Yorkton Stories

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Yorkton Psychiatric Centre was a first (and cutting edge) in 1964

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Dick DeRyk

They came from far and wide, those working in the field of psychiatry and mental health treatment across Canada and the United States. They came to Yorkton in 1964 and several years after in large numbers to see for themselves how a new way of treating patients with mental health issues was being implemented at the new Yorkton Psychiatric Center. It was a brand new facility, consisting of an annex to what was then the Yorkton Union Hospital, and five standalone buildings or cottages to house patients. All of it was a radical departure from what had been standard mental health treatment in Saskatchewan. Large impersonal buildings at Weyburn and North Battleford that from the outside could easily be mistaken for jails, were called mental hospitals, and were generally referred to as asylums. Patients lived in large, overcrowded wards and had little privacy, and the doors were locked at night. The new facilities in Yorkton were a stark antithesis, due in large part to a new way of thinking within the provincial government and the work of an architect who went to some lengths to understand the mindset of patients with mental health issues.

We explored the story of the Yorkton Psychiatric Center with two people who have, perhaps, the most insight into the history and operation of that facility. Dr. Erika Dyck is a professor of history and Canada Research Chair in the History of Medicine at the University of Saskatchewan, who has researched and written extensively about mental health care in Saskatchewan going back to the early 1900s. Among her publications are books and papers examining psychiatric care in Saskatchewan, including how the architect of the Yorkton Psychiatric Center, Kyoshi Izumi, applied his experience with LSD to come up with a radical new design for psychiatric hospitals.

Much more about her writing, as well as a paper she wrote about Mr. Izumi and his work Spaced Out in Saskatchewan, can be found on our website, yorktonstories.ca. There is, admittedly, more detail to this story than we can cover in this podcast. You can find some of that on our website, all of it providing a fascinating insight into the care of mental health patients and the Yorkton Psychiatric Center.

Peter Legebokoff provides us with his feet on the ground experience, working in psychiatric care, first in Weyburn and then in the new Yorkton facility. Born and raised in the Pelly area, he started a career in psychiatric nursing at Weyburn Hospital in 1957, and came to Yorkton in 1962 when the Yorkton Psychiatric Center was under construction. He worked there until his retirement in 1988 and still lives in Yorkton, where he has been actively involved with the Yorkton Flying Club at the

airport, the Lions Club, New Horizons Senior Center, and other community activities. Now in his late 80s, both his memory and the documents he has preserved about the center were of immense value in developing this podcast.

Peter's documents include the history of the first 25 years of the Yorkton center, written by Kathleen Wood, better known as Kay, who was the first nurse hired when the center was opened in 1962. She was the superintendent of nursing at the center, and in 1966 became the Director of Nursing for the entire Yorkton hospital. She spent 42 years in the nursing profession, most of it in Yorkton, and died in November of 2015 at the age of 96.

In the early 1960s, the CCF government under Premier Woodrow Lloyd adopted what was called the Saskatchewan Plan, developed by Dr. Donald Griffith (better known as Griff) McKerracher of the University of Saskatchewan Psychiatry Department, and Dr. Sam Lawson, the director of the government's psychiatric services branch at the time. The plan ran counter to what was in place in the province at the time. Instead of two large facilities in more remote areas of the province, along with small wards at hospitals in Regina and Saskatoon, it proposed that medical and counseling services be available close to where people live and work. That would allow early intervention and avoid isolation of patients. And it said rehabilitation should be provided to help patients get back to a more normal life in or close to their home community to reduce the likelihood of readmission to hospital.

The concept was not new. In 1953, the World Health Organization had recommended that patients should eat, sleep, and work in groups of 10 or less and have a maximum amount of privacy. It also said that mental health facilities should operate in close conjunction with general hospitals.

Which brings us to Kyoshi Izumi, the architect who designed the Yorkton Psychiatric Center. Based on unconventional thinking at the time, and of course his experimenting with a hallucinogenic LSD, he came up with a concept he called the socio pedal, small units, each providing a private space and bath and toilet facilities for a dozen patients, as well as group areas for small and large groups, food service areas, laundry, a visitor area, nursing station, and a landscaped outdoor recreation area.

