BOARDING-OUT THE INSANE, 1857-1913: A STUDY OF THE SCOTTISH SYSTEM

HARRIET C.G. STURDY

DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY
UNIVERSITY OF GLASGOW

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SUPERVISOR W.LL. PARRY-JONES

ABSTRACT

The pioneering policy of boarding-out harmless, chronic insane patients in the community was implemented formally by the Scottish Board of Lunacy in 1858, following the passage of the Lunacy (Scotland) Act, 1857. Up to 25% of registered pauper and private patients were boarded-out under the terms of this Act. In the early years of the system, a large proportion of those boarded-out were congenitally weak-minded; idiots and imbeciles, residing with their relatives. As the system developed, increasing numbers of patients suffering from acquired forms of insanity, having reached a quiescent stage, were discharged unrecovered from asylums to private dwellings. Generally such patients were placed under the care of strangers, often in special licensed houses in close proximity to other patients. Despite the innovative nature of the system, the number of patients involved and its marked impact on Scottish lunacy administration, the policy has received little systematic attention this century. This study undertakes, therefore, a detailed assessment of the nature of boarding-out, the demographic and clinical characteristics of patients, the status, role and responsibilities of guardians, and the extent and effect of official supervision.

The system was endorsed firmly by the Scottish Commissioners in Lunacy, who advocated its widespread adoption throughout the country. However, despite official encouragement, boarding-out came under sustained attack from certain medical and parish officials and from the general public. Facilitated by extensive recourse to contemporary medical journals, official lunacy reports and parish records, this study assesses the beneficial aspects of the system, and in addition offers a critique of prevailing shortcomings. Physicians from across the world came to see boarding-out in practice. The nature and success of international family care policies, and the extent to which the Scottish system was imitated overseas, therefore, are considered. Boarding-out continued to be utilised in the 20th century, albeit with a gradual transformation in its nature. The changing nature of boarding-out is examined, and its gradual decline, and replacement by the less closely organised policy of community care explored, thereby enabling tentative analogies to be drawn between the two systems.

Keywords: Boarding-out; registered insane; pauper; private; idiots and imbeciles; acquired forms of insanity; private dwellings; guardians; special licensed houses; Commissioners in Lunacy.

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University of Glasgow

In accordance with these regulations and as a candidate
for the degree of Doctor of Philosophy
I declare that
this thesis has been composed by me
and is a result of my own enquiries.

Harriet C.G.Sturdy
March 1996

ABBREVIATIONS

GBCLS	Annual Reports of the General Board of Commissioners in Lunacy for Scotland
GBC	General Board of Control (Scotland)
GBCL	General Board of Commissioners in Lunacy, England
MS AR	Annual Reports of Medical Superintendents of asylums
CR	Commissioners' Reports on asylums (appended to asylum annual reports)
NHS	National Health Service

CHAPTER 1

INTRODUCTION

1. Overview

Boarding-out insane patients in the community formed an integral part of Scottish lunacy administration in the nineteenth century. In this chapter, the nature of boarding-out is defined and the terms used throughout the thesis are clarified. Trends in provision for the insane and the growing concern among the public and professionals regarding possible increased incidence of insanity are assessed. These issues are considered in relation to the ideals underlying the introduction and development of boarding-out. The various forms of institutional provision in Scotland are defined and described and, finally, the specific objectives of the study are presented and the layout of the thesis is described.

1.1 Introduction

The system of boarding-out the insane in private dwellings in the community under the care of relatives or strangers was introduced in Scotland in the mid-nineteenth century. Up to a quarter of registered insane patients were provided for in this way, offering the benefits of increased freedom in a domestic setting, while vacating space in overcrowded asylums.[1] This study explores the nature, growth and influence of the system of boarding-out pauper and private patients in nineteenth and early-twentieth century Scotland, locating the Scottish practice in a broad, comparative context.

During the last 20 years, the study of the history of psychiatry has become increasingly popular. Historians of nineteenth-century provision for the insane have focused largely on the growth of asylums and the general move towards the "incarceration" of the insane. Detailed histories of asylums throughout England and Wales have been assembled.[2] Recent

[1] All patients who were under the formal control of the General Board of Lunacy were classified as registered. Although the number of patients boarded-out fluctuated annually, reports from the Board of Lunacy (*passim*) indicate that from the 1880s, between 22% and 25% of the registered insane were provided for in this way.

[2] Among them, for example, the histories of asylums at Bedford, Buckinghamshire, Northampton, Bodmin and Sheffield have been published.

work on lunacy provision in Scotland has focused on the prestigious royal asylums; either as a group[3], or in profiles of individual institutions; Crichton Royal, Dumfries,[4] Montrose Royal[5], Glasgow Royal[6] and Edinburgh Royal[7]. However, the contribution of district asylums, with the exception of Fife and Kinross[8] and private madhouses has not yet received any detailed historical assessment.[9]

The influential system of boarding-out has been almost wholly neglected. Boarding-out was an important component of lunacy provision, particularly in Scotland, but, despite its intrinsic interest and implications for late-twentieth century attempts at community care for the mentally ill, it has received no systematic study. In contrast to the sustained interest shown in boarding-out in the nineteenth century, there has been no detailed survey of the system this century. The few recent articles which acknowledge the existence of an official system of non-institutional provision do little more than refer readers to the work of Parry-Jones[10] and McCandless[11]. Both of the latter studies offer a brief and tantalising introduction to the system, but neither are, or were intended to be, comprehensive.

Dominant themes in the field of mid-nineteenth century lunacy provision in Britain included moral management, the development of the ideals of hospitalisation (encouraging the incorporation of the features of general hospitals into asylum practice), and, more tentatively, domestic care for selected patients. Medical superintendents and lunacy administrators faced real dilemmas in their attempts to define and to clarify the appropriate function of the asylum. Boarding-out needs to be seen, therefore, in the context of an

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[3] Rice, F. (1981) *Madness and industrial society: a study of the origins and early growth of the organisation of insanity in nineteenth century Scotland.c1830-70.* PhD thesis. University of Strathclyde.
[4] Easterbrook, C. (1940) *Chronicle of the Crichton Royal. 1833-1936.* Dumfries: Courier Press.
[5] Presly, A.S. (1981) *A Sunnyside chronicle, 1781-1981. A history of Sunnyside Royal Hospital.* Dundee: Tayside Health Board.
[6] Andrews, J. and Smith, I. (eds.) (1993) *"Let there be light again." A history of Gartnavel Royal Hospital from its beginnings to the present day.* Glasgow: for Gartnavel Royal.
[7] Beveridge, A. (1995) Madness in Victorian Edinburgh. A study of patients admitted to Royal Edinburgh Asylum under Thomas Clouston, 1873-1908, part 2. *History of Psychiatry,* vi, **22**, 113-156; Beveridge, A. and Barfoot, M. (1990) Madness at the Crossroads: John Home's letters from the Royal Edinburgh Asylum, 1886-1887. *Psychological Medicine,* **20**, 263-284 and Thompson, M.S. (1984) *The mad, the bad and the sad: psychiatric care at the Royal Edinburgh Asylum 1811-1894.* PhD thesis. University of Boston.
[8] Doody, G. (1992) *Fife and Kinross District Asylum.* MSc thesis, Edinburgh University.
[9] However, a study of the Scottish "trade in lunacy" is currently being undertaken by Parry-Jones, W.Ll. and Sturdy, H. (1996)
[10] Parry-Jones, W. Ll. (1981) *The model of the Geel lunatic colony and its influence on the nineteenth century asylum system in Britain.* In *Madhouses, maddoctors and madmen: the social history of psychiatry in the Victorian era* (ed. A. Scull), pp201-217. London: Athlone.
[11] McCandless, P. (1979) Build, build! the controversy over the care of the chronically insane in England, 1855-1870. *Bulletin of the History of Medicine,* **53**, p558.

increasing trend, nationally and internationally, towards institutionalisation of the insane, and the steady growth in the number and size of asylums.

The experimental nature of boarding-out was reflected in the way it represented a bold attempt to establish alternatives to institutional care, in its implications for care of the insane in general, and in facilitating a redefinition of the role of the asylum. As this study will indicate, the influence of the system on asylum construction, and its close links with the open door system, cottage system, hospitalisation movement and convalescent houses, all combine to highlight the wider significance of the closely controlled policy introduced by the Scottish General Board of Lunacy in 1857.

The essence of the system is particularly topical when viewed alongside the controversial community versus hospital debate currently occupying the attention of health care professionals, voluntary groups and the general public. The community today is viewed as the "proper" place for the majority of elderly and chronically mentally ill patients, while the psychiatric hospital is seen increasingly as merely the repository for a minority of patients, with recent or acute illnesses. Parallels between the nineteenth and late-twentieth century systems are evident. This study considers, therefore, the benefits and drawbacks of the Scottish boarding-out system, in relation to the system in force today.

The parameters of the study are the years 1857-1913. There was no official centralised provision for single patients in Scotland before the mid-nineteenth century, and it was not until the Lunacy (Scotland) Act, 1857, that such patients were brought under the official cognisance and supervision of a newly created General Board of Lunacy. The Act came into effect in January 1858. The legal and administrative changes inaugurated by the Mental Deficiency and Lunacy (Scotland) Act, 1913, including the replacement of the Board of Lunacy by the Board of Control, provide an appropriate end-point for the study.

1.2 Definition of boarding-out

The essential feature of the boarding-out system lay in providing regulated and closely supervised care in the community for insane persons who were not considered to be in need of asylum treatment. Boarding-out, while administered locally by parish officials, was regulated by a centralised administration based in Edinburgh, namely the General Board of

Lunacy. Commissioners appointed to the Board were entrusted with the management and supervision of all registered insane patients in Scotland, whether private or pauper, in institutions and private dwellings. They instituted instructions and regulations for the guidance of parochial officials, and directions to guardians regarding the acceptable standards for accommodation, clothing, food and general treatment.

Under the terms of the Lunacy (Scotland) Act, 1857, all insane patients were ordered to be admitted to an asylum or other institution for the insane. However, patients who were certified as incurable and thought to be unable to benefit from asylum provision could be kept in a private house with the sanction of the Board of Lunacy. Insane persons could be admitted to the roll of boarded-out patients either having received "dispensation from removal to an asylum" by the Commissioners, thereby remaining in their own homes, or having been transferred from institutions for the insane to private dwellings. They were then visited at regular intervals by Deputy Commissioners in Lunacy and by local parish officials. Patients were placed in private dwellings with relatives or unrelated persons (generally described as strangers by the Commissioners) "in their own condition of life", either singly or in numbers not exceeding four. Sanction for residence outside an asylum could be withdrawn at any time by the Board of Lunacy. To the Commissioners, the essence of the system lay in:

> "an attempt to place all quiet and harmless insane people who no longer require asylum care and who have no homes in which they can be cared for, under home conditions as ideal as can be obtained."[12]

The system of closely regulated non-institutional provision for insane patients was pioneered in Scotland. In view of its far-reaching reputation, there has been speculation about the influence of the lunatic colony at Gheel, Belgium, on the development of the Scottish boarding-out system.[13] In fact, several Commissioners from Scotland did visit the colony in the early 1860s. However, the only correspondence between the two systems was the employment of non-institutional care of the insane.[14] Moreover, the visit to Gheel by the Commissioners in 1860 post-dated the official adoption of boarding-out by three years. Although the colony at Gheel was known worldwide, it was run according to different principles, catering for patients with a wide-range of mental disability, boarded with

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[12] Marr, H. (1925) John Fraser's obituary. *Journal of Mental Science*, **293**, p191.
[13] Rice, F. (1981) *op. cit.*, p358, and Raftery, J.P. *op. cit.*
[14] *Vide infra* Chapter 14.

unrelated guardians in a closely confined area, with an infirmary as the central focus. In contrast, patients suitable for boarding-out in Scotland had to be certified as harmless and quiescent, were widely dispersed throughout the country, often remaining in their family home, and had no contact with asylum superintendents.[15] The distinctive features were summed up by Fraser, an active proponent of boarding-out, and a Deputy Commissioner for 17 years, who declared that:

> "it is only in Scotland that those resident with their parents or natural guardians are subjected to the inspection and control of a central government board...the extent to which this method of provision has been developed among the pauper insane in this country is the feature in Scotch lunacy administration which has been deemed distinctive".[16]

1.3 Clarification of terms

In this study, in accordance with the policy of the Board of Lunacy, the term patient is used to refer to all persons registered as insane. Both pauper and private patients were placed in private dwellings,[17] although the Board of Lunacy had limited jurisdiction over private patients. Only those with confirmed insanity, or who were under curatory,[18] kept for profit, or confined to the house under restraint or coercion, came under the Board's control. Therefore, the assessment of the care and treatment of pauper patients forms the greater part of this study, such patients constituting the majority of boarded-out cases. Records of the conditions and characteristics of pauper patients were scrupulously maintained by lunacy and parochial officials, thereby allowing greater research focus on their experiences. However, where relevant evidence is extant, conditions experienced by private patients are also examined.

From 1858, all registered boarded-out patients were visited by Deputy Commissioners from the General Board of Lunacy, while Commissioners in Lunacy were responsible for the visitation of patients in asylums. However, for ease of reference, the former are described throughout the thesis as Commissioners. Where the term "the Board" is used, this applies to the Board of Lunacy, while other boards, for example the Board of Supervision

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[15] Patients had no contact with asylum physicians unless their mental condition deteriorated and they were certified as in need of asylum treatment.

[16] GBCLS 23rd AR (1881), p119.

[17] A pauper patient had their maintenance costs paid by the local parish out of the poor rate. A private patient made no claim to any public allowance.

[18] Patients under curatory were classified as private patients who were unable to manage their own affairs and were therefore placed under the order of the Court. The Board of Lunacy was informed of their existence by the Accountant of the Court of Session, in order that they may be visited and supervised. Not all private patients were placed under curatory. In 1873, for example, out of 139 private patients, 93 were curatory cases. No specific distinction is made in this thesis between private and curatory patients.

(the body responsible for the care of all paupers) and parochial boards, are referred to specifically.

Patients categorised as idiots and imbeciles, as well as those suffering from "acquired forms of insanity" (the term adopted by the Commissioners to describe persons who had become insane since reaching adulthood), were boarded-out. The Lunacy (Scotland) Act, 1857, defined lunacy in such a way that it included every person certified by two physicians to be a "lunatic, an insane person, an idiot, or a person of unsound mind."[19] This classification included every degree of mental weakness or defect that prevented a person from earning his own living. However, there was an awareness among the Commissioners that the term lunacy, which included "any mad or furious or fatuous person, or person so diseased or affected in mind as to render him unfit...to be at large"[20], was not strictly applicable to the majority of idiot and imbecile patients deemed suitable for residence in private dwellings.[21] The broader term insane, therefore, was utilised frequently as an alternative in describing boarded-out patients. The Commissioners recognised two broad divisions of insanity, the first comprising idiot and imbecile patients, and the second, embracing all acquired forms of insanity, including dementia, chronic mania and melancholia. A distinction between congenital idiocy and imbecility, and acquired insanity was not made on a daily basis by the Commissioners. Nevertheless, the terms lunatic and insane were used interchangeably in annual reports, and no clear distinction was made in articles discussing boarding-out.[22]

In view of this terminological and nosological ambiguity, the decision has been taken in this thesis to use the generic term "insane" to describe all persons of unsound mind, unless discussing a specific patient's history, in which case rigorous sub-classification will be applied. The terminology of insanity, lunacy and mental deficiency remained confusing

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[19] An Act for the Regulation of the Care and Treatment of Lunatics, and for the Provision, Maintenance and Regulation of Lunatic Asylums, in Scotland. 25th August 1857 [20 and 21 Victoria cap 71]

[20] *Ibid.*

[21] GBCLS 3rd AR (1861), main text, piv.

[22] The lack of any uniformity is evident in the titles of some of the most prominent books and articles on boarding-out. For example, Mitchell, A. (1864) *The insane in private dwellings.* Edinburgh: Edmonston & Douglas; Sutherland, J.F. (1897) *The insane poor in private dwellings.* Edinburgh: E. & S. Livingstone; Tuke, J.B. (1870) The cottage system of management of lunatics as practised in Scotland, with suggestions for its elaboration and improvement. *Journal of Mental Science*, **15**, 524-535; Robertson, A. (1870) On boarding the insane in licensed private houses. *Journal of Mental Science*, **15**, 411-415; Turnbull, A.R. (1888) Some remarks on boarding-out as a mode of provision for pauper insane. *Journal of Mental Science*, **34**, 366-376 and Tuke, D.H. (1889a) Boarding-out of pauper lunatics in Scotland. *Journal of Mental Science*, **35**, 503-512.

until the early-twentieth century. For the sake of clarity and consistency in the text, and reflecting the practice of the Lunacy Commissioners, idiot and imbecile patients, therefore, are incorporated under the term "insane."[23]

Boarded-out patients were placed in private dwellings, generally comprising the cottage of a suitable guardian, in either a town, or, more usually, a farming or village community. Thus, the term boarding-out is used synonymously with that of care in private dwellings. The policy was known by some physicians, particularly in England, as the cottage system, and by others as the domestic treatment of insanity. In some respects, the term boarding-out was misleading, since only a proportion of patients, albeit increasing in size each year, were removed from asylums and boarded in private dwellings, while a considerable number had never been in asylums and remained in their family homes. Some Commissioners maintained, therefore, that the term "boarding-out" applied only to patients residing under the care of strangers. Reflecting this, Commissioner Lawson, announced:

> "it is only when the parochial authorities place pauper lunatics in the homes of people not related to them that they are correctly spoken of as being boarded-out".[24]

Although strictly the term boarding-out applied to patients in such a position, the fuller application of the term embraced any patient, pauper or private, living in the community under the care of relatives or strangers and this interpretation is used throughout this study.

1.4 Trends in provision for the insane

To enable the developing system of boarding-out to be set in context, the impact of changing trends in lunacy provision is considered throughout the thesis. Unlike the ideals and practice of moral management in the 1840s, boarding-out was not immediately or enthusiastically adopted by all asylum physicians in Scotland. Both Doerner and Scull have maintained that the mid-nineteenth century was "the classic age of confinement,"[25] with increasing recourse to seclusion and specialist treatment at a time when, "throughout the

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[23] The Report of the Royal Commission contained the declaration that "we shall take the liberty, in accordance with the usual phraseology, of employing the terms "insane persons" or "lunatic" as applying to them all, unless where a different meaning is indicated." Report of the Royal Commission (1857) p3.

[24] GBCLS 36th AR (1894), p102. To another Commissioner, Turnbull, the system was applicable only to pauper patients. He declared that boarding-out "is simply trying to do, under appropriate circumstances and in a systematic way, for pauper patients what is done (and as we believe, rightly done) as a matter of course by the relatives in the case of many private patients." GBCLS 30th AR (1888), p370.

[25] See discussion in Spierenburg, P. (1984) *The emergence of carceral institutions: prisons, galleys and lunatic asylums. 1550-1900.* vol. 12. Erasmus Universiteit Rotterdam. In Spierenburg's view, it was the period from the mid-16th century up to the second half of the nineteenth century which saw the emergence of modern institutions, rather than an unthinking response to the growing pressures and demands of a developing capitalist society.

length and breadth of the country, huge specialised buildings had been built or were in the process of being built to accommodate the legions of the mad."[26] It could be argued, therefore, that in this theoretical climate, a system of domiciliary care would be viewed with some scepticism. Thus, Scull views the growth of institutional provision as indicating the perceived inevitability of the asylum as a solution:

> "By the mid-nineteenth century...with the achievement of what is now conventionally called "lunacy reform", the asylum was endorsed as the sole officially approved response to the problems posed by mental illness".[27]

However, the present study provides evidence to challenge Scull's tendency to embrace Scotland in this claim. While asylums were built across Scotland from the mid-nineteenth century, a system which encouraged the removal of chronic patients into private dwellings in the community was being endorsed and developed by lunacy officials at the same time. In this context, Simmons' criticism of the insistent claims of the supremacy of asylum provision has much to support it:

> "too often historians have implied that the late-nineteenth century and early-twentieth century was completely dominated by the custodial movement and by custodial institutions, and that the movement towards community care only began after the Second World War".[28]

Instead, it can be contended that those involved in the care of congenitally weak patients never argued that all such patients should be institutionalised. Distinctions were made reflecting the ability of a patient to live outside the constraints of an asylum. Boarding-out, it is suggested, represented a real alternative to institutionalisation for selected patients. Therefore, although Scull continues to insist that asylums were primarily places for the "incarceration" of the insane, where not even the pretence to provide cure was maintained, the increasing movement towards developing hospital features in asylums, and the growing acceptance of greater freedom for certain patients, exemplified in Scotland by the boarding-out system, casts some doubt on his thesis. In addition, despite his preoccupation with the alleged "domestication of madness", the development of the open door policy and more importantly, the increasing recourse to boarding-out for certain categories of the insane, especially in Scotland, are not discussed by Scull.

It has been suggested by Busfield that, by the second half of the nineteenth century, many

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[26] Scull, A. (1980) *op. cit.*, p39.
[27] Scull, A. (1980) A convenient place to get rid of inconvenient people: the Victorian lunatic asylum. In *Buildings and Society* (ed. A.D. King) London: Routledge & Kegan Paul. p38.
[28] Simmons, H.G. (1982) *From asylum to welfare.* Canada: National Institution Mental Retardation, p108.

asylum physicians "were not even paying lip service to the principles of moral treatment."[29] However, an opposing, more positive theory, recognising the enormous impact of moral management, appears to reflect more accurately the treatment as recorded in annual reports of Scottish medical superintendents and Commissioners in Lunacy, and in articles in prominent medical journals. Such reports observed in detail the development and gradual transformation in the treatment of the insane. Moral management, popularised by the Tukes' at the York Retreat in the early-nineteenth century, espoused the use of personal "internal" self-restraint, as a substitute for external mechanical coercion. Patients were encouraged to regain the power of self-control and to think for themselves under a system of rewards and privileges. In the opinion of the eminent Scottish alienist, Browne (later the first Commissioner in Lunacy) the premise behind moral treatment was simple; the employment of kindness and the provision of occupation for patients. His ideal, albeit recognised by him and discarded by many as Utopian, was straightforward:

> "Conceive a spacious building ...airy and elevated, and elegant, surrounded by extensive and swelling grounds and gardens. The interior is fitted up with galleries and workshops and music rooms. The sun and air are allowed to enter at every window, the view of the shrubberies and fields, and groups of labourers, is unobstructed by shutters or bars, all is clean, quiet and attractive...The house and all around appears a hive of industry....."[30]

Although such a vision never came close to fulfilment, ideals of greater freedom and a more domestic system of care for all patients gained credence as the century progressed. To many commentators at the time and subsequently, there was little doubt that the introduction of moral treatment, as practised at the Retreat, "was an outstandingly successful experiment", which had an enduring impact on lunacy administration throughout the century.[31]

Not all nineteenth-century medical commentators were impressed by the claims of moral management. One anonymous physician, for example, maintained that although modern treatment of the insane was praised increasingly, the underlying fear and prejudices surrounding the insane had not been eroded at all. Thus, he announced:

> "we don't shut them away in gloomy bastilles...we don't even put them in straitwaistcoats, yet it is much to be feared that of the real nature of insanity, men's knowledge is but little advanced, while their feelings towards lunatics are much what they were a great many years ago."[32]

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[29] Busfield, J. (1986) *Managing madness: changing ideas and practice.* London: Hutchinson, p231.
[30] Browne, W.A.F. (1837) *What asylums were, are and ought to be.* Edinburgh: A & C. Black, p229.
[31] Scull, A. (1993) *The most solitary of afflictions. Madness and society in Britain, 1700-1900.* New Haven and London: Yale University Press, p102.
[32] Anon. From a Mad Doctor's point of view. (1865) Acquitted on the grounds of insanity. *Cornhill Magazine,* **12**, p440.

Notwithstanding the underlying strength of this claim, it is evident that advances in treatment and provision for the insane continued to be made. As early as the 1850s, reflecting the new mood of optimism, the transformation of asylums into a "farming or industrial colony", with a proportion of patients boarded in cottages under the charge of asylum attendants was proposed, thereby enabling the asylum to be employed largely as a hospital for the treatment of acute cases.[33]

Although policy on these lines was not introduced for many years, the last three decades of the nineteenth century witnessed a growing movement towards increasing the liberty of asylum patients, and the development of what physicians maintained was a more humane treatment of those remaining inside the asylum. In Scotland in 1868, for example, the abolition of walled airing courts, introduced at the Argyll and Bute District Asylum, was reported on favourably by medical commentators. The prison-like aspect of the asylum was diminished and a reduction in the number of escapes and a rise in recovery rates was recorded. Similar results were claimed following the introduction of the open door system, initiated in Fife and Kinross District Asylum in 1871, and the increasing tendency to allow patients liberty on parole. In addition, asylum farms were developed, offering healthy occupation, particularly for male patients. Proponents advocated the extension of such farms, arguing that their growth diminished the prison-like features of asylums, and made "the patients lives more like that of an industrial community."[34] The erection of detached buildings (the villa system) for convalescent, quiet patients was an international development,[35] which was endorsed fully by Scottish physicians, and reflected in the transformation in asylum structure throughout Scotland and the rest of Britain towards the end of the nineteenth century.[36]

The adoption of the villa system had far-reaching implications, but the impetus towards increased freedom for the insane, and the movement away from close congregation in large

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[33] For example, as planned in an anonymous article published in 1857. Anon. (1857c) Scottish Lunacy Commission. *North British Review*, **27**, p115.

[34] Sibbald, J. (1897) *On the plans of modern asylums for the insane poor.* Edinburgh: Printed J.Turner, p18.

[35] In the 1880s, for example, one Canadian inspector was convinced that the erection of "monster" asylum buildings had "become a thing of the past, and that the asylum of the future will... be entirely on the so called cottage plan." Reported in Simmons, H.G. (1982) *op.cit.*, p31.

[36] An inevitable feature of most asylums had been the "barrack-like" nature of the buildings. The development of detached villas therefore had a profound impact on asylum structure. Edinburgh, Aberdeen and Renfrew District Asylums are superior examples of the villa system. Glasgow District Asylum at Lenzie is a good example of innovation added to the existing structure. The asylum, in the early twentieth century comprised a reception house, a hospital, a house for idiots, and a pathological laboratory.

institutions, had been in evidence many years earlier. Thus, Lindsay, medical superintendent of the Murray Royal Asylum, Perth, and one of the earliest proponents of the boarding-out system, had observed in 1871, the growing popular feeling against what he termed "monasticism", prompting him to state that the tendency of the time was "to *diffuse, not to mass* the sick and dependent".[37] Resulting from the success of the principle, he contended that this ethos would inevitably be applied to the treatment of the insane. Such a system, he concluded, would gradually supersede the asylum system for all chronic insane patients:

> "the family system, in some of its many forms, is destined, I believe to become *the predominant* mode of treating the insane in all civilised, as it is already in all savage, countries."[38]

Although his claim proved to be unduly optimistic, it reflected, nevertheless, a gradual transformation in the treatment of the insane, and was in tune with the growing recognition that greater flexibility in lunacy provision was not incompatible with the implementation of safe and effective methods of care.

1.5 Possible increased prevalence of insanity

From the mid-nineteenth century, the perceived increase in insanity in the United Kingdom prompted vocal debate among physicians and the general public. In England, the number of certified insane rose by 253% between 1859 and 1910[39] and data issued by the Scottish Board of Lunacy and the Board of Supervision indicated that registered pauper insanity also increased steadily in Scotland in the second half of the nineteenth century. Between 1868 and the mid-1890s, for example, the number of insane persons known to official sources had risen by 50%.[40] In Scotland, this perceived "smouldering epidemic of insanity"[41] prompted in-depth consideration of the issue in Scottish newspapers and popular journals, and public meetings were held to discuss potential remedial measures.[42] Reflecting

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[37] Lindsay, W.L. (1871) The family system as applied to the treatment of the chronic insane. *Journal of Mental Science*, **16**, p504.

[38] *Ibid.*

[39] Turner, T. (1992) A diagnostic analysis of the casebooks of Ticehurst House Asylum, 1845-1890. *Psychological Medicine*, Monograph Supplement, **21**, p3.

[40] Editorial. (1894) On the supposed increase of lunacy. *Poor Law Magazine*, **4**. p229.

[41] *Ibid.*, p225.

[42] There were frequent alarmist headlines questioning whether Scotland was becoming a race of lunatics. The Scotsman in the early 1860s focused on this, and also in 1897 when a series of articles were published entitled "The growth of insanity" Other papers entering into the debate included: Fifeshire Journal, 15.11.70 and 18.11.79, Glasgow Herald, 26.1.87, 2.5.87, 31.3.87, 21.5. 07, 20.4.07, 23.4.07, 25.4.07, 29.4.07, The Stirling Journal and Advertiser, 9.5.90, 2.5.93, 8.5.03, 19.3.76, 20.5.81 26.5.82, 18.8.82, 12.5.05, 25.10.07, 16.11.11, 15.10.86, 9.12.92, 8.5.03, 18.2.15., Dumfries and Galloway Standard and Advertiser, 21.8.89, 21.5.87, 5.5.94, 21.8.75. The Poor Law Magazine was among the most involved among journals in the debate. Articles published in the Poor Law Magazine included: Editorial. (1894) On the

this widespread concern, an editorial in the Poor Law Magazine questioned "are we Scotchmen, hitherto acknowledged to be shrewd sagacious, hard-headed, rapidly becoming as a race, mad or imbecile or are we not?"[43] Inspectors of poor, medical men and superintendents of asylums were reported to be both "amazed at the recent increase of this unfortunate class", and alarmed at the magnitude of growth of new asylums. Observers also pointed to the added burden brought about by the alleged increase in the number of the insane, to the extent that parochial boards "have their hands so full that their proper disposal is a matter of some concern and difficulty".[44]

Scottish alienists and Lunacy Commissioners were not detached from the discussions.[45] In attempts to allay mounting fears, the Commissioners and a number of prominent physicians, endeavoured to reassure the general public that the increase was "not real only apparent."[46] Thus, alternative explanations for the rise in the number of insane patients throughout Scotland were offered. Although Lunacy Commissioners accepted that the number of registered patients had increased dramatically, they emphasised that this was attributable not to any increase in mental disease, but to a greater propensity to admit patients to asylums.[47] A gradual diminution among the general public of the long-standing fears of the risks of wrongful or permanent confinement in asylums, and a greater readiness among the poorer classes to send relatives to asylums contributed to the initial rise. This was thought to be due to "the adoption therein of humane and enlightened methods of treatment" and to the growing recognition of the advantages to be gained from early admission.[48] This change in popular perception was facilitated by the erection of new asylums for pauper patients in localities where no asylum accommodation had previously

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supposed increase of lunacy. 4, 225-233, Hadwen, E. (1901) The increase of pauper insanity. 11, 349-359, Sinion. (1904) On the supposed increase of insanity, a plea for prevention. 14, 111-120, Carswell, J. (1893) The alleged increase of insanity and the hospital treatment of mental diseases. 2, 625-634 and Spence, T.W.L. (1901) Increase of pauper lunacy in Scotland. 11, 404-412. There were many others.

[43] Editorial. (1894) On the supposed increase of lunacy, *op. cit.*, p225.

[44] *Ibid.*, p226.

[45] Articles in dominant medical journals included: Anon. (1895) Alleged increasing prevalence of insanity in Scotland. *Journal of Mental Science*, 41, 498-513, Bresler, J. (1896) On the increase of insanity and the boarding-out system. *Journal of Mental Science*, 42, 315-320, Robertson, A. (1878) Report on increase of lunacy. Read to Glasgow City Parochial Board, 174-177 (MP 5). Editorial. (1898b) Growth of Insanity in Scotland. *Journal of Mental Science*, 44, 218-219. The Board of Lunacy published a supplement to 36th AR of the GBCLS (1894) discussing the alleged increase of insanity in Scotland, which included contributions from Mitchell, Sibbald and Spence, pp1-98.

[46] Anon. (1895) Alleged increasing prevalence of insanity in Scotland. Review of supplement to Scottish Lunacy Commissioners 36th Annual Report. In *Journal of Mental Science*, 41, p512.

[47] *Ibid.*, p507.

[48] *Ibid.* This perceived unwillingness to retain an insane relative at home was thought to be due to the discomfort, expense and consequent diminution of earnings of the family in such circumstances.

existed and to increasing ease of access therein, as improvements were made in arrangements for travelling.

In addition, lunacy commentators reported greater willingness among parochial authorities to recognise claims to poor relief on the grounds of insanity. This was attributed to the introduction of a government grant-in-aid in 1874, which paid half the cost of maintenance for all registered insane paupers. Parochial officials, therefore, were encouraged to grant a certificate of insanity to a greater number of paupers, thereby enabling the parish to receive four shillings a week for each registered patient. Finally, and crucially, following the advent of the Board of Lunacy, increasing numbers of patients had received certification as insane, whereas formerly they had been regarded simply as weak-minded or had simply gone unnoticed by any official body. As one anonymous critical commentator explained:

> "In those days every village had its fool...He was generally a popular fellow...but these good old days have passed away, and the fool no longer enjoys his freedom and prestige. He too must advance with the times. He may no longer waste his time fooling on the village green, but render himself up to the scientific study of the alienist to see if he cannot be made a more rational and useful member of society. A different sphere and habitation have been prepared for him.[49]

This widening of medical and public opinion regarding the degree of mental defect which could be certified as "lunacy" led to a marked rise in the number of persons registered as insane. Therefore, although medical commentators recognised, and devoted much attention to the concerns regarding an increase in insanity among the nation, they remained convinced that the apparent rise could be explained by changing trends in admission procedures and had little basis in fact. They emphasised too, the perceptible decrease in the number of inmates below the age of 25 in asylums.[50] While their conviction did little initially to reassure public fears, the volume of attention given to the subject declined after a somewhat frenzied period and, by the turn of the century, few articles discussing the growth in the number of registered insane and its implications appeared in the major specialist or general journals.

1.6 Institutional provision

Although this study explores the growth of a system of non-institutional provision, it is necessary to consider the wider context and to record the number, type and location of

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[49] Editorial. (1894) On the supposed increase of lunacy. *op. cit.*, p229.
[50] *Ibid.*

establishments for the insane in existence during the years 1857 to 1913 (Figures 1.1 and 1.2). The Lunacy (Scotland) Act, 1857, led to marked growth in asylum provision, on a similar scale to that implemented over a decade earlier in England and Wales. Before this legislation, provision for the insane in early-nineteenth century Scotland had been wholly inadequate for the growing demands of the population. Within ten years of the passage of the Act, available repositories for the insane from all social classes comprised royal asylums, a steadily developing network of district asylums, a small number of parochial asylums, licensed wards in poorhouses for the reception of pauper lunatics, a proliferation of private madhouses, two schools for the training of imbecile children, at Baldovan, in Dundee and the Royal Scottish National Institution, Larbert, and the Lunatic Department at Perth prison.

There were seven royal (Chartered) asylums, established long before the legislation of 1857, which for many years received both pauper and private patients, the former being maintained either through charitable funds or admitted on reduced rates.[51] The practice of admitting paupers, unavoidable before the growth in alternative provision, declined by the end of the nineteenth century, when, of the seven royal asylums, three refused admission to paupers, although the remaining four continued to accept such patients under contract with the District Boards of Lunacy.

District asylums were public institutions erected and managed by the District Boards of Lunacy, created in 1857. They were intended for the reception of pauper patients in localities where such provision was not otherwise available, and their development across Scotland was steady (Appendix 1). In the years 1860-1870, the only public asylum existing before 1857, at Elgin, received recognition as a district asylum, and institutions were opened in Lochgilphead, Argyll, in 1863, and in Perth (1864), Inverness (1864), Banff (1865), Fife (1866), Haddington (1866), Ayr (1869) and Stirling (1870). Over the next ten years, district asylums were erected in Roxburgh and Midlothian. At the same time, Glasgow lunacy district ordered the provision of greatly increased accommodation for their pauper insane, with the erection of Gartloch, Lanark (Hartwood) and Govan District Asylums, in rapid succession during the period 1892-1897. An additional district asylum

[51] Montrose (opened 1781), Aberdeen (1800), Edinburgh (1813), Glasgow (1814), Dundee (1820), Perth (1826) Dumfries (1839).

was established in Glasgow in 1898, when the former parochial asylum, Woodilee, came under the control of the District Lunacy Board. In the early-twentieth century, district asylums were established in Dundee, Aberdeen, Edinburgh, Renfrew and Paisley.

Parochial asylums were erected out of taxes levied upon parishes. They were managed by parochial boards, but licensed by the Board of Lunacy. Viewed as the equivalent to lunatic wards of poorhouses, they received paupers suffering from all forms and degrees of insanity. In 1860, there were six parochial asylums, all in the west of Scotland; Barony, City of Glasgow, Govan, Abbey (in Paisley), Paisley Burgh and Greenock. Their existence was not secure and, by 1913, only Greenock Parochial Asylum remained open. The asylums for the parishes of Paisley and Barony had become recognised as district asylums, and the others ceased to exist, unable to compete with the district asylums favoured by the Board of Lunacy.

Certain wards in poorhouses accommodated insane patients. In 1857, there were 17 such poorhouses, accommodating over 800 pauper patients.[52] The poorhouses were granted licenses from the Board of Lunacy for the reception solely of harmless patients not amenable to curative treatment. Further, it was stipulated that such patients must "have no habits or infirmities which render care difficult".[53] The mental characteristics of patients were broadly comparable to those found among the majority of boarded-out patients. The cost of maintenance per head in the poorhouse was substantially lower than that for asylums. However, the Board viewed them with disfavour, regarding them as of merely temporary utility until district asylums were erected and able to accommodate all pauper insane patients.

By 1863, the number of licensed wards in Scotland had fallen to 12, receiving a total of approximately 400 patients. However, despite the negative attitude of the Commissioners, the number of licensed poorhouses fluctuated throughout the nineteenth and early-twentieth century, although never rising above 17. Thus, in 1878 there were 14 such wards in poorhouses; in 1890 there were 16, and in 1909 there were 12.[54] Many alienists were convinced of the value of their existence, among them, for example, Clouston recorded his

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[52] GBCLS 1st AR (1859), main report, piii.
[53] Lunacy (Scotland) Act, 1857 [20 and 21 Victoria cap 71].
[54] GBCLS AR *passim*.

belief that "where well managed these wards can accommodate approximately one-fourth or fifth of the total number of insane in the district."[55]

In the first half of the nineteenth century many insane patients, private and pauper, resided in small private madhouses. In 1857 there were 23 such establishments, located predominately in and around Edinburgh and, to a lesser extent, in Glasgow, providing accommodation for a total of 745 patients.[56] However, from 1863, with the growth of district asylums for the reception of pauper patients, private provision began to decline and suffer a rapid demise. Throughout its history in Scotland, just as in England, the private madhouse system was "subjected to persistent disparagement and censure", attributable largely to the fact that patients were received for profit, and "so became the objects of financial speculation."[57] Parry-Jones has charted the development and tenacity of private establishments in England and Wales, where, in 1848, half of all lunatics confined in institutions were in private madhouses. In the second half of the century, private madhouses were used in some locations to compensate for the lack of county asylums, or for the overcrowding of existing establishments.

In contrast to the flourishing "trade in lunacy" in England and Wales in the nineteenth century, the influence of such establishments in Scotland from 1857 was less marked, being publicly censured by the Board of Lunacy with its firm prejudice against private provision.[58] The Commissioners were explicit in their disapproval, and while they continued to license private madhouses for pauper lunatics until district asylums were erected, they were active in overseeing the gradual elimination of pauper admissions. By 1878, no pauper patients were sent to such establishments and, by 1913, only three private madhouses remained.[59]

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[55] Clouston, T.S. (1894) Discussion on workhouses, following paper by Nolan, M.J. (1894) The insane in workhouses. *Journal of Mental Science*, 40, p629. An article in the Dundee Year Book of 1888 described the parish poorhouse in highly favourable terms. It was reported to be scrupulously clean, "the floors of the dormitory are varnished and waxed and laid with strips of carpet in the passages and between the beds. Prints and mirrors adorn the walls." How the Poor Live (1888), Dundee, p110.

[56] GBCLS 1st AR (1859), main report, pii. Private madhouses were particularly profuse in Musselburgh due to the ease with which licences could be obtained in Midlothian. In the early 1850s, there were 24 private asylums in the county of Edinburgh. Until adequate public provision was established, few improvements could be made to such establishments.

[57] Parry-Jones, W.Ll. (1972) *The trade in lunacy. A study of private madhouses in England in the eighteenth and nineteenth centuries.* London: Routledge & Kegan Paul.

[58] The expression "trade in lunacy" is taken from the phrase adopted by Parry-Jones in his detailed assessment of the private madhouse system in England and Wales. Parry-Jones, W.Ll. (1972) *op.cit.*

[59] The extent to which the closely supervised, officially endorsed system of boarding-out posed a challenge to the increasingly tenuous survival of private madhouses is an interesting consideration which warrants further research attention.

In 1913, there were seven royal asylums, 21 district asylums, one parochial asylum and three private madhouses. Further, there were 14 poorhouses licensed to receive lunatics. Although not distributed evenly throughout the country, there was, therefore, a network of institutions across Scotland receiving both pauper and private patients.

1.7 Objectives of the study

The general aims of the research that formed the basis of this study were to describe and assess the implementation and development of the boarding-out system in Scotland, and to explore its impact upon lunacy provision nationally and internationally. These aims comprised the following specific objectives.

1. To examine the condition of the insane prior to 1857, assessing prevailing institutional accommodation, existing arrangements for single patients, the role of sheriffs and parish officials in supervising the care of the insane, the impact of the Royal Commission appointed in 1855 to inquire into the state of lunacy in Scotland and the subsequent legislation of 1857 (Chapter 3).
2. To chart the development and modifications made to the system, as boarding-out became increasingly widespread, assessing the constant fluctuation in the numbers thus provided for, the nature and extent of supervision for patients and the influence of the government grant-in-aid (Chapter 4).
3. To describe the introduction and development of special licensed houses, their geographical location, and the impact of their development on the existing system of boarding-out (Chapter 5).
4. To analyse the demographic characteristics of boarded-out patients; the mental conditions acceptable for such provision; predominant behavioural and clinical features; and, as far as possible, the experiences of patients living in the community (Chapter 6).
5. To describe the demographic characteristics of those involved in the daily care of patients, to consider the attitude of guardians towards their charges and to ascertain the motivations behind receiving patients into their homes (Chapter 7).
6. To explore the relative costs of domestic and institutional provision and the benefits associated with a more domesticated environment, and to assess the extent of relief to overcrowded asylums and the degree to which boarding-out facilitated a transformation in their nature (Chapter 8).

7. To chart the extent of boarding-out in different locations across Scotland, and to consider why parish officials from certain districts remained comparatively inactive, either by design or through difficulties created by the specific location of the parish (Chapter 9).

8. To analyse the prevailing criticisms and shortcomings of the system; the perceived threat to asylum provision; the encouragement of a "trade in lunacy" and the risks facing vulnerable patients from potentially ill-motivated guardians; and to assess the degree of local opposition to the presence of the insane and prevailing fears regarding the perpetuation of hereditary degeneracy (Chapter 10).

9. To examine the powers, attitudes and activities of the Commissioners of the General Board of Lunacy, and to consider the extent to which the responsibility granted to them by the Lunacy (Scotland) Act, 1857, influenced the boarding-out system (Chapter 11).

10. To review the encouragement and opposition given to the system by medical superintendents of asylums, the degree of enthusiasm with which individual superintendents embraced the system and to assess the ability they had to obstruct widespread expansion of the policy (Chapter 12).

11. To examine the influence of parish officials over the system of boarding-out; their attitude towards asylum superintendents and Lunacy Commissioners, and their role and responsibilities in selecting suitable homes and guardians for patients (Chapter 13).

12. To assess the scale of boarding-out provision in other countries, describing the policies existing in Europe and worldwide, thereby locating the Scottish experience in an international context; to make comparisons between policy in Scotland and the rest of the United Kingdom and to examine the interchange of ideas and reciprocal influences between Scotland and other countries (Chapter 14).

13. To describe the continued activity in boarding-out after 1913, and survey more recent developments in community care, particularly in light of recent government initiatives; to attempt to draw analogies between the prominence of the nineteenth-century system, and the more controversial position of patients living in the community in the late-twentieth century; and to address the debate concerning the appropriate balance between institutional and community care of the mentally ill (Chapter 15).

14. To assess the impact of the boarding-out policy and offer conclusions as to the success or otherwise of the system (Chapter 16).

Despite the pessimism and possible truth of Hegel's remark that "we learn from history that we do not learn from history", the potential value of historical insights into contemporary medical issues is widely recognised. Parry-Jones, for example, is confident in his commitment to historical research, and the benefits attainable by the extension of different academic disciplines into the sphere of medical research. Thus, in relation to psychiatry he contended that:

> "the application of historical data and principles is crucial to the understanding of psychiatry at its present stage of development Although the application of scientific methodology rightly must play the foremost part in extending psychiatric knowledge, the full evaluation of current issues and theories cannot be achieved without historical perspective... we cannot yet afford to overlook any information which can be derived from historical sources about the management in the past of those problems that still perplex us at the present day."[60]

From a different perspective, social scientists have also echoed this point, stressing the importance of examining "the historical origins of existing ideas and institutions." In this context, it has been asserted that:

> "the current shape and character of psychiatry and of the mental health services...are as much a product of past needs, pressures and struggles as of present forces. It is for this reason that a full understanding of present-day psychiatry requires an analysis of its past development."[61]

Despite the growing recognition of the importance of historical awareness in current debates concerning the mentally ill, however, Scull, prominent among other historical researchers, has made clear his scepticism of historical studies of their specialities by clinicians. Further, only a minority of medical faculties offer the study of the history of medicine in their curriculum. Guthrie's plea in 1957 for a:

> "more widespread application of the historical aspect of medicine in medical education, and for a closer attention to history by all who, of necessity, have become specialists in one of the numerous branches of medicine"[62]

remains largely unheeded. To facilitate this, he recommended that the history of medicine must not be regarded as "a branch of knowledge to be studied by itself having no close link with everyday medical practice."[63] In this way, in an attempt to bridge the divide between historians and clinicians, this thesis has been written by a historical researcher working within a medical faculty. Although only Chapter 15, with its examination of community care in the twentieth century, has direct relevance to the work of clinicians, the content of the thesis has been received with interest from clinicians regarding the historical context in which this study is set.

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[60] Parry-Jones, W.Ll. (1972) *op.cit.*, p292.
[61] Busfield, J. (1986) *op.cit.*, p145.
[62] Guthrie, D. (1957) Whither medical history? *Medical History*, 1, p317.
[63] *Ibid.*, p308.

While detailed in its description of the adoption, implementation and development of boarding-out, incorporating all currently known relevant source material, and offering an assessment of the strengths and impact of the system, this thesis cannot claim to be definitive. The constraints of time and space mean that discussion regarding the development of Scottish psychiatry, the gradual transformation in the prevailing ethos of care and attitudes towards the insane, and the revisionist ideas of certain historians concerning the nature of institutional provision, can only be touched upon briefly. This study offers, instead, an analysis of a pioneering system of care in the community, the basis of which has important implications for mental health provision in the twenty-first century.

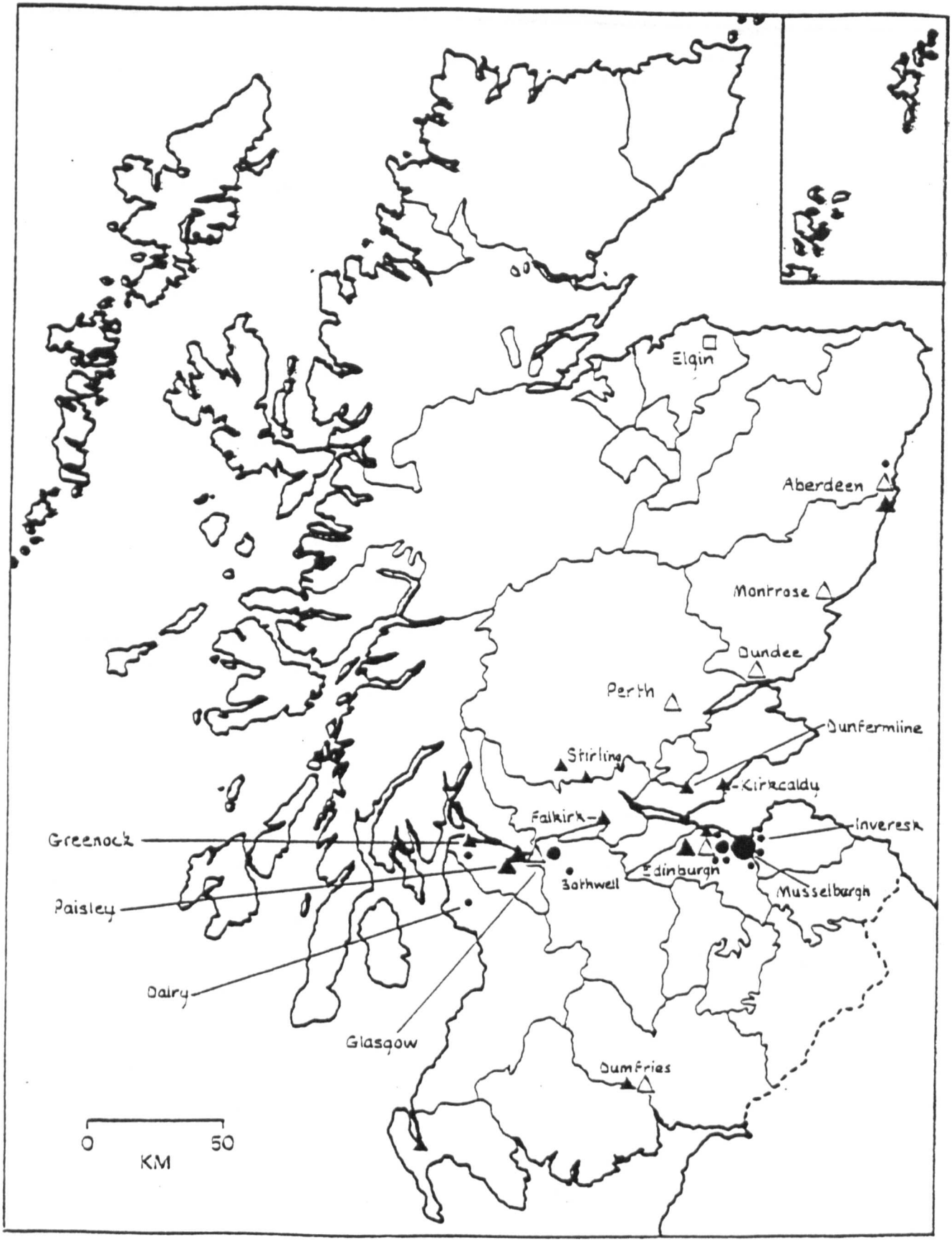

Figure 1.1 Map of institutional provision in Scotland, 1857[1]

△ Royal Asylum
⊏ Public Asylum
• Private Madhouse
● 2 Private Madhouses
● 9 Private Madhouses

▲ Poorhouse with lunatic ward(s)
▲ 2 Poorhouses with lunatic ward(s)

[1] Source of data: Report of the Royal Commission, (1857) passim. Map outline includes pre-1975 Scottish county boundaries. Institutions shown on the map have only been approximately located.

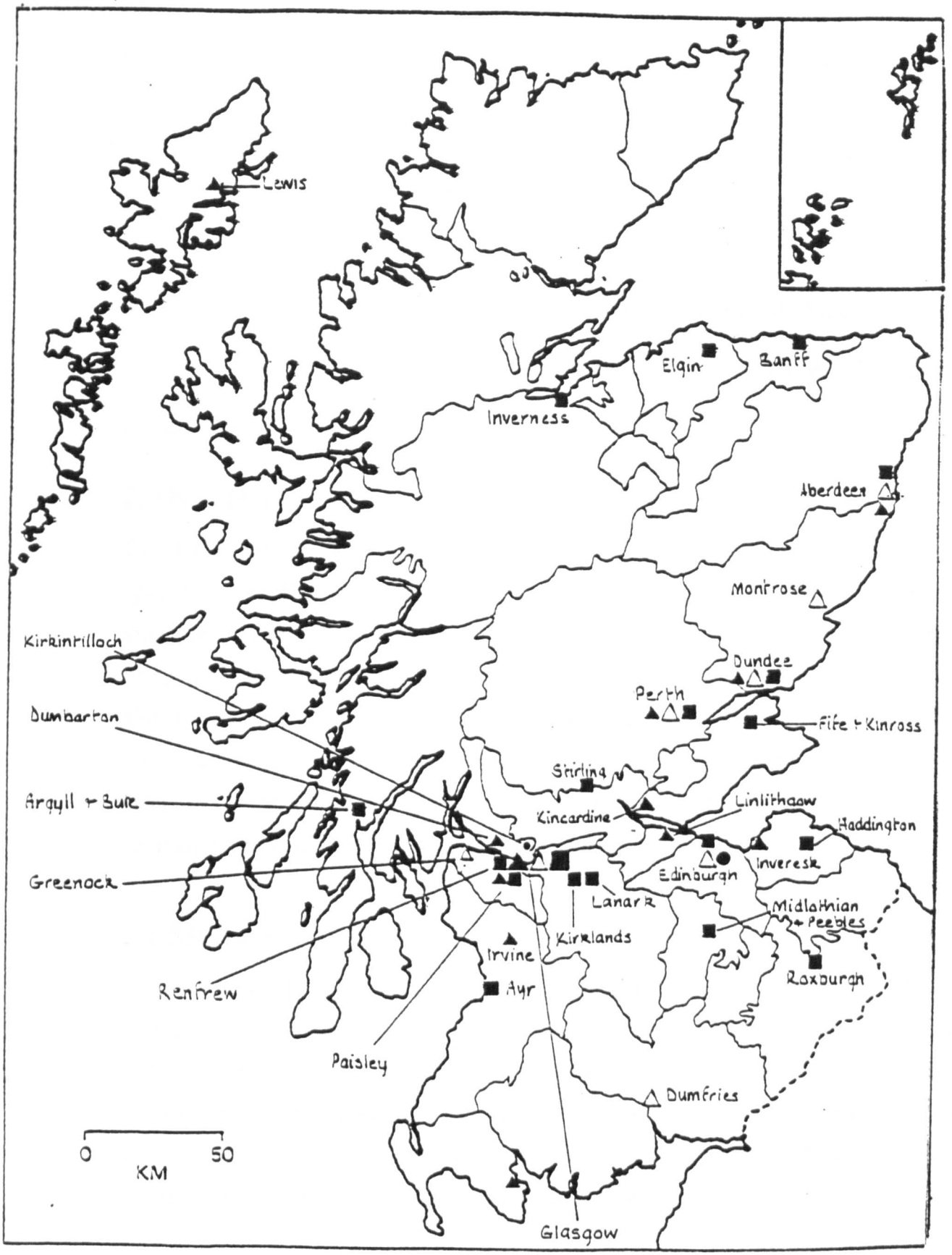

Figure 1.2 Map of institutional provision in Scotland, 1913[1]

△ Royal Asylum
■ District Asylum
■ 3 District Asylums
△ Parochial Asylum
• Private Madhouse
● 2 Private Madhouses
▲ Poorhouse with lunatic ward(s)
▲ 2 Poorhouses with lunatic ward(s)

[1] Source of data: GBCLS 55th AR (1913), passim. Map outline as for Figure 1.1. Institutions shown on the map have only been approximately located. It has not been possible to locate one poorhouse lunatic ward.

