these treatments, since women did not work on Colony Farm. Young, 'Annual Mental Hospital Report 1913'.
[888] Conway F John, *The West: The History of a Region in Confederation* (James Lorimer Limited, Publishers, 1994).

identifying that the efficiencies in the mental hospital depended on the nursing staff.[889] Doherty used very deliberate language in his 1913 annual report stating "we, now, with our well-organized nursing staff, feel confident that our directions will be intelligently carried out, and that the comfort of the patient will be the constant care of the nurse".[890] His words suggest that BC RPNs were part of a broad strategy to elevate the value of the mental hospital, echoing similar findings of Boschma's 2003 study on the rise of mental health nursing in the Dutch asylums.[891] Doherty was constructing a narrative to distance the previous asylum from the modern mental hospital. He praised Provincial Secretary Young for giving the Medical Superintendent autonomy such that "the ignorant, shiftless, lazy, eye-serving, and sometimes drunken attendant of former days is unknown in this Hospital...It was the constant complaint of our immediate predecessors that their best-directed efforts were being effectually thwarted by incompetent nursing".[892]

Though it is unclear where the divide of attendant and nurse lay, what is clear is that Doherty blamed the deficiencies of the previous medical superintendents on incompetent attendant and nursing staff. He and previous superintendents referred to "incompetent nursing" as a barrier to carrying out their "best-directed efforts" of treating patients.[893] Doherty defined the expectation of the nurse's primary role as performing the directions of the physician, with the medical superintendent holding power to dismiss those nurses who did not follow along. Such comments show distaste for the power held by women staff.

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[889] Young, 'Annual Mental Hospital Report 1913'.
[890] Young, H7.
[891] Young, H7; Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920*.
[892] Young, 'Annual Mental Hospital Report 1913', H7.
[893] Young, H7.

Changes in the nurse's role were apparent in the changed classification of nursing staff in the 1920s. Prior to 1921, the Annual Report of Mental Hospitals listed nursing staff and tradesmen together. In 1922, nursing staff at Essondale, Colony Farm, and New Westminster were separated into their own category, including the Matron and Supervisor of Nurses and the Chief Attendant.[894] This shows a shift in perception of the clinical hospital roles as separate from those of tradespeople. Prior to 1920, nursing did not appear to be a priority, as demonstrated by a lack of adequate housing. It was not until 1920, that the Nurses' Home at New Westminster was nearing completion.

Formal shifts in the structure of nursing staff were apparent in the 1921 annual report in which Maria Fillmore, who for many years was the Matron of the New Westminster Asylum, was named as Matron and Supervisor of Nurses.[895] In 1925 two new nursing leader positions in Essondale were created, the Superintendent of Nurses (held by Florence Van Wyck) and Head Nurse (held by Bell).[896] Van Wyck, who had specialized post-graduate training in mental diseases, was the first identified RN to work at Essondale.[897] In preparation for admission to women patients in 1927, an RN, N. Lewthwaite, was appointed to the role of Matron at Essondale.[898] The nurses' role was intertwined with the medicalization of the mental hospital. The yearly reports of the mental hospital stated that they used malarial and tryparsamide treatments for psychosis. They also classified nursing staff with medical staff. The

[894] 'Mental Hospitals Superintendent's Report'.
[895] 'Mental Hospitals Superintendent's Report'.
[896] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925'. Bell's first name was not included in the Annual Reports.
[897] British Columbia Mental Health Branch, 'A Summary of the Growth and Development of Mental Health Facilities and Services in British Columbia 1850-1970'; 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925'.
[898] 'Mental Hospital Report 1927'.

recommendations included a new wing for chronic patients, a building for psychiatric patients, social services, separate facilities for the intellectually disabled, and medical care facilities.

Medical Treatment at Essondale

Occupation was popular until medical treatments that offered the potential of curing mental illness gained prominence. [899] Medical treatments began to appear in the BC mental hospital annual reports in 1913, the year that Essondale opened.[900] Hydrotherapy was the first medical treatment offered; it was a pseudo-scientific treatment generally applied to an array of mental issues.[901] Doherty described it as having superior delivery at Essondale compared to what he had observed in hydrotherapeutic departments in Eastern Canada.[902] Its popularity was influenced by German psychiatrist Emil Kraepelin who began publishing on the practice in the late 1800s.[903] The benefits of hydrotherapy were touted as decreasing use of restraints and sedative medications.[904] Hydrotherapy was widely adopted across North American mental hospitals with proper administration of hydrotherapy identified as an essential component of nurse training in the American state hospitals until the rise of pharmacotherapy.[905]

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[899] Kelm, 'A Life Apart'. Doherty was not a huge proponent of medication use, and he and his staff publicly downplayed the use of chemical and mechanical restraint in the mental hospital in favour of burgeoning medical treatments. Doherty wrote that the use of sedatives impeded mental recovery and that the advent of hydrotherapy eliminated the need for restraint, and drugs like paraldehyde, hyoscine, and sulphonal were often used to sedate disruptive patients.

[900] Young, 'Annual Report of the Public Hospital for the Insane of the Province of British Columbia for the Year 1912'.

[901] Young, 'Annual Mental Hospital Report 1913'; J. Allen Jackson, 'Hydrotherapy in the Treatment of Mental Diseases - Its Forms, Indications, Contraindications and Untoward Effects', *Journal of the American Medical Association* LXIV, no. 20 (15 May 1915): 1650–51, https://doi.org/10.1001/jama.1915.02570460026009.

[902] Young, 'Annual Mental Hospital Report 1913'.

[903] Rebecca Bouterie Harmon, 'Hydrotherapy in State Mental Hospitals in the Mid-Twentieth Century', *Issues in Mental Health Nursing* 30, no. 8 (1 January 2009): 491–94, https://doi.org/10.1080/01612840802509460.

[904] Henry Esson Young, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the Year 1914', Government Report, Sessional Papers of the Province of British Columbia (Victoria, 1915), UBC Open Archive, http://resolve.library.ubc.ca/cgi-bin/catsearch?bid=1198198. Notes on patient's response to treatment identified their increased compliance to rules and social norms as a sign of treatment success and patient recovery.

[905] Harmon, 'Hydrotherapy in State Mental Hospitals in the Mid-Twentieth Century'; Jackson, 'HYDROTHERAPY IN THE TREATMENT OF MENTAL DISEASES'.

Into the 1920s physical examination and physiological causes of mental illness had increased prominence which increased potential of medication treatment as cures. In the early years of the Essondale Hospital, it was noted that medications were not well understood nor effective in many cases.[906] The exception was venereal disease, which accounted for a significant number of mental hospital admissions and was discovered as curable if detected and treated early.[907] By 1925 syphilis (termed general paralysis of the insane) contributed to fewer new admissions which was attributed to the treatment of venereal diseases.[908] At the outset Essondale was designed to support patient segregation and treatment pathways based on illness acuity to improve patient care.

Acute treatment – the psychopathic hospital

Throughout his tenure as Medical Superintendent, Doherty (1905-1920) advocated for the construction of a dedicated building for acute patients. As discussed in Chapter 4, by the end of his leadership he established that the acute building should accommodate at least 200 patients and be fully equipped with the standard equipment of psychopathic hospitals.[909] Essondale was behind its Washington state counterparts in separating care for acute care patients, but the opening of the new admission and treatment building in 1924 put it ahead of Canada's Eastern

[906] Young, 'Annual Report of the Public Hospital for the Insane of the Province of British Columbia for the Year 1912'.
[907] Young, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the Year 1914'. An important part of the mental hospital psychiatrist's work was identifying and monitoring syphilis cases, a disease that led to general paresis. During the 1910s developments were made in diagnosis and treatment of syphilis.
[908] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925'. The detection and treatment was carried out by the Venereal Disease Clinics established by the Public Health Department.
[909] MacLean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the 15 Months Ending March 31st, 1920'; Wickham, 'Into the Void'. Doherty compared the lack of BC's progress to the progress of Washington State in which three similar size mental hospital were constructed within the same time frame

and Prairie mental hospitals.[910] The Acute Psychopathic Unit, known as Centre Lawn, opened after a similar institution in Winnipeg, Manitoba, but ahead of Ontario.[911]

Many of the decisions made in the BC mental hospital were aligned with the direction of Dr. Clare M. Hincks who in 1926, organized the Canadian National Committee for Mental Hygiene (CNCMH).[912] This was after the Mental Hygiene Movement was established in the US. The psychopathic hospital was intended to be a place of scientific research and professional training.[913] As previously discussed, Ontario physicians C.K. Clarke envisioned psychiatry as linked to preventative medicine. Trained ancillary workers were needed to achieve this goal by freeing up psychiatrists from doing administrative work. Additional clinical staff also included specially trained social workers and nurses who would do follow-up and home visits. At the beginning of the 1920s a territorial struggle was happening between the burgeoning hospital-based medical profession of psychiatry and psychology.[914] Classification of patients based on standard criteria became more prominent in the psychiatric hospital, supporting the need to segregate patients as determined by mental disorder.

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[910] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended March 31st 1925'.

[911] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British COlumbia for 12 Months Ending March 31st 1923', Legislative Proceedings, Sessional Papers of the Province of British Columbia (Victoria, B.C.: British Columbia Legislative Assembly, 1924), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0300578. The admitting service located at the PHI closed to centralize services and reduce staff burden. The opening of a stand-alone psychopathic hospital like the ones opening across the United States in the 1920s and 1930s would not happen as Essondale until 1948 when the 300 bed Crease Clinic of Psychological Medicine opened.

[912] Clarence Meredith Hincks, 'The Canadian National Committee for Mental Hygiene', *Canadian Medical Association Journal* 17, no. 1 (January 1927): 97–98, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC406884/. The organization later became the Canadian Mental Health Association (CMHA).

[913] H. C. Hendrie and J. Varsamis, 'Historical Note: The Winnipeg Psychopathic Hospital 1919-1969 An Experiment in Community Psychiatry', *Canadian Psychiatric Association Journal* 16, no. 2 (1 April 1971): 185–86, https://doi.org/10.1177/070674377101600217; Rothwell et al., 'Report on the Royal Commission on Mental Hygiene (Appointed under the Public Inquires Act by Order in Council Dated December 30th, 1925)'. In comparison, the first psychopathic hospital in Canada opened in Winnipeg in 1919. In 1925 the Toronto Psychopathic Hospital opened under the directorship of Dr. C.B. Farrar.

[914] *History of Psychiatry and Medical Psychology* (Columbia, SC, USA: Springer, 2008). Clarke believed that his plans would firmly establish the place of psychiatry within medicine, keeping it from the encroaching psychologists and teachers who were using intelligence tests in Ontario schools.

Psychiatric diagnoses and classification - treatment pathways

The mental hospital era saw psychiatrists gaining power and centralizing in large institutions. In the 1930s and 1940s efforts were made to solidify the necessity of medical treatments for mental patients. Starting in the 1930s, under the leadership of Medical Superintendent A.L. Crease, the patient's treatment pathway began with admission to the Psychopathic Wards.[915] The purpose of this ward was close observation and study of each patient to determine their correct classification and to ensure transfer to a ward with similar patients. Unfortunately, the overcrowding and limited space impeded proper time for observation. The two treatment streams seem arbitrary because they were divided by patients who had five years duration or less of their psychosis, to be centralized and followed up on intensely and those with long-term psychosis who did not respond to treatment. Chronic patients were identified as requiring custodial care, in less expensive quarters on a separate ward from those requiring intensive treatment.[916] The hospital centralized its services and focused its resources on patients who were more likely to respond better to treatments.

Impacts of World War I and World War II

Soldiers returning from WWI experienced psychosis and shellshock. The government response was instrumental in changing mental hospital treatment in Canada.[917] In Eastern

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[915] 'Mental Hospitals Annual Report 1935-36'. In the 1930s annual mental hospital reports diagnostic testing and the importance of lab and other medical equipment was becoming more prominently reported on. Various physicians were involved in diagnostic and lab testing like electro-cardiographic work, x-ray, and lab. Similarly, medical progress in diagnosing syphilis led to the increase of laboratory testing.

[916] 'Department of Provincial Secretary Annual Report of the Mental Hospitals of the Province of British Columbia for 12 Months Ended MARCH 31ST 1937'. In 1937, Crease suggested a plan for the province to establish an intuitional school for the subnormal, to prepare a future site for a Mental Hospital, remodeling the New Westminster PHI for intensive treatment for the patients, and an educational centre for the treatment and a preventative program for the province.

[917] Katherine Jane Kruger, 'Shell Shock: The First World War and the Modernization of Psychiatry in Canada' (Master's Thesis, Guelph, The University of Guelph, 2006), https://atrium-lib-uoguelph-ca.login.ezproxy.library.ualberta.ca/xmlui/bitstream/handle/10214/23409/Kruger_KatherineJ_MA.pdf?sequence=1.

English-speaking Canada psychiatrist's professional medical role was bolstered in their treatment for the problem of shell shock seen in soldiers returning from WWI. Treatment was provided at the mental hospitals.[918] Public awareness of shell-shock in men returning from war helped shift the large mental institutions to focus on making improvements to more broadly treat the mentally ill.[919] Increasing mental illnesses were an outcome of the soldiers who were sent off to war in service of Canada, supporting that all people could become mentally ill, and the responsibility of the Canadian government to take care of them on their return.[920] In the USA, RN professionalization was fueled by an influx of government money for trained nurses, psychiatrists, and psychologists to care for returning soldiers suffering from the consequences of war.[921] Subsequent treatment developments that emerged following World War II fundamentally changed RPNs role in the mental hospital, because of their impact on changing public understanding of mental illness, and also because of the global nursing shortages.

In the post-World War II era moral treatment embodied in the work farms decreased, and psychopharmacology and therapeutic modalities gained prominence in the mental hospital. Plagues by overcrowding, the need to decrease patient population in the mental hospital required a changed definition of mental patients, to identify who should and should not be considered appropriate patients. The Homes for the Aged and Schools for the Mentally Retarded were staffed by nurses, but the focus of care in those institutions was not illness; people that lived in these institutions were not considered patients but rather residents and students, respectively. The economic pressures, the shifting understanding of mental illness, human rights, the development

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[918] MacLean, 'Annual Report of the Mental Hospitals of the Province of British Columbia for the 15 Months Ending March 31st, 1920'.
[919] Deighton, 'The Last Asylum: Experiencing the Weyburn Mental Hospital 1921-1939'.
[920] James H. Capshew and Professor James H. Capshew, *Psychologists on the March: Science, Practice, and Professional Identity in America, 1929-1969* (Cambridge University Press, 1999); Kruger, 'Shell Shock: The First World War and the Modernization of Psychiatry in Canada'.
[921] Shorter, *A History of Psychiatry*.

of effective treatments, and integration of various mental health providers shifted the role that RPNs played in the treatment of mental health patients.

Shifting from occupation to occupational therapy

Occupational therapy (OT) as a profession in Canada developed in parallel with RPNs as a response to caring for people with mental illness. The profession was rooted in the idea that occupying mental patients could reduce use of restraints and improve problematic behaviours.[922] OT was first implemented in the military hospitals in Montreal, Quebec during World War I and was integral to mental hospital functioning.[923] At Essondale the steady increase of patient admissions during WWII and limited funds for hospital expansion led to the conversion of rooms that had been previously used as Occupational Therapy Departments into spaces for patient residence in 1943. The patients work sustaining the hospital was decreasing.[924] The anticipated result was the decreased industrial occupation, meaning greater expenditure was required for mending, manufacturing, and other hospital needs that were being previously fulfilled by patient labour.[925]

Delivery of OT had shifted to the wards which was helpful because activities became accessible to those patients who could not leave the wards. The work was described as helpful to the hospital, and primarily beneficial for patient treatment.[926] The value was evident in funding

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[922] Judith Friedland, *Restoring the Spirit: The Beginnings of Occupational Therapy in Canada, 1890-1930* (McGill-Queen's Press - MQUP, 2011).
[923] W. J. Dunlop, 'A Brief History of Occupational Therapy', *Canadian Journal of Occupational Therapy* 1, no. 1 (1 September 1933): 6–10, https://doi.org/10.1177/000841743300100102. Originally called ward-aides, these young women would help occupy injured soldiers in the military hospitals. Like nursing, maternal instincts and gendered characteristics of women were thought to provide the basic skills for the most beneficial patients interactions. The Canadian Association of Occupational Therapy, led by physician Dr. Goldwin Howland, was organized in 1926.
[924] Patient labour was previously of great importance at the BC mental hospital in the 1910s and 1920s. All occupational departments, including the upholstering, shoe, and woodworking shops functioned at a profit, while the tailor shops showed a $2000 loss.
[925] 'Mental Hospitals Report, 1942-43'.
[926] 'Mental Hospitals Report, 1941-42'.

spent on educating therapeutic staff. For example, D.A. Tisdall in the Occupational Department Women's Building and Admission Service was taking a course at Washington University in St. Louis Missouri to advance treatment at Essondale.[927] After her return in 1945, plans were underway for an expansion of the OT program.[928]

In the 1940s recreation became a larger part of the therapeutic patient experience. Recreation activities included dances, concerts, and picture-shows in the winter, and tennis, baseball, and football in the summer.[929] The pressing need for recreation and entertainment for staff and patients lead to the hiring of staff to organize and deliver recreation. In 1946, a Director of Recreation, W.R. Brown, was appointed to relieve the monotony of institutional life.[930] Under Brown' direction the hospital life was thought to improve with the development of the recreation program described as greatly appreciated by patients, their relatives and friends.[931]

Tuberculosis

Tuberculosis hospitals in Canada reached their peak in bed numbers in 1953, then virtually disappeared in the following decade because of the improvement in preventative medicine and effective treatments.[932] Tuberculosis treatment in BC primarily took place at the city of Kamloops Tranquille Sanatorium that opened in 1907.[933] The 230-bed North Lawn Building for TB patients at Essondale cost $1,648,400 and was officially opened on May 4,

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[927] 'Mental Hospitals Report, 1940-41'.
[928] Pearson, Geo. S., 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31st 1945'.
[929] Pearson, Geo. S.
[930] 'Mental Hospitals Report, 1945-46'. Equipment was purchased for a range of activities including sports, music, and movies (which were shown in the wards using a 16-mm. machine). Music was supplied at the dances and other entertainment. Outdoor music also began to be played on the public address system.
[931] 'Mental Hospitals Report, 1946-47.'
[932] Gregory P. Marchildon, *Making Medicare: New Perspectives on the History of Medicare in Canada* (University of Toronto Press, 2012).
[933] Glennis Zilm and Ethel Warbinek, 'TB Nurses in B.C. 1895-1960 : A Biographical Dictionary' (British Columbia, October 2012), UBC Open Archive, https://doi.org/10.14288/1.0084593.

1955.[934] All patients with infectious disease were transferred to the North Lawn Building, alleviating the spread of diseases in the East and West Lawn Buildings. With the decline of TB in the mental hospitals, North Lawn was reorganized as a medical and surgical centre for MHSB.

Growth of Hospital-Based Treatment (1951-1964)

Federal and provincial legislation about hospital insurance, mental defectives, the provincial mental health centres, management of patients and their estates, and power over who could involuntarily commit patients to the mental hospital were passed between 1951 and 1973. Federal laws passed during this period shaped funding, delivery, and access of Canadians to health care services, including mental health care services. Provincial legislation determined ways for patients in BC to access treatment, dictated mechanism for involuntary and voluntary treatment, defined who would have access and care under the mental health umbrella, and increased mental health patient's rights.

Accessing Voluntary Treatment

The government proclaimed the Clinics of Psychological Medicine Act on January 1, 1951, making access to mental health care a priority.[935] This Act was a significant shift in the trajectory of treatment because it made it possible to admit patients at an earlier stage in their illness. R.A. Pennington halted plans for a new mental hospital for long-term psychotic patients due to the act's passing. Separate types of inpatient accommodations were provided for older adults and mentally defective individuals to reduce overcrowding in the mental hospital. The

[934] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.
[935] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'. Prior to the passing of this act a patient could be admitted to the mental hospitals until their illness had become so serious that for their own safety and for the protection of the community, they were removed from the community by a combination of medical and judicial process.

development of day hospitals and outpatient clinics was a positive step in reducing long-term hospital stays.[936] However, in BC admissions to mental hospitals soared compared to general hospitals.[937]

Program Changes–Segmenting Mental Patient Populations

Across Canada there was a split of special groups into alternate forms of care, particularly geriatric patients and those classified as mentally retarded, to reduce the number of admissions to mental hospitals. These changes were responsive to changes in the definitions of mental patients and mental illness.[938] Mental hospital admission rapidly increased in the latter half of the 1940s. This was attributed to increases in the provincial population, increased life expectancy, improved and increased facilities for care of older adult psychotic patient, improved community relations, and a widening horizon of psychiatry. [939] The result was a greater number of voluntary admissions, and the opening of the Crease Clinic.[940] The program comprised three elements:

1. The West Wing, housing the men's wards (formerly known as the Veteran's Block when opened in 1934)
2. The East Wing, housing the women's wards

[936] Jean Howarth, 'New Mental Centre Arms B.C. for War', *The Province*, 18 March 1957, ProQuest Historical Newspapers, https://www.proquest.com/news/docview/2369030165/E77626DEE6A04779PQ/8?accountid=14474.
[937] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51', 5. On March 31, 1951, 6028 patients were in general hospitals, and 5394 were in mental hospitals, with 200 "defectives and seniles" on the waiting list.
[938] J. Ivan Williams and E.J. Luterbach, 'The Changing Boundaries of Psychiatry in Canada', *Social Science & Medicine (1967)* 10, no. 1 (January 1976): 15–22, https://doi.org/10.1016/0037-7856(76)90134-7.
[939] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'. The purpose of the Crease Clinic was to admit patients for assessment, intensive treatment, and rehabilitation.
[940] Straith and Department of Provincial Secretary. The purpose of the Crease Clinic was to admit patients for assessment, intensive treatment, and rehabilitation.

3. The Central Wing, housed the administrative Mental Health Services (MHS) headquarters and the specialized medical departments for investigation, diagnosis, and teaching.[941]

The Crease Clinic operated under a separate Act (proclaimed on January 1, 1951) from the mental hospital. The Act allowed patients to be admitted for voluntary treatment.

Changing design and delivery of care

Mental patient freedoms and human rights became more important after the 1950s due to better treatments and laws allowing voluntary hospital admissions. The mental hospital was becoming "respectable enough to consider admitting" oneself as a patient voluntarily.[942] This was a dramatic shift towards conceptualizing mental illness as episodic, with the new perspective that once treatment was completed, the patient could return to their community and to their former status as a resident.[943] Shifts in treatment reduced and alleviated symptoms which influenced change in the design and structure of large, controlled and restrictive buildings and wards. Design, policy, and organization structure changed to better meet patients needs and allocate resources, which ultimately changed nursing scope and practice.