As Dr. Dyck recalls in her book, Psychedelic Psychiatry, LSD on the Canadian Prairies, the experimentation with LSD and mescaline goes back to the 1950s in Weyburn by psychiatrists Abram Hofer and Humphrey Osmond. In fact, she discovered the word "psychedelic" was brand new at the time, coined by them in Weyburn, Saskatchewan. Dr. Dyck writes that the LSD research was taken seriously in the psychiatric profession worldwide, and the work at Weyburn was cutting edge. However, LSD's association in the 1960s, with the counterculture promoted by Timothy Leary, among others, meant it lost credibility. But not before Izumi tried LSD for the first time in 1957. Further experimentation convinced him that earlier researchers were correct. LSD produced sensations that mimicked psychotic perceptions, which allowed him to gain a unique insight into schizophrenic perceptions.

In Spaced Out in Saskatchewan, Dr. Dyck writes, Izumi wandered through the halls of Saskatchewan's largest mental health facility, the Provincial Mental Hospital at Weyburn, while under the influence of LSD. He noticed, for example, that corridors seemed infinitely long, echoes

sounded like voices, and dark colors appeared as holes in surfaces. These kinds of observations led him to conclude that the asylum was a frightening place for psychiatric patients. That greatly influenced his design of the Yorkton facility, which was based on the socio-pedal concept. But that was not to be scuttled by the realities of the day, building codes, hospital construction standards, and the government's reluctance to get too far out on a limb. Instead, Yorkton ended up with an annex to the hospital and five small buildings, cottage-like, that could house 30 patients each, linked by a network of underground tunnels. All of those buildings and the tunnels are still there on Bradbrook, but only the building attached to the hospital and one cottage are still being used for what is now called the Yorkton Mental Health Center, with the cottage unit housing inpatients. The other units have been converted to use by hospital administrative staff, home care, and other health services.

When it opened in 1964, the Yorkton Psychiatric Center was the first small regional mental health inpatient center in North America, as had been proposed by the Saskatchewan plan. It emphasized outpatient care, a team approach involving all of the mental health professionals, decentralization of services into rural areas, and reduction in the length of time people stayed in mental health hospitals. The provincial government changed in April of 1964, five months before the official opening of the Yorkton Psychiatric Center. The Liberals under Ross Thatcher defeated the CCF, forerunners to today's New Democrats, by a margin of 660 votes province-wide. Several years later, the new government commissioned Dr. Shervert Frazier of Texas to study Saskatchewan's psychiatric services and make recommendations, resulting in what is known as the Frazier Report. He strongly supported the Saskatchewan plan, but noted that it had not been fully implemented because the budget of the psychiatric services branch was insufficient. Unsatisfactory salaries and working conditions led to an exodus of key professions. The emphasis had also changed to providing more funding to the mental health associations and its local branches for more community programs with the intent to require less space for patients in a hospital-like setting.

Peter Legebokoff
In Saskatchewan, with the odd exception, Saskatoon University Hospital had a psychiatric ward on site. And in Regina General Hospital, there was a psychiatric ward. And that was about it for in-hospital-based psychiatric services. And they were hard to access because there's a very limited number of beds. And everything else was done in the large mental hospitals. So many became sort of chronically ill and institutionalized, and the population of these big mental hospitals continued to rise and rise. Weyburn had been built to accommodate, I think, 1,200 patients. In the mid-40s, they had double that number.

When I came there in 1956, there were still, you know, 1,500 patients there. So the Saskatchewan plan envisioned that in order to reduce this institutionalization that they would try something different, establish treatment centers in other parts of Saskatchewan attached to the regional general hospitals. And Yorkton was the first place that was approved for it. We started an 11-bed psychiatric ward in the basement of the south wing in the spring of 1962. So we were operating a psychiatric inpatient service in Yorkton. And by 63, we were occupying some of the units of the new psychiatric center, as it was called. The 11-bed ward was where we established the procedures and the principles and the protocol of inpatient service in the general hospital setting and not in some distant mental hospital.

It was a hospital-based program. We had the inpatient staff, psychiatric nurses looking after the patients who were admitted to the hospital. And there was a community staff, social workers who were working in the region. That was probably the first time that there was a psychiatric social work service extended out to the community from any of these locations.