CHAPTER 2

METHOD, SOURCES AND MODERN LITERATURE REVIEW

2. Overview

This thesis presents the first compilation of information collected systematically on the system of boarding-out insane patients in nineteenth-century Scotland, necessitating, therefore, a largely descriptive format. This chapter identifies the main research methods employed in the study and reviews the availability of both printed and manuscript material. The strengths and weaknesses of the source material are evaluated and the value of oral history and newspapers as sources of information is assessed. In addition, the contribution made by twentieth-century medical and general historical texts to a study of non-institutional provision for the insane is considered.

2.1 Method

In order to conduct a detailed assessment of a subject which has very rarely been addressed by historians of lunacy provision, a systematic analysis of relevant contemporary printed and manuscript sources, medical journals, reports of Royal Commissions and Select Committees and contemporary European and American literature was undertaken. Further, a comprehensive review of the modern literature on nineteenth-century British, particularly Scottish, methods of provision for the insane was carried out.

The development of boarding-out, the quality and extent of provision and the demographic characteristics and daily activities of patients are explored within the constraints of the surviving source material. The sources which formed the basis of this research comprised the extensive annual reports of the Commissioners in Lunacy and, to a lesser extent, parochial board minute books and annual reports of asylum superintendents. A necessary part of the project was the location and processing of hitherto unexplored manuscript

material, which included registers of boarded-out patients and visiting report books. Constraints imposed by time, logistics and availability of material meant that this aspect was largely exploratory, but communication with archivists and librarians indicates that all currently extant material on boarding-out has been scrutinised.

Letters were sent to all the record offices in Scotland (20), the local Health Board archives (3), civic libraries (7) and psychiatric hospital archives (6), and to record offices in England (60), Wales (9) and Ireland (3), requesting information regarding the location of any source material on boarding-out in the United Kingdom. In addition, visits were made to 24 record offices, libraries and local government offices in Scotland. Forty-two letters were sent to selected libraries, hospitals, and to researchers in the history of psychiatry throughout Europe and America. The detailed and enthusiastic replies of the majority of respondents were gratifying and constructive. Excerpts from theses, pertinent articles, lists of holdings and suggestions for further useful contacts were received. The responses from archivists in England, Wales and Ireland indicated that, while a number of insane patients resided in the community and were recorded as single patients in parish records, there was no detailed discussion of their cases. This finding reflects the lack of interest by physicians in an organised form of domestic care in the nineteenth century, with the exception of Scotland. In contrast, the lengthy, informative responses from the United States, Canada and continental Europe, served to indicate the existence of a widespread application of a system of domestic provision. The references recommended by many respondents facilitated an extensive survey of international journals.

2.2 Source material

The following sources have been utilised:

2.2.1 Annual reports of the General Board of Commissioners in Lunacy

The printed annual reports of the General Board of Lunacy constituted the single most useful and important primary source for this study. Each year, the main report contained a brief discussion of the condition of single patients and of the progress of the system. Detailed accounts of visits made by the Deputy Commissioners across the country during the year and their assessment of boarding-out in practice were documented in appendices. The general condition, geographical location, numbers and details of individual cases were

recorded with scrupulous care. Sustained attention was devoted to assessing the quality of guardianship, the suitability of patients and the development of the system. The reports appeared annually in edited form in the Journal of Mental Science.

Despite the meticulous documentation in the annual reports of the development and expansion of boarding-out, the determination of the Commissioners to emphasise the beneficial aspects of the system led to a tendency to counter and dismiss criticisms too readily. Throughout the reports, the generally positive attitude of the Commissioners to the system, as practised under their control, prompts reservations as to the utility of this source as a dispassionate indicator of the potential benefits of boarding-out. However, despite the fact that the reports contain an undoubted element of self-congratulation, the possibility that they were constructed mainly for propaganda purposes, emphasising only the advantages of boarding-out, in an attempt to consolidate the system, is not reflected in the overall content.

An additional problem is posed by the process of selection of case studies for detailed assessment. Notwithstanding their undoubted usefulness, the often lengthy descriptions of individual boarded-out patients do little to clarify the mental condition and circumstances of the majority of satisfactory cases. Although care has been taken in this study not to give disproportionate attention to the more sensational accounts of the experiences of particular patients, case histories documented in official reports had already been pre-selected by the Commissioners. In this context, the Commissioners displayed a clear tendency to highlight the more interesting, usually more extreme, cases, at the expense of a portrayal of the more typical experiences. Nevertheless, the reports did undertake to describe overall standards encountered, highlighting, where appropriate, specific cases of improvement brought about by their recommendations. An attempt has been made in this study to focus on examples which can be seen as generally representative of typical cases. Therefore, while a proportion of case studies documented contain shocking aspects, it is contended that a general assessment of the conditions and experiences of boarded-out patients can be elicited on the basis of careful selection from the numerous cases recorded annually by the Commissioners.

Despite certain drawbacks, therefore, annual reports of the Commissioners in Lunacy offer

the most concise and informative insight available into the characteristics and experiences of boarded-out patients. In addition, they provide a valuable source of information for social historians, regarding the lives of the poor, with their graphic descriptions of the type and pattern of employment, standard of housing, and dietary and sleeping arrangements found in the cottages of crofters and labourers throughout the country.

2.2.2 Parish records

Parish records include monthly minutes from parochial board meetings across Scotland, registers of poor and annual reports of the Board of Supervision. They provide a useful source of information for patient statistics, but are less valuable for recording attitudes towards the system of boarding-out, or supplying details about individual patients, other than the name, location, cost of maintenance and provision of clothing. Registers of poor, for example, simply list each pauper in the parish in receipt of poor relief, and record which paupers were insane and where they resided. With regard to the system of boarding-out, however, the main focus of parish records is on financial aspects. An exception to this were registers of boarded-out patients. Those held in Glasgow for Barony parish (1886-1923), for example, discussed in detail the mental and physical condition of each patient, as well as giving the usual information regarding the name, location and cost of maintenance. Each year, a few lines were added regarding the activities and condition of patients (See Appendix 2 for a typical entry). Regrettably, similar registers have not been located for other parishes in Scotland.

Despite scrupulous analysis of the content of parish records across Scotland, the majority of information uncovered added little further insight into the administration and general attitudes towards the policy of boarding-out. The records contain extensive discussions on employment, applications for poor relief and countless other aspects of parochial administration. However, although a number of parishes, particularly the larger, urban ones, devoted sustained attention to the condition of the insane in their district with several pages of parochial board minutes being taken up with discussions on lunacy, this was unusual. Most parishes only reported the number of their patients in asylums or in private dwellings, and the costs incurred, with no consideration of the merits of the respective forms of provision.

Even in parishes where boarding-out was implemented actively, there was little in their official records to reflect this, with the exception of the copious parochial board minutes from Glasgow City and Barony parishes. Other parishes with equally active records of boarding-out made little mention of the system. Among them, for example, reports for Edinburgh City, a parish with one of the highest rates of boarding-out over many decades, contained only minimal discussion. The practice was part of accepted policy, and did not incite any vigorous debate; discussion merited only a few short paragraphs among several hundred pages of reports and no critical appraisal of the system was apparent. Similarly, at Stirling, Inverness, Ayr and Perth, all popular locations for boarded-out patients, minutes of parish meetings were occupied mainly with the administration of schools, poor relief, sanitary issues and the boarding-out of pauper children. The condition of, and provision for, the insane were rarely discussed, other than to record basic details of the names, location, and cost of patients. Where allowances were granted for additional clothing, or if a patient had been removed to another dwelling, or to the asylum, this was recorded, but this comprised the sum of information offered about boarded-out patients. Similarly, at Orkney, where, of necessity, a very high proportion of patients remained in their homes, parish reports listed names and location, but only described a case in detail if the patient was removed to a mainland asylum.

2.2.3 Visiting report books

Visiting report books were held in every house which received boarded-out patients. Basic details regarding the mental condition of the patient, cleanliness of the house and suitability of guardianship were recorded at every visit by lunacy and parochial officials. Details of the specific clothing requirements, for example, were reported regularly. In addition, space was provided for suggestions and recommendations. In this way, these books (each between 46 and 48 pages long) supply valuable information into the minutiae of the lives of patients, but almost nothing about the mental condition, or attitudes of patients themselves. Officials merely entered terms such as "weak" or "idiotic" under the State of Mental Condition, and "good" or "fair" under State of Bodily Health.

A detailed search of record offices and libraries in Scotland has revealed the existence of only seven such books, relating to five boarded-out patients in Bellie Parish, Morayshire, conserved in Aberdeen City Archives. It is probable that most of these books remained in

the care of individual guardians and were never collected centrally and preserved. Appendix 3 contains a photocopy of the content of one of the surviving books from Aberdeen, indicating the particular areas of concern focused on by visiting officials, with evident preoccupation regarding the cleanliness of the house and patient, the state of bedding and clothing and consideration as to whether the duties of the guardian were "satisfactorily performed."

2.2.4 Annual reports of asylums

The annual reports of medical superintendents illustrate well the concerns of the individual superintendent and asylum, but in addition, the majority contained consideration, often at some length, of the system of boarding-out and the relief this could bring to overcrowded asylums. Medical superintendents took the opportunity offered in their annual reports to announce, often with evident satisfaction, the number of discharges of incurable patients to private dwellings and certain superintendents periodically devoted several paragraphs to assessments of the system.[1] Nevertheless, by focusing on reports made by medical superintendents and taking remarks made on boarding-out out of context, it is easy to exaggerate their significance and, thus, misrepresent the degree to which asylum physicians were preoccupied with the system. Therefore, the views of medical superintendents as outlined in published articles or presented at conferences and meetings of the Medico-Psychological Association are also employed as a useful information source.[2]

On their twice-yearly visits to each asylum, the Lunacy Commissioners assessed the extent of boarding-out from each asylum and, where appropriate, made recommendations for further activity. These remarks were appended to the annual reports of each asylum and referred to with some frequency by medical superintendents, particularly when they reflected favourably on the asylum.

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[1] Contained within the medical superintendent's annual report, for Gartloch Asylum, 1896 was a special report by Robertson, the Consulting Physician, comprising three pages discussing the boarding-out system. It is significant that such a large portion of an asylum's annual report was devoted to this.

[2] For example: Fraser, J. (1878) On the disadvantages of boarding-out certain harmless lunatics and on the advantages of open-doors in asylums. *Journal of Mental Science,* **24**, 297-299, Lindsay, W.L. (1871)The family system as applied to the treatment of the chronic insane. *Journal of Mental Science,* **16**, 497-527, Robertson, A. (1870) *op.cit.*, Sibbald, J. (1861) *The cottage system and Gheel. An asylum tract.* London. J.E Adlard, Tuke, J.B. (1870) *op.cit.*, and Turnbull, A.R. (1888) *op.cit.*

2.2.5 Contemporary books and pamphlets

Little substantial work in book-form was undertaken regarding the boarding-out system in the nineteenth or twentieth centuries. A notable exception to this was Mitchell's seminal work of 1864, intended primarily for parochial officials, but which came to be read widely, nationally and internationally, and referred to regularly by observers of the Scottish system.[3] Although focusing extensively on the "dark side"[4] of such provision, it furnishes the most instructive, detailed account of conditions encountered by Lunacy Commissioners in the early years of their work. Many of the examples cited were taken from the Commissioners' reports and, while Mitchell's work adds little that is new, the pages of detail reinforce the impression of the inadequacy of provision for single patients in the first half of the nineteenth century. In addition, there were several short, but detailed, pamphlets, which contained useful descriptions of boarding-out, among the most informative being those by Sutherland[5] and Sibbald[6]. The detailed chapters in books by Tucker[7], Letchworth[8], Alt[9] and Tamburini et al.[10] offer valuable assessments of the Scottish boarding-out system, as well as describing similar systems across the world.

Publications by medical superintendents of Scottish asylums, and other influential alienists, often paid no attention to the boarding-out system. For example, Clouston, Skae and Yellowlees rarely mentioned the system in their numerous publications, despite the fact that the former two endorsed its development, as superintendents of Edinburgh Royal Asylum. In England, Maudsley[11], Bucknill[12] and Arlidge[13] were among a small number of alienists who considered the merits of domestic provision at length. In 1886, East published a work intended only as a supplement to the "larger and more perfect manuals."[14]

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[3] Mitchell, A. (1864) *op.cit.*
[4] Mitchell adopted the term "dark side" to describe the general conditions witnessed in private dwellings both by members of the Royal Commission in 1855 and in the early years following the creation of the Board of Lunacy. Mitchell, A. (1864) *op.cit.*
[5] Sutherland, J.F. (1897) *op.cit.*
[6] Sibbald, J. (1895) *Lunacy administration in Berlin and in Scotland.* Lewes: Southern Counties Press.
[7] Tucker, G.A. (1887) *Lunacy in many lands.* Sydney:C.Potter.
[8] Letchworth, W.P. (1889) *The insane in foreign countries.* New York and London: G.P.Putnam & Sons.
[9] Alt, K. (1899) *Über Familiare Irrenpflege.* Sammlung Zwangloser Abhandlungen aus dem Gebiete der Nerven und Geisteskrankenheiten. 2, 7.8. Halle an der Saale. Verlag von Carl Marhold.
[10] Tamburini, A., Ferrari, G.C., and Antonini, G. (1918) *L'assistenza degli alienati in Italia e nelle varie nazioni,* particularly Chapter 5: Assistenza familiare degli alienati e colonie familiari, 559-584. Torinese Milano, Napoli, Palermo, Roma: Torino Unione Tipografico.
[11] Maudsley, H. (1867) *The physiology and pathology of the mind.* London: Macmillan.
[12] Bucknill, J.C. (1880) *The care of the insane and their legal control.* London: Macmillan.
[13] Arlidge, J. (1859) *On the state of lunacy and the legal provision for the insane.* London: J.Churchill.
[14] East, E. (1886) *The private treatment of the insane as single patients.* London: J. Churchill.

While broadly in favour of private care for the insane, the approach is from an English perspective, concerned wholly with wealthy patients, and makes no mention of the Scottish system of boarding-out. In general, therefore, little specific attention was devoted to the system in contemporary books, the on-going debate regarding its merits and drawbacks being undertaken in a proliferation of articles in prominent medical journals.

2.2.6 Contemporary journals

The degree of attention devoted to boarding-out by physicians in Scotland and worldwide is reflected in the relatively large volume and range of articles in nineteenth and early-twentieth century medical journals. The editors of the Journal of Mental Science (established in 1853 as the Asylum Journal) the most prominent journal for physicians of the insane, maintained an enduring interest in the system. Although a few articles appeared in the 1860s outlining the newly-introduced system, it was from the 1870s, almost every year for a period of at least two decades, that the journal published a descriptive article or recorded a discussion by members of the Medico-Psychological Association on the merits of boarding-out. The journal can be seen as an accurate reflection of the most topical views of the day and, thus, indicates the continuing level of interest in the system. The other influential journal concerned with lunacy, the Journal of Psychological Medicine (established in 1848) displayed markedly less interest in boarding-out, devoting more attention to asylum care. Alternative methods of containment were seldom given much consideration.

The content of general medical journals indicate that some interest was shown in the system of boarding-out. Brief articles were often published in the British Medical Journal and in the Lancet discussing boarding-out, and reports of new assessments of the system were recommended to readers. However, not unexpectedly, given the focus of these journals on general medical issues, the detail and frequency of these was far more limited than articles in the Journal of Mental Science. Other journals, such as the Edinburgh Review, and the Medical Critic and Psychological Journal, published articles outlining the system, or assessments of it within a wider debate on non-restraint or open-door policies for the treatment of the insane.

The Poor Law Magazine, the mouthpiece for parish officials, displayed a clear interest in

boarding-out, and brief discussions of the system were published every few years (particularly in the 1860s with focus on assessments of the new policy). Although the predominant concern reflected in the Magazine appeared to be with education, general health and the welfare of children, articles debating whether lunacy was increasing, and assessments of different modes of provision for the insane, were published frequently. The detailed contribution in 1902 by Spence, Secretary to the Board of Lunacy, provides a notable example.[15] Thirteen years earlier, and somewhat remarkably, a detailed review of the boarding-out system by the renowned French physician, Féré, which first appeared in the Revue Scientifique, was translated and printed for the Barony Parochial Board.[16] The Poor Law Magazine, therefore, provides a useful representation of the view of parish officials in the administration of the pauper insane.

From the 1870s up to the turn of the century, lengthy discussions of family care policies, particularly the Gheelois and Scottish systems, appeared almost annually in the contemporary medical journals of Europe and America. The Allgemeine Zeitschrift für Psychiatrie and the Annales Médico-Psychologiques, in particular, contained animated discussions on the merits of domestic provision, as well as detailed descriptions of boarding-out in Scotland. In this context, it is noteworthy that annual reports by Scottish Commissioners were circulated internationally.[17]

2.2.7 Reports of Royal Commissions

The main report and appendices of the Royal Commissioners on the Care and Control of the Feeble-minded, 1908, (in particular, the minutes of evidence relating to Scotland) and the Royal Commission on the Poor Laws and Relief of Distress, Scotland, 1909, contain detailed reports and assessments of the boarding-out system, from parish and lunacy officials, and medical observers. The responses from Lunacy Commissioners in these reports are particularly valuable for their concise clarification of the essence of the boarding-out system and the pattern of its development over a period of fifty years.

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[15] Spence, T.W.L. (1902) The present position of the insane poor under private care in Scotland. *Poor Law Magazine*, **12**, 621-646.
[16] Féré, C.H. (1889) The insane in private dwellings in Scotland. *Poor Law Magazine*, **17**, 281-289.
[17] Chapter 14 details the most informative articles in various nineteenth century European and American medical journals.

Less informative, but nevertheless pertinent, is the evidence given to the Select Committee appointed to inquire into the operation of the Poor Law in Scotland, 1868-1869. The system of boarding-out was discussed by a number of witnesses and recommendations for its further expansion were forthcoming. In addition, the Select Committee appointed in 1877 "to enquire into the operation of the Lunacy Law, so far as regards the security afforded by it against violations of personal liberty" was an important inquiry, encompassing over 11,500 questions and answers relating to lunacy administration. Considerable interest was shown in the Scottish system of boarding-out, although no specific recommendations as to the mode of its development were forthcoming.

2.2.8 Newspapers

Newspapers, such as The Glasgow Herald and The Scotsman, occasionally printed articles on the growth of insanity, questioning "is lunacy increasing in Scotland?" However, the usefulness of newspapers as a source for this study was limited, due to the sparsity of any detailed discussions of boarding-out. Although many of the larger papers published excerpts from the annual reports of the Board of Lunacy and from asylums, these were not accompanied by any discussion. Despite being written by non-medical men, therefore, and presumably reflecting, to some extent, the opinions of the general population, little insight can be gleaned from newspaper reports regarding the popular attitude towards insane persons residing in the community.

2.2.9 Oral history

A visit to the village of Kennoway, in Fife, noted for the large number of insane patients boarded there in the nineteenth century, was undertaken in 1994. The reminiscences of seven villagers and one surviving guardian provided unique and valuable supplementary information (See Chapters 5 and 15).

2.3 Modern literature review

2.3.1 Medical history works

A study of any aspect of the history of Scottish lunacy provision is, therefore, dependent almost entirely on primary manuscript or printed official material. Although there is a growing interest in the history of various aspects of psychiatry, there are few recent studies

for the researcher to draw upon, with the exception of the works listed in the opening paragraphs of Chapter 1. Notable studies published in the last twenty years have been devoted largely to developments in English psychiatry. For example, Scull's arguments do not extend to the Scottish system, and his radical views on institutionalisation offer little insight into the development of non-institutional provision in Scotland. No consideration was given to the extent to which boarding-out offered medical superintendents the opportunity to concentrate on therapeutic asylum practices. In fact, despite the worldwide attention in the boarding-out system by nineteenth-century alienists, Scull simply observed that "the Scots insist[ed] that a combination of family care, the boarding-out of lunatics with strangers, and the limited accommodation provided by a handful of charity asylums (the so-called royal asylums), was superior to English asylumdom."[18] This reflects a neglect frequently encountered regarding developments north of the Border.

Similar lack of coverage of the Scottish system is apparent in the work of other researchers in the history of lunacy provision, eg: Jones[19] and Busfield.[20] In addition, one of the few articles in recent years addressing the developments of provision for the insane in nineteenth century Scotland, failed even to mention boarding-out, concentrating instead on asylum growth and the foundation of psychiatry in Scotland.[21] Even where the system is acknowledged, its full significance has tended to be misunderstood and minimised. Bennett for example, summarised boarding-out as a "system of offering free social life differing little from life in a large private family [which] was repeated both in England and Scotland, where variants of the family system were tried". Such an assessment ignores the prolonged influence of a system which provided at times for over a quarter of Scotland's insane pauper patients.[22]

Notwithstanding this, there have been a few, albeit brief, discussions of the boarding-out system. In the space of eight pages, Henderson, author of a standard text on Scottish psychiatry, described the policy in Scotland, Gheel, and other parts of Europe and America,

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[18] Scull, A. (1991) *The Asylum as Utopia.* London: Routledge, pxx.
[19] Among her many publications, no mention is made of the early Scottish experiment at community care. Jones, K. (1972) *A history of the mental health services.* London: Routledge & Kegan Paul, Jones, K. (1993) *Asylums and after, a revised history of the mental health services.* London: Athlone.
[20] Busfield, J. (1986) *Managing madness: changing ideas and practice.* London: Hutchinson.
[21] Walmsley, T. (1991) Psychiatry in Scotland. In *150 Years of British Psychiatry, 1841-1991* (eds. G. Berrios and H.Freeman), pp 294-305. London: Gaskell.
[22] Bennett, D (1991) The drive towards the community. In *150 Years of British Psychiatry, 1841-1991* (eds. G. Berrios and H.Freeman) London: Gaskell. p322.

assessing both the praise and censure that was meted out to the system. However, the impact of his comments becomes lost in the overall thrust of his book, which emphasises the supremacy of the royal asylums, the work of their medical superintendents and the beginnings of research in psychiatry.[23]

In his assessment of the lunatic colony at Gheel, Parry-Jones described the implementation and development of domestic provision.[24] He went on to examine its influence in Britain, at a time when it was becoming increasingly clear that the asylum could not cater for all pauper lunatics considered to need institutional care. The study offers a brief survey of boarding-out in Scotland, thereby becoming one of the first since the turn of the century to discuss, or even acknowledge, the existence of the system.

While Rice assessed the organisation of insanity in early and mid-nineteenth century Scotland, his thesis was more concerned with the growth and development of the royal asylums, in the context of the radical assertions of Scull, regarding the correlation between industrialisation and mass institutionalisation of the insane.[25] The system of boarding-out was mentioned briefly, leading to the conclusion that "it is essential not to over employ the importance of this innovation...while this expedient was to become widely practised, nevertheless it still only ministered to a minority of the entire insane population."[26] This is to minimise the true nature of a system, which provided for large numbers of registered insane patients for over 50 years during the nineteenth and early twentieth century. However, Rice's work affords a valuable and informative overview of Scottish psychiatric provision in the nineteenth century, at a time when no related work had been undertaken.

Raftery's impressive study examined the activities and costs of psychiatric services in England, Wales, Scotland and Ireland over the years 1845-1985.[27] However, beyond a brief discussion of the introduction and early development of boarding-out, the study contained no new interpretation or descriptions of the system. Nine years earlier, Thompson did little more than remark on the existence of the boarding-out system, and reflect on the need for

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[23] Henderson, D. (1964) *The evolution of psychiatry in Scotland.* Edinburgh: Livingstone, pp95-103.
[24] Parry-Jones, W.Ll. (1981) *op. cit.*
[25] Rice, F. (1981) *op.cit.*
[26] *Ibid.*, p359.
[27] Raftery, J.P. (1993) *The economics of the psychiatric services. United Kingdom and Ireland. 1845-1985.* Ph.D thesis. London: London School of Economics.

further research on the subject.[28] Doody's informative study of the Fife and Kinross District Asylum emphasised the vital role of district asylums in providing accommodation for all insane patients, regardless of financial position, or mental condition. Successive medical superintendents of Fife and Kinross were firm advocates of boarding-out and this is acknowledged by Doody, although no detailed assessment of the policy was undertaken.[29]

Turner has endeavoured to find an explanation for the lack of lively discussion of the "rich historical background" in current debates concerning psychiatric provision, and in particular, the policy of community care. He questions whether this is due to a general lack of awareness and interest in past methods of care of the insane and to the limited availability of nineteenth-century profiles of asylums and developments in lunacy provision.[30] In this context, references to the experiment of boarding-out in nineteenth-century Scotland are almost entirely absent and this can be attributed to the lack of any substantial published work on this subject. An exception to this is the brief, informative summary of boarding-out in a review of guardianship in Scotland by Richards and McGregor.[31] As they have justifiably observed, the system of boarding-out has been regarded by contemporary writers as little more than just a theme in poor law and lunacy reports. Footnotes to this book indicate a volume of articles discussing the system of guardianship in Scotland in the twentieth century but again, the pioneering nature of its direct forerunner, boarding-out, remains unrecorded.[32]

The brief discussions by Henderson, Parry-Jones, McCandless,[33] Rice, Richards and McGregor, and Andrews[34] comprise the sum of current literature on the Scottish boarding-out system. In particular, Parry-Jones' short article of thirteen pages, combined with the as yet unpublished examination by Andrews of the work of the Scottish Lunacy Commissioners, although inherently restricted in detail, bring more understanding of the

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[28] Thompson, M.S. (1984) *op.cit.*
[29] Doody, G. (1992) *op.cit.*
[30] Turner, T. (1985) The past of psychiatry. Why build asylums? *Lancet,* ii. p709.
[31] Richards, H. and Mc.Gregor, C. (1992) *Guardianship in Scotland.* Edinburgh: Mental Welfare Commission for Scotland. HMSO.
[32] Among pertinent articles are those by: Ward, A. (1984) *Scots Law and the mentally handicapped.* Scottish Society for the mentally handicapped, Whyte, W. and Hunter, S. (1989) *Mental health officers and guardianship of the person.* Edinburgh University, and Weatherhead, A.E. (1991) Why isn't guardianship more popular in Scotland? *Psychiatric Bulletin,* **15**(6), 341-343.
[33] McCandless, P. (1979) *op.cit.*
[34] Andrews, J. (in preparation) Scottish Lunacy Commissioners and lunacy reform in nineteenth century Scotland. In *The changing face of Scotland's health and medicine* (ed. M. Nicolson) London: Routledge.

system of boarding-out in Scotland, than any published work in the last fifty years.

2.3.2 General historical works

The condition of the insane in general, whether in asylums or in the community, receives little attention in general historical studies.[35] The detailed work of Smout,[36] for example, contains no discussion of insanity and its treatment. Similarly, more recent work by Crowther,[37] Levitt[38] Slaven[39] and Devine[40], while detailed and concise in their portrayal of the lives, economic position and general physical health of the Scottish poor, do not consider the mental health of the population.[41] Notwithstanding the impact of boarding-out on the development of Scottish lunacy administration, the complete lack of awareness of this subject in general historical studies of Scotland is not surprising, in view of the absence of any discussion on the specific issues surrounding mental health provision in the nineteenth century. It may have been expected, however, that some mention of boarding-out would be made in historical surveys of the Highlands and Islands, since the policy not only flourished there, but, in such relatively small communities, the presence of often clearly insane persons would have been observed widely. Therefore, it could have been presumed that modern authors would be aware of the policy and its significance in introducing a system of control over the insane.

A number of studies assessing the nature and implications of poor law legislation mention briefly the policy of boarding-out (for example, Mackay[42]) but there is no systematic analysis of its impact. Ferguson's somewhat dated study examined Scottish social welfare,

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[35] An exception to this is the work of Checkland which contains outlines of the developing institutional provision for the insane. Checkland, E.O. (1980) *Philanthropy in Victorian Scotland. Social welfare and the voluntary principle.* Edinburgh: John Donald, and Checkland, E.O. and Lamb, M. (1982) *Health care as social history. The Glasgow case.* Aberdeen: Aberdeen University Press.

[36] Smout, T.C. (1987) *A century of the Scottish people. 1830-1950.* London: Fontana, and with Wood, S. (1990) *Scottish Voices, 1745-1960.* London: Collins.

[37] Crowther, M.A. (1990). Poverty, health and welfare. In *People and society in Scotland. 1830-1914.* Vol. 2 (eds. W. Hamish Fraser and R.J. Morris), pp265-287. Edinburgh: John Donald, in association with Economic and Social History Society of Scotland.

[38] Levitt, I. (1988) *Poverty and welfare in Scotland, 1890-1948.* Edinburgh: Edinburgh University Press.

[39] Slaven, A. (1975) *The development of the west of Scotland.* London: Routledge & Kegan Paul.

[40] Devine, T.M. (1988)*The great Highland famine.* Edinburgh: John Donald. Chapter 12 is the most useful, with its discussion of the impact and aftermath of the famine on the west Highlands and Islands, and Devine, T.M. (1994) *Clanship to Crofters' war. The social transformation of the Scottish Highlands.* Manchester and New York: Manchester University Press. (In particular the last six chapters covering life during and after the famine).

[41] Also useful for information concerning the social conditions of Scotland's population are articles in Hamish Fraser, W. and Morris, R.J. (eds.) (1990) *op. cit.,* among them: Anderson, M. The people, pp8-45, Campbell, R.H. and Devine, T.M. The rural experience, pp46-72 and Morris, R.J. Urbanisation and Scotland. pp73-102.

[42] Mackay, G. (1907) *The practice of the Scottish Poor Law.* Edinburgh: William Green & Sons.

in the very period when boarding-out became an official policy. In a book of six hundred pages, lunatics are considered in scanty detail, although the Lunacy (Scotland) Act, 1857, and its implications are assessed. This book provides a useful overview of legislation, but there is no discussion of the system of boarding-out; the focus remaining on institutional provision.[43] The same is true of studies of health care in Scotland. Macgregor's review of public health in Glasgow includes a brief section on asylums, but does not consider any alternative forms of provision.[44] Similarly Comrie dealt with the royal asylums, and, briefly, the movement towards encouraging general hospital features, but, in common with other studies, did not discuss non-institutional provision.[45]

2.4 Summary and conclusions

It is evident from a review of modern literature on lunacy provision that there has been no systematic study assessing boarding-out. Although the ideals of moral management and the changes in asylum practice over the nineteenth century have been documented extensively, the steady development of the boarding-out system, and its widespread influence, nationally and internationally, appear to be largely unknown. This is in stark contrast to the profusion of nineteenth-century work assessing the system.

Substantial use has been made in the present study of official reports, which proved a valuable source of detailed information, but, there can sometimes be a problem with the ideologies behind the writers of official sources. The descriptions and assessments of boarding-out were recorded, almost entirely, by medical men, and to a lesser extent, by parochial officials. Such reports inevitably contain implicit bias, in their tendency to uphold the legitimating view. It is necessary to be aware, therefore, that the Lunacy Commissioners were determined to promote policies which, in their minds, were appropriate. Similarly, it is likely that medical superintendents would be inclined to uphold the legitimating view, and this is reflected in their annual reports, by the apparent acceptance of stated central policy.

In contrast to histories of institutional provision, due to the limitations of extant material,

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[43] Ferguson, T. (1948) *The dawn of Scottish social welfare.* Edinburgh, London, Melbourne and Toronto: Nelson & Sons Ltd.
[44] Macgregor, A. (1966) *Public health in Glasgow, 1905-46.* Edinburgh and London: Livingstone Ltd.
[45] Comrie, J.D. (1932) *History of Scottish medicine,* Vol **2.** 2nd edition. London: Bailliere, Tindall & Cox.

there can be no extensive use of case notes in a study of non-institutional provision. The annual reports of the Board of Lunacy did not consider, in detail, specific case records and with few exceptions, little can be gleaned from parish records beyond basic details of each patient. As with so many other areas of medical history, it is the unofficial voice that remains unreported and unheard. Although editorials of prominent Scottish newspapers occasionally remarked upon the policy, usually to report on accidents occurring to boarded-out patients, with the exception of petitions put forward by villagers in two small communities, the attitudes of the local population can be presented only from the viewpoint of the official visitors.

However, although this study placed much reliance on official reports from the Lunacy Commissioners and parish officials, some insight can be gained into the characteristics and lifestyles of the patients, even though it is rarely possible to discover the attitudes of patients towards their situation. Such testimonies exist in a limited number of asylum reports and in letters written by patients in asylums, but there is no comparable record for patients who were boarded-out. A representation of the thoughts, feelings and experiences of the latter can only be constructed from secondary, often official material. It remains true today that the patient is often the least vocal among participants of the mental health care system. Historians of medicine frequently cast doubt on the value of research which does not incorporate material from patients themselves. However, it is not always essential to have access to individual opinions to create an accurate representation of historical truth. With regard to the present study, the view is taken that insight into the opinions and experiences of patients are invariably enlightening and humanising, but their absence does not negate the utility of official reports, or obstruct a portrayal of the experiences of boarded-out patients.

CHAPTER 3

ARRANGEMENTS FOR THE INSANE PRIOR TO THE LUNACY (SCOTLAND) ACT, 1857

3. Overview

Insane patients resided in the community long before any legislation was passed formalising their status. However, the majority were under no formal control or legal protection. Early reports by the Commissioners in Lunacy, regarding the unsatisfactory conditions in which many patients were boarded, testified to the previous inadequacy of official supervision and a general lack of interest regarding provision for the insane. The extent and quality of prevailing institutional provision, the existing arrangements for single patients and the responsibilities of sheriffs and parish officials are considered in this chapter. Further, the impetus behind the passing of the Lunacy (Scotland) Act, 1857, is examined, with an assessment of the findings and effect of the Royal Commission (1855-1857) which was established to inquire into conditions for the insane.

3.1 Introduction

In 1855, there were an estimated 7400 insane persons in Scotland; approximately 2600 congenital idiots and 4800 lunatics.[1] In the years before 1857, there was no centrally supervised or regulated system of care for the insane, and no national, public provision for pauper patients. Accommodation in royal asylums, which were governed independently, was considered barely sufficient for one third of the insane. Following the establishment of the Board of Supervision for the relief of the poor in 1845, some form of central control of the welfare of the population existed for the first time. However, little specific provision was made for insane paupers. Although inspectors of poor had the authority to place patients in the homes of strangers, or to select asylums for them, arrangements were *ad hoc*

[1] This figure was calculated by members of the Royal Commission. Report of the Royal Commission (1857), p35.

and often unsuitable. Dangerous patients often remained in the community, while harmless idiots and imbeciles were detained in overcrowded asylums.

It was the duty of the Procurator Fiscal to ensure that sheriffs attended to the demands of the pauper population, although they had no powers of visitation and were under no obligation to erect asylums for the insane.[2] The sheriffs of each county had the responsibility of supervising any insane persons in their jurisdiction, visiting asylums and adjudicating over any complaints.[3] However, they, like the inspectors of poor, were ignorant of the existence of a large proportion of the insane, particularly those in private dwellings. Further, there was no uniformity over arrangements in different districts. The degree of efficiency regarding provision for the insane in each county, therefore, was dependent upon the whims of each sheriff and this was reflected in the marked discrepancy in the quality of provision in various counties. While a minority of patients were detained by order of the sheriff, on receipt of two medical certificates, the remainder were under no legal protection or official sanction. Unscrupulous guardians, with no threat of official intervention, accommodated patients for profit and single patients were locked up in cages, or chained in outhouses, often deprived of food and fresh air. These and other abuses remained largely unchecked until the establishment of a Royal Commission in 1855 to assess conditions for the insane.

Insane persons had long been regarded as in possession of evil spirits and the general consensus was to remove them from the public domain.[4] Throughout Scotland, particularly in the Highlands, various methods were employed in attempts to exorcise the spirit. For example, a popular approach to curing epilepsy involved burning a black cock alive with a lock of the sufferer's hair and parings of his nails in the location of his last seizure. The predominance of such methods declined as the century progressed, although Mitchell, a Lunacy Commissioner, suggested that the influence of the "evil eye" remained pervasive in certain parts of the country[5] and as late as 1871 it was reported that insane persons were

[2] The Procurator Fiscal was a local law officer of the Crown resident in the district in which he acted, who investigated cases of suspected crime and acted as Public Prosecutor.
[3] Sheriffs were the highest judicial officers of counties. They acted as Judges of Appeal and had jurisdiction in all cases except divorce.
[4] Mitchell, A. (1862) On various superstitions in the north west Highlands and Islands of Scotland, especially in relation to lunacy. *Proceedings of the Society of Antiquaries of Scotland*, **4**, 251-288.
[5] *Ibid.*, p280.

immersed in lochs near Sutherland.[6] However, while Mitchell found "nothing more heathenish than the sacrifice of a cock and nothing coarser than the drinking of the water in which a dead sister had washed," he maintained that throughout most of the country, such practices were "probably unknown."[7] Nevertheless, he recognised that the belief that drinking blood, particularly the fresh blood of a criminal, and that the touch of a seventh son was curative remained strong in the north-west of the country.[8] With such deeply entrenched superstition among the general public regarding insanity, the newly appointed Commissioners in Lunacy from 1857 were faced with a heavy burden of duty, not only in ameliorating the condition of the insane, but in attempting to ensure they were not regarded and treated as dangerous curiosities.

3.2 Development of lunacy legislation

The contention of one well-informed observer, Letchworth, in the 1880s, that it was "not until 1855 that any effective movement began to establish a humane and comprehensive lunacy system"[9] was broadly accurate, even though there had been earlier acts relating to the insane. The Lunacy Act of 1845 in England had established a central authority for the general supervision of all insane persons. However, although sporadic attempts were made to create a similar body in Scotland, the General Board of Lunacy was not created until 1857, following the passage of the Lunacy (Scotland) Act of that year. The first significant legislation to regulate the treatment of lunatics in Scotland was passed in 1815. Preceding that, a minor legislative enactment of 1806 ordered £2000 to be paid to the city of Edinburgh towards erecting an asylum.[10] The Act regulating Madhouses in Scotland, 1815, placed madhouses under the jurisdiction of the sheriff of the county, and ordered the regular inspection of all such establishments. Sheriffs were authorised to intervene, where necessary, in the treatment of patients, and to order their removal if warranted. Houses accommodating the insane were to be licensed and inspected by sheriffs and medical officials. While it was the duty of the sheriff to ascertain whether patients were properly confined, the provisions of the Act did not extend to single patients. Further there was no consideration of the condition of the insane poor. Praise for the new legislation was,

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[6] Campbell, R.B. (1932) *op. cit.*, p775.
[7] Mitchell, A. (1862) *op.cit.*, p280.
[8] *Ibid.*
[9] Letchworth, W.P. (1889) *op. cit.*,p111.
[10] Tuke, D.H. (1882) *Chapters in the history of the insane in the British Isles.* London: Kegan Paul, p323.

therefore, justifiably muted, although as Tuke maintained, the Act was "an important advance in the right direction, though far from perfect."[11]

Three years later, in 1818, there was an abortive Bill for the erection of district asylums in Scotland. Powerful dignitaries throughout the country condemned the proposed introduction of a measure:

> "uncalled for and inexpedient, novel in its application and arrangement, substituting regulations of compulsion, to the exclusion of the more salutary exertions of spontaneous charity..." [12]

The fierce opposition from landowners, magistrates and freeholders and the number of petitions presented against the Bill contributed to its failure. An Amending Act in 1828 increased the degree of visitation of asylums and introduced preliminary record keeping whereby admission and discharge books were to be kept in every institution and an entry made of every act of restraint. In 1841, an Act was passed "to Alter and Amend certain Acts regulating Madhouses in Scotland, and to Provide for the Custody of Dangerous Lunatics". Pauper insane patients were to be confined in public asylums and, where such establishments did not exist, the sheriff was authorised to send patients to an adjoining county. Further advances were made in the maintenance of official records. A register was to be kept in all licensed madhouses in Scotland, containing details of the house, the residents and their mental condition. In Glasgow and Edinburgh these were inspected annually by members of the Royal College of Physicians and Surgeons.[13]

Attempts to introduce additional legislation in 1848, to amend the existing laws and to establish asylums for pauper lunatics, proved unsuccessful. As in 1818, petitions were sent to the Lord Advocate from the landed classes throughout the country, and the Bill was defeated, both in 1848 and when re-introduced the following year.[14] The legislation in force at the time of the establishment of the Royal Commission in 1855, therefore, was comparatively ineffective and liberal in its provisions. There was no uniformity of inspection or supervision and few powers of compulsion. Despite sporadic attempts to enforce minimum standards in lunacy provision, as Letchworth observed:

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[11] *Ibid.*, p325.
[12] *Ibid.*, p327.
[13] See for example the Minute Books of the inspectors of madhouses, from the Faculty of Physicians and Surgeons, Glasgow. 1841-1857.
[14] Campbell, R.B. (1932) *op. cit.*,p782.

> "these several Acts which may be said to have formed the Scottish code of lunacy, were so ambiguously framed and so contradictory in many of their provisions that there was great difficulty in administering them."[15]

3.3 Establishment of the Royal Commission, 1855

The Royal Commission was established in 1855 "to inquire into the condition of Lunatic Asylums in Scotland, and the existing law in reference to Lunatics and Lunatic Asylums in that part of the United Kingdom".[16] It was prompted largely by the actions of a teacher from Massachusetts, Dorothea Dix, "the American invader", who travelled through Scotland in 1855, exposing the neglect and ill-treatment of the insane. As a result of what she observed, she put pressure on the Home Secretary, Sir George Grey, to appoint a Royal Commission. Although successful in her intention, the pressure, however, was unwelcome, and Grey announced, with regret, that the reform was due to a "foreigner, and that foreigner a woman and that woman a dissenter."[17]

The Commission was chaired by the Sheriff of Fife and included on its staff two English Commissioners, Gaskell and Campbell, together with the Scottish physician Coxe, who drew up the exhaustive report of 1857. In an attempt to ascertain the conditions experienced by insane patients who were not in establishments, members of the Commission visited single patients throughout the country. Reports were also sent in by the Procurator Fiscal or superintendent of police of each county, detailing the number and circumstances of insane patients residing at home.

3.4 Institutional provision

3.4.1 Forms of institutional provision

The availability of existing institutional provision for the insane had a direct bearing on the number and location of patients residing in private dwellings, both before and after the Lunacy (Scotland) Act, 1857. It will therefore be useful to assess the extent and quality of asylum accommodation before 1857. It was generally recognised by physicians, and confirmed by members of the Royal Commission, that asylum provision was wholly inadequate for the needs of the country. In 1818, a return by parochial clergy recorded the

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[15] Letchworth, W.P. (1889) *op.cit.*, p111.
[16] Report of Royal Commission (1857), [2148. Session 1] v.1.293
[17] In Jones, W.L. (1983) *Ministering to minds diseased. A history of psychiatric treatment.* London: Heinemann, p102.

existence of 4628 insane persons, of whom only 416 were accommodated in public and private asylums.[18] Not only was there a "lamentable insufficiency" of institutional provision, but popular opinion regarded asylums as merely places of safe custody for the dangerous insane, rather than as curative institutions.[19] As Browne, superintendent of the Crichton Royal Asylum, Dumfries, declared, while calling for more asylum accommodation:

> "it is known that lunatics are immured in cellars, closets and lofts, that they are allowed to wander nearly nude in the pitiless storm, that they are ill fed neglected, and cast out."[20]

In 1781, the first royal asylum was erected at Montrose. Before the erection of chartered asylums, magistrates frequently confined the insane in prisons for long periods. Preceding the establishment of the royal asylum in 1814, there was little provision for insane pauper patients in Glasgow, the only repository being a ward in the Town's Hospital. Similarly, before the establishment of the Edinburgh Royal Asylum in 1813, the only public provision for the insane in the capital consisted of 12 cells attached to Edinburgh Infirmary and wards in the City's "Bedlam". This prompted the influential nobleman, Halliday, to write a series of letters to a leading Edinburgh newspaper, highlighting the dearth of asylum provision, and calling for the establishment of asylums in every county, with regular inspection of private madhouses.[21] Ten years later, he observed the continued inadequacy of asylum provision, declaring that "district national asylums remain as great a desideratum as ever."[22] The proportion accommodated in asylums remained low, while many quiet insane and imbecile persons were lodged within poorhouses. Halliday estimated that in 1828, for example, nearly 1200 insane persons were detained with private individuals, with only 650 patients in public and private asylums.[23] The seven royal asylums (opened between 1781 and 1839) erected through philanthropic efforts and personal bequests, were all located in or near the large urban centres of the country and open to both pauper and private patients. Elgin Asylum, established in 1835 with accommodation for 40 patients, was the one public

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[18] Campbell, R.B. (1932) *op. cit.*, p778. A number of parishes failed to send in any return from parochial clergy. Therefore the number of insane patients residing at large throughout the country was significantly higher than the figures recorded.

[19] Letchworth, W.P. (1889) *op.cit.*, p110. As Sibbald recorded, irons and chains to restrain all inmates were in constant employment. Sibbald, J. (1897) *On the plans of modern asylums for the insane poor.* Edinburgh: J.Turner.

[20] AR (1846), Crichton Royal Asylum. Recorded in Easterbrook, C. (1940) *Chronicle of the Crichton Royal. 1833-1936.* Dumfries: Courier Press, p27.

[21] Halliday, A. (1816) *A Letter to the Right Honourable Lord Binning containing some remarks on the state of lunatic asylums.* Edinburgh: Francis Pillans.

[22] Halliday, A. (1828) *A general view of the present state of lunatics and lunatic asylums in Great Britain and Ireland.* London: Underwood, p26.

[23] *Ibid.*p28.

asylum and the only establishment north of Aberdeen. The districts of Inverness, Sutherland, the Highlands and Islands had no institutional provision for their insane.

The number and location of insane patients throughout the country in the mid-nineteenth century was established by the Royal Commission (Table 3.1). The impetus towards confining the insane increased rapidly following the establishment of the royal asylums and by 1857, over 2300 patients were provided for in an asylum. However, many insane deemed to be in need of such provision were denied access. The alternative of admission to private madhouses or poorhouses remained unsatisfactory, although there was evidence of considerable recourse to private madhouses, for both pauper and private patients, and of poorhouses for largely pauper cases. There was, therefore, a large number of pauper and private patients residing in the community under no formal control, although the proportion and distribution of private cases could not be ascertained accurately.

Location	Private patients	Pauper patients	Total
Royal and public asylums	786	1594	2380
Private madhouses	219	526	745
Poorhouses	6	833	839
Private dwellings	1810*	1784	3594
Total	2821	4737	7558

*estimated figure by Royal Commission.

Table 3.1 Number and location of the insane in Scotland, 1857[24]

In 1857, there were 17 poorhouses with lunatic wards, accommodating 833 pauper patients, and 6 private cases. Private madhouses too, had flourished in the early-nineteenth century, untrammelled by any effective official control and in 1857, there were 23 such madhouses catering for private and pauper patients. In the years preceding the Lunacy (Scotland) Act, 1857, there had been a marked increase in the number of private madhouses receiving pauper cases, and by 1857, 526 paupers were boarded within them.[25] This can be explained largely by the lack of adequate alternative accommodation, the prohibitively high rates of

[24] Source of data: Report of the Royal Commission (1857), p35. Also in GBCLS 1st AR (1859), main report, pii.
[25] GBCLS 1st AR (1859), main report, pii.

payment in chartered asylums, and a general absence, at this time, of any concerted disapproval among official bodies regarding private provision.

3.4.2 Quality of institutional provision

Not only was the volume of asylum provision inadequate to meet the needs of the population, but members of the Commission, already aware of conditions in English asylums exposed by earlier investigations, asserted that patients accommodated within the asylums were often exposed to cruelty and neglect. Browne's damning appraisal of conditions in early-nineteenth century British asylums is widely known:

> "the building was gloomy, a perfect gaol...the creak of bolts and the clank of chains are scarcely distinguishable amid the wild chorus of shrieks and sobs which issue from every apartment. The passages are narrow, dark, damp, exhale a noxious effluvia...Your conductor has the head and visage of a Charib; carries...a whip and a bunch of keys, and speaks in harsh monosyllables...The floor is covered, the walls bedaubed with filth and excrement; no bedding but wet decayed straw is allowed, and the stench is so unsupportable that you turn away and hasten from the scene."[26]

Although the assessment of the Royal Commission did not produce such graphic descriptions, conditions prevailing in many Scottish asylums met with condemnation from many medical commentators. Within a few years of opening, the royal asylums were overcrowded. The effectiveness of any attempts to attain high standards of provision, therefore, were restricted, although Webster, a physician touring Scottish asylums in 1856, reported that, in general, they had "kept pace in the onward march of improvement, fully commensurate with modern civilisation".[27] However, asylums which were praised by Webster, were, one year later, firmly criticised by the Royal Commission.[28] It was noted, for example, that Montrose Royal Asylum was located in an unsuitable area, was grossly overcrowded and offered inadequate treatment for patients. The seclusion rooms were "mere cells with stone floors and darkened windows...loose straw cast on the floor".[29] The extensive use of seclusion and restraint, as well as the lack of occupation and amusement

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[26] Browne,W.A.F. (1837) *op.cit.*, p132. In his annual report for Crichton Royal he recorded his vision of future asylum provision for pauper patients of the district. "It is proposed to erect an edifice....which shall contain strong and substantial and fireproof wards for those who are affected with furious or destructive mania, but which shall chiefly consist of large, warm, well-aired, well-lighted, cheerful and comfortable dwellings for...gentle or inoffensive or helpless imbeciles and monomaniacs who will constitute a large majority of the occupants." Southern Counties Asylum for pauper patients in Dumfries was opened in 1849. AR (1846) Crichton Royal Asylum. Recorded in Easterbrook, C. (1940) *op.cit.*, p27.

[27] Webster, J. (1856) Notes of a visit to the public lunatic asylums of Scotland. *Journal of Psychological Medicine*, 9, p362.

[28] The assessment of the Commission regarding conditions prevailing in the royal asylums were recorded at length in the main report of the Royal Commission (1857), pp59-99 and in Appendix B, pp37-100.

[29] Report of the Royal Commission (1857), p81.

was condemned.[30] There was general consensus that the royal asylums did not fulfil "to the extent of which they are capable, their purpose of curative institutions."[31] Members of the Commission advocated the erection of more simple buildings, with a domestic atmosphere, in accordance with the needs of economy and comfort. To reinforce the argument, the Report highlighted the statement of one witness from the Glasgow Royal Asylum, who recorded the discomfort experienced by paupers from Paisley who, he maintained, were overwhelmed by the grandeur of the asylum and wished to be returned to the more modest poorhouse in their home town.[32]

Notwithstanding widespread recognition of the shortcomings of asylums, a number of royal asylums were singled out for praise, both by medical commentators, and by members of the Commission. In 1816, Halliday had declared Glasgow Royal Asylum to be "one of the finest establishments of a limited nature in any country"[33] and this was echoed by witnesses to the Commission. The treatment of certain patients, particularly those of the "educated class" was regarded as "liberal and judicious."[34] The Report concluded that, despite serious defects in the mode of administration and standard of provision, many of the royal asylums were well constructed, and "in many respects in a highly satisfactory state"[35] particularly when contrasted to alternative accommodation for the insane.