In the 1950s, the design of the mental hospital changed in accordance with similar trends across North America.[944] The architecture of new buildings had smaller, functional nursing units adapted to treatment purposes rather than dormitory-style care for custodial care of large groups

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[941] 'Mental Hospitals Report, 1952-53'.
[942] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955', M 18.
[943] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.
[944] Tom Brown, 'Architecture as Therapy', *Archivaria*, 10 January 1980, 99–124, http://archivaria.ca/index.php/archivaria/article/view/10813.

of patients.[945] Superintendent A.M. Gee reported that these changes were part of a philosophical shift to include "environmental therapy" purported as "the greatest single advance in our therapeutic programme".[946] This was in part because of the greater understanding of biological causes of certain illnesses that moved out of the realm of psychiatry (namely epilepsy and syphilis), and more active treatments for patients diagnosed with schizophrenia.[947]

Toward the end the 1950s the model of the large-scale mental hospital became obsolete. The provincial mental health service leaders sought guidance and recommendations from psychiatric leaders who publicly voiced their assessment of an unsustainable centralized institutional model. For example, Dr. Harry C. Solomon, president of the APA suggested that mental hospitals such as Essondale would not be able to adequately staff their institutions if they continued to build more, negating the pursuit of turning them into "true hospitals," because the large populations only allowed for custodial care.[948] BC followed trends across Canada in which social change influenced the downsizing of large (often remote and isolated) mental institutions to community-oriented services and delivery of psychiatric care in general hospital settings.[949]

New models of care were developed to avoid institutionalizing people with mental illness. In Britain, Dr. W.W. Maclay, Senior Commissioner in the Ministry of Health, described

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[945] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'. Gee highlighted that the present-day influences of psychiatry as force in the changing architecture of new buildings doing away with small glass paned windows with steel and building exteriors that were constructed to environmentally restrain patients.
[946] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955', M 18.
[947] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'. For example, general paresis, which previously accounted for 10 to 12 percent of admissions was now eliminated from the psychiatric treatment and treated with medication in the early stages of syphilis. Similarly, epilepsy, which accounted for a significant proportion of long-stay patients was also being managed by medication allowing those afflicted with the condition to live normal lives in the community.
[948] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958', 9. The underlying assumption being that a real hospital was the template for the general hospitals of the time.
[949] Boschma, 'Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950-1980'.

how trends in psychiatry were moving towards community-based treatment to better serve the patient, and the CMHA made similar recommendations in Canada.[950]. Provincial leaders in partnership with medical leadership within the MHS took a proactive role in assessing the mental health needs of the province. The Province of BC sought the services of the APA to conduct a survey of the mental-health needs and resources of BC to assist in creating long and short-term plans for mental-health programs.[951] This assistance, and the repeated referral by MHSB Superintendents to the guidance and approval of APA, point to the authority APA at the time and its influence on the organization of mental health services across North America.

Patient admissions steadily increased in the 1950s. The policy goals for the 1950s included focus on increasing early active treatment to prevent patients entering the long-treatment, mental hospital area, and to alleviate overcrowding.[952] Infectious disease remained an issue with a building for treatment of tuberculosis patients urgently required.[953] The increase in patient admissions led to an increase in scrutiny over the limited resources available for the mental hospitals. It was not economically feasible to house long-term patients as was already known by similar trends in the American mental hospitals.[954] As medical treatments became available that helped ease symptoms of mental illness provincial mental health policies focused on keeping patients in home communities, prevention, and early intervention, and researching treatments for the purpose of discharge. The two policies that guided development of provincial mental health services in the early 1950s were designed to:

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[950] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'.
[951] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'.
[952] 'Mental Health Services Report, 1951-52'.
[953] 'Mental Health Services Report, 1951-52'.
[954] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'.

1. Increase early active treatment facilities to prevent patients from entering the long-term treatment mental hospital.
2. Alleviate the overcrowding conditions of the mental hospitals.[955]

A human rights focus was also coming to fruition resulting from critical social theory and revisionist histories.[956] The result was more accessible service and increases to patient freedoms within the hospital.

Unlocking the doors

As the 1950s progressed treatments shifted. In 1952, MHSB Annual Report Chief Male Nurse W. Creber painted an optimistic picture of male nursing care stating that, "the use of physical restraint had been abolished," and that, "a ward with unlocked doors has been established, whereby patients may come and go at will."[957] In the Crease Clinic two wards became open wards, meaning the doors were unlocked and patients could independently leave the wards. By 1955, there were five unlocked wards in the Provincial Hospital and Crease Clinic (537 patient population).[958] These policies were aligned with those already happening in Eastern Canada. For example, the Allan Memorial Institute in Montreal, Quebec was a mental hospital that had operated on an entirely open basis since 1943.[959] As reflected in the 1955 annual report, the once double locked hospital wards (individual wards were locked along with hospital

[955] 'Mental Hospitals Report, 1952-53'.
[956] Goffman, 'Asylum: Doubleday Gorden City New York'; Foucault, *Madness and Civilization*; Szasz, 'The Myth of Mental Illness'.
[957] 'Mental Health Services Report, 1951-52', Q58.
[958] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.
[959] D. Ewen Cameron, 'Allan Memorial Institute: An Open Mental Hospital', *South African Medical Journal* 32, no. 37 (1958): 921, https://journals-co-za.login.ezproxy.library.ualberta.ca/doi/pdf/10.10520/AJA20785135_39057; D. Ewen Cameron, 'Allan Memorial Institute Reviews 15 Years of Operation as an Open Hospital', *Nordisk Psykiatrisk Medlemsblad* 12, no. 3 (January 1958): 219–20, https://doi.org/10.3109/08039485809131297. The hospital admitted all types of patients including people with schizophrenia, alcohol issues, dementia and mood disorders. Women and men also lived on the same wards.

buildings) removed their locks to enable patients to independently leave their ward and go onto the hospital grounds, and similarly, patient's friends and relatives could freely visit.[960] By 1959, approximately 70 percent of the patients at Essondale were living on open wards.[961]

Schools for the mentally retarded

Once the School for Mental Defectives Act was proclaimed in 1953 the Woodlands School opened.[962] Beginning December 1, 1952, all patients under the age of 6 were directly admitted to Woodlands School. The division of services made it possible to effectively organize programs for the management and treatment of several kinds of patients admitted to the Woodlands School. The homes for the aged were also opened in 1951, allowing for the removal of older adult patients who required longer term care.

Homes for the aged

Additional programs were opened for older adults by the1950s.[963] Long-term patients from WWI and WWII were housed in the west wing of Crease Clinic, but for the Clinic to function as an acute admission and treatment unit, those patients were transferred to a different facility, a new 295 bed building constructed on the Colony Farm. A rehabilitation department was also opened in 1951.[964] In 1953, an additional 500 patients at Essondale over the age of sixty-five were separated from the Mental Hospital, with all new patients over the age of sixty-five being directly admitted to the Home for the Aged.[965] Expansion continued with the 1959

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[960] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'. The so-called "open wards" increased to five in the Mental Hospital and two in Crease Clinic, serving a total of 537 patients.
[961] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'.
[962]. 'Mental Hospitals Report, 1952-53'. Two-hundred eighty two patients were transferred from Essondale to The Woodlands School, alleviating some of the overcrowding at the Mental Hospital
[963] 'Mental Hospitals Report, 1949-50'. The former military hospital in Terrace was renamed Skeenaview Home for the Aged in 1951. One-hundred and fifty-three patients were transferred to Terrace on October 3, 1950.
[964] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'.
[965] 'Mental Hospitals Report, 1952-53'.

opening of an infirmary building, The Valleyview Building, was opened at the Home for the Aged in Port- Coquitlam.[966]

Treatment Changes in BC Mental Hospitals

Provincial mental hospitals were undergoing significant changes, such as centralization and specialization. Between 1948, and 1959, approximately 20 000 beds for mental patients were constructed across Canada; 1000 in general hospitals and small psychiatric institutions, 7000 in institutions for the mentally retarded, and the remaining 12 000 were in the existing mental hospitals.[967] At the end of the 1950s mental hospitals comprised only 5.6% of the total hospitals in Canada but had approximately one-third of the hospital beds.[968] The mental hospital system continued to grow across Canada until it reached the peak of bed numbers recorded in 1961.[969] In BC the 1950s brought change in the established mental hospital system. As the 1950s progressed the population of the mental hospitals ballooned as the population of BC steadily grew (see Table 6.1).[970]

[966] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1960'.
[967] Ivan Williams and Luterbach, 'The Changing Boundaries of Psychiatry in Canada'.
[968] Marchildon, *Making Medicare*.
[969] Marchildon.
[970] John Belshaw, *Becoming British Columbia: A Population History* (Vancouver, BC: UBC Press, 2009).

Year	BC Population Total
1950	1 137 000
1951	1 165 000
1952	1 205 000
1953	1 248 000
1954	1 295 000
1955	1 342 000
1956	1 399 000
1957	1 482 000
1958	1 538 000
1959	1 567 000
1960	1 602 000
1961	1 629 000
1962	1 660 000
1963	1 745 000
1964	1 745 000
1965	1 874 000
1966	1 874 000
1967	1 945 000
1968	2 003 000
1969	2 060 000
1970	2 128 000
1971	2 240 000
1972	2 302 000
1973	2 367 000

Table 6.1 - BC Population 1950-1973

However, with the changes in mental health legislation more and more patients arrived to mental health inpatient services voluntarily, as one-third of the total patient population was voluntary by 1954.[971]

Evolving medical treatment and research

Across Canada mental health was becoming a health care priority. The benefit of widespread implementation of emerging medical treatments was the decreased length and severity of symptoms, which allowed patients to potentially return to society. Starting in the 1950s the mental hospitals used federal mental health grants to support medical and research development. The prevalent experimental medical treatments of the 1940s and 1950s including induced seizure, psychosurgery, and coma therapy quickly waned in popularity when research

[971] 'Mental Hospitals Report, 1953-54'.

showed efficacy of psychotropic medications. Rehabilitation was the focus of treatment. Socialization treatments, occupational and recreation therapies, social casework, and psychotherapy were integral for patient treatment to support their return to the community.[972] As the 1950s progressed health research was focused on increases in medical testing via lab and x-ray.[973] By the late 1950s the combination of medical therapy, talk therapy, occupational therapy, and recreation were emphasized for successful reintegration into community-based social activities that helped lead to discharge.[974]

Lobotomy

With the increase in use of tranquilizers came a decrease in use of lobotomies and electroconvulsive therapy.[975] Lobotomies were an important part of patient treatment throughout the 1950s, but were reserved for patients deemed severe cases, those unresponsive to other types of treatment and those who could not live in the social environment of the hospital.[976] As the decade progressed, it's use waned with very few patients undergoing the treatment.[977] While lobotomies were thought to be always reserved for the most severe, treatment-resistant cases of

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[972] Roberts, 'Psychiatric Treatment and the Future of Mental Hospitals in Canada'.

.[973] 'Mental Hospitals Report, 1949-50'. In the fiscal year ending March 31, 1951, $17 542.03 was received in grant funding with the majority used on purchasing laboratory equipment and training personnel for the largely hospital-based mental health programs. The lab was also used for investigation specific to newly developing psychosurgery, for example to research the cerebral dysfunction in the lobotomized and non-lobotomized patients.

[974] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'. On April 1, 1954, the Neurological Research Centre was formally transferred to UBC to become the Department of Neurological Research.

[975] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'. Only 4 lobotomies were done in the 1957-58 fiscal year.

[976] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'. The peak of lobotomy treatments were in the early 1950s, 48 in 1950, and 39 in 1951. Human lobotomy studies, and experimental lobotomy studies were two research projects that had received financial support from the Mental Health Grant in the 1955-56 fiscal year (the projects received $12 440. 81 and $11 374. 29 respectively). The research was conducted in partnership with the Department of Neurological Research at the UBC.

[977] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'; 'Mental Hospitals Report, 1952-53'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'. A total of 20 were reported in 1953, 11 in 1956, and 4 in 1958. Lobotomies were no longer mentioned as treatment in subsequent reports.

schizophrenia in his 1957, Clinic Director I.S. Kenning stated that, "the 1950 figure [number of treatments] represented a more desperate staff using radical procedures to control chronically disturbed people when there was less in the way of treatment resources. Let us not return to that former state."[978] Connie Hopkins, a former RPN student at the School (class of 1956), remembers that lobotomies were still being done when she was a student, but she never participated.[979] Marleine Wagner (class of 1959) recalled that there might have been "the odd lobotomy done," confirming that by that time the treatment was performed infrequently.[980]

Convulsive and coma therapies

At the end of the 1940s insulin coma therapy continued, but it was identified that many hospitals stopped this treatment due to insufficient staff, and that it lacked a scientific foundation.[981] Experimental convulsive treatments soon fell out of favour with psychiatrists. The treatment was used for those with reasonably good prognosis who had failed to respond to other treatments.[982] Insulin coma treatment was moved from the Women's Division of the Crease Clinic to the male side in October 1959, with male and female nursing staff under male staff supervision.[983] The introduction of a new therapy, prolonged sleep, was introduced for resistant cases of paranoid schizophrenia.[984]

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[978] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957', Q 66.
[979] Connie Hopkins, Participant Interview - Connie Hopkins, audio recording, 18 January 2022.
[980] Marleine Wagner, Participant Interview -Marleine Wagner, audio recording, 5 February 2022.
[981] 'Department of Provincial Secretary Mental Hospitals Province of British Columbia Annual Report for 12 Months Ended March 31ST 1948'.
[982] Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'. For example, electronarcosis was a new treatment that involved a state of coma induced by means of electricity. The experimental nature of the treatment is indicated by the 1000s of patients that were admitted to the mental hospital and small number of patients who received the treatment. In the 1950-51 years 67 treatments were completed.
[983] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1960'. During this time period several research projects were carried out on new medications on ward J 4.
[984] Prolonged sleep was drug induced sleep most often with barbituates. 'Mental Health Services Report, 106-/61'.

By 1960, coma insulin therapy was used to a much lesser extent. Interview participant Fred Hodson (class of 1958) recalled his participation in insulin coma treatments.

> "Residents would get the insulin, and we would…subdue them. We would restraint them with sheets, a figure "x" across their chest and, you know, across the knees…And there was always a doctor present at the time, in the room with us. And they would decide when, who comes out, or what times. And he did teach us, I don't know if we were supposed to do it, but he did instruct us on giving IVs...which worked out really quite good…as I say he would just do the supervising and watch us and, one by one they would come out of the coma insulin. You know, we would unrestraint them, and then it would be shower time, and back to the normal day."

Participant Noella Pertch (class of 1971) recalled her involvement in complex treatments of the time such as insulin coma therapy, describing them as treatment in the "experimental stages." Marilyn Melville (class of 1972) explained that "they were just phasing out coma insulin, I was never part of it, but I did observe as a student a coma insulin treatment."

Psychotherapy

Despite the increasing medicalization of treatments therapeutic relationships were identified as the central feature of the psychiatric hospital. In his 1957 Annual Report, Dr. I.S. Kenning, Medical Director of the Provincial Mental Hospital and Crease Clinic of Psychology Medicine, Essondale, quoted the World Health Organization (WHO) in stating that:[985]

> "The most important single factor in the efficiency of the treatment given in a mental hospital appears to be an intangible element which can only be described as atmosphere. One of the characteristic aspects of the psychiatric hospital is the type of relationship between people that are to be found within it."[986]

Kenning indicated that stable staff who demonstrated optimal interpersonal skills were key to good patient treatment. This highlighted the importance of the human factors and ambiguity of what was considered mental hospital treatment. RPNs were the main clinical staff providing

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[985] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957'.
[986] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957', Q 19.

patient care at Essondale in the 1950s, even though nurses were not specifically named in the annual reports.

Group psychotherapy under the direction of psychologists was also of increasing importance.[987] The three groups identified that were meeting for psychotherapy were the women's rehabilitation ward, the women's lobotomy ward and the men's alcoholic clinic.[988] Multiple interview participants who were in the RPN program in the 1960s and 1970s recalled the importance of group therapy, and first learning about it in their education program.[989]

Changes in treatment –the rise of pharmacotherapy

By the late 1960s treatments such as insulin coma, sleep therapy and hydrotherapy were no longer considered safe and effective mental health treatments. Accordingly, the nurse's role in treatment delivery evolved. Pharmacotherapy and the role of medication administration became a large part of the RPNs role as their value in alleviating and even eliminating symptoms facilitated the goal of hospital discharge. Participant Lorraine Lyons recalled that:

> ...we'd heard about this insulin coma therapy and those baths and everything, but they didn't have any of that when we entered [the program]. It was like group therapy, community meetings. You know your medication the pharmacotherapy was big, you know, and ECT [was still around].[990]

The convulsive treatments that were widely used and praised in the 1940s and early 1950s were being replaced by new medications in the 1960s.[991] Psychotropic medications soon became the prevalent treatment for mental disorders which, in the latter half of the 1950s, included use of tranquilizing drugs, resulting in a decrease in insulin coma therapy and electro-convulsive

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[987] 'Mental Hospitals Report, 1952-53'.
[988] 'Mental Hospitals Report, 1952-53'.
[989] Noella Pertch, Participant Interview - Noella Pertch, audio recording, 21 February 2022; Marleine Wagner, Participant Interview -Marleine Wagner; Heather Horgan, Participant Interview - Heather Horgan; Lorraine Lyons, Participant Interview - Lorraine Lyons, audio recording, 12 November 2021.
[990] Lorraine Lyons, Participant Interview - Lorraine Lyons.
[991] Convulsive treatments include pharmachologic and electrically induced seizure therapies. 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.

therapy.[992] The first medications that had a positive effect on specific psychiatric symptoms of psychosis was chlorpromazine (often referred to as Largactil) and introduced in 1954.[993] The new tranquilizers, including chlorpromazine and reserpine, were touted in the mental hospital annual report as reducing the need for nursing care by reducing symptoms of destructive, agitated and restless behaviours.[994] Marleine Wagner (class of 1959) recalled the popularity of first-generation antipsychotics and psychotropic medications:

> "…then medications, actually we started when the Chlorpromazine had just come in. And when I say just came in, we were using a lot of Chlorpromazine, Thioridazine, Ritalin, Dexedrine… It was actually more, you know what I think [Ritalin and Dexedrine] was, it was like for side effects because a patient would be, maybe too drowsy because of the other medication."[995]

Wagner and Hopkins (class of 1956) recalled the importance of administrating antipsychotic medication as students. They recalled that antipsychotics were especially important for tranquilizing patients who were combative, hallucinating, and delusional.[996] Psychotropic medications described as tranquilizers were believed to ease symptoms that characterized the acute phase of schizophrenia, providing the patient with comfort and relief from severe tension, anxiety, and agitation.[997] Their popularity rapidly rose in the 1960s and 1970s, and were widely

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[992] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957'.

[993] These medications had applications in reducing symptoms but were not viewed as curative agents of mental illness. 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'; H. Azima, 'The Use of Chlorpromazine and Respierine in Psychological Disorders in General Practice', *Canadian Medical Association Journal* 74, no. 11 (1956): 929–31, https://europepmc-org.login.ezproxy.library.ualberta.ca/backend/ptpmcrender.fcgi?accid=PMC1824703&blobtype=pdf; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'.

[994] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.

[995] Interestingly the use of stimulants is not mentioned in any annual reports.

[996] Helen Margaret Jones, 'A "White Cross" Social Centre: An Evaluative Review of the Canadian Mental Health Association Social Centre in Vancouver, British Columbia, Its Origins and Operation, 1959-1960' (1962). At that time phenothiazine and anti-depressant drugs were identified as playing a useful role for treatment of disturbed and depressed patients.

[997] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'.

used at Essondale. As psychoactive drugs became a routine component of inpatient treatment, the administration of these medications became an important part of the RPNs day to day practice. Many medication research trials were funded during this time, particularly for epilepsy and symptoms of schizophrenia.[998]

Changes in Psychiatric Nursing

In the early 1950s RPNs began to carve out a unique position in BC health care and across the Western provinces. The importance of nursing at the BC mental hospitals, particularly RPNs, was clear in the increasing prominence of nurse-focused content in the MHSB Annual Reports published between 1951-1973.[999] These changes were the results of significant changes in psychiatric nursing, beginning in the 1950s when legal distinction of RPNs in the province occurred.[1000] The many changes in the mental health system in the 1950s and 1960s deeply

[998] 'MHSB Annual Report 1966'. For example, a clinical trial was started with haloperidol for psychotic overactivity, tegretol for psychomotor epilepsy, and an injection formulation of phenothiazine for maintenance therapy of schizophrenic inpatients and outpatients.

[999] 'Mental Hospitals Report, 1949-50'; Straith and Department of Provincial Secretary, 'Mental Hospitals Report, 1950-51'; 'Mental Health Services Report, 1951-52'; 'Mental Hospitals Report, 1952-53'; 'Mental Hospitals Report, 1953-54'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1956'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957'; 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'; 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'; 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1960'; 'Mental Health Services Report, 106-/61'; 'Mental Health Services Report, 1961/62'; 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1963'; 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1964'; 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1965'; 'MHSB Annual Report 1966'; Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'; Loffmark, 'Mental Health Branch Report, 1967/68'; 'Mental Health Branch Province of British Columbia Annual Report 1969', Sessional Papers of the Province of British Columbia (Victoria, BC: Legislative Assembly of British Columbia, 1970), UBC Open Archive, http://open.library.ubc.ca/collections/bcsessional/items/1.0373638; Tucker, 'Mental Health Branch Province of British Columbia Annual Report 1970'; Ralph R. Loffmark, 'Mental Health Branch Province of British Columbia Annual Report 1971', Annual Report, Sessional Papers of the Province of British Columbia (Victoria: Department of Health Services and Hospital Insurance, 20 January 1972), UBC Open Archive, http://dx.doi.org/10.14288/1.0373856.

[1000] Hicks, 'From Barnyards to Bedsides'; Peterson, 'A Fight for Survival'.

impacted the RPNs role in patient care. As discussed in the previous chapter the 1950s were a period of integral development to the profession of psychiatric nursing following the 1951 passing of the Psychiatric Nurses Act. Major influences on mental patient care in this period included psychotropic medications and the development of therapeutic modalities as influenced by psychiatrists, psychologists, and occupational therapists. These changed the type of nursing care delivered.