Whatever we learned in the 11-bed ward operation was applied to the new units as they opened up. And of course the staff were extended, and more and more community workers were hired. And it was a combined effort. Community service, early detection, early treatment, home visiting, bring the patients in for acute treatment. And they could be discharged in maybe a matter of weeks, sent home, and they would be followed up at first by social workers, and then they would be followed up either, you know, visiting a local clinic at Canora or Kamsack, or they might be requested to come back and see a psychiatrist or follow-up person in Yorkton. The fact that there was follow-up available, you know, provided for early discharge and shorter stays. We didn't seem to be developing any chronic patients in the early days of the services. We got the impression that if a patient was first treated in Yorkton in our services, they would never become chronically ill, like Weyburn and North Battleford was loaded with chronically ill institutionalized patients who had little or no prospect of ever being discharged. The longer the patient stayed there, the more likely they would become resistant to treatment, they would become withdrawn, desocialized, institutionalized, and unable to function in the open society. They became used to the security of the mental hospital service and all that it offered. It was familiar, it was a safe environment for them. There was nobody harassing them as they might have experienced in the open society.

Institutionalization, it was a bad thing. It just led to long, long stays. We thought we could avoid that. However, in subsequent years, we had to admit there's a certain number of these patients would become chronically ill and that they would need continuing care and supervision, that they would never fully recover. But because of care and supervision and follow-up was readily available, their treatment ongoing was more effective and more humane, you might say, than the big institutional setting. We had to admit that some people who become chronically ill that we could just not rehabilitate them completely, but there were a minimum number. I think we had pretty good success. Back to the community, back to work, back to the family.

Dr. Erika Dyck
The Saskatchewan plan is a really interesting example of where Saskatchewan was really experimenting with things both in public policy and in health practice. And you have kind of an intersection here of a political desire to support people in psychiatric facilities or people with psychiatric diagnoses, so support them financially, but also to innovate within psychiatric practice. So the Saskatchewan plan recognizes, for example, that patients who suffer from different psychiatric disorders also experience stigma or discrimination in the community. And one of Griff McKerracher, who one of the architects of the Saskatchewan plan, readily recognized that general hospitals were no places for psychiatric patients, that you can't just mix them with the general population because they have particular needs, not just clinical needs, but social needs as well. However, they shouldn't be shunted off to the corners of the province or the corners as far as the roads went in North Battleford, where we had a hospital that was built in 1911, or in Weyburn, a hospital that was built in 1921, specifically for psychiatric patients.

Huge gothic structures that, you know, really kind of loomed large on the prairie landscape, I think created this kind of dwarfing sense for anyone who was approaching those buildings. You know,

that sense of authority or imposing infrastructure was designed with intention. Griff McKerracher, who was at the time the director of psychiatric services in Saskatchewan, hired by Tommy Douglas to kind of lead this investigation but oversee how psychiatric care could change under a publicly funded health mandate. He thought not only that psychiatric facilities needed to create a welcoming atmosphere or needed to be welcoming to patients, but they also couldn't be so far away from their families. And again, if you imagine, you know, where does somebody from Prince Albert go? You know, they may end up in Weyburn, they may end up in North Battleford. Often it depended more on their condition and on the availability of beds.

But both facilities were overcrowded and people were being removed from any kind of kin network or any kind of network of people, a social network that they were familiar with. And psychiatrists readily recognized that that was actually detrimental to their improvement or their capacity to ever return into those communities. And as we kind of move towards an idea that care in the community is going to be superior to isolation and perhaps living out the rest of your life in a custodial facility, you know, there's a desire to have psychiatric facilities in smaller centers that can accommodate people within at least some kind of reasonable amount of space from or like geographical distance from their families.

And that goes hand in hand with reducing costs. Although it costs to build smaller institutions, it also reduces cost from if the idea is that people will ultimately be able to return to their families or return to their communities. That's going to reduce the burden of cost for a government that's particularly interested in implementing a publicly funded system.

Dick DeRyk
In 1958, there was a pilot project in Swift Current.

Dr. Erika Dyck
Swift Current gets chosen. And I've read this recently, and there was something kind of perfect or ideal about the Swift Current region that made it a great experimental test case for, you know, kind of imagine you're on your graph paper, you're drawing out, you know, the ideal precursors for Medicare. And Swift Current was chosen as the region and it had some existing infrastructure in place. And they thought it had a good catchment area, a good distribution of population to be able to test out some of these ideas about a publicly funded system, including provisions for mental health care. And so it ends up as this test case for a variety of different health issues. And then elements of that are meant to then move into these other districts, Regina, Saskatoon, and of course Yorkton is also identified as an ideal location for another one of these health districts with comprehensive care within driving range of about 100 miles.