Without exception, the living conditions and the high mortality rate in poorhouses were criticised in the Commission's Report.[36] The number of insane inmates had grown rapidly in the five years preceding the appointment of the Commission, and it had become common in certain counties to send all insane cases, regardless of mental condition, into overcrowded poorhouses where they mixed freely with sane paupers, often sleeping two to a bed. Many patients were admitted with no medical certificate and were then often placed under permanent restraint for many years.[37] There were seldom any trained attendants, few

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[30] The asylums of Glasgow, Montrose, Aberdeen and Edinburgh were singled out for the excessive recourse to seclusion of patients. *Ibid.*, p85.
[31] *Ibid.*, p240.
[32] Dr Rainey, of Glasgow Royal Asylum. *Ibid.*,p66.
[33] Halliday, A. (1816)) *op.cit.*, p16.
[34] Report of the Royal Commission (1857), p95.
[35] *Ibid.*, p94.
[36] See Report of the Royal Commission (1857), pp128-150 and Appendix D, pp148-184. The high mortality rate was regarded by the Commission as "quite appalling", p148.
[37] *Ibid.*, p143.

amusements or forms of exercise or occupation and no religious services "to elevate the moral tone of the inmates".[38]

The official view of the arrangements in the majority of private madhouses was equally disparaging.[39] In many establishments, outhouses were filled with beds, large dormitories were insufficiently furnished and heated and most were overcrowded.[40] There was rarely any system of classification, or even separation, of male and female patients. Seclusion and the employment of restraint was in daily use, with almost all proprietors resorting to regular use of straitwaistcoats, handcuffs, leglocks, gloves and straps.[41] The absence of any occupation or amusements and the lack of any therapeutic intervention were considered to be among the many disadvantages of private madhouses, where, "scarcely anything is done to break the cheerless monotony of their existence."[42] Members of the Royal Commission, vocal in their disapproval of the profit-making "trade in lunacy", argued that the sole aim, especially where madhouses received pauper patients, was to accommodate the greatest possible number at the smallest financial outlay, and that "profit is the principal object of the proprietors."[43] The ease with which licences to run such establishments were granted to persons with no knowledge of the nature and treatment of insanity was condemned by the Commission. It was noted that many proprietors were totally unfit for such "highly responsible and delicate duties".[44] Among the various occupations recorded were an unsuccessful baker, an ex-victual dealer, and a woman who also kept a public house, and "was waiting to see which proved to be the more successful speculation".[45]

The Report of the Royal Commission contained details of numerous unsatisfactory examples of maltreatment and neglect in various different institutions for the insane. There is no convincing documentary evidence with which to dispute these assessments; the Report stands alone in its comprehensive review of mid-nineteenth century lunacy

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[38] *Ibid.*, pp248-249.
[39] See Report of the Royal Commission (1857), pp99-127 and Appendix C, pp104-147.
[40] *Ibid.*,pp101-102.
[41] *Ibid.*, p111.
[42] *Ibid.*, p248.
[43] *Ibid.*, p125. The extensive use of private madhouses for pauper patients was clearly attributable to their economy. As Grieg, the inspector of poor for St Cuthbert's parish, Edinburgh admitted, "we certainly keep them cheaper than we could in the poorhouse." *Ibid.*, p360.
[44] *Ibid.*, p100. In 1855, for example, the Commission recorded that only seven out of 23 proprietors of madhouses had any medical training. p53.
[45] *Ibid.*

provision in Scotland.[46] Typical of the many critical case reports was a description of the treatment of two male patients at Hillend Private Madhouse, near Greenock. Both patients were of a "respectable position", each paying over £40 annually for their maintenance, although they were discovered sharing a small room, with a third patient. All slept together, naked, in one bed, on bedding of loose straw:

> "they were dirty in their habits, and the straw was filthy and saturated in urine. They were associated with the pauper patients and their accommodation and treatment was similar to that of the lowest class."[47]

Similar conditions were observed in other establishments and witnesses to the Commission described conditions in both private madhouses and poorhouses where patients were seen lying on urine-soaked mattresses or on straw, often "in a state of perfect nudity."[48]

There was little formal visitation of any institution for the insane. Parish officials were occupied with the more immediate demands of local administration and, despite the legislation of 1815 and 1828, private madhouses were largely neglected by official bodies.[49] Thus, while the Commissioners conceded that the quality of provision in royal asylums was generally adequate, the necessity for substantial improvements in all institutions for the insane was recognised. These could not be implemented until the pressure on space was alleviated by the erection of additional asylums. The continued existence of private madhouses and poorhouses were, however, sanctioned only until alternative accommodation became available.

3.5 Arrangements for single patients

Arrangements for patients residing in private dwellings before the Lunacy (Scotland) Act, 1857, were, frequently, far inferior to even the most unsuitable conditions encountered in institutions. Annual reports from the Board of Supervision and early reports by the Commissioners in Lunacy remain the most detailed source for descriptions of the condition of single patients. The investigations of the Royal Commission exposed "deplorable" instances of what was regarded to be neglect, cruelty and insanitary living conditions. Descriptions of the wretched surroundings and ill-treatment of private and pauper single

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[46] However, their assertions were supported by the earlier allegations of, for example, Halliday and Browne among other prominent alienists.
[47] *Ibid.*, p105.
[48] *Ibid.*, p121.
[49] *Vide supra* 3.2.

patients formed the most graphic section of the Commission's Report,[50] and it was recognised that the volume of unsatisfactory reports would have been greater if all the returns had been made by medical officials. This was because the standards of constables who sent in the reports were thought to be lower than those of qualified practitioners; where there was no evidence of active cruelty, constables reported that conditions were adequate without considering the lack of any curative treatment.[51]

3.5.1 Living conditions

The standard of personal cleanliness was low among the Scottish poor[52] and Commission members therefore encountered some difficulty in determining the degree of neglect of patients, when measured against the poverty, dirt and hunger found in the majority of families visited. Even taking into account the likely preconceived ideas of official visitors as to what constituted acceptable provision, conditions in the houses of the general population were, in general, of an extremely low standard, as evidence given to various inquiries testified.[53] Pauper lunatics were seen in crowded rooms, sleeping on damp earth covered only by straw, in houses presenting a "most depressing picture of dirt, wretchedness, and want."[54] Such houses, accommodating large families, frequently lacked windows, or adequate ventilation, and were sparsely furnished, with no means of cooking food. One witness at an earlier enquiry, regarding the hand-loom industry, made an impassioned criticism of the wynds in Glasgow, condemning the:

> "labyrinth of lanes... small square courts, each with a dunghill reeking in the centre. Revolting as was the outward appearance...I was little prepared for the filth and destitution within. In some of these lodging rooms we found a whole lair of human beings littered along the floor...men, women and children, huddled promiscuously together. Their bed consisted of a layer of musty straw, intermixed with rags...No pains seem to be taken to purge this Augean pandemonium, this nucleus of crime, filth and pestilence, existing in the second city of the empire."[55]

Similar assessments of other areas of Scotland abounded in Chadwick's report of 1843; for example, one Edinburgh physician deplored the fact that the dwellings of the poor:

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[50] See particularly, Appendix I of the Report of the Royal Commission (1857), pp167-220.

[51] Nevertheless, many of the conditions reported by the Constabulary Force were graphic in their portrayal of the neglect and cruelty experienced among single patients. Appendix L of the Report of the Royal Commission comprises a special report on individual lunatics made by the Procurator Fiscal or superintendent of police and extracts from returns made by the Constabulary Force. pp244-272.

[52] See Slaven, A. (1975) *op. cit.*, and Levitt, I. (1988) *op. cit.*

[53] For example, evidence given to the Handloom Inquiry. Recorded in Alison, W.P. (1841) *Observations on the management of the poor in Scotland and its effect on the health of great towns.* Edinburgh. The inadequate state of cleanliness in the west of Scotland, in particular, was condemned, with the debasement and generally lower standards attributed to the influx of Irish immigrants. Report of the Royal Commission (1857), p180.

[54] *Ibid,* p172.

[55] Observation by Assistant Commissioner on the Handloom Inquiry. In Alison,W.P. (1841) *op. cit.*, p13.

> "are generally very filthy...always ill-ventilated. A few...have a bedstead, but most make up a kind of bed on the floor with straw, on which a whole family are huddled together, some naked and others in the same clothes they have worn during the day."[56]

Conditions in rural districts were no better. Cottages were reported to be "of the rudest description", commonly with no windows or chimneys, and only the most inadequate drainage.[57] The presence of cattle in the same living area as the family and accumulation of cattle dung inside cottages was not unusual. The fire was generally in the centre of the room, posing an additional danger to insane patients, particularly those suffering from epilepsy; mutilation by burning was reported frequently in the early years of the boarding-out system. The newly appointed Commissioners of the Board of Lunacy expressed their incredulity that such living conditions were tolerated in:

> "a land resounding with the highest professions of Christianity; with Kirk and Free Kirk next door to each other in almost every parish...Do these Scotch ministers deem it no part of their duty to visit the desolate and sore stricken in their affliction?"[58]

3.5.2 Health and welfare of patients

The profusion of critical reports documented by members of the Royal Commission, and in the first annual report by the new Lunacy Commission suggest that the majority of patients in private dwellings were in an unsatisfactory condition, both regarding their accommodation and the nature of care they received. However, any detailed assessment of the proportion is impossible, due to the limitations inherent in the records of the Board of Lunacy. Although failing to record any accurate statistics relating to the standard of care among single patients, the new Commissioners recognised that a small proportion were kindly, if ineptly treated.[59] Nevertheless, relatives often admitted to restraining patients out of fear, for the safety of the family, and on occasion, for the patient himself.[60] Further, family members were often absent at work during the day, and it was unusual to find families prepared to forfeit the wage of one worker, to enable them to supervise insane relatives.

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[56] Chadwick, E. (1843) Report on the Sanitary Condition of the Labouring Population of Great Britain (509.) xii.395.
[57] GBCLS 2nd AR (1860), p214.
[58] Reported in Anon. (1860) *Journal of Mental Science*, **5**, p449.
[59] AR of GBCLS *passim*. 1858-1865.
[60] Among many examples noted by the Commission, one man was confined by his brother in an outhouse, chained by the arm to a heavy chain, fastened to the wall. He appeared to be kindly treated in other respects, and was well-fed and clothed, leading members of the Commission, to conclude that he was "kept out of love". Report of the Royal Commission (1857), p332.

Numerous descriptions of patients covered in vermin and clothed only in rags were documented in the Report of the Commission. Cases were reported where patients were confined "in the water closet, or in a press under the stair".[61] Others were found restrained with chains, many more were in wooden cages in darkened rooms, unable to move. Wholly unsuitable patients, subject to delusions and mania, were discovered working on farms or bogs. Many remained at home out of misguided loyalty on the part of the family, and a pervasive fear of asylums, reinforced by the lack of any suitable institutional provision. It was also cheaper for parishes to provide for patients in their own homes. Further, it was noted by members of the Royal Commission that incidents where imbeciles, often brother and sister, had shared a bed, leading to pregnancy, happened with alarming frequency. Such occurrences prompted serious concern at the time, leading the Commission to question "whether for the sake of public morality all fatuous females should not be restricted in their liberty".[62] This same issue was confronted by subsequent Lunacy Commissioners and commentators on the system, the vulnerability of female patients proving to be among the most immediate and enduring concerns of the Board of Lunacy.[63]

Lengthy reports of typical cases would be superfluous, due to the marked similarity of defects in the conditions recorded, and so only the smallest proportion of cases, easily replicated by others, are outlined here. Representative of other cases, A.B, a pauper patient was seen lying on a bed of loose straw. She was reported to be extremely dirty, and "of very filthy habits, occasionally taking her excrements and rubbing them up in her hands".[64] Equally unsatisfactory conditions were recorded in the case of M.M'L, a 32 year old female suffering from dementia, residing with her mother and sister, who were deemed "wholly unfit for such a charge". The Visiting Commission member recorded his shock at the conditions he encountered:

> "I cannot convey any idea of the filth and rags in which I found this woman...With the exception of a piece of old bag, put on shawl-ways, she was quite naked above the waist".[65]

Although the parochial board had been willing to assist M.M'L, her relatives had refused, instead removing her name from the poor-roll and so from any official jurisdiction.

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[61] *Ibid.*, p502.
[62] Discussed in some detail in Report of the Royal Commission (1857), p185 and Appendix I, pp195-199.
[63] The particular fear regarding the propagation of hereditary weakness was, however, vocalised more towards the end of the century. *Vide infra* Chapter 10.
[64] Report of the Royal Commission (1857), p188.
[65] *Ibid.*,p178.

The Commission Report indicated that at least half the patients visited were in need of the constraints and treatment of an asylum. The Commission defined a fatuous state as being a degree of mental power insufficient for self-protection. However, it was alleged that parochial officials often refused to recognise the presence of mental weakness. Inspectors of poor had no medical training and were unable to classify the condition of insane persons. Many fatuous patients were regarded by the Board of Supervision as sane.[66] For example, two fatuous paupers, R.P, aged 44 and A.P, aged 27, who lived together, had been seen by members of the Commission, and reported to be suffering from a form of general paralysis that inhibited their ability to move and speak. Both were unable to care for themselves, and were discovered in an extremely dirty condition, covered in vermin and barely intelligible to the Visiting Committee. Nevertheless, a certificate had been issued declaring that neither man was lunatic or fatuous, and they were eventually removed to a poorhouse.[67] Even where patients were clearly unable to care for themselves, therefore, inspectors of poor and parochial surgeons were capable of ignoring their condition; the cost of providing for the insane far outweighing the costs incurred for the general pauper population.

Private patients were also discovered in conditions as unsatisfactory as those endured by paupers. The Commission Report estimated that in 1857 there were 1810 single patients not in receipt of parochial relief, many of whom were detained against their will. Only ten were in houses reported to the sheriff, the remaining 1800 received no official recognition and were therefore under no formal supervision. Members of the Royal Commission observed among them "a vast amount of neglect and misery", many were emaciated and filthy, but it was against the interest of parochial authorities to inquire into the mode of treatment, in cases where no demands were made on parochial funds. Even in cases where a medical certificate had been issued, there was no guarantee of suitable treatment. While a small proportion of such cases were from the higher social classes (approximately 5% according to the Board of Lunacy's estimate for the late 1850s[68]), the majority (70%) were those only slightly removed from pauperism and unable to afford the costs of maintenance

[66] The Commission remarked upon the difficulty in determining the meaning of "fatuity" and regretted the tendency of inspectors and parochial surgeons to "ignore its presence, even when the patients are totally incapable, from mental deficiency, of taking care of themselves." It was noted, too that even where there was a medical certificate, this did not ensure proper treatment. *Ibid.*, p175.
[67] *Ibid*, p173.
[68] Mitchell, A. (1864) *op.cit.*, p8.

in the royal asylums. By no means in a unique position, one patient, M.D, aged 25, and living with her parents, was discovered:

> "occupying a wretched room on the ground floor, a portion was rudely railed off to form a cage, 8 foot by 5...contains a miserable bed, placed on the floor of damp earth. a hole was scooped out to serve as a receptacle for her evacuations. She lay on the bed, but the bars of the cage were so broad, and the room so dark, that it was impossible to tell exactly what condition she was in as to clothing and cleanliness. All the surroundings, however, betokened it to be miserable."[69]

M.D. had resided in such conditions for a number of years. Although her mother had some personal wealth, she had refused intervention or assistance from parochial authorities, out of fear that they would confiscate her property to help defray the expertise such assistance would entail. Several hundred other equally disturbing descriptions could have been selected for inclusion here. Although cases reported to the Commission had already undergone a process of discriminatory selection, the sheer volume of unsatisfactory examples was such that there is no suggestion that only the most sensational cases were included in the Commission's Report. Looking back, 50 years after the Report was published, Sutherland, a Lunacy Commissioner, viewed the "startling revelations" of neglect and inhuman treatment with disbelief. Such treatment was "little better than the innocent or guilty Moor receives at the present time at the hands of the powers that be."[70]

In an attempt to explain the existence and continuance of such conditions among the insane, Spence, Secretary to the Board of Lunacy, suggested that many of the cases of misery and neglect had arisen not out of cruelty and inhumanity, but more frequently as a result of pride. It was for this reason, he contended, that families were reluctant to resort to public relief. Others were ignorant as to the best means of providing for their insane relative. The outcome was often "silent, helpless despair in the face of a calamity which the family neither had the knowledge nor the means to contend with".[71] His explanation appears justified in view of the nature of many of the examples documented by the Commission.[72] Notwithstanding widespread recourse to mechanical restraint, few cases of active cruelty were recorded (although the distinction between neglect and cruelty can be a fine one, with many people anxious to provide well for their insane relative but constrained through fear or ignorance from offering effective care). Commission members documented

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[69] Report of the Royal Commission (1857), p175.
[70] Sutherland, J.F. (1897) *The insane poor in private dwellings*. Edinburgh: E. & S. Livingstone, p9.
[71] Spence, T.W.L (1902) *op.cit.*, p627.
[72] Throughout the Report examples are given where relatives endeavoured to treat their insane charge with kindness, but proved unable to do so effectively. Report of the Royal Commission (1857), *passim*.

effectively the mood of despair among families unable to provide for their insane relatives. Perhaps as Spence suggested, therefore, "ignorance not inhumanity was at the root of the evil."[73]

Regardless of the cause of inadequate conditions, members of the Royal Commission concluded, that "an appalling amount of misery prevails throughout Scotland" in the lives of single patients.[74] Countless patients were in need of asylum provision, others, who were harmless, and quiet, required accommodation in a closely supervised home, far removed from the filth and neglect in which they lived. Despite exposing conditions which in themselves were disturbing enough to lead to far-reaching legislation, the Report concluded on an ominous note, announcing that:

> "these details give only an imperfect representation of the true state of matters. They form only a part of the picture of misery and had we been able to extend our investigation it would, we are convinced, have assumed a much darker shade..."[75]

3.6 Duties of sheriffs

The Act regulating Madhouses in Scotland, 1815, had given sheriffs a substantial role in overseeing the care of lunatics. However, despite being granted the legal authority to initiate change, the cursory nature of their annual visits to asylums did little to improve or affect existing conditions. As members of the Royal Commission contended, visits by sheriffs were too infrequent, and insufficiently thorough, often being little more than mere formality. Further, although sheriffs had the power to withdraw licenses for private madhouses, such action was rarely taken. Andrews has observed that some sheriffs did not even consider "the care and cure of lunatics as a matter within the scope of their competence"[76] The supervision they offered was lax and largely ineffective, meaning that large numbers of patients remained in private dwellings under the care of strangers, with no sheriff's warrant, their existence unknown and unreported to any official body.[77] However, ignorance of the conditions experienced by patients was not always attributable to apathy and neglect on the part of the sheriffs. In evidence to the Royal Commission, the Sheriff of Aberdeenshire highlighted the difficulties experienced in locating single patients, either in their own homes, or when boarded with strangers. He also maintained that there was an

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[73] Spence, T.W.L (1902) *op.cit.*, p628.
[74] Report of the Royal Commission (1857), p196.
[75] *Ibid.*, p197.
[76] Andrews, J. (in preparation) *op.cit.*
[77] Any stranger receiving an insane patient was legally ordered to be in receipt of a sheriff's warrant.

absence of any effective system enabling them to ascertain whether patients were improperly detained. The power of the sheriff was effective only when the treatment of a patient was demonstrably criminal. Beyond that, he claimed, they were largely impotent, even where evidence of neglect or ill-treatment was apparent.[78] Others disputed such assertions, among them, Ellice, the M.P for St Andrews, who maintained that the powers of the Board of Supervision and the sheriffs were "amply sufficient", and that both were guilty of severe neglect of their duties.[79]

A number of sheriffs were wholly opposed to the practice of allowing patients to reside in private dwellings under the care of untrained guardians; the Sheriff of Ayrshire, for example, refused to give licences for single patients, arguing that "common cottagers" were not suitable to be entrusted with the care of such vulnerable charges. Similarly, the Sheriff of Dumbarton maintained that every pauper lunatic should be confined in an asylum:

> "I would entirely do away with the practice of boarding. It is impossible that they can be properly treated when they are boarded, and although in the great majority of cases they are in no very different situation from that in which they would otherwise be placed, still their situation is so wretched that I think they should be better provided for". [80]

Such resounding statements of belief were rare among a body of men occupied with other more pressing affairs. Provision for the insane poor remained low on any list of priorities until the advent of the Board of Lunacy and the introduction of new powers of compulsion.

3.7 Duties of parish officials

Until 1857, the Board of Supervision had overall control over the insane poor. The Poor Law Act of 1845 had given responsibility to inspectors of poor to ensure the pauper insane were accommodated in asylums, or other establishments authorised to receive them. However, according to the Report of the Royal Commission, inspectors of poor rarely visited their patients and parochial medical inspectors paid little attention to their duties. Statutory registers held in private madhouses were "imperfectly kept" in "by far the greater number of houses" and in some of the establishments, the registers, including records of restraint, were not even provided.[81] Inspectors failed to investigate the minutiae of living conditions, by ascertaining, for example, the quality of bedding and washing facilities.

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[78] Report of the Royal Commission (1857), p332.
[79] *Ibid,* p349. He argued that existing legislation was" in a great measure was very ample for the protection of the great proportion of the pauper lunatics in Scotland, if it were properly administered."
[80] Report of the Royal Commission (1857), p455.
[81] *Ibid.*, p113.

Despite clear evidence of neglect of duty, the Secretary to the Board of Supervision refused to acknowledge these failings, maintaining that the condition of the insane in private dwellings, as well as in public and private establishments was closely examined by officials, and that financial aid was only granted where standards were approved. He declared:

> "I don't recollect of any cases in which the patients were placed in out-houses...Of course if so, or in any portion of the house caged off, it would be an objection to the granting of dispensation. If there was any tendency to excitement, or any restraint was necessary, the Board of Supervision invariably require the patient to be placed in an asylum or poorhouse."[82]

The degree of vigilance claimed, however, was not reflected in the conditions encountered by members of the Royal Commission in 1855.

In the three years following the inception of the Board of Supervision in 1845, 2003 pauper patients residing in the community were investigated by parish officials. Removal to the asylum was ordered in only 38 cases, a particularly low figure when contrasted to the volume of cases prompting censure by the Royal Commission a decade later. The greater influence of pecuniary concerns, at the expense of the comfort of insane patients was also condemned. Critics of the Board of Supervision condemned their "selfish inhuman, parsimonious economy" in allowing patients to remain in private dwellings, when institutional confinement was clearly necessary.[83] Echoing this, one witness to the Royal Commission, Sir Archibald Allison, Sheriff of Lanarkshire for 21 years, maintained that "economy is the great thing parochial boards look to. I don't think they almost ever look to anything else."[84] It was recognised however, that no improvements would be forthcoming "until the strong arm of the law compels parochial authorities to do their duty to the insane poor."[85] Nevertheless, inspectors of poor across the country defended themselves against such criticisms, maintaining that their single patients were well treated and supervised. Existing lunacy legislation was, in fact, recognised widely by commentators to be obscure and difficult to follow. The early Commissioners conceded, therefore, that unsatisfactory arrangements were attributable less to any failure on the part of the Board of Supervision than to the lack of statutory powers to effect and maintain reforms. The supply of staff was inadequate for any effective supervision of the insane. Furthermore, public opinion was

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[82] *Ibid.*, p345.
[83] Editorial. (1857) Scottish Lunacy Commission. *North British Review*, **27**, p114.
[84] This view was reiterated by Renton, a fellow of the Royal College of Physicians, Edinburgh, who deplored the fact that among parochial boards, "economy is in fact their chief object." Report of the Royal Commission (1857), p223.
[85] Scottish Lunacy Commission (1857) *op. cit.*, p114.

largely indifferent to the well-being of the insane and more pressing demands in connection with the daily administration of poor relief were made upon parish officials.

3.8 Effect of the Royal Commission Report, 1857

Following publication of the Report of the Royal Commission in 1857, the M.P for Aberdeen announced it to be one of the most horrifying documents he had ever seen, and argued that parochial boards, sheriffs, justices of the peace and clergymen should share the guilt in allowing such conditions to prevail.[86] While declaring himself unable, through a sense of propriety, to give any graphic detail to the House of Commons, he deplored:

> "a state of things which they could not before have believed to prevail in any civilised country, much less in this country, which laid peculiar claims to civilisation and boasted of its religious and humane principles."[87]

The Report included proposals to conserve the existing royal asylums, to dispense with poorhouse lunatic wards and private madhouses, and erect in their place district asylums and to enforce a system of regular supervision over patients residing in private dwellings. The major recommendations were adopted, although poorhouse lunatic wards and private madhouses remained in existence, since members of the Commission recognised that the accommodation they provided would remain necessary until the completion of district asylums across the country.

The resulting legislation of 1857 repealed all previous Lunacy Acts, and came into operation on January 1st 1858. A General Board of Lunacy was created, which included an unpaid Chairman, a Secretary, two unpaid Legal Commissioners, two paid Medical Commissioners (Coxe and Browne) and two paid Medical Deputy Commissioners (Mitchell and Cockburn). Clause XXII of the Act provided that after five years the General Board would cease to exist. The paid Commissioners were to become Inspectors-General in Lunacy for Scotland, exercising all the powers of the General Board, except the granting of licenses, which was to become the duty of the sheriff.[88] Despite attempts by parochial officials to ensure that clause XXII was upheld, the Board of Lunacy was in fact retained in its original form until 1913. Lunacy Commissioners had the power to manage and regulate

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[86] Parliamentary debates, 3rd series vol. cxlv p1027.
[87] *Ibid.*
[88] An Act for the Regulation of the Care and Treatment of Lunatics, and for the Provision, Maintenance and Regulation of Lunatic Asylums in Scotland. 25th August 1857 [20 and 21 Victoria cap 71], p10.

the provision and care of all registered insane patients. To facilitate this, they established a system of regular visitation to institutions for the insane and to private dwellings.[89]

The Act provided for the division of the country into 27 lunacy districts, which comprised groups of counties, single counties or single parishes. Local authorities were to form themselves into District Boards of Lunacy, whose officials had responsibility for the care of all insane persons within their district. The District Boards were to ensure that asylums were erected in their area and were responsible for their management. Royal asylums remained independent, the only power over them granted to the Board of Lunacy being the right of visitation, and recommending changes via the issuing of reports. Parish authorities were instructed to send all insane patients to asylums, unless a Commissioner had approved their continued residence as a single patient. Control of the insane poor was removed from the Board of Supervision. The Commission had highlighted the apathy and, in many cases, neglect, of parish officials concerning the welfare of their pauper insane. This removal of autonomy, and the extensive powers granted to the Commissioners, created lasting resentment from the Board of Supervision, and relations between the two Boards remained uneasy throughout the nineteenth century.[90]

3.9 Summary and conclusions

This chapter has provided a brief outline of conditions prevailing before the establishment of the Board of Lunacy, thereby facilitating an assessment of the changes brought about by the newly appointed Commissioners from 1858. In particular, the legal position and living arrangements for patients residing in private dwellings in the first half of the nineteenth century have been recorded, enabling contrasts to be drawn between existing *ad hoc* arrangements and the closely regulated supervision of single patients introduced by the Board of Lunacy. With no centralised, regulated body of control until the mid-nineteenth century, conditions for the insane in Scotland had gone unchecked and, as indicated in the Report of the Royal Commission, had been of a generally low standard. The main focus of the remainder of the study lies in the resulting state of lunacy provision, in so far as it affected the care and control of single patients.

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[89] The unfavourable impression of existing affairs in asylums gained by the Royal Commission is illustrated in the emphasis they placed on regular visitation, and the demand for medical men to reside in asylums. All asylums licensed for over 100 patients were ordered to have a resident medical attendant, those accommodating over 50, were to be visited daily by a medical official, and establishments licensed for under 50, to be visited twice weekly.

[90] *Vide infra* Chapters 11 and 13.

Lunacy legislation in Scotland post-dated similar legislation in England by several years. The effectiveness of the Act of 1857 was, therefore, enhanced by an awareness of the Lunacy Acts of 1845 and 1852 in England and Wales. The establishment of central supervision over the insane in Scotland to oversee the attainment of minimum standards and the new element of compulsion regarding the erection of district asylums (in England county asylums) reflected clearly the legislation introduced in England over ten years previously. The Lunacy (Scotland) Act, 1857 had far-reaching implications for the treatment of the insane. Further, the development of local responsibility, under the auspices of centralised control was encouraged. The Board of Lunacy was granted ultimate supervisory control over lunacy affairs in Scotland, while parish officials and members of District Boards of Lunacy were authorised to implement the practical aspects of provision for the insane. In general, Henderson's contention that the Act "revolutionised the care and treatment of the mentally affected in Scotland" is warranted.[91] The advent of the Board of Lunacy did not result in instant amelioration in the conditions for all insane patients. Nevertheless, a beginning was made. Annual reports of the newly appointed Commissioners indicate that conditions for the insane in asylums and private dwellings rose steadily, if gradually, over the following decades. Therefore, while perhaps an accurate reflection of conditions in the early-nineteenth century, the following condemnation by a visiting physician became increasingly inapplicable as a description of the circumstances of insane in Scotland as the century progressed:

> "Palaces are provided for the accommodation of the greatest villains and disturbers of society while these unfortunate beings are left in misery, and I am grieved to add that I am a living witness that the swine of Germany are better cared for. "[92]

[91] Henderson, D. (1964) *op.cit.*, p93.
[92] Expressed by the German physician, Spurzheim, on a visit to the Edinburgh Bedlam. In Halliday, A. (1816) *op.cit.*, p10.

CHAPTER 4

IMPLEMENTATION AND DEVELOPMENT OF BOARDING-OUT IN SCOTLAND

4. Overview

The system of boarding-out insane patients in private dwellings was a unique feature of Scottish lunacy administration. The application procedure for boarding-out patients and the responsibilities of official bodies are outlined in this chapter. The early years of the system were characterised by a diminution in the number of patients boarded-out, as unsuitable cases were removed to asylum and throughout the period 1858-1913, there was constant fluctuation in the numbers provided for in this way. Reasons for this variation are examined, in conjunction with an assessment of the gradual development of the policy. The impact of the government grant-in-aid as an incentive to board-out is considered and the nature and extent of supervision of patients is explored.

4.1 Introduction

With the creation of the Board of Lunacy in 1857, boarding-out was instituted as a legally controlled system of providing for the insane. The censorious report of the Royal Commission, published in 1857, had concluded that it was unnecessary and undesirable to place all insane patients in asylums, since many could be provided for more appropriately in domestic surroundings, if properly regulated by officials. As the Commissioners in Lunacy asserted:

> "the features of insanity are so variable and so dependent for their expression on the circumstances in which the patients may be placed, that it is extremely desirable that the law should afford every reasonable facility for varying the manner of their disposal."[1]

Section 95 of the Act declared that pauper lunatics not requiring asylum treatment could be kept in private houses with the sanction of the Board of Lunacy. Observers saw in this an attempt to register all defective patients by bringing them under official supervision, but

[1] GBCLS 3rd AR (1861), main report pxxxvii.

without the formality of commitment. In light of the unsatisfactory nature of prevailing conditions in private dwellings, the Lunacy Commissioners determined that existing arrangements should be formally controlled and supervised. The Board of Lunacy therefore took advantage of these arrangements, imposing strict supervision and careful selection of suitable patients to modify the long-established practice of allowing insane persons to remain in their homes. No attempt was made to introduce any special system and instead, the Board:

> "allowed the mode of administration to shape itself; and the form which it actually took grew naturally out of the Board's efforts to obtain the correction of what was bad and to encourage the development of what was good."[2]

Sibbald, one of the first Lunacy Commissioners, and a leading proponent of the policy, remarked with accuracy upon its inception, that it was "not boarding-out, but refraining from sending in".[3] Following initial visits by the Commissioners to houses throughout Scotland, in the late 1850s and early 1860s, resulting in the removal of unsatisfactory cases, suitable patients were granted exemption from removal to an asylum and so remained in their own homes, thereby forming the nucleus of the boarding-out system. It could be argued, therefore, that boarding-out evolved rather than had a specific, planned introduction.

Although insane persons had long resided among the local population, the early years of the nineteenth century witnessed the growing belief among the general public that such persons should be removed from the public sphere and placed in asylums.[4] Reports to the Commissioners and other alienists regarding the attitude of the local population, through their spokesmen, the inspectors of poor, indicate that all patients, whether in an active phase of insanity, or chronic, quiet and harmless, were viewed similarly as dangerous and unapproachable lunatics. Many medical superintendents also subscribed to the belief that the asylum was the only suitable place for the insane.[5] Scull suggests that by the mid-nineteenth century, therefore, the insane :

> "found themselves incarcerated in a specialised, bureaucratically organised, state-supported asylum system which isolated them both physically and symbolically from the larger society".[6]

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[2] GBCLS 33rd AR (1891), main report, pxxxv.
[3] Noted in Riggs, C.E. (1895) The boarding-out system in Scotland. *American Journal of Insanity*, **52**, p320.
[4] *Vide supra* Chapter 3 and Scull, A. (1993) *op.cit.*, pp1-45. In this, Scull discusses the movement towards confinement at length.
[5] *Vide infra* Chapter 8.
[6] Scull, A. (1993) *op.cit.*, p1.

Patients who were incurable and harmless were retained in overcrowded asylums and, unless confident that the patient was fully recovered, or at least "relieved", superintendents were reluctant to allow their discharge. This was motivated largely by concern that a change of circumstances could lead to adverse alteration in the mental condition of a patient. Re-admission to an asylum necessitated new medical certificates and a fresh order by the sheriff, thus entailing considerable expense and trouble for parochial authorities. As a compromise, the Commissioners recommended the removal of certain patients on probation for a six month period, during which the original order and certificates remained in force.[7] Patients were returned, when necessary, to the asylum with comparatively little effort or expense. Following the adoption of this method, the number of patients boarded-out from asylums rose steadily, connected closely with a growing flexibility regarding the mental characteristics of those thought to be suitable for such provision.

Sutherland, a prominent Commissioner in the late-nineteenth century and a staunch advocate of the expansion of boarding-out, published an informative pamphlet in 1897 in which he described four epochs of the policy. The first two were the Lunacy Acts of 1857 and 1862. The latter Act allowed the Board of Lunacy to grant special licenses to unrelated guardians for the reception of up to four insane patients of the same sex. This procedure was instituted in 1862, and applied increasingly from the 1870s.[8] Prior to this, guardians were allowed to receive only one patient. This legislation gave considerable impetus to boarding-out and was closely linked to the rise in the number of patients discharged unrecovered from asylums to the care of unrelated guardians.[9]

The third significant development was the introduction of the Government grant-in-aid in 1875. Previously, each parish had borne the entire maintenance costs of their insane paupers. As a result, the burden of poor relief had been unequal over the country, being dependent in each district upon the number of people claiming relief. Smaller, impoverished parishes were therefore often barely able to provide for their paupers. The

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[7] AR GBCLS (1859-1870), *passim.*

[8] The particular significance of these houses is examined in Chapter 5, in view of their marked impact upon the system of boarding-out.

[9] This Amendment Act, and a further Act in 1866 facilitated the development of boarding-out in Scotland. Between 1862 and 1885, 413 special licenses were granted. The Act of 1866 stipulated the requirements which the Board of Lunacy deemed suitable for the supervision and medical visitation of lunatics in private dwellings. Parochial boards were given power to remove pauper lunatics from asylums by Minute of the Council, Section 10 made it obligatory to inspectors of poor to inform the Board within 14 days of the removal of a patient, the situation of the house, name of guardian and amount of allowance paid by the parochial board.

Act of 1875 (modified in 1889) provided for an annual Parliamentary grant, whereby half the cost of upkeep for each pauper patient was paid to the parish. The fourth notable development was the establishment of parish councils in 1894, which Sutherland maintained, were "the legislative expression of an enlightened public opinion."[10] Their officials, inspectors of poor and medical officers, were responsible for ensuring that patients in private dwellings were suitably provided for. This final step, however, does not compare in significance to the three other points identified by Sutherland. Before 1894, parochial boards had already undertaken the care of their insane paupers, and there was little modification of this with the creation of parish councils. Nevertheless, Sutherland's perception is broadly accurate and, once established, the system developed rapidly, facilitated by legal enactments, under the close regulation of the Board of Lunacy.

4.2 Application of the boarding-out system

4.2.1 Responsibilities of official bodies

Commissioners for the newly created Board of Lunacy were responsible for the superintendence of all matters relating to the pauper insane, including the various establishments in which they were placed. Although their duties were largely supervisory, the Commissioners constituted a powerful body, whose recommendations were adhered to closely. Their responsibility over pauper patients, whether boarded-out or in establishments, was not executive, or direct, rather it entailed sanctioning measures adopted by parochial boards for the provision for each patient. While their control over boarded-out pauper patients was extensive, their authority over private patients was always severely circumscribed, an issue which proved to be a frequent irritant to the Commissioners.[11]

The designated duties of the Board, regarding patients in private dwellings, were made clear immediately. The condition of every registered patient, guardian and household were to be inspected by a Deputy Commissioner, at least once a year.[12] However, while all patients were subject to the control of the Board of Lunacy, the primary responsibility for

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[10] Sutherland, J.F. (1897), *op. cit.*, p20 (Although in fact, Sutherland dated the establishment of Parish Councils incorrectly, dating their introduction from 1892).
[11] The extent of control over private cases has been outlined in the introduction, and is examined in detail in Chapter 11.
[12] However, the Commissioners recognised that they would not always be able to visit patients in the Orkneys and Shetlands, when weather conditions made the islands inaccessible.

the care of the pauper insane lay with their natural guardians and with the individual parochial authorities. Therefore, where conditions for patients were seen to be adequate, the Board stated that it had no wish to intervene further and merely granted sanction from removal to an asylum. Initially, however, a large proportion of cases were found to be unsuitable for such provision, as the graphic reports of the Commissioners in the early years of the system testify.[13] Such patients were removed to asylums or other establishments licensed for the reception of the insane. For those patients unable to benefit from asylum provision, but who were living in squalid surroundings, the Board recommended their removal to the care of an unrelated guardian who received a fee, and was subject to the control of both Commissioners and parish officials.

Resentment among parish officials at the removal of their authority over insane paupers was perceptible from the very establishment of the Board of Lunacy and only mitigated after many years of collaboration with the Commissioners.[14] The main duty of each parochial board lay in the administration of the affairs of all paupers chargeable to their parish. Inspectors of poor were responsible for notifying their parochial board within seven days of the details of every insane pauper that came to their attention. The parochial board then informed the Board of Lunacy and either instituted procedures for the removal of the patient to an asylum or supplied the Commissioners with satisfactory reasons for their continued existence outside an institution.

4.2.2 Certification procedure

The application procedure for the sanction of the Board of Lunacy was extensive and no patient could be received into a private dwelling without such sanction. A distinction was made between private and pauper patients. Application to receive pauper lunatics was made by the local inspector of poor on behalf of the guardian. He certified that the applicant was "of good moral character and a proper person to be intrusted with the care of patients".[15] Details were recorded of the locality of the house, number of rooms, number of sane inmates, presence of children, distance of the house from medical officer and inspector of poor, quality of sleeping accommodation and the number of lunatics proposed

[13] AR GBCLS (1859-1864), *passim*.
[14] The hostility of parish officials is discussed in Chapter 13.
[15] Enshrined in Schedule D of the Lunacy (Scotland) Act, 1857 [20 and 21 Victoria cap 71].

to be accommodated. Where the answers were regarded as satisfactory, sanction for the reception of a patient was granted by the Board of Lunacy. While the Commissioners insisted that the same criteria was met for private patients, the initial application was made by the potential guardian, not the inspector of poor.

Boarded-out patients who had never been admitted to an asylum, but were granted exemption from removal, were issued with two medical certificates, confirming that the patient "does not require, either for his own welfare or the public safety to be placed in an asylum, and is a proper person to be detained under care and treatment in a private dwelling".[16] These were accompanied by a written testimony by parish officials certifying that the house was suitable for the reception of patients. Patients discharged unrecovered from asylums, however, required only a statement from the medical superintendent recording their mental condition.[17] This enabled the Board of Lunacy to ascertain the patient's suitability for such provision. If a patient was to be boarded with an unrelated guardian, the sanction of the Board and a warrant from the local sheriff was required. If, following the detailed information forwarded to the Board of Lunacy by parish officials, sanction for admission to the roll of boarded-out patients was granted, the parochial board then placed the patient in the approved private dwelling. If the application was for the residence of more than one patient, in a special licensed house, sanction was not granted until the visit and approval of a Deputy Commissioner. Such houses had to be in a "healthy situation, in good repair, and affording comfortable and appropriate accommodation." Certification was demanded to ensure that "the circumstances in which the patient will be placed are suitable and sufficient for his proper care and treatment".[18]

4.2.3 Supervisory regulations

The nature and extent of supervision of pauper patients was commented on adversely by critics of the boarding-out system.[19] The Commissioners, however, were confident that the number of official visits ensured that persistent abuse or neglect could not remain undetected.[20] In conjunction with the visits by Deputy Commissioners, patients were visited

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[16] *Ibid.*, pp17-18
[17] Sutherland, J.F. (1897), *op. cit.*, p32.
[18] GBCLS 12th AR (1870), p251.
[19] *Vide infra* Chapter 10.
[20] To Sutherland, "the supervision extended over the patients is to my mind one of the most satisfactory and outstanding features of the system." GBCLS 38th AR (1896), p120.

officially by inspectors of poor, twice annually, but in practice with greater frequency because, in smaller parishes, inspectors of poor lived in close proximity to many of the patients, thereby facilitating frequent, surprise visits. Their official visits were often made in the company of deputations from the parochial board of origin. The parochial medical officer made four visits annually, advising on the management and control of the patients. His duties included ensuring that patients received sufficient outdoor exercise and suitable employment. The food was inspected and recommendations for dietary improvements made. All visits were unannounced. As Tuke observed, when acting as temporary Visiting Commissioner, until he arrived in the house, guardians had no idea that he was connected with the Board of Lunacy: "I was therefore able to see exactly how the patients lived from day to day, and to judge accordingly".[21]

Medical commentators and Commissioners recognised that the most effective safeguard against abuse was the unofficial supervision of neighbours. As one physician contended, "the eye of the public in rural parts of Scotland keeps everybody's business within its ken."[22] Patients wandered freely about their village, and were well known to local residents. It was considered likely that instances of neglect would soon be brought to the attention of an official, prompting one Commissioner, Macpherson, to declare that:

> "[it is] a distinct advantage that most of the aggregations [of patients] are in villages or hamlets where there are many residents not directly concerned with the boarding-out system, and where the everyday life of all the inhabitants is seen and freely commented on by the community at large."[23]

Board of Lunacy regulations governing the care of boarded-out patients were detailed and extensive.[24] Sufficient space for personal belongings had to be provided and it was generally recommended that patients were given a separate bed. Much emphasis was placed on the importance of sharing mealtimes with the guardian, who was also expected to encourage patients in suitable occupation and exercise and in attendance at church. Such strictures were laid down to ensure that patients were treated, as much as possible, as members of the host family.

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[21] GBCLS 38th AR (1896), p135. (J.B.Tuke, junior)
[22] Hogben, E. (1898) On pauper lunatics in private dwellings. *British Medical Journal*, 2[1], p690.
[23] GBCLS 38th AR (1896), p134.
[24] These are recorded in Chapter 7.

The Commissioners felt able to declare, with an element of self-congratulation, that the knowledge acquired from their regular visitations ensured that all boarded-out patients were well provided for. Further, they maintained that the work involved led to the creation of a more accurate and detailed picture of the insane in private dwellings than had been achieved in any other country. The steady improvements recorded in annual reports suggest that this confidence was warranted. If conditions were considered unsuitable, the Board had the power to withdraw their sanction, and the patient was removed. However, the comparative infrequency with which this occurred (less than 1% of boarded-out patients were removed from private dwellings annually due to unsatisfactory living conditions or treatment[25]), indicates the success of parish officials in their selection of both patients and guardians, and the merits of a system which accommodated large numbers of the insane in domestic surroundings.

4.3 Early years of the boarding-out system

In 1858, the year the Lunacy (Scotland) Act came into operation, 1784 pauper lunatics were in private dwellings, under the care of relatives, strangers or living alone with no official guardian responsible for their care.[26] Counties with no asylum accommodation had, inevitably, a greater proportion of patients detained at home, many of whom, the Commissioners contended, were in need of asylum provision.[27] Such patients were among the first to be affected by the provisions of the Lunacy (Scotland) Act, being ordered into asylums following the instructions of the Board of Lunacy. Originally, the Commissioners had envisaged that recourse to boarding-out would be motivated by the need to relieve overcrowded asylums and they therefore expected a steady flow of discharges of incurable patients from asylums across the country. However, although the alleviation to asylums was acknowledged in the early years of the system, the urgency recorded from the 1870s was less apparent, and throughout the 1850s and 1860s, the majority of boarded-out patients had never been inmates of an asylum.[28] For example, in 1860, 160 applications for

[25] For example, in 1893, 7 patients out of 1019 visited by one Commissioner were returned for this reason, and in 1903, Sutherland reported that less than 3% of patients were returned to the asylum during the year, for a number of different reasons, and in under 1% of cases was this due to unsatisfactory living conditions. GBCLS 35th AR (1893) and 45th AR (1903).

[26] *Vide supra* Chapter 3 and Table 3.1.

[27] GBCLS 1st AR (1859), main report, pxxix.

[28] As outlined in the introductory chapter, a rapid growth in asylum provision was authorised in Scotland following legislation in 1857. The severe pressure on asylum accommodation so roundly condemned in later years was not, therefore, perceptible initially. *Vide supra* Chapter 8.

exemption from removal to an asylum were made, of which 136 were granted.[29] In contrast, only 26 patients were transferred to private dwellings from asylums. Ten years after the policy was brought under official control, the greater proportion of boarded-out patients (72%) lived with their relatives, and less than 17% had ever been admitted to an asylum. The great majority had been allowed to remain where the Commissioners had found them, following the fulfilment of certain criteria and recommendations. Nearly 90% of these patients were recorded as being idiotic or demented, for whom asylum treatment was thought to be unsuitable or unnecessary.[30]

One marked change in the circumstances of boarded-out patients residing in private dwellings after 1857 was the decline in the proportion living alone, with no official guardian.[31] At the instigation of the Commissioners, large-scale removals of patients discovered sleeping outside, or in outhouses, under no form of control or protection, led to a considerable reduction in the number of these patients. By 1864, for example, of 600 patients visited by one Commissioner, only 28 (4.5%) were living alone, and by 1895, less than 1% were so placed.[32] Nevertheless, despite a determination to place patients under suitable guardianship, the Commissioners accepted that certain patients, generally elderly females with delusions, who valued their long-standing independence, were able to reside alone. If they were harmless and quiet, a compromise was reached, whereby the parish agreed to pay a regular fee to a neighbour to offer such help as would be accepted. Many such patients were, in fact, able to cater for themselves, when in receipt of an adequate allowance. Lawson visited one patient in 1882 who had rented a room in Glasgow, bought her own food and even saved enough money to pay for a trip down the Clyde each summer. Although insane, the Board recognised that she could be little better cared for under the charge of a guardian, and would only miss her independence and ordered life.[33] The great majority of patients, however, were boarded with guardians and so were subject to close supervision.

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[29] GBCLS 3rd AR (1861) main report, pxxxv. Exemptions from removal, to adopt the phrase of the Board of Lunacy, simply meant that patients were allowed to remain in their home, rather than be removed to an asylum.
[30] GBCLS 9th AR (1867), p240.
[31] In 1855 the number living alone was calculated to be 11% of all single patients. Report of the Royal Commission (1857), p47.
[32] GBCLS 38th AR (1896), p126.
[33] GBCLS 24th AR (1882), p169.

4.3.1 Living conditions

In the early years of the operation of the Act, the annual reports of the Commissioners contained extensive descriptions of the squalid circumstances in which many patients were found, with marked similarities to the conditions documented members of the Royal Commission in 1855. For example, families were visited where the patient lived in a back-room, with no fireplace, and only a small amount of hay on a damp floor, as bedding. The all-pervading dirt and stench were remarked upon frequently. In certain districts of Scotland, the Commissioners reported on the practice of pigs and cows living in the same apartment as the family, so that the "interior of the house steams with animal ordure"[34]

Although it seems inevitable that the more extreme cases were mentioned, to the exclusion of more innocuous, satisfactory ones, to emphasis the impact of official intervention, evidence collected in the first five years of the Board of Lunacy's existence does confirm the extreme deprivation and suffering experienced by patients from all categories of mental disorder.[35] In the Commissioners' first annual report, for example, the appendices were taken up wholly with descriptions of cases of misery and neglect (5 pages, with up to 12 patients per page), unsatisfactory conditions (4 pages), injudicious management and insufficient surveillance (4 pages), pregnancies and erotic tendencies (6 pages), violence and restraint (5 pages) and numerous other pages detailing unfavourable circumstances, "bad accommodation" and insufficient allowances. There is little evidence to dispute the veracity of the graphic content of the Commissioners' reports; such conditions were documented by Chadwick in 1843[36] and again almost thirty years later in Select Committee reports on the Poor Law (Scotland) in 1869.[37]

The descriptions of living conditions documented by the Commissioners in the late 1850s were so lengthy and detailed, that although reporting on specific cases below, they have been selected as representative of countless other examples, and are therefore all the more disturbing in their wretchedness. For example, G.W, a fisherman, had remained in his bed

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[34] GBCLS 3rd AR (1861), p248. Reports also recorded numerous cases of patients and their families infested with lice. One Commissioner documented a visit made by himself and a clergyman. After spending 15 minutes in the house, five large lice had to be knocked off the clergyman's coat.

[35] *Vide supra* Chapter 2.

[36] Chadwick, E. (1843) Report on the Sanitary Condition of the Labouring Population of Great Britain (509.) xii.395.

[37] Report from the Select Committee appointed to inquire into the operation of the Poor Law in Scotland, with the Proceedings, Minutes of Evidence, Appendices and Index. 1868-1869 (301.) xi.1.

for four years, and was discovered emaciated and with shrunken contracted limbs; D.M'D was found in rags, "wild looking and very dirty". He was of unclean habits, and slept in a closet on a clay floor, which was wet with urine; C.M, lived in a room with no furniture and was seen lying in bed, covered with vermin. Neighbours reported that she emptied her chamber pot on the floor and threw excrement into the ashes. Other unexceptional cases among the many recorded included W.B, who was of dirty habits, pale, anaemic and haggard "as if he were confined constantly in the low, sunless filthy room he inhabits." He was dressed in a petticoat, and slept in a box on loose straw, and J.M'G, who was alleged to be offensive to public decency, having an "unpleasant and repulsive look", and clothed in a loose cassock. He spent his day begging and at night slept on a bed of ferns on the floor in a house which was reported to be dilapidated, cold, dirty and uncomfortable.[38]

Living conditions among non-pauper patients were also censured by the Board of Lunacy. It was almost exclusively among patients who were beyond the jurisdiction of the Board that the most severe cases of cruelty and neglect occurred. The Commissioners reported that many just above pauperism, "are, from no worse motives...than ignorance and poverty, kept in a state of dirt...and discomfort that would not be tolerated in the case of paupers."[39] Seventy percent of boarded-out private patients were considered to be in indigent circumstances. The probability that they and their families would become pauperised as a result of their insanity was high. A family member was forced to remain at home to look after the patient, and so the work of a wage earner was liable to be forfeited. Many patients were restrained, largely out of desperation and fear by their families. It was evident to the Visiting Commissioners that such cases were often in a more unfortunate condition than pauper patients, particularly as there was no direct way to ameliorate their circumstances.

Among unfavourable circumstances condemned by the Board following initial visits to boarded-out private patients, were those of two sisters discovered in a condition of "abject misery". One was found lying in filth, confined in a cage. The other was found wandering through the woods half naked. The Commissioners declared that "the whole picture was an intensification of filth, inhumanity, and demoralisation that defies description."[40] Again, the case of a "gibbous jawed dwarf" reported on in 1864, may appear particularly scandalous,

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[38] GBCLS 1st AR (1859), pp176, 178, 181, 182, 188.
[39] GBCLS 7th AR (1865), p247.
[40] GBCLS 1st AR (1859), p175.

but was not, in fact, a solitary example. E.G. lived with her mother and brother, in an affluent looking house where "all was shockingly filthy". Her hair was reported to be matted and solid, her teeth had gone, her skin was covered in burn marks, with her left arm and leg almost entirely burnt and she was unable to walk. While she could see and hear, the Commissioners were uncertain whether she could distinguish pain, cold or heat. She was found "grovelling in ashes close to the fire...[where] she crouches during the day."[41] This patient, however, came from a comparatively wealthy family and she herself owned a share of her late father's farm. Nevertheless, her family argued that the cost of maintenance in an asylum was beyond their means. Despite being found in such a condition, she was not removed to Inverness District Asylum for several years; being a private case, the Board of Lunacy was powerless to intervene.

4.3.2 Acceptable standards

The Lunacy Commissioners, coming from privileged backgrounds, were criticised at times, particularly by parish officials, for their perceived insensitivity and unrealistic expectations of living standards among the working population. On the basis of available evidence, including reports from interested observers and the Commissioners, it can be seen that that they had at least some recognition and understanding of the contrasting standards, and, frequently, of the hardship found among the peasantry and small farmers throughout the country. This is reflected, for example, in the following statement:

> "in no part of Scotland do we find that section of the population from which pauper lunatics are drawn lodged in cottages covered with roses and woodbine, furnished with pianos, decorated with pictures, supplied with baths, and presenting an air of refined comfort and ease. The pity is that such is not the case, but if private dwellings are to be used at all we must take them as they are, not as we might wish them to be."[42]

Nevertheless, despite this general recognition that the living conditions of crofters and peasants would not meet their own ideal standards, it is apparent that the Commissioners were not quite as willing to accept existing conditions as they wished to portray. Minor recommendations for improvements to the houses or the care of patients were almost invariably forthcoming after every visit. In the early years of the system, it is clear that this was justified, although the Board of Lunacy was concerned that boarding-out should not be portrayed wholly negatively. Therefore, and "in justice to parochial authorities and

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[41] GBCLS 6th AR (1864), main report, pxxvi.
[42] GBCLS 12th AR (1870), main report, pxxxix.

relatives", the Commissioners announced that a large proportion of single cases were treated with kindness and consideration, and "it is on this fact that rests our chief hope of the success of the cottage system."[43] Further, it was accepted that if the condition of the patient matched that of the rest of the family, the situation could not be regarded as entirely unsatisfactory. The general condition of the labouring classes in each district was taken into consideration when judging the standards in private dwellings and patients were supposed only to be placed in conditions comparable to those of neighbouring residents. The report of the Royal Commission had recognised that:

> "the standard of personal cleanliness is, in general, so low among the Scottish poor, that parochial surgeons cannot afford to be very fastidious in deciding that a fatuous pauper is not properly kept. If he was, then a large proportion of paupers at present living with relatives or strangers, would require to be removed."[44]

Mitchell summed up the situation when he declared that, "we can hardly ask that they be better fed clothed and housed than the rate-payers themselves."[45] In fact, in some cases, patients were reported to be better cared for than the rest of the family, prompting Lawson, when Deputy Commissioner, to conclude that many were "more readily recognised by [their] superiority in apparel and cleanliness than by [their] marks of mental inferiority".[46]

The need for flexibility in assessing accommodation was emphasised. For example, establishing an exact cubic space for sleeping and living accommodation for all patients was deemed unhelpful in view of the fact that patients in country districts were more likely to spend a greater part of the day outside, while those in urban surroundings needed perhaps more indoor space. In many districts, rooms were occupied by relatives of the guardian in the summer months and the Commissioners maintained that rather than insisting on the patient remaining in a designated area, it was more appropriate if he was treated like the rest of the family:

> "if the patient is to share family life, and this is what I regard as the outstanding good point of private care, he ought to share to some extent the inconveniences that the family with which he is boarded willingly and cheerfully bear. Most of the patients enjoy the greater bustle and stir which they produce."[47]

Where guardians were in the practice of letting rooms to paying guests, however, the Commissioners made it clear that patients' rooms should not be disturbed. The Board of

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[43] GBCLS 1st AR (1859) main report, p l.
[44] Report of the Royal Commission (1857), p187.
[45] GBCLS 3rd AR (1861), p251.
[46] GBCLS 23rd AR (1881), p125.
[47] GBCLS 46th AR (1904), p169.