The 1951 to 1964 years also saw a significant development in RPNs professionalization and education. These changes profoundly changed patient treatment because of shifts in the patient-nurse relationship. Registered Psychiatric Nurse professionalization happened at a time when physicians held power in the mental hospital, and allied health professions that included psychologists, occupational therapists, recreation therapists, and social workers became integral to the delivery of patient care within Essondale. Bringing together the hospital and the community became paramount in terms of discharging mental patients and prevention of mental illness. Application of science to treatment was also firmly developed within the BC mental hospitals and psychiatric clinics, positioned as the key to modernizing and converging with the standard of care delivered in the general hospitals.[1001] Registered Psychiatric Nurses had a close relationship with patients in delivering the day-to-day care. Their care activities shifted with increased use of medical treatment, psychotropic medications, and group therapy. In the 1950s, knowledge drawn from psychology, sociology, anthropology, and religion was identified as necessary to improve patient care. With this, appropriate staff training was also identified as a necessity to facilitate the best patient care.[1002]

[1001] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'. In the 1950s and 1960s RPNs across Western Canada were seeking recognition and rights like that of RNs.
[1002] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1955'.

As discussed in Chapter 5 several key factors led to the development of RPNs as a distinct profession in the 1950s. In Western Canada, as identified by Tipliski and Hicks, the pressures of short staffing, gender, and stigma of psychiatric nurses led to control of psychiatric nurse education by psychiatrists in the mental hospitals.[1003] In BC during this time period curriculum was developed for the psychiatric nurse program, an affiliation program for general hospital schools of nursing, for post-graduate nurses seeking knowledge of psychiatric nursing, and for psychiatric aides (who played a prominent role in the delivery of care). Legislation, the changed attitudes toward mental illness, and developments in psychiatry led to the solidification of the RPNs role within the mental hospital as an integral piece of the day-to-day functioning of the hospital. Education was developed to support RPNs in specific mental hospital roles, under medical superintendents' direction.[1004]

Defining scopes of practice–finding nursing solutions

In the 1950s, general hospital services opened at Essondale which stretched the scopes of practice of RPNs, especially because of difficulties in recruiting RNs. A new surgical ward was opened on March 3, 1953, which employed both RNs and male and female RPNs.[1005] The extensive use of the operating-room facilities required operating-room (OR) staff that included three surgical nurses and four male nurses trained in OR procedures and oxygen therapy.[1006] As

[1003] Tipliski, 'Parting at the Crossroads PhD'; Hicks, 'From Barnyards to Bedsides'.
[1004] The Committee on Psychiatric Nursing Standards, 'Syllabus for Schools of Psychiatric Nursing in British Columbia - An Act Respecting the Psychiatric Nurses Association of British Columbia', 1966, Riverview Hospital Historical Society Collection, City of Coquitlam Archive; 'Psych News', *Psych News*, May 1966, Box - 520353486, Folder - Psych News 1964-1968, British Columbia College of Nurses and Midwives Archive; 'Psych News', *Psych News*, April 1966, Box - 520353486, Folder - Psych News 1964-1968, British Columbia College of Nurses and Midwives Archive. Psychiatric Nurses did not have their own curriculum until 1966. It was developed after 16 months of research and evaluation by the Psychiatric Nurses Association of BC. PNABC was seeking a standard of education on par with that of nurses trained in the general hospitals. They sought the return to a three year course and raising the entrance standards.
[1005] 'Mental Hospitals Report, 1952-53'.
[1006] 'Mental Hospitals Report, 1953-54'.

the 1950s progressed the pressing need for more trained nursing staff (both RN and RPN) increased. RNs fulfilled leadership roles, including administrative and teaching positions, and would also be employed as head nurses on wards for care of the physically sick and infirm. [1007]

Loss of nursing staff was a significant issue that began in WWII but continued throughout the 1950s. In 1957, the attrition rate of staff was 35.6 percent, with the highest rate in the women's nursing division.[1008] A five-day forty-hour work week was instated for RPNs and aides effective October 1, 1957, with an increase in seventy-seven positions.[1009] Nursing positions throughout the MHSB were difficult to fill including nursing leadership.[1010] In response leadership was restructured to create the position of Director of Nursing Services, a position based at the MHSB headquarters rather than at Essondale Hospital.[1011] The Director of Nursing Services served two roles, one as a consultant in all phases of nursing throughout the MHSB (encompassing their responsibility to coordinate nursing activities throughout the Branch), and second as Director of the School of Psychiatric Nursing (encompassing responsibility for the direction of the nursing educational programs).[1012]

[1007] 'Mental Hospitals Report, 1953-54'. The distinction in roles and responsibilities of RNs and RPNs was more clearly defined in the 1954 MHS Annual Report. RNs would also be employed as general duty nurses throughout the nursing service.

[1008] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31st 1957'.

[1009] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'.

[1010] 'Mental Health Services Province of British Columbia Annual Report for Twelve Months Ended March 31ST 1958'. In 1958 Edith Pullan (Director of Nursing) left her position to assume the position of Director of Nursing at the Royal Columbian Hospital located in New Westminster, BC. Her position remained unfilled. The Assistant Director of Nursing who temporarily filled the position also resigned in July 1958.

[1011] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'.

[1012] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31st 1959'. A second position, Superintendent of Nurses, became the superintendent of female nursing staff in the Crease Clinic and Provincial Mental Hospital, being directly responsible for the duties there. In September 1958 Mrs. M.L. McKay was appointed as Superintendent of Nurses for the Crease Clinic and PMH, and in December 1958, Beverly Mitchell was appointed to Director of Nursing Services.

A Community Focus–Philosophical Changes

Doors were unlocked, gender integration happened for patients and then staff, the focus of treatment shifted from occupying patients to scientifically tested medical treatments, psychopharmacology, and psychosocial rehabilitation. With the need for patients to be discharged from hospital and resources diverted to the community came shifts in hospital-based treatments. With deinstitutionalization came an increased spotlight on patient rights, and gender integration of patient care. This did not happen in clearly defined timeframes but was influenced by changes in the health care system, understanding of mental illness, and education. Change in the philosophy of mental health changed the knowledge needed to deliver mental health care. Registered Psychiatric Nursing curriculum was shaped by the changing philosophy of care to a rehabilitation focus in which the idea of a continuum of care in which patients moved through the system and back into the community became the norm.

A changing philosophy of care

In 1963, the changing philosophy of patient care within the Riverview Hospital led to a period characterized by organizational changes, including consolidation of services, and the assessment of the goals of patient care.[1013] The new philosophy at Riverview prioritized the rehabilitative aspects of treatment, emphasized the involvement of more of the community outside of the Hospital, and sought to fully utilize internal facilities to optimize patient care.[1014] Nurses took on more leadership roles within the hospital. For example, nurse supervisors became involved in building programs, specific to their areas, which lead to more independence of patients through teaching them to care for themselves and take greater responsibility for their

[1013] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1963'.
[1014] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1963'.

actions.[1015] The philosophical changes within Riverview Hospital aligned with the broader changes happening across North American mental hospitals. These changes were the outcomes of revisionist history of the mental asylums and institutions such a those from Foucault, Perucci, and Goffman, that challenged the evolution of psychiatry and mental institutions as those of steady progress.[1016] The changes influenced a change in caregiving roles at the mental hospitals which reflected the focus on human rights, rehabilitation, and voluntary treatment.

Voluntary treatment – provincial mental health legislation

Mental health legislation for voluntary admission was first introduced in Canada beginning in the 1950s.[1017] Treatment was impacted with the differences between forced and voluntary care. An increasing number of patients sought voluntary admissions to the hospital which necessitated enacting provincial legislation to ensure protection of their human rights while balancing the need to protect the public. The result was the development of the 1964 provincial Mental Health Act.[1018] Several pieces of legislation lead up to this complex piece of legislation.[1019] The major change was the inclusion of a mandatory identification of the medical reason for admission of the patient to the hospital. Admission could be under a formal (involuntary) or an informal (voluntary) basis. [1020]

[1015] 'Mental Health Services Branch Province of British Columbia Annual Report For Twelve Months Ended March 31st 1963'.

[1016] Abraham S. Luchins, 'Social Control Doctrines of Mental Illness and the Medical Profession in Nineteenth-Century America', *Journal of the History of the Behavioral Sciences* 29, no. 1 (1993): 29–47, https://doi.org/10.1002/1520-6696(199301)29:1<29::AID-JHBS2300290105>3.0.CO;2-5.

[1017] Ivan Williams and Luterbach, 'The Changing Boundaries of Psychiatry in Canada'.

[1018] A new MHA was passed at the session of the Legislature in spring of 1964, coming into effect April 1, 1965. An Act Relating to Mental Health.

[1019] In 1964 a study was completed of mental health legislation in the province to provide recommendations for change reflective of the recent advances in psychiatric and mental health concepts. Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1964'.

[1020] Chapter 6. An Act relating to Clinics of Psychological Medicine.; Chapter 207. An Act relating to Mental Hospitals.; Schools for Mental Defectives Act; 'Chapter 304 - Provincial Child Guidance Clinic Acts', 1955, c. 8, s. 1. § (1960), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/2037006151/search/CIVIX_DOCUMENT_ROOT_S

The Mental Health Act attempted to bring the treatment and care of the mentally ill in line with the treatment of physical illness, and to make treatment more readily accessible for those who required it.[1021]To align operational hospital practices and processes with the other legislative changes, procedures were developed in patient admission and discharge and in the review procedures. The result was that in 1965, the Crease Clinic of Psychological Medicine and the Provincial Mental Hospital, Essondale were combined to function as one mental health facility named Riverview Hospital.[1022] The Crease Unit and the Centre Lawn Unit became the designated admitting and active-treatment units.[1023]

In the 1960s and 70s the mental health acts of many Canadian provinces reflected the attempt to balance the rights of the mentally ill to ensure they could exercise autonomy while also receiving appropriate treatment.[1024] At that time the basic principles of the mental health act legislation across Canada was uniform.[1025] On May 26, 1970, the regulations under the MHA

TEM:(mental%20health%20act)?10#hit1; 'Provincial Mental Health Centres Act', 1955, c. 48, s. 1. § Chapter 310 (1960), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/676848735/search/CIVIX_DOCUMENT_ROOT_STEM:(mental%20health%20act)?1#hit1. The Act consolidated all the features of the five Acts dealing with mental health care, treatment, and management: the Clinics of Psychological Medicine Act, Mental Hospitals Act, Schools for Mental Defectives Act, Provincial Child Guidance Clinics Act, and Provincial Mental Health Centres Act.

[1021] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'. Provisions were made in the Act for certain public hospitals to be designated as observation units for the purpose of admitting mentally ill person. The public hospitals designated as observation units were: Vancouver General Hospital, Royal Jubilee Hospital, Lions Gate Hospital, Kelowna General Hospital, Nanaimo Regional General Hospital, Penticton Hospital, Vernon Jubileee Hospital, Kootenay Lake General Hospital, St. Eugene Hospital, West Coast General Hospital, Prince Rupert General Hospital, Prince George General Hospital, Royal Inland Hospital, Trail-Tadanac Hospital, Chilliwack General Hospital, St. Joseph's General Hospital, Powell River General Hospital.

[1022] 'Mental Health Services Branch Province of British Columbia Annual Report for Twelve Months Ended March 31 1965'.

[1023] Those patients admitted to each unit were divided by their geographic origin. Patients from the Vancouver metropolitan area were admitted to the Crease Unit, and those from the remainder of the province to the Centre Lawn Unit.

[1024] Richard L O'Reilly, 'Mental Health Legislation and the Right to Appropriate Treatment', *The Canadian Journal of Psychiatry* 43, no. 8 (1 October 1998): 811–15, https://doi.org/10.1177/070674379804300805.

[1025] Gilbert Sharpe, 'The Ontario Mental Health Act, 1978: A Legal Perspective', *The Canadian Journal of Psychiatry* 24, no. 6 (1 October 1979): 517–19, https://doi.org/10.1177/070674377902400605; William H. Angus, 'The Mental Health Act of Alberta', *The University of Toronto Law Journal* 16, no. 2 (1966): 423–30, https://doi.org/10.2307/825186; B. L. Strayer, 'New Mental Health Act in Saskatchewan', *The University of Toronto Law Journal* 15, no. 1 (1963): 219–21, https://doi.org/10.2307/824919; Keith Turner, 'Mental Health Legislation in Manitoba', *The University of Toronto Law Journal* 15, no. 1 (1963): 213–19, https://doi.org/10.2307/824918.

were further amended, the majority of which were revisions to required documentation. The Mental Health Act would not be reviewed again until the 1990s.[1026]

A Shift to Community–Treatment Pathways to Home (1965-1990)

As discussed in the literature review chapter, deinstitutionalization was a decades-long process that involved changing the structure of mental health care delivery in Canada beginning in the late 1960s.[1027] The process was characterized by the swift movement of patients out of the provincial mental hospitals and into the community in which mental health services grew at a slower rate than necessary to meet the increasing need.[1028]

Innovative approaches

In the 1960s came a better and more engaged attitude of nursing staff within the mental hospital because of greater emphasis on clinics, group conferences, in-service education, and better nursing supervision. Registered Psychiatric Nurses were pivotal in the shifts of patient care from lengthy custodial care to therapeutic strategies intended to decrease length of stay because of their integral role in delivery of this care. All wards at the Crease Clinic adopted a team nursing model and were finding it improved nurse-patient relationships.[1029] The result was beneficial to nurses and patients because those patients considered regressed began to demonstrate progress.[1030] In 1963, a hospital-wide study was organized to better understand the various nursing activities through compiling data and making recommendations for the more

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[1026] Emily Yearwood-Lee, 'Mental Health Policies Historical Overview', 2008, Legislative Library of British Columbia, http://www.llbc.leg.bc.ca/.
[1027] Some scholars would argue that deinstitutionalization in an ongoing process that continues today. Within this dissertation deinstitutionalization is marked by the closure of the large-scale provincial mental hospital.
[1028] Sealy and Whitehead, 'Forty Years of Deinstitutionalization of Psychiatric Services in Canada'.
[1029] 'Mental Health Services Report, 1961/62'. In East Lawn the staff on Ward H4 initiated group nursing, which provided improvement of previous assignments.
[1030] 'Mental Health Services Report, 106-/61'.

effective use of nursing personnel. The newly implemented Unit Nursing Conference was held monthly, providing a forum in which members concentrated on more efficient use of standing and task committees for special projects such as reviewing the eligibility list policies, changing the uniforms for nursing personnel and revising nursing procedures.

Nursing care was becoming more structured and integrated into the day-to-day care delivery, for example, Kardex cards were introduced to include nursing care plans with their introduction on several wards in the three large hospital units.[1031] The nursing role evolved as part of community mental health care delivery. The Nursing Liaison Committee met every two months and prepared a detailed description of the functions of the public health nurse in meeting the needs of the psychiatric patients and his family in the community. A blueprint was proposed for liaison between MHS and the public health agencies involving the use of liaison nurses.

By 1964, nursing staff spent more time with groups of patients either assisting in therapy or in some cases, conducting groups. By 1965, nurses had become more involved in the therapeutic aspects of patient treatment. Nurses were leading groups like relaxation therapy.[1032] A number of other changes were occurring: wider utilization of ward clerks was allowing charge nurses to supervise the nursing care more adequately; team or group nursing was accepted by staff and applied more throughout the hospital; and there was greater acceptance of further education and a growing demand for it.[1033] A closer relationship was developing between the men's and women's divisions of nursing, indicating more unity of purpose in goals for nursing care and readiness for integration of staff.

[1031] Pearkes and Martin, 'Mental Health Services Branch Province of British Columbia 1964'. The Kardex was a compact type of information and reference-card file that contained information for up to 40 patients and could be easily transported by the nurse during wards rounds. Narrative charting was also introduced, proving valuable to nurse and medical staff.
[1032] Pearkes and Martin.
[1033] Pearkes and Martin.

Gender integration of nurses

Mental hospital services saw a rise in the importance of nurses in the mid-1960s due to better understanding of their administrative and supervisory roles. Care of men and women patients were integrated beginning in the 1950s, but the RPN staff remained segregated. This changed in the mid-1960s when ongoing challenges in recruiting suitable male staff into nursing service led to the placing of female staff on most of the male wards of the hospital. In 1965, at Dellview Hospital (located in Vernon, BC) consideration was being made about the possibility of integrating male nurses on women's ward.[1034] At that time M.M. Lonergan, Director of Nursing Education & Consultant in Nursing communicated via memo to Deputy Director F.G. Tucker that female nurses were not required to perform nursing procedures like catheterization on male patients, thus it was unnecessary to teach female nursing students such a skill nor any other "male nursing procedures."[1035] It was also determined that, though possibly advantageous to have male staff on many types of wards, it would remain female ward aides and practical nurses to carry out "intimate care" of female patients.[1036]

In the latter half of the 1960s a closer relationship developed between the men's and women's divisions of nursing, indicating more unity of purpose in goals for nursing care and readiness for integration of staff. By the 1960s gender segregation of staff seemed largely arbitrary and was no longer sustainable at the end of the 1960s because the number of male students steadily decreased.[1037] This followed similar trends to the USA where gender

[1034] The Valleyview Hospital, Essondale, Dellview Hospital in Vernon, and Skeenaview Hospital in Terrace were sites that provided care for older adult psychiatric patients.
[1035] M.M. Lonergan, 'Re: Male Nurses on Women's Wards - Dellview Hospital', Memo, 21 June 1965, Box 7 000069-0707 Folder 1:5:07-3 Psychiatric Nurses in Training, BC Archive.
[1036] Lonergan.
[1037] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'. At the end of the 1966-67 fiscal year 34 of the 43 Riverview Hospital wards had gender integrated nursing staff.

segregation of staff persisted into the early 1960s, with men performing care of male patients and senile patients (who were considered asexual).[1038]

On May 1, 1966, the MHSB men's and women's nursing divisions were united into one nursing service under the leadership of the Director of Nursing.[1039] Gendered nursing care ended earlier, in 1964, at the Woodlands School when the nurses' division were combined resulting from the gender integration of students at the school, and the shortage of male nurses. The MHSB annual reports presented the rationale that a gender-integrated nursing model aligned with the belief that children benefitted from having two heteronormative parent-like figures.[1040] Since the late 1950s resignations were increasing from male graduate RPNs in the male treatment wards with the reported reason as more remunerative work elsewhere.[1041] Retention of male RPNs was not unique to BC, but also encountered in the Saskatchewan mental hospitals.[1042]

Deinstitutionalization (1965-1990)

Growth of community psychiatric nursing

Fewer patients were admitted to long-term mental hospitals in Canada in the 1960s and 1970s than had occurred in the past. In BC this translated into a greater need for RPNs to care for patients in the community. In Manitoba, Community Psychiatric Nursing (CPN) began through hospital-based nurses doing follow-up visits.[1043] Community Psychiatric Nurses in Manitoba worked primarily within two models, the first delivered care within a hospital-based centralized

[1038] Bernard E. Segal, 'Male Nurses: A Case Study in Status Contradiction and Prestige Loss', *Social Forces* 41, no. 1 (1 October 1962): 31–38, https://doi.org/10.2307/2572917.
[1039] Pearkes and Black, 'Mental Health Services Branch Province of British Columbia Annual Report 1967'.
[1040] 'MHSB Annual Report 1966'.
[1041] BC Government, 'An Act to Amend the "Mental Hospitals Act"', § Chapter 29 (1958).
[1042] Tipliski, 'Parting at the Crossroads PhD'.
[1043] Annette D. Osted, 'Community Psychiatric Nursing - Rights and Responsibilities', *This Month*, December 1975, Box 520353485 Folder - This Month 1975 Volume 7, British Columbia College of Nurses and Midwives Archive.

multidisciplinary teams for patients in and around smaller communities in rural areas, and the second model was utilized in Northern communities where they worked independently as the sole mental health resources.[1044] Boschma conducted an oral history of community mental health nursing in Alberta, and characterized the transition as "turbulent" because it was developed during the deinstitutionalization taking place in the 1960s and 1970s.[1045] Community care in Alberta developed while patients continued to be admitted to Alberta Hospital in large numbers, resulting in a strategy intended to provide care to equivalent numbers of patients.[1046] Similar to BC, Alberta had opened psychiatric departments in general hospitals throughout the 1970s and 1980s in response to the downsizing of the provincial mental institution.[1047] Boschma identified a paradigm shift in patient treatment with the move to the community that was also reflected in the content of community mental health nursing textbooks of that era.[1048]

Although the shift from mental hospital to community-based services was intended to be a gradual and smooth transition, interview participants did not experience the change in that way. Marilyn Melville (class of 1972) reflected that:

> "…as patients got sent to the community, they lost a lot of the hands-on day to day care that some of them still needed. And they also lost their community because if you were on a ward and you lived with somebody for many years, whether you liked them or not…it was a family-setting type thing. When they went [to the] community a lot of people kind of got lost. And they were…very vulnerable. They didn't have a lot of skills of self-preservation, they were easy targets for people to do to take advantage of….I think we went from being primarily concerned about psychiatric condition and assessing and treatment to becoming kind of a psychiatric nurse/social worker/parole officer…I mean, when I was in New West working I had so many patients that were coming out of forensics or coming out of BC Women's [prison] or coming out of one of the prisons, and I would have to deal with the probation officers or parole officer and it just seemed like so much of my time was spent with the social aspect instead of the psychiatric aspect…if

[1044] Osted. RPNs working within the centralized multidisciplinary team reported back daily or weekly.
[1045] Boschma, 'Community Nursing in Alberta'. Boschma utilized a case study method to focus on patient discharged from Alberta Hospital located in Ponoka, Alberta to the city of Calgary.
[1046] Boschma.
[1047] Boschma.
[1048] Boschma.

> you take that into consideration and then realize that they're downsizing…They say that that each therapist should have about 30 patients, 25 to 30 patients…when you consider that most of them are pushing 50, so almost double what they really are supposed to be dealing with, and then they have this expanded role of what they're expected to do."