But Yorkton gets a different kind of influence here because they've got the Yorkton Psychiatric Hospital as it's being conceptualized, also has input from some rather innovative players on the scene, including a psychiatrist who's interested in psychedelic therapies, and an architect who quickly becomes friends with that psychiatrist and is also interested in what a psychedelic experience can do to him as an architect, conceptualizing space that is designed for patients who, many of whom suffer from disorders that we know now are punctuated by hallucinations and delusions. So this kind of altered sense of reality, which they believed could be kind of mimicked or mirrored by taking psychedelics. So you've got this interesting blend of a kind of

empathetic approach to designing a space for the actual consumers or clients of that space, the patients themselves.

Izumi's story is really fascinating. I mean, I think more Canadians should know about his story for so many reasons. What's fascinating about Izumi really predates his experiences with psychedelics. You know, he grew up in Vancouver during World War II. Of course, Japanese Canadians were being interned, and there were all sorts of questions about whether or not these Japanese Canadians were enemy aliens. Though he'd been born in Canada, like many other Japanese Canadians at this time, it didn't really matter. And he was already destined for school at that time and headed to Saskatchewan. He ended up going to school in Manitoba. But he came to Saskatchewan. Saskatchewan did not have internment camps for Japanese Canadians, which is not to say that we were so progressive and enlightened. We were just cheap. And it was cheaper to have the RCMP monitor Japanese Canadians and kind of keep them in a hotel in Moose Jaw at a certain point, or kind of implement something like the past system that we saw on Indigenous Reserves or First Nations reserves. So you had something similar operating with Japanese Canadians in Saskatchewan at the time.

And one of the families in Regina was the Nomura family. And this is where he will meet his wife. And he ended up staying with that family for a little while as well. And you see a kind of coming together of Japanese Canadians at this time outside of those internment camp spaces. That left an important impression on him, and he stayed in Saskatchewan. You know, there's this, again, a kind of awkward, but maybe gentler approach to dealing with people who were designated as enemy aliens. And this is not to, again, excuse the behavior of the state at the time. But Izumi, it left an impression on him. And he returned to Saskatchewan after completing his architecture degree in Manitoba. He became friends with Humphrey Osmond, who at the time was the superintendent of the Saskatchewan Mental Hospital at Weyburn. And Osmond had come to Saskatchewan in 1951 at the behest of Tommy Douglas, who invited him over to take over this massive mental hospital. And Osmond was already interested in psychedelics. He was already interested in hallucinations and what they could teach us about how people interpreted reality and therefore how we might think about either adjusting their environments to be more conducive to their lives, or how we could learn to interpret their language, kind of mediated through this filter of unreality or different reality, in an effort to try to understand what was antagonizing that illusion or hallucination or delusion in the first place.

Osmond teamed up with a bunch of different people, including Izumi. And they became such good friends that Amy Izumi, his now wife, Amy Nomura, became the godmother to one of the Osmond children. And Osmond became the godfather to one of Izumi or Joe, as they called him, Joe and Amy's eldest son, Gordon. So there's this interesting, like close connection that forms. And the early psychedelic experiments are much unlike what you might imagine from kind of Timothy Leary style. You know, the Grateful Dead haven't started taking LSD yet. The music was very different. Most of it was classical that they listened to.

But as I understand it, they met, and this is from an interview I did with Amy many years ago. They met at the Osmond home, which was on the kind of campus of the hospital in Weyburn. And they had read about, you know, Humphrey had talked to Joe or Kiyo quite extensively ahead of time and said, you know, you may experience something quite different. And Kiyo was quite enthusiastic about this prospect that it could change the way he theorizes architectural space.

So he took some, so did Amy, so did Osmond, and they began to sort of think through this and were prepared to take some notes. I think the notes kind of went by the wayside on the first experience, the home experience. But although Amy had a rather unpleasant reaction, she felt quite nauseous, she didn't feel calm at all. Kiyoshi had a different experience in that, at first he claimed that he could see more clearly without his glasses than with them. And this subtle but really poignant change in his perception encouraged him to sort of lean into the experience. I'm sure that was also aided by the encouragement of Humphrey Osmond, who would have certainly said something similar. We don't have a record of this particular experience. The notes, if there were some, didn't last. But I have correspondence between these two men who were kind of making sense of it after the fact and that direct conversation that I had with Amy. So it's based on that kind of flimsy evidence that we try to piece together this experience that led Izumi to believe that this might be helpful to him. And his next experience, he did so in a much more sort of professional setting.