Lunacy was determined that no guardian should require patients to experience any discomfort for the sake of their own private profit.

Despite repeated adverse comment on the nature of provision available, the Board of Lunacy continued to emphasise the benefits of residence in a familiar, if modest, domestic environment for insane patients. Fraser, demonstrating an understanding of local circumstances held to be unusual by critics, conceded that "the homes of the poor afford advantages which are not at first sight apparent, and which are often not properly appreciated."[48] The assimilation of patients into the lives of the household in which they resided was established as one of the major tenets of the boarding-out system. It was for this reason that the Commissioners, on each visit, undertook close investigation of the dietary and sleeping arrangements made for boarded-out patients.

4.3.3 Diet and eating arrangements

The importance of diet in the treatment of the insane was of common interest among alienists and is reflected in the attention devoted to the subject in annual reports for asylums.[49] One physician, Campbell, contended that demented, incurable patients had greater appetites than the curable insane or sane.[50] It is not surprising, in this light, that the Commissioners regarded ensuring the adequacy of dietary provision for patients as a vital aspect of their work. The Board of Lunacy stipulated that boarded-out patients should receive a diet of the same quality and quantity as that consumed by the rest of the household. Meals were to be taken at the table, together with the family, although guardians were allowed to serve patients separately when their table manners were deemed offensive. The diet of boarded-out patients and the contrast to the closely controlled quality and quantity in institutions however, was often criticised. Campbell, for example, recorded his disagreement with the estimates of dietary needs by Scottish Commissioners, declaring that the maintenance payment to guardians was inadequate for the provision of a suitable diet. He denounced remarks in their annual reports which:

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[48] GBCLS 22nd AR (1880), p116.

[49] For example, Clouston, in his annual reports for the Edinburgh Royal Asylum discussed with some frequency the importance of adequate diet as a means to modify the mental condition. MS AR Edinburgh Royal Asylum, *passim*. See also Beveridge, A. (1991) Thomas Clouston and the Edinburgh School of Psychiatry. In *150 Years of British Psychiatry, 1841-1991* (eds G. Berrios and H. Freeman), pp359-388. London: Gaskell, in which he discusses Clouston's emphasis on diet and his "Gospel of Fatness."

[50] Campbell, J.A. (1886) On the appetite in insanity. *Journal of Mental Science*, **32**, p196. In this he gave instructions to medical superintendents as to suitable diet for the different categories of mental illness.

> "would lead one to think that the summum bonum of earthly bliss consists in being a boarded-out dement and being cheaply kept".[51]

Nevertheless, despite Campbell's concern, there is no indication from parish officials or from visiting report books that dietary regulations were ignored, although inevitably there were exceptions.

However, while few instances of inadequate diet were reported, the quality of food available in certain districts was condemned by Visiting Commissioners. The staple article of diet among the poorer classes was meal, supplemented by potatoes. It was not unusual to encounter families in which no-one ate meat. In Shetland, Orkney and fishing villages along the coast, fish was the major component of local diet. A large proportion of the population, not just those in receipt of poor relief, lived habitually on a "sloppy" diet.[52] In special licensed houses in Fifeshire, for example, breakfast consisted of porridge and milk, dinner was usually broth with beef or home-cured pork, with bread and butter for tea. Before retiring to bed, bread and milk was offered.[53] The monotony of the routine diet for many families was broken occasionally when meals were supplemented with various luxuries such as bacon, dripping, eggs or treacle. In the opinion of the Commissioners, the quantity and quality of food was almost equal to the diet of soldiers in peace-time and was at least 25% above a bare subsistence diet.[54]

The cost of providing an adequate diet was estimated to be between 2s6d and 3s a week, during much of the nineteenth century. The Board of Lunacy emphasised the need to establish a fair rate of payment for guardians, to ensure that there was no temptation to deprive the patient at mealtimes. The following list was proposed as an adequate representation of the nature and cost per head of the weekly diet of the labouring classes: 7lbs of oatmeal at 8d, 6 pints of skimmed milk at 3d, ¼ stone of potatoes, 2d, 4lbs of bread, 7d, ¼lb of butter, 4d, condiments, 1d, 1½ oz of tea, 3d, and ½lb of sugar, 2d, making the weekly cost of food, 2s6d.[55] The frequent improvements in the physical health of patients sent to private dwellings was held by the Commissioners to be testimony to the adequacy of dietary provision, and the quality of food provided in the majority of households was

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[51] *Ibid.*
[52] GBCLS 26th AR (1884), p147.
[53] GBCLS 29th AR (1887), p134, A similar diet was recorded by other Commissioners for families throughout Scotland.
[54] GBCLS 9th AR (1867), p174.
[55] *Ibid.*

accepted as satisfactory. As long as patients received the same meals as the host family, there was little condemnation of this aspect of care by the ever-vigilant Commissioners.

4.3.4 Sleeping arrangements

Inadequate sleeping accommodation had been one of the most frequent criticisms of the Royal Commission in 1857, with reports of patients discovered sleeping on straw on the floor, with little in the way of covering. The Board of Lunacy insisted that patients were provided with ample, clean bedding, of a standard comparable to that of the rest of the family and endeavoured to instigate improvements. However, this proved problematic on many occasions, as suitable sleeping arrangements were rarely encountered among pauper families throughout Scotland, particularly in the Highlands and Islands. Even at the turn of the century, a visit to Lewis revealed what the Commissioners regarded as unacceptable sleeping arrangements, where the whole community slept on beds of straw. The visiting Commissioner, Macpherson, was informed that "it had been an exceptionally bad year...and a great many cattle had died of starvation." Notwithstanding this, Macpherson recommended that each patient be provided with a mattress.[56]

Patients were not allowed to sleep in the same room as a person of the other sex, although almost ten years after the Report of the Royal Commission, cases were reported where active, able-bodied male insane patients were sleeping with adult women.[57] Where patients were boarded in special licensed houses, separate beds were to be provided. However, the Commissioners accepted that if the bed was large and comfortable, female patients could sleep together, at their own request, since, "it would be unfeeling and unwise to enforce a hard and fast rule prohibiting such association."[58] In 1889, for example, in 38 special licensed houses where females were sharing a bed, 30 of them had either asked to do so, or accepted the situation.[59] Nevertheless, complaints were made by some patients about being forced to share a bed, which, in turn, enabled guardians to receive more boarders. Sometimes, male patients were also discovered sharing a bed for the sake of warmth but this was deemed unacceptable by the Board, even though "the practice of sharing a bed

[56] GBCLS 45th AR (1903), p155.
[57] GBCLS 6th AR (1864), p229.
[58] GBCLS 31st AR (1889), p132.
[59] *Ibid.*

prevails in all ranks of sane society".[60] It seems clear that the sensibilities of the Commissioners were more affronted by the prospect of male than female patients sleeping together and steps were taken to ensure this was not common practice. Among females, however, there was "no need for such stringence."[61] Objections were also made regarding patients with depraved habits or those who "restless through delusions or hallucinations," created a disturbance throughout the night.[62] However, even this contrasts favourably to conditions experienced on asylum wards, where large numbers of often noisy, highly disturbed patients slept in close proximity.

4.3.5 Clothing

Considerable attention was given to the clothing of patients, the Commissioners requiring that patients should be dressed warmly and respectably.[63] Integral to this concern was the belief that "the insane as a rule are of comparatively lower vitality than their neighbours, and require warmer clothing for the maintenance of their health."[64] Clothing requirements were recorded precisely. It was the duty of parish officials to ensure their patients were well-clothed, and the state of clothing was reported on by the medical officer and inspector of poor at every visit and recorded in the Visiting Book placed in each house (Appendix 3). Their statements were verified by the Visiting Commissioner.

The reluctance of some parochial authorities to provide adequate clothing, particularly the expenses for new boots or a coat, was condemned by the Board.[65] In addition, guardians were often diffident in applying for extra clothes, although some patients were destructive of what they wore.[66] While the majority of patients required replacement of clothes annually, it was sometimes necessary to recommend more frequent renewal, particularly for men working on farms. The Commissioners therefore ordered that such patients be supplied with regular replacements of warm, strong clothing[67] and at Benderloch in Argyllshire, for example, patients were reported to be "well clad in good tweed suits and

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[60] *Ibid.*
[61] *Ibid.*
[62] GBCLS 34th AR (1892), p112.
[63] See Regulations for guardians of boarded-out patients, GBCLS 15th AR (1873), p311 and Chapter 7.
[64] GBCLS 38th AR (1896), p134.
[65] This reluctance was documented in for example, GBCLS 19th AR (1877), p129 and 38th AR (1896), p134.
[66] Thus Mitchell observed a general hesitation or delay in the supply of new clothing, with guardians waiting for the clothes to wear out. GBCLS 6th AR (1864), p228.
[67] Paterson was anxious to emphasise the importance "in this climate" of providing warm outer clothing, generally woollen, which should be renewed at a fixed time, i.e. the beginning of winter. GBCLS 9th AR (1867), p246.

had ample supplies of underclothing."[68] In addition, each male patient was provided with an overcoat, a sailor's oilskin coat and leggings.

The Commissioners also drew attention to the importance of patients being dressed in clothes that resembled those of the general population, to minimise any obvious differences there may have been between insane patient and local resident. In this context, Mitchell noted that:

> "the ragged cast-off coat or battered hat of a gentleman has led many an idiot or imbecile into the hands of the police and thence for life into an asylum... It is a great mistake to allow such persons to be dressed so as to make them kenspeckle objects on our roads..., thus attracting the attention of the thoughtless, by whom they are teased and provoked into acts which bring them under the notice of the Procurator Fiscal."[69]

As a consequence, he urged the provision of more suitable clothing for those patients who accompanied their guardians to church, for secular rather than religious reasons:

> "I have recommended this, not because of any benefit expected from pulpit instruction, but on the general principle that the patients should do what their guardians do, whenever that is possible."[70]

The emphasis on the suitable clothing of patients illustrates well the determination of the Board of Lunacy to encourage the integration of insane patients into the life of the community, as comfortably and unobtrusively as possible.

4.4 Development of the boarding-out system

A number of factors contributed to the general consolidation and endorsement of the boarding-out system, including the increased efforts by asylum superintendents to discharge chronic patients in order to relieve overcrowding; greater enthusiasm among parish officials to co-operate with the Board of Lunacy; and the steadily rising costs of maintenance in asylums. The Commissioners did not consider that the growth in boarding-out was attributable to circumstances and conditions peculiar to Scotland because other countries possessed "retired hamlets and villages...and respectable, matronly housewives who would make excellent nurses for the insane."[71] Thus they suggested that:

> "the system has been firmly established in Scotland, and is growing there, mainly, if not entirely, because there is faith in it, and earnest efforts have been made to render its working satisfactory."[72]

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[68] GBCLS 44th AR (1902), p164.
[69] GBCLS 7th AR (1865), p235.
[70] GBCLS 10th AR (1868), p229.
[71] GBCLS 27th AR (1885), p129
[72] *Ibid.*

The initial practice of placing patients with strangers had demonstrated to parish officials that there was a plentiful supply of suitable, willing guardians to receive patients. As the century progressed, an increasing proportion of paupers were granted certificates of insanity. One explanation for this lay in the introduction of the grant-in-aid, which encouraged officials to register weak-minded, chronic cases. Greater flexibility in governing the classification of insanity further contributed to the increase, with people displaying characteristics not formerly associated with lunatic behaviour, being recognised and registered as insane. As Fraser observed:

> "the result of this extension of the domain of lunacy is to include among the insane a larger proportion of persons with weak mind, of depressed spirits or of excitable temperament, persons showing evidence of impaired memory or of mental decay, imbeciles of various grades of mental deficiency and also of paralytics and epileptics in whom the mental condition is enfeebled."[73]

The majority of such patients were eminently suitable for boarding-out. The continuation of boarding-out, therefore, was assured, for as long as such persons were classified as insane and so under the jurisdiction of the Board of Lunacy.

4.4.1 Increasing acceptance

Despite vocal opposition to the system among many alienists[74], especially in England, and from parish officials already overburdened with duties relating to the care of the poor, the practice of boarding-out was adopted enthusiastically in Scotland. Lindsay, superintendent of the Murray Royal Asylum, Perth, had long recommended its adoption worldwide, declaring that:

> "the development of the system of boarding-out and of the grouping in communities of insane boarders is a natural one, requiring only organisation and supervision for successful growth...this natural development and growth has hitherto been prevented only by official restriction, professional prejudice and public ignorance or apathy."[75]

There was always considerable variation in the degree to which districts implemented the system; officials from large urban parishes being the most active.[76] In 1900, 2,793 patients were boarded-out across Scotland (2,669 paupers and 124 private). Two thirds of these patients resided with unrelated guardians.[77] The development of the system was associated with what appears to have been an increasing acceptance among the general public of the

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[73] GBCLS 33rd AR (1891), p98.
[74] *Vide infra* Chapter 10.
[75] Lindsay, W.L. (1871) *op. cit.*, p508.
[76] *Vide infra* Chapter 9 for a detailed analysis of regional variation in boarding-out.
[77] GBCLS 43rd AR (1901). Among pauper patients, 987 resided with relatives, while 1682 were boarded with strangers. There are no reliable figures for private patients.

notion of insane persons living in the community. The earlier scepticism regarding the suitability of housing the insane in private dwellings, which had been intensified by the revelations of the Royal Commission of 1855, became less prominent as the system expanded. It is difficult to assemble corroborative evidence, but Lawson was able to announce in 1880, that boarding-out had "made rapid progress towards maturity", with an increasing recognition among the "lower classes" of the merits of the system and a general tolerance of the supervision involved.[78]

Further, the Commissioners reported that a new generation of parochial officials were less suspicious of the system and more willing to co-operate in its implementation.[79] During the early years of boarding-out, asylum superintendents and inspectors of poor had been generally uncooperative in assisting in the selection and placement of suitable patients.[80] By the 1880s, however, it was evident that asylum and parochial officials, as well as the general public, displayed an increasing interest in the condition of those in private dwellings. This was encouraged by the realisation that certain types of insane patients could reside in a village with no danger to the public. After an initial decline in the number of patients boarded-out, therefore, the rising proportion of cases provided for in this way, with apparent success, ensured that the system was regarded increasingly by medical commentators as a significant and useful, supplement to asylum provision.

Boarding-out attracted extensive attention from lunacy administrators and physicians in Scotland and throughout Europe. By 1890, however, the Commissioners emphasised that, despite sustained international interest, the system was no longer a novelty, but, rather, had

> "reached the stage of maturity at which its successful working is best shown by its unobtrusiveness and by routine performance of its functions."[81]

The majority of large parishes practised the policy, the selection of suitable patients and guardians becoming an integral part of the duties of the inspector of poor. In certain districts, generations of children grew up in the presence of an insane patient in their household. In this way, boarding-out was in many places "an institution associated with the

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[78] GBCLS 22nd AR (1880), p133.
[79] Thus, for example, in 1885, Fraser contended that "during the last ten years, there has been a more general acceptance of the system. Inspectors of poor and superintendents of asylums more generally admit the desirability of its development and extension, and many of them give a willing and earnest assistance in this matter." GBCLS 27th AR (1885), p129.
[80] This lack of mutual co-operation was a frequent source of concern and frustration to the Commissioners. *Vide infra* Chapters 12 and 13 for discussion of this.
[81] GBCLS 32nd AR (1890), p119.

earliest impressions of a very large number of the inhabitants".[82] To such persons it was entirely natural to share a house with a harmless lunatic. The familiarity with which the system was viewed, its economic benefits, and the gradual breaking down of prejudices against the insane, assisted the steady development of boarding-out. Concerted pressure and encouragement by the Board of Lunacy further ensured its growth throughout Scotland.

4.4.2 Rise in living conditions

For the Commissioners, the stabilisation of the boarding-out system was a "long and difficult task."[83] Following the profusion of critical reports, over approximately the first decade of the system's implementation, annual reports began to record a gradual advance in the quality of provision in private dwellings. The nature and extent of the Commissioners' visits across the country placed them in a unique position to witness any rise in standards.[84] Although it is difficult to assess the nature of the improvements claimed, their assertions can be supported by the recognition of an increase, even if barely perceptible to many, in the material comfort of the general population. Nevertheless, overcrowding continued to cause problems of hygiene, with people living "at appalling densities" in the heart of large towns,[85] and as late as 1870, the inadequacy of drainage and ventilation was remarked upon. In this context, an inspecting officer for Kirkcaldy district reported with distaste that:

> "the habits of the population seem to be disgusting; the only means of disposing of filth of every description is to cast it from the doors of the houses; the side gutters are thus constantly foul, manure is freely accumulated sometimes by the roadside."[86]

Despite the valid concerns raised by such reports, the Commissioners recorded their satisfaction at what they considered to be a gradual rise in the standard of living and the quality of accommodation in the houses of the poor.[87] The structure of many houses underwent marked improvement, as repairs were made to roofs, and partitions erected to divide living and sleeping areas, with a consequent enhancement in cleanliness and neatness. Windows were introduced for the first time in many houses, providing light and

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[82] *Ibid.*
[83] GBCLS 27th AR (1885), p128.
[84] These improvements were documented in a number of annual reports, for example, GBCLS 12th AR (1870), 23rd AR (1881), 32nd AR (1890).
[85] Slaven, A. (1975) *op.cit.*
[86] Report from an inspecting officer in Dysart. (1870) In Levitt, I. (1988) *op.cit.*, p177.
[87] The progress towards achievement of hygienic living conditions among the labouring poor, should not, however, be exaggerated. In 1901, half the population of Scotland lived in houses of one or two rooms, and 11% in houses of one apartment. Infectious diseases flourished in conditions of such severe overcrowding and inadequate ventilation, leading to a high proportion of deaths being attributed to respiratory failure. Gordon, G. and Dicks, B. (eds) (1983) *Scottish urban history.* Aberdeen University Press.

air for the occupants. For the Commissioners, the rise in the standard required in the selection of houses contributed to a general advance in the accommodation of boarded-out patients. While Mitchell had reported extensively upon "numerous sensational cases of cruel restraint and gross neglect"[88] in the years immediately following the introduction of the system, he asserted that by the mid-1860s, no such cases existed in Scotland.[89] His claim is verified by the increasing rarity of reports concerning unsuitable living conditions, or neglect or abuse by guardians. Similarly, and the reduction in the volume of cases requiring intervention. The low mortality rate, good physical condition and general contentment reported among patients provide further testimony to the advances made in provision by the Board of Lunacy. This was achieved as a result of the greater exercise of control by the Commissioners, increased activity and vigilance by inspectors of poor and the transfer of unsuitable patients to asylums. The beneficial nature of the grant-in-aid and the power the Board of Lunacy had to withhold the allowance was also an influential factor in stimulating attempts at amelioration of adverse conditions in houses which contained patients.[90] In addition, greater care was taken in the selection of cases, enabling Mitchell to describe in 1864, an explicitly discriminatory policy:

> "by weeding out, or removing those cases which... cannot be properly cared for in private houses, by insisting on efficient and respectable guardianship, by disseminating correct and humane principles of treatment, and by refusing to sanction new arrangements which are not made with prudence and consideration, there will eventually remain...a certain number of the insane poor provided for in private houses, in a manner leaving nothing more to be desired by any one." [91]

He maintained that this had already been partially achieved without substantial diminution in the proportion of patients boarded-out. Many overtly unsuitable, physically infirm patients had died. Suicidal, violent and dirty patients were refused sanction to remain in private dwellings, while those who were ill-treated or neglected were transferred to the care of more suitable guardians. Further, guidelines enforced by the Board of Lunacy led to a general rise in the standard of care for boarded-out patients, facilitated by an increase in the rate of maintenance payments to secure greater cleanliness, sufficient clothing and better living conditions. However, while the maintenance of minimum standards was enforced by the regular visitation of Commissioners and parochial officials, a considerable degree of

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[88] GBCLS 8th AR (1866), p237.
[89] Mitchell's condemnation of existing circumstances was, in fact, accompanied by a recognition that many patients were treated with "devotion and self sacrifice" and a conviction that "a large number of the insane can be properly treated in private dwellings". Mitchell, A. (1864) *op. cit.*, p12.
[90] *Vide infra* 4.4.4.
[91] GBCLS 6th AR (1864), p232,

flexibility was allowed. Time and opportunity was given to implement recommendations and wherever possible, patients were allowed to remain in domestic care. When recommendations failed to be carried out, the Board of Lunacy ordered the removal of a patient, but, in general, the Commissioners considered that their suggestions were implemented in good faith and alleged with confidence that "we cannot doubt that their general condition becomes more and more satisfactory every year."[92]

It is clear that the Commissioners were aware that there would always be critics of boarding-out under the living conditions of the labouring classes. By the mid-1870s, however, they maintained that all but a small minority of patients were provided for adequately, although unsuitable arrangements continued to be reported with comparative frequency among those boarded with relatives.[93] Despite continuing concerns regarding the care of such cases and about private patients in straitened circumstances, the Board of Lunacy was clearly confident that the majority of boarded-out patients were well cared for. Thus the Commissioners announced with enthusiasm that "it may be said without hesitation that the condition [of boarded-out patients]...is superior to that of the working class population generally throughout Scotland".[94] In particular, the high standard of care of patients in special licensed houses was praised. Twenty years later, confidence in the quality of guardianship, selection of patients and general living standards was unabated, although the existence of a minority of unsatisfactory cases and living conditions was inevitable. A small number of cases in need of attention annually did not detract, in the Commissioners' opinion, from the alleged overall improvements in the care of boarded-out patients.

4.4.3 Changing nature of boarding-out

There were three categories of patients in private dwellings, namely those discharged unrecovered from asylums, those discharged on probation for a year and those who had never been admitted to an asylum. Their demographic characteristics are considered later[95], but a brief review of these groups of patients is necessary to understand the gradual

[92] GBCLS 25th AR (1883), p159.
[93] *Vide infra* Chapter 7.
[94] GBCLS 17th AR (1875), p259.
[95] *Vide infra* Chapter 6.

transformation in the pattern of the boarding-out system, to accommodate a wider range of insane patients.

The Board of Lunacy granted exemption from removal to an asylum to any patient who was apparently incurable, harmless and not suffering from any bodily or mental disorder requiring specialised treatment. The Commissioners were firm in their conviction that such patients did not need the discipline or treatment available in asylums and instead took up valuable space that could be better utilised by more recent cases of acute insanity. However, as Lindsay recognised, the concept of incurability was problematic to some physicians, who maintained that no insane person should be classified as incapable of improvement.[96] They argued that regardless of the extent of dementia, congenital defect and helplessness of patients, attention and training could lead to improvement. Sympathisers with this view included the American alienist, Kirkbride, who, in deploring the proposal for separate institutions for the insane, maintained that:

> "no one can say with entire certainty who is incurable...When patients cannot be cured, they should still be considered under treatment, as long as life lasts; if not with the hope of restoring them to health, to do what is next in importance, to promote their comfort and happiness and to keep them from sinking still lower in the scale of humanity...what is best for the recent is best for the chronic"[97]

Many Scottish physicians concurred, accepting that, theoretically, it was not appropriate to regard any patient as incurable. In practice, however, it was recognised that many patients accumulating in asylums were unable to benefit from available treatment and, therefore, could be suitably provided for outside the confines of an institution.

Patients were also discharged from asylums on probation for a year, in order to ascertain their suitability for prolonged residence in a private dwelling, or before permanent discharge. The mental classification of these patients was varied, and included incurable cases and those suffering from acute forms of insanity, having reached a quiescent stage. Such patients remained on the asylum register and their return to the asylum, when necessary, was straightforward, without incurring the expense or trouble of a medical certificate or sheriff's orders. The procedure was adopted in the 1860s, and resorted to by a small number of medical superintendents, particularly at Woodilee, Roxburgh and

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[96] Discussed by Lindsay, W.L. (1871) *op. cit.*, p523. *Vide infra* Chapter 10.
[97] Grob, G. (1994) Mad, homeless and unwanted. A history of the care of the chronic mentally ill in America. *Psychiatric Clinics of North America*, 17(3), p547.

Inverness District Asylums. However, the system of discharge on probation was never utilised on the same scale as the formal discharge of patients to private dwellings.[98]

The majority of patients boarded-out between 1858 and 1880 had never been admitted to an asylum. They were boarded with relatives and suffered from congenital forms of insanity, in particular, imbecility and idiocy. The gradual transformation in the classification of patients was one of the most notable developments of the system. Thus in 1858, two-thirds of the pauper insane in private dwellings suffered from imbecility and idiocy. Twenty years later, with the development of the policy of removing suitable patients from asylums, the proportions had altered markedly.[99] Increasing numbers of patients were discharged from asylums in a state of chronic insanity, or "passive mania", a manic condition having passed into a quiescent stage. Experience had shown that if such patients were quiet and harmless, they were as suitable as those suffering from congenital forms of insanity. In the early years of the twentieth century, therefore, it was estimated that 47% of boarded-out patients were classified as congenitally defective, while 53% were reported to suffer from various forms of acquired insanity, predominantly dementia.[100]

The transformation in the classification of boarded-out patients was a result of the sharp rise in those discharged unrecovered from asylums, usually to special licensed houses. By the 1870s, the steady growth in the number of special licensed houses, filled largely by patients from Glasgow and Edinburgh, had encouraged other parochial boards to send patients from asylums in small groups to certain localities, especially in central Scotland. In the first twenty years, patients certified insane and granted "dispensation from removal" to an asylum made up 85% of the total number of boarded-out patients.[101] However, by the late 1870s, the increase in former asylum patients was marked. For example, in 1873, among patients visited by Fraser, only 29% (200) of patients had previously been in an asylum, while 71% (482) had received dispensation from removal and remained in their homes.[102] By 1881, 43% (324) of 758 patients visited by him were ex-asylum patients.[103]

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[98] The system of probation as a preliminary to boarding-out is assessed in detail in Chapter 12.
[99] Spence, T.W.L. (1902) *op. cit.*, p626.
[100] GBCLS 45th AR (1903), p149. Of those patients classified as suffering from acquired forms of insanity, 72% had dementia, 13% delusional insanity, 7% chronic mania, 4% melancholia and 4% had various forms of degenerative disease.
[101] Spence, T.W.L. (1902) *op. cit.*, p625.
[102] GBCLS 16th AR (1874) However, the gradual change was already apparent, with 57% of patients receiving sanction for boarding-out that year being discharged from asylums.
[103] GBCLS 24th AR (1882).

The disparity continued to widen as the system developed (Figure 4.1) and between 1885 and 1900, 65% of boarded-out patients had been discharged from an asylum.[104]

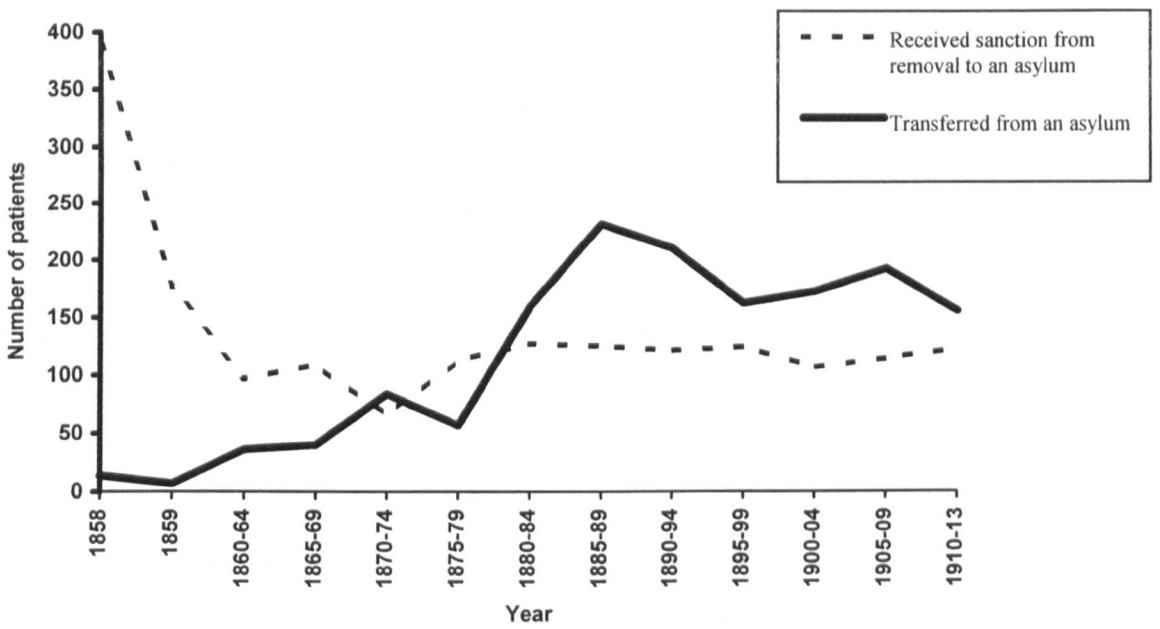

Figure 4.1 Mode of admission to the roll of patients in private dwellings, 1858-1913[105]

In 1858, 75% of patients in private dwellings were boarded-out under the care of relatives but this proportion declined steadily during the 1880s and 1890s.[106] Cases remaining with their families were almost exclusively suffering from congenital insanity of a more profound nature than those placed with unrelated guardians. In contrast, the majority of patients boarded-out unrecovered from asylums were sent to the care of unrelated guardians. Thus, for example, in 1902, of 2631 boarded-out pauper patients, 36% (954) were under the care of relatives and 64% (1677) with unrelated guardians, two-thirds of whom held special licenses.[107] This was due partly to the lack of relatives suitable and willing to care for patients discharged from asylums and to the fact that unrelated guardians were more easily controlled by the Board of Lunacy.

The economical nature of boarding-out increased the impetus to remove patients from asylums wherever possible. Individual parochial boards had the authority to pass a

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[104] Spence, T.W.L. (1902) *op. cit.*, p625.
[105] Source of data: GBCLS AR, 1858-1913, *passim*. The rise in the number of patients receiving sanction from removal to an asylum was directly related to the introduction of the Government grant-in-aid of 1875.
[106] *Vide infra* Chapter 7.
[107] Spence, T.W.L. (1902) *op. cit.*, p630.

resolution for the discharge of an unrecovered patient from an asylum. Although the asylum superintendent could refuse to allow their removal and appeal to the Board, discharge was rarely opposed and parish officials were, in general, guided by the recommendations of superintendents.[108] Further, the problems of overcrowding impressed upon officials the need to ameliorate such conditions. It was recognised that the policy of building new asylums and extending existing buildings could not continue indefinitely. By the turn of the century, therefore, a number of factors had combined to alter the nature of boarding-out. Patients boarded with strangers, following discharge from an asylum, far exceeded those placed with relatives, while those with acquired insanity outnumbered idiots and imbeciles.[109]

4.4.4 Effect of the Government grant-in-aid.

The government grant-in-aid, first given in 1875, was a fixed annual contribution by the Exchequer of four shillings weekly towards the maintenance costs of pauper lunatics (Appendix 4). Initial proposals had suggested that only inmates of asylums would receive the grant. However, this prompted concern that it would be a powerful inducement for parochial authorities to send all their patients to asylums, regardless of the severity of their mental condition and to retain them there even when no benefit could be attained. Under such a system, critics argued, asylum wards would become encumbered with chronic cases and extensive additions would be required. Following pressure from lunacy officials, therefore, the grant was paid for all pauper insane patients, whether in asylums, poorhouse lunatic wards or private dwellings.[110]

An immediate result was an increase in the number of registered insane paupers, and in the number boarded-out.[111] Before the existence of the grant, many insane persons were treated as ordinary paupers, even if mentally disturbed. Following its introduction, parochial medical officers granted certificates of insanity with greater frequency, aware that half the cost of maintenance would be defrayed by the Government. This led to a growing number of weak-minded persons with less pronounced forms of insanity, residing with relatives,

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[108] The attitude and activities of medical superintendents in relation to boarding-out are explored in Chapter 12.
[109] Spence, T.W.L. (1902) *op. cit.*, p626.
[110] GBCLS 24th AR (1882), main report, pli.
[111] Discussed by Fraser at length in GBCLS 20th AR (1880).

being registered as insane paupers and entering the roll of boarded-out patients.[112] Abuses were reported; paupers who were physically disabled were issued with certificates and categorised as lunatics, to enable the parish to receive the grant and the additional funds were used, at times, to support the whole family, diverting the grant from its designated use. Notwithstanding potential abuse, the Commissioners remained convinced about the overall benefits, concluding that the addition to the register of "a few doubtful cases of insanity", was "less evil" than the possibility that there may be inadequate information about, and supervision of, genuinely insane paupers.[113]

The nature and extent of the abuses perpetrated were not viewed as serious by the Commissioners who maintained that the grant was "a valuable boon to poor and heavily burdened parishes" and, further, that it allowed greater power of intervention in unsuitable cases.[114] A certificate from the Board of Lunacy was necessary before a claim for a grant could be processed. Greater attention, therefore, was paid to recommendations for improvements and when these were not forthcoming, the grant could be withheld. Previously, when there had been no such threat, difficulties were reported in making parish officials implement suggestions, since the Commissioners' only power lay in ordering a patient's removal to an asylum. The grant was issued only when it was clear that the patient was suitably provided for, thereby empowering the Commissioners to enforce minimum standards. Although the Board rarely used its power to remove the grant, the possibility of such action nevertheless acted as an effective stimulus to parish officials. More efficient local supervision and improved treatment of patients in private dwellings were indeed reported in the years following the introduction of the grant.[115] Although the cost of lunacy provision rose with the increase in registered paupers, the living standards of a greater proportion of the insane were monitored, and the gradual rise in standards reported by the Commissioners suggest that Fraser's confidence was not misplaced:

> "another year's experience has confirmed my opinion of the advantages, which in an administrative point of view, the parliamentary grant... confers on those responsible for the condition of the boarded-out insane...It cannot be doubted that it is, in the hands of the Board, a beneficial and powerful aid in the administration of the boarding-out system." [116]

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[112] GBCLS 20th AR (1878), p99, and 24th AR (1882), p146.
[113] GBCLS 22nd AR (1880), p118. A number of inspectors of poor admitted openly that they attempted wherever possible, to get certificates of lunacy "so as to obtain to the utmost the relief to the rates which is afforded by the grant."
[114] GBCLS 19th AR (1877), p126.
[115] GBCLS 20th AR (1878), main report, plxviii.
[116] GBCLS 23rd AR (1881), p117.

4.5 Fluctuation in number of patients

Despite legal enactments that facilitated the policy of boarding-out, the number provided for in this way fell between 1859 and 1876, rising steadily thereafter until 1913. In 1859, two years after the passage of the Lunacy (Scotland) Act, 1804 single patients were on the register of the Board of Lunacy, but by 1875, the number had fallen to 1472.[117] Although there was some concern about this decline, the Board of Lunacy was reassured when, in the early 1870s, the extent of the annual decrease diminished. Preceding this there had been an average annual decrease of 35 patients a year. In 1871, the decrease was 6 and a year later an increase of 27 patients was recorded.[118] The initial decline was evidently due to the gradual elimination of unsatisfactory cases and to the establishment of new district asylums, in areas previously deficient in accommodation. Access to asylums became easier, facilitated by the improvements in travel across the country. Further, some asylum superintendents were reluctant, initially, to discharge unrecovered patients to the care of untrained guardians. The Commissioners suggested another plausible reason for the decline, relating it to the gradual rise in wages and the improvement in circumstances among the labouring classes. Reports from the Board of Supervision indicated a material decrease in the total number of paupers and a concomitant decrease in the proportion of insane cases requiring parochial relief. The most convincing explanation, however, is the impact of the growth in asylum provision, with increased ease of admission and the greater rigour with which patients were selected for boarding-out.

Despite such rational explanations, there was considerable anxiety among the Commissioners over the apparent decline in their strongly advocated policy. This was particularly frustrating in view of the steady rise in asylum admissions in the first twenty years of the Board's existence. Despite the rapid extension of asylums across Scotland, and the relief offered by boarding-out, demand for in-patient accommodation exceeded expectations; the need for extensions to existing buildings and the erection of new establishments had become apparent by the 1870s. This was not attributed to a growth in lunacy throughout the country, but to the accumulation of incurable cases in asylums. Such patients, the Commissioners contended, should be boarded-out, if the great expense of continued asylum buildings was to be avoided. They further announced that:

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[117] GBCLS 18th AR (1876) main report, pii.
[118] GBCLS 14th AR (1872), p286.

> "it would be much to be regretted if a movement from which so much was anticipated in the way of relieving asylums from an accumulation of...incurable cases and restoring them to what has properly been stated to be their primary purpose as hospitals for treatment and not boarding houses for lodging incurables, had shown a tendency to suffer interruption."[119]

From 1876, the proportion of patients boarded-out rose. Relative causative factors were the introduction of a Government Grant the previous year and overcrowding in all district, and most royal, asylums. However, although the general trend was one of increase, there continued to be a degree of fluctuation in the number of patients boarded-out annually (Figure 4.2). As Sibbald, a staunch advocate of the system observed:

> "efforts to extend the private dwelling system have not been steady and continuous. In one year they are characterised by energy, and in the next a relaxation has occurred." [120]

This was attributed to the fact that many parochial authorities and asylum superintendents acted to board-out patients only when asylums became severely overcrowded, but that "where there is ample asylum accommodation the boarding-out of patients is apt to be either neglected or languidly carried out".[121] It would have unrealistic to expect that the same number of suitable patients could be found each year. Where an asylum discharged a large number of incurable patients one year, it was likely that the same asylum would have a reduced figure the following year. Nevertheless, asylum patients underwent changes in their mental condition, with, for example, active mania, or acute melancholia subsiding, thereby allowing a certain proportion of the asylum population to be discharged to private dwellings annually.

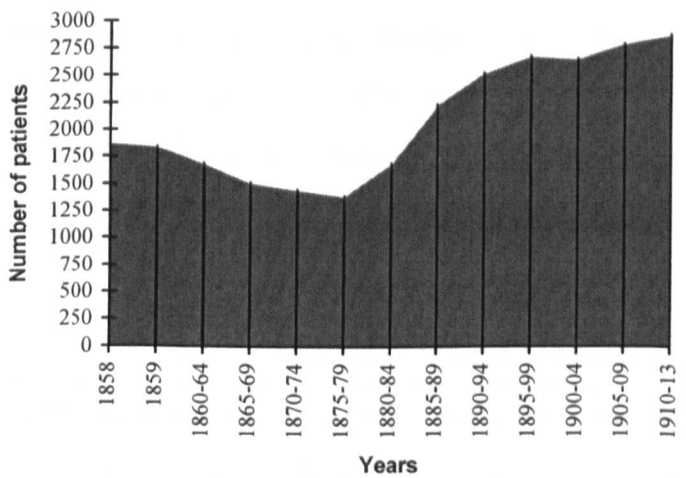

Figure 4.2 Number of patients boarded-out, 1858-1913[122]

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[119] GBCLS 16th AR (1874), p310.
[120] GBCLS 30th AR (1888), p107 .
[121] *Ibid.*
[122] Source of data: GBCLS AR *passim.*

The most notable trend in lunacy administration in the late-nineteenth century was, in fact, a continued increase in asylum admissions.[123] Even though the system of boarding-out was adopted in parishes across Scotland from the 1860s, and in spite of the assertion by the Commissioners that there was no increase in insanity,[124] admissions to asylums rose annually. However, despite this increase, over 20% of registered pauper insane were boarded-out from the 1880s up to the first decade of the twentieth century. In 1888, for example, out of 11,609 registered insane patients (private and pauper) 2402 (20.6%) were in private dwellings, albeit with substantial variation among districts.[125] Among registered pauper patients, 2270 (23%) of 9760 were boarded-out.[126] In 1913, this had declined quite significantly with 2909 (18%) of 16,115 pauper patients provided for in this way.[127] Private patients only comprised a small proportion of boarded-out cases. In 1858, 20 were boarded-out with the sanction of the Board, and although 35 years later, this number had increased to 115 out of 2034 private patients (5.6%) this was only a tiny proportion of those actually residing in private care, the majority of whom remained undetected and therefore, unsupervised. In the same year, 1616 private patients were accommodated in royal and district asylums and 157 in private madhouses.[128]

In 1890, 70% of registered insane patients were located in asylums, 2% were in private madhouses, 7% in poorhouse lunatic wards and 21% in private dwellings[129] (Figures 4.3 and 4.4). If the latter two classes had been placed in asylums, it would have forced the erection of new buildings, at a cost of approximately £700,000.[130] This provides an indication of the economic value of the boarding-out system. At its peak, at the turn of the century, almost 25% of patients (3000) were boarded-out. Had they been retained in asylums, it was estimated that they would have filled six district asylums.[131]

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[123] See Cameron, D. (1954) Admissions to Scottish mental hospitals in the last hundred years. *British Journal of Preventive and Social Medicine.* **8**, 180-186 for a useful discussion of this rise.
[124] *Vide supra* Chapter 1 for discussion on the concerns surrounding a perceived increase of insanity among the population.
[125] GBCLS 30th AR (1888), main report, px. Thus in Shetland, for example, 54% of their pauper insane were boarded-out, contrasted to only 8% in Nairn.
[126] *Ibid.*
[127] *Vide infra* Chapter 15 for assessment of the reasons behind the decline in numbers boarded-out from 1913.
[128] GBCLS 35th AR (1893), main report, px.
[129] GBCLS 33rd AR (1891), *passim.*
[130] Clouston, T.S. (1893) Lunacy administration of Scotland. In *Commitment, detention, care and treatment of the insane.* (eds G. Alder Blumer and A.B.Richardson), pp186-197. International Congress of Charities. Baltimore: Johns Hopkins Press.
[131] In 1900, for example, 2703 pauper patients resided in private dwellings. Sutherland, J.F. (1897) *op. cit.*, p629.

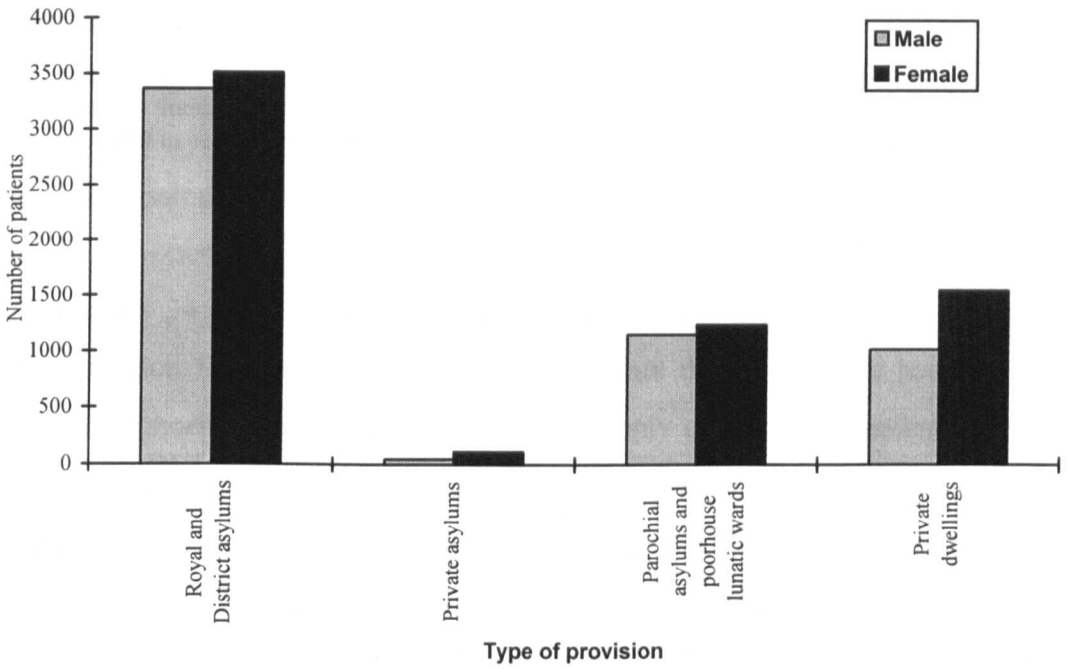

Figure 4.3 Distribution of registered insane patients according to sex, 1890

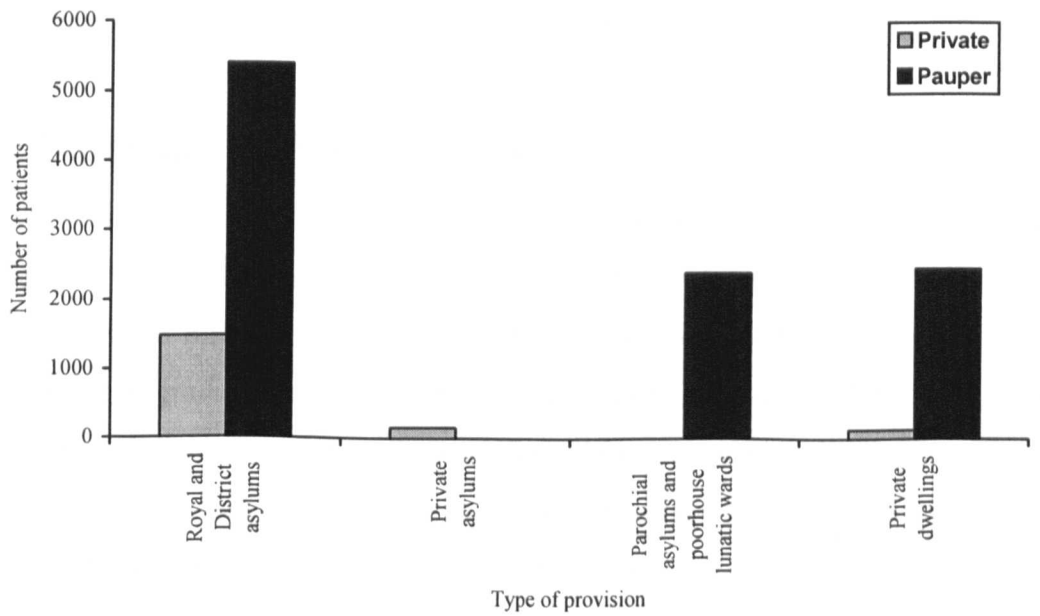

Figure 4.4 Distribution of insane patients according to status, 1890

Nevertheless, it was reported that while the number of patients boarded-out was the highest ever reached, the proportion had declined relative to the total chargeable insane.[132] Sutherland observed with regret that:

> "curiously enough, in spite of all the excellent features of the system, the boarding-out phase of Scottish lunacy administration, which has always in our own country been recognised as essential to successful administration, lags behind."[133]

The Commissioners expressed concern that parish officials and asylum authorities had ceased to co-operate in selecting and placing suitable patients in private dwellings. In 1901, a decline of 34 patients was reported, with a further fall of 38 the following year.[134] However, such figures did not necessarily indicate that the system had lost favour with parochial authorities, but rather, that a ready supply of incurable patients was not always available.[135] Further, it was recognised that an increasing proportion of admissions to asylums were patients who were physically weak or suffering from transitory attacks of acute insanity and so were wholly unsuitable for boarding-out. It is clear that the benefits of the system were accepted gradually by parish officials and asylum superintendents throughout Scotland, although there remained a small number who were unconvinced of its merits. The actual number boarded-out in private dwellings almost doubled between 1876 and 1908, from 1492 to 2907 patients (private and pauper).[136]

4.5 Summary and conclusions

Every year, a large proportion of chronic, harmless patients were granted sanction to reside in private dwellings. The number of cases boarded-out increased, albeit irregularly, throughout the nineteenth century. As the system expanded, the nature of boarding-out underwent a gradual transformation. A wider classification in the mental condition of patients was evident, with patients suffering from mania, melancholia and epilepsy, if quiescent, discharged from asylums to private dwellings. Such patients were usually sent to unrelated guardians, often in special licensed houses.

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[132] The actual number of patients boarded-out in 1908, 2770, was similar to the number boarded-out ten years earlier. The percentage of boarded-out insane to total insane, however, fell from 21% to 18%. Royal Commission on the Care and Control of the Feeble minded (1908), p15.

[133] GBCLS 53rd AR (1911), p156.

[134] GBCLS 44th AR (1902), 45th AR (1903).

[135] This assertion was accepted widely. Robertson, observing the perceptible diminution in boarded-out patients, announced that "the number suitable for such care will not necessarily bear any fixed proportion to the total number in asylums." The activity of one year could not always be repeated. To Robertson, the real decrease began in 1914. Robertson, G.M. (1922) The hospitalisation of the Scottish asylum system. Presidential Address. *Journal of Mental Science*, **68**, 321-332.

[136] GBCLS 18th AR (1876) and 50th AR (1908).

The growth of boarding-out owed a great deal to the close control exerted by the Board of Lunacy, and its wholesale endorsement of the system. Legislation (the Acts of 1857 and 1862 and the introduction of the grant-in-aid in 1875 in particular) facilitated the development of the policy, but it was the pressure from overcrowded asylums and the recognition of the inherent advantages of domestic care, for certain patients and for ratepayers, that ensured regular recourse to boarding-out. Nevertheless, the utilisation of the term "boarding-out" conveyed an inaccurate impression given that placement in private dwellings was in no way dependent on previous asylum admission. Up to 30% of the total number boarded-out had received exemption from removal to an asylum and granted sanction to remain at home or, though less often, sent to the care of an unrelated guardian, without ever having been in an asylum. The Commissioners were eager, therefore, to dispel the impression that the essence of the system lay in removing patients from asylums. In practice, the policy of boarding-out was not concerned with, or influenced by, the previous residence of a patient. Instead, the guiding principle was that no patients in receipt of poor relief could reside in private dwellings unless under conditions approved of by the State and it was "the broad sweep of this principle...which really distinguishes the Scottish method from that followed in other countries."[137]

Boarding-out continued in the first three decades of the twentieth century, although the number provided for in this way declined during World War 1 and failed to achieve pre-war levels in the following years.[138] Fostered closely by Lunacy Commissioners, the system became an integral part of Scottish lunacy administration. In achieving this, policy makers overcame sustained opposition from many prominent alienists and initial scepticism and fear from villagers and local officials. The declaration by the Secretary to the General Board of Control, illustrates well the pride felt in the system:

> "the boarding-out of pauper lunatics in private dwellings has been a distinctive feature of Scottish lunacy administration since its formation upwards of 60 years. It has attracted the favourable attention of those interested in the care of the insane in all the civilised countries of the world, and its value in promoting the welfare and happiness of certain classes of the insane has been confirmed by long experience."[139]

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[137] Spence, T.W.L. (1902) *op. cit.*, p626.
[138] The characteristics of the system in the 20th century, and its development into the more widely known system of "guardianship" in the 1950-1970s are discussed in Chapter 15.
[139] Letter in GBC, 6th AR (1920), p46.

CHAPTER 5

GROWTH AND DEVELOPMENT OF SPECIAL LICENSED HOUSES

5. Overview

Following legislation passed in 1862, insane patients were not only placed singly in private dwellings, but also boarded under the care of unrelated guardians, in houses licensed for the reception of up to four patients. Providing for patients in these specially licensed houses became an increasingly important component of the boarding-out system as the century progressed and its growth is reviewed in this chapter. Special licensed houses were distributed across Scotland, but a notable feature was the aggregation of patients in small villages in a number of districts, particularly in central Scotland. Prominent locations are outlined, with a brief description of the major colonies. Patients from large urban parishes, notably Edinburgh and Glasgow, were predominant and the reasons for this are assessed.

5.1 Introduction

From 1858 to 1862, patients under the official cognisance of the Board of Lunacy, who were accommodated outside an institution, were boarded singly. Statutory enactment held that not more than one lunatic could be placed in any household, unless a costly annual license fee of £15 was paid, whereupon such houses were regarded as private madhouses. This expense was seen as an effective obstacle against the introduction of a more home-like system of provision for the insane. Both Commissioners and alienists had discussed the advantages inherent in a "cottage system" of accommodating the insane several years before the legislation of 1862.[1] One alienist contended that such a system offered "favourable circumstances for supervision, and may be rendered subservient to the establishment of suitable accommodation and treatment succursal to the district asylum."[2]

[1] The term "cottage system" is used to describe a system whereby patients resided in private cottages, either in asylum grounds cared for by asylum attendants, or, and more usually, independently of an asylum. See p7.
[2] Anon (1862a) Colonisation of lunatics by the Legislature. *Medical Critic and Psychological Journal*, **2**, p440.