The education and training for community mental health nurses did not prepare them for the growing number of patients with complex issues beyond the RPN's traditional role in mental hospitals. Initially, a staged process of mental hospital closure was planned which aligned with strategies implemented Alberta.[1049]

Workforce issues - the never-ending shortage

The serious nursing shortage in the BC mental hospitals continued into the 1970s. Extensive advertising across Canada was unsuccessful. Advertising in the Great Britain continued, leading to hiring of 46 nurses from Great Britain in 1972.[1050] For interview participants who graduated in the 1960s and 1970s the benefit of ongoing short staffing was the ease of returning to work at Riverview Hospital after taking time off because of the number of nursing vacancies.[1051]

Streamlining services

Streamlining of services continued into the 1970s under the fiscally conservative Social Credit party led by W.A.C. Bennett.[1052] In 1971, organization of the central office was modified to improve communication with major facilities.[1053] The Vancouver office was closed, and most staff were relocated to Victoria. Re-structuring occurred which placed all in-patient facilities reporting directly to the Deputy Minister (previously reporting to the Director of Mental Health

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[1049] Sealy and Whitehead, 'Forty Years of Deinstitutionalization of Psychiatric Services in Canada'; Boschma, 'Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950-1980'.
[1050] 'Mental Health Branch Report 1973'.
[1051] Noella Pertch, Participant Interview - Noella Pertch.
[1052] David Joseph Mitchell, *W.A.C. Bennett and the Rise of British Columbia* (Vancouver: Douglas & McIntyre, 1983).
[1053] Loffmark, 'Mental Health Branch Report, 1971'.

Services). Extensive patient surveys were carried out at the beginning of the 1970s, to identify and assess the changes in patient population.[1054] The findings of these reports were intended to identify and assess the most cost-effective strategy for managing patients. Surveys were done on patient populations and categorization of patients according to type and quantity of service required to care for them.[1055] Statistical data supported that hospital patients in MHSB were in these institutions because the most effective and economical resources for their care did not exist in sufficient quantity in the community. It was estimated that with continued development of community-based programs that two-fifths of the in-patient population at that time in the institutions could be returned to the resources developed in the community.[1056] The support for such ambitious estimates was based on the parallel development of non-MHSB mental health organizations, community health (including regional general hospitals), and volunteers. Increased funding for research was also made available by the federal government. The number of health care professionals working in the mental hospital was increasing, threatening the survival of RPNs if efforts were not made to develop the profession.[1057]

Fulfilling a care need - a shifting need for RPNs

In the late-1970s with the anticipated downsizing of Riverview Hospital, the place where most RPNs worked, more scrutiny was placed on justification for the continuance of the different nursing groups of RN, RPN and LPN. Regionalized care delivery was expanding in acute mental

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[1054] Tucker, 'Mental Health Branch Province of British Columbia Annual Report 1970'; 'Mental Health Branch Province of British Columbia Annual Report 1969'. The surveys were recommendations of the Consultant in Sociology.
[1055] Tucker, 'Mental Health Branch Province of British Columbia Annual Report 1970'.
[1056] Tucker.
[1057] 'Excerpts from the Report of the Committee on the Health Arts for Ontario', *This Month*, July 1970, Box - 520353486, Folder - This Month 1970, British Columbia College of Nurses and Midwives Archive. An excerpt of a report published by the Psychiatric Nurses Association of Ontario was published in the RPNABC newsletter which identified that three recommendations made to solidify psychiatric nursing as a separate profession were a separate training centre, separate qualifying exams, and separate registration within the College of Nurses.

health units in the general hospitals and in community based mental health services. At that time there were RPN leaders who were strongly positioned to provide the evidence for maintaining and expanding the separate profession of psychiatric nursing. A Task Committee was established by the Health Manpower Working Group within the Ministry of Health at the request of the RPNABC. The Division of Health Services of the Health Science Centre at UBC prepared a Descriptive Report about the state of RPNs in the province. The rationale for the report was to establish a computerized database on RPNs with the RPNABC, (including the demographic, educational and employment data necessary for manpower planning), and to contribute (along with other information collected on psychiatric nursing in the province of BC) to the decision-making process regarding the supply of RPNs over the following five years.[1058] The report addressed replies from RPNs to a mailed-out questionnaire in the summer of 1977. At that time the definition of RPN was a nurse who,

> "gives psychiatric/mental health nursing care to enable individuals, families and groups to function at their optimal level of psychological well-being by developing more effective adaptive behaviours and by increasing their resilience to stress. The RPN must be competent to provide basic physical nursing skills and must also have a highly developed level of communication skills (verbal/non-verbal/written). The RPN works with children, adolescents, and adults with maladaptive behaviour and/or those who are mentally handicapped. He/she may work as a member of the health care team or independently, utilizing appropriate consultation. He/she may be employed in an inpatient facility (institution, psychiatric unit of a general hospital, mental health centre) or, with a suitable academic preparation and/or experience, in a community setting."[1059]

Exploration began on the economic benefits of either continuing or amalgamating nursing programs in the province. This led to the commissioning of a study on the state of nursing education (the *Kermacks Report*).[1060] The basic nursing programs that were in operation in 1979,

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[1058] Division of Health Services UBC, 'Registered Psychiatric Nurses in British Columbia, 1977: A Descriptive Report' (British Columbia: University of British Columbia. Division of Health Services Research and Development, 1980), UBC Open Archive, http://hdl.handle.net.login.ezproxy.library.ualberta.ca/2429/50005.
[1059] Division of Health Services UBC, 2.
[1060] 'Kermacks Report Discussed with Health Minister'.

included six aide programs, eight practical nursing (or equivalent) programs, two RPN programs, and eleven RN programs.[1061] Questions were raised about the need for a separate designation of RPNs.

Problems with deinstitutionalization

The deinstitutionalization movement was a global trend. Mental impairment was increasingly considered an illness, aligned with medicalization of psychiatry focusing efforts on finding scientifically based cures for specific illnesses. In the UK, evidence supported that many patients were successfully discharged from mental hospitals into the community where they lived independently or with some support.[1062] However, in the UK, as the 1980s approached, the view of deinstitutionalization as a progressive and ever increasing success was facing criticism. This was related to a certain segment of the mental health patient population being more symptomatic and chronically ill such that they required a higher level of community support. In addition, some mental patients were unable to find a place to live outside of an institutional setting.[1063] These limitations resulted in the persistence of institutional care delivery in settings such as prisons, forensic institutions, and acute hospital care.[1064] Similar trends occurred in BC.

Riverview slowly eroded as the primary worksite of RPNs. The new need was for community-based and specialized mental health education for RPNs, marking a definitive move away from the traditional RPN curriculum that catered toward institutional-focused psychiatric nursing care delivery.[1065] In the 1970s and 1980s large psychiatric institutions in BC were scaled

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[1061] Kermacks, 'Nursing Education Study Report, April 1979 - Kermacks Report.'
[1062] Turner, 'The History of Deinstitutionalization and Reinstitutionalization'.
[1063] Turner.
[1064] Novella, 'Mental Health Care in the Aftermath of Deinstitutionalization'; Turner, 'The History of Deinstitutionalization and Reinstitutionalization'.
[1065] 'Committee on Nursing Education & Practice Report', *This Month*, July 1979, Box 520353485 Folder - This Month 1979 Vol 11, British Columbia College of Nurses and Midwives Archive.

down and closed, replaced by smaller units within general hospitals and community-based care.[1066]

The downsizing of Riverview Hospital was first formally addressed in the Mental Health Planning Survey released in 1979.[1067] The survey results led to the development of a provincially adopted strategy directed by the Ministry of Health for a strict admission policy resulting in people experiencing mental illness having much-reduced lengths of stay, along with a significant number being diverted from hospital admissions altogether.[1068] The shifting of patients away from admission to the large-scale mental institutions directly influenced the demand from RPNs to receive education in community-focused psychiatric care.[1069] Hospitalization of acutely ill patients with complex behaviour management problems were for aggressive treatments aimed at limiting the length of stay, a direct result of deinstitutionalization and a move of care delivery to acute care hospitals.[1070] Simultaneous shifts of care delivery to the community demanded an increase in psychiatric nurses in community health centres, home health agencies, and for care with increasing vulnerable populations, in particular the homeless mentally ill.[1071]

Downsizing and Closure of the Provincial Mental Hospital (1991-2012)

Changing Mental Health Care Trends (1980-1990)

[1066] Happell, 'Appreciating the Importance of History'.
[1067] British Columbia. Mental Health Planning Survey., 'Report of the Mental Health Planning Survey' (Victoria, B.C.: Ministry of Health, 1979).
[1068] British Columbia. Mental Health Planning Survey.
[1069] Annette D. Osted, 'Clinical Facilities Studied', *This Month*, December 1975, Box 520353485 Folder - This Month 1975 Volume 7, British Columbia College of Nurses and Midwives Archive; UBC School of Nursing, 'Helen Niskala - Dr. Helen Nisklala (Professor Emerita)', The University of British Columbia - Faculty of Applied Science UBC Nursing, accessed 8 October 2022, https://nursing-alumni.sites.olt.ubc.ca/in-memoriam/helen-niskala-in-memoriam/. The call for opportunities to pursue education that would move RPNs forward with changing mental health care delivery was led by the RPNABC under the direction of Dr. Helen Niskala who served as Director of Education Services for the RPNABC from 1976 to 1982.
[1070] Patricia C. Pothier et al., 'Dilemmas and Directions for Psychiatric Nursing in the 1990s', *Archives of Psychiatric Nursing* 4, no. 5 (October 1990): 284–91, https://doi.org/10.1016/0883-9417(90)90046-N.
[1071] Pothier et al.

The ongoing fear of RPNs was their discontinuation as a separate designation because of the lack of perceived need with the closure of the provincial mental hospital and other long-term institutions along with the recommendations made in the 1979, *Kermacks Report*. However, strong advocates within RNABC continued to advocate for the continuation of the profession.

Manpower studies on nursing

Multiple labour studies were conducted in the province to address the issue of nursing shortages. The Psychiatric Nursing Manpower Task Committee met for the fourth time on April 15, 1977, in Vancouver, BC. The Task Committee was established by the Provincial Health Manpower Committee at the request of the RPNABC. The role of the Task Committee was to determine how many mental health nurses the province required, and where they would come from. In 1977 the Committee conducted a study in which they identified the number of mental health nurses (RPNs and RNs) currently employed and where, areas of shortages, the past and present sources, and the projected future requirements for mental health nurses.[1072] The study included an attempt to determine how many new mental health nurses were required each year, how many would be returning to work and how many new registrants. Data was collected through questionnaires to employers and individual nurses, from the RPNABC's records, and questions to employers to determine movement of nurses.

[1072] 'RPN's Come Through Poorly', *This Month*, April 1977, Box 520353485 Folder - This Month 1977 Vol 9, British Columbia College of Nurses and Midwives Archive, https://onedrive.live.com/?cid=470B2949FE17011C&id=470B2949FE17011C%215716&parId=470B2949FE17011C%215207&o=OneUp. In 1977 RPNABC reported that RPNs were not cooperating with the study participation. Less than 50% of the RPNs returned completed questionnaires. A repeat questionnaire was sent out. Concrete examples were provided in the March/April 1977 RPNABC newsletter to explain to members the value of completing the survey.

The Changing Rights of Mental Health Patients (1991-2012)

The 1990s saw many important changes that improved the way rights of mental health patients were addressed. Riverview Hospital Society reorganized under the BC Mental Health Society. Across Canada the rights of people living with mental illness were being recognized. A Supreme Court ruling determined that the mentally ill in psychiatric facilities had the right to vote in national elections.[1073] Riverview Hospital was leading the patient advocacy and rights works for mental patients in Canada. Two important pieces of advocacy work completed in the 1990s were the Charter of Patient Rights and the Patient Sexuality Policy, both completed and adopted in 1994.[1074] These two pivotal policies were important pieces of a shifting in the treatment of mental patients within the province. In turn, nursing care was integrally influenced by the increased autonomy of mental patients and their ability to engage in self-advocacy and sexual relationships that were previously not formally addressed.

Mental Health Policy Change (1991-2001)

In 1990, the Provincial Mental Health Initiative intended to move many mental health services to smaller, more specialized regional facilities, including the "maintenance" of a smaller specialized facility at Riverview as a Centre of Excellence. A new 358 bed tertiary hospital was planned for the Riverview site. In 1992, the downsizing process of Riverview Hospital was formalized. In 1994, a revealing Ombudsman report focused on an eighteen-month investigation

[1073] 'Voting Rights in Canada', The Canadian Encyclopedia, 2022, https://www.thecanadianencyclopedia.ca/en/timeline/voting-rights-in-canada. It was not until 1993 that mental patients involuntarily detained in mental health facilities were able to vote.
[1074] Steven J Welch and Gerrit W Clements, 'Development of a Policy on Sexuality for Hospitalized Chronic Psychiatric Patients', *The Canadian Journal of Psychiatry* 41, no. 5 (1 June 1996): 273–79, https://doi.org/10.1177/070674379604100503; 'Riverview Hospital Charter of Patient Rights Guidebook' (Riverview Hospital, 1996).

of administrative fairness at Riverview Hospital.[1075] The impetus for the investigation arose from concerns raised by patients, families and community advocates about the willingness and ability of staff at Riverview to transparently and equitably work with patients advocating for themselves or as part of a group.[1076] Ninety-four recommendations were made in the report, the most prominent being the provincial government appointing a Mental Health Advocate to support and promote advocacy efforts on behalf of individual patients in mental health services across the province.[1077] Recommendations were also made to reform the Mental Health Act. Riverview Hospital was a pioneer in Canada in developing a Patient Sexuality Policy and a Charter of Patient Rights in the early 1990s.[1078] The Hospital also developed an Advocacy Project Team (APT), bringing together hospital staff, patients, and advocates from the community to design an advocacy program to support the hospital patients.

Psychosocial rehabilitation – a new model of care

The Psychosocial Rehabilitation (PSR) movement was increasingly adopted in remaining Riverview programs.[1079] The underlying philosophy of PSR was that treatment of people living with mental illness required more than psychotropic medications. The approach emphasized a multi-disciplinary approach that helped patients reacquaint themselves with social and vocational skills, including skills of personal choice. Three strategies to achieve PSR were identified as

[1075] Province of BC Ombudsman, 'Review of Riverview Hospital'.
[1076] Province of BC Ombudsman. The findings addressed fairness at Riverview and on a grander scale within the provincial mental health service system.
[1077] Province of BC Ombudsman.
[1078] Province of BC Ombudsman. The Charter of Patient Rights was approved by the Board of Trustees of BC Mental Health Services in February 1994. The limitations of the Charter as a hospital policy and not formal legislation were apparent in the Ombudsman's explicit comments about enforcement. Commitment of the leadership and staff was necessary to ensure that implementation and ongoing adherence to the Charter was maintained. There was a suggestion to incorporate the Charter into a revision of the Mental Health Act.
[1079] Province of BC Ombudsman; British Columbia Ministry of Health, 'Revitalizing and Rebalancing British Columbia's Mental Health System' (Victoria: Ministry of Health and Minister Repsonsible for Seniors-Adult Mental Health Division, 1998), http://www.llbc.leg.bc.ca/public/PubDocs/bcdocs/313907/mhpd.pdf.

pharmacological interventions, psychological methods emphasizing the behavioural strengths and social interaction skills, and social-environmental methods that assist persons with adaptive skills for everyday living.[1080]

The PSR approach involved a multidisciplinary model of care that included regulated. Each patient in the hospital had a treatment team composed of a psychiatrist, general practitioner, primary nurse, and social worker. To meet the newly introduced standards in June 1994, the Riverview Management Committee authorized the development of guidelines for a form of Care Plan.[1081] The introduction of this Care Plan marked a collaborative step to increase transparency and collaboration with the patient in the decision-making and information transfer about their care. Such changes took time and organization for the planning, implementation, and evaluation. However, there proved to be little time to fully develop the recommendations made in the 1994, Ombudsman report because of impending closure of Riverview Hospital.

A leader in patient rights

In 1994, a Charter of Patient Rights, the first in Canada, was approved.[1082] It was developed over a number of years, beginning in 1991, when Riverview hospital staff who were part of the Patients' Environmental Needs Committee began exploring a rights document for patient, after the Patient Empowerment Society (PES) requested that the hospital be involved in

[1080] Province of BC Ombudsman, 'Review of Riverview Hospital'. Specific wards at Riverview delivered PSR, the Community Psychiatric Division, Fernwood Lodge, and Brookside. Relationships were built between these units and the operator of a semi-independent living units and clubhouse in Vancouver.
[1081] Province of BC Ombudsman. Team members would raise any problems of which they were aware, including medications and behaviour issues. Recommendation of an accessible and understandable, comprehensive treatment plan providing an outline of the essential elements of an overall plan were new standards of The Canadian Council on Health Services Accreditation for the acute care sector. The standard would include diagnosis, modalities of treatment (medications, special behaviour programs, skills acquisition programs etc.), explanations of what each modality intended to accomplish and how, prognosis, discharge plan, a section to record patient input and her or his signature.
[1082] Province of BC Ombudsman.

the development of such a document in 1990.[1083] Background research was provided by lawyers from the Mental Health Law Program on the Riverview grounds. A Joint Task Force met multiple times over 1991, producing a draft Charter of Patient Rights for Presentation to Riverview Hospital through its policy committee structure in the spring of 1992.[1084] A Patient Sexuality Policy, again the first in Canada, was introduced.[1085]

Part of the BC Ministry of Health strategic plan was building or expanding the mental health facilities in the communities across the province, including the Riverview redevelopment project.[1086] Redevelopment of Riverview entailed the move of services from a centralized model to regionally delivered services, a plan that had been in the making for the previous four decades. The goal was to ensure patients with severe mental disorders who required sustained, complex medical treatment would continue to receive care within services that were patient-centered, meaning integration of providers and care to ensure seamless delivery to support recovery and quality of life.[1087]

The Final Years (2002-2012)

The final period of Riverview downsizing were the years between 2002-2012. The reforms that were implemented during that period were a realignment of the mental health system which involved depopulation of the hospital and admission diversion which was consistent of contemporary understanding of deinstitutionalization.[1088] In 2002, a Senior

[1083] Province of BC Ombudsman. PES was the patient run advocacy body at Riverview Hospital which was funded by the Ministry of Health.
[1084] Province of BC Ombudsman.
[1085] Welch and Clements, 'Development of a Policy on Sexuality for Hospitalized Chronic Psychiatric Patients'.
[1086] Ministry of Health Services, '2009/10 Annual Service Plan Report' (Victoria, BC, 2010).
[1087] Ministry of Health Services.
[1088] Livingston, Nicholls, and Brink, 'The Impact of Realigning a Tertiary Psychiatric Hospital in British Columbia on Other Institutional Sectors'.

Operating Officer was appointed to manage the amalgamation of Riverview Hospital and the Forensic Psychiatric Services Commission. A major goal of the system realignment was to refocus on a regional health delivery model in which capacity and expertise was developed to meet the needs of community members requiring tertiary-level psychiatric inpatient care.[1089] The target patient population for those patients deemed appropriate for transfer to tertiary facilities were those diagnosed with severe and persistence mental illness whose service needs exceeded the capacity of lower-intensity community-based live-in facilities.[1090] Regional facilities retained 24-hour nursing coverage within a multidisciplinary care team that included nursing, psychiatric and general medical care.[1091] The focus of care was PSR with care goals that included eventual transfer to less structured and more independent living environments.

Simon Fraser University (SFU) planned for expansion of its health sciences programs and services in the 2000s, highlighting opportunity for research collaborations at Riverview.[1092] The City of Coquitlam Mayor's Riverview Task Force presented this as an opportunity to deepen and strengthen the university's research collaboration with Riverview. However, this plan seemed short-sighted given the planned closure of the facility in the next seven years.[1093]

[1089] Livingston, Nicholls, and Brink.

[1090] Livingston, Nicholls, and Brink. For each tertiary psychiatric bed that was closed bed was opened in a purposefully built or renovated regional facility, and patients and resources were transferred to that facility. Regional facilities were expected to continue providing tertiary-level psychiatric services within a more home-like environmental intended to normalize them within communities rather than delivering care in isolated, outdated and the institutional Riverview Hospital setting.

[1091] Livingston, Nicholls, and Brink.

[1092] Mayor's Review Task Force, 'For the Future of Riverview - Riverview Task For Report for City of Coquitlam Council' (Victoria, B.C., 3 February 2005), Legislative Library of British Columbia. Focus of expansion of programs and services included campus wellness, community health, early childhood development, and gerontology. There was also an identified need for the university of use this research and development to address the cost of sustainability of the provincial health care delivery models.

[1093] Mayor's Review Task Force. Outlines in the SFU *Report to the City of Coquitlam: Riverview Lands Task Force* included recommended research and education program focused on graduate teaching and research in forensic psychology, expanded health sciences research, public health and preventative medicine, development of a research institute for health research and education, gerontology and early childhood development, and other education opportunities that may arise to take advantage of the campus like setting at Riverview Hospital. Riverview also housed botanical gardens that were presented as potentially a future site of a Horticulture Centre and Provincial Botanical Garden.

Recommendations were made to develop a Centre for Excellence on Riverview Lands to deliver mental health and mental health services regionally and provincially.[1094] Two clusters of complimentary services were identified as the foundation of the Centre for Excellence, the first for delivery of mental health services at Riverview and the second for development of an alternative medicine and wellness treatment centre. Mental health services included tertiary mental health services for patients living in the Fraser Valley, a provincial neuropsychiatry program, specialized medicine and sciences beds/services for complex refractory cases referred by secondary services across at province, and a Provincial Mental Health Council to address province-wide mental health issues and priorities.[1095] The facility, aligned with the image of Riverview as a place of healing, wellness, and sanctuary was thought to be a growth industry potentially attracting private investment to support a much-needed facility upgrade of East Lawn.

A changing mental health focus - the future of Riverview

In 2002, the BC government launched a comprehensive mental health strategy to focus on early detection and evidenced-based care, develop a communications infrastructure to improve mental health literacy, better integrate mental health care throughout the health system, and focus on self-management and clinical practice guidelines.[1096] A significant shift in mental health services occurred in 2004, with the release of the *Every Door is the Right Door: A British*

[1094] Mayor's Review Task Force. Plans for continued research and health professional education with research-based post-secondary institutions were publicized. The relationship between SFU and Riverview Hospital was envisioned as focusing on opening a research and education centre for mental health and addictions capitalizing on and enhancing relationships between SFU, the Forensic Institute, and UBC.

[1095] Mayor's Review Task Force. The alternative medicine and wellness treatment centre was described as aligning with an emerging industry focused on research and delivery of alternative medical treatments. The Riverview grounds were identified as being the future home of the SFU Center for Advanced Education in Graduate Teaching and Research in Forensic Psychology. The school became the focal point for graduate teaching and research in forensic psychology. Riverview was thought to be a place to expand health sciences research, public health, and preventative medicine research by SFU. Lastly, an Institute for Health Research and Education, Gerontology, and Early Childhood development would be built.