So this time he came with a junior architect, a fellow by the name of Arthur Allen, who I've spoken extensively with and who gave me many more notes and had much more sort of record keeping. That was his job at the time. And this time, they walked through the halls of the major mental health facility in Weyburn, which is a classic kind of gothic style, large asylum, in some ways, the kind of symbol of what to avoid in architectural thinking going forward. These long hallways, you know, beige paint on the walls, a fairly efficient place in that, what Izumi decided was a building designed more for the staff than for the people for whom it was their home. And that became a central piece of his thinking moving forward as he wanted to implement changes in the future building. This would become the Yorkton Psychiatric Center and later the Hantelman Building, a psychiatric wing in Saskatoon, where he tried to imagine what it was like to have alterations in your perception and what kind of design features might accommodate that rather than exacerbate something that might produce feelings of anxiety or fear.

I'll give you one example. If you're in your room and you're told to come out for a meal or some activity, and you look down and there are tiles with different colors, they may appear as holes or gaps rather than continuous on a similar surface. And so we felt that it was possible that people who had difficulty communicating their feelings or express themselves at that time were actually staying in their rooms not because of a lack of desire to participate in said activity, but rather because their perception of their environment made it feel dangerous or difficult to move through this space. So he writes down, or Arthur Allen wrote down, think about tiles. Think about paint color. Think about making things that appear homey rather than institutional. And that's a really tricky balance to strike in a place that needs to maintain qualities of hygiene and has to be easy to clean. But surely we could put names on doors with a little adornment or that people could elaborate on in their own ways. And so those are some of the features that we start to see implemented in the Yorkton facility. Small things at first, but once you start to put them all together, you begin to see how those little features in combination with ideas about shortening the hallways, so they don't seem particularly echoey or long or maybe impenetrable if you're walking, if you have any mobility concerns. Some of those features kind of came together and created this inviting space that staff and patients alike embarked on.

Dick DeRyk
The talk at the time was about the fact that the beds were lower, so that when somebody swung their legs out of bed, they put it on the floor instead of dangling there. Windows, the window design was changed. A lot of that, even though the concept changed for political and other reasons, in the end, he did manage to incorporate a fair bit of what he had learned into the design of Yorkton.

Dr. Erika Dyck
This comes back to, I think, some of his roots as a Japanese Canadian as well. And this is something that Amy mentioned when I met with her. Amy had mentioned the importance of Japanese gardens and how strong an influence that was on Kiyoshi's ideas as well. So bringing elements of life into sometimes what otherwise might feel like a sterile environment. And I recall hearing from one of the tour guides at the Yorkton Psychiatric Center that, you know, there were gardens and people had houseplants, sort of. There was, again, that reminded me of something that I know he held very dear was this idea of some kind of flow and fluid transition between the outside space and the indoor space. And we know here in a wintry province that that's not always possible to maintain. Sometimes you want to keep the outside out. But nonetheless, that sense of distinction as well from an otherwise perhaps rather generic hygienic environment, but rather sterile and impersonal, it really can make a difference to someone seeking a kind of recovery to feel a little bit unique or a little bit different in a positive way, not in one that leads to discrimination, but one that helps someone sort of retain the boundaries on their own identity.

Peter Legebokoff
Contract went to a local company called Matheson Brothers, but then they had a lot of sub trades. All of the furnishings for those units was specially designed and built by Eatons of Winnipeg, and it is very strongly made, and you can still identify pieces in use throughout the whole hospital system. They lasted forever, it was a special order, and you wouldn't find them anywhere else. The beds were metal construction with small desks and pretty large closed closets, and of course the windows in each room were designed to be ventilated windows with a view, but you couldn't crawl into them or you couldn't crawl out.

Dick DeRyk
Did that happen?

Peter Legebokoff
Yeah, we probably had to extract people trying to make their way out that window, yeah. That was a pretty rare occurrence. Our philosophy was that the doors would never be locked. We lived with that for a long time. That requires a huge amount of surveillance and so on to ensure patients' safety. So eventually, after one patient got out of an open door in Weyburn in the 60s and trolls outside, you know, you have an incident like that, you might have to lock the doors temporarily to control maybe people who wander around. Yeah, you had to take some security measures and you had to sort of compromise on that principle of never locking a door.