If no license fee was charged, the costs would be lower than that of both private and public asylums, thereby encouraging parochial boards to support such a residence for their paupers. The author continued prophetically:

> "it may be fairly anticipated that into such cottage asylums will be gathered not merely the outlying and deserted and friendless, as well as the chronic...insane..., but...patients recently discharged from asylums, either during their probationary period, or as a new and untried mode of amelioration, or because they have no relatives or friends to whom they can be entrusted when the disease is found to be intractable".[3]

Interested observers recognised that if the restriction imposed by a license fee was lifted, an efficient system of provision could be developed for the insane who were not in need of asylum care. The Commissioners recommended, therefore, that licenses be granted for the reception of up to four patients in a private house.

The Amending Act of 1862 empowered the Board to grant "special licenses", without charge, to occupiers of houses for between two and four patients of the same sex. Although this provision was utilised immediately in a number of large urban parishes for boarding-out patients from asylums, initially, recourse to this alternative was not widespread. From the late 1860s, however, special licensed houses became an important component of non-institutional provision for the insane. While some private madhouses often contained under four patients, they were run on very different principles, catering for all classes of the insane, rather than a carefully selected minority. The two forms of provision represented distinct, even opposing systems of care. Although there was no desire among the Commissioners to instigate any major alteration of the existing system of lunacy administration, which had been defined only six years before the introduction of special licenses, the advantages brought about by the removal of legal obstructions were acknowledged widely. The growth of special licensed houses was rapid, often taking the form of "colonies" in a village and within 30 years of their introduction, more patients were placed in such houses, than were boarded singly. Regulations concerning treatment for guardians were identical regardless of the number of patients boarded.[4]

The demographic characteristics of patients in special licensed houses were, in general, indistinguishable from those placed singly, in that they were chronic, quiet and harmless.[5]

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[3] *Ibid.*

[4] These regulations are detailed in Chapter 7.

[5] *Vide infra* Chapter 6 for full description of demographic and mental characteristics of patients.

However, their backgrounds tended to be different. While many patients boarded singly had never been in an asylum, the majority placed in special licensed houses were former patients of an asylum. There are no examples of a related guardian being granted a license, probably due to the general recognition that the quality of care bestowed by such guardians was inferior to that offered by strangers.[6] This provision, as with the boarding-out of single cases, was applicable largely to pauper patients, although private patients were also accommodated on a more limited scale. For example, by 1864, when 21 special licenses had been granted, 16 were for the reception of pauper patients and only 5 for private patients.[7] The Commissioners expressed surprise at the limited degree to which such houses had been used for private cases, although in 1882, 42 of 128 boarded-out private patients were in special licensed houses.[8]

The term "lunatic colony" was often applied to aggregations of special licensed houses, observers drawing on parallels to the system in Gheel and other European lunatic colonies. However, in practice, there were few similarities to the colonies overseas and, although the Board of Lunacy adopted the term "colony" on occasion, it was eager to stress that the Scottish system and its origin had little in common with Gheel. Although there were districts in Scotland where many patients were boarded-out in close proximity, the dispersion of single patients throughout the country of, initially, the great majority of patients, and always at least 30% of the total number, was a vital part of the system. Further, Gheel and other foreign colonies accommodated patients with a wider variety of mental incapacity.[9] Scottish alienists outlined the differences repeatedly, expressing frustration that the system in Scotland was often perceived to be little more than a "Scottish Gheel". While the Commissioners recognised that the success of aggregations in the villages of Kennoway, Balfron and Aberfoyle indicated that it would be quite possible to replicate the system of Gheel, they concluded that it would be unwise to attempt to create such an institution. Where conditions favoured the development of an aggregation, the Board considered this should be allowed to operate, but, as Fraser observed, such a development had received "no special fostering from the Board."[10] Echoing this, Deputy

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[6] *Vide infra* Chapter 7 for an assessment of the standards of care found among related and unrelated guardians.
[7] GBCLS 7th AR (1865), main report, pxxv.
[8] GBCLS 22nd AR (1882), main report, pix.
[9] *Vide infra* Chapter 14 for a discussion of the major differences. This chapter explores in detail the similarities and differences between the Scottish system and those in Europe, particularly Gheel and the United States.
[10] GBCLS 22nd AR (1880), p123.

Commissioner Paterson announced that the existence of special licensed houses in particular localities:

> "which has led so many to imagine that the out-door system of providing for lunatics in Scotland was but a reproduction of that of Gheel, has been rather the result of accidental circumstances than of any efforts by the Board."[11]

The aggregation of special licensed houses in the village of Kennoway was the most well-known to observers of the boarding-out system.[12] Physicians and administrators from overseas were taken, almost invariably, to this village, thereby creating the false impression that the grouping together of lunatics in small areas was the archetypal feature of the Scottish boarding-out system. While this was misleading, the importance of "colonies" such as that at Kennoway cannot be disputed. These villages became well-known for the presence of insane residents and the memory of this remains strong in Kennoway today.[13]

5.2 Granting and withdrawal of special licenses

The procedure for granting licenses for residence in private dwellings was rigorous and extensive. Following the Act of 1862, licenses were applied for frequently and granted where the guardianship and accommodation were certified to be suitable. However, only ten years after the introduction of licensed houses, the Board of Lunacy had become increasingly reluctant to grant licenses for more than two patients and would only do so after the house had been visited and approved by a Deputy Commissioner. Further, licenses were granted only to experienced guardians, who could show that they were: "engaged in some form of occupation which makes it probable that he and the patients will spend much time together."[14]

For several reasons, the Commissioners became aware that houses suitable for the accommodation of two patients, could prove to be unsatisfactory when they housed three or four. In particular, special emphasis was placed on the importance of patients sharing fully in the daily life of the household, which, the Commissioners asserted, was difficult to achieve when more than two patients lived together because, "they overwhelm and destroy,

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[11] GBCLS 17th AR (1875), p254.
[12] An extensive description of the village of Kennoway, taken largely from the observations of Mitchell, one of the great enthusiasts of the system, is found in Appendix 5.
[13] On a visit to Kennoway in 1994, several villagers remembered the time when patients lived among them. Their reminiscences are recorded in Chapter 15.
[14] GBCLS 36th AR (1894), p104.

instead of contributing to, the family life."[15] The house was thought to be more likely to take on the characteristics of a small asylum and a tendency among some guardians to relegate patients to special rooms and to serve their meals separately was reported, thereby depriving them of the company of "sane associates." This was particularly unwelcome to the Commissioners, as the chief objective of the boarding-out system, emphasised throughout their annual reports, was that patients should be placed in "as similar circumstances possible as they would be in if not insane."[16] By the turn of the century, the policy was firmly set against allowing three or four patients to reside in one house, except where circumstances were "exceptionally favourable."[17] Despite the concerns of the Board, however, many houses licensed for more than two patients were seen to offer extremely satisfactory accommodation and treatment. Therefore, no measures were taken to reduce the existing number of licenses for three and four patients. Instead, new licenses were rarely granted, and the number of such houses declined gradually, following the death of a guardian, or the removal of patients.

In view of the emphasis placed on ensuring that patients were able to participate fully in the life of the household, the combination noted by one Commissioner is particularly unusual. Turnbull reported on an elderly widowed guardian in Kennoway, caring for two female lunatics, as well as a ten year old girl and a blind woman. As he observed, it was "a matter of surprise that so many dependants differing so materially in their mental and physical conditions should receive common care under the same cottage roof."[18] It was far more usual to find patients of a similar age boarded together in a licensed house, as sole boarders. The presence of sane, paying boarders was considered inappropriate by the Board of Lunacy, which argued that guardians should devote their attention exclusively to their insane patients. Licenses were, therefore, seldom granted to households such as this.

In 1876, 14 years after the introduction of special licenses, there were 78 special licensed houses, of which 30 (38%) were for two or more patients. Over 30 years later, 184 (32%) were licensed for the reception of three or four patients (Figure 5.1). The large number of

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[15] GBCLS 15th AR (1873), p293. This concern was noted frequently. Sutherland, for example, observed that "we need unmistakable evidence that the guardians are equal to the task of supervision and of providing suitable outlets for work. Sutherland, J.F. (1897) *op.cit.*, p39.
[16] GBCLS 38th AR (1896), main report, pxliv.
[17] Spence, T.W.L. (1902) *op.cit.*, p633.
[18] GBCLS 29th AR (1887), p139.

licenses for more than two patients was attributed to the action of officials from large parishes. Where three or four patients were lodged together, the burden of administration was reduced by the diminished labour of visitation for inspectors. Further, many guardians of two patients had spare accommodation and appeared able to take on the care of additional patients. Accommodation already proven to be of a favourable standard was utilised and, as inspectors of poor recognised, the keeping of three or more patients was more profitable than having only one or two. With this in mind, they suggested that guardians attached greater value to the license and were more anxious to perform their duties in a way which ensured their retention of it. They also claimed, although the nature of their records make this impossible to verify, that a higher class of guardians could be found for the reception of a group of four. Therefore, houses continued to be licensed for more than two patients, where significantly, more than two-thirds of the residents were female.[19] However the Commissioners' reluctance to do so was recorded frequently.

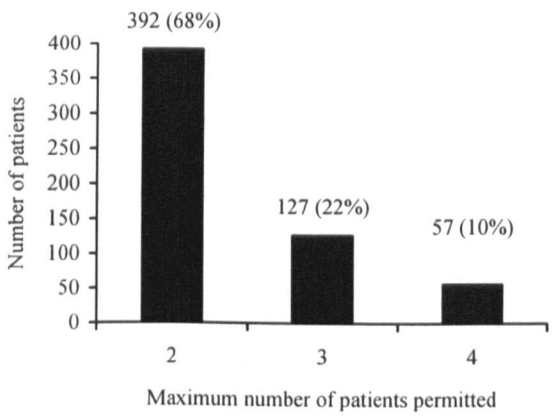

Figure 5.1 Classes of special licensed house for pauper patients, 1907[20]

There were comparatively few reports of special licenses being withdrawn by the Board of Lunacy. The Commissioners paid frequent visits to houses where the accommodation or treatment of patients was considered unsatisfactory. On occasion, they recommended the removal of a patient allowing the guardian to keep a reduced number, usually one, insisting that no more patients could be received unless conditions were improved. The fluctuation and occasional decline in the number of special licensed houses can be attributed less to dissatisfaction with the manner in which the houses were run, than to the death of a

[19] *Vide infra* Chapter 6.
[20] Source of data: GBCLS 49th AR (1907), main report, pxliii.

guardian, or as a result of moving house, or resigning the license through choice. Between 1862 and 1873, 53 out of 156 licenses had ceased (Table 5.1). Fifteen had been licenses for the reception of private lunatics and it was considered that there were "many private reasons why the holder should no longer wish to continue." Six were cancelled following an unfavourable report from the Visiting Commissioner and others lapsed because the holders obtained no patients. Of 16 licenses granted in the first two years, nine were still in force 11 years later, with six of the original patients remaining.

Reasons for cancellation	Licenses for private patients	Licenses for pauper patients	Total
Resignation by holder	6	4	10
Death of holder	2	4	6
Change of residence	0	4	4
Surrender in exchange for another license	2	6	8
No patients	2	5	7
On recommendation by inspector of poor	0	11	11
By resolution of the Board (unfavourably reported on by Visiting Commissioner)	2	4	6
Unknown	1	0	1
Total	15	38	53

Table 5.1 Reasons for the cancellation or lapse of licenses, 1862-1875 [21]

Among specific cases where it had become necessary to cancel the license, one involved a house which had been licensed for 20 years, with satisfactory reports. However, through illness, the guardian had become unable to care for the patients, and although a sister had taken over, she had proved to be "of such intemperate habits as to be quite unsuitable for the care of any house." Another house had been licensed for seven years, but had never been wholly satisfactory. The patients had been well cared for, but, according to the Commissioners, they were never contented. Initially the guardian had been allocated male patients, but they were replaced by females "in the hope that she would get on better with them."[22] However, the Visiting Commissioner, Macpherson, concluded that her temper made her unsuitable to care for any patients and, as the female patients proved equally unhappy, the license was cancelled. Throughout the period of this study, however, the withdrawal of licenses due to unfavourable conditions was rare, with no such action being

[21] Source of data: GBCLS 17th AR (1875), p255.
[22] GBCLS 51st AR (1909), p155.

taken in most years which, as the Board maintained, was testimony to the careful selection of patients and guardians, by both parish officials and Deputy Commissioners.

5.3 Aggregations of insane patients

Special licensed houses were spread across Scotland and, while many districts contained only one or two such houses, certain parishes became notable for the particularly large presence of insane patients (Figure 5.2). The growth of such aggregations was most marked in the 1870s, in Fifeshire, Stirlingshire and Perthshire, until the Board of Lunacy was compelled to limit their development, forcing parish officials to adopt new localities.[23]

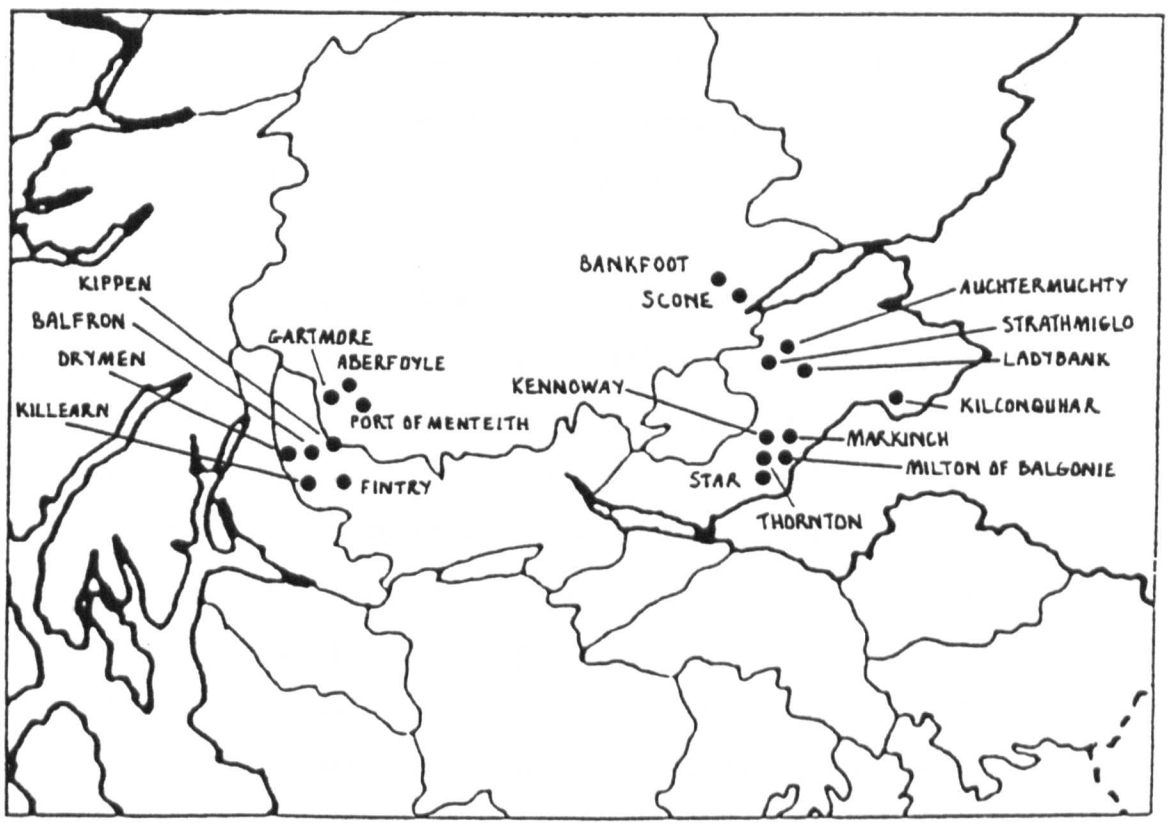

Figure 5.2 Location of major aggregations of special licensed houses in 1880[24]

[23] Special licensed houses continued to flourish in these locations, however. See Appendix 7 for description of patients boarded in the counties of Lanark, Perth and Fife in 1906.

[24] The year 1880 has been selected to illustrate the concentration of houses in central Scotland, particularly Fifeshire, which had prompted the Board of Lunacy to order a limitation in the number of licenses to be issued in the area. Only aggregations with over 10 patients boarded-out in a small area have been indicated.

Reports in medical journals, particularly those from overseas observers, indicate a tendency to focus on these specific districts when discussing the system of boarding-out. The existence of aggregations of the insane in these small villages was attributed initially to the success that ensued from Edinburgh parish officials boarding-out pauper children in the village of Kennoway, Fifeshire and, from 1862, they began to send pauper lunatics as well.[25] Several neighbouring parishes in the county of Fife were also deemed suitable for the reception of lunatics, and, in this way, an aggregation of insane patients developed rapidly, facilitated by a steady supply of guardians and suitable accommodation.

Within the first few years of the introduction of special licenses, applications for patients from certain villages rose rapidly, following the realisation that the presence of an insane patient caused no problems and that the payment could constitute a valuable addition to a family's finances. In this way, the sphere of willing applicants widened, enabling greater discernment to be applied in the selection of guardians and it is apparent that the expansion of special licensed houses was facilitated by word of mouth, independent of officials.

One characteristic feature of the location of aggregations was their tendency to occur in places which had once been active areas of industry, for example, centres of hand-loom weaving, which from the mid-century underwent a rapid decline with the introduction of power looms. The population in these districts had decreased, with the exodus of younger people to urban centres in search of employment. In turn, their departure created superfluous accommodation. Although the positive effect of the presence of patients in certain locations was perhaps exaggerated by the Commissioners, their comments throughout annual reports from the 1870s indicate their conviction that the development of special licensed houses had saved certain Fifeshire villages from extinction.

Figure 5.3 displays the distribution and capacity of special licensed houses in the counties and districts where this form of boarding-out was most actively pursued. The year selected, 1893, illustrates clearly the degree of variation among districts, although any year from the early 1870s onwards would serve to indicate the extensive disparity and the particular predominance of such houses in Fifeshire when contrasted to other locations.

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[25] The system of boarding-out pauper children by parochial boards throughout Scotland is examined in detail in Macdonald, H. (1994) *Care of children under the Scottish Poor Law*. Ph.D. thesis (unpublished) University of Glasgow.

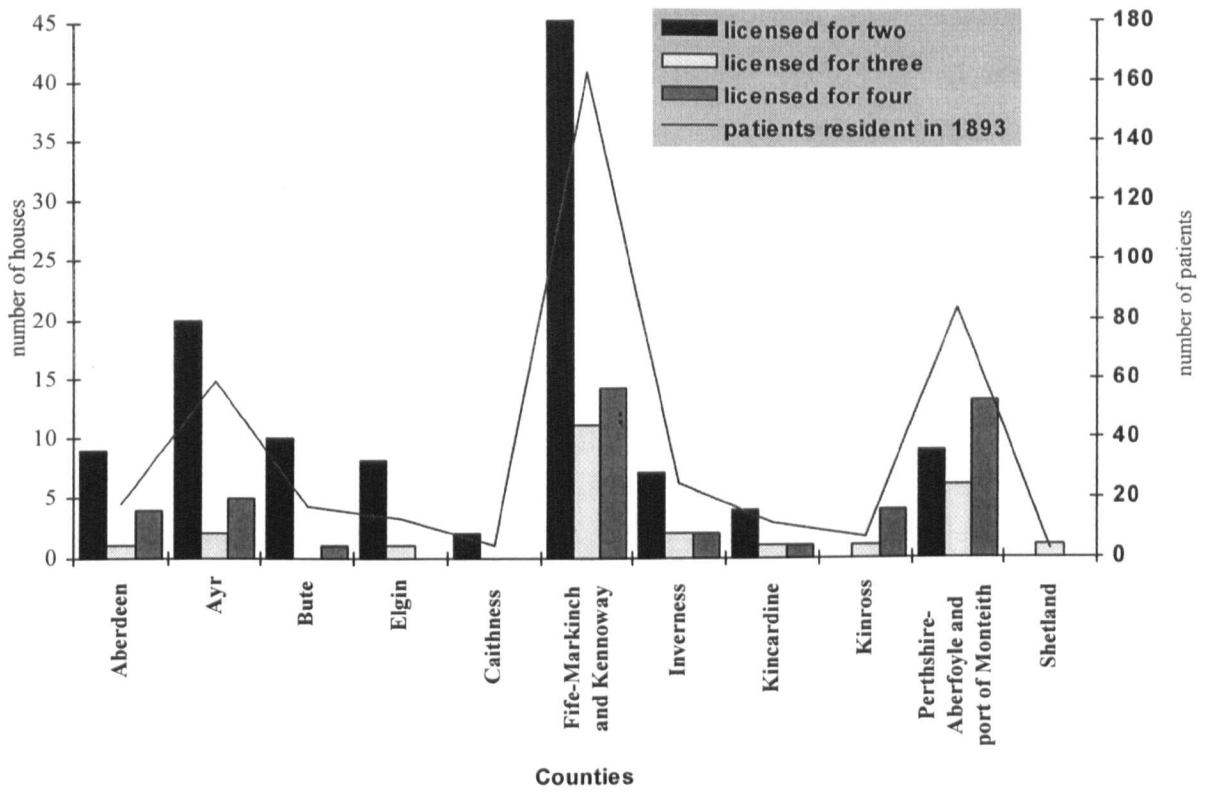

Figure 5.3 Distribution and capacity of special licensed houses, 1893[26]

Although remarkably few objections were raised against the aggregations, there was concern by the Commissioners and the general public that the presence of large numbers of insane persons would make them appear too prominent.[27] The aim, expressed repeatedly by the Board of Lunacy, was to restore patients as far as possible to the circumstances of ordinary life and to expose them to contact with sane persons. However, if they were in a village where the insane were "so numerous as to form an appreciable element of the population"[28], patients could lose the benefits of domestic life and be treated as a class apart from the rest of the community. The Commissioners maintained that such a distinction would create in the guardians "a mental attitude which lessens the likelihood of the patients being looked on and treated as ordinary members of the household."[29]

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[26] Source of data: GBCLS 36th AR (1894), p101. Unfortunately statistics for Stirlingshire, a district with a number of aggregations of special licensed houses were not available.

[27] *Vide infra* Chapter 10 for a description of severe criticisms levelled against lunatics boarded in Kennoway and Collessie.

[28] GBCLS 36th AR (1894), main report, pxliv.

[29] GBCLS 38th AR (1896), main report, pxliv.

There was also some anxiety by Commissioners and parochial officials at the possibility that one small district could be overrun by insane patients from other parishes, and that if patients formed a noticeable element in the population, public feeling might become unfavourable. Paterson's observation illustrates this, when he remarked that officials from certain parishes had, in an attempt to avoid the trouble involved in finding suitable accommodation in new locations, "invaded the district and even the very houses in which lunatics were already lodged."[30] He also noted the resulting problems created by divided authority and management, and of the "inconveniently large aggregations of cases within a limited area."[31] In 1877, therefore, the Board of Lunacy prohibited any increase in the number of lunatics boarded at Kennoway; a similar prohibition was enforced in 1885 at Balfron, in Stirlingshire, and the possibility of doing so for other villages was considered. The Commissioners determined that no patients could be received into a special licensed house where there was already a patient chargeable to any other parish, without the consent of the inspector of poor of that parish. At the same time the Board of Lunacy emphasised that there were many other places which were equally suitable for the reception of the insane. Despite this action, however, the number of patients residing in these areas remained high for several years.

In the villages of Kennoway, Star, Auchtermuchty, Gartmore and Scone, patients were located in an area no greater than one square mile. The effect of the determination of the Commissioners to reduce the density of patients was evident towards the end of the century, when numerous special licensed houses were visited which were comparatively scattered, often being so far apart that when making official visits "it is expedient to drive, not walk".[32] This dispersal of patients was encouraged strongly by the Commissioners, who recorded their satisfaction that "the policy of preventing over much aggregation is being successfully pursued".[33] Rather than encouraging large village aggregations, the system of small colonies in agricultural districts was favoured, and by 1900, a steady diminution of numbers in the larger aggregations was apparent.

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[30] GBCLS 17th AR (1875), p255.
[31] *Ibid.*
[32] GBCLS 36th AR (1894), p103.
[33] *Ibid.*

5.3.1 Fifeshire

More patients were boarded in special licensed houses in Fife than in any other district. Its accessible position, the proliferation of small villages in the county, the high proportion of small-holdings and the "thrifty homely character of the people" were held by the Commissioners to make the district inherently suitable for the reception of large numbers of patients. In addition, they highlighted the "almost complete decadence of the handloom weaving", which had deprived many villagers of employment The most prominent parishes utilised for boarding-out were Kennoway, Star and Markinch, where villagers became familiar with the presence of the insane and made frequent requests for patients. For several years from 1862, only patients from Edinburgh were boarded in Fife. Within ten years, however, inspectors of poor from a number of other urban parishes sent large numbers of insane patients, and the annual statistics of boarded-out patients record a striking increase throughout the district.[34]

By 1897, the proportion of insane patients to the population in Fifeshire was 1 to 75 (with 489 patients residing among a population of 28,976).[35] Nearly 80% (394) were located in a small area of 6 miles by 15 miles. Only two other colonies exceeded these proportions; Dun-sur-Auron, in France, with 500 patients in 1897, and Gheel in Belgium, the first and largest colony of its kind, with 1983 patients scattered over an area of 40 square miles, among a general population of approximately 7000.[36] With these figures in mind, the Board maintained that there was no cause for over-riding concern that the insane formed too large a proportion of the population. However, its determination to reduce the size of aggregations was apparent. In 1889, for example, the number of patients visited by Commissioners in Markinch and Kennoway was almost as high as the number residing in all the other parishes in the county, but by 1892, the number of patients in the two villages had diminished slightly, from 174 to 168. In the same three year period, other parishes in Fife saw an increase, from 182 to 237 patients.[37] The caution insisted upon by the Commissioners had been effective.

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[34] As the Commissioners observed, "Fife has for more than 30 years been regarded by the authorities of large urban parishes as a county which offered special facilities for boarding-out harmless lunatics". GBCLS 38th AR (1896), main report, pxliii.
[35] GBCLS 39th AR (1897), p123.
[36] *Ibid* and *vide infra* Chapter 14.
[37] GBCLS 35th AR (1893), p106.

Conditions for patients boarded-out in Fifeshire were little different from those prevailing throughout Scotland. However, overseas visitors were usually taken to Kennoway, and, although less frequently, to Markinch and Star, due, it seems, to their longevity as locations for boarding-out and to their greater size. The continued feting of Kennoway as the embodiment of the boarding-out system proved to be an irritant to critics who complained that the village was:

> "patronised, petted, fostered by the Board of Lunacy; the cottages, families, and their insane charges have been selected, and the whole entourage sustained at a high standard by frequent visitation and by the general interest and attention directed to the experiment."[38]

This being so, it might be expected that the existing standard of care would be somewhat superior to the less renown aggregations of special licensed houses on the west coast or Inverness-shire. In fact, conditions elsewhere were also of a steadily high standard. Nevertheless, reports by urban parish officials regarding Kennoway were particularly favourable, and they considered that "no better locality could be found for boarding-out."[39]

5.3.2 Perthshire

Perthshire became another centre for the aggregation of patients in specially licensed houses, and was also a popular location for patients boarded singly, dispersed throughout the district. The number of patients sent there increased rapidly in the 1880s, although not on the same scale as in Fifeshire. For example, from 1884 to 1887, the number of patients boarded-out in Perthshire increased by 35%, while in Fife in the same period, an increase of 120% was recorded.[40] Nevertheless, by 1898, it was reported that Perthshire had the largest increase of patients accommodated in special licensed houses in any county, 50 being boarded there with relatives, and 250 with strangers.[41] The majority of patients, as in Fifeshire, came from Glasgow, and Edinburgh, although a considerable number were also referred from Stirling District Asylum.

One of the first aggregations to develop was in the village of Gartmore, near Aberfoyle. 76 patients were boarded there in 1907, making it the largest colony of insane patients in the county.[42] However, just as in Fifeshire, and despite confidence in the proper treatment of

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[38] Shaftesbury, giving evidence to Select Committee of 1877. Documented in the Dillwyn Committee report of the same year, p6.
[39] Barony Parish Report by Visiting Committee (1898), Fife District. p4.
[40] GBCLS 30th AR (1888), p118.
[41] GBCLS 41st AR (1899), p145.
[42] GBCLS 49th AR (1907), p152.

patients, and the lack of any recorded objections by inhabitants, the Commissioners expressed concern, on occasion, that so many were resident within such a circumscribed area. Patients were also boarded at Aberfoyle, and in the parishes of Port of Menteith and Bankfoot, the latter a small village accommodating 27 patients in 17 houses, markedly less than Gartmore and established many years later. A group of small agricultural holdings in the neighbourhood of Braco flourished, with 24 patients boarded in 15 houses within an area of 6 by 4 miles. The Commissioners recognised that such localities presented excellent locations for boarding-out, observing with satisfaction that as the district was cultivated by small farmers with holdings in close proximity to each other, guardians were easily supervised, and the "example of proper care [was] communicated from one house to another."[43] Further, the houses were not too large to prevent patients sharing in family life, and the agricultural work provided enhanced opportunities for boarding-out male patients.

The conclusions of officials from Glasgow City parish, following their regular visits to Gartmore and adjoining districts, were favourable. In 1898, when 52 patients from Glasgow were boarded in the area (14 men and 38 women), reports indicated that they were clean and well cared for, and that their "general aspect...indicated contentment, and their relations with their guardians are obviously of a friendly character."[44] Nevertheless, on the instructions of the Board of Lunacy, a reduction in the number of patients sent to the district from Glasgow took place, with a decline from 70 patients in 1895 to 52 five years later.[45] This was due to the utilisation of new districts, as Lanark and New Scone became important centres for patients from Glasgow City parish.

5.3.3 Stirlingshire

The largest aggregation of special licensed houses in Stirlingshire was in the village of Balfron. A significant number of patients were also boarded in the neighbouring parish of Drymen and in the villages of Kippen, Fintry and Killearn. Again, the majority of patients were sent from large urban parishes, particularly from Glasgow. In 1863, only one year after the passage of the Amendment Act, Glasgow City Parochial Board had sent a deputation to Balfron and Killearn, with the intention of discovering residences for a

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[43] *Ibid.*, p153.
[44] Lists of children boarded-out by Barony parish: includes lists of boarded-out patients, Strathclyde Regional Archives, D.HEW 24.14. (1898) p4.
[45] *Ibid.*

number of their insane patients.[46] However, there was apprehension among villagers at the presence of the insane and difficulties were reported in finding suitable houses and agreeing upon adequate remuneration of guardians. Nevertheless, four houses were selected to receive eight patients from the parochial asylum and within ten years, 30 patients were accommodated there.[47]

Throughout the 1870s and 1880s, approximately 1500 inhabitants resided in Balfron, employed mainly in rural occupations, in particular on dairy and stock-rearing farms. The Commissioners regarded the village as particularly suitable for the reception of boarded-out patients, especially since almost every house had a large garden, offering employment for the insane residents. By 1889, following concerted activity by the local inspector of poor, 52 patients were boarded there and, according to the Commissioners, "could not be happier, healthier and more comfortable or contented in the wards of an asylum"[48] However, despite approval of prevailing conditions, as in other districts, concern was expressed at the increasing "undesirable aggregation" of the insane. This had occurred due to the enthusiasm of villagers, who, having overcome their initial fears, actually visited the inspector of poor in Glasgow, requesting patients "such as their neighbours had."[49] The Board of Lunacy was forced to intervene again, to prevent any further additions. Neighbouring villages, however, continued to receive patients and Stirlingshire remained a favoured location for the accommodation of large numbers of pauper patients.

5.3.4 Inverness-shire

The most northerly aggregation of special licensed houses was in Inverness-shire, in Leachkin and in the city of Inverness (Appendix 6). From the late-1880s, the Commissioners had reported a steady increase in the number of patients boarded-out in the district[50] and many crofters' houses in Leachkin and Aberiachin, on the populated slopes near Loch Ness, accommodated one or more patients. In 1897, for example, Leachkin, two miles from Inverness, had a population of 115, and a colony of ten male and ten female

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[46] Paterson, in his annual report, reprinted a detailed, incisive report issued by the Parochial Board of Glasgow, Deputation from the House Committee appointed to visit the insane belonging to the Parish of Glasgow boarded in Licensed Houses in the Country." GBCLS 15th AR (1873), p274.
[47] *Ibid.*
[48] GBCLS 31st AR (1889), p122.
[49] *Ibid.*, p121.
[50] Discussed in, for example, GBCLS 33rd AR (1891), p100 and 34th AR (1892), p104.

patients, in 13 farmhouses dispersed over a square mile. There were ten other houses in the area, with no patients. The proportion of insane to sane residents throughout the 1880s and 1890s was 1 to 5.75 (17%), considerably higher than the aggregations in Fife, Stirling and Perthshire.[51] While this appeared extremely high, the Board of Lunacy, in contrast to its concerns regarding other aggregations, was not unduly concerned. In this instance the Commissioners maintained that Leachkin was not a village in any sense of the term and, therefore, bore no real comparison to the other aggregations. There were large fields between each farmhouse, and crofts of between six and 12 acres which offered suitable employment to patients. To the Commissioners this was "an ideal settlement."[52] Patients were better occupied and provided for than if they were in a crowded town or an overcrowded asylum. Although no house was licensed for the reception of four patients, two had three residents, three had two and the majority, eight, had one. Leachkin, therefore, provides a good example of an aggregation of patients where not all residents were in special licensed houses.

Sustained activity was also recorded in the parish of Inverness. Lawson observed that the inspector of poor had "developed the admirable resources of that town, and the neighbourhood, to an extent one would scarcely have thought possible".[53] It was unusual for an aggregation of patients to be found in an urban area. However, by the very contrast in the degree of industrialised work and occupation available in the city of Inverness, conditions were hardly comparable to those found in such overcrowded and busy centres as Glasgow or Dundee. Thus, while attempts to limit the size of aggregations in the rest of Scotland were reported frequently, there was no such anxiety about the considerable number of insane boarded in close proximity in centres north of Perth.

5.3.5 Other aggregations

A number of other districts accommodated patients in special licensed houses in small aggregations. In the 1890s, parochial officials turned to the counties of Ayr and Banff in particular, in their search for suitable accommodation. Developments in these locations were later than those in central Scotland, with marked growth from the turn of the century.

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[51] GBCLS 39th AR (1897), p124.
[52] *Ibid.*
[53] GBCLS 27th AR (1885), p142.

Their existence and expansion was a clear response to the determination of the Board of Lunacy to prevent continued growth in already widely utilised villages.

In Ayrshire, in 1909, 103 of 181 boarded-out pauper patients, mainly chargeable to the parish of Glasgow, lived in special licensed houses.[54] They were distributed, broadly, into three colonies, the oldest being Ballantrae in the south of the county, which developed in the early 1890s. The village, which was "in easy reach of Glasgow and Edinburgh"[55] contained 57 patients and, as with other village colonies, the larger proportion (49) were female. All but two were placed in special licensed houses. Macpherson praised the quality of care at Ballantrae, noting that regular inspection had led to the elimination of unsuitable guardians and patients, thereby enabling the attainment of a "high standard of efficiency and education" among the guardians:

> "Consequently the colony, in point of uniformity in the care of patients and acquiescence on the part of the guardians, in all official regulations, resembles a well regulated institution."[56]

The villages of Stewarton, Beith and Dunlop were also utilised. In 1909, this district contained 34 patients, of whom 25 were in special licensed houses and again females (27) were predominant. This colony was smaller and of later origin than that of Ballantrae, but in the opinion of the Commissioners, "it promises to become one of the most interesting colonies in the country."[57] The third aggregation in Ayrshire was located on the western seaboard of the county, from Girvan to Maybole. In the early 1900s, 38 patients were boarded there. Unlike the village colonies, the majority of patients in this rural area were male, there being only eight females. This was attributed to the greater enthusiasm of small-holders to receive men, who could be useful on their land. In this aggregation, again unlike the other colonies of Ayrshire, more patients were located in unlicensed houses, with 26 of the 38 patients boarded singly.[58] This scattered rural colony, therefore, cannot be compared fully to more highly organised colonies such as Ballantrae.

The last significant colony to develop in Scotland was in the fishing villages in Rathven, Banffshire, in the mid-1890s. This rural district was populated sparsely by crofters and small farmers. When visited by the Commissioners for the first time in 1895, four patients

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[54] GBCLS 51st AR (1909), p146.
[55] GBCLS 32nd AR (1890), p110.
[56] GBCLS 51st AR (1909), p146.
[57] *Ibid.*
[58] *Ibid.*, p147.

resided there. By 1908, Rathven, with the neighbouring parishes of Fordyce and Deskford, was reported to be a "vigorous and prosperous colony" with 44 patients (26 male and 18 female) scattered over a district of 30 square miles. Thirteen were in houses licensed for two patients, 13 were boarded with relatives and the remainder with unrelated guardians.[59] The presence of so many patients was attributed to the work of Deputy Commissioner Fraser, who, following a visit to the district in 1889, encouraged parochial officers to board-out any suitable patients. One Commissioner, visiting many years later, was able to conclude that:

> "one of the most pleasing visits of the year is the day spent visiting the little colony in the parish of Deskford, in Banffshire... I was informed that in earlier years the introduction of insane patients was looked on with disfavour by the estate management, but experience of the good conduct of the patients, and the advantage of their presence to the tenants has removed all objections then made."[60]

5.4 Predominance of patients from Edinburgh and Glasgow

One of the most important purposes of special licensed houses lay in accommodating patients who could not be provided for otherwise, having no suitable relatives, or relatives who lived in large cities, where residence for boarded-out patients was not encouraged. Due to the lack of suitable accommodation in many towns, the discovery of villages in certain districts was welcomed.[61] Without the opportunity of discharging patients to quiet, rural villages, city parishes would have been severely restricted in finding suitable homes. Although theoretically attainable in any rural location, in practice it was the aggregations in central Scotland which offered a steady supply of houses and guardians, for patients from urban locations, thus minimising the initial work of inspectors of poor in searching for satisfactory accommodation. There was the added benefit that the development of such houses in healthy rural settings was considered beneficial. As Paterson observed:

> "in the cases of single patients it is the desire of the Board to disturb as little as necessary the family relationships and domestic associations of the lunatic. In some cases it is necessary to do so, especially in the case of large towns, the crowded lanes and dwellings of which are not desirable residences for the insane...It is principally to meet such cases that the system of special licensed houses...is found to be so useful."[62]

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[59] *Ibid.*, p152.
[60] GBCLS 48th AR (1906), p172 Another colony flourished at Kirkfieldbank in the parish of Lesmahagow, two miles from Lanark, 32 patients were boarded among a population of 828. Again the majority were chargeable to the urban parishes of Glasgow, and Paisley. GBCLS 39th AR (1897), p125.
[61] GBCLS 12th AR (1870), p272.
[62] GBCLS 16th AR (1874), p307.

It follows that parochial officials from the City parishes of Glasgow and Edinburgh were the first, and always the most active in sending their patients to such houses. Out of 118 applications for residence in special licensed houses, granted in 1870, 53 were from the City parishes of Edinburgh and Glasgow, 10 from Abbey parish, Paisley, and 18 from other town parishes, all for houses situated beyond the bounds of their own parishes.[63] Most patients boarded-out from Edinburgh were sent to Fife, in 1870, for example, 27 of 55 pauper lunatics residing there were from Edinburgh.[64] Officials from Glasgow City parish utilised locations in Perth and Stirling predominately, and in 1870, 30 out of 50 patients boarded in these districts came from Glasgow.[65] This indicates that one of the most important purposes of special licensed houses was in providing healthy, quiet accommodation for those patients whose homes were situated in crowded, highly populated centres.

The figures recording the number of patients chargeable to Glasgow or Edinburgh City parishes discharged from asylums and boarded-out singly, as well as in special licensed houses, were from the 1870s, always among the highest of all Scottish parishes. This is a reflection not just of the necessity to resort to such a system, but also definite approval of this option by their parish officials. Asylums in these two urban areas suffered from problems of overcrowding, but they were not alone in this. Dundee, Greenock and Aberdeen all experienced similar difficulties, but were never active in sending patients to special licensed houses.[66] The Commissioners considered that while it was natural that two of the largest and most important of town parishes should have been the first to adopt the policy, other parishes could benefit from sending their patients to special licensed houses. They were aware, too, that it was only the "city" parishes of Edinburgh and Glasgow that were active, "the other parochial boards, representing large and populous districts of both cities have so far evinced no disposition to take it up."[67] Even when other parishes began to

[63] GBCLS 12th AR (1870), p254.
[64] GBCLS 12th AR (1870), p254. Four years earlier, in 1866, 19 patients were boarded-out in special licensed houses from Edinburgh City parish, of whom 10 were boarded in Kennoway, 4 in Loanhead, 3 in Costorphine, 1 in Markinch and 1 in Biggar. In 1876, 35 were in special licensed houses, 17 were in Kennoway, 8 at Markinch. In 1884, 58 were boarded-out, 20 in Kennoway (Lists of Poor, Edinburgh City archives).
[65] GBCLS 12th AR (1870), p254.
[66] Although by the 1890s the City parish of Dundee began to send considerable numbers to board in Fifeshire. Of 85 boarded-out from Dundee City, (24 male and 61 female) 4 were sent to Kennoway, 2 to Windygates, 16 to Thornton, 14 to Star, 5 to Markinch, and 12 to Auchtermuchty. Minutes of Dundee Parochial Board (1900).
[67] GBCLS 9th AR (1867), p264.

utilise the option of special licensed houses, patients from Glasgow and Edinburgh continued to be the most numerous in the aggregations of central Scotland.

5.5 Growth of special licensed houses

The growth of special licensed houses was comparatively slow, to the surprise of the Board of Lunacy. In the first two years following legal enactment, only 21 houses received licenses for the reception of two to four patients; 35 patients were accommodated within them.[68] The Commissioners agreed unanimously that while the option of boarding patients in special licensed houses was a useful adjunct to existing lunacy provision, "no active efforts have been made or should be made, to develop the system."[69] Thus, by the early 1870s, the system had attained only "modest dimensions", and over 70% of boarded-out patients were still placed singly with relatives.[70]

The Board of Lunacy maintained that growth would remain limited, unless the removal of chronic pauper patients from asylums was made compulsory. Although this was never achieved, the rapid spread of special licensed houses in the 1870s, continuing over several decades, testified to the utility of providing for a small number of lunatics under one roof, often in circumscribed locations. Paterson, one of the first Commissioners, while expressing cautious confidence in the growing number of special licensed houses, recognised that if boarding-out patients from asylums was:

> "destined to prevail to any extent in Scotland, it will probably develop itself in this direction... but however valuable and important an auxiliary they may become in the future, they have not yet attained such proportions as materially to affect the numbers in asylums."[71]

By the mid 1870s, a steady increase in the granting of licenses was apparent. This was attributed to a widespread recognition that the existence of special licensed houses had already proved "a convenience to the public, and a benefit to...friendless patients, who could not otherwise have enjoyed the great liberty accorded to them."[72] Visitation of patients was undertaken by two Deputy Commissioners, each covering approximately half of Scotland. When visiting his half of the lunacy districts in 1879, Lawson recorded that 62 pauper patients were in specially licensed houses. When he visited the same area in 1893

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[68] GBCLS 7th AR (1865), main report, pxxv.
[69] GBCLS 11th AR (1869), p296.
[70] In the 12 counties visited by Paterson in 1872, out of 701 lunatics, only 89 were lodged in special licensed houses. GBCLS 16th AR (1874), p306.
[71] GBCLS 9th AR (1868), p242.
[72] GBCLS 11th AR (1869), p296.

there were 729. The increase is impressive, particularly when contrasted to the statistics of single patients for the same area; in 1879, Lawson visited 634 patients in single dwellings, but by 1893, this had only risen to 680.[73] One important observation, however, regarding houses where single patients were boarded with unrelated guardians, was that a significant proportion of existing guardians expressed a desire to accommodate more than one patient. Many applied for special licenses, thereby creating a tendency for the number of single patients to diminish as the number in specially licensed houses proliferated. The discrepancy between the growth in number boarded singly and those boarded in special licensed houses was most marked, predictably, in the districts of Fife, Perth and Stirling.

The continued endorsement of the Board of Lunacy for the accommodation of insane patients in special licensed houses is evident in the steady increase in the number of licenses issued during the 1880s and 1890s. During the eight years after the 1862 Amendment Act, 96 special licenses were granted, whereas between 1885 and 1890, 357 were issued. A total of 770 special licenses were granted between 1862 and 1890, of which 310 had been cancelled and 460 remained in use, receiving 925 patients.[74] The possibility that aggregations of the insane could overwhelm certain areas was taken seriously by the Commissioners, who limited the number of licenses granted in specific districts. Nevertheless, the number of boarded-out patients in special licensed dwellings continued to rise during the early years of the twentieth century, through the utilisation of new locations. In 1913, 45% of pauper lunatics were boarded-out as single patients with 55% in special licensed houses.[75] In 1902, Spence, Secretary to the Board of Lunacy, confirmed that special licensed houses had become "of great importance as a means of providing for the insane poor," and, echoing the beliefs of Commissioners 40 years earlier, forecast accurately that "if the system undergoes further expansion it will doubtless be in this direction."[76]

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[73] Thus the increase in the number of patients provided for in special licensed houses was 667 whereas the rise in those provided for singly was only 46. GBCLS 36th AR (1894), p102. Similarly, in the shorter period between 1889 and 1893 there was an increase of 350 patients in special licensed houses, while the number of single patients rose by 141.
[74] GBCLS 32nd AR (1890), p110.
[75] GBCLS 55th AR, (1913), p167.
[76] Spence, T.W.L. (1902) *op.cit.*, p635.

5.6 Summary and conclusions

The growth in the number of special licensed houses was an extraordinary feature of the boarding-out system. From the outset, it was evident that the Commissioners favoured the growth of these houses, although as one observer recognised:

> "village colonies couldn't exist without the permission of the Board, but [they]are of natural growth. The determination of the locality has been accidental and the grouping of patients in particular villages chance".[77]

Although the Board of Lunacy never overtly encouraged the expansion of special licensed houses, the Commissioners were consistently enthusiastic about the advantages of such a system. With the growing proportion of patients being discharged from asylums as incurable, the existence of experienced guardians in locations where other patients had been boarded successfully, was welcomed. Despite the initially slow expansion, therefore, the system of granting special licenses flourished and by the turn of the nineteenth century, more patients were accommodated in such houses than were boarded singly.

The geographical spread of patients in special licensed houses was extensive. Many were placed in groups of between two and four, in locations where such houses were unusual. Others, although boarded singly, formed part of a colony, to the extent that they were lodged in close proximity to many other houses. However, it was the existence of colonies where up to four patients were placed together in one house in areas of central Scotland, that was one of the most remarkable features of boarding-out. There were many advantages to a system where patients were congregated into moderate-sized groups, not least that the work of visiting officials was reduced. Annual reports of the Commissioners praised the conditions in which the patients were boarded, and, further, commended the integration of the insane into the community and the greater personal freedom attainable.

Few criticisms were levelled specifically at the system of special licensed houses. Rather, any discontentment or cynicism concerned the whole system of boarding-out.[78] One of the most valid concerns was that large aggregations might make patients appear too distinctive and so increase the possibility of resentment among the community, but such fears were diminished by the actions of the Board. The Commissioners also questioned whether the growing tendency towards aggregation and alien guardianship was anomalous, in view of

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[77] Lindsay, W.L. (1871) *op.cit.*, p509.
[78] These criticisms are outlined in Chapter 10.

the aims of the lunacy administration to break up aggregations in institutions and return patients to a domestic setting. Therefore, while they were in favour of the provision of special licenses, they became increasingly vigilant in their determination that licenses should not be issued to guardians living in close proximity to existing licensed houses. Instead they recommended that new districts should be explored and utilised. In this they facilitated the growth of special licensed houses throughout Scotland.

Although the aggregations were often described as "Scottish Gheels", this view was highly inaccurate. Large numbers of patients were congregated together in villages such as Kennoway and Gartmore, but the total number is comparatively insignificant when compared to the volume of patients at Gheel. The change of attitude towards the system shown by Jolly, a well-known German alienist, following a visit to Kennoway in 1873, which had been undertaken with some scepticism, reflected the favourable conditions witnessed and highlighted the differences between Gheel and Scotland. He admitted to thinking, initially, of the Scottish system as ineffective and "having already within it the seeds of dissolution." However, his views were modified by his visit, after which he concluded, "I am convinced there is no Gheel in the North, but an organisation which rests on a quite different and much sounder basis".[79] His approval was echoed widely not only by the Board of Lunacy, but by many commentators on the Scottish lunacy system, nationally and internationally. By the end of the century, providing for patients in special licensed houses had become an integral and highly successful part of the Scottish system of boarding-out.

[79] Jolly, F. (1875) On the family care of the insane in Scotland. *Journal of Mental Science*, **21**, p41.

CHAPTER 6

CHARACTERISTICS AND EXPERIENCES OF BOARDED-OUT PATIENTS

6. Overview

The demographic characteristics, behavioural and clinical features of boarded-out patients are described in this chapter and their lifestyles and activities explored. The occurrence of pregnancy or sexual assault against patients and their exposure to potential violence is considered. Reasons for removal from private dwellings and admission to asylums are discussed and finally, an appraisal of the quality of care from the patient's perspective is attempted.

6.1 Introduction

Lunacy Commissioners determined what was an acceptable level of care for boarded-out patients. The standards of treatment and living conditions tolerated were often adjudged to be lower than those demanded in asylums. However, the benefits of living in a domestic setting and the lack of confinement were held, by proponents of boarding-out, to be sufficient compensation. The Commissioners asserted that the mental condition of many in private dwellings was broadly analogous to that of children, both being of an imperfect mental condition, the difference being that the condition in the child was only temporary. Many patients, particularly imbeciles and idiots, were considered to be as tractable as children, and so equally suitable for boarding-out. Thus Lindsay's assessment of the characteristics of suitable patients found favour with the Commissioners when he declared that many were "equally helpless, equally trustful, equally docile, calling for the same kind and degree of care" as children.[1] As the system became established, however, and more patients were discharged as incurable from asylums, increased variation in the mental condition of boarded-out patients became evident.

[1] Lindsay, W.L. (1871) *op.cit.*, p502.

Following their placement in a private dwelling, many patients remained with the same guardian for the rest of their lives and, if they outlived their guardian, they were sometimes placed under the care of the late guardian's son or daughter. The extended length of stay of a considerable majority of patients was testimony to the satisfactory conditions in which they lived and the careful selection of both patients and guardians. Nevertheless, perhaps inevitably, there was a small number of patients who lived an unsettled, insecure existence, being transferred frequently in and out of asylums. Upon discharge, patients were not always returned to their original guardian. Repeated changes in residence were attributed to inadequate care by guardians, unsuitable living conditions, the existence of ill-feeling between the two parties, or, most frequently, inappropriate behaviour from patients. A number of guardians refused to keep their patients, if their habits or personalities became a source of annoyance.[2]

Available records indicate that, in general, facilitated by the increased vigilance of official visitors, living standards of boarded-out patients rose steadily[3] and the Commissioners expressed confidence that the selection of both patients and guardians by inspectors of poor had become steadily more skilled. As a result, notwithstanding inevitable exceptions, the stability of both the system itself and the lives of individual patients became more assured.

6.2 Demographic characteristics

6.2.1 Social class

The majority of registered insane patients were in receipt of poor relief and pauper patients constituted approximately 95% of all boarded-out cases.[4] It is not unexpected, therefore, to discover that the predominant occupations of boarded-out patients were domestic servants, labourers, millworkers, weavers and housewives. Other occupations recorded among patients boarded-out from Woodilee District Asylum, for example, included miners, hawkers, cotton-spinners, book-folders and colliers[5] (Appendix 8). These occupations were broadly representative of the boarded-out population, although many patients classified as

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[2] The case of a 26 year old patient illustrates well the unsettled nature of life for some patients. In the space of six years, between 1898 and 1904, he was admitted to Stirling District Asylum six times, often for a period of only three months, before being boarded-out again on probation, to a new guardian. Similar unfortunate cases were reported, if not annually, then with some regularity in parish records. Visitors Report Pocket Book: Dollar Parish Council, 1904-1912 (XK2/2/33)

[3] *Vide supra* Chapter 4.

[4] GBCLS 35th AR (1893), p103.

[5] Register of admissions, discharges and deaths, Woodilee District Asylum, 1875-1908 (HB30 6/1)

congenitally insane had never been employed. From existing descriptions of their case records, these patients too came from the poorer classes of society. Their parents or other immediate relatives were almost invariably recorded to be "humble crofters" or working people. Others were not working, with entire families claiming poor relief. The unsatisfactory sanitary conditions in which many patients were discovered was further proof, to the Commissioners, of the lowly, uneducated class from which such patients came.

While large numbers of non-pauper patients remained in a domiciliary setting, an accurate representation of their wealth and social class is unattainable. Many were never under the jurisdiction of any official body and remained unknown to official sources, with the exception of the census, which did not always record whether a patient was insane. Private patients of comfortable means were provided for in the royal asylums, which, in the nineteenth century, were establishments of some prestige and in the small number of private madhouses which survived throughout the period (Figure 6.1). Wealthy patients were not subject to official sanctions and regulations, and were able to remain under the care of relatives, unreported to the Commissioners[6], or to be boarded with medical men, thereby avoiding the stigma of admission to an asylum.[7]

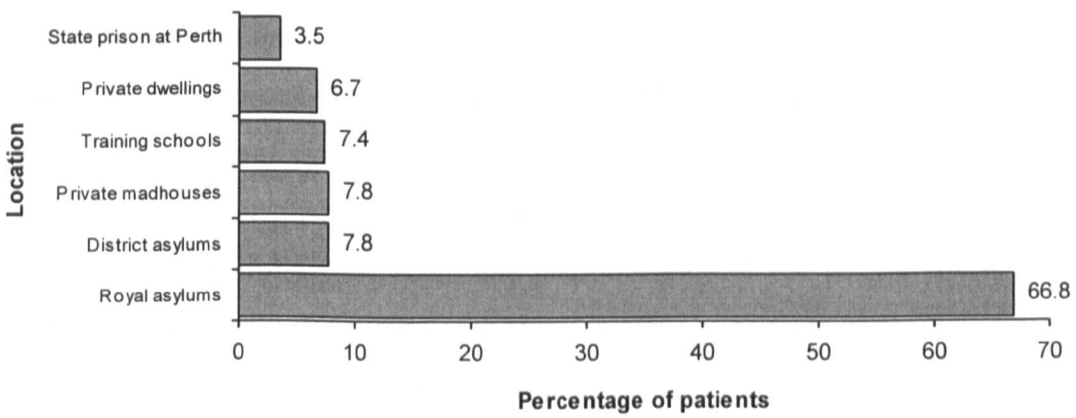

Figure 6.1 Location of private patients, 1886[8]

[6] With certain exceptions, private patients residing with relatives were not under the jurisdiction of the Board of Lunacy. *Vide supra* Chapter 1 and *vide infra* Chapter 11 for further discussion.