[1096] Ministry of Health Services, '2002/03 Annual Service Plan Report'.

Columbia Planning Framework to Address Problematic Substance Use and Addiction report which addressed a comprehensive approach to substance use and addiction.[1097] A larger focus was placed on addressing substance use issues evidenced by the release of a provincial framework for addressing crystal meth and amphetamine use, a first of its kind in Canada.[1098] Psychiatrists and psychologists held control as leaders in the research that was happening at Riverview Hospital until the end of the institution.

Chapter Summary

Chapter 6 provided an in-depth exploration of changing influenced on treatment over the lifespan of Essondale. This chapter was divided into four parts based on different eras of patient care in the mental hospital, the birth of the mental hospital (1913-1949), growth of psychiatric hospital treatment (1950-1964), deinstitutionalization (1965-1989), and demise of the provincial mental hospital (1990-2012). Treatments that occupied patients with hospital labour and recreation activities were prominent until the 1930s when medical treatments based on scientific research gain prominence. Psychiatrists who sought to solidify their foothold in the mental hospital were keen to develop research-based medical treatments like psychosurgery, and convulsive therapy that required trained nurses. In this period, RPNs were integral in delivering direct patient care alongside psychiatric aides. As allied health professions grew like OT, psychologists, social workers, and recreation therapy RPNs worked alongside both allied health and psychiatrists. As the mental hospital grew in the 1950s, so did the various treatments offered.

[1097] Dan Reist et al., 'Every Door Is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction' (Victoria: British Columbia, Ministry of Health Services, May 2004), https://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf.
[1098] Brenda Locke, 'Crystal Meth and Other Amphetamines: An Integrated BC Strategy' (Victoria, British Columbia: British Columbia Ministry of Health, April 2005), http://www.healthservices.gov.bc.ca/mhd/pdf/meth_final.pdf.

In the late 1950s and 1960s, psychotherapeutics became a cornerstone of RPN work. Mental health services in BC, as they were across Canada, were institutionally based until the 1960s.

The RPNs at Essondale were integral to patient care, their role solidified with the passing of provincial legislation that delineated them from RNs. With deinstitutionalization (1965-1989) the location of treatment changed, from the large mental hospital to regionally based care delivered in acute hospital settings and in the community. During that period the care of patients was also changed with legislation that enabled people to voluntarily seek treatment for their mental illness. Federal legislation that made health care human right in Canada was influential in impacting access to mental health institutions and development of psychiatric services outside of the hospital setting. I described exploration of psychiatry, treatment, and structural changes to provincial health services that led to the downsizing of largescale mental hospital and the impact this had on scope, education, and demand for RPNs in the province. The chapter ended by exploring the changes in mental health care delivery with the downsizing and closure of the provincial mental hospital and steps taken to move to RPNs into general hospital and community-based care. Though Riverview closed RPNs continued as an important nursing profession to deliver care in the acute inpatient psychiatric units constructed in the general hospitals of the province.

Chapter Seven – Discussion and Conclusion

This study ambitiously explored RPN education in BC, Canada, focusing on Riverview Hospital's lifetime from 1913 to 2012. Riverview Hospital was a key facility in the education of RPN students from 1930 until the hospital closure in 2012. Primary sources were used to construct the findings and analysis chapters (chapters four, five and six), structured around the history of Riverview Hospital, beginning with the first years of mental health care delivered in the province. I integrated secondary data to analyze the evolution of the hospital within the greater contact of Canadian and international mental institutions. Chapter Four was the story of the hospital, unfolding to include its expansion (1912-1950), reorganization and contraction (1951-1992), and eventual closure (1993-2012). The chapter explored of the evolution of the hospital, identifying major social, economic, and political changes that influenced RPN education in BC. Chapter Five was the story of RPN education from its formal conception in 1930 as the BC School of Psychiatric Nursing. Chapter Six covered the development of patient care treatments, and the changing roles of different care providers in the institution in the early years of the mental hospital, and throughout the deinstitutionalization process. RPNs were part of a team of mental health care providers that included psychiatrists, RNs, psychiatric attendants, OTs, and social workers.

The story of RPN education in BC is one of persistence. In the early 1900s, a need was identified to train the men and women attendants in the newly formed mental hospitals that were controlled by men superintendents. These findings show that RPN education in BC is inextricably connected to the evolution of provincial mental hospitals, psychiatry, and mental health care models and philosophies. The research questions that guided this study were:

1. When and how did RPN training and education begin in BC?

2. How did the development of RPN education relate to trends in psychiatric nursing within the broader historical context of nurse education and various social, political, and economic influences in the development of the profession over the past century?
3. What socio-political factors of the early 20th century led to the formation of Essondale (later Riverview) Hospital and the BC Psychiatric Nursing School?
4. What role did the BC Psychiatric Nursing School at Riverview Hospital play in the development of Registered Psychiatric Nursing as a distinct nursing designation?
5. What provincial legislation influenced the formation, education, and professionalization of RPNs in BC?
6. What were the social, political, and economic influences on the development of the mental health nursing program structure and curriculum at the BC School for Psychiatric Nursing?
7. What was the role of Psychiatric Nursing in BC during institutionalization?
8. What were the impacts of the de-institutionalization movement on the role of RPNs in BC and subsequent impacts on program design and curriculum?

To weave together a narrative of the story of psychiatric nursing education in BC, I addressed all research questions. This research has made a significant contribution to the existing knowledge on psychiatric nursing in Western Canadian provinces, and mental health care and nursing in BC. Historical research is more than a collection of facts, it allows for an in-depth look into the events of the past, how they were shaped and their influence on the events of today. The history of psychiatric nursing in BC has a long history that is deeply intertwined with the

history of nursing, psychiatry, and mental health care in the province. The profession endured despite the closure of mental health institutions, reinforced at critical historical junctures.

I structured this final chapter into four sections, organized around the findings addressed for each of the research questions. The opening section is a synopsis of findings. I elaborate on the formation of the BC School of Psychiatric Nursing, including social, economic, and political factors. The second section focuses on the interconnection between RPN education and professionalization. The third section is centred on the relationships among curriculum, institutionalization, and deinstitutionalization. Section four discusses how the RPNs' role in mental health care delivery has evolved and its connection with nurse education. This conclusion ends with a personal reflection, study strengths and limitations, dissemination plans, and ideas for future research.

Synopsis of Findings

Registered Psychiatric Nurses were essential to mental health care at the provincial mental hospital. Their responsibilities were determined by superintendents and psychiatrists and impacted by the therapeutic treatments offered in the hospital. Riverview's growth led to RPNs growth as a separate nursing profession, but deinstitutionalization threatened its future. The persistence of RPN leaders and ongoing workforce needs for nurses in regionalized general hospitals and community-based mental health services supported the persistence of RPNs as separate but working alongside RNs.

Education for RPNs in Canada emerged when mental health care was primarily delivered in the mental hospital setting. In BC, the separate nursing designation persisted despite the downsizing and eventual closure of the provincial mental hospitals. Originally it was psychiatrists in medical superintendent positions who developed education to legitimize their

specialty and acquire control in mental hospitals. In Western Canada, RPNs led by those in BC sought to build their own professional nursing group, a goal that was achieved in the 1950s alongside Saskatchewan RPNs. Though RPNs role was deeply connected to patient care delivered in the mental hospital, they developed and implemented their own education program in post-secondary institutions in 1973.

The goal of this research was achieved because I successfully constructed a historical analysis of the development of psychiatric nursing education in the province of BC. The previous comprehensive studies of psychiatric nursing in Canada were conducted by Chris Dooley, Veryl Tipliski and Beverly Hicks, all based at the University of Manitoba. This study built on the research of Dooley, Hicks and Tipliski, by providing an explanation of the development of RPNs education in BC as closely related to the need of psychiatrists to have trained nurses proficient in the developing treatments, and the need to staff the exponential growth of the mental hospital population. Registered Psychiatric Nurses and RNs worked side by side at Riverview Hospital. The 1960s and 1970s saw mental health services shift to community and general hospital-based services. Registered Psychiatric Nurses advocated to gain access to continuing education to allow them to move into the community. In the late 1970s, the BC government reorganized health care services and studied the nursing workforce need to best staff health care in the province. There was a decline in enrollment in post-secondary RPN programs and the BC government policy makers sought out the substantive differences in competencies and care provided by RPNs versus RNs and LPNs. The strong advocacy of RPN leaders played a key role in keeping the profession alive, but no research was done to determine the specific impact on patient outcomes. Today, RPNs and RN continue to work side-by-side despite a lack of research

to support the substantive differences in delivery of patient care, and the benefit to patient outcomes. Entry to practice education remains separate.

RPN Education and Professionalization

The BC School of Psychiatric Nursing opened in 1930, with the first graduates completing the program in 1932. The last RPN class graduated in1974. RPNs were created to staff new psychiatric hospitals that were first developed in the 1900s. The patient population at Essondale grew exponentially with the development of the psychiatry as a medical specialty, the mental hygiene movement, and the need to contain and control the insane who posed risk to the public and themselves. In the early to mid-1900s, Canada constructed publicly funded mental institutions on a large scale. By the second half the 20th century, the financial pressures of mental institutions that housed mental patients for decades was an unsustainable model, nor was it aligned with the emerging perspective of a human rights, focused on mental health care.

Registered Psychiatric Nursing education changed to meet the needs of the mental health care system over time, from containing patients to assisting psychiatrists with performing medical treatments. The education of RPNs was linked to RN education, and both worked in mental institutions. The development of the provincial mental BC hospital was instrumental in the development of the RPN profession as the hospital needed a supply of care providers. This evolution happened across Western Canada.[1099] The decline of the provincial mental institution and development of regionally delivered community-based services; the inclusion of a range of health care professionals in mental health care delivery; and changes in nursing education in Canada all contributed to the evolution of education for psychiatric nursing and the work of

[1099] Tipliski, 'Parting at the Crossroads: The Emergence of Education'; Hicks, *Politics, Personalities, & Persistence*; Dooley, 'Mental Nurses at Brandon Hospital'.

RPNs. Registered Psychiatric Nurses persisted under the repeated threats to their existence. The continued existence of RPNs in BC today was influenced by changes in political party leadership, funding allocation to health care and mental health services, organization of advanced education, and the professionalization of nursing.

Moving RPN education to colleges helped create a separate educational path and professionalize RPNs in BC. Despite mental hospital closures, the RPN designation continued with the opening of a degree program in 2006. This research does not examine the development of the degree program because it occurred near the end of the lifetime of Riverview Hospital and primary sources were not found within the archives accessed for this research. To understand mental health nursing better, we need to study the differences between RPN and RN job duties, education, and scopes of practice.

Despite threats, RPNs continued to exist in the province, as well as in Alberta, Saskatchewan, and Manitoba.[1100] The utilization of RNs in the mental hospital was like that of Manitoba and Ontario in that they worked alongside RPNs. British Columbian superintendents stressed the need for an RPN education model equal to that of RNs in the general hospital. Furthermore, RNs held the leadership positions in the hospital and the nursing school because they had the formal education. This contrasted the situation of Saskatchewan in which medical superintendent MacNiell rejected the general hospital nursing training model.

The Weir report was the first formal recommendation against the pseudo-specialization of psychiatric nursing, with the recommendation that RN programs includes curriculum to prepare psychiatric nursing. That strategy was contingent on the creation of RN affiliation programs. British Columbia had these programs until the general hospitals built acute mental

[1100] Hicks, *Politics, Personalities, & Persistence*; Martin, 'Determinants of Destiny'; Boschma, 'Community Nursing in Alberta'.

health units during the deinstitutionalization movement. The acute mental health units in the general hospitals became the places of clinical rotation for RN students in hospital-based school, and marked the end of the affiliation program at the BC School of Nursing. The embracing of psychiatric nursing curriculum in RN education enabled RNs to staff the acute mental health units in general hospitals, while RPNs continued to staff the inpatient units at Riverview.

Connection Between Curriculum, Institutionalization and Deinstitutionalization

Interpretation in the historical research process involves synthesizing the data, creating a whole from well-connected and organizing support sources to tell a story of the interconnected historical event or events.[1101] Registered Psychiatric Nursing education in BC at times led and followed trends across Western Canada. Their education was generally influenced by local changes in mental health care, including research and practice changes influenced by psychiatrists, psychologists, allied health, and RNs. This study shows that psychiatric nursing in BC evolved in relationship with changes in mental health care and in nursing. Regional influences, such as the agendas of medical superintendents, policymakers, and patients' needs in BC were more prominent in development of RPNs than national factors. Unlike the stance taken by Medical Superintendent McNeill in Saskatchewan which rejected RNs from the mental hospitals, BC's Superintendent A.L. Crease welcomed RNs alongside RPNs.

Curriculum models were informed by psychiatric nursing and the American Psychiatric Association (APA) in the USA. The content of curriculum followed trends in mental health care, including classification of mental health conditions as illnesses, and classifying and treating them rather than as chronic conditions requiring lifetime care. Accordingly, the RPNs and RNs role in

[1101] Boschma, Grypma, and Melchior, 'Reflections on Subjectivity'.

mental health care shifted over time, as did the service delivery in general hospitals. Care shifted from hospital delivery by unskilled workers, to care provided by educated nurses, and then to a mix of both regulated and unregulated professionals, including RPNs, in community settings. Curriculum in the RPNs education programs needed to change in the 1960s to ensure that they had the theoretical knowledge to deliver mental health care outside of the institutional hospital setting.

The future of RPNs was at risk of discontinuation in the 1970s and 80s as a critical lens focused on the shortcomings of the large-scale institutional models of inpatient mental health care were remedied with the solution of the deinstitutionalization movement. Advocates from RPNABC and staff RPNs helped maintain the separate nursing profession to meet mental health care needs. Questioning of the need for RPNs emerged in the early 2000s but again, the persistence of RPNs was secured by the need to address nursing shortages in mental health services across the province. Ultimately, in 2006, the number of seats allocated to RPN education programs was expanded and remained in-demand when Riverview Hospital ceased operation in 2012.

Curriculum and Legislation

Registered psychiatric nursing persisted in the demise of the large-scale provincial mental institution from which it developed the profession. RPN leaders built an education curriculum autonomous from psychiatry, and carved out a distinct place in nursing alongside RNs first within the mental hospitals, and then to general hospitals, and the community. Their education adapted to changes in social, political, and medical understanding of mental illness and wellness, and triumphed despite multiple setbacks and rough terrain in which the future of the basic education entry to practice for RPNs was unclear.

Professionally, the development of a legislated definition of RPNs as a distinct nursing designation in 1951, and the eventual legislation of psychiatric nursing as a self-regulated nursing profession solidified the position of RPNs. The scope of RPN practice in BC was tied to the care delivered in the mental hospital. This was not unusual, as the same was true for Manitoba mental hospital RPNs.[1102] The *1964 Mental Health Act* shaped mental institution care by outlining care standards, determining who had treatment decision power, and identifying parameters for determining involuntary and voluntary patient admissions. This legislation impacted the RPN day-to-day practice and who directed their care.

The Changing Role of RPNs in Mental Health care Delivery

Registered Psychiatric Nursing was, at its root, nursing. This research shows that curriculum and courses developed to teach RPNs in the hospital-based school were largely taught by RNs who utilized nursing models and theories that were founded by RNs. Lecture documents from the 1950s and 1970s drew upon the work of American nurse theorists such as Hildegard Peplau and Dorothy Gregg. Neuman's Systems Model, another nursing model, was used as the foundation for the Douglas College Psychiatric Nursing program when it transitioned to a post-secondary delivered program in the 1990s. As found in Hick's research on the development of RPNs in Manitoba, repeated efforts were made by the provincial government to examine the need for the separate distinction. The 1979 *Kermacks Report* was the major study that recommended the discontinuance of the separate RPN program under the assumption that the scopes of practice of RNs and RPNs were similar enough to have only one nurse education stream. However, the position of RPNABC was that these were distinct practice areas requiring

[1102] Hicks, 'From Barnyards to Bedsides'.

separate education. This stand, along with the workforce needs to staff mental hospitals, led to the continuation of the RPN designation and thus education.

The changing conception of mental illness and mental health directly influenced the basic curriculum of psychiatric nurses. Institutionalized mental health care focused primarily on delivery of care in a controlled, hospital setting led by a psychiatrist and inclusive of interdisciplinary team members including social workers, occupational therapists, psychologists, recreation therapists, and RNs. The deinstitutionalization movement led to advocacy and action of the psychiatric nursing association, RPNABC, to demand recognition and education for psychiatric nurses to work in specialized settings that included the forensic hospital and community mental health centres.

Curriculum revisions aligned RPN education across the Western provinces. Trials were undertaken to implement a career ladder education system with the benefit of nursing at the Douglas College nursing program receiving the same first foundational year of nursing and then choosing to either become LPNs, or move forward to become RNs and RPNs. This system proved unsuccessful with its implementation at a time when the future of large mental institutions was dwindling and the job security of RPNs seemed at risk. By the 1980s, a distinct entry to practice RPN program was established with a basic curriculum intended to prepare inpatient nurses.

In BC, as in Alberta, Saskatchewan, and Manitoba, RPNs remained in demand into the 2000s. RPNs were integrated into the regionalized acute psychiatric units of the general hospitals, the specialized tertiary mental health inpatient centres, forensic psychiatry, corrections, community mental health centres, and in the long-term care facilities. Deinstitutionalization led to the inclusion of what was previously considered advanced psychiatric nursing, that of

community mental health, into the basic psychiatric nursing program. Furthermore, deinstitutionalization led to psychiatric nurses working side-by-side with RNs in general hospital settings.

From hospital to community and changes in program design and curriculum

The shift of RPN education from the hospital-based system to the post-secondary institution marked a significant change in the vested interest of RPNs, as their education aligned with education trends of RNs in the province. The separation of the two programs, like the strategy implemented in Alberta and Manitoba contributed to the persistence of the distinct category of nurses. Registered Psychiatric Nursing education was largely delivered by RNs because of the limited opportunities that RPNs had to obtain graduate degrees and solidify their position within the post-secondary institution. The future of RPNs in the province seemed to be on shaky ground until the decision was made to open two additional psychiatric nursing programs in the province. The overarching models used to inform that system early on were aligned with nursing theorists popular at the time, namely Peplau and Neumann.

Men held positions as directors of the RPNABC but not in the education of RPNs. Hicks found the same to be the case in Manitoba. The director and education leaders in psychiatric nursing at the BC School of Nursing were largely RNs. Care was gender segregated until the 1960s, but this ended based on need. There simply were not the numbers of men required to fill psychiatric nursing staff positions. Enrollments of men students sharply decreased in the latter half of the 1960s. Unlike rural Manitoba, BC men worked in industries such as forestry and fisheries rather than in health care. Leadership positions in the mental hospital and in education were taken by women RPNs and RNs. The fewer numbers of men in RPN education and administrative positions in the mental hospital facilitated a close relationship between RPNs and

RNs in BC. There was resentment of RPNs towards RNs throughout the 1960s and 1970s, but also motivation for RPNs to take steps to move toward baccalaureate education, and to develop distinct professional practice standards and curriculum. Registered Nurses were also integral in the RPNABC. The move of the program to the post-secondary institution, BCIT, in 1974 and then again to Douglas College in 1983, marked a time when work was done to develop unique curriculum that drew on psychosocially based RNs models.

Implications for Nursing Education

The findings of this research have implications for the future of nursing and nursing education. Examination of the near century that the Essondale/Riverview Hospital was open highlights the deep connection that the provincial mental institution had in the foundation and structure of RPN education in BC. As mental health care moved from the mental institution to regional community and general hospital settings so did the content of RPN education. From the 1970s to the 2000s, when it was clear that large-scale provincial institutions were outdated, a push and pull occurred in which RPN advocates within the RPNABC reinforced the need of the separate profession. Workforce reports were commissioned in the 1980s and 1990s to substantiate the need for RPNs as a separate profession that required a separate education. The move of RPN education from the hospital training school to the post-secondary institution was an important turning point that allowed RPNs to take control of their education. Psychiatric nursing education carved out a unique program alongside the RN program, first at BCIT, and then at Douglas College.

It is telling that the attempts made in the 1980s to create a base program from which RNs and RPNs would choose their stream following the same foundational year failed due to insufficient numbers of students choosing to continue on to the RPN steam. The 1978 *Kermacks*

Report was seen by RPNABC as a move for the provincial government to discontinue the RPN program. RPN advocates, most strongly those in the RPNABC held their position that a stand-alone program for RPNs should exist. Although the question of whether RPNs should merge with RNs was alluded to in 2001, it was not raised again in the documents examined for this research. Today RPNs hold an integral role in the delivery of mental health care. Seats to the existing education programs in BC are increasing, making this historical exploration of persistence and perseverance relevant to ongoing development and planning of nurse education in the province.[1103]

Implications for RN curricula

Implications of this study related to education for RPNs in current and future Canadian nursing curricula. In the early 2000s psychiatric nursing was at a crossroads, at risk of losing its identity within the greater body of nursing. An important finding of this research is that in Western Canada the profession has not moved forward as a cohesive unit. Medical, political and psychiatric nursing leaders in British Columbia played key roles in ensuring the separation of psychiatric nursing as a stand-alone psychiatric nursing profession. Integrated curriculum was attempted as seen in the 1983 move of BCIT to Douglas College. Strong advocacy ensured the persistence of the profession, growing in the 2000s based on nursing shortages exacerbating the need for more psychiatric nurses along with more nurses in general. The last time the integrated curriculum model was attempted was with the initial design of the ladder system at Douglas College which proved a failure. It was not attempted again. In 2006, with the need for more nurses the BC government funding increased seats for RPNs, leading to degree programs and a

[1103] Health, 'Hundreds of New Nursing Training Seats Coming Provincewide | BC Gov News', Government, BC Gov News, 20 February 2022, https://news.gov.bc.ca/releases/2022HLTH0004-000250.

diploma program.[1104] Most recently, with the COVID-19 pandemic and opioid overdose epidemic there has been a heightened awareness of the need for mental health nursing. The International Council of Nurses (ICN) holds the position that, "the world is facing a global emergency in mental health".[1105] Mental health is foundational to all nursing. However, there have been questions of the quality of mental health nursing content in RN programs, with some RN students receiving varied clinical experience in mental health settings.[1106]

Research Reflection

The goal of pursuing this research study was to create a novel historical exploration of RPN education in BC by drawing heavily on the history of Riverview Hospital, the major provincial mental institution in the province. My project required identification, analysis, and synthesis of a large array of written, photo and video sources to construct a plausible narrative of the history of psychiatric nurse education in BC. Oral interviews were successfully used to supplement archival documents and references by adding additional context and first-person narrative from nurses who studied and worked at Riverview Hospital. Through this research, I built a foundation on which to pursue further historical research to explore more nuanced pieces of RPN education in BC, including the relationship between RPN and RNs.