Psychiatric center was designed with short corridors, three wings on each of those units with 10 beds in each wing. 10 single rooms, so there weren't any intimidating long corridors and empty spaces. You know, people encouraged to sit together to talk, to visit. There was an attempt to make a home-like atmosphere from the very beginning. That was successful in that way. And a lot

of things that I assume he may have read about from the findings of the existing staff and his own experiences, you know, with perceptual disorders, experiencing perceptual disorder like a schizophrenic person might. He took all that into consideration when he's designing these units to provide for a more therapeutic type of surroundings or social surroundings to get away from the stark austere institutional setting.

Psychiatrists were the primary caregivers to begin with, then social workers came on the scene, then psychiatric nurses, and in latter years clinical psychologists. You know, like Brian Woodward was one of the last ones to be working here.

Peter Legebokoff: 34:35
Social workers traveling, visiting people in their homes, and then eventually psychiatric nurses were identified as needed to do this home visiting and follow-up care. And then the concept of the community psychiatric nurse emerged, and a large number of them were hired in subsequent years to do this follow-up in outpatient clinics.

So that was the way it emerged, and as the the construction proceeded, they built all the units at once. The concept was that you would need 148 beds, I think it was for the inpatient services in this region. That was based on current statistics. How many beds would you need for the populations out there? Well, all these 148 beds were made, but there was never more than 60 of them ever occupied. Those spaces became redundant to the mental health services' needs. Fortunately, the architect designed it in such a way, and that was by design, that it must be suitable for use for alternate services.

Dr. Erika Dyck
As this building was conceptualized, there's a lot of excitement and momentum. There's an attention, international attention on what's going on here in Saskatchewan, particularly in Yorkton. And by the time the building designs are approved, not only does the cost factor, you know, balloon out of control, the idea initially of building a round building where patients could sort of retreat into these private spaces around a circular center, the cost of round windows and some of the landscaping designs and the ductwork and sewage and all of those sorts of things within the infrastructure were difficult. They imagined it was going to be difficult and costly to put into this what they thought was maybe an aesthetically pleasing design, but wasn't really one that should be borne by the taxpayers of Saskatchewan. So you have this political economic tension that builds at the same time, the government changes. And we move from a government, you know, whose mandate it was to introduce Medicare to a Liberal government who comes in with a mandate to move us away from Medicare or to end Medicare. So that political struggle is sort of spilled over the front pages of newspapers as this building is being conceptualized.

At the same time, psychiatrists across North America are beginning to question whether or not patients are best served in institutions or whether they would be better cared for in homes. There are a lot of debates there as well. But I think the Yorkton facility is sort of symbolic sacrifice in this moment. There are a lot of hopes of a particular way of thinking that are invested in the Yorkton Psychiatric Center. And yet it kind of almost represents something of a bygone era by the time that it is built, not only from those financial savings, but also the idea is patients should be moving into communities. The idea that you could take chlorpromazine or an antipsychotic medication that has just come onto the Canadian market in 1954, that it could ameliorate your symptoms and

maybe people could work. Maybe not even in a sheltered employment facility, but they could work in communities. This would alleviate the need for people to have long-stay hospital visits. So the hospital is almost a remnant of an older way of thinking in some respects. Now, very quickly, people recognize that that was wrong-headed. We still need hospitals, but the orchard facility is sort of straddling these two different ways of thinking about patient care.

Dick DeRyk
At what point did the psychiatric care that was envisioned in the facilities that were envisioned slide by the way?

Dr. Erika Dyck
In many respects, despite the challenges it faced with the financing of it and also the changing contours of care, it's still a success story. You know, the building was built. It was at a smaller scale than first imagined, and it was a different shape than they first anticipated. But despite this kind of low, more linear-shaped building than the round facility they originally conceptualized, it got a lot of attention. From my perspective as a historian, going through the archives and looking at letters to local newspapers and conversations on the radio, the idea from both families and staff, as well as patients, was that this was the nicest facility they had visited. This was, this had a welcoming environment. And I think here the architect is really important. Kiyoshi Izumi is really important because not only did he have a vision for the exterior and the landscaping, but he also paid really close attention to interior design details. And those seemed to have a lasting impression on the people who encountered this facility and certainly made a good impression on psychiatric authorities abroad who pointed to the psychiatric facility at Yorkton as a model for the future.