[7] Hervey's account of Alexander Morison's life, and his work with single patients indicates that it was from among the wealthier classes that such patients were drawn in England. Hervey, N. (forthcoming) Sir Alexander Morison, 1779-1866: Treating the mad outside asylum walls. In *The transformation of the mad-doctoring trade: psychiatric lives and careers in nineteenth-century Britain.* Princeton: Princeton University Press.

[8] Source of data: GBCLS 29th AR (1887).

As an approximate guide to the social class of private patients, Mitchell estimated that in the early 1860s, only 4.6% were affluent and that a further 25%, including clergymen, lawyers and teachers, were from comfortable circumstances.[9] The great majority of private patients, therefore, were in straitened circumstances, with little hope of any amelioration of financial constraints, due to the loss of earnings of the patient and, sometimes, of the person responsible for their daily care. Often the only difference between private and pauper patients was that certain families had not yet been forced to claim relief. For many, it was only a matter of time before they experienced the pauperising effects of insanity; a fact causing considerable anxiety to those responsible for lunacy and parochial administration. As Sutherland remarked, a large proportion of patients claiming poor relief would never have become paupers "in the ordinary acceptance of the term" were it not for the occurrence of insanity.[10]

6.2.2 Sex

Imbalance in the distribution of male and female patients was a marked feature of boarding-out. Female patients predominated in private dwellings, especially in houses licensed for three or four patients (Figure 6.2). Only very rarely were four male patients boarded together in one house, the Commissioners maintaining that physically active males were too demanding for a single guardian. Taking 1872 as representative of a typical year, out of 1492 boarded-out pauper patients, 645 were males and 847 females. The ratio of males to females was approximately 100:134 among single patients and 100:187 in licensed houses. Thus, while the imbalance was more marked among those in special licensed houses, as Jolly observed, "this predominance of the female sex is also found, though not so markedly, in looking at the total number of patients under family care."[11] The contrast remained strong as the system of boarding-out developed. In 1903, for example, the ratio of male to female patients boarded singly was 100:119, in special licensed houses it was 100:200 and among all boarded-out patients, 100:156. These figures demonstrate that the ratio of male to female single patients narrowed during the course of the period whereas that in special licensed houses widened, largely due to the reluctance of the

[9] Mitchell, A. (1864) *op.cit.*, p8.
[10] Sutherland, J.F. (1897) *op. cit.*, p20.
[11] Jolly, F. (1875) *op.cit.*, p43.

Commissioners to place male patients in groups. In asylums, the ratio was much lower, in 1895, for example, being only 100:106.[12]

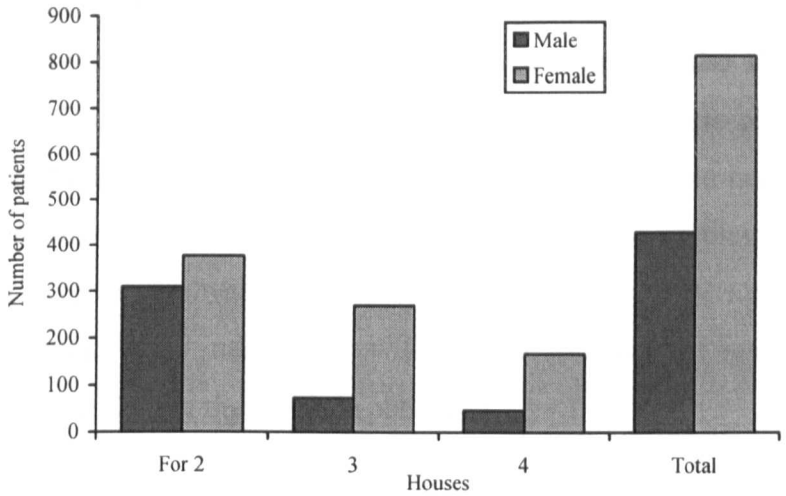

Figure 6.2 Distribution of male and female patients in special licensed houses, 1912[13]

The discrepancy in favour of females was less apparent among private patients. In 1864, for example, 55% of all private cases were male.[14] This is explained, to some degree, by the less rigid selection process involved in providing for non-pauper patients in private dwellings. Relatives took charge of their patient, when desired, regardless of sex. Notwithstanding this, by the turn of the century, with the increase in unrelated guardianship, the balance had swung in favour of female patients, and in 1906, the proportion was recorded as 100:120.[15] The disparity was attributed to the greater ease with which female patients could be occupied, since finding employment for male patients was more problematic. As Sutherland noted:

> "the difficulty of finding suitable work for many men in village homes too often leads to enforced idleness and inactivity, and induces a condition of discontent which not infrequently ends in return to an asylum." [16]

Where men were boarded-out, either singly or in special licensed houses, it was deemed favourable to place them with small farmers or crofters, where there was suitable outdoor occupation. Approximately 80% of boarded-out males were sent to guardians, usually farmers, in rural districts, to the satisfaction of the Commissioners who concluded, "this

[12] GBCLS 38th AR (1896), p121.
[13] Source of data: GBCLS 55th AR (1913).
[14] Mitchell, A. (1864) *op.cit.*, p7.
[15] GBCLS 48th AR (1906).
[16] GBCLS 44th AR (1902), p157.

arrangement commends itself in the method of disposing of healthy active males".[17] In contrast, female patients were reported to be equally suited to placement in villages or farms and were occupied easily with household tasks, wherever boarded. The Commissioners contended that there was less urgency to find them active outdoor employment. Reflecting this, Spence, Secretary to the Board of Lunacy, declared that "females are more easily provided for...and take their place more naturally among the surroundings of domestic life." Further, unmanageable habits were considered to be less common among women, who, in the view of the Commissioners, "manifest few or none of the propensities which would render the presence of the insane objectionable".[18] The Board of Lunacy thus maintained, with confidence, that the number of female boarders could safely be double that of male patients.

6.2.3 Age

The age-range of patients in private dwellings was narrower than that of patients in asylums, where people of all ages were admitted. In 1864, for example, among 605 boarded-out patients visited by Paterson, only 5% (32) were under 20 years, 35% (210) were between the ages of 20 and 40, 38% (231) between 40 and 60 and 22% (132) over 60 years.[19] There was some diversity in the age-range of patients suffering from congenital and acquired insanity, with a marked preponderance of younger patients classified as idiots or imbeciles, reflecting, to some extent, their shorter life-span. In the early 1860s, Mitchell reported on 693 patients suffering from congenital forms of insanity, of whom 35% (240) were under 20 years old and another 29% (201) between 20 and 30 years. The age-range of those with acquired forms of insanity was comparable to the average range throughout private dwellings, with 39% being between the ages of 30 and 50 and 20% between 50 and 60 years.[20]

The age distribution of patients in special licensed houses was little different from that recorded among single patients, with the exception of houses licensed for three or four patients where the average age was usually over 50 years. Figures recorded in 1909 regarding a sample of patients from special licensed houses were fairly typical of those

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[17] GBCLS 39th AR (1897), p122.
[18] Spence, T.W.L. (1902) *op.cit.*, p636.
[19] GBCLS 6th AR (1864), p238.
[20] Mitchell, A. (1864), *op. cit.*, p7.

noted annually. Four patients were under 20 years (9%), six (14%) largely male, were between 21 and 30, 22 (50%) were between 31 and 60 and 12 (27%) between 61 and 80.[21]

Specific risks relating to younger patients often prevented their residence in private dwellings receiving firm endorsement from the Board of Lunacy. Not only were young men considered harder to occupy, but there was greater apprehension among potential guardians regarding the safety and suitability of such patients. There were also enduring concerns that young women could be sexually assaulted or become pregnant. Where there was a risk of pregnancy, or where the patient was sexually disinhibited, sanction to reside in a private dwelling was not granted. The effect of this prompted Jolly to remark upon the comparative absence of women of child-bearing age boarded-out in Kennoway. At the time of his visit, in 1873, he found only three females under 40 years, in stark contrast to the high number of such patients at Gheel. At Kennoway, the average age of patients was well over 50 years.[22] Thus, although the Board of Lunacy declared that there was no rule for the exclusion of young women[23] its attitude was clear:

> "for obvious reasons, it was considered that the female patients, who constituted the great majority of removals, should be past middle age, though several young women were lodged in houses where there were no male inmates."[24]

As the system developed, and supervision at a local level became recognised as largely effective, the age-range of boarded-out patients widened. Although in 1903, for example, over 50% of those boarded-out were between the ages of 30 and 50, several cases were recorded of patients under the age of 20, generally classified as suffering from congenital insanity, being placed successfully under the care of unrelated guardians.[25] Elderly patients were welcomed by guardians, who maintained that they would be less troublesome and would require less supervision than younger persons. There was also a growing tendency among parish officials, stimulated by the prospect of the government grant-in-aid, to certify old, infirm paupers as insane, rather than simply senile. Increasing numbers of older persons therefore were placed on the list of insane paupers, usually suffering from

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[21] GBCLS 51st AR (1909).
[22] Jolly, F. (1875) *op.cit.*, p43.
[23] GBCLS 30th AR (1888), p104, and 35th AR (1893), p109.
[24] GBCLS 15th AR (1873), p274.
[25] In 1903, for example, all but one of eight patients under the age of 20 who were visited by Sutherland were classified as imbeciles. GBCLS 45th AR (1903), p152. The majority of children under 16 were placed in the two training schools for imbecile children, at Baldovan in Dundee and Larbert, near Stirling, although a proportion were found in asylums each year.

dementia or delusional insanity[26], although Lawson attributed this rise more to a "prevalence of clearer ideas as to what constitutes definite insanity in the aged as distinct from mere senile mental decay."[27] While the Board of Lunacy recommended that many such subjects should be removed to an asylum, it conceded that "such a serious step in the case of such persons of advanced years," meant that their death was "usually hastened by their removal from old associations."[28] The frequency with which deaths occurred rapidly in these cases supported this fear; the combination of the shock of change and the physical weakness of many upon admission often proving too great. Many elderly patients were thought to be unable to benefit from formal treatment in an asylum and it was therefore considered to be more humane to allow them to remain in familiar surroundings.

6.2.4 Religion

Religion was a major part of life in nineteenth-century Scotland. Smout spoke of "a universal stillness" over Glasgow and Edinburgh during service times, maintaining that "on Sundays the churches held the country in thrall for Christ."[29] The majority of the population, boarded-out patients included, attended church regularly. Nevertheless, concerns were voiced at a gradually declining church attendance, particularly among the younger generation and it was estimated in 1874 that up to one-fifth of Scots had no connection with any church, this figure was cited again in the 1890s.[30] Towards the end of the century:

> "there was no doubt at all that the Church was ceasing to be at the forefront of most people's lives...For large numbers of the working class it was profoundly identified with a middle-class ethos for which they could feel less and less enthusiasm"[31]

Notwithstanding this decline, regular church attendance remained a feature in the lives of many of the poor and as Smout concluded, the extent of decline in religious belief should not be exaggerated. It was barely perceptible in the lives of many and in the Highlands and the western and northern islands, zeal for the church remained largely undiminished.

Hogben, a physician from Fife with an enduring interest in boarding-out, observed the frequency of visits made by clergyman to the homes of patients and reported the pleasure

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[26] GBCLS 45th AR (1903), p152.
[27] GBCLS 33rd AR (1891), p114.
[28] *Ibid.*
[29] Smout, T.C. (1987) *op.cit.*, p183.
[30] *Ibid.* p201.
[31] *Ibid.* p205.

this brought to those visited.[32] A number of patients retained the mental capacity to gain solace from church attendance. For example, one patient boarded at Ballantrae had formed links with the local Established Church. Her subsequent removal to a new guardian, some miles distant, prevented her attendance, and this severance was the subject of bitter complaint to visiting officials.[33]

Although the overwhelming majority of guardians in the aggregations of special licensed houses in central Scotland would have been Presbyterian, a proportion of patients, particularly from Glasgow, were Catholic.[34] However, there is little indication of any consideration by the Commissioners concerning the denominational preferences of patients. Beyond the recommendation that all patients receive religious instruction, the issue of religious beliefs was seldom discussed in their annual reports.[35] Similarly, parochial officials did not appear to recognise the importance of religion to boarded-out patients until the closing years of the nineteenth century. Until that time, patients were boarded-out without any consideration of their religious denomination and examples were reported by parish officials when guardians who were members of the Established Church refused access to visiting Catholic priests. In 1890, however, a motion was passed by the parochial board of Glasgow City that:

> "boarding-out lunatics of a harmless and chronic condition be suitably provided for, in regard to their religious requirements, and not indiscriminately as at present."[36]

This was not encompassed in Lunacy Board policy until five years later, when, following complaints from a number of guardians, and reports of tension among patients of different religions, the Board announced that wherever possible Catholic patients should be boarded with Catholic guardians. It further recommended that local clergy should be informed of the religious persuasion of new patients and that Catholic patients should be placed near Catholic churches. If this change was not forthcoming, many patients would be confined unnecessarily in asylums, due to the difficulties in finding guardians who were tolerant of the non-Established Church. It is evident, therefore, that over 40 years after boarding-out was adopted, the Board of Lunacy and parish officials had come to recognise that it was

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[32] Hogben, E. (1898), *op. cit.*, p690.
[33] Parochial Board Minutes, Ballantrae, 1892-1899 (CO3.24.2).
[34] In 1905, for example, of 519 patients boarded-out from Glasgow, 437 (84%) were Protestant and 82 (16%) were Catholic. Lists of children boarded-out by Barony parish: includes lists of boarded-out patients. D.HEW 24.20 (1905), pp46-51.
[35] *Vide infra* Chapter 7 for a list of regulations for guardians, which encouraged the attendance of patients at religious services.
[36] Glasgow City Parochial Board Minutes (1890), D.HEW 1/1/6., p384.

unfair to patients to allow difficulties incurred in finding guardians who shared their religious beliefs to jeopardise their opportunity for liberty.

6.3 Selection criteria

The Board of Lunacy had a clear perception of what constituted suitability for boarding-out (Appendix 9). Patients suffering from congenital forms of insanity were widely recognised as being unable to benefit from asylum provision and, therefore, suitable for domestic care. However, those suffering from epilepsy or progressive brain disease were generally considered unsuitable. If restraint or confinement was necessary, or if patients were dirty, troublesome, "offensive to public decency," or a possible danger to themselves or other people, they were equally unsuitable. Patients who were in the habit of wandering, liable to erotic tendencies, or likely to refuse food were also disqualified. To the Commissioners, "recurrent attacks of mania or melancholia, however quiet or cheerful the patient may be in the intervals, should be a decided contra-indication."[37] One Commissioner, Lawson, maintained that patients with delusions of grandeur were generally unsuitable, because they could be irritating to their guardians and difficult to manage. Further, any patients who were potentially curable were to be provided for in an asylum.

Mitchell's assessment of suitable patients was widely accepted by the Commissioners. He stated that:

> "the forms of disease which...have been found to be most suitable for care in private dwellings are idiocy, imbecility and dementia...The semi-insane do not prove easily managed...nor those labouring under delusional insanity, especially if the delusions be those of suspicion. In the most suitable, the unsoundness of mind is well marked, but in the direction of weakness or destruction rather than perversion of the mental faculties. Their mental state should be one of defect rather than of disease, and should be a settled and well established condition, and not a progressive or changing one. So far as mind goes, their condition should as much as possible be one of simply of loss, or want, or void..."[38]

Nevertheless, the Board of Lunacy recognised that not all patients in these categories were necessarily suitable and that patients suffering from other forms of mental disease, especially when they were long term, were potentially appropriate. Certain congenitally insane persons proved unsuitable, for example, one unusual case was reported in 1910 when an imbecile patient had attempted to rape his mother, and later made another criminal

[37] GBCLS 29th AR (1887), p125.
[38] GBCLS 8th AR (1866), p240.

assault on a girl, before being sent to an asylum.[39] In general, however, imbeciles and idiots were regarded as harmless, friendly and trustworthy, and in possession of "a fair share of general gaiety in which the ordinary Scotch peasant is apt to be defective."[40] The presence of such persons in the community was, in the view of the Board of Lunacy, beneficial for the patients, and for the residents of the neighbourhood, because:

> "imbeciles can and do have an excellent influence upon the class of society whom they live with. They develop cheerfulness and kindness amongst their benefactors..."[41]

Within a few years of the introduction of boarding-out, the increased experience of parish officials led to the identification of new categories of patients as suitable or unsuitable for trial in private dwellings. For example, in 1897, Lawson stressed the problems created by "clever plausible grumblers, being as a rule, sharper witted than their guardians, they can make matters very uncomfortable in a household."[42] Such patients caused more trouble in domestic surroundings than when assimilated into the asylum population. Lawson's description of them was vivid:

> "they are generally well-nourished and sleek looking, with an expression of cunning, fluent in speech, but deliberate and dextrous in the employment of it."[43]

It is likely that few guardians had sufficient forbearance to tolerate such patients and the majority, usually women, were returned to asylums. Two such demanding patients were seen by parish visitors in 1909, when it was noted, with some incredulity, that:

> "one seems an incessant talker, the other an incessant weeper. The guardian made no complaint, but really how she can stand it beats my comprehension."[44]

The Commissioners were firm in their conviction that care must be taken in sending suitable patients to special licensed houses where boarders were already present. They reported situations when the balance of a household was disrupted by the arrival of a noisy, troublesome patient and urged parochial officials to be aware that such houses were not small asylums, but private houses where all the patients had to mix with each other. However, it was often difficult to ensure the suitability of all patients; many proving to be a disturbance when boarded-out. One such case was documented, when the arrival of M.M'F, "a noisy, vociferating woman", altered the previous tranquillity of the house. The existing

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[39] MS AR (1910) Roxburgh District Asylum.
[40] GBCLS 25th AR (1883), p172.
[41] GBCLS 19th AR (1877), p172.
[42] GBCLS 39th AR (1897), p126.
[43] *Ibid.*
[44] Lists of children boarded-out by Barony parish: includes lists of boarded-out patients. D.HEW 24.24 (1911), p1.

patients complained of her "violent and vituperative language" and neighbours reported her to be noisy and troublesome. Concern was expressed that her presence would cause the hitherto contented patients to relapse. Consequently, she was removed to an asylum.[45] A number of similar cases were reported when the guardians were forced to devote more attention to a troublesome patient at the expense of the well-being of the others. Such behaviour also increased the possibility that neighbouring villagers would take offence at the presence of insane persons in such close proximity.

6.4 Mental condition

Attempts to formulate psychiatric diagnoses retrospectively have become increasingly popular among historians of psychiatry, although such endeavours are often dismissed as unhelpful in the understanding of nineteenth-century case histories. Beveridge, for example, while assessing patients at Edinburgh Royal Asylum, recognised that due to the lack of detail in the case records, a high proportion of patients remained unclassifiable, thereby diminishing the value of such attempts.[46] Nevertheless, Turner, Beveridge and Doody have offered modern diagnoses for nineteenth-century case studies, with considerable success.[47] The mental condition of over 80% of patients from Ticehurst Private Madhouse analysed by Turner over the years 1845-1890, had "a significant modern diagnosis," leading him to remark upon the "sheer recognisability of the cases recorded".[48] In the present study, however, with almost no detailed information on the mental condition of boarded-out patients, retrospective diagnoses would be impossible. Instead, it has been decided that where the mental condition of a patient is apparent, the diagnosis offered at the time is retained. This, it is contended, does not restrict in any way a broad understanding of the predominant mental characteristics of boarded-out patients.

Gibson, writing in the 1920s, contended that from a psychiatric standpoint boarded-out patients did not present many interesting features.[49] His assertion seems valid when it is noted that the most frequent disorders included mild and chronic mania, harmless

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[45] GBCLS 35th AR (1893), p107.
[46] Beveridge, A. (1995) *op.cit.*, p142.
[47] Turner, T. (1987) Rich and mad in Victorian England. In *Lectures on the history of psychiatry. The Squibb series,* 1990 (eds. T. Turner and R.M. Murray), pp170-192. London: Gaskell, Turner, T. (1992) *op. cit.* Doody, G. (1992) *op.cit.* and Beveridge, A. (1995) *op.cit.*
[48] Turner, T. (1987) *op.cit.*, p189. In particular, patients conforming to Research Diagnostic Criteria categories for schizophrenia, and manic depressive disorder were easily classified.
[49] Gibson, G. (1925) The boarding-out system in Scotland. *American Journal of Psychiatry,* 71, p256

delusions, dementia, congenital insanity, idiocy and, though less often, dipsomania.[50] Patients suffering from severe delusions and active insanity were rarely found in private dwellings. There was little to distinguish the mental characteristics of patients boarded singly and those placed in special licensed houses. All had to be certified as unable to benefit from asylum treatment, prompting the observation from Hack Tuke, following a visit to special licensed houses, that the patients "were quiet [and] mostly weak-minded, either congenitally or from secondary dementia."[51]

6.4.1 Congenital forms of insanity

The great majority of patients in private dwellings in the first 20 years of the system had been mentally defective from birth, or from a very young age.[52] Others were judged to have been of sound mind until adulthood, when, following an attack of mania, their mental condition was observed to have passed into a state of fatuity or imbecility. Although delusions and other mental peculiarities still existed, such patients remained harmless and manageable. The Commissioners argued that patients from these categories should always constitute the majority of boarded-out cases. Their needs were limited, requiring little more than comfortable living conditions and adequate food and clothing, while the activities of a household were held to be of more interest to these patients than the monotonous, regimented life in an asylum.[53]

It is evident that the Board of Lunacy was never very sure of the utility of making an exact distinction between imbecile and idiot patients, maintaining that the difference was one of degree only.[54] In fact, a number of physicians in the early-nineteenth century, such as Pinel in 1806, and Spurzheim in 1817, used the terms "almost synonymously."[55] The Commissioners contended that it was impossible to stipulate where imbecility ended and idiocy began. Broadly, if patients were unable to acquire habits of cleanliness in their personal hygiene, their condition was regarded as idiocy. This degradation was

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[50] Dipsomaniacs were boarded in considerable numbers in the island of Arran, the majority of them private cases. *Vide infra* Chapter 9 for description of the peculiar characteristics of patients boarded there.
[51] Tuke, D.H. (1889a) *op.cit.*, p505.
[52] GBCLS 7th AR (1865), p244.
[53] As Mitchell observed, "the cottage kitchen is an ever shifting busy scene...[we] cannot imagine a tranquil pauper patient passing from acute disease into incurable imbecility, more favourably situated than at its fireside, where the surroundings are natural and the influences healthy". GBCLS 9th AR (1867), p253.
[54] GBCLS 24th AR (1882), p164.
[55] Parry-Jones, W.Ll. (1995) The concept of imbecility: some historical observations (unpublished paper).

accompanied by physical and mental shortcomings, and by "an appearance of abject repulsiveness which forces a diagnosis upon the observer."[56] An imbecile, however, had limited capabilities of improvement, and "acquirements surpassing those of the most intelligent of the lower animals".[57] Thus Esquirol suggested that "the term imbecility be used to denote a category of mental deficiency of a lesser degree than idiocy".[58] Those of a higher level of imbecility were almost indistinguishable from persons regarded as simpletons, but not of unsound mind.[59] Patients from both categories were boarded-out in large numbers.

6.4.2 Acquired forms of insanity

As the system of boarding-out expanded and increasing numbers of patients were discharged unrecovered from asylums, the diagnostic profiles of patients in private dwellings underwent marked transformation.[60] The putative success of boarding-out certain potentially problematic patients each year led to the inclusion as suitable for boarding-out of a "greater variety of cases from a pathological point of view".[61] In 1864, Mitchell observed that 77% of patients were suffering from imbecility and idiocy and 23% from various manifestations of acquired insanity, mainly dementia, chronic mania and melancholia.[62]

The classification of boarded-out patients across 22 districts in Scotland in 1882 is summarised in Table 6.1. The year 1882 has been selected as approximately mid-way between 1857 and 1913 and serves to highlight the continued predominance of patients with congenital disorders in every district visited. (Edinburgh, a district with one of the

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[56] GBCLS 24th AR (1882), p164. Such statements regarding the apparently disturbing physical appearance of certain patients offer revealing insights into the way congenital mental defects were perceived by physicians. See Saunders, J. (1988) Quarantining the weak-minded: psychiatric definitions of degeneracy and the late-Victorian asylum. In *The anatomy of madness.* vol. 3. *The asylum and its physicians* (eds. W. Bynum, R. Porter and M. Shepherd), pp273-296. London and New York: Routledge.

[57] GBCLS 24th AR (1882), p164.

[58] Parry-Jones, W.Ll. (1995) *op. cit.* Taken from Esquirol, E. (1845) Mental maladies. A treatise on insanity (Trans. E.K. Hunt) Philadelphia: Lee & Blanchard, pp448-454.

[59] *Ibid.* Parry-Jones records the classification given by Copland in his Dictionary of Practical Medicine (1858) in which imbecility is described as "a chronic form of insanity characterised by impairment of the sensibility and of the will, by incoherence of the ideas, and by the loss of the powers of consciousness and of the understanding". Dementia and amentia are also included in this description.

[60] *Vide supra* Chapter 4 for discussion of this.

[61] GBCLS 24th AR (1882), p156. The mental weakness of one 17 year old boarded-out patient was so imperceptible that he enlisted successfully in the Territorials, passing a medical examination. Boarded-out mental patients registers. (1914) D.HEW 7/4/4.

[62] Of 963 patients in private dwellings in 1864, for example, 693 suffered from idiocy or imbecility, and 270 from various manifestations of acquired insanity. Mitchell, A. (1864) *op.cit.*, p7.

highest numbers of boarded-out patients was not among the districts assessed and is therefore not recorded here).

	Total number	Imbecility	Idiocy	Dementia	Melancholia	Mania
Ayrshire	62	34	4	7	4	13
Banffshire	45	25	6	4	1	9
Berwickshire	15	5	4	3	1	2
Caithness	62	24	17	7	1	13
Clackmannan	9	3	1	3	-	2
Dumbartonshire	8	7	-	1	-	-
Elginshire	37	22	5	7	-	3
Forfarshire	54	39	5	3	-	7
Haddington	15	11	1	3	-	-
Invernessshire	93	36	11	11	3	32
Kirkcudbright	25	10	7	2	-	6
Lanarkshire	102	51	18	13	3	17
Nairnshire	7	7	-	-	-	-
Orkney	29	13	11	1	2	2
Peebleshire	4	2	-	-	-	2
Renfrewshire	24	12	5	4	-	3
Roxburghshire	16	11	1	-	1	3
Selkirkshire	3	-	-	-	-	3
Shetland	45	15	9	4	1	16
Stirlingshire	52	19	1	18	1	13
Sutherlandshire	26	16	4	2	1	3
Wigtownshire	32	19	10	1	-	2
Totals	765	381	120	94	19	151

Table 6.1 Classification of boarded-out patients in 22 districts of Scotland, 1882[63]

Of the 765 patients boarded-out in these districts, 66% (501) suffered from congenital mental defects (50% idiocy and 16% imbecility) and 34% (264) from acquired forms of

[63] Source of data: GBCLS 24th AR (1882), p165.

insanity. However, despite the continued prominence of congenital forms of insanity, when compared to the figures recorded in 1864, it is evident that there was a gradual rise in the proportion of patients classified as suffering from acquired forms of insanity. This rise led to the balance between the two forms of disorder being almost equal by the 1890s[64] and in 1900, of 1139 patients visited by Sutherland, 48% were cases of insanity which had developed in adulthood, while 52% were congenital idiots or imbeciles.[65] Nevertheless, proliferation of acute cases in private dwellings was never actively encouraged by the Board of Lunacy. One of the major tenets adhered to by the Commissioners was the early removal of patients to asylums, following a period of acute insanity, since it was assumed that the potential for cure was higher when patients were in immediate receipt of asylum treatment.

Patients suffering from what was termed "maniacal insanity" (mainly cases of chronic mania and melancholia) were also boarded-out on occasion, despite initial scepticism from the Board. In 1867, for example, 13% of patients were classified in this way.[66] Within a few years of such patients being offered trial in private dwellings, however, the Commissioners conceded that they were among the most satisfactory of cases and by 1895, 23% of boarded-out patients were reported to be suffering from mania or melancholia.[67] This was attributed to the fact that:

> "a recurrent maniac, during a period of quiescence, often stands out among the people they live with, as a cultivated and amiable member of the household, and seems to cultivate during periods of repose that sympathy which ensures good treatment and forbearance during attacks of excitement."[68]

Many remained in bed during the period of excitement. Nevertheless, patients suffering from mania, with delusions of suspicion and hallucinations, melancholics with suicidal propensities and those with recurrent mania all required particular attention from Visiting Commissioners, where sanction had been granted for them to be boarded-out. Critics maintained that patients in such categories should invariably be sent to an asylum, enabling close supervision and all the advantages of medical expertise.[69] The Commissioners

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[64] Sutherland, J.F. (1897) *op.cit.*, p35.
[65] GBCLS 43rd AR (1901), p154. Patients belonging to the first class were largely secondary dements (26%), chronic maniacs (11%) and a small number suffering from melancholia (4%). The second class included all grades of congenital or infantile defect, from idiocy to only a slight degree of imbecility. Patients suffering from imbecility and dementia constituted 79% of the total number.
[66] GBCLS 9th AR (1867), p240.
[67] GBCLS 38th AR (1896), p122.
[68] GBCLS 23rd AR (1881), p129.
[69] This issue is considered in Chapter 8.

responded with reassurances that many lunatics with "well-pronounced delusions of suspicion and incessant hallucinations of sight and hearing", remained insane while manifesting no signs of violence or resentment against the objects of their suspicion.[70] Hence, if patients were not dangerous, and appeared largely quiescent, the Board of Lunacy displayed increasing flexibility in allowing such patients to undergo trial periods in domestic care.

6.4.3 Epilepsy

During the first twenty years of visitations by the Commissioners, patients suffering from epilepsy were not classified separately. Many cases were reported of imbecile and idiot patients who also had epilepsy, or other "complications of the mental disease," including paralysis or chorea, although the existence of epilepsy was considered incompatible with boarding-out.[71] This was due to concerns about the occurrence of accidents during a fit, if patients were inadequately supervised. Therefore, patients with epilepsy were more often sent to asylums. Among 219 patients assessed by one Commissioner in 1866, for example, 12 (5%) were reported to experience occasional episodes of epilepsy.[72] The majority of these were congenitally insane and had developed the condition in childhood. Recommendations for arrangements to "obviate or lessen the danger from fire" were made by the Commissioners.[73] An unquantifiable number of persons suffering from mild epilepsy also remained at home, under no official control. However, among registered patients, the Board of Lunacy announced that if any were epileptic, noisy, or dirty in their habits, this was "sufficient objection" against their residence in private dwellings.[74] Despite the fact that patients with epilepsy demanded extensive supervision, certain physicians were convinced that that many could be placed successfully in private dwellings. Ewart, an enthusiastic proponent of epileptic colonies, was convinced of the benefits to be gained from plain homes, familiar occupations and greater freedom. He asked that:

> "instead of erecting mammoth asylums, a blot on the intelligence of the age, to which year after year wings are added, creating a "wilderness of lunatics" ... why not place them in simple and inexpensive cottages, where they could be well looked after under medical and state supervision."[75]

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[70] GBCLS 23rd AR (1881), p126.
[71] GBCLS 8th AR (1866), p244.
[72] *Ibid.*
[73] GBCLS 6th AR (1864), p229.
[74] GBCLS 15th AR (1873), p274.
[75] Ewart, C.T. (1892) Epileptic Colonies. *Journal of Mental Science*, **38**, p212.

While aware that few people were willing to receive such patients, he recommended trial admissions into private dwellings whenever possible. By 1880, when greater variety in the mental condition of boarded-out patients was evident, the Commissioners authorised trial in private dwellings for growing numbers of patients whose only mental defect was reported to be epilepsy. In 1881, for example, 10% of boarded-out patients had this classification,[76] although Commissioners were never entirely confident about the safety of such patients. Fraser, voicing the attitude of the Board of Lunacy, declared that "the amount of anxious supervision and careful management which insane epileptics require is well known."[77] However, by the turn of the century, the Commissioners accepted that, if closely supervised, these patients could be suitable for boarding-out, since few serious accidents were reported even among patients with epilepsy who also suffered from various forms of mental disorder.

6.4.4. Interim conclusions

It is evident, therefore, that although imbeciles and idiots were recognised as particularly suitable for care in private dwellings, there was substantial variation in mental condition. The Board of Lunacy emphasised the importance of treating each case individually, maintaining that it was impossible to define scientifically what constituted a chronic, harmless case. A number of such patients in fact proved ultimately unsuitable for domestic care. The Commissioners recommended instead that officials:

> "must not attach too much importance to the terms dementia, melancholia etc as per se they do not afford any absolute or reliable indication of the suitability or otherwise of placing persons in private dwellings, because it is not so much the form of insanity which determines the propriety of boarding-out but considerations such as physical infirmities, defective habits, temper and conduct.[78]

Further, as one physician, Hogben, observed, the form of insanity was not always distinct, and exact classification was impossible in a proportion of cases.[79] The Commissioners maintained that the care and treatment of patients was more important and influential than specific mental classification. They were clear about this; emphasising that the degree of success in boarding-out patients classified as suffering from similar forms of insanity

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[76] GBCLS 24th AR (1882), p167.
[77] *Ibid.*, p156.
[78] GBCLS 38th AR (1896), p122.
[79] Hogben, E. (1898) *op.cit.*, p690. He further cautioned that "too much importance should not be attached to the terms melancholia, mania and dementia. These conditions or phases of mental disease are apt to merge into each other in chronic patients, other considerations such as general character temper, conduct, habits and physical infirmities have to be taken into account when proposing to remove the unrecovered from asylums".

varied markedly, depending upon the suitability of the guardian, the nature of accommodation, and the individual personality of each patient. Two cases, both visited in 1860, illustrate the variation in results when boarding-out patients of broadly similar mental condition, and highlights the futility of segregating patients as specifically suitable for care in private dwellings or for care in asylums. H.M. was classified as suffering from mania of vanity. She whitewashed her face, wore frilled clothing and insisted on being addressed as "Her Majesty." She was under suitable guardianship, in comfortable surroundings. In contrast, M.W. also suffering from mania of vanity, similarly whitewashed her face and her furniture, considering herself to be related to "half the dukes and earls in the land". However, she lived alone in wholly unsuitable conditions. Had she been placed under the care of a competent guardian, the Commissioners maintained that she would have been equally suitable for continued care outside an asylum.[80] To the Commissioners, therefore:

> "the whole matter of boarding-out is essentially a practical one, and therefore its merits and demerits can only be ascertained by the actual boarding-out of patients who seem suitable."[81]

6.5 Daily activities

Patients were encouraged to remain active during the day. Those considered responsible enough were allowed to wander through the village, without being under the constant surveillance of their guardian. Many attended church on their own, "went messages" (shopping) and received visitors. Mitchell reported on one female patient who went to chapel alone, walking a distance of several miles, even though she was subject to severe delusions, believing "that she has personal interviews with the Apostle Paul."[82]

Great attention was given by alienists to the importance of daily exercise. In asylums, this was regarded as a fundamental tenet of the daily routine. The benefits of exercise were also cited regularly by the Commissioners on their visits to boarded-out patients, and on occasion, they felt obliged to insist that guardians allowed the patients greater freedom.[83] Where the gardens were small, the Board recommended that patients be sent out on errands, and, when they could be trusted, to take walks in the surrounding countryside.

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[80] GBCLS 3rd AR (1861), p252.
[81] GBCLS 24th AR (1882), p156.
[82] GBCLS 9th AR (1867), p253.
[83] Thus in one house in Ayrshire, patients were only allowed only along the garden path, even though they lived by open countryside. GBCLS 34th AR (1892), p111.

Many patients had no inclination to take exercise and had to be encouraged to do so. While praising the general standards attained in houses, a committee of lay visitors from Glasgow, condemned the tendency of patients to remain indoors where possible. Although well cared for, patients appeared to be listless, discontented and reluctant to do anything. To the visitors: "it seemed as if they sadly needed some slight duty being given to them to relieve the dullness of their unfortunate position".[84]

However, in general, the Commissioners praised the extent of liberty afforded to boarded-out patients. Many made successful, unaccompanied visits to relatives and friends and as Fraser remarked:

> "it is a satisfactory feature of the private dwelling system that there are so few escapes, seeing that the amount of liberty enjoyed by them, in the great majority of cases, is practically unbounded, they go freely about, they work by themselves, there are no locked gates or walled airing courts around their homes".[85]

Patients in private dwellings were reported to be visited more frequently than those in asylums. Occasionally, patients were taken out for the day by relatives, to visit the local fair, or countryside, leading the Commissioners to note, with satisfaction that "in many cases periodical visits are paid with the greatest regularity and are anticipated and recalled with pleasure both by the patient and guardian."[86] Such freedom did have its drawbacks. Excluding those who made deliberate attempts to escape, a small number of patients each year (never exceeding five or six) were reported to have wandered away from their homes and to have become lost.[87] In addition, patients were discovered in public houses, prompting parish officials to warn publicans not to allow patients any drink.[88] Although the Commissioners were anxious to allow patients freedom around their homes, they discouraged the practice of extensive roving, regarding the majority of boarders to be unfit for such unsupervised freedom. Thus, in 1865, albeit a rare occurrence, patient F.M was reported to have been in the habit of attending all the fairs, weddings and funerals for miles

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[84] Report by Visiting Committee in Lists of children boarded-out by Barony parish: includes lists of boarded-out patients. (1906) D.HEW 24.21., p1.

[85] GBCLS 31st AR (1889) p124. In this way, it is evident that the Commissioners attempted to mollify critics of boarding-out emphasising the potentially greater opportunities for freedom and occupation than were available in even the best-run asylums.

[86] GBCLS 33rd AR (1891), p116.

[87] GBCLS AR *passim*.

[88] One patient boarded-out at Balfron, and "quite unfit to manage for himself" was reported to be in the habit of frequenting public houses, and behaving unsuitably while there. Campsie (Stirling)Parochial Board Minute Book (1887-1894) co7/3/4.

around his home, "getting a share of what refreshments there were." On his return from a funeral, when crossing a river, he drowned.[89]

The limitations of available sources make it difficult to create a detailed picture of the activities of boarded-out patients. Although official reports described the work of patients, little was recorded of how the remainder of their day was spent. One rare glimpse is contained in reports for Barony parish, where it was observed that one of the female patients "treated us to a kind of "Fantasia" on the piano. All the tunes tried ending alike in "we're a noddin."[90] In another house, licensed for three female patients, one played the piano, "very nicely" while another sang to her accompaniment.[91]

6.6 Employment

The encouragement of employment for patients in asylums had long been a preoccupation of medical superintendents. Clouston, for example, at the Edinburgh Royal Asylum, placed great emphasis on the curative power of work. In his view, "digging mother earth [is] the simplest and most healthful toil for restoring tone to exhausted brain cells".[92] This same belief in the benefits of employment was reflected in the Commissioners' reports of boarded-out patients. Annual reports recorded assessments of the ability of patients to work, either in performing useful household tasks or outdoor work. Guardians were encouraged to provide employment for their patients, on the premise that they were more easily managed when occupied and able to attain real satisfaction at their labour, even when the work was unprofitable. Further, the Commissioners contended that certain patients increased in usefulness after being placed in private dwellings:

> "the various duties of home life, the emergencies which are apt to arise in a household, and the different interests which a piece of land and all its gear possess, tend to waken up such capacity for work and usefulness as exists, and often produces a desire to help even in the most apathetic and demented."[93]

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[89] GBCLS 7th AR (1865), p250.
[90] Report by Visiting Committee in Lists of children boarded-out by Barony parish: includes lists of boarded-out patients. (1906) D.HEW 24:21., p310.
[91] *Ibid.*, (1909) D.HEW 24:22., p652.
[92] Discussed in Beveridge, A. (1991), op. cit., p366.
[93] GBCLS 24th AR (1882) p145. Lindsay too, observed that "however trivial the value of such work, no other mode of treatment is so likely to develop any latent mental or physical energy that may exist". Lindsay, W.L. (1871) *op.cit.*, p520. *Vide infra* Chapter 8.

The nature of occupation varied widely.[94] In 1864, for example, Mitchell visited patients who were winding yarn, weaving, and doing harvest work. Many of the women assisted in ordinary household duties, knitting, sewing and cleaning.[95] Thirty years later, the type of work undertaken had barely changed, although the Commissioners observed that the wide use of threshing machines had created further suitable occupation, allowing imbecile and idiot patients to follow the machine around the farms, carrying water for the engine.[96] Others chopped wood, looked after cattle and worked in the fields. At Kennoway, one guardian reported that while one of her patients had breakfast in bed, "the tither ane gets up and scrubs the floor and carries water frae the well."[97] The presence of a baby was held to have a humanising influence and female patients were seen to "nurse with real attachment and assiduity."[98]

Within the first few years of the officially supervised system of boarding-out, the Board of Lunacy reported that a high proportion of patients were more or less profitably occupied. However, the Commissioners were aware that encouraging the employment of patients could lead to exploitation, since assistance in various tasks was recognised to be of great help to the guardian.[99] Close inquiry was therefore made regarding the possibility that patients were being received just for their ability to work. Few examples of exploitation were ever discovered by the Board, although it is probable that some patients were overworked. As Macpherson noted, there were always some complaints among patients that they were made to do too much work, for no reward, although inquiries showed there was little foundation for them.[100] The Commissioners were clearly aware that a balance had to be reached, so that the patient was enabled to work, thereby promoting feelings of personal usefulness, while, at the same time, their work was not to be relied on to raise the guardian's income.

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[94] Even with the expansion of asylum farms, it is apparent that opportunities for employment were more diverse in private dwellings than in asylums, although, somewhat surprisingly, the Commissioners did not dwell on this point, in their continual endeavours to emphasise the advantages of boarding-out.
[95] GBCLS 6th AR, (1864), p232.
[96] GBCLS 36th AR (1894), main text pxl.
[97] GBCLS 29th AR (1887), p134.
[98] GBCLS 38th AR (1896), p120.
[99] *Vide infra* Chapters 7 and 10.
[100] GBCLS 45th AR (1903), p155.

6.7 Violent behaviour

One of the most important criteria influencing the operation of boarding-out was that all patients were certified as harmless. Where there was any risk of violence, the patient was removed immediately to an asylum. Reports of violent patients remaining in private dwellings, therefore, were comparatively unusual, although the Commissioners recorded several cases where manifestations of violence prior to removal were evident. In the early years of the system, many patients were removed to asylums due to violent tendencies. The majority of these, usually male, had been under the care of relatives, who were often judged by the Commissioners to be less able than unrelated guardians at exerting control.

The first annual report of the Board of Lunacy contained many illustrations of violence among single patients. One patient, a 30 year old man suffering from "melancholia hypochondria", living with his mother, had complaints lodged against him by neighbours, who regarded him as "a dangerous person". He suffered from a number of delusions, expecting to be engulfed in flames and for the world to end. He was reported to break furniture, and make holes in the wall, declaring that while doing so he felt indifferent to his actions, but afterwards was "overwhelmed with regret". Before the Board could order his removal to an asylum, he was arrested as a dangerous lunatic and committed to prison.[101] In several cases, the violence was severe. Among them, for example, one patient attacked his daughter with a stake and threatened to stab his family. On the morning of the Commissioner's visit, he had stripped naked, put a stool on the fire and tried to get out of the house by going up the chimney. Another patient struck his mother repeatedly, kicked his sister and threatened to "brain" his father. He was able to work on the farm, but did so "roughly and rapidly", and no-one could approach him when he had a hoe or other implement in his hand. He was eventually ordered to be placed in an asylum.[102]

Twenty years after boarding-out came under official control, reports of violence committed by single patients had become rare and thus all the more noticeable when they occurred. A number of violent occurrences were recorded as late as the 1890s. However, it was recognised that the mental condition of insane patients was liable to sudden alteration. For this reason, the Board accepted that periodic episodes of violent behaviour were

[101] GBCLS 1st AR (1859), p200.
[102] GBCLS 3rd AR (1861), p254.

unavoidable but that if they were sustained, or exposed the public to danger, removal to an asylum was essential.

6.8 Restraint, seclusion and confinement

One of the conditions under which patients were exempt from removal to asylums was that they were not kept under any restraint, or confined to bed when they were not ill. If guardians insisted that the patient's condition required the employment of restraint or seclusion, such patients were clearly unsuitable for boarding-out. In the years immediately following the establishment of the Board of Lunacy, many patients were reported to have been confined to bed, often for many years. Many were secluded, not because of their dangerous condition, but because of the extent of their infirmity and a lack of alternative solutions. Some guardians admitted to secluding their insane relatives out of shame for their condition, or desperation, as well as to prevent them wandering off, or being exposed to potential abuses. Other patients were encouraged to stay in bed, "to relieve those around from the irksomeness of supervision."[103] Such precautions were resorted to more frequently in towns, where it was less reasonable to allow patients to wander freely.

The Commissioners condemned the employment of any form of restraint or seclusion. Their determination to detect and rectify any employment of these methods reinforced the legitimacy of boarding-out, by emphasising the freedom attainable to patients provided for in this way, in contrast to the often systematic employment of seclusion or restraint in asylums, regardless of the nature of disorder.[104] Such methods, the Commissioners contended, exacerbated the mental condition of patients, while creating problems of mobility due to limb contractures and bed-sores. It was not the mere indolence which was objectionable, but such a situation led to degraded, often indecent behaviour and allowed the guardian to neglect the patient. In such cases:

> "the bed is in some instances a mere substitute for the seclusion room in asylums, as padlocks and chains may occasionally be discovered on the box bed; showing that means of repression are available."[105]

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[103] GBCLS 2nd AR (1860), p196.

[104] The employment of restraint in nineteenth-century asylums is discussed in detail in Tomes, N. (1988) The great restraint controversy: A comparative perspective on Anglo-American psychiatry in the nineteenth century. In *The anatomy of madness.* vol. 3. *The asylum and its physicians* (eds. W. Bynum, R. Porter and M. Shepherd), pp190-225. London and New York: Routledge.

[105] GBCLS 3rd AR (1861), p254.

Recommendations for improvements were made on these occasions and if they were not implemented, patients were removed to an asylum or to the care of a more suitable guardian. The fault was often attributed to lax guardianship, rather than to any real need to restrain a patient. However, as Mitchell observed:

> "it would be unreasonable... in every case of restraint to urge removal to an asylum, for many cases have become known...in which restraint was applied when it was quite unnecessary, its use having been commenced in the early and active stage of disease and continued after the patient had become incurable, harmless and easily managed."[106]

Despite a high number of reports of restraint and seclusion in the early years of the Board's establishment, by the mid-1860s such occurrences were becoming unusual and almost always involved related guardians and patients, who were less easy to control.[107] Nevertheless, almost every year, a small number of cases were highlighted as being subject to cruel treatment and restraint. In 1867, for example, one patient was restrained during the day because a woman who was paid to look after her while her guardian was at work, regarded her as possessed by the devil. She was found confined to her bed and restrained by a strait waistcoat and a strap buckled round her ankles. The sleeves of the jacket were sewn up at the ends, to prevent any use of her hands. In the view of the Commissioners, the patient was passive and tractable, but on their instruction, she was removed to the asylum, even though she was unlikely to benefit from such provision.[108] There were other similarly disturbing cases in the 1860s, which shocked the Commissioners and resulted in removal to an asylum, despite the apparent suitability of the patient for life in a private dwelling. This was sometimes attributed to the lack of suitable alternative guardians, or to the degradation in the mental condition of the patient, following years of ill-treatment. Thus, one young woman had spent many years in a state of nudity in a "frightful cage" and another young girl had been chained constantly to a stone.[109] But as the Commissioners observed, while they were serious, they only represented a small proportion of patients boarded-out. Forty years later, it was most unusual to discover cases of such overt mismanagement or cruelty, even among related guardians. Macpherson reported in 1904 on the only case of restraint he had come across in recent years. This involved a young woman living with her parents who had been found tied to a table with a light chain fastened round her ankle. The excuse given was that unless they did this or watched her constantly, she ran

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[106] GBCLS 10th AR (1868), p239.
[107] *Vide infra* Chapter 7.
[108] GBCLS 9th AR (1867), p267.
[109] GBCLS 8th AR (1866), p237.

away. Although she was treated with kindness in all other respects, the use of restraint was deemed unacceptable and her parents were given the opportunity of discontinuing with such treatment or allowing her removal to an asylum.[110] Often the threat of removal was enough to bring about a change in the patients' circumstances.

6.9 Suicide

The Board of Lunacy listed the cause of death for all patients in each annual report. No suicides were recorded among patients in private dwellings until the 1890s. However, it is not possible to ascertain whether this was due to inadequate reporting and a wish to avoid classifying death as suicide, or to the fact that the type of patient boarded-out in the earlier years of the system was less likely to have suicidal propensities. The careful selection of patients deemed suitable for care outside an asylum must have gone some way towards denying the more vulnerable patients such freedom. However, this is likely to have been counteracted by the fact that increasing numbers of patients were discharged unrecovered from asylums, often having been actively manic or melancholic, the very kind of mental state more at risk from suicide. Certainly, from the 1890s and in the early-twentieth century, serious attempts and successful suicides were reported by the Commissioners.

While attempted suicides were recorded occasionally, the Commissioners were not concerned at any increased risk to the lives of patients when boarded-out, arguing that those in asylums were equally vulnerable. Cases were documented where patients cut their throats or tried to drown themselves. Such attempts met with little sympathy from some parish officials; one inspector of poor even declared that such patients "shammed" for "the purpose of extorting sympathy and help."[111] Nevertheless, events such as the following case documented by Lawson in 1891 were rare. A.G, a quiet, gentle patient was discovered hanged. Although seen to be in a state of mental confusion, the Commissioners had detected no suicidal tendency, and he was considered harmless to himself and others.[112] The Commissioners and his guardian reportedly anguished over whether they had neglected any signals, but Lawson insisted that A.G. had appeared contented and that his suicide could not have been prevented if he had been in an asylum. Thus no blame was attached to the

[110] GBCLS 46th AR (1904), p173.
[111] GBCLS 1st AR (1859), p202.
[112] GBCLS 34th AR (1892), p116.

guardian, or to the system itself. Similarly, when, in 1894, a 65 year old male patient hanged himself, the Commissioners absolved his guardian of any responsibility for the death. The patient had been discharged from an asylum 13 months earlier, and was reported to be actively employed and apparently content. Reporting on the case, Fraser announced that the patient had shown no suicidal tendencies while under his sister's care and concluded that "the impulse must have seized him on the morning of the deed."[113] In 1903, an elderly patient cut her throat with a razor, having been boarded-out for over 20 years, albeit with frequent re-admissions to the asylum.[114] Another patient shot herself a few years later,[115] but despite approximately 2500 patients a year residing in private dwellings under the cognisance of the Board of Lunacy, such incidents remained exceptional. Therefore, the rare occurrence of a suicide was not considered to be a threat to the existence of the system, or an indication that the overall policy itself was unwise or dangerous.

6.10. Assault

6.10.1 Assault against patients

Despite concern voiced by critics that vulnerable insane persons were exposed to numerous risks of abuse and cruelty by members of the public, remarkably few instances of assault by strangers were ever reported. Minor incidents may have been a regular occurrence, but there is nothing to suggest that boarded-out patients were abused regularly by their neighbours or guardians. Further, in contradiction of the beliefs of certain observers, the Commissioners maintained that real abuses would come to light during the regular visits by officials.

Among isolated cases, a newspaper article of 1889 reported the case of a slater being tried at a court in Dundee on a charge of aggravated assault on a 61 year old imbecile woman, boarded-out in Kennoway. It was alleged that the assault had taken place when he was "stupid with drink" and he was imprisoned for three months.[116] A successful conviction was also obtained in 1899, when a man was sent to prison for a year for assaulting a patient with intent.[117] Other criminal charges were less successful, insane patients being perceived

[113] GBCLS 36th AR (1894), p98.
[114] GBCLS 45th AR (1903), main report, pxlvii.
[115] GBCLS 51st AR (1909), p151.
[116] Unidentified newspaper clipping inside jacket of Boarded-out mental patients registers. (1889) D.HEW 7/4/1.
[117] GBCLS 46th AR (1904), p164.

as notoriously unreliable witnesses. However, if the lack of reference to such events in any official reports is a reliable indicator, serious violence against patients, with the exception of sexual assaults, was not a frequent occurrence.