The analysis is an important record of RPN pioneers in the BC, and is an integral piece in understanding their role in Western Canada. The dissertation provides a vital record of RPN

[1104] Ministry of Advanced Education, 'New Seats Bring Student Nursing Increase to 75%' (B.C. Government, 22 September 2006), https://archive.news.gov.bc.ca/releases/news_releases_2005-2009/2006AE0045-001149.htm.
[1105] International Council of Nurses, 'International Council of Nurses Position Statement - Mental Health' (International Council of Nurses, 2020), 1, https://www.icn.ch/sites/default/files/inline-files/PS_A_Mental%20Health_0.pdf.
[1106] Allie Slemon et al., 'Undergraduate Students' Perspectives on Pursuing a Career in Mental Health Nursing Following Practicum Experience', *Journal of Clinical Nursing* 29, no. 1–2 (2020): 163–71, https://doi.org/10.1111/jocn.15074.

pioneers in BC and helps to understand their role in Western Canada. This historical research also served as a transformative journey in my understanding of RPNs in the province. When I embarked on this journey, I held a perspective as an RN with a vested interest in understanding the connection of RPNs to Riverview Hospital. This historical research project was a transformative learning process that enabled me to gain insight into the evolutionary path of RPNs in relationship to mental institutions, psychiatry and the development and delivery of mental health care treatment. I have a thorough understanding of how and why RPNs became a separate nursing profession through my research, but still have many questions about how it evolved compared to RNs. Through my research process additional questions emerged about the ethical implications the continued persistence of a separate nursing designation in terms of the student, and also in terms of patient care outcomes. British Columbian RPNs were instrumental in the evolution of the profession in Western Canada, and played an integral role in their regulation as a distinct nursing profession alongside RNs.

The RPNABC fought to maintain a unique educational path for RPNs in post-secondary institutions. Unlike RNs in the province, RPNs profession was built on principles of caring for patients who were highly stigmatized, marginalized, and often outcasts from normal society. Within RPN education and practice is a skill-set based on relationships with patients who were characterized as abnormal, and was intertwined with a unique focus on psychosocial aspects of health, rehabilitation, and improving quality of life across the continuum of health care services.[1107] RPNs held an integral role in the delivery of care in mental health services in the province as Riverview Hospital wound down its final years of operation. Their education was

[1107] Dooley, 'We Gave Loving Care'; Hicks, *Politics, Personalities, & Persistence*; Tipliski, 'Parting at the Crossroads PhD'.

adapted to changes in social, political and medical understanding of mental illness and wellness in response to major events such as the world wars, deinstitutionalization, and nursing regulation.

Through this research my own understanding has grown of the role that RPNs held in mental health care delivery alongside psychiatrists, RNs, psychiatric aides, and emerging allied health professions such as occupational therapy, social work and psychology. Their education was connected to legislative changes that impacted both the mental health services and the professionalization of nursing. The profession persisted despite multiple setbacks and rough terrain in which the future of the basic education entry to practice for RPNs was unclear.

The application of Brennan's critical interpretive approach allowed me to highlight two key concepts that were inextricably linked in my exploration of the evolution of RPN education within the context of the BC provincial mental hospital, that of gender and stigma. Gender and stigma shaped the utilization of RPNs in the development, expansion and closure of Riverview Hospital, the evolution of RPN education, and the role of the RPNs in patient treatment of mental health patients.

Gender and stigma were factors that directly influenced the evolution of the profession in the close links of women to nursing, the role that women nurses played in the formation of the hospitals, and the role of men and women nurses had in shaping psychiatry. Stigma played a central role in the analysis of nurses' evolution in Riverview hospital due to the link between stigmatized mental patients and the RPNs who worked there. Like the findings of Dooley on RPNs in Saskatchewan and Manitoba, I found that RPNs at Riverview Hospital were institutionalized along with their patients, and with the deinstitutionalization movement they had

to advocate for education to prove their value and benefit in delivering mental health care outside of institutional settings.[1108]

Strengths

This research builds on more recently published research by Hicks that offers a comprehensive exploration of the transitions of Manitoba RPNs from asylum training programs to the university setting.[1109] I have done the same for BC, to demonstrate the nuances of the evolution of RPN education from early mental hospital to the post-secondary institution. Canadian research on psychiatric nursing for undergraduates faces a challenge: it often concentrates on traditional concepts of psychiatric nursing knowledge without examining their origin and evolution in relation to psychiatry and care within provincial mental institutions. The strength of this study is that it provides a comprehensive analysis of the development of RPN in BC. This is an area which has not received attention in studies on the history of nursing and thus this work fills a gap in the story of nursing in Canada.

The oral interview component of this study allowed nurses who felt a deep connection to their chosen profession of RPN to share their stories in an unrestricted manner. Many of the participants interviewed expressed their gratitude for being able to take part in this research. Though challenges arose in the poor retention of documents to give fulsome insight into the RPN curriculum content from the 1950s, an in-depth exploration of the content of their education in BC was possible because of the retention of an array of accessible records. These records were located in the BC Royal Museum Archive, the City of Coquitlam archives, the Douglas College,

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[1108] Dooley, 'We Were Institutionalized'.

[1109]. Hicks, *Politics, Personalities, & Persistence*. Hicks conducted a historical exploration of the content of psychiatric nursing curriculum in Manitoba, the content that they learned and how it was connected to the structures, practices and policies of both the hospitals and the greater Manitoba health care system

and British Columbia Institute of Technology (BCIT) Archives, and in the BCCNM archive in Vancouver, BC. These were all necessary to understand the content of existing Government of Canada reports.

Limitations

When I began this research, I did not fully appreciate the depth and breadth of the historical items I would find. A major limitation in this study was the retention and collection of documents on which to base this research. I developed this study from the primary and secondary sources that were available. While I could locate ample historical records about the formation of Essondale, RPNs and the development of the RPN school, they were stored in multiple sites with different organizations that had limited accessibility during the COVID-19 pandemic. I faced multiple roadblocks in my attempt to find records reflective of the junctures in time. For example, unfortunately, after the BC School of Psychiatric Nursing closed in 1973, the education program moved to different post-secondary institutions. The preserving of the school records was inconsistent between institutions. The RPNABC was amalgamated with the RNABC and BCPNA in 2018, resulting in loss of records. Similarly, the amalgamation of CRPNBC, CRNBC and BCCNP in 2018, resulted a loss of digital records due to lack of electronic archiving and preservation strategies. Future research is needed to locate the multiple sources of archival primary sources to assist nurse research interested in pursuing research in this area.

Besides using written and video primary and secondary sources, I interviewed eleven RPNs, ten who attended the BC School of Psychiatric Nursing, and one who worked at Riverview Hospital and had extensive experience with the association and union. The main limitation of using oral histories is the ability of nurses to accurately recall details of events that

happened early in their lives. Nonetheless, the information obtained through oral interviews was used to supplement written records.

Dissemination Strategy

Sharing my research will contribute to nursing history and the nursing profession. My dissemination plan includes the publication of parts of this dissertation in academic journals and presentations to various groups. The research will be presented as a lecture to nursing and psychiatric nursing programs at Douglas College and Kwantlen Polytechnic University. The BC Historical Society of Nursing, who supported this work through bursary funding, will receive a presentation. I will also submit abstracts for presentations at the Canadian Association for the History of Nursing (CAHN) conference in 2024. Journal articles will be submitted to various peer-reviewed nursing and historical journals.

Directions for Future Research

I embarked on this research with the goal of acquiring an in-depth understanding of the rich history of RPNs in the province of BC. Prior to engaging in this research I knew that RPN was an integral yet poorly understood nursing profession in terms of the connection to Riverview Hospital, psychiatry, and nursing in the province. Through this research, it is evident that RPNs play a crucial role in mental health care in the province and RPN practice is closely linked to the progress of psychiatry and nursing. Suggestions for future research focus on pursuit of in-depth understanding of the relationship of psychiatric nurses to other health professionals in the mental hospital, exploration of similarities and differences between RN and RPN education, deeper examination of formation of the psychiatric nurse degree, and exploration of leaders, change agents, and icons who helped move RPNs forward.

Although the end of the period researched was 2012, the findings are helpful in illuminating the current state of mental health nursing in the province. They are valuable for the future planning of nursing in BC. RPNs in BC were, and continue to be, a separate stream of entry to practice nursing that fulfilled a glaring health care workforce need. The definition of mental health services changed in the near one hundred years that Riverview Hospital was open, impacting the scope of practice and work opportunities available to RPNs in the province. RPNs worked in services designed to help those with mental illness, including mental health-specific services.

In the 20th century, RPN faced threats to its future. Registered Psychiatric Nurses persisted in the province, increasing in numbers into the 21st century, and developing standards of education on par with RNs. I began this study wondering what separated RPNs and RNs. During my study, I discovered the history of RPNs, education leaders, mental hospital connections, mental health care trends, psychiatry development, and nursing education. The mental health care profession of Registered Psychiatric Nursing survived beyond mental institutions and is still important today. Research that explores the change in scope of RPNs in relation to psychiatry and allied health professionals such as social workers, occupational therapists and psychologists in the mental hospital can help to articulate the distinct role of mental health nurses.

There is a dearth of scholarly work focused on the development of RPN education in Canada. In Western Canada, the entry to practice competencies of both RNs and RPNs allow them to work in the same jobs in psychiatric areas, making it challenging to research. Scholars fail to separate the distinct experiences of each nursing profession. For example, the researchers who recently conducted a study on the experience of RPNs in Manitoba assumed that their

experience was unique, likely due to the fact that RNs and RPNs have separate education and unique scopes of practice. [1110] However, they failed to include RNs in the sample to substantiate this distinction.

My research covered a large time period (1913-2012). I found many sources during the years when the BC School of Psychiatric Nursing was operational at Riverview Hospital (1930-1973). Future research focused on the formation of the degree program including an in-depth analysis of the course curriculum may benefit understanding of the relationship between general nursing and psychiatric nursing. Registered Psychiatric Nursing programs remained distinct at Douglas College and Kwantlen Polytechnic University, growing into degree programs that would eventually phase out the diploma programs. The differentiation and distinction between the general nursing and psychiatric nursing education programs was beyond the scope of this research but is necessary to explore to understand the differences and overlapping competencies and practices that inform education planning. This study did not examine the nursing models used at nursing schools. But, investigating the connection between these models in the schools that offered RN and RPN education programs can help identify the similarities and differences between the programs.

The RPNs role in BC expanded over time, moving from institutional mental hospital settings to general hospitals, community, and forensic settings. Future research is necessary to understand the relationship that RPNs have with RNs in these settings and how that has changed over time. Lastly, some research participants mentioned names of RPN leaders that they viewed

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[1110] Jan Marie Graham et al., 'Educating the Educators: Determining the Uniqueness of Psychiatric Nursing Practice to Inform Psychiatric Nurse Education', *Issues in Mental Health Nursing* 41, no. 5 (3 May 2020): 395–403, https://doi.org/10.1080/01612840.2019.1678081; Candice Waddell et al., 'Battling Associative Stigma in Psychiatric Nursing', *Issues in Mental Health Nursing* 41, no. 8 (2 August 2020): 684–90, https://doi.org/10.1080/01612840.2019.1710009.

as integral to the persistence of the profession. The breadth and dispersion of archival sources along with the large timeframe of this research did not permit in-depth exploration of individual psychiatric nurse and psychiatric nurse allies who promoted and progressed the profession. Biographical research on leaders in psychiatric nursing in the province can help illuminate the achievements of RPNs.

Over the lifespan of Riverview many provincial government changes happened which directly impacted the changes in organization of mental health services. This is beyond the scope of this study, but future research to systematically examine the impact of changing governments may uncover the way in which these system changes were impacted by the government agendas. Comparative research with other provinces can reveal the government's influence on mental health care in various provinces and territories and in Canada.

Summary and Conclusion

This research illuminates the history of RPN education in the province of BC, increasing its visibility within the history of nursing provincially and within the history of RPNs in Western Canada. This history of nursing education in BC sheds light on its contribution to the formation of RPNs as a distinct profession in Western Canada. Analysis of the persistence of the distinct education stream highlights the core facilitators that led to the perseverance of RPNs in overcoming threats and barriers to their existence. These include the integral relationship to the development of psychiatry, the formation of Riverview as a large-scale mental institution that had workforce needs, and the advocacy of RPNABC in maintaining the distinction.

Each analysis chapter was developed to provide a robust narrative of RPN education at Riverview Hospital, positioned within the evolution of the mental hospital. Chapter Four focused on the story of Riverview Hospital from it's opening in 1913, through its expansion, downsizing

and to its closure in 2012. I explored how the pivotal first years of Essondale Hospital solidified its position as the major mental hospital in BC, supporting the delivery of mental health care for the province. In this first era, the hospital rapidly expanded with construction of numerous buildings that housed various mental health care programs and services for patients, students, staff, and their families. Chapter Five focused on the education of nurses at the BC School of Psychiatric Nursing. Exploration began with the planning of the school for RPNs, and explained the evolution of RPN education within the hospital system and beyond the closure of the school in 1974, continuing until the closure of Riverview Hospital in 2012. Chapter Six focused on the development of treatment for psychiatric patients over the lifetime of the hospital, linking it to the evolution of psychiatry, RPN education, political and economic changes that happened throughout the 20th century. The chapter ended with an examination of changes to the provincial mental health policy and goals, and the impacts this had on the role of RPNs and other caregivers at Riverview Hospital until its closure in 2012.

Registered Psychiatric Nurses in BC fulfilled an integral need for educated nurses in the provincial mental hospital, limited to the institutions until the 1970s. The BC School of Psychiatric Nursing played an important role in educating both RNs and RPNs until the 1970s when general hospitals began to open psychiatric nursing units and educating their own nursing students. Registered Psychiatric Nurses experienced a cohesive transition from the hospital training school to the post-secondary setting because there was only one school to organize in contrast to the many hospital-based schools for RNs. A symbiotic but contentious relationship existed between the RN and RPN programs in the 1970s, when there was a question about the future of RPNs which came because of deinstitutionalization, the shift from longer-term inpatient institutionalized care to community-based care. In the 1990s, health care services reorganized

and reduced 52 organizations to 6, which streamlined services. Mental hospitals closed early because of a liberal government's austerity measures in the 2000s, while nurse education increased during the same time period.

Registered Psychiatric Nursing education was rooted in the necessity of training staff to care for people in the mental hospitals. For almost a century, from 1913 to 2012, the training of psychiatric nurses evolved from a recommendation for a separate and necessary distinct nursing profession. I achieved the overall goal of illuminating the history of RPNs in the province, making this research journey a vehicle for compiling a valuable contribution to the history of nursing in BC and the history of nursing in Canada. Ultimately, this research will act as a starting point for additional studies on the history of RPNs and the way this has shaped Western Canadian nursing and mental health care.

Archives

British Columbia College of Nurses and Midwives Archives

British Columbia Institute of Technology Archives

City of Coquitlam Archives

City of Vancouver Archives

Douglas College Archives

Provincial Archives of British Columbia

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Appendix A – Interview Guide

The purpose of this interview is to learn more about the BC School of Psychiatric Nursing at Riverview Hospital from you.

1. What years did you work at Riverview Hospital?
2. What did you do at Riverview Hospital?
3. What years were you a nursing student at the BC School of Psychiatric Nursing at Riverview Hospital?
4. What led you to choose the psychiatric nursing program?
5. Can you tell me about what the structure of the program when you attended, for example the length of the program, what subjects/topics were included in the curriculum? How long were practicums and where you placed for them?
6. What were the living quarters or nurses' residence like?
7. Who taught you the course material (for example physicians, nurses, allied health)?
8. Can you tell me about different staff that you worked with and what their roles were?
9. Can you tell me about the patients that you cared for? What were the most common diagnoses? What were the ages of the patients?
10. What kinds of treatments were offered?
11. Was there a difference between treatment for men and for women?
12. Do you remember where patients were from?
13. Describe your typical day. What were the different activities and tasks that you did each day?
14. If you had different roles (student nurse, RPN, Nurse Manager) can you tell me about what you did each day in the roles?

15. What changes did you notice when programs like Riverview hospital began closing down and care was shifted to community-based care?

Appendix B – Letter of Invitation

To: [list of recipients]
cc: research team
Subject: Invitation to participate in an interview on your experiences of being a psychiatric registered nurse and recollections of psychiatric nurse education at Riverview Hospital.

Dear [name of potential participant],

Invitation to participate
Please find following details regarding a study about **the history of psychiatric nurse education in British Columbia.**

Investigators: Michelle Danda, Dr. Tanya Park, Dr. Margot Jackson, Dr. Pauline Paul

This is to invite you to participate in a study conducted by a doctoral nursing student and members of the Faculty of Nursing, University of Alberta. The study is a historical examination of the evolution of psychiatric nurse education in British Columbia (BC), Canada, from 1913 to 2012. The focus of this study is on the development of psychiatric nursing as a distinct profession, the structures, and strategies used to educate psychiatric nurses in BC. The purpose of my dissertation research is to explore the history of RPN education in BC with a particular focus on Riverview Hospital and the BC School of Psychiatric Nurse Education.

Why is this study significant?

In BC, registered psychiatric nursing (RPN) is a distinct profession with its own legislation and code of ethics. In the province of BC, since the amalgamation of the BC Nurses (registered nurses, nurse practitioners, registered psychiatric nurses and licensed practical nurses) in 2018 to one college there are common standards of practice across nursing groups. While there are common standards amongst the groups there remain unique scope of practice and professional standards. RPNs in BC emerged within a specific historical, socio-political, legal, intellectual, and gender context that was shaped by the nursing, education, and beliefs about mental illness within that time. The rationale for conducting this historically based study is to engage in a multifaceted analysis of the intersections of the events and beliefs of time and how it shaped the formation, evolution, and ongoing persistence of RPN. Existing research on the development of psychiatric nursing focused on professionalization and education of psychiatric nurses within the context of the provinces of Manitoba, Saskatchewan, and Alberta.

Why am I being asked to take part in this research study?

You have been asked to take part because you worked at Riverview Hospital at or around the time that the BC School of Psychiatric Nursing operated and/or you were a student at the school.

What will I be asked to do?

You will be asked to participate in an individual interview with one member of the research team. You will be asked for your consent for the interview to be audio recorded, you can refuse the recording of the interview. The interviewer will ask you questions about your experiences of being a psychiatric nurse and/or being a psychiatric nursing student at Riverview Hospital. You can choose to answer or not answer the questions. It is expected that the interview will last no longer than 60 minutes. The interview will be conducted using the teleconference computer program Zoom, allowing you to be in a location of your choice. You can use a telephone line to join the Zoom meeting. You can ask for a break at any time during the interview. You can also ask to terminate the interview at any time. You will be identified by name in the interviews because this is historical research. Participating in this study requires your name to support reliability of the research and for potential use of future researchers. If you agree, the recording of your interview will be retained in an archive for other researchers in the future to use in other historical projects.

How do I participate?

If you are interested in being interviewed or would like further information, please contact:

Michelle C. Danda
Faculty of Nursing, University of Alberta
Email: danda@ualberta.ca
Tel: 587-215-8606

The participant information sheet and consent form attached to this email will provide you with more detailed information about this study.

Please forward this email and attachments to any of your colleagues who work in mental health programs.

Thank you for your consideration,

Michelle C. Danda
Doctoral Nursing Student
Faculty of Nursing, University of Alberta
Email: danda@ualberta.ca
Tel: 587-215-8606

Appendix C – Consent Form and Oral Consent Script

Consent Form

Study Title: Exploring the History of Registered Psychiatric Nursing Education in British Columbia for the Years 1913-2012

Research Investigator:
Michelle C. Danda
Graduate Office - Faculty of Nursing
Edmonton Clinic Health Academy
11405 - 87 Ave NW
University of Alberta
Edmonton, AB,T6G 1C9
Email: danda@ualberta.ca
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Supervisor:
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Faculty of Nursing,
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Edmonton Clinic Health Academy
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Edmonton AB, T6G 1C9
Email: tmpark@ualberta.ca
Tel: 780-492-9109

Background

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It will provide a summary of the research and what your participation involves. If you would like more details about anything mentioned in this form, or information that is not included here, please ask. Please take time to read this carefully and to understand any additional information.

In the province of BC, since the amalgamation of the BC Nurses associations and regulatory bodies (registered nurses, nurse practitioners, registered psychiatric nurses and licensed practical nurses) in 2018 to one college there are common standards of practice across all three nursing groups. While there are common standards amongst the groups there remain unique scope of practice and professional standards. While Registered Psychiatric Nursing (RPN) is a professional designation common to the Western Canadian provinces of Alberta, BC, Manitoba and Saskatchewan, there is not a common standard of education and curriculum development equivalent to that of Registered Nurses (RN). The goal of this study is to better understand the education and development of Registered Psychiatric Nursing in the province of BC.

The following information is being given to you to inform your decision about whether or not you wish to participate in this study. You can withdraw from the study at any point in time without affecting your relationship with this researcher and the University of Alberta, and without any prejudice to any pre-existing entitlements you hold. Consent will be discussed throughout the research process. Your participation is voluntary, and you may refuse to answer any question, or you may withdraw from the study at any time.

Purpose

The purpose of this study is to understand the history of the RPN education in BC. The information collected will be published in my Doctoral dissertation. If you wish, I will share the results with you at the completion of the study. I will email you a link to my dissertation when it is completed. The information may also be used beyond the dissertation project to write papers published in scientific journals, to present at conferences and workshops, or to share with other nurse or mental health colleagues.

Study Procedures

Oral interviews will be conducted that will be approximately 60 minutes in duration. Interviews will be conducted at a time that is convenient to the participant. Interviews will be conducted using the video conference computer application Zoom. Interviews will be recorded. If joining via the video conferencing your camera can be turned off. A direct telephone line will be available to join by phone. Interviews will be transcribed by the primary investigator. Participants in this study are required to have their name used with their data.

The computer files, audio-recordings, handwritten notes, and transcripts of our conversations will be kept confidential and accessed only by myself, Michelle Danda. The computer files will be saved on a flash drive and stored with the notes in a locked filing cabinet.

Benefits

There may be no direct benefit to your participation in this study. Potential benefits to participating are that you will be given the opportunity to share your stories, as well as share concerns and feelings about their experiences in an unrestricted manner. The stories that you share will be used to gain greater understanding of psychiatric nurse education in British Columbia, and in Canada.