Dick DeRyk
It attracted attention from all over North America. Was there an awareness generally in Yorkton of how special this was?

Peter Legebokoff
There was an awareness. Because even before the 11- bed ward, we had Dr. Tony Ives. Tony Ives was the first director of this place. And he was one of the first people on the scene. There was a mental health clinic in downtown Yorkton, where the psychiatrist and the social worker, the very first ones in town, had their offices there and they start seeing patients referred to them by local doctors. So there was already an awareness that mental health services had come to Yorkton for a couple of years before anything was actually started here, an outpatient type of clinic. Of course, that would get into the local media and the 11-bed ward opened up. All these things were reported locally. And then when the psychiatric center, long before it was built, there was a lot of publicity associated with it.

Dick DeRyk
The attention that it attracted within the profession from outside from all over North America. My understanding is that at one time, there was actual, there were tours being conducted of the facilities for visitors that were coming from further away.

Peter Legebokoff
That is correct. This was an innovation that caught the attention of lots of professionals. And you might say all of North America came to look. There were representatives from many other provinces, the United States, etc. They wanted to see for themselves, can this really work? How is it doing? And Saskatchewan had set the trend of trying to thin out the population of traditional mental hospitals, and others in the United States were beginning to do the same. And they were watching to see how this will work. Can it be done or will there be a backlash from society? They wanted to see how it was going in Yorkton.

But at the same time, in the early 60s, the trend to empty out the mental hospitals continued and it accelerated. And pushback was developing in Weyburn, for example. Too many people discharged, they couldn't absorb them in the community, there were complaints, etc. So that was the time of one of the first reviews. They had to take a look and maybe slow it down a bit. But then it continued that way. And then in 1967 there was a very tragic event occurred, as a result of which massive pushback and walk back began and had to be accomplished. There was a mass murder in Shell Lake, Saskatchewan and made big, big news throughout the province and elsewhere. It was probably North America worldwide story. And that resulted in a very close review of the incident itself and the whole system of psychiatric services in Saskatchewan.

Our director in Regina, his name is Colin Smith. He called in a man, by the name of Frazier from Baylor University in Texas. The Frazier report was really an earth-shaking review of that whole incident and the services of Saskatchewan at the time. He made many recommendations that we had to deal with. He came back and did a follow-up survey, and this had sort of nothing to do with the Saskatchewan plan. I think it was due to an error made by the North Battleford staff who were taking in patients, acute treatment patients. And the patient who was voluntarily admitted there suffered very dangerous delusions and hallucinations, he had voices talking to him. They discovered that he had all these delusions, they gave him immediate treatment because the drug therapy was well underway at that time. It was widely used and it was very effective in controlling schizophrenic behavior. And he was thought to have been successfully treated initially. His symptoms went into remission and he was discharged, as it turned out, prematurely.

He was discharged with medication to the care of his parents. His parents never knew the extent of his delusions and hallucinations. He had confessed to the psychiatric staff in North Battleford that he was, you know, he had delusions like maybe voices telling him to kill his parents among other things. They didn't know that. I think once he got home he stopped taking his medication, maybe it had unpleasant side effects, he stopped taking his medications, these delusions and hallucinations persisted. S

So one day he just was driving around with a loaded gun, and the voices told him to stop with this totally randomly selected farmhouse. He murdered seven children and their parents. One little girl survived, four years old. Frightful, a frightful incident and caused a massive review. It turned out that North Battleford discharged its patient prematurely with no follow-up plan.

So it caused a great deal of review and and walking back on some of the procedures and policies. And there were subsequent inquiries made and changes made to the Mental Health Services Act. But that was an earth-shaking event that really caused people to take a good strong look at what was happening. And then as time went on in the 1960s, there was continual pushback to the

mental hospitals being depopulated. And it got to the point where the communities couldn't absorb any more repatriation. So I had to walk that back a bit and then develop a series of group homes and approved homes to discharge these patients to approved homes so they'd be fostered by other adults and families and and given maybe more supervision than they might otherwise have got by simply being discharged.

Dick DeRyk
What impact did that have on the Yorkton Psych Center?