6.10.2 Assault by patients

Similarly, there was little evidence that insane patients residing in the community were a threat to their neighbours. Only rarely were complaints made against a patient for committing an assault. In many successive annual reports, the Commissioners declared, with evident satisfaction, that no offences had been committed by patients during the year. Inevitably, there were exceptions, but never so frequent as to jeopardise the stability of the system. In 1865, The Scotsman newspaper reported the double murder by a patient of his mother and sister. However, he had not been reported as a single patient and, therefore, was not under the jurisdiction of the Commissioners. The Board of Lunacy insisted, with considerable justification, that the event bore no reflection on the officially regulated system of boarding-out. In 1896, however, a "deplorable occurrence" at Collessie, Fifeshire, was recorded, when a patient attacked his guardian's wife with a table knife and stabbed her child in the head, inflicting a fatal injury. He had been boarded-out for five years and was not regarded as dangerous. Following an inquiry, the Board of Lunacy emphasised that the case was unique and that because it was a solitary incident during 38 years of boarding-out, there were no grounds for attaching special significance to the occurrence.[118] Seven years later, Macpherson documented the murder of a guardian by a patient, when on a fishing trip (see Appendix 10). However, despite the severity of these incidents, the Commissioners stressed "the exceeding rarity of any violent conduct on the part of the boarded-out insane generally."[119]

Incidents of lesser severity were recorded occasionally; for example, in 1890 an elderly boarded-out male patient was accused of "indecently interfering with little girls" and in the same year it was alleged that a 27 year old imbecile man "indecently interfered with certain boys."[120] In this case, the sheriff concluded that he was "the ready instrument of the vices of

[118] GBCLS 38th AR (1896) main report, pxlv. *Vide infra* Chapter 10 for discussion of subsequent petition against the presence of insane patients in the locality.
[119] GBCLS 45th AR (1903), p157.
[120] GBCLS 32nd AR (1890), p114.

others".[121] The rarity of such incidents were highlighted by the Commissioners, who remained convinced that the careful selection and subsequent supervision of patients minimised the possibilities of violence. They maintained further, that despite strict supervision, it was impossible to prevent every such incident, and that patients under the strict surveillance of asylum attendants were also, on occasion, charged with assault.[122] However, as Sutherland contended, when such incidents occurred in asylums:

> "one does not expect to find them in the provincial newspaper, as is the case in private dwellings open to the fullest publicity...one accident does not justify disparagement."[123]

Thus the Commissioners were able to maintain that the limited number of assaults committed indicated "a record of success no asylum could equal," a view echoed frequently by enthusiasts.[124]

6.11 Pregnancy or sexually disinhibited behaviour

A greater problem than that presented by infrequent attacks by or against patients was the possibility of pregnancy among patients. In fact, one of the major criticisms levelled against the boarding-out system was the risk incurred in placing vulnerable females in a community where they could be sexually assaulted. The Board of Lunacy shared the preoccupation of critics and the general public regarding the threat of hereditary degeneracy and instructed the Commissioners to warn guardians, at every visit, to keep close watch on their charges.[125] Where patients were sexually disinhibited, or "actively erotic" (the term adopted by the Board of Lunacy) they were removed to an asylum, and if guardians appeared inefficient, others were selected. However, the Commissioners maintained that the low tone of morality in certain districts in Scotland, particularly in the Highlands and Islands, where males and females often shared a bed, rendered the protection of imbecile or weak-minded young women a difficult task.[126] Where this was so, and such accidents were regarded as of minor importance, it was found to be impossible to induce guardians to exercise as much care as the Commissioners considered desirable.

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[121] *Ibid.*
[122] *Ibid.*, p115.
[123] Sutherland, J.F. (1897) *op.cit.*, p14. As this statement indicates, the Board of Lunacy was clearly aware, and almost resentful of the fact that the system of boarding-out was exposed to more potentially adverse publicity than institutional care.
[124] GBCLS 43rd AR (1901), p163.
[125] *Vide infra* Chapter 10.
[126] GBCLS 20th AR (1878), p99. The particular identification of the Highlands and Islands as districts of "low morality" serves to emphasise an apparent prejudice among Lowland Commissioners for the mode and values of life in these areas. *Vide infra* Chapters 9 and 13 for discussion of the variation in standards of living in districts across Scotland, and the accusation made by parish officials concerning inherent prejudices among the Commissioners.

In the early years of the Board's supervision, the occurrence of pregnancy among patients was reported frequently. In the first annual report, for example, it was recorded that 18 patients had given birth to illegitimate children.[127] In addition to the threat of pregnancy, a further fear entertained by the Board, and on occasion realised, was the offence caused to "public decency" by the erotic behaviour of certain patients. Patients with erotic tendencies were usually those classified as suffering from congenital idiocy or imbecility, as were the majority of patients who became pregnant. In every other way, these women were regarded by the Commissioners to be suitable for care in private dwellings. However, complaints were made by villagers concerning imbecile women wandering around the village improperly clothed, and "showing no shame" when menstruating. One such case deemed particularly offensive by the Board was recorded in their first annual report. A 28 year old imbecile, described as "a good-looking...girl...of strongly erotic temperament" was seen to call the attention of children to her discharge when menstruating. She had given birth to twins, one of whom was imbecile, but showed no affection towards them. Both she and her mother had been in prison for drunkenness and disorder. The Commissioner was informed that the patient, like her mother, was a prostitute, who admitted having sexual intercourse with three men together:

> "I.R's obscene and profane language, and the unblushing manner in which she discoursed of men and their doings with her reinforced the probability of this".[128]

Unusually, she had been boarded with unrelated guardians. The Board of Lunacy refused to grant dispensation for her continued residence outside an asylum.

Other cases reported to the Board of Lunacy were less easily dealt with, particularly when the vulnerable patient was in the charge of her immediate family. Sexual assaults and pregnancy rarely occurred among those under the care of strangers. Thus Macpherson reported that of ten cases of pregnancy in ten years, seven patients had been under the care of their relatives.[129] Similarly, two pregnancies recorded by Sutherland in 1910, both occurred in patients who resided with near relatives. One, an idiot, was reported to be a "repulsive woman with a markedly simian countenance".[130] Again, the sexual risks had been pointed out clearly. The Commissioners were able to enforce strict adherence to regulations by unrelated guardians. In contrast, they were often obstructed, when, following

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[127] GBCLS 1st AR (1859), p195.
[128] *Ibid.*, p200.
[129] GBCLS 48th AR (1906), p176.
[130] GBCLS 52nd AR (1910), p169.

threats to remove a patient to an asylum or other guardian, relatives announced that they would remove their insane charge from the poor roll, preferring to forgo the aliment than tolerate the intervention of the Board. If this action was taken, they were then removed from the jurisdiction of the Commissioners.

As the system expanded, the Commissioners became increasingly reluctant to enforce removal to an asylum, unless the women displayed "thoroughly bad sexual propensities".[131] In cases where women showed "no grossness and no talk about men, but, rather a modest coyness, and a general bearing"[132] it was difficult to justify their forcible removal to an asylum. Beds were always at a premium and such patients were rarely able to benefit from treatment in an institution. Further, the expense of providing for them all in asylums would be prohibitive and as Sibbald emphasised, when reporting two cases of pregnancy in 1888, "absolute security from such accidents cannot be obtained under any system."[133] Two years later, in 1890, when there were 669 potentially vulnerable women aged between 15 and 49 years, the Board of Lunacy announced that:

> "to relegate all such imbecile women to confinement in an asylum, there to pass a monotonous and perhaps health injuring existence, would be nothing short of cruelty, besides entailing a waste of public money, since experience has shown that such persons may be cared for in private dwellings in such a way as to keep them safe".[134]

In further defence of the boarding-out system, the Commissioners contended that a number of incidents were not necessarily due to the patient being imbecilic or idiotic, but that, instead, many offences were unavoidable. A.L, for example, had long resided with a careful guardian and enjoyed much freedom. She was criminally assaulted, while out for a walk, by a man "apparently utterly stupefied with drink".[135] It was clear, in this instance, that any woman was vulnerable under such conditions and the fact that she was a boarded-out lunatic was held to be "a mere accident". It was often extremely difficult, at times impossible, to obtain a conviction against those who committed an assault. In many cases, the patient was insufficiently coherent to make an accusation and in others, there was inadequate evidence. For example, C.P.B, a 25 year old imbecile residing with her mother, became pregnant in 1887. A young man living in the same building was believed to be

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[131] GBCLS 35th AR (1893), p109.
[132] *Ibid.*
[133] GBCLS 30th AR (1888), p113.
[134] GBCLS 22nd AR (1880), p126.
[135] GBCLS 32nd AR (1890), p126.

responsible and was eventually sentenced to four months imprisonment. However, in the defence it was denied that the woman was an imbecile and an attempt was made to show that she gave consent.[136] Similar doubts were placed on the testimony of another patient who was raped in Argyll. The circumstances surrounding her case, and the cynicism with which her charge was greeted provide a revealing insight into the legal attitude held towards the insane (Appendix 11).

The occurrence both of pregnancies and manifestations of sexually active behaviour, declined as local inspectors became more familiar with the selection and supervision of patients and by the 1890s, reports of sexual assaults were rare. In 1896, Sutherland declared that there had been no such accidents among the 689 females he visited, although 38% (267) were of child-bearing age. This was, to him, striking testimony of the care exercised by guardians, parish officials and Commissioners. While critics of boarding-out received new ammunition each time a pregnancy was recorded, supporters maintained that incidents of assault, illegitimate pregnancy and offensive behaviour were an inherent feature of life among the sane population and, therefore, impossible to eradicate.

6.12 Accidents

Despite the mental disturbance of boarded-out patients, serious accidents were comparatively rare and no more frequent than those occurring among the general population. In the years 1889 and 1893, for example, only five accidents were recorded and this was typical of most years. The most common accident was among patients with epilepsy who suffered burns when having a fit and almost every year there were reports of such injuries.[137] In 1886, one female patient suffering from "chronic Bright's disease" died following burns received to her arms and face, when her dress caught fire. This was the only fatal accident reported in 1886.[138] Another patient was burnt when left alone in the house. Macpherson reported that the patient was well behaved and had been told "not to meddle with the fire". However, her guardian had gone shopping and on her return discovered the patient with severe burns from her chin to her knees and her clothes on fire. She died a month later as a result. In this case no blame was attached to the guardian who

[136] GBCLS 22nd AR (1880) p114.
[137] See for example, GBCLS 16th AR (1874), p323, 30th AR (1888), p114, and 32nd AR (1890), p114.
[138] GBCLS 29th AR (1887), p115.

was considered to have "an excellent reputation in the neighbourhood for the kindliness and attention she bore her patients."[139]

Drowning was the other most frequent accident and, in one year, two patients died in this way. To the Commissioners, however, "both were pure accidents, as could happen to any in the community." One of the victims, for example, had slipped into the canal on a foggy evening.[140] Less serious accidents followed fights between patients and falls resulting in fractured bones.[141] Such minor occurrences were expected and barely registered as a problem by the Board of Lunacy. Reflecting this, few critics highlighted the occurrence of accidents in their condemnation of the boarding-out system, although a number of accidents were attributable solely to the mental condition of the victim. Thus, one patient was struck by a train when standing on a rail track looking at an engine. Another, an epileptic died from drowning, having fallen into some liquid manure during a fit.[142] Nevertheless, the Board of Lunacy remained convinced that patients were as safe from accident and abuse as were their neighbours, declaring that:

> "this immunity from accident in so large a community of individuals, less capable than average citizens of avoiding the accidents of daily life, is remarkable and speaks volumes for the care which the guardians bestow in their charges".[143]

6.13 Contentment in private dwellings

Only very general impressions about the attitude of patients can be gleaned from official documents and other source material. The Commissioners reported remarkably few complaints by patients, even though many were questioned when the guardian was absent, to ensure that they were not intimidated. Nevertheless, the stature of the Commissioners and the unusual situation of a formal interview inevitably imposed severe restraints upon the freedom with which patients spoke. Further, the mental condition of many is likely to have prevented them from expressing any clear opinion, or opinions which the Board would regard as plausible. Many complaints were dismissed as manifestations of patients' mental disorder. In addition, some physicians declared that they would not put too much reliance on the statements of patients. For example, in a debate at a meeting of the Medico-Psychological Association, Thomson claimed that many patients "stood in considerable

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[139] GBCLS 42nd AR (1900), p147.
[140] GBCLS 34th AR (1892), p107.
[141] For example, those reported in GBCLS 30th AR (1888), p114.
[142] GBCLS 54th AR (1912), p149.
[143] GBCLS 34th AR (1892), p106.

awe of those in charge of them, and were very reluctant to state anything that would be objectionable to them."[144] Macpherson appeared more confident, however, observing of the patients he visited that:

> "their cheerful appearance and the frank way they answered my inquiries made in the presence of the guardian showed they were well treated and satisfied with their homes." [145]

Despite certain constraints, therefore, it is evident that the Board of Lunacy was satisfied at the general contentment of patients and their almost unanimous expression of preference for domestic rather than asylum life. The physical condition and appearance of patients was, in fact, often of greater influence in reassuring the Commissioners.

There were few reported protests about sleeping, clothing or eating arrangements, although some patients complained that they were inadequately fed. The most frequent complaints related to the restriction of freedom. Many patients discharged from asylums had enjoyed parole both inside and outside the asylum grounds and it is evident that some patients had even less freedom than when they were in an asylum, surrounded by plentiful open spaces. As Macpherson conceded:

> "these women expect that when they leave the asylum they are going to enjoy still greater liberty, and when they find instead that they cannot go beyond the garden gate, they become excited and rebellious, indulge in hysterical ravings ...or threaten to commit suicide."[146]

Nevertheless, other patients expressed their satisfaction at the freedom permitted; one patient boarded in Kennoway, for example, and in no way unusual, declared that she "has jist to gae oot an tak a walk doon the lane when she likit."[147] However, the initial contrast between the accommodation and facilities of a large public institution and those of a cottage prompted some unhappiness among some patients, who reported a sense of isolation, having been removed from the company of wards of patients.[148] A few complained of the dullness of country life and one patient, although well cared for, appeared to be "moping", and was reported to "complain bitterly of his wife not writing

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[144] In Anon. (1870) Notes and News. *Journal of Mental Science*, 15, p301. The report by the Mental Welfare Commission asked extensive questions to 147 male patients boarded-out in the 1960s. The replies indicate well the attitude of those questioned. Their discontents were largely compatible with those reported in the nineteenth century. No folks of their own. A report on one aspect of community care of the mentally handicapped. (1970) Edinburgh: Her Majesty's Stationary Office.

[145] GBCLS 48th AR (1906), p172.

[146] GBCLS 54th AR (1912), p160.

[147] GBCLS 29th AR (1887), p137.

[148] The validity of this particular criticism is considered in Chapter 10.

him".[149] Others were upset at teasing from young villagers and there were also complaints of overwork, for inadequate pay.

The assessment of official visitors throws additional light on the general attitude of patients. Notwithstanding minor complaints by patients, parish and lunacy officials alike stressed the general contentment among the majority. This was not necessarily blind optimism. Inspectors of poor and lay visitors appointed to accompany them on their official visits almost invariably reported on the contentment witnessed among patients. Lay visitors had no particular desire to stress the happiness of patients, at the expense of accuracy, in an attempt to propagate the system, although, like the Commissioners, an element of self-congratulation at the apparent happiness of patients was sometimes evident. For example, visitors from Glasgow announced in 1894 that they:

> "came away with a deepened interest in and sympathy with the insane poor and with the conviction that... we are still enabling them to make the most of their sadly incomplete life, by placing them in circumstances where they have fresh air and healthful surroundings and are in contact with home influences and family life."[150]

Visitors reported that some patients were able to express themselves and were "perfectly happy with their surroundings, and looked upon their stay in the country as a holiday."[151] Further, in the majority of houses, the patients were seen to fill "an important place in the family and were consequently very happy," some even holding tea-parties and picnics.[152]

However, the results were not always so favourable. The lives of many patients did not conform to the domestic idyll consistently portrayed by the Commissioners. For some patients, despite several attempts at boarding in different homes, they were ultimately found to be unsuitable and were returned to the asylum. Many experienced insecurity and an unsettled life, being moved to different guardians, often in new locations, having to undergo a new process of assimilation into the neighbourhood on each occasion.

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[149] Report by Visiting Committee, in Lists of children boarded-out by Barony parish: includes lists of boarded-out patients. (1911), D.HEW 24.24., p3.

[150] Printed Minutes: Glasgow Parochial Board and Committees, Medical Committee Report. (1894), D.HEW 2.2.18, p119.

[151] They observed too that many of the private dwellings were situated among "scenes of great beauty, which for all we know may be appreciated by the unfortunate patients in some half conscious way." Lists of children boarded-out by Barony parish: includes lists of boarded-out patients. D.HEW 24.21. (1897), p310.

[152] Ibid. (1909), D.HEW 24.22., p652. Similarly, visitors to Kilwinning district, reported that "it was reassuring to find patients in some instances expressing gratitude at being boarded-out and pleading not to be sent back to the asylum."

6.14 Removal from private dwellings

Many patients were removed from domestic care in the first ten years of the system, following the establishment of certain basic standards.[153] By the 1880s, unsuitable living conditions, or cruelty by guardians, were rarely cited as reasons for removal. The great majority of those removed from private dwellings were admitted to asylums following an alteration in their mental condition, rather than removed due to recovery or dissatisfaction with the system (Figure 6.3). On many occasions, re-admission was temporary, until the acute phase of illness subsided. Many of those sent to an asylum had been boarded-out for a long period, and were well treated, but with the infirmities of old age and the difficulties brought about by chronic illness, institutional facilities eventually became necessary. Admission to an asylum was also ordered for patients who had become violent, in need of restraint, of dirty habits, or who exhibited "erotic" behaviour or other sustained anti-social behaviour. The case of one patient, an "adept poacher", who was returned to the asylum because the authorities were unable to "restrain his illegal piscatorial habit" seems somewhat harsh. He had been boarded-out for five years, and was harmless and wholly suitable in every other way for continued residence in a private dwelling. However, the Commissioners recorded their expectation that his admission to the asylum would be temporary. [154]

Repeated swearing and "filthy" language was often cited as the reason for a patient's return. One patient was considered a public nuisance, with her "habitual and extraordinary obscenity and profanity of language", a situation exacerbated by her proximity to a school.[155] Similarly, those who failed to adapt to residence in their new homes and who disrupted the household were not allowed to remain. This was a particular problem in special licensed houses, with up to four patients present. Those with less extreme behaviour disturbance, but, nevertheless, who were in need of intervention, were placed under the care of more vigilant guardians.

With the exception of those exhibiting sexually disinhibited tendencies, who, as observed above, were largely imbecile, the majority of patients requiring admission to an asylum

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[153] *Vide supra* Chapter 4.
[154] GBCLS 39th AR (1897), p132.
[155] GBCLS 6th AR (1864), p231. Less justified perhaps was the removal of one patient following complaints that she was a gossip who "goes too much about". Boarded-out mental patients registers. (1913-1920) D.HEW 7/4/5., p385.

were those suffering from acquired insanity, often with delusions, which had been quiescent for a number of years. There was no marked predominance in the sex of those returned to the asylum, although women were frequently reported to be uncooperative or to adopt abusive language. In 1903, for example, 28 of the 48 patients returned to an asylum were female.[156] The proportion of recoveries over the period is notable, in view of the fact that all boarded-out patients were certified as incurable and unable to benefit from further medical treatment. A small number of patients were also removed from the roll of boarded-out pauper patients to the care of friends or relatives, even if their mental condition was unchanged. This was often done against the recommendation of the Commissioners, who then had no further control over their care.

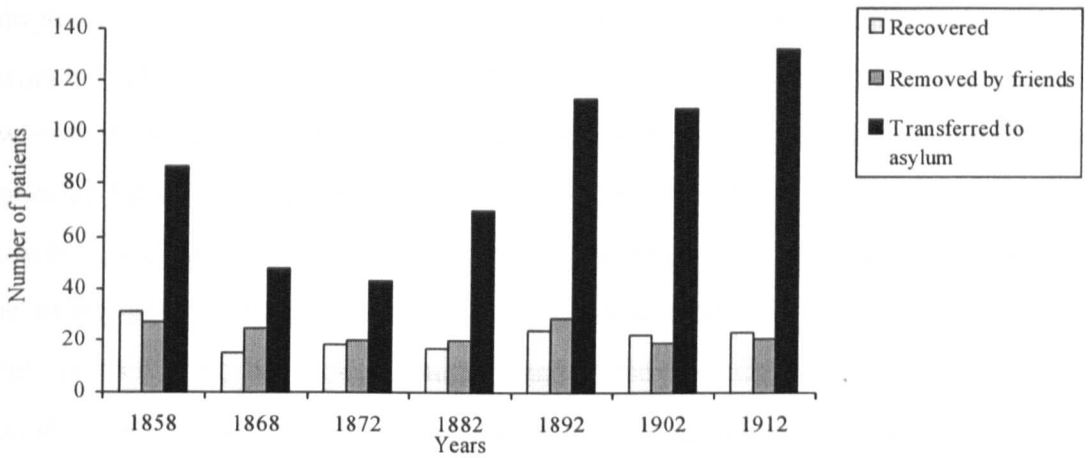

Figure 6.3 Mode of removal from private dwellings, 1858-1913[157]

The procedure for admitting a boarded-out patient to an asylum was straightforward. Parish officials were able to enforce the removal of a patient regardless of the wishes of a guardian, if the patients' behaviour, or the conditions in which they resided were deemed unsuitable. New medical certificates were issued, sanction for residence in a private dwelling was withdrawn and removal was ordered. However, Commissioners and parish officials alike wished to avoid the expense and trouble incurred in returning patients to an asylum and caution was therefore required in determining the unsuitability of patients. Many patients needed considerable time to become accustomed to life outside an asylum, but the inhibitory influences of domestic life and surroundings often encouraged patients to conform to expected behaviour.[158] In addition, inexperienced guardians often needed a trial

[156] GBCLS 45th AR (1903), p152.
[157] Source of data: GBCLS AR (1858-1913) *passim.*
[158] *Vide infra* Chapter 8 for discussion of the beneficial influences of domestic life.

period to prove that they were entirely capable. Despite evidence of much vigilance and devotion among many guardians, in some years a small number tired of the responsibilities involved, and requested the patient's removal.[159] Some guardians became disappointed with the capabilities of their charges and asked for their replacement by more useful boarders. Others, on getting married, or moving house, declined to take the patient with them. Typical of many removals was the transfer of one patient because her guardian was marrying an "undesirable man."[160]

With the widespread implementation of the system throughout Scotland, new problems emerged in maintaining the selection criteria. By the 1880s, more parochial authorities had adopted the policy, but having had no previous experience of boarding-out, made frequent errors of selection, both of patients and guardians. In addition, the Commissioners were aware that the suitability of a growing proportion of patients discharged from asylums was doubtful, because ex-asylum patients often suffered from more severe mental disturbance. However, following initial activity in removing quiet, incurable patients from the asylum, the supply of such patients was eventually exhausted and less suitable patients were given trial. In this way, bed-ridden patients and those suffering from recurrent mania were boarded-out.[161] Many had to be returned within a month of discharge. This rise in the proportion of patients transferred to an asylum was marked and mistakes in selection continued to occur in the early-twentieth century (Figure 6.3). In 1903, for example, out of 48 patients returned to asylums, 15 had been boarded-out for under a year, and 12 of them, for less than six months. At the other extreme, four patients were returned after 30 years in private dwellings.[162]

6.15 Summary and conclusions

The demographic characteristics and mental condition of boarded-out patients exhibited substantial variation. While the average age of patients was between 40 and 60 years, by the 1880s, a considerable proportion were markedly younger or older. There was always a preponderance of female patients in private dwellings, particularly in special licensed houses, due to the belief that females were more easily occupied and contented in a

[159] *Vide infra* Chapter 7 which considers the role and attitudes of guardians of boarded-out patients.
[160] Boarded-out mental patients registers. (1905-1917) D.HEW 7/4/4, p86.
[161] GBCLS 35th AR (1893), p103.
[162] GBCLS 45th AR (1903), p152.

domestic setting than active males, and were less likely to exhibit violent tendencies. Although the Board of Lunacy was confident that patients with congenital mental weakness were especially suitable for provision within the community, there was increasing willingness to board-out patients suffering from recent attacks of melancholia or mania, if they were considered to be quiescent and harmless. These patients were only placed with experienced guardians, under strict supervision.

Notwithstanding the limitations of the source material, prevailing records indicate overall contentment among patients, the majority of whom, the Commissioners insisted, were well cared for and allowed the freedom commensurate with their mental condition. However, it is all too easy to construct an idealistic picture of life as a boarded-out patient. It must be noted, therefore, that exceptions to the satisfactory living conditions and treatment praised by all Commissioners and the majority of observers, were reported almost annually. A proportion of patients remained unsuitably provided for, despite repeated attempts to ameliorate existing circumstances. Complaints about overwork and a sense of isolation were noted by visiting officials, albeit infrequently. The occurrence of pregnancy or serious sexual assault was reported with alarming regularity, even towards the end of the century, despite reassurances from the Board of Lunacy that the incidence was negligible, when set against the large numbers of vulnerable women boarded-out each year. However, despite being allowed greater freedom and independence than was compatible with institutional provision, there were few serious accidents or suicides among patients. The tone of a newspaper cutting reporting the death of one patient boarded-out in Glasgow, illustrates the affection with which some boarded-out patients were regarded, and the general contentment experienced by the more fortunate, and, if the Commissioners are to be believed, the majority. Thus the paper announced:

> "Today the grave closed over the remains of P.D, a character who has been well known in the East end of Glasgow for upwards of 50 years. He was kindly treated by many of the shopkeepers and mill workers. His illness was only of a few days duration, and his end, like his life, was peaceful."[163]

[163] Unidentified newspaper cutting inside jacket of boarded-out mental patients registers. (1889) D HEW 7/4/1. p1.

CHAPTER 7

CHARACTERISTICS AND ROLE OF GUARDIANS OF BOARDED-OUT PATIENTS

7. Overview

The quality of guardianship was an important determinant of the success of boarding-out. As the system expanded, patients were placed increasingly with unrelated guardians, who received an allowance to cover maintenance costs. Reasons for this policy in favour of strangers are explored in this chapter and the selection procedure and demographic characteristics of guardians outlined. Any system which allowed strangers to receive patients into their house for profit was viewed with disfavour by certain prominent critics and the motives behind applications by prospective guardians are discussed. Further, the relationship between patients and their host family, and the extent to which genuine assimilation into the lives of the family was achieved is assessed.

7.1 Introduction

Boarded-out patients were placed under the care of relatives or strangers, who were paid a weekly sum for the maintenance of each individual. Although the Board of Lunacy did not undertake the selection of guardians, it laid down strict guidelines for parish officials regarding the type of person most suited to take on the guardianship of insane persons. When patients had been granted exemption from removal to an asylum, they habitually remained in their own homes. A minority, however, were removed to the care of a stranger, if their relatives were considered unsuitable, or unable, to take charge of them. Where a patient was boarded with a relative, that guardian was not allowed to receive any further, unrelated, patients. The gradual decline in the proportion of patients boarded with relatives is one of the most notable developments in the system: the increase of boarding-out from asylums being another, closely linked transition, with such patients generally being discharged to the care of strangers, frequently in special licensed houses. Although not a

designated part of official policy, the increase of unrelated guardians was welcomed by the Board of Lunacy, which contended that the quality of care offered by them was superior.

During the first decade of annual reports by the Commissioners, numerous cases of unsatisfactory guardianship were recorded. As the system became established, however, unsuitable guardians were "weeded-out" (to use the Commissioners' terminology) in much the same way as the patients. Reports of neglect, restraint and seclusion of patients declined during the 1860s and 1870s.[1] Under the newly empowered Board of Lunacy and with the growth of asylum provision, particularly in areas without any institutions for the insane, facilitating the admission of patients unsuitable for boarding-out, conditions improved swiftly. Twenty years after the system was implemented, reports of extreme neglect or cruelty were unusual, prompting the Commissioners to observe that guardians were:

> "as a rule are faithful and intelligent, and are often found to devote themselves to the discharge of duties exceptionally burdensome, in a way that is worthy of all commendation."[2]

Nevertheless, critics of boarding-out argued that there were considerable risks of abuse of vulnerable patients by "common, uneducated people", who were frequently of "a low and coarse class."[3] These "lay speculators in lunacy"[4] were defended by the Commissioners, who argued that financial gain was rarely the sole motivation. To illustrate this, they described cases in which guardians had developed affectionate relationships with their boarders and expended much effort ensuring their proper care. Further, they contended that, in conjunction with careful selection of guardians, vigilant official inspection ensured that exploitation was unlikely and where present was easily detected and curtailed.

7.2 Role and responsibilities of guardians

The importance of the quality of guardianship was emphasised frequently by the Commissioners who were convinced that this was one of the major determinants of the success of each case. The duties of guardians were defined clearly in regulations which had to be displayed in a prominent place in every private dwelling (Table 7.1). Their basic responsibilities lay in ensuring that the patient was clean, contented, well-fed and clothed.

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[1] *Vide supra* Chapter 6.
[2] GBCLS 19th AR (1877), p119.
[3] Mitchell, A. (1864) *op.cit.*, p76.
[4] The expression "lay speculators in lunacy" coming from C.L. Robertson. Noted in Mitchell, A. (1868) The care and treatment of the insane poor, with special reference to the insane in private dwellings. *Journal of Mental Science*, **13**, p486.

Patients were not to be excluded in any way, or isolated from the living arrangements of the family.[5] Where guardians provided pleasant surroundings, and treated the patient efficiently and with kindness, the Board considered that its instructions had been fulfilled.

The Commissioners contended that the standard of care of trained asylum attendants was often no better than that provided by dedicated guardians in private dwellings. A survey of cases documented from the 1870s onwards suggest that this is a fair assessment.[6] Further, although the Board did not approve of dirty, or helpless patients being boarded-out, they conceded that guardians were well equipped to modify disagreeable habits, partly out of a desire to reduce the unpleasant tasks of cleaning the patient. Although not stipulated as part of their duties, the more experienced guardians tried to improve the abilities and education of their boarders, often with notable success, to the satisfaction of the Commissioners.[7] The majority, however, simply provided comfortable living conditions, and a pleasant environment, thereby fulfilling their duties, even if in a less impressive way. In general, the Commissioners were satisfied that guardians adhered to their responsibilities and the success reported in the majority of cases indicates that their determination that patients were treated as part of the family was not an idealistic, impractical aim.

7.3 Process of selection

The selection of guardians and homes was the duty of parochial officials, while the Board of Lunacy had ultimate responsibility for the choice. Guardians were chosen with great care and many applications for licenses were rejected annually, either on the grounds of unsuitability of the dwelling, or incompetence of the potential guardian. Inspectors of poor had to ascertain that applicants were of good moral character, that they were not motivated solely by the prospect of financial gain and that they were capable of providing a comfortable home. When contrasted to the attributes of guardians before the system was regulated, who might include the "retired or bankrupt butcher or baker,"[8] it is evident that most guardians receiving approval by the Board were far superior. The opinion of local officials, the clergyman, doctor and schoolteacher was sought frequently since inspectors from distant parishes had no knowledge of the characteristics of each applicant.

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[5] *Vide supra* Chapter 4.
[6] GBCLS 12th-55th AR (1870-1913), *passim.*
[7] GBCLS 6th AR (1864), p232, 19th AR (1877), p131.
[8] Anon. (1862a) Colonisation of lunatics by the legislature. *Medical Critic and Psychological Journal*, **2**, p441.

Instructions to Persons receiving Patients under the Jurisdiction of the General Board of Commissioners in Lunacy.[9]

Reception of Patients: Not more than one patient can be received into any house, unless specially licensed for the reception of a larger number by the Board. The sanction of the General Board of Lunacy is necessary before a patient can be received into any House. Occupants are consequently required to ascertain in every instance when receiving a patient that the sanction has been obtained.

Cleanliness: The Guardians or Nurses shall attend strictly to the cleanliness of those under their charge; and to insure this, they shall see that their faces, necks and hands are thoroughly washed every morning that their entire persons are washed once a week, except when illness prevents, and that their hair is combed with a fine toothed comb at least once a week. They shall change the stockings and cotton underclothing of the patients once a week, their flannel underclothing once a fortnight and the sheets of the beds at least once a fortnight.

Clothing: They shall take care that every patient is furnished with a full change of clothing; and they shall be responsible for having the whole clothing of their patients clean and in good repair. A separate box or drawer must be set apart for the clothing of each patient; and this shall always be kept in a neat and tidy manner and be submitted to the inspection of the Commissioners in Lunacy and the Parochial Officers.

Bedding and Sleeping rooms: They shall see that the sleeping rooms of the patients, and also their bedding, are aired daily. They shall take care, especially in the cold season, that the bedding is suitable and sufficient. They shall frequently ascertain whether the patients are comfortable and warm in bed; and when found otherwise, they shall supply additional coverings and do whatever else is necessary.

Food: They shall take their meals along with the patients and at the same table, unless the medical officer shall for some special reason decide otherwise; and they shall supply them with the same kind of food as they take themselves. This must always be sufficient in quantity, of good quality, and carefully cooked.

Medical Care: In the event of bodily illness, or of any marked change being apparent in the mental condition of the patients, the local medical officer must at once be called in; and his instructions must be carefully followed.

Occupation: They shall do all they can to get the patients to employ themselves in work suited to their training and ability; but they shall at the same time be careful not to overtask those who are inclined to be industrious. It is also desirable that every patient who is fit for it, should have outdoor exercise every day when the weather is suitable.

Religious Exercise: They shall wherever the nature of the case admits of it, encourage the attendance of the patients at Divine Service and Religious Exercises.

General Treatment: They shall, as much as possible, treat the patients as members of their own families, and shall do all that they can to improve their health and increase their happiness.

Table 7.1. Regulations for guardians of boarded-out patients

[9] GBCLS 15th AR (1873), p311.

The possession of particular qualifications or experience was not deemed necessary; kindness and honesty were considered enough. Among those regarded as unsuitable, former asylum attendants were thought to be unsatisfactory, because, the Commissioners maintained, they were often too regimented and official in their approach to patients.

In the early years of boarding-out, when inspectors of poor had only a limited number of applicants to choose from, difficulties had been encountered in the selection of guardians. The Commissioners recognised that the majority of labouring people were deterred from receiving insane patients out of fear of their behaviour and characteristics.[10] Notwithstanding this hesitancy, once the practice had become widespread, applications for patients were made by neighbours of existing guardians. The ease with which patients were accommodated, and the affectionate relationship which developed in many cases, encouraged others to make applications as people became "educated...as to the practicability of caring for the insane in their homes."[11] Thus, by the 1880s, the number of applications for patients in certain locations exceeded the number of available patients. To the Commissioners, it seemed to be "only necessary to plant the boarding-out system in some suitable spot, for it to grow until it requires pruning at the hands of the Board".[12]

There were few discernible differences between guardians of single patients and those in charge of two or more patients. However, the Commissioners recommended that where three to four male patients were boarded together, the guardian must be experienced and able to offer outlets for employment. It was also recognised that the work incurred in caring for four active female patients was beyond the capabilities of the majority of guardians. Where four females were placed together therefore, it was necessary that at least two of them were apathetic and easily managed.

7.4 Demographic characteristics

There were few extensive descriptions of the demographic characteristics of guardians in official reports. It is not possible, therefore, to disentangle the characteristics of related and unrelated guardians, in terms of age, sex or social class. Although the Commissioners

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[10] See for example, comments in GBCLS AR (1859-1862) *passim.*
[11] GBCLS 23rd AR (1881), p123.
[12] *Ibid.* This was particularly apparent in the aggregations of special licensed houses which developed in central Scotland. *Vide supra* Chapter 5.

reported on many guardians who were pensioners, there does not appear to have been any particular discrimination between young or old applicants. The majority were middle-aged and still actively employed. Younger applicants with children were also accepted as suitable, provided the family was not too large. There was no evident preponderance in the sex of guardians who received unrelated patients, although it was likely that the daily care of the patient was undertaken by women. The entrenched belief that women were better able to care for vulnerable people was accepted widely in the field of domestic provision. In this context, the view of de Boismont went unchallenged, when he attributed the success of boarding-out to feminine influence, declaring that:

> "the character of man cannot bend itself to this kind of slavery. The attempt to do so is, indeed, most distressing, as one must listen continually to the same complaints, the same pains and the same demands. The character of woman accommodates itself better to these incessant annoyances."[13]

Nevertheless, the head of the household was listed usually as the guardian, and almost invariably, therefore, was male. Patients boarded with relatives were generally cared for by a female; for example, 201 of 387 guardians assessed in 1882 were mothers and sisters. Fathers, brothers and aunts were listed next, with sons and daughters only rarely having charge of their insane parents.[14] Unmarried women were allowed to receive patients, the Commissioners regarding spinsters to be among the most conscientious and devoted of guardians. Such women, they maintained, had a genuine wish for companionship, and no desire for the exploitation of cheap labour. In contrast, there are no records of single men applying for guardianship. Widows, encouraged by the prospect of supplementing their meagre income, constituted a significant proportion of guardians, although the majority of guardians were married, with both husband and wife sharing responsibility for the patient.

Critics of boarding-out condemned guardians indiscriminately as "ignorant and needy," motivated only by the prospect of financial gain. Thus one vocal critic, Robertson, a prominent English asylum superintendent, announced that there was "little but the sixpence a day between them and neglect and want".[15] The Commissioners objected to such assessments, explaining that for this reason, the very poor were not selected to be guardians. Although the rate of maintenance paid allowed for a small profit, guardians

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[13] de Boismont, B. (1868) The utility of family life in the treatment of the insane. *Journal of Mental Science*, **13**, p571.
[14] GBCLS 24th AR (1882), p148.
[15] Discussed in Mitchell, A. (1868) *op. cit.*, p493.

were usually from the "respectable poor", and while appreciative of the money, they did not depend on it for survival. Far from reflecting the image portrayed by critics, and even though they were neither learned or affluent, the majority, in fact belonged to the respectable working class. Further, as Mitchell explained, they were less ignorant and needy than many relatives with whom patients resided and were of the same, or higher, social class than asylum attendants.[16]

To facilitate the assimilation of an insane patient into the life of a household, the Board of Lunacy announced that guardians should be, as closely as possible, of a "corresponding position of life" to the patient.[17] However, as boarding-out became widespread, parish officials increasingly looked for homes among a superior class of guardians, principally in larger farmhouses where, it was maintained, better food and housing would be secured. While the Commissioners conceded that conditions in these houses were often excellent, in terms of cleanliness and quality of provision, the emotional relationship was rarely satisfactory, as such guardians "too often consider the patient as beneath them in the social scale, and not fit to sit at the same table or same fireside."[18] Consequently, officials who looked for guardians among the "genteel class" were discouraged. The Commissioners had a clear preference for modest homes where the patient was seen as part of the family, rather than large houses where a boarder was lodged some distance from the other inhabitants. Macpherson, echoing the view of his colleagues, had no hesitation in declaring that:

> "patients boarded with people in their own position in life, or lower, are generally much more happily placed and, though the house is poor and the food often inferior in quality, they have a much better prospect of living happy lives...than those who are placed in the houses of guardians who consider themselves socially far superior to the patients."[19]

Therefore, although one American commentator considered that guardians were "composed of persons in the humblest walks of life...[living] in a very primitive manner,"[20] the Commissioners took the view that the labouring population, in general, were comfortably housed and well fed. Reflecting the standards deemed acceptable by the Commissioners, Lawson claimed that:

> "when all in the house sit around the same table, the chances are that the patient's interests are being looked after. The small compact household of a plain, industrious unassuming man or woman forms at all times the best kind of a home for a pauper lunatic"[21]

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[16] *Ibid.*, p490.
[17] GBCLS 10th AR (1868), p305.
[18] GBCLS 33rd AR (1891), p110.
[19] Macpherson, C. (1903) Boarding-out of pauper lunatics. *Poor Law Magazine*, **8**, p125.
[20] Stearns, H.P. (1881)The care of some classes of the chronic insane. *Archives of Medicine*, **5**, p31.
[21] GBCLS 29th AR (1887), p118.

There was little difference between the occupations of special license holders and guardians of single patients.[22] Throughout the nineteenth century, guardians were occupied as crofters, small farmers, carpenters, weavers, labourers and shoemakers, living in humble, but comfortable dwellings. However, where patients resided with farmers, the Commissioners dictated that they must be under special observation, so as not to be left "to the mercy of men, who, when they have the power, are not infrequently disposed to make the patient the butt of their coarse jests or cruel banter."[23] Miners and oil-workers were rejected as being too rough, with a low standard of comfort and morality,[24] while market gardeners were singled out as offering particularly suitable accommodation and care. The Commissioners expressed their confidence in "their character and rank in life [which] gives assurance that their patients will be treated with kindness and sociability".[25] Further, the nature of their occupation provided suitable employment for patients, and, in the view of the Board of Lunacy, it was considered unlikely that there could be a class of people better suited for guardianship.

The Commissioners also highlighted the importance of placing patients under the care of "not over intelligent lay guardians".[26] They had reached this conclusion following observations that where patients were treated by experienced physicians, insane beliefs and tendencies were constantly awakened by the methods used to ascertain the existence of delusions. The case of a chronic maniac was cited in support of this claim. The patient suffered from obscure delusions of persecution. Her guardian was an "honest and sensible gamekeeper", who did not consider his boarder to be ill and the consequent fact that his treatment of her was unlike that for an insane patient was regarded as an advantage. Thus Lawson asserted that daily supervision by experts could not have been more beneficial than the constant companionship of her unlearned guardians. He concluded that some cases of insanity were better dealt with by ordinary persons than by experienced specialists, because patients who were treated as if they were sane were under the most favourable circumstances for:

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[22] In the aggregations at Stirling, for example, the occupations of guardians were varied. Several were labourers, and farmers, others were foresters, ploughmen, shopkeepers, and dressmakers. Nevertheless, in view of the predominance of special licensed houses in agricultural districts, a high proportion of guardians were farmers and crofters.
[23] GBCLS 23rd AR (1881), p130.
[24] GBCLS 29th AR (1887), p127.
[25] GBCLS 27th AR (1885), p142.
[26] GBCLS 24th AR (1882), p171.

> "throwing off...delusions and becoming sane...A guardian...has not the skill to detect a phase of insanity which is at once evident to the expert...It is only in private dwellings that patients can possibly obtain the benefit of the presumption of sanity on the part of those around them, for [residence] in an asylum,... affords the strongest possible presumption of insanity...the result will be that the success with which he deals with his patient may be in inverse ration to the accuracy of his diagnosis."[27]

Notwithstanding the concerns of the Board, a steady rise in the social class of applicants became apparent, prompting Lawson to note in 1890 that guardians were "more well off than used to be the case". To him, such guardians, artisans, small shopkeepers and small farmers "prove themselves to be good guardians and tolerant of the presence of the insane in their own circle."[28] Where private patients were boarded with strangers, it was rarely possible to find a person of the same social class to receive them. In practice, many were boarded satisfactorily with persons far inferior to them socially, but better able to provide a comfortable home. However, a considerable proportion of private patients were boarded in their own homes, under the charge of close relatives.

7.5 Number of patients with related and unrelated guardians

In 1868, Mitchell observed that "there is good reason for believing that the majority of single patients will always, as now be found under the care of friends."[29] However, his assertion proved erroneous. From the mid-1870s, the trend towards placing patients with strangers was established (Figure 7.1). In 1861, 1384 patients were in the care of relatives, representing 75% of the total number in private dwellings. Among them were most of the cases regarded as unsuitable for home care. By 1875, the number boarded in this way had declined by approximately 40%, to 843 patients. One explanation for this was the introduction of the parliamentary grant-in-aid in that year, which led to a rise in the numbers of weak-minded persons being classified as insane and registered as pauper lunatics.[30] Many were then removed to asylums. The decline in patients boarded with relatives, however, was neither rapid or consistent and at times, there was a slight rise in their number. In 1882, for example, 951 patients were boarded-out with related guardians. Nevertheless, the overall decrease since 1861, of 433, was notable.[31] Thus, while in 1861, 23% (403) of patients were boarded with strangers, twenty years later in 1881, the

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[27] *Ibid.*
[28] GBCLS 32nd AR (1890), p119.
[29] GBCLS 10th AR (1868), p489.
[30] *Vide supra* Chapter 4.
[31] GBCLS 24th AR (1882), p146.

proportion had doubled to 46% (777). The extent of the transformation is further indicated by noting that of the 228 patients admitted to the roll of boarded-out patients for the first time in 1881, nearly three-quarters of them were committed to the care of strangers.[32]

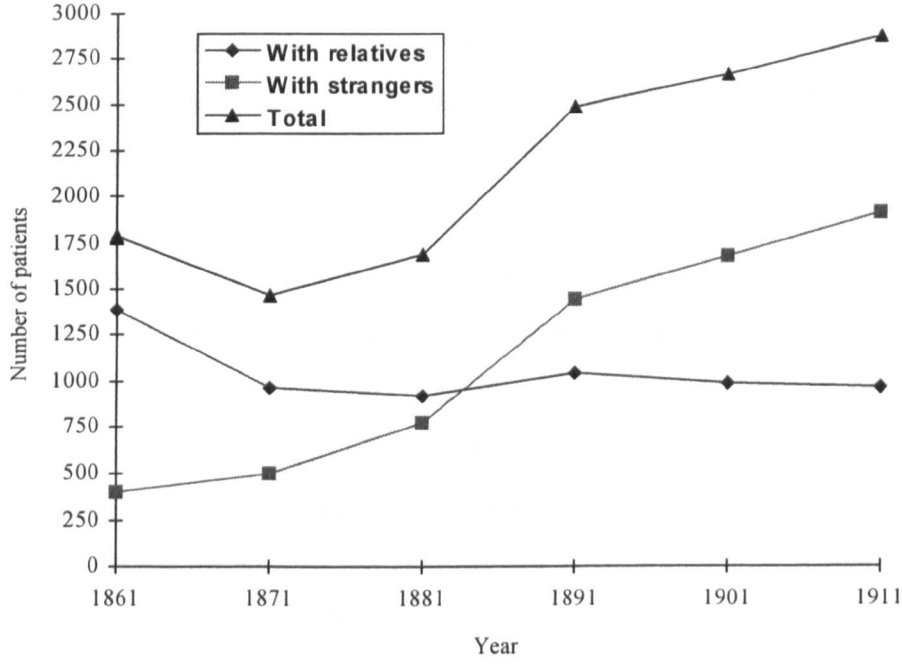

Figure 7.1 Number of patients boarded with related and unrelated guardians, 1861-1911[33]

While recognising that, in general, unrelated guardians provided better accommodation and treatment, the Commissioners contended that the decrease in those resident with relatives was not necessarily a desirable change. They indicated repeatedly that one of the most important objectives of the boarding-out system was to enable patients to live as far as possible in the way they had done before becoming insane. Thus:

> "there is no advantage in placing patients elsewhere than in their own homes, so long as the circumstances of their homes and the character of the relations make them suitable and when the insanity of the patients does not involve a perversion of the natural affections. In their own homes, patients are most favourably placed for being interested in the affairs of sane life, and for being influenced in their conduct by sane motives."[34]

It was accepted, however, that not all relatives possessed the personal qualities required for good guardianship. The transition was further explained by the unsuitability of living

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[32] *Ibid.*
[33] Source of data: GBCLS AR (1861-1911) *passim.*
[34] GBCLS 33rd AR (1891), main report, pxxxvii.

conditions in many urban areas where patients were often confined in small crowded rooms, without fresh air or exercise.[35] These restrictions, the Commissioners contended, rendered their homes unsuitable even when relatives were otherwise capable of guardianship. The transfer of many patients from their homes and from asylums to the care of unrelated guardians therefore was encouraged. Thus it was in relation to patients boarded-out from urban parishes that the increase in unrelated guardianship was most marked. The rapid expansion in the number of special licensed houses was an additional factor explaining the change.

Although the expansion of boarding-out with strangers did not arise from any particular preference of the Board of Lunacy, some Commissioners conceded that the increase was satisfactory. In Fraser's opinion, for example, the policy of placing of patients with unrelated guardians was being too slowly developed. He maintained that it was "not only possible, but advantageous to everyone concerned to extend this mode of providing for the harmless insane."[36] By the turn of the century, the great majority of patients still residing with their families were those suffering from congenital mental defect. They were more numerous in poorer, rural districts of the country, particularly in the Highlands and Islands; for example, the percentage of insane boarded with relatives in the Western Isles and along the western seaboard of the mainland was the same in 1900 as it had been in 1862. In contrast, the majority of those boarded with strangers in central and southern parts of Scotland had been in asylums, and suffered from acquired forms of insanity: dementia or mild forms of mania or melancholia. By 1900, over 60% of boarded-out patients were under the care of unrelated guardians, and it was this transformation that was considered by some Commissioners to be "more remarkable than the change in the proportion of cases of acquired and congenital insanity boarded-out recently."[37]

7.6 Standard of care provided

There was lively consideration by those concerned with lunacy administration regarding the standard of care available. In general, annual reports of the Commissioners were complimentary and only rarely were there extensive recommendations for improvement.

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[35] *Vide infra* Chapter 9.
[36] GBCLS 24th AR (1882), p147.
[37] GBCLS 38th AR (1896), p123.

Most visits appeared to convince them that, notwithstanding the need for occasional reminders for greater cleanliness, patients boarded with both unrelated and related guardians, experienced satisfactory treatment. Following his annual round of visits in 1885, Lawson assessed the relationship between form of guardianship and quality of care, concluding that the percentage of satisfactory and unsuitable provision was remarkably similar throughout the country. He divided the condition of patients into categories of "very good", "good", "middling" and "bad".[38] The greater proportion of both "good" and "very good" cases were found among unrelated guardians, particularly among special license holders.[39] However, although the care provided in 20% of cases boarded with relatives was considered to be below the acceptable standard set by the Board, the majority were cared for satisfactorily, in line with the expectations of the Board of Lunacy.[40] Similarly, an assessment of the quality of guardianship in 1898 indicates the general suitability of guardians throughout the latter part of the nineteenth century. Of 1117 patients visited by one Commissioner, the quality was deemed to be "bad" in only five cases, and "indifferent" in nine. Minor faults capable of swift improvement, such as want of proper supervision, inadequate cleanliness, or insufficient accommodation were recorded in 34 other cases.[41]

Where cases were reported on unfavourably, the Commissioners contended that the faults were due to injudicious management, rather than intentional cruelty. The impression gained from examples recorded throughout official lunacy and parish reports appear to confirm this claim. Any neglect of patients was condemned, as was the retention by some guardians of paying lodgers, to whom the comfort of the patients was sacrificed. Guardians in health resorts were warned against allowing visitors to board with them. Despite a steady improvement in conditions, instances of inappropriate treatment were nevertheless recorded almost annually. Mitchell's report in 1864 concerning two young women confined to bed, in a state of nudity, "exposing their persons continually in the most indecent manner" was representative of numerous cases of inadequate management and neglect.[42] In both cases the patient lived in a public room, exposed to visitors of both sexes. Although originally both had been suitable for boarding-out, they had become so degraded by

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[38] GBCLS 27th AR (1885), p139.
[39] A classification of "good" was given to 54% of unrelated guardians of single patients and "very good" to 31%, while the classification of "good" applied to 73% of special license holders and "very good" to 25%.
[40] 58% getting the classification "good" and 22% "very good".
[41] GBCLS 40th AR (1898), p123.
[42] GBCLS 6th AR (1864), p231.

continued neglect that removal to an asylum was the only alternative. This was attributed to the lack of any effort to act on the repeatedly expressed instructions of the Board.

Within a few years of the introduction of boarding-out, the extensive visitation and vigilance of the Commissioners ensured that most unsuitable guardians had been identified and disqualified. Guardians who drank heavily, treated the patients as servants rather than companions, or abused them in any way, were refused permission to continue receiving patients. Among unsatisfactory examples, a helpless dement was seen living in the "utmost wretchedness", under the care of "a drunken termagant in a common lodging-house of questionable character."[43] In the case of J.G, a change of residence was recommended, on the grounds that she was not properly protected against the risk of pregnancy because her mother kept a whisky-shop.[44] Cases were also reported where patients were left alone for long periods of each day, or even for several days, while the guardian went out to work. Among the more extreme situations, one guardian from Fifeshire was reported to be away in Edinburgh training as a nurse, while her patient remained at home.[45] Although a steady improvement in the quality of care was observed among both related and unrelated guardians by the 1880s, occasional discoveries by visiting officials served to highlight the difficulty of ensuring adequate provision by all guardians, notwithstanding regular supervision and visitation by officials.

7.6.1 Related guardians

When suitable guardians were identified among relatives, the policy of the Board of Lunacy had been initially to send patients to them. However, as indicated above, there was a wider variation in the standard of care of those boarded with relatives. Annual reports consistently included detailed descriptions of neglect or unsuitable treatment of patients, and as the system of boarding-out expanded, it became increasingly apparent that the largest proportion of distinctly unsatisfactory cases were among those who residing with relatives. East, although referring to single patients in England, expressed views increasingly accepted by the Commissioners when he declared that it was well-known:

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[43] *Ibid.*
[44] GBCLS 3rd AR (1861), p259.
[45] Similarly, Mitchell observed guardians "in the habit of leaving home for days or weeks on end, no substitute being provided during these absences". GBCLS 6th AR (1864), p227.

> "that friends or relations are the worst possible companions or nurses for patients of unsound mind, so far as treatment or real control likely to do good is concerned."[46]

To him, private treatment in the house of a medical man offered the best hope of cure.[47] Thus it was among related guardians that problems of over-involvement or resistance to recommendations were encountered most frequently. However, the Commissioners emphasised that this did not imply that the "Scotch poor are as a whole incompetent guardians of their insane relatives."[48] Rather, fondness and attachment were evident, but often misplaced, with inadequate discipline proving, ultimately, to be detrimental to the patient. This is demonstrated in the reports regarding J.M'M, a weak-minded person living in the Highlands with his parents who were convinced that he was a genius. Sibbald observed in 1874 that "his chief mental characteristic is an overweening belief in his own extraordinary literary power and religious knowledge".[49] If placed under judicious guardianship, he would be suitable for residence in a private dwelling. However, his parents were reported to be infatuated with him and encouraged him in his obsessions with writing manuscripts. As a consequence, his personal cleanliness was neglected and he was offered no occupation which, Sibbald thought, may have led to moderation of his mental condition. Although his removal to another guardian was recommended, Sibbald recognised that this was unlikely to happen, as his maintenance costs were largely met by his father, thereby severely limiting the Board's power of intervention. This case illustrates how the existence of family connections could frustrate the intentions of the Commissioners, and obstruct their attempts to effect improvements.