Risk

While there are no specific interview questions that are thought to cause distress, you may decide to share experiences that are difficult to discuss. If you find yourself in any discomfort or distress during the interview, please let me know and we will discuss postponing or cancelling the interview, and finding you help. There will be time at the end of the interview for debriefing.

Voluntary Participation

You are under no obligation to participate in this study. The participation is completely voluntary nor not obliged to answer any specific questions even if participating in the study.

Your consent will be given verbally. Verbal response of “yes” to the statements about consent indicate that you have understood the information provided about your participation in the research project and agree to participate. This consent will be recorded. This does not waive your legal rights nor release the researcher or the involved institution from their legal and professional responsibilities. Your continuing participation should be as informed as your initial consent, so feel free to ask for clarification or new information at any time.

Confidentiality & Anonymity

This research will be used for a dissertation project, peer-reviewed research articles, presentations, teaching, and web posting. Participants may be personally identified in these projects.

Confidentiality: Because of the nature of this project, your name will appear in the final report and any publications that may come from this study. However, you will have the opportunity to read and comment on any and all contributions before publication.

The computer files, audio-recordings, handwritten notes, and transcripts of our conversations will be kept confidential and accessed only by myself, Michelle Danda, and the members of my supervisory team, Dr. Tanya Park, Dr. Pauline Paul and Dr. Margot Jackson. The computer files will be saved on a flash drive and stored with the notes in a locked filing cabinet.

Participants will receive a copy of a report of the research findings and how participants can indicate an interest in receiving such materials. We may use the data we get from this study in future research, but if we do this it will have to be approved by a Research Ethics Board.

After the study is done, and with your consent, study data will be stored in a secure data repository (BC Archive), to facilitate re-use of the data by approved researchers. Personal information (i.e. email address, telephone number) that could identify you will be removed or changed prior to sharing the data with other researchers. Any researcher who wants to use this data must have the new project approved by an ethics board and sign an agreement ensuring your confidentiality and restricting data use only to the approved project. Your data may be linked with other data for research purposes only to increase the usefulness of the data, as subject to scientific and ethical oversight as mentioned above.

Email transcripts of your interview will be mailed to you once completed. If you choose to withdraw from this study you may do so up to two weeks after you have reviewed the finalized transcripts. The same 2 week timeline applies to withdrawal from consent to store your interview data in the BC Archive. To withdraw from the study provide a written email stating that you are withdrawing.

Contact Information

Do not hesitate to ask any questions about the study before, during, or upon completion of your participation. If you have any questions concerning your participation you may contact me directly at (587) 215-8606 and danda@ualberta.ca. You may also speak with my supervisor, Dr. Tanya Park at (780) 492-9109 and tmpark@ualberta.ca. For questions regarding ethics you may contact the University of Alberta Research Ethics Committee.

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

Consent Statement

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form after I verbally confirm that I agree to participate in this research study.

Consent

Title of Project: Exploring the History of Registered Psychiatric Nursing Education in British Columbia for the Years 1913-2012 Principal Investigator(s): Michelle C. Danda, Tanya Park Phone Number(s): 587 215 8606		
	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached Information Sheet		
Do you understand the benefits and risks involved in takin part in this research study?		
Do you understand who will have access to the informatio you provide?		
Have you had an opportunity to ask questions and discuss this study?		
Do you understand that you are free to withdraw from the study at any time without having to give a reason?		
Has the issue of confidentiality been explained to you?		
I agree to be quoted directly understanding that my name and identifying information will be published.		

Who explained this study to you?

_____

I agree to take part in this study: YES ☐ NO ☐
I agree to have my interview recorded YES ☐ NO ☐

Signature of Research Subject:

By stating "yes" to the above questions I am agreeing to participate in this research study.

_____

Oral Consent Script

The consent process will be recorded as part of the digital recording.

[Oral information giving stage]

As part of the research process I will be obtaining your verbal consent to participate in this research project. The oral consent process will be recorded and kept if you agree to be a participant in this research study. A copy of the consent form has been given to you, as part of the process of informed consent. It will provide a summary of the research and what your participation involves. If you would like more details about anything mentioned on the consent form, or information that is not included in the oral consent process, please ask. Please take time to read the consent form carefully and to understand any additional information.

Background

In the province of BC, since the amalgamation of the BC Nurses associations and regularly bodies (registered nurses, nurse practitioners, registered psychiatric nurses and licensed practical nurses) in 2018 to one college there are common standards of practice across all three nursing groups. While there are common standards amongst the groups there remain unique scope of practice and professional standards. Registered Psychiatric Nursing (RPN) is a professional designation common to the Western Canadian provinces of Alberta, BC, Manitoba and Saskatchewan, but there is not a common standard of education and curriculum development equivalent to that of Registered Nurses (RN).The goal of this study is to better understand the education and development of Registered Psychiatric Nursing in the province of BC.

The following information is being given to you to inform your decision about whether or not you wish to participate in this study. You can withdraw from the study at any point in time without affecting your relationship with this researcher and the University of Alberta, and without any prejudice to any pre-existing entitlements you hold. Consent will be discussed throughout the research process. Your participation is voluntary, and you may refuse to answer any question, or you may withdraw from the study at any time.

Purpose

The purpose of this study is to understand the history of the RPN education in BC. The information collected will be published in my Doctoral dissertation. I want to know more about your experience as a psychiatric nursing student and psychiatric nurse. If you wish, I will share the results with you at the completion of the study. I will email you a link to my dissertation when it is completed. The information may also be used beyond the dissertation project to write papers published in scientific journals, to present at conferences and workshops, or to share with other nurse or mental health colleagues.

Study Procedures

Oral interviews will be conducted that will be approximately 60 minutes in duration. Interviews will be conducted at a time that is convenient to the participant. Interviews will be conducted using the video conference computer application Zoom. Interviews will be recorded. Interviews will be transcribed by the primary investigator.

The computer files, audio-recordings, handwritten notes, and transcripts of our conversations will be kept confidential and accessed only by myself, Michelle Danda. The computer files will be saved on a flash drive and stored with the notes in a locked filing cabinet.

Benefits

Benefits to participating in this study are that you will be given the opportunity to share your stories, as well as share concerns and feelings about their experiences in an unrestricted manner. The stories that you share will be used to gain greater understanding of psychiatric nurse education in British Columbia, and in Canada.

Risk

While there are no specific interview questions that are thought to cause distress, you may decide to share experiences that are difficult to discuss. If you find yourself in any discomfort or distress during the interview, please let me know and we will discuss postponing or cancelling the interview, and finding you help. There will be time at the end of the interview for debriefing.

Voluntary Participation

You are under no obligation to participate in this study. The participation is completely voluntary nor not obliged to answer any specific questions even if participating in the study.

Your verbal consent indicates that you have understood the information provided about your participation in the research project and agree to participate. This does not waive your legal rights nor release the researcher or the involved institution from their legal and professional responsibilities. Your continuing participation should be as informed as your initial consent, so feel free to ask for clarification or new information at any time.

Email transcripts of your interview will be mailed to you once completed. If you choose to withdraw from this study you may do so up to two weeks after you have reviewed the finalized transcripts. The same 2 week timeline applies to withdrawal from consent to store your interview data in the BC Archive. To withdraw from the study provide a written email stating that you are withdrawing.

Confidentiality & Anonymity

This research will be used for a dissertation project, pee-reviewed research articles, presentations, teaching, and web posting. Participants may be personally identified in these projects.

Confidentiality: Because of the nature of this project, your name will appear in the final report and any publications that may come from this study. However, you will have the opportunity to read and comment on any and all contributions before publication.

The computer files, audio-recordings, handwritten notes, and transcripts of our conversations will be kept confidential and accessed only by myself, Michelle Danda. The computer files will be saved on a flash drive and stored with the notes in a locked filing cabinet.

Participants will receive a copy of a report of the research findings and how participants can indicate an interest in receiving such materials. We may use the data we get from this study in future research, but if we do this it will have to be approved by a Research Ethics Board.

After the study is done, and with your consent, study data will be stored in a secure data repository (BC Archive), to facilitate re-use of the data by approved researchers. Personal information (i.e. email address, telephone number) that could identify you will be removed or changed prior to sharing the data with other researchers. Any researcher who wants to use this data must have the new project approved by an ethics board and sign an agreement ensuring your confidentiality and restricting data use only to the approved project. Your data may be linked with other data for research purposes only to increase the usefulness of the data, as subject to scientific and ethical oversight as mentioned above.

Contact Information

Do not hesitate to ask any questions about the study before, during, or upon completion of your participation. If you have any questions concerning your participation you may contact me directly by phone or email. You may also speak with my supervisor, Dr. Tanya Park. Our contact information is provided on the written consent form. For questions regarding ethics you may contact the University of Alberta Research Ethics Committee.

Consent Statement

I will now read the Consent Statement to confirm that you are providing your informed consent. Please answer yes or no.

- Do you understand that you have been asked to be in a research study?
- Have you read and received a copy of the attached Information Sheet?
- Do you understand the benefits and risks involved in taking part in this research study?
- Do you understand who will have access to the information you provide?
- Have you had an opportunity to ask questions and discuss this study?
- Do you understand that you are free to withdraw from the study at any time without having to give a reason?
- Has the issue of confidentiality been explained to you?
- Do you agree to be quoted directly understanding that your name will be published?

- Do you agree to take part in this study?
- Do you agree to have my interview recorded?

Appendix D – Ethics Approval Letter

Notification of Approval

Date:	October 13, 2021
Study ID:	Pro00113662
Principal Investigator:	Michelle Danda
Study Supervisor:	Tanya Park
Study Title:	Exploring the History of Registered Psychiatric Nursing Education in British Columbia from 1913 to 2012
Approval Expiry Date:	October 12, 2022

Thank you for submitting the above study to the Research Ethics Board 1. Your application has been reviewed and approved on behalf of the committee. The following documentation forms part of this approval:

Approved Documents:

Letter of Initial Contact

Letter of Invitation

Consent Forms

Consent Form

Oral Consent Form Script

Questionnaires, Cover Letters, Surveys, Tests, Interview Scripts, etc.

Interview Guide

Any proposed changes to the study must be submitted to the REB for approval prior to implementation. A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the REB does not constitute authorization to initiate the conduct of this research. The Principal Investigator is responsible for ensuring required approvals from other involved organizations (e.g., Alberta Health Services, Covenant Health, community organizations, school boards) are obtained, before the research begins.

Sincerely,

Stanley Varnhagen, Ph.D.
Associate Chair, Research Ethics Board 1

Note: This correspondence includes an electronic signature (validation and approval via an online system).

Appendix E – Research Agreement Royal BC Museum

292-30/20-0022

November 9, 2020

Michelle Danda
146 Seventh Avenue East
New Westminster, BC
V3L 4H6

Dear Michelle Danda:

Re: Request for Access to Records

I am responding to your application received by the BC Archives on November 2, 2020, in which you requested access to GR-0133, GR-0264 and GR-3925 for use in a research project on the history of Registered Psychiatric Nurses.

The BC Archives Information and Privacy Section has reviewed your application in accordance with the *Freedom of Information and Protection of Privacy Act* (the *FOIPPA*), and I am pleased to advise that, in general, your access to the records listed in the attached addendum is approved. A copy of the approved research agreement is enclosed for your records.

Please bring your copy of the research agreement, and this letter, when you visit the BC Archives. This will assist the staff on duty in the Reference Room to help you more efficiently. Please cite the research agreement number if you wish to order photocopies from the archives.

While your research agreement provides for access to personal information, which would otherwise be denied to you under the *FOIPPA,* the records you have requested may contain other kinds of information that is excepted from disclosure under the *FOIPPA* or other legislation. For this reason, you may be denied access to some of the records you have requested. Furthermore, all photocopies from the requested records may be reviewed by BC Archives staff before they are mailed from our facility.

. . ./2

If you have any questions about this letter, or your request, please contact me at privacy@royalbcmuseum.bc.ca; (250) 208-4610; or at our mailing address.

Sincerely,

Michael Carter
Government Records Manager

Enclosure

BC Archives

ACCESS TO PERSONAL INFORMATION FOR RESEARCH OR STATISTICAL PURPOSES:

INTRODUCTION TO THE APPLICATION AND AGREEMENT FORM

The Freedom of Information and Protection of Privacy Act:

The Legislature of the Province of British Columbia passed the Freedom of Information and Protection of Privacy Act, RSBC 1996, c. 165 ("the Act") on 23 June 1992 and it came into force on 4 October 1993. The Act covers all records in the custody or control of public bodies with only a few exceptions, including records placed in the British Columbia Archives (BC Archives) by a person or agency other than a public body, and certain judicial records. The purposes of this Act are to make public bodies more accountable to the public and to protect personal privacy. To achieve this, the Act contains the following features:

- The public has a general right of access to records.
- Exceptions to the right of access are limited and specific. These exceptions protect the legitimate needs of government for confidentiality in certain instances.
- Individuals have a right of access to, and a right to request correction of, personal information about themselves.
- Privacy is protected by the prevention of unauthorized collection, use or disclosure of personal information by public bodies. Personal information may not be disclosed to any person other than the individual to whom the information relates, except in certain limited circumstances.
- Decisions to disclose or withhold information under the Act are subject to independent review by the Information and Privacy Commissioner. Under the Act's appeal provisions, any decision relating to access to records can be appealed by the person requesting access or by an affected third party.

PLEASE NOTE: THE ACT ALLOWS UP TO 30 BUSINESS DAYS TO APPROVE AN APPLICATION.

Definition of Personal Information:

The Act defines personal information as "recorded information about an identifiable individual." This includes, but is not limited to, the following types of information:

a) the individual's name, address or telephone number,
b) the individual's race, national or ethnic origin, colour, or religious or political beliefs or associations,
c) the individual's age, sex, sexual orientation, marital status or family status,
d) an identifying number, symbol or other particular assigned to the individual,
e) the individual's fingerprints, blood type or inheritable characteristics,
f) information about the individual's health care history, including a physical or mental disability,
g) information about the individual's educational, financial, criminal or employment history,
h) anyone else's opinions about the individual, and
i) the individual's personal views or opinions, except if they are about someone else.

Section 22 of the Act determines whether the release of such information would constitute an unreasonable invasion of privacy.

Research Agreements:

One circumstance where personal information may be disclosed is when the disclosure is for research or statistical purposes. Section 35 of the Act allows public bodies to grant researchers the privilege of access to records containing other people's sensitive personal information, but only if certain confidentiality terms and conditions are met. This ensures that the privacy of the individuals identified in the records is protected.

Section 35 allows a public body to exercise the discretion to disclose personal information for a research purpose, including statistical research, only if the following conditions are met:

a) the research purpose cannot reasonably be accomplished unless that information is provided in individually identifiable form or the research purpose has been approved by the commissioner,

a.1) the information is disclosed on condition that it not be used for the purpose of contacting a person to participate in the research;

b) any record linkage is not harmful to the individuals that the information is about and the benefits to be derived from the record linkage are clearly in the public interest,

c) the head of the public body concerned has approved conditions relating to the following:
   (i) security and confidentiality;
   (ii) the removal or destruction of individual identifiers at the earliest reasonable time;
   (iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form without the express authorization of that public body, and

d) the person to whom that information is disclosed has signed an agreement to comply with the approved conditions, this Act and any of the public body's policies and procedures relating to the confidentiality of personal information.

Requests by researchers for access to records in the custody and control of BC Archives that contain personal information are administered through the use of an "Application and Agreement for Access to Personal Information for Research or Statistical Purposes," generally referred to as a research agreement. These are legal agreements and will only be authorized for a bona fide research project. Access privileges are granted only to the person or persons who enter into the research agreement and only for the purpose stated in the agreement. Any additions or amendments to the agreement require the approval of BC Archives.

A research agreement, once approved, gives the researcher immediate access to the requested records. It is advantageous to the researcher because it avoids possible delays caused by BC Archives' need to examine large numbers of documents, line by line, to remove personal information. Further, since the researcher will not be reading partial documents, the meaning of the records may be more clear.

Completing the Application:

BC Archives will consider the date when the complete research agreement application is received as the date of the request for access. A carefully completed form will hasten the process by which access to the records can be authorized.

The following documents are required for a research agreement application to be complete:

- The attached form entitled "Application and Agreement for Access to Personal Information for Research or Statistical Purposes." This form identifies the researcher and the records requested, and enumerates the terms and conditions under which access is permitted. It must be completed and signed by the researcher. A friend, colleague, or BC Archives staff person must witness the researcher's signature.

- A detailed (and preferably typed) description of the proposed research project for which the records are being requested (see Part B of the research agreement for a list of what this description must include).

- The researcher's curriculum vitae or resume, including 3 references (see Part B).

Duration of Access Privileges:

Access privileges to the original records requested are granted for a limited period of time, generally for up to two years from the date of approval of the research agreement. **If the researcher requires more time to complete the research project, they must submit a written request to BC Archives for an extension of the expiry date, BEFORE IT OCCURS; otherwise a new application will be required.**

Moreover, under the terms and conditions of access, the researcher agrees to destroy all individual identifiers contained in any information removed from BC Archives in the form of research notes, photocopies and/or databases. This destruction will take place at the earliest possible time, and not more than two years from the date of approval of the research agreement.

Additional Exceptions:

The research agreement only concerns access to personal information. In certain circumstances, the Act's other exceptions to the right of access, such as legal advice, information harmful to law enforcement, information harmful to the financial interests of the Province, and information harmful to third party business interests, may apply to the requested records. If any of these other exceptions are applicable, or if access is restricted under legislation other than the Freedom of Information and Protection of Privacy Act, an Information and Privacy Section analyst will explain your options.

Youth Criminal Justice Act (replaced the Young Offenders Act, 1 Apr 2003)

Access to some personal information is restricted under both the Freedom of Information and Protection of Privacy Act and the Youth Criminal Justice Act (Canada), SC 2002, c.1. The Youth Criminal Justice Act, which concerns the treatment of and information about young people who have come into contact with the law, generally restricts access to information that could be used to identify them. Section 126 of the Youth Criminal Justice Act does, however, provide for access to records containing young offender information that are held in provincial archives under certain conditions. Specifically, section 126 (Records in the custody, etc., of archivists) provides as follows:

> When records originally kept under sections 114 to 116 are under the custody or control of the National Archivist of Canada or the archivist for any province, that person may disclose any information contained in the records to any other person if
> (*a*) a youth justice court judge is satisfied that the disclosure is desirable in the public interest for research or statistical purposes; and
> (*b*) the person to whom the information is disclosed undertakes not to disclose the information in any form that could reasonably be expected to identify the young person to whom it relates.

If the records to which access is requested do, or might reasonably be expected to, contain information about young offenders, an undertaking pursuant to section 126(b) of the Youth Criminal Justice Act will be required. An Information and Privacy Analyst will contact you and provide you with the undertaking form. Upon receipt of the completed and signed undertaking, and subsequent approval of an application by BC Archives, the application will be forwarded to the Provincial Court of British Columbia for the consideration of a youth justice court judge.

Review and approval process:

Each research agreement application must go through an approval process that consists of three steps. First, an Information and Privacy Section analyst will review your application and will contact you if any clarification or additional information is required. Second, the analyst will make a recommendation concerning the application, which is then reviewed by the Manager, Information and Privacy Section. Finally, all research agreements must be approved by the delegated head of BC Archives.

PLEASE REMEMBER, THE ACT ALLOWS UP TO 30 BUSINESS DAYS TO APPROVE AN APPLICATION.

Further Information about Research Agreements:

If you have any questions or would like further information about use of a research agreement for obtaining access to personal information held by BC Archives, please feel free to contact one of the analysts in the Information and Privacy Section. They may be reached by telephone at (250) 356-0698, or by writing to the following address:

Manager, Information and Privacy Section
British Columbia Archives
Royal BC Museum
675 Belleville Street
Victoria, B.C. V8W 9W2

Date of receipt: Nov 2, 2020 Access request number: 292-30/ 20-0022

BC ARCHIVES

APPLICATION AND AGREEMENT

for

ACCESS TO PERSONAL INFORMATION FOR RESEARCH OR STATISTICAL PURPOSES

Purpose: This form is for use in requesting access, for research or statistical purposes, to personal information found in records covered by the Freedom of Information and Protection of Privacy Act, RSBC 1996, c. 165 and the Youth Criminal Justice Act (Canada), SC 2002, c. 1. Once the researcher has signed this form and the terms and conditions of access have been approved by BC Archives and a youth justice court judge, this form becomes a legal agreement between the researcher and BC Archives.

Collection of the information on this form, and the conditions of access described, are authorized by Section 35 of the Freedom of Information and Protection of Privacy Act. Any questions about this form may be directed to the Manager, Information and Privacy Section, BC Archives, Royal BC Museum, 675 Belleville Street, Victoria, B.C., V8W 9W2, tel. (250) 356-0698.

PART A - Identification of Researcher

Danda, Michelle C.
Name (last name/first name/initials)

Registration Number

Address: 146 Seventh Avenue East
New Westminster, BC
V3L 4H6

Telephone: 587 215 8606

Please provide the following additional information, if applicable:

Institutional Affiliation: University of Alberta, Faculty of Nursing
(include department, if relevant)

Position: Phd Student

Academic Advisor (if student): Dr. Tanya Park

PART B - Description of Research Project

Please attach the following information (preferably typed):

1) A general description of the research project (include the objectives of the project and the proposed method(s) of analysis).

2) An explanation of why the research project cannot reasonably be accomplished without access to personal information in individually identifiable form (i.e. personal information about named or identifiable individuals).

3) An explanation of how the personal information will be used, including a description of any proposed linkages to be made between personal information in the records requested and any other personal information (e.g. linkages between personal information found in mental health case files and newspaper reports about suicides).

4) The expected period of time during which access to these records may be required.

5) The process and timeline for the removal or destruction of individual identifiers associated with the records listed in Part C at the earliest possible time (please see Part E, Paragraph 14). If the retention of individual identifiers is required for the full term of the research agreement, please provide a detailed explanation.

6) The benefits to be derived from the research project.

Please also provide a copy of your curriculum vitae or resume. It should include education, research experience, and the names and addresses of three references.

PART C - Records Requested (Use additional sheets as required)

Please list all records containing personal information to which access is requested. This research agreement only covers records listed below. Any requests for changes or additions to this list after the application is submitted should be made in writing and will require approval in writing from BC Archives.