Peter Legebokoff
Well, in the Yorkton Psychiatric Center, we never had a large number of patients admitted, and we were just able to successfully discharge most of them. And if some of them became long-term and chronically ill, they were eventually, they may have had to be admitted in turn back to Weyburn or North Battleford, which remained as sort of a long-term facilities.

Dick DeRyk
Before we finished our conversations, I couldn't resist asking both Erika and Peter about the film One Flew Over the Cuckoo's Nest, made in 1975, starring Jack Nicholson and also featuring a very young Danny DeVito. And it was the first film role for Christopher Lloyd. The film was a huge success, won five of the major Academy Awards. It was set in Oregon in 1963 about those in a mental hospital. I wondered if that was anything like a realistic representation of the treatment in this province before the Saskatchewan Plan and before the Yorkton Psychiatric Center.

Peter Legebokoff
It was representative in in many ways. Yeah, they had electroshock therapy, which received a bad rap. But you know, quite frankly, it was the ultimate treatment of choice for depression. The alternative was patients would be suicidal, and maybe the last intervention that would be successful was that ECT. And it was successful to get rid of really low-down depression. The regimentation of patients that they depicted there, well, that was perhaps somewhat exaggerated. I believe we had more respect for patients' rights and so on in Saskatchewan early on.

Dick DeRyk
You were doing better than Nurse Ratchet?

Peter Legebokoff
Yes, indeed. Nurse Ratchet probably was a military type, would not have survived in our service. When I visited the Boston State Hospital, I was there for six weeks on practicum. You know, you could see that all the elements of where that could have been, you know.

Dr. Erika Dyck
Many, many people saw the portrayal of Randle McMurphy in In One Flew Over The Cuckoo's Nest and, you know, the evil Nurse Ratchet, and this really quite, you know, stark representation of what is ultimately kind of the evils or the cruelty of psychiatric facilities. And that it's such a poignant demonstration of a space of power gone amok and the abuses of psychiatry that is really operating in a space that has very little oversight. And there's that wonderful part of the film where, you know, Jack Nicholson, you know, commandeers a bus, steals a bus, emancipates a bus, depending on your views, and takes these guys fishing. And all he does is simply attach the

label of doctor to the patients and their odd behaviors or their quirks and, you know, things that got them into the institution in the first place appear, you know, erudite. And it's this wonderful twist on, you know, how the spaces we inhabit actually contribute to those identities.

Psychiatric facilities across North America and really throughout the western world would bear some resemblance to the Ken Kesey portrayal or the Jack Nicholson. Ken Kesey is, of course, the author of the book the film is based on, but there were some similarities, the locked rooms, the nursing stations, the medication time, the group therapy.

You know, there are many of those features that we would see in Weyburn or North Battleford or many, many other facilities. Weyburn did not have as many lobotomies. The facility that's on display in film is based on a California facility. And we know now that California had the most lobotomies of any place in North America. Weyburn was one of the lowest. Medical students were trained to critique One Flew Over The Cuckoo's Nest because it had such a profound impact on their ideas about the kinds of therapies to use that it was starting to turn psychiatrists into anti-psychiatrists right in the classroom. It's a really important film and a really great comparison. But what I can't resist, Ken Kesey, who is the author of the book that inspired the screenplay, took LSD too. He, of course, became a kind of infamous prankster who commandeered his own bus, painted it day glow with his friends, and drove around America, suggesting we should all take acid, more in the style of Timothy Leary, and became a real critic of the American dream and kind of the American way of life. And so he too is kind of tied in.

He met Humphrey Osmond. I have no proof that he met Kiyoshi Izumi, but it's part of the zeitgeist of the 1950s and 1960s, this kind of frustration with the way things have been going and a number of people trying to like throw paint at the walls or change the walls themselves, in Izumi's case, to change the way that we manage people with different perspectives on reality. Kesey's part of that story as well. And I'd be remiss if I didn't throw that out there as just another fun little thread that ties these things together. And he knew about Saskatchewan. He was a student volunteer. He had worked as an orderly in a major psychiatric hospital in California. And he signed up as a volunteer to take a number of psychedelic drugs, including LSD. And he will probably go down in history as this non-ordinary psychonaut who didn't meet a substance he didn't like or something like that. So this really transformed him personally, but also led to him being this cultural icon for challenging state authority.