In each case, please provide the following: BC Archives identifying number (e.g. GR number); box, volume or reel number(s); GR title; file name(s); outside dates. If access to less than an entire box or reel is requested, please also provide the number(s) and title(s) of the file(s) requested.

Example: GR 1234, vol. 5 (Provincial Archives of B.C., Donor files), file 67 (Y-Z), 1975-1976.

1) GR-3925 964242-0001 18 The Nurse in treatment services / Irene Smith 1964

2) GR-3925 964242-0021 9 Institutional loss: an examination of a bereavement reaction in 22 mental nurses losing their institution and moving into the community / Paul Massey 1990

3)

4) GR-0133, 6, D.M. 1.18.03-3 Construction of Nurses Training School Centre 1949-1958

5) GR-0133 7 1:8:01-1 Psychiatric Nurses Mass Resignations 1967

6) GR-0133, 7, 1:5:14 Staff Organization Nurses in Mental Deficiency 1957-1958

Originals may be consulted only at BC Archives. Will you require that the above records be copied (at your expense) for viewing elsewhere?

Yes_____ No X

PART D –Youth Criminal Justice Act (Canada)

If the records listed in Part C of this form contain information that is restricted from disclosure by the Youth Criminal Justice Act (Canada), SC 2002, c.1, I undertake not to disclose the information in any form that could reasonably be expected to identify the young person to whom it relates.

PART E - Agreement on Terms and Conditions of Access

If I am granted access to the records listed in Part C, I understand and will abide by the following terms and conditions.

Security

1) I understand that I am responsible for maintaining the security and confidentiality of all personal information found in or taken from these records.

2) The following person(s) will be working with me on this project and will have access to the requested personal information:

I will be the only person viewing these records.

Before any personal information is disclosed to these persons, I will obtain a written undertaking from each of them to ensure that they will not disclose that information to any other person and that they understand and will abide by the terms and conditions of the present agreement. I will maintain a copy of each such guarantee and will provide BC Archives with a photocopy.

[Please Note: BC Archives requires copies of the undertakings described above in order to process an application for a research agreement. These undertakings are required before approval will be granted. Please include them when submitting your application.]

No other person(s) will be given access to personal information disclosed under the terms of this agreement, whether contained in the original records, research notes, photocopies or databases.

3) None of these records (including copies of them or notes containing personal information taken from them) will be left unattended at any time, except under the conditions described in Paragraphs 4, 5 and 6, below. If I am using these records in the BC Archives Reference Area, and I must temporarily leave the room, I will hand them in to Reference or Security staff until I return.

4) All copies of the requested records and any notes that contain personal information taken from them will be kept at the following address(es):

146 Seventh Avenue East
New Westminster, BC
V3L 4H6

5) Physical security at the above premises will be maintained by ensuring that the premises are securely locked, except when one or more of the individuals named in paragraph 2) are present, as well as by the following additional measures (e.g. locked filing cabinet):

Documents will be kept in a locked filing cabinet in a locked office. Electronic files will be kept on laptop that is password protected in files that are also password protected.

6) Personal information taken from the records covered under this research agreement will be entered into and stored on a computer system.

Yes X No

If yes, please read and initial the attached Schedule A – Electronic Data Security.

7) I will permit BC Archives staff to carry out any measures deemed necessary to verify compliance with the terms and conditions set out in this agreement. Such measures may include, but are not limited to the following:

- on-site inspection of premises or computer databases to confirm that stated security precautions are in effect;
- receipt upon request of a copy of any written or published work based on research carried out under the terms of this agreement;
- verification from the researcher that the destruction of all information about identifiable individuals has been carried out by the date specified in this agreement.

8) Any application of data or information linkages (manual or computer) will be handled with the greatest consideration for personal privacy. Particular attention will be paid to linkages of personal information from government records with information in publicly available sources. I will not make any information linkages other than those specified in the description of the research project (Part B).

9) Papers or any other works which describe the results of the research undertaken will be written or presented in such a way that any personal information contained in them is rendered sufficiently anonymous that the individual to whom the information pertains cannot be identified. There will be no exceptions to this rule without prior written permission from BC Archives.

[The researcher should bear in mind that it is frequently possible to identify an individual by a combination of characteristics or variables, even if that person is not named. For example, many people might well know who is being discussed if mention is made of a tall female gas station attendant in New Denver who is 35 years old and was born in Windsor, Ontario. Therefore, anonymization may require more than simply removing names. The researcher is responsible for taking whatever measures are necessary to protect individual privacy.

This rule applies to ALL personal information in the subject records, including personal information about elected and other public officials, as required by section 35(c)(iii) of the *Act*. However, BC Archives routinely authorizes the use of such personal information in individually identifiable form, whenever the personal information is related to the public official's position and duties.]

10) Any case file numbers or any other individual identifiers which appear in my written or other work will be created by me and will not relate to any real case file number or identifier found in the records.

11) Any case file numbers or other individual identifiers to be recorded on computer will be created by myself or one of the persons listed in paragraph 2) and will not relate to any real case numbers found in the records.

12) Unless expressly authorized in writing by BC Archives, no personal information that identifies or could be used to identify the individual(s) to whom it relates will be transmitted by means of any telecommunications device, including telephone, fax, modem or electronic mail.

13) No direct or indirect contact will be made with the individuals to whom the personal information relates.

14) Individual identifiers associated with the records listed in Part C will be removed or destroyed at the earliest time at which removal or destruction can be accomplished consistent with the purpose of the research project. At the latest (maximum 2 years), this will occur by:

2022 / 11 / 2
(year/month/day)

Any extension to this time limit must be approved in writing by BC Archives. The removal of individual identifiers will be done in a manner that ensures that any remaining information cannot be used to identify the individual to whom it relates. If necessary, this will be done by destroying copies of records or pages of notes in their entirety. Disposal of any research notes, photocopies or computer disks containing personal information must be carried out in a manner that ensures the protection of privacy.

15) I understand that I am responsible for ensuring complete compliance with these terms and conditions. If I become aware of a breach of any of the conditions of this agreement, I will immediately notify BC Archives in writing. Contravention of the terms and conditions of this agreement may lead to the withdrawal of research privileges, and BC Archives may also take legal action to prevent any further disclosure of the personal information concerned.

Signed at New Westminster, this 2 day of November, 20 20

Signature of Researcher

Signature of Witness

Kelly Davison, R.N.
Name and Position of Witness

PART F - Approval of Terms and Conditions

The terms and conditions of this agreement are hereby approved. BC Archives reserves the right to withdraw access to records without prior notice if this becomes necessary under the provisions of the Freedom of Information and Protection of Privacy Act.

The expiry date for access to the records listed in Part C is: / / (year/month/day)

Signature (BC Archives)

Date

Position

Signature (Youth Justice Court Judge)

Date

15) I understand that I am responsible for ensuring complete compliance with these terms and conditions. If I become aware of a breach of any of the conditions of this agreement, I will immediately notify BC Archives in writing. Contravention of the terms and conditions of this agreement may lead to the withdrawal of research privileges, and BC Archives may also take legal action to prevent any further disclosure of the personal information concerned.

Signed at New Westminster, this 2 day of November, 20 20

Signature of Researcher

Signature of Witness

Name and Position of Witness

PART F - Approval of Terms and Conditions

The terms and conditions of this agreement are hereby approved. BC Archives reserves the right to withdraw access to records without prior notice if this becomes necessary under the provisions of the Freedom of Information and Protection of Privacy Act.

The expiry date for access to the records listed in Part C is: 2022/11/02 (year/month/day)

Michael Carter
Signature (BC Archives)

Nov 9, 2020
Date

Govt. Records Manager
Position

Signature (Youth Justice Court Judge)

Date

SCHEDULE A

ELECTRONIC DATA SECURITY

1) Ensure the computer(s) used for accessing, viewing or storing any of the personal information taken from records covered under this research agreement is secured with a login and strong password. For Windows computers this means enabling user passwords and CTRL-ALT-DELETE access. Fast User Switching must be disabled. Macintosh computers enable login and password access by default.

2) Ensure the computer(s) used for accessing, viewing or storing any of the personal information taken from the records covered under this research agreement meet(s) the following anti-virus/anti-malware specifications. This is to ensure the computer and data manipulated with the computer is protected from various forms of attack including malware, key-stroke loggers and other forms of data theft. Be aware that attack software can "lurk" on an unprotected computer and collect data for later transmission even when the computer is disconnected from network access:
    a. If the computer runs Microsoft Windows (XP, Vista or Windows 7) then it should be protected with a "paid-for" commercial, well-regarded anti-virus/anti-malware program such as those available from Symantec, Trend Micro, McAfee, AVG and others. "Free" or "open-source" anti-virus solutions are not acceptable for use in this scenario.
    b. If the computer runs Microsoft Windows (XP, Vista or Windows 7) then the Windows firewall should be enabled and the machine should have Windows/Microsoft updates applied on a regular basis, preferably monthly.
    c. If the computer runs Microsoft Windows (XP, Vista or Windows 7) then it should be scanned on a regular basis with a standalone anti-malware/anti-spyware program such as Super Anti-Spyware, Malwarebytes or Ad-Aware, preferably monthly.
    d. If the computer is a Macintosh then it should be protected with a "paid-for" commercial, well-regarded anti-virus/anti-malware program such as TrendMicro "Smart Surfing for Mac", Norton "Internet Security for Mac" or McAfee "VirusScan for Mac". "Free" or "open-source" anti-virus solutions are not acceptable for use in this scenario. It is a fallacy that Macintosh computers are "immune" to viruses, malware and other types of "attack" software and therefore require no anti-virus software.

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SCHEDULE A (CONTINUED)

ELECTRONIC DATA SECURITY

3) Ensure any records covered under this agreement that contain personal information are stored on a secured, encrypted hardware device such as a hardware-encrypted USB memory stick that utilizes strong 256-bit FIPS-compliant hardware encryption and password or biometric access security. Examples of such devices would be the Lexar "JumpDrive SAFE FIPS", the Kingston "Data Traveller 5000" and the SanDisk "Cruzer Enterprise FIPS Edition" units.When using such a device it is imperative that you read and follow the directions that come with the device and always choose a strong, not-easily-guessed password of at least 8 characters. Biometrics-secured devices are exempt from this requirement. The secured storage device should always be stored in a secured location (eg: a locked cabinet) when not in use.

4) Ensure that any passwords used to access the encrypted storage device are NOT written down or recorded in any way. A password is of no use if it is easily guessed or, worse, written on a Post It note and attached to a screen or the USB device.

5) Ensure the computer used to access and manipulate data from records covered under this agreement is **disconnected** from any form of network - wired, wireless, Bluetooth, telephone-modem or otherwise - while records containing personal data are being accessed. It is imperative that no alternate access into the computer via any network or other means is available while the records contained on the encrypted storage device are open to the computer. To ensure compliance disconnect the network cable and turn off wireless and Bluetooth access while accessing data from the encrypted device.

6) Ensure you clean up any temporary files that are left on your computer after accessing any records containing personal data. This will ensure that no "footprint" is left behind that may contain personal data. On a Windows computer the "Disk Cleanup Tool" (available in XP, Vista and Windows7) on the Disk Properties page has appropriate selections for erasing temporary files. Macintosh computer users should open a command window and issue the command **sudo periodic daily** in order to erase temporary files. The computer should then be rebooted to complete the process and ensure any memory-resident data is cleared.

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SCHEDULE A (CONTINUED)

ELECTRONIC DATA SECURITY

7) If the computer is backed up in any way to any type of storage medium, ensure the secured storage device is **not** connected to the computer while the backup process is running. Under no circumstances will you allow the personal data contained within records covered by this agreement to be copied out to any other storage device or storage medium including, but not limited to other non-secure USB devices, hard disks and cloud storage mediums (egCarbonite, Mozy, Amazon S3). Backups should only be performed after the tasks in Step 5 above have been performed.

8) Ensure the computer is never left unattended while the secured storage device is attached to the computer. The secured storage device should be closed and disconnected from the computer and the keyboard should be "locked" requiring a password for access.

9) At the end of this agreement, all media used to store records containing personal data covered under this agreement -- including the computer hard drive, the secured storage device and any other storage device that may have been used -- should be "sanitized" in order to remove all traces and remnants of personal data. The steps used to perform this sanitizing should conform to those defined by the Manager, Information and Privacy Section, BC Archives based on the level of sensitivity of the records in question. The US National Institute of Standards and Technology publishes a Guide for Media Sanitation (NIST Special Publication 800-88, http://csrc.nist.gov/publications/drafts/DRAFT-sp800-88-Feb3_2006.pdf) which details steps that can be taken to ensure compliance. The secured storage device should be securely erased/re-formatted (the device manufacturer should provide instructions on the needed process) and any files stored on the computer itself should be securely erased/destroyed (you may require a secure file deletion program in order to complete this step).

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Lay Summary

Registered Nurses (RN) and Registered Psychiatric Nurses (RPN) work together in acute and community mental health areas, but often experience role confusion. RPNs in BC emerged in the early to mid-1900s, within a specific historical, social, political, legal, intellectual, and gender context that was shaped by the nursing and education beliefs about mental illness at that time. Clear understanding of the history of the RPN profession is needed to understand the relationship between RNs and RPNs. A historically-based study is best suited to gain an in-depth understanding of the various factors that influenced psychiatric nursing education in BC from its' beginning, and to see how it has changed over time. A historical method will allow the researcher to find and analyze current records of information related to psychiatric nursing in BC in the 20th century. The method will highlight the changes of RPN education in BC over the 20th and 21st century.

My study is designed to address a number of research questions to identify how social, political and economic factors influenced the place and role psychiatric nurses:

- What socio-political factors of the early 20th century led to the formation of Essondale Hospital and the BC Psychiatric Nursing School?
- How did provincial legislation influence the formation, education, and professionalization of RPNs in British Columbia?
- What were the social, political and economic influences on the development of mental health nursing curriculum in relation to general nursing programs in BC?
- What role did the BC Psychiatric Nursing School at Essondale Hospital play in the development of Registered Psychiatric Nursing?
- What role did RPNs play in the closing of Riverview Hospital, and the de-institutionalization movement in British Columbia?
- What was the role of Psychiatric Nursing in British Columbia at the end of the institutionalization?

Existing research on the development of psychiatric nursing was focused on professionalization and education of psychiatric nurses in the provinces of Manitoba, Saskatchewan and Alberta. The value of my research is the unique focus on British Columbia, a coastal province, a leader in harm reduction, hard hit by the opiate overdose crisis, and grappling with important issues like changing mental health laws.

Proposed Research Project Summary

Mental Health care is fractured. There is disagreement about attributes of mental health versus psychiatric nurses. Recent changes of the BC nursing regulator, association and union necessitate an exploration of the differences in the education and training of Registered Nurses (RN) and Registered Psychiatric Nurses (RPN) to better understand why professional segregation began and why it has persisted. Historical inquiry will uncover how RPN education and training developed, and bring conceptual clarify to the role of psychiatric and mental health nurses in BC and in Canada.

Research Question

The study design includes a series of research questions aimed obtaining in-depth understanding of how social, political and economic factors influenced the place and role psychiatric nurses. The research questions are:

- What socio-political factors of the early 20th century led to the formation of Essondale Hospital and the BC Psychiatric Nursing School?

- What role did the BC Psychiatric Nursing School at Essondale Hospital play in the development of Registered Psychiatric Nursing?
- How did provincial legislation influence the formation, education, and professionalization of RPNs in British Columbia?
- What were the social, political and economic influences on the development of mental health nursing curriculum in relation to general nursing programs in BC?
- What role did RPNs play in the closing of Riverview Hospital, and the de-institutionalization movement in British Columbia?
- What was the role of Psychiatric Nursing in British Columbia at the end of institutionalization?

Objectives

The value of understanding history is that it does more than simply tell us about successes, it also tells us when we have failed, which is the only way that we can know when to do better. The main objective of this research is to understand the history of the formation of the psychiatric nursing profession in BC. A critical and interpretive perspective will be used to problematize the separation of the two professions within a nursing landscape in which both RNs and RPNs work in the same places and spaces, and with the same patient populations, yet have segregated education.

Methodological Approach

Historical research method will be used. The value of historical research is that it forces nurses to confront the past. I believe that the history of psychiatric nursing in BC is worth documenting because it will provide a means of understanding and reflection for psychiatric nurses in the province who are not aware of the history of their profession, and the connections that it has to the provincial mental health institutions of the 20th century and the connections that they have to the education of RPNs in other provinces. The City of Coquitlam Archive and the BC Archive houses the majority of required documents to support this project. The UBC digital archives will also be utilized.

Expected Outcomes

Today, there is increased understanding about the importance of trauma and violence informed practice, person and family centered care, strengths-based care, and relational practice in all nursing. The expected outcomes are that a historical understanding of the formation of nursing psychiatric education and training in BC will be gained. This research will illuminate how and why the two professions developed in BC, to inform if the separate streams should continue.

Rationale for Personal Information/Identifiable Individuals

The purpose of this historically focused research project is the development of the profession of psychiatric nursing in BC. The project requires a depth of information that includes nursing meetings, correspondence, evaluations, facility reviews, newsletters etc. that may include identifiable information.

The information will be used as part of a historical project in which prominent government figures, administrators, educators, and nursing staff may be named for the purpose of describing the processes and developments that occurred in creating the BC School of Psychiatric Nursing and the Registered Psychiatric Nursing self-regulated body in BC. Patients are not the focus of this project, therefore patient records will not be used.

I am planning to access these records on November 21-24th 2020. I am travelling form the Lower Mainland, BC in order to access these documents. At the latest the removal and destruction of the individual identifiers with records listed in Part C will be completed November 2, 2022.

Benefits of the Research Project

Mental health nurses are in a unique position in Western Canada. Registered Psychiatric Nursing, a designation that is not recognized in Eastern Canada, is an integral nursing profession in the delivery of mental health care services in Western Canada. There are 6 psychiatric nursing programs in Western Canada. Three of them are located in the Lower Mainland, BC. According the CIHI statistics on nursing supply in Canada, almost half (47%) of RPNs in Western Canada are registered in the province of BC. Three of six psychiatric nursing education programs are located in the Lower Mainland, BC. There is no historical research on the history of registered psychiatric nurses in BC, limiting understanding of the profession including the development of the role and how it fits into the larger profession of nursing. This research will make a significant contribution to the nursing profession in Canada and raise the prominence of the RPNs in BC.

Mental Health care is fractured, with ongoing debate about what constitutes a mental health nurse and a psychiatric nurse. With the recent changes of the BC nursing regulator, association and union in the last decade, it is of value to explore the differences in the preparation of RNs and RPNs to better understand the differences in training and education, why it persisted through the 20th and into the 21st century, and how this may change as the century progresses to clarify the role of mental health nurses in BC and in Canada. Historical exploration of registered psychiatric nursing education through an interpretive and critical lens can illuminate questions that are more difficult to ask including: why was separate education considered to be the best choice within certain historical contexts, what was the difference between education of RNs and RPNs, and should the independent education streams persist?

References

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Additional Records Requested

1. GR-0133 Box 7 Classification 1:05:07-5 File Title: Staff Organization - Psychiatric Nurses - Salaries 1937-1965
2. GR-0133 Box 7 Classification 1:5:07-3 File Title Psychiatric Nurses in Training 1951-1967
3. GR-0133 Box 7 Classification 1:5:07 File Title General Psychiatric Nurses 1952-1959
4. GR-0133 Box 12 File Title Nursing - Psychiatric Nurses 1963
5. GR-0133 Box 13 Board of Nurse Examination 1964-1971
6. GR-0133 Box 13 R.N.A.B.C. - Criteria - Schools of Nursing 1965-1967
7. GR-0133 Box 13 R.N.A.B.C. - Nursing Education 1970-1971
8. GR-0133 Box 13 R.N.A.B.C. - Psychiatric Nursing 1957-1963
9. GR-0133 Box 13 Reports on Nursing Education 1963-1971
10. GR-0133 Box 13 Nursing Profession 1959-1969
11. GR- 0133 Box 13 Nursing Service 1955-1967
12. GR- 0133 Box 13 Accreditation 1956-1961

13. GR-0133 Box 15 Role of Psychiatric Nurse 1954-1965
14. GR-0133 Box 15 Team Nursing - References 1962-1966
15. GR-0133 Box 15 Trends in Nursing 1958
16. GR-0133 Box 15 Nursing Liaison - Sub Committee 1962-1963
17. GR-0133 Box 15 Liaison Nurse - Materials 1964
18. GR-0133 Box15 Nursing Liaison Committee 1962-1969
19. GR-0133 Box 15 Nursing Council Minutes 1959-1962
20. GR-0133 Box 15 Nursing Council Minutes 1963-1969
21. GR-0133 Box 16 Nursing Council Terms of Reference 1961-1966
22. GR-0133 Box 16 1-10.02 Public Health Nurses 1963-1966
23. GR-0264 Box: 000504-0001 Box 1: Minutes of meetings of the Council of Psychiatric Nurses (1951-1958), including lists of licensed nurses and nurses whose licenses were cancelled

24. GR-0264 Box: 000504-0001 Box 2: correspondence, report, and brief regarding an investigation of certain conditions at Essondale (Bloomfield 1947

Appendix F – Letter of Permission

City of Coquitlam
ARCHIVES
SEARCH · ACCESS · DONATE

August 24 2023

Dear Michelle,

I can confirm you may use the following City of Coquitlam Archives photographs in your PhD thesis.

Please list them as follows:

Essondale's West Lawn - Straight-on View, ca. 1914, C5-S01-SS02-EH.003, City of Coquitlam Archives

Staff Photo with Dr. Arthur L. Crease and Florence Van Wyck, 1924, C5-S01-SS05-F6-C5.618, City of Coquitlam Archives

Nurses' Home No. 1 and 2, Essondale 1939, C5-S09-F17-F17-4, City of Coquitlam Archives

Please send us copy of your thesis for our files.

King Regards

Jamie

Jamie Sanford BA (Hons/First Class) MAS| City Archivist

City of Coquitlam Archives| 3000 Guildford Way | Coquitlam, BC | V3B 7N2

T: 604.927.3907| E: jsanford@coquitlam.ca

We acknowledge with gratitude and respect that the name Coquitlam was derived from the hən̓q̓əmin̓əm̓ word kʷikʷəƛ̓əm (kwee-kwuh-tlum) meaning "Red Fish Up the River". The City is honoured to be located on the kʷikʷəƛ̓əm (Kwikwetlem) traditional and ancestral lands, including those parts that were historically shared with the sq̓əc̓iy̓aʔɬ təməxʷ (Katzie), and other Coast Salish Peoples.

File #: 97/1 Doc #: 4979229.v1