A further obstacle encountered was the occasional, open resentment at recommendations for improvements. If removal to an asylum was threatened by a Commissioner, the patient could be removed by the relative from the poor roll, and therefore from the Board's jurisdiction. Such restriction of the Commissioners' capacity to modify adverse conditions of patients living with relatives proved to be one of the major defects of boarding-out. It is illustrated in a case reported in the early years of the system in which the Commissioners refused to grant dispensation from removal to an asylum to a demented female, M.M'L,

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[46] East, E. (1886) *op.cit.*, p5.

[47] Echoing this, Wood, an English alienist, announced that when he saw people in their own homes: "they were surrounded by persons utterly incompetent to be about them, they are either exceedingly anxious, or indifferent...As a rule patients are better away from their own families. In their own homes they consider they are entitled to do as they like; in the house of another person they...come to submit to what they find to be the law of the house..." In Anon. (1871) Notes and News. *Journal of Mental Science*, **16**, p459.

[48] GBCLS 27th AR (1885), p140.

[49] GBCLS 16th AR (1874), p323.

residing with her sister, "a passionate loud speaker, and an unprepossessing woman" and her mother who was "no less disagreeable."[50] Relatives would not allow her to be placed in any other house, preferring instead to have her name removed from the poor roll. Such a frustrating position was unlikely to arise among those boarded with unrelated guardians, because, as one physician observed: "one has more hold on the stranger, you can change them without any difficulty, and you can out the screw on them a little better."[51]

Even towards the end of the century, and in the early 1900s, the Commissioners were still commenting on the need for an improvement in the standards among those with relatives. Occurrences of pregnancy or abuse of a sexual nature were far more common among patients boarded with relatives and it was among such guardians that conditions of cleanliness and decency were least upheld.[52] Thus Macpherson noted in 1906 that of the ten cases of pregnancy occurring over the past ten years, seven of the patients had been under the care of their nearest relatives[53] Notwithstanding this, the Board found it particularly difficult to enforce the removal of patients who were treated in a kindly way, even if often dirty and undisciplined. Ties of kinship were held to compensate, to some extent, for the lack of cleanliness and order, and although such cases:

> "will always be the despair of the Visiting Commissioners, as permanent improvement is not to be hoped for, yet as the patients are otherwise treated with kindness, there is no sufficient justification for separating them from their natural guardians."[54]

The maternal or, though less often, sisterly solicitude which characterised the care of many patients, and the tenderness with which they were nursed, were noted with satisfaction by Commissioners familiar with cases of neglect in families. They reported on "many gratifying instances of the greatest self-sacrifice...and affection on the part of the relatives".[55] For example, the devoted attention paid to a 21 year old idiot was remarked upon as an instance where related carers were, in certain circumstances, eminently suitable. The patient was unable to stand, or speak, and behaved like a baby, but had a look of

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[50] GBCLS 1st AR (1859), p178.
[51] Royal Commission on the Care and Control of the Feeble-minded (1908), Vol. VIII, p200.
[52] Thus for example, the Commissioners reported that of the two "sexual accidents" in 1892, and of the three cases of pregnancy in 1898, the patients were all under the care of their parents: "indeed by far the greater number of accidents happen with those with relatives. The danger has been pointed out, and close supervision advised...often a foolish and unfounded sense of security on the part of the guardian that no such danger could possibly come to their child." GBCLS 34th AR (1892) and 40th AR (1898). *Vide supra* Chapter 6.
[53] GBCLS 48th AR (1906), p176.
[54] GBCLS 46th AR (1904), p169.
[55] GBCLS 33rd AR (1891), p99.

"placid content...[which] brightened into a happy gleam when his mother spoke to him".[56] He was provided with toys, and reported to be as clean as any neighbouring child. To the Commissioners "nothing can surpass the excellence of the care" in such cases and they took the view that where patients were congenitally weak-minded, they were often better cared for by relatives. It was unlikely that idiots or imbeciles of the lowest class, who were helpless and dirty, would be accepted by an unrelated guardian and, if they were removed from relatives and placed in an asylum, at no benefit to themselves, space was taken that could be utilised more profitably by potentially curable patients.

Nevertheless, despite support for the care of certain patients by relatives, the possibility that parents of the insane may also have some defect in their mental condition was mentioned on several occasions in official reports. One Commissioner, Lawson, considered that "so many of the relatives...are themselves unreasonable, impracticable or depraved, that a large number of them are in the position of blind leaders"[57] Echoing this, Hack Tuke, a vocal critic of aspects of boarding-out, declared that while he had "no great liking" for employing strangers in the care of the insane, he accepted that they were often more suitable, "partly because the immediate relatives are themselves so often peculiar."[58] This view was often reiterated, Macpherson, for example, announcing that:

> "when one takes into account the strong heredity of insanity, the fact that an idiot or imbecile is usually the offspring of a parent with an unstable nervous system, we must recognise that while the child will probably be treated with great affection, it will not likely be brought up in a way to give it the best chances of improving mentally."[59]

Notwithstanding these reservations, the role of related guardians was recognised to be of marked importance in cases where no alternative provision could be found.

7.6.2 Unrelated guardians

Commissioners and physicians alike recognised the potential difficulties created by the close association of patients with their relatives. Such patients often had delusional ideas about their relatives, and while they proved unmanageable in their own home, many were reported to behave "remarkably well" with strangers. While Lawson emphasised that "the

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[56] GBCLS 19th AR (1877) pp130-131.
[57] GBCLS 27th AR (1885), p143.
[58] Tuke, D.H. (1886) On a recent visit to Gheel. *Journal of Mental Science*, 32, p495.
[59] GBCLS 38th AR (1896), p134.

demonstration that...the alien guardian is the best custodian of the insane...is not that which one would prefer to make" he accepted that:

> "even family affection can be so greatly misdirected as occasionally to lead an observer to conclude that there are cases in which an insane person could not be worse off than in the house of his own relatives."[60]

From the Commissioners' standpoint, therefore, the increase in alien guardianship was "not an evil at all",[61] although some perceived the relationship as a purely commercial one. In such cases, they contended, the guardians were merely attendants whose contract could be annulled at any time. Such an assessment, although potentially accurate in certain cases, nevertheless appears unduly harsh in view of the general attitudes of guardians reflected in official reports. The extent to which it is justified will be considered in the following section. Reports indicate that many guardians developed affectionate relationships with their boarders, and provided comfortable surroundings for them out of a genuine desire to treat them well.[62] The steady endorsement of care among unrelated guardians appear to have been justified by the results prompting the Commissioners to remark annually on the superiority of such care. Nevertheless, a system which offered payment to strangers to care for vulnerable patients was, inevitably, open to exploitation and abuse and the fear that only the poorest persons would apply to receive patients.

7.7 Motives for receiving patients

One of the fiercest objections voiced against boarding-out was that the majority of guardians were poor and that their willingness to take patients was created only by their wish to benefit financially.[63] To facilitate a consideration of the degree to which the prospect of financial gain motivated applications for patients, the rate of maintenance paid will be assessed. While at all times the cost of boarding-out was lower than that of institutional provision, the amount paid to guardians varied considerably throughout the country. Those boarded with relatives received only a token sum, to cover living costs. The Board of Lunacy argued that relatives had a legal and moral obligation to maintain their

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[60] GBCLS 27th AR (1885), p143.
[61] GBCLS 30th AR (1888), p142.
[62] One notable event occurring in 1873 confirms this. A guardian of a special licensed house was awarded a Morison prize for meritorious attendance on the insane. Mrs Knox, from Balfron, was praised for the consistently high standard of care shown to her patients, despite having no formal training. Of the four male patients, who had resided there for 15 years, one was an active imbecile, and the only useful patient, the second was "blind, deaf, delusional and incoherent," the other two were demented and delusional. GBCLS 15th AR (1873), p275.
[63] Chapter 10 explores in detail the concerns of critics regarding the potential exploitation of patients.

patient, and that payment should merely cover any losses incurred, although it was aware that on occasion, sacrifices were made which were:

> "out of all proportion to any payment that is given. In such cases the claims of affection count for much, but it is proper that the loss incurred should be recognised."[64]

When placed with a stranger, the payment was intended to cover maintenance and repay to some extent, the efforts expended by the guardian. In 1867, for example, related guardians received on average, 3s6d a week, while unrelated guardians received 5s6d. In special licensed houses, guardians received 6s a week for male patients, and 5s for females, exclusive of payment for clothing.[65] The rate paid barely increased throughout the century, and in 1897, unrelated guardians received between 6-7s a week, plus clothing, for each patient, while the fee paid to related guardians ranged from 1s 6d to 5s a week.[66]

In determining the rate of payment, the standard of living among the general community, and the variation among districts was appraised. Parish officials also assessed the extent of special care that patients needed and their capacity for useful work. Where a patient needed special attention, the payment was higher. This is illustrated in the case of a J.T, a 78 year old pauper. Following a stroke, he had become bed-ridden and in need of considerable supervision. Consequently, in 1887, the allowance for his maintenance was raised from 7s to 8s a week, and an additional 5s a week given to a neighbour to relieve the guardian occasionally.[67] In cases where a patient had noticeable peculiarities, making it difficult to find anyone willing to assume guardianship, the pecuniary return was also higher. The sum paid was of considerable value when assessed next to the average annual income for unskilled labourers. In 1867, this was £20 10s, while for lower skilled workers, it was £29 13s and for the higher skilled, £47 2s.[68] In 1900, a skilled machine-minder received between 22 and 28s a week. Thus the payment of 7-8s a week for a boarded-out patient was a significant bonus for many families, which were likely to have earned far less than the figures quoted. The balance to be struck was a difficult one. The Board of Lunacy was aware that while the rate paid had to be sufficient to encourage applicants, it was equally important that excessive payments were not made. If the sum paid greatly exceeded the

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[64] GBCLS 25th AR (1883), main report, pxxxix.
[65] GBCLS 9th AR (1867), p245.
[66] Sutherland, J.F. (1897) *op.cit.*, p42. Thus, a lower rate was paid in the Highlands and Islands, where large numbers were boarded with their families. In 1894, for example, the cost for patients boarded-out in Edinburgh was 7s7d a week, whereas in the Shetland and Orkney islands, it was half that.
[67] GBCLS 29th AR (1887), p131.
[68] Baxter, R.D. (1867) National income of the UK. In Smout, T.C. (1986) *A century of the Scottish people, 1830-1950.* London: Fontana. p111.

cost of maintenance it would be an injustice to ratepayers. The possibility existed that high rates of board were held out by parochial officials as an inducement to potential guardians who, otherwise, would not have considered receiving insane patients. Similarly, as the Commissioners asserted, "it is never a satisfactory arrangement when the care of a patient is felt to be more of a burden than a benefit."[69] If guardians considered that the rate paid to them was unacceptably small, there were increased risks that patients would be forced into excessive labour. In circumstances where guardians relied on the labour of their patients, the range of cases to be boarded-out would become increasingly circumscribed; only useful patients being regarded as acceptable. If the profit was modest, treatment was more likely to be acceptable, and the attitude of the guardian more that of regarding the patient as a member of the family, rather than as a valuable commodity.

It is evident that where wages were good and employment constant, people of the labouring classes were less likely to take in insane boarders, while in areas where industry had declined and unemployment had increased, applications for patients were high.[70] Thus one feature apparent among many holders of special licenses was their recourse to guardianship in the face of declining employment prospects.[71] The validity of the claim made by critics in the nineteenth century is strengthened by the comments of residents of Kennoway, in 1994, who suggested that the predominant motivation behind guardians receiving patients was to make money. Whether this is an unduly cynical assessment is difficult to ascertain. It appeared that guardians this century were often of a higher social class than the average villager, one being the wife of a schoolmaster who had lost his job. Patients were seen working for their guardians, many being sent to do the shopping. One guardian was reported to send her boarder to the shops without enough money, on a regular basis. This was remembered by more than one resident, and symbolised the exploitation and humiliation they perceived as practised by some guardians.[72] However, focusing solely on the wealth of an area and the financial position of applicants is to be unduly simplistic, as there were other factors which influenced the development of boarding-out across districts, in particular, the accessibility of asylum accommodation.

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[69] GBCLS 25th AR (1883), main report, pxxxix.
[70] The decline of the hand-loom industry in Fifeshire being an obvious example. However, the need for money cannot be the sole explanation for this. Residents were more readily available to care for patients, and, if employed in farming, and other out-door occupations, better able to offer the patient useful employment, under their close supervision.
[71] *Vide supra* Chapter 5.
[72] Opinions expressed on a visit to Kennoway in 1994. *Vide supra* Chapter 15.

The Commissioners were under no illusions about the underlying motives of most guardians. However, while acknowledging that the relationship between guardians and patients was never wholly philanthropic, they considered that the attitude need not be one of self-sacrifice. Rather, and more realistically, "services are rendered and sacrifices made for a monetary consideration. That attitude bulks as largely in this as it does in every department of life."[73] Illustrating this, the Commissioners cited the profit attainable by special license holders. In houses where patients were well cared for, after all expenses were accounted for, 2s a week remained as profit. A guardian therefore realised a profit of at least 8s a week on four patients.[74] This was deemed particularly valuable to female guardians, many of whom might otherwise have been forced to apply for public relief. Nevertheless, if the sum remaining was any greater than this a reduction in payment was ordered. Any situation where a patient was a source of considerable profit was firmly condemned.[75]

Even if strict supervision ensured that patients were rarely exploited or overworked, it was accepted that ability to assist in daily work was valued highly and that, in many cases guardians benefited from work done by the patient. If voluntary, and for the benefit of patients, employment was approved.[76] However, the Commissioners insisted that guardians make no attempts to compel their boarders to work and that patients in fair health, who were clean and free from objectionable habits, were suitable for boarding-out even if their capacity for work was small.[77] Nevertheless, in several annual reports, officials recorded with some disapproval, that when helpless or idle patients were sent, requests for their subsequent removal were common. Reflecting this concern, Norman, a keen protagonist of boarding-out, stressed the importance of patients not being made to feel mere servants, warning that otherwise, "boarding-out will become mere farming-out, and the whole arrangement will end in a vile system of white slavery."[78] In order to combat dissatisfaction

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[73] Royal Commission on the Care and Control of the Feeble-minded (1908) Sutherland, J.F. p242.

[74] GBCLS 31st AR (1889), p137 This same profit was attainable in 1908. Of 7s paid to a guardian in 1908, after all costs had been met, there was often 2s a week remaining as profit. Royal Commission on the Care and Control of the Feeble-minded (1908), p45.

[75] However, many claims put in for additional expenses were justified. Parish reports detailed regular requests for extra allowances to provide articles of bedding or clothing destroyed by patients. These were granted without question, as were costs incurred in the recovery of patients who had escaped or become lost through wandering. The Commissioners accepted that guardians could not be expected to forfeit their own, limited income, on the care of patients.

[76] *Vide* Chapters 6 and 8 for further discussion of the effects of employment on boarded-out patients.

[77] When patients were employed, the Commissioners recommended that they be rewarded with a small wage, or additional tobacco or sweets. GBCLS 45th AR (1903), p155.

[78] Norman, C. (1890) On boarding-out as a means of providing for the chronic insane of the poorer class. *Transactions of the Royal Academy of Medicine in Ireland*, **8**, p475.

among guardians, the Commissioners suggested that inspectors of poor could diminish complaints, if they did not hold out to prospective guardians great expectations about the employability of boarders, and if they stressed that patients were not boarded-out for the guardians' benefit. Rather they must accept that payment for the maintenance of the patient was reasonable remuneration. If this were done, the Commissioners argued, there would be a reduction in the numbers returned every year to asylums as "unmanageable" or "unsuitable" for boarding-out.[79]

The Board of Lunacy was also aware that, on occasion, the fee paid was not properly employed to the patient's benefit, particularly when guardians shared the bedding or clothing supplied among the whole family, or gave inadequate portions of food to the patient. However, such behaviour was thought to be increasingly rare as the system developed.[80] Despite valid concerns that applicants were motivated by the prospect of financial benefits or the opportunity for assistance in daily work, the Commissioners conceded that some profit was both acceptable and necessary. Thus they declared:

> "the inducement to undertake this responsible office lies in the small margin of profit that remains from the parochial allowance, after defraying the cost of the patient's maintenance, together with the saving and gain derived from their work."[81]

That this was so did not necessarily detract from the quality of treatment available and, despite recognition that patients were vulnerable to exploitation, the attitudes towards patients and the care provided, were generally regarded, by Commissioners and parish officials, to be satisfactory.[82]

7.8 Relationship between patient, guardian and family

A major objective of boarding-out was to secure a degree of freedom and contentment for patients, without the constraints and discipline imposed in an institution. The relationship between patient and host family was, therefore, of utmost importance. The Commissioners believed that it was usually possible to decide, during a short visit whether patients were

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[79] GBCLS 54th AR (1912), p159. In Belgium and France, for example, it was made clear that the patient's labour did not belong to the guardian, and that when the patient was able to work, he should receive due payment.
[80] GBCLS 6th AR (1864), p227.
[81] In Anon. (1881) Reviews. *Journal of Mental Science*, **27**, p609.
[82] Thus, Copp, among many enthusiastic foreign alienists, concluded that "the guardians appear to be kind hearted and respectable. Their motive for work is evidently thrifty, but not unworthy." Copp, O. (1904) Characteristics of the Scotch Lunacy System. *American Journal of Insanity*, **61**, p59.

integrated into the family circle or treated as outsiders. The emphasis placed on this was fully justified, because:

> "upon this question of admission to the family life hinges the whole success of the Scottish system; where it is neglected, however perfect in other respects the guardianship may be, the results are disappointing; where it is conscientiously adhered to official visitation tends to become less inquisitorial and more a means of strengthening a relationship which in itself is the surest prevention of abuses." [83]

Throughout official reports, cases were documented of patients who had deteriorated so badly that removal to an institution was necessary, but where guardians pleaded to retain the patient. In such circumstances, guardians reportedly devoted all their time to the patients, even sleeping with them to prevent their wandering at night.[84] In the view of the Board of Lunacy, the fact that certain guardians were willing to undertake the care of patients when ill and in need of constant attention, often exerting themselves beyond the required limits, testified to the degree of attachment formed in many cases.

Although critics suggested that the presence of patients had a deleterious influence upon the family and, in particular, compromised the well-being of children, this was strongly disputed by the Board of Lunacy, which argued that young people and patients often derived enjoyment from each other's company.[85] In addition, some patients were of use in entertaining the children, and when visited by the Commissioners, were often seen playing with children, a practice which was thought to be beneficial for them and indicates the regard in which they were held by the guardian. One patient, discharged from an asylum, was reported to be a favourite with children, who held his hands and stayed close to him while he was interviewed by a Commissioner. The guardian was so pleased with the way he had fitted in with the family that she requested another boarder.[86] Another striking example of mutual affection found between patients and guardians was recorded in 1911. Three female patients had boarded for over ten years with an elderly couple. When visited by Macpherson, the wife was bed-ridden. Nevertheless, the house was scrupulously clean; one patient was found baking bread, another caring for her sick guardian. He noted, with some surprise, that the house had been run solely by the patients for several weeks and that

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[83] GBCLS 49th AR (1907), p153. Lawson's short assessment of the "Importance of personal character and influence of the guardian" outlines the desired characteristics of guardians, and is worth noting. GBCLS 31st AR (1889), p138.
[84] Reported for example, in GBCLS 21st AR (1879), p139.
[85] D.H.Tuke was one of the most vocal critics concerning the placement of insane patients with young children. *Vide infra* Chapter 10 for an extensive discussion of this.
[86] GBCLS 31st AR (1889), p120.

they were "all as much concerned about her as if she had been her mother".[87] Although similar instances of devotion among patients and guardians were recorded frequently, evidence of such independence was rarely witnessed by the Commissioners.

Even protagonists of the system accepted that there would always be disappointing cases, where patients were regarded merely as paying residents or where they were treated cruelly. However, by the 1890s, cases of abuse were reported only rarely and Sutherland asserted, with a confidence that was warranted, that the patient:

> "virtually becomes one of the family circle, and is as a rule treated with equal consideration. He has got, so to speak, the run of the house...and participates in all that goes to make up life in a ... rustic dwelling."[88]

The following figures are testimony to this confidence. In one year, 1903, less than 3% of boarded-out patients had to be returned to an asylum, for any reason, and only 1% of guardians were reported to be unsatisfactory.[89] Following initial activity in identifying and removing unsuitable patients and guardians, comparable figures were observed annually. Facilitating the achievement of an increasingly high standard of care was the unbroken connection with patients experienced by a number of families. This was recognised by the Commissioners to be "one of the best and most encouraging features of our Scottish system", particularly when contrasted with the limited and tenuous relationship between patient and asylum attendant. The experience and expertise accumulated in such cases was sometimes thought to be the determining factor in seemingly intractable patients becoming easily managed and helpful. Thus, the notable successes attained by generations of guardians were highlighted:

> "it is not uncommon to find guardians who have conscientiously... managed those committed to their care, and who have, when ill health and other circumstances made it impossible for them to carry on..., handed it over to younger members of the family trained by long experience to the ways and peculiarities of patients and to the methods of dealing with them practised so successfully by their parents."[90]

In the great majority of houses, therefore, patients appeared to be on comfortable terms with their guardians and integrated successfully in the life of the family. Many guardians spoke with gratitude of the help patients were to them and of the pleasure they brought to the family. One widow, for example, reported the change in her patient following the death

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[87] GBCLS, 53rd AR (1911), p160.
[88] GBCLS, 38th AR (1896), p120.
[89] GBCLS 45th AR (1903), p146.
[90] GBCLS 45th AR (1903) Such continuity was most famously observed at Gheel, where families automatically took over the care of an insane patient when the elderly guardian was no longer capable.

of her husband. From being "idle and useless", he appeared to develop a feeling of responsibility and became an useful worker, "of immense assistance in keeping the house together".[91] In this way, it is apparent that, despite the underlying financial arrangement, many guardians and patients were able to develop a satisfactory, warm relationship.

7.9 Summary and conclusions

The wealth of information in the extensive reports of lunacy and parish officials on the nature and quality of guardianship, makes it possible to assess whether guardians were merely custodians, or whether they offered the benefits of family life. Great emphasis was placed on the recognition that patients were treated as one of the family,[92] although the extent to which insane boarders could ever be wholly assimilated into the lives and homes of strangers must be questioned. Nevertheless, while critics argued that only impecunious persons applied for patients, corruption, exploitation and deviousness were seldom reported. In most cases, it appears that patients were integrated successfully into the household and many guardians proved able to provide for patients that the Commissioners were initially hesitant about boarding-out. The devotion and proficiency demonstrated by many guardians was a source of pleasure to Commissioners and parochial officials alike and cases outlined in annual reports testify to the generally high standards of care bestowed on those in private dwellings, particularly those placed with unrelated guardians.

By stimulating patients and providing a comfortable home life for them, harmless chronic patients were able to live in relative happiness, often resulting in improvements in their mental and physical health. It was recognised widely that in determining the suitability of patients for boarding-out, the nature of the guardian was of equal importance as the condition of the patient. As one Commissioner concluded in 1933, "were it not for their infinite patience, understanding, kindness and care, boarding-out would not have reached the high level at which it stands today."[93] The overall impression gained from official reports suggest that this claim is valid. To many Commissioners, therefore, it was not the fact of being in an asylum or in a private dwelling which ensured suitable treatment for patients, but rather, the manner in which they were treated, "the system is subordinate, the

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[91] GBCLS 51st AR (1909), p155.
[92] As the physician, Hogben concluded, "the key to the whole position in the relationship of guardian to patient is that the latter shall be one of the family...[and] not to be treated like lodgers," Hogben. E. (1898) *op.cit.*, p690.
[93] Kate Fraser, in Pollock, H.M. (1936) The family care system of Scotland. *Mental Hygiene*, New York, **20**, p421.

management is the essential feature."[94] While this confident declaration serves to highlight the importance and potential benefits of successful management, it is in danger of minimising the specific benefits of the system of boarding-out in private dwellings.[95] Nevertheless, it does illustrate the particular significance of the role of the guardian, and, as such, is worth recording.

It could be argued that, in their determination to emphasise the benefits of the system they so fiercely embraced, the Commissioners may have refused to accept apparent evidence of abuse or neglect. However, this does not seem to be the case; many patients were removed from unsuitable guardians and officials were well aware of potential abuses. While there was an strong element of complacency among the Commissioners, this was a reflection of their confidence that in the majority of cases, guardians were genuine and able and, while grateful for additional income, also endeavoured to treat the patient with consideration. Newspapers in the 1990s contain frequent reports of scandals occurring with current community care facilities.[96] Vulnerable people dependent upon poorly paid carers, are, it is argued, open to neglect, abuse and fear. While this was inevitably true among a minority of patients boarded-out a century ago, the extensive policy of official visitation ensured that such cases were identified and dealt with rapidly. Although there were unsuitable guardians, the evidence indicates that, generally, patients were well cared for and in this light, Pollock's warm commendation of the "wise, kind hearts and ever faithful Scotsmen" seems justified. To him, and to all enthusiasts of the system:

> "the fact of the continuance of family care in Scotland through more than eight decades is of itself strong evidence of its value as a supplement to institution treatment...These guardians understand how to manage their boarders in order to make them useful and happy. The example of these successful guardians is a potent influence in maintaining the Scotch system on a high plane."[97]

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[94] GBCLS 26th AR (1884), p146.
[95] *Vide infra* Chapter 8.
[96] *Vide infra* Chapter 15 for discussion on community care in the 1990s.
[97] Pollock, H.M. (1936) *op.cit.*, pp418 and 423.

CHAPTER 8

REASONS FOR THE ADOPTION AND IMPLEMENTATION OF THE BOARDING-OUT SYSTEM

8. Overview

The officially controlled policy of boarding-out developed as a response to continuing overcrowding in asylums and out of the recognition that institutional provision was not necessary for all insane patients. Its inherent advantages were soon realised, further stimulating the tendency to provide for certain patients in private dwellings. Improvements in the physical and, on occasion, mental health of patients were attributed to the benefits of a natural, domesticated environment. Protagonists emphasised that boarding-out was economical, and that the reduction of pressure on asylum accommodation allowed asylums "to turn more to their proper purpose of acting as hospitals for the cure of the insane" instead of being "mere lodging-houses for [those] who happen to be of unsound mind."[1] In this chapter, this assertion is assessed in detail and its validity questioned. Reasons for the tenacious survival of the system of boarding-out over many decades are also explored.

8.1 Introduction

The inadequacy of institutional provision had been highlighted in the Report of the Royal Commission in 1857, prompting the newly appointed Lunacy Commissioners to explore the alternative of allowing harmless patients to reside in private dwellings. Boarding-out came under official control at a time when a marked growth in asylums had been sanctioned. There is an apparent disparity between endorsing rapid growth in asylum accommodation at the same time as sanctioning widespread employment of non-institutional provision. However, this can be explained largely by recognising that in the interval between the order to erect district asylums and their completion (the first one,

[1] Turnbull, A.R. (1888) *op.cit.*, p371.

Argyll and Bute, not opening until 1863) large numbers of insane patients had been sent to the existing asylums. This influx into institutions, prompted by the revelations of the Royal Commission, thereby added to the already severe overcrowding.

Early annual reports of the Commissioners, therefore, indicate that the policy was adopted as a means to reduce overcrowding in asylums. At the same time, concern was being expressed at the admission and retention of patients of all categories of mental disorder in asylums. Reflecting this, the few brief discussions of the system, in recent years, have all emphasised the relief of asylums as the major motivation towards boarding-out, for example, Henderson,[2] McCandless[3] and Parry-Jones[4]. Henderson maintained that

> "the fundamental reason for introducing boarding-out was to release more bed space for acutely distressed patients who were urgently in need of hospital treatment."[5]

Similarly, McCandless has concluded that "Scots adopted boarding-out as much out of necessity as for any ideal purpose."[6] Nevertheless, recognition of its value soon led to the system becoming a valuable component of lunacy administration. Further, while the prospect of relieving asylums from overcrowding was a considerable stimulus to the expansion of boarding-out, this focus became increasingly important as the years progressed and admissions to asylums increased. In 1857, however, the Board of Lunacy was aware that within a short time, the district asylums would open, thereby reducing the pressure on existing asylums, and, in fact, in the early years of boarding-out, the number in private dwellings declined markedly.[7] It was not until the 1870s, with the realisation that the expected relief had not materialised, or at best had been only temporary, that the need to relieve asylums became a major argument for expanding the system. As such, it was referred to constantly in discussions in medical journals and official lunacy reports, but in assessing reasons for the introduction, rather than just the tenacity of boarding-out, there is evidence of wider theoretical concerns, not least the growing strength of arguments in favour of more humanitarian care of the insane. Therefore, although the most apparent reason behind the endorsement of the system was the relief it offered to asylums, it was not the sole impetus.

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[2] Henderson, D. (1964) *op.cit.*
[3] McCandless, P. (1979) *op.cit.*
[4] Parry-Jones, W.Ll. (1981) *op.cit.*
[5] Henderson, D. (1964) *op.cit.*
[6] McCandless, P. (1979) *op.cit.*, p588.
[7] The pattern of growth in the numbers boarded-out has been discussed in Chapter 4.

Parry-Jones has contended that therapeutic optimism was at a low ebb in the 1850s and 1860s and that concerns had been raised about the efficacy of the asylum system.[8] The proportion of curable lunatics in asylums had declined, prompting the realisation that many chronic patients filling the wards could be cared for satisfactorily without the constraints imposed by asylum discipline. Large and enduring aggregations of patients in asylums were condemned increasingly by alienists as undesirable both in the interests of the insane and of the general community. The wider recognition of alternative modes of provision was also attributable, in some degree, to the earlier success of moral management and to the experiments being made tentatively in adopting an open-door policy in asylums (although this was to reach its apotheosis in the 1870s rather than the 1850s[9]). Representative of the change in attitude was Maudsley's condemnation of the indiscriminate sequestration of the insane in asylums in his notable work of 1867.[10] His arguments were echoed by many other influential alienists throughout the United Kingdom, among them, Mitchell, the first Commissioner in Lunacy for Scotland, Lindsay, superintendent of the Murray Royal Asylum, Perth, Bucknill, of the Devon County Asylum, Clouston of the Edinburgh Royal Asylum and Norman, of the Richmond Asylum, Dublin.[11]

The initial inclination of the Board of Lunacy was to give the system a trial, as an adjunct to the district asylums. The Commissioners suggested, with cautious optimism that:

> "if kind, humane treatment is found in cottages even under the present system of imperfect supervision,... it could be so fostered in growth as to open up a prospect of escape from the many questions that are every year rendering the care and management of the insane poor a problem of more difficult solution."[12]

Despite this emphasis on humane treatment, it could be argued that boarding-out developed less for humanitarian reasons, than out of recognition of pecuniary advantages. Certainly, there is no doubt that the economic benefits of the system were welcomed by officials. Concern about the proper role of the asylum came later, with increased focus on the hospitalisation of the asylum achieving prominence from the 1880s.[13] But in conjunction with prevailing trends in lunacy provision, with the widespread acceptance of moral management, and greater freedom for suitable insane patients, the rationale for boarding-

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[8] Parry-Jones, W.Ll. (1981) *op.cit.*, p207.
[9] *Vide supra* Chapter 1.
[10] Maudsley, H. (1867) *The physiology and pathology of the mind.* London: Macmillan.
[11] *Vide infra* Chapter 14.
[12] GBCLS 1st AR (1859), pl.
[13] *Vide* Chapters 1 and 12 for discussion of the impact on asylums following the introduction of some of the features of the general hospital to asylum practice.

out was strengthened by economic considerations.[14] This chapter does not discuss the reasons for the continuation of the system in any order of priority; rather it can just be recorded that a multitude of reasons ensured that boarding-out was accepted enthusiastically by many alienists in Scotland.[15]

8.2 Relative costs of institutional and domestic provision

It was inevitable that questions of cost concerned administrators of lunacy provision. The acknowledged economies to be made by expanding a system of non-institutional care enhanced its appeal significantly, although some alienists denied any interest in such mercenary aspects, insisting that the welfare of patients was of foremost consideration:

> "As physicians we are called upon to heal and not to economise; our concern should be confined to the medical and moral aspect of each case, to the best and readiest means of cure...To allow the expense of the course to be pursued, to enter into, or to sway our mode of treatment, is to chaffer with the most sacred interests of our profession and of humanity, and to save money at the risk of sacrificing reason and of adding suffering to incurability."[16]

Despite such noble sentiments, critiques of boarding-out highlighted consistently the economy of the system. Maintenance costs for those boarded-out was almost half that in asylums. Indeed, while advocates declared that its relative economy was only one argument in favour of its adoption, the weightiest being the welfare of patients, constant reference to its lower costs belied protestations that "economy, though very properly an object, should most unquestionably not be the first object in boarding-out the insane."[17]

Foreign alienists, when propounding the merits of the system, reiterated the traditional belief that Scotsmen were preoccupied with mercenary concerns and that they accepted the system of boarding-out with enthusiasm for that very reason.[18] The Commissioners argued that to overlook financial considerations would be a "neglect of a public duty," although they emphasised that "no saving would be sanctioned which would be injurious to the

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[14] Turnbull, a medical superintendent, was a warm advocate of the system, summarising the advantages as follows: It provided "a natural, healthy and satisfactory mode of accommodation for a certain proportion of the insane", it was economical and it reduced the pressure on asylum accommodation, "enabling the institutions to... [act more] as hospitals for the cure of the insane". Turnbull, A.R. (1888) *op.cit.*, p371.

[15] This chapter focuses on the reasons behind the endorsement of the boarding-out system by Lunacy Commissioners and asylum officials. While parish officials had a vital role in implementing the system, their personal attitude towards boarding-out was rarely recorded explicitly and their opinions appear to have been confined more to expressions of resentment of the authoritarianism of the Board of Lunacy, rather than any discussion of the merits of the system itself.

[16] Anon. (1866c) *op.cit.*, p280.

[17] Lindsay, W.L. (1871) *op.cit.*, p518.

[18] This was also observed by a physician from Fifeshire who announced that, "Scotsmen have the reputation of keeping an eye on the pecuniary aspect of any question." Hogben, E. (1898) *op.cit.*, p689.

interests of the insane poor."[19] Dual concerns were evident throughout arguments for the development of the system, prompting Fraser to conclude that:

> "in our lunacy administration economy must have its weight, so long as efficiency is not sacrificed, and as, in the boarding-out system the patients are not deprived of anything that would promote their health or happiness, its comparative cheapness becomes an argument in its favour of great weight."[20]

The financial savings were considerable. In 1870, the rate of board per annum for a pauper in an asylum ranged between £19 and £31, with an average of £25. Poorhouse lunatic wards cost, on average, £20 per annum, while those boarded-out in special licensed houses cost between £13 and £15.[21] The disparity did not diminish as the century progressed. Thus protagonists of the system had at least one indisputable fact among their arguments.

The ability to utilise existing accommodation further added to the appeal of boarding-out. Cottages were already available and little expense was required in making them suitable for patients. There was a growing reaction against "the Chinese Lantern style of aesthetics" in many pauper asylums, with critics contending that such extravagance and grandeur appealed more to the Boards of Governors and staff, than to the inmates.[22] Excessive expenditure on asylums was condemned amid suggestions that rather than lavish such large sums, a rigorous economy should be exercised in providing for the chronic insane. Thus, the money saved by an enthusiastic implementation of boarding-out by Edinburgh City Parish was spent in developing the hospital and admission departments, and in making the institution more overtly medical, prompting Clouston, superintendent of Edinburgh Royal Asylum, to observe that from the point of view of ratepayers, physicians and administrators, the system was useful.[23] This recognition was echoed by the majority of medical superintendents and strongly emphasised by the Commissioners.

8.3 Relief to ratepayers

In highlighting the advantages to be gained by widescale implementation of boarding-out, the Board of Lunacy also documented the relief gained by ratepayers, not only in respect of

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[19] GBCLS 8th AR (1866), p238.
[20] Turnbull, A.R. (1888) *op.cit.*, p371.
[21] In 1864, for example, the annual cost of providing for the 1,637 paupers in private dwellings was £14,937. If they had been in lunatic wards in a poorhouse, the cost would have been £30,489 and if in a district asylum, £40,206. By offering an alternative to institutional provision, the reduction in the annual cost of maintenance was significant: a saving of £15,552 compared to the cost in a poorhouse, and £25,269 if in an asylum.
[22] Tuke, J.B. (1889) Lunatics as patients, not prisoners. *19th Century Journal*, **25**, p604.
[23] MS AR, Edinburgh Royal Asylum, *passim*.

the diminished overall weekly costs of maintenance, but by the reduced necessity for funds to pay for continued extensions to asylums. The same point was made frequently by overseas protagonists of the system, in their endeavours to encourage enthusiasm towards its adoption in their country. Among them, Copp, an American alienist, noted that in 1902, the county of Edinburgh saved three shillings a week on each of its 343 boarded-out patients. He further praised the saving attained by not having to build and maintain an estimated six asylums needed to house these patients. To Copp, as to many others, "such economic result is extraordinary."[24]

Given that the major concerns of medical superintendents lay with the daily administration of their asylums, the frequency with which they made reference, in their annual reports, to the relief attainable to ratepayers by boarding-out is surprising.[25] At Stirling District Asylum, where there was an active policy of boarding-out, this was strongly emphasised, almost to the extent of superseding concern for patient welfare. Thus, Skae argued that even if chronic, inoffensive lunatics were happier in asylums, this should not be taken into consideration.[26] Instead, he maintained, when an incurable patient no longer required detention in an asylum, for his well-being or for the safety of others, he should be discharged, even against his will. He justified this by observing that in every large town, there were:

> "miserable, poverty-stricken creatures to be pitied just as much as the chronic insane, yet who have been denied the comforts of an asylum...after all, insanity is but one of many miseries, and that one section of the poor may be getting more than their just share of benevolent attention."[27]

Even if such an opinion was not shared by all superintendents, sustained attention was devoted to fiscal matters in the annual reports of asylums. Typical of many comments was the observation by Keay, superintendent of Inverness District Asylum, in 1903, that "every patient unnecessarily kept in an asylum lays an unjustifiable burden upon the parochial rates."[28] A further financial saving occurred on occasions when patients improved

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[24] Copp, O. (1904) *op.cit.*, p61.

[25] Even officials at Perth District Asylum, an asylum with one of the lowest rates of boarding-out, noted that such a system relieved ratepayers of a burden they ought not to bear. MS AR (1904), Perth District Asylum, p13.

[26] He announced that "when once a district has provided an asylum sufficient for the proper care of all the insane who are curable, or who need to be detained...the provision of further accommodation becomes an injustice to the ratepayers." MS AR (1875) Stirling District Asylum, p19.

[27] *Ibid.*, p19.

[28] MS AR (1903) Inverness District Asylum, p32. Similarly at Woodilee, it was noted that if the burden of pauper lunacy on Glasgow parish was to be lessened, "it will be by a steady pursuance of the policy of boarding-out." CR (1907), Glasgow District Asylum, Woodilee, p28

sufficiently to maintain themselves to some degree and, therefore, were no longer chargeable to the rates. There was no restraint among officials in highlighting the pecuniary savings to be made, nor did they attempt to disguise them with humanitarian concerns, by stressing exclusively the increased well-being of patients provided for in this way.

8.4 Improvement in the condition of patients

8.4.1 Benefits of a natural family environment

It was recognised by protagonists of boarding-out that the conditions in which patients were placed could not compare with the cleanliness and organisation of an asylum. Allied to this, the Commissioners posed the rhetorical question: "what leads a pauper to prefer a miserable pittance in a private dwelling to the comparative luxury of even a poorhouse?"[29] They asserted that in even the humblest of cottages, patients were happier than in the best furnished asylums. This was explained by comparing the feeling of imprisonment and the "irksome discipline" of an institution, to the personal liberty, sane influences of the population and the diversions of a village existence, all in stark contrast to the necessarily conventional routine of the asylum. While recording marked improvements in the health of many patients, Fraser reported his firm conviction that:

> "if institutional routine and discipline had been substituted for family life and influence, and the freedom which these patients have enjoyed..., their standard of health and physical condition would not have been so high, and their happiness and contentment would have been far less." [30]

A further benefit often highlighted was the opportunity for patients to share in the daily life of the guardian's family. This was deemed of utmost importance to the Commissioners, who maintained that a "well-housed, well-bedded, well-clothed and fed" patient became:

> "more manageable, healthier, happier and more contented, and if it does not make him less idiotic or imbecile, at any rate it makes his idiocy or imbecility less apparent and reduces the unpleasantness of the difference between him and those around him."[31]

To many enthusiasts, the chief benefit was held to be the relief from confinement for large numbers of incurable patients. It was recognised that imbecility or dementia did not destroy a yearning for a home or a sense of liberty. Thus, Fraser maintained that those who advocated asylums as the only suitable place for the insane argued from a speculative point of view. He suggested that if they had a month's trial of the daily life of the most liberally

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[29] GBCLS 24th AR (1882), p166
[30] GBCLS 35th AR (1893), p93.
[31] GBCLS 7th AR (1865), p242.

managed asylum, experiencing its discipline and monotony, they would not advocate placing any patients in asylums unless absolutely necessary.[32] This was accepted by many physicians, including a number from England, although boarding-out from asylums was never developed on any significant scale there.[33] One English alienist, McDowall, stated during a debate at a meeting of the Medico-Psychological Association, that:

> "it was well known that when people were detained in an asylum their one cry and desire was to get home, which was very natural. Their associations with a particular district made certain spots in it very dear to them. And in suitable cases, nothing so improved a chronic lunatic and increased his personal happiness as returning to his native place."[34]

The Commissioners contended that it was those commentators whose sole experience was within asylums who objected to patients being deprived of the amusements and entertainments of the hospital. Furthermore, they asserted that the "lower class Scotsman does not consider amusements, such as concerts and dances as the most important item of social happiness."[35] In their view, a boarded-out patient was re-integrated with the class of people he was accustomed to and was not continually reminded of his illness. The Commissioners were confident in their belief that "this regular, healthy, natural life more than compensates for the loss of amusements and entertainments of an asylum."[36] The emphasis given to this aspect of boarding-out was consistent. Without exception, in every discussion propounding the merits of expanding the system, the beneficial effects of a natural domestic environment were stressed, not only by the Commissioners, but, perhaps more surprisingly, by many asylum superintendents as well as other interested physicians.[37] Each year, proponents of boarding-out detailed instances of amelioration in the condition of chronic lunatics, attributed to their greater happiness and autonomy in private dwellings. Notwithstanding some cynicism, it was widely, and increasingly, recognised that:

> "properly carried out and supervised family care forms the most suitable, natural and humane provision that can possibly be made for...a large number of the chronic insane.[38]

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[32] GBCLS 24th AR (1882), p166.
[33] *Vide infra* Chapter 14.
[34] Anon. (1909a) The boarding-out of the insane in private dwellings. Discussion in Notes and News. *Journal of Mental Science*, **55**, p181.
[35] GBCLS 39th AR (1897), p135.
[36] *Ibid.*
[37] Exemplifying favourable attitudes, for example, the superintendent of the Richmond Asylum, Dublin, maintained that the chief credit of boarding-out was "that it relieves from the misery of imprisonment patients whose mental state does not necessitate the infliction of that added suffering...Although not completely a free man...he is in a home-like place with home-like surroundings, and the...interests of home can again spring up in him." Norman, C. (1890) *op.cit.*, p470.
[38] GBCLS 48th AR (1906), p171.

8.4.2 Therapeutic claims

Although the majority of boarded-out patients were classified as incurable, improvements in the patients' physical and mental health were occasionally reported and attributed to the sense and reality of greater liberty, and the opportunity of becoming useful, possibly self-supporting members of the community. The Commissioners contended that, on occasion, the mere change in surroundings acted as a "tonic", which was sufficient to prompt patients drifting towards confirmed dementia to a noticeably improved mental condition.[39] The unnatural environment of the asylum was cited repeatedly by advocates of boarding-out, who argued that life in an institution repressed a patient's capacity for usefulness. Among the most vocal of critics, Maudsley argued that the asylum patient had no outlet for his energies, so that in many cases:

> "an outlet is made for them in maniacal excitement and perverse conduct; he goes through recurrent attacks of that kind, and finally sinks into a state of chronic lunacy, becoming an asylum-made lunatic".[40]

Proponents of boarding-out documented examples of individuals who appeared to be "a useless lump of clay" in the asylum, but who, on admission to a domestic environment, "brightened into an intellectual being."[41] While this may appear somewhat exaggerated, results were often impressive. Illustrating this, marked improvement was recorded in one patient who was removed from an asylum in 1888, despite the reluctance of the superintendent. Upon discharge he was reported to be "exceedingly reticent", refusing to speak to anyone. Within a few months, the inspector of poor announced that he was fully occupied during the day working on the farm, and that "his conversation with me was ready and often flavoured with mother-wit." He was reported to sing to the family in the evenings and to take "a keen delight in playing draughts...and frequently scores a victory."[42] An additional benefit was held to be the greater degree of attention paid to boarded-out patients, when contrasted to that in the overcrowded asylum wards. Such patients were often not simply under the charge of the named guardian, but of several members of the household. The staff:patient ratio in the average asylum was, at most, 1:15.[43] With this in mind, the Commissioners contended that the treatment of boarded-out patients compared favourably with that found in even the better private madhouses, especially in regard to the

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[39] GBCLS 25th AR (1883), p159.
[40] Maudsley, H. (1871) Insanity and its treatment. *Journal of Mental Science*, **16**, p327.
[41] Hogben, E. (1898) *op.cit.*, p690.
[42] GBCLS 31st AR (1889), p120.
[43] GBCLS 22nd AR (1880), p117.

treatment of severely deformed, helpless idiots, the care of whom took up such a large part of the energies of asylum staff.

The restrictions necessarily imposed on patients, the companionship of sane persons and the presence of children were all deemed to influence patient behaviour. The Commissioners were satisfied that:

> "the patient soon understands that objectionable behaviour and words are not liked in the family; and having sane conduct and influences constantly around him, he is brought naturally to square his conduct with that of others around him."[44]

One example of this was recorded by Fraser, when in his role as Deputy Commissioner, he recorded the improvement in the condition of a patient with acute mania who had been discharged after six years in Fife and Kinross Asylum. When medical superintendent, Fraser had refused to recommend his discharge, despite repeated requests by the inspector of poor, considering him to be untrustworthy in all his actions and "proud, vain and difficult to manage". However, he was discharged by Fraser's successor and reported to be doing well in his native village. When visited, he had "lost his flightiness and excitability."[45] He was subsequently removed from the poor roll as recovered. Fraser accepted that such improvement would not have occurred had he remained among the insane whose behaviour and words he used to imitate, concluding that his recovery must be attributed to the healthier, more natural surroundings in which he resided.

The influences of home-life and the acquisition of domestic habits were also held to be both educative and stimulating. The opportunity was there for patients to be drawn out of their introspection and interaction with sane people was deemed to have the effect of encouraging patients to think for themselves, motivated by a feeling of being part of the household. Recognition of these advantages were well recorded in an extensive study of boarding-out by Sutherland, who claimed that:

> "the best results are most likely to be obtained...[by] an assimilation of the life to that of sane people as far as is practicable...the acquirements of domestic habits long in abeyance, and the influence of the society of sane people, have the effect of drawing out sociable instincts, and of revealing and developing a latent capacity for work and usefulness. After a short residence in a private dwelling, responding to these stimuli, patients begin to think, and act for themselves... Everything conspires to make them feel that not only are they persons of some importance entrusted with certain duties, but...an integral, essential part of the household".[46]

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[44] GBCLS 31st AR (1889) p120. This point was also made by Turnbull when he stressed that the "insane feelings and habits" of patients should be "counteracted and repressed by association with sane people instead of bulking largely and perhaps gaining ground from association with other lunatics." Turnbull, A.R. (1888) *op.cit.*, p369.
[45] GBCLS 26th AR (1884), p130.
[46] GBCLS 39th AR (1897), p120.

Marked improvement in physical health was often referred to. Commissioners suggested that as many as 80% of those in private dwellings were in good health. This is less impressive, however, when it is noted that among the criteria for selecting patients for boarding-out was the insistence that they were not seriously physically ill or incapable of caring for themselves to some extent. Nevertheless, any recoveries were notable, because in order to be admitted to the roll of single patients a certificate of incurability was required. Despite this, the percentage of recoveries recorded annually among boarded-out patients was estimated to be nearly one third of the percentage attained in asylums.[47]

8.4.3 Increased activity and usefulness

Patients who were seen as industrious in the asylum were regarded as even more so when working for their own profit. Sibbald suggested, plausibly, that "the relish of self-interest permeates the labour and energies of a lunatic out of an asylum, but is absent when he is detained in one."[48] Similarly, one physician, Hogben, maintained that the unnatural environment of the asylum "perhaps imprisoned...[a patient's] potentiality for usefulness" and that in favourable cases, "it awakened a long dormant capacity for labour."[49] Although by the turn of the century, most asylums had farms attached to them, patients working on an ordinary farm mingled with sane people, "practically on a footing of equality", whereas in an asylum, it was argued, they were one among a vast group working under the close supervision of an attendant.[50] The majority of patients were occupied more in helping out their guardians, but some worked for profit, earning £12-18 per annum, as quarrymen, masons, farmworkers and weavers. While their earnings were rarely high, examples were cited where patients had "become either almost, or entirely self-supporting."[51] Even when earnings were small, they were useful in providing patients with luxuries. As Lindsay, a firm advocate of boarding-out, indicated, as a result of increasing the possibilities of remunerative employment of patients, the burden of poor relief was reduced and, in his opinion, patients began to be "regarded more and more an independent and valuable member of society."[52] One patient reported to Fraser that he had earned only 4 pence during

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[47] GBCLS 15th AR (1873), p279. One unusual outcome was the marriage of a boarded-out woman who had been admitted to the asylum for attacks of depression. GBCLS 9th AR (1867), p266.
[48] GBCLS 30th AR (1888), p104.
[49] Hogben, E. (1898) *op.cit.*, p690.
[50] GBCLS 43rd AR (1901), p163.
[51] GBCLS 24th AR (1882), p145. In contrast, in asylums, work undertaken was almost invariably for the benefit of the asylum, with no payment made to the patients. *Vide infra* Chapter 12.
[52] Lindsay, W.L. (1871) *op.cit.*, p520.

27 years in an asylum, but after two years in a private dwelling, he had earned over £7. From this he had bought "a trunk and a full suit of Sunday clothing for which he demanded my admiration."[53] Another patient, who had been confined in an asylum for five years on account of visual hallucinations and delusions, built up a shoemaking business, and was reported to make £1 a week and, was, therefore, able to support himself, even though subject to continued delusions.[54] However, transformation to full employment, and the concomitant respect, rather than pity or fear, of patients was rare.

Further testimony to the benefits of domestic care were found in declarations of happiness from the patients themselves.[55] The Commissioners reported that at least 90% of patients capable of responding to questioning announced that they preferred their life in the country.[56] Whether patients were ever as fully integrated as the Commissioners implied is doubtful. Many idiots were too severely disabled to appreciate their new surroundings and it is unlikely that they would be treated in exactly the same way as the guardian's own family. Notwithstanding this, improvements were observed in many patients, and their contentment contrasts strongly with the complaints and appeals for discharge recorded frequently among asylum inmates.

Another positive aspect of boarding-out emerged following the recommendation by the Board of Lunacy that imbeciles and idiots receive training in the basic necessities of daily life. The result of this was hailed as a success, in many cases far beyond the expectation of the Board. For example, M.W, an idiot, who could not tell how many fingers she had, or how many pence in a shilling, was taught to knit, sew, and "do household work under direction", for which she earned one shilling a week.[57] While the Commissioners recognised that such patients could never become self-supporting, they were confident that many could acquire clean habits and become "innoxious to themselves and others", as well as acquire an interest in the daily affairs of family life.[58] The Board of Lunacy was emphatic in its praise for the improvements in the health of the boarded-out insane, highlighting the

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[53] GBCLS 31st AR (1889), p119.
[54] GBCLS, 30th AR (1888), p112.
[55] These have been considered in Chapter 6.
[56] GBCLS 43rd AR, (1901), p163.
[57] GBCLS 3rd AR (1861) p245. Commissioners praised efforts made to develop any capacity for useful occupation which the imbeciles seemed to possess. "In doing this, habits of self-control have been fostered. Two or three have, under careful steady training, been led from filthy into cleanly habits. Many have learned to put dress without assistance, and to wash and feed themselves."
[58] GBCLS 19th AR (1877), p132.

"dementia dispelling effect of domestic treatment" encouraged by the arousing of patient's affections and the opportunity to express their individuality.[59] Therefore, despite scepticism among many alienists towards the claim that, in a number of cases, domestic treatment could be curative, the Commissioners were in no doubt that this was so.[60]

8.4.4 Lower death rate

The mortality rate of boarded-out patients was the lowest among all classes of the insane. This was recorded repeatedly by the Commissioners and cited as confirmation of the favourable living conditions and high quality of care. During the period 1865-1869, for example, the average annual death rate was only 5.9% of all boarded-out patients, and this had improved considerably by 1912, when the rate recorded for the years 1908-1912 had dropped to 3.8%.[61] Commissioners announced that this low rate was particularly impressive in view of the wide age range of patients and their tendency to suffer from mental conditions which lowered physical vitality. Even more remarkable was the consistently lower death rate for patients in special licensed houses, compared with those placed singly. In 1875, for example, this was 3.2%, compared with an average of 5.5% for single patients.[62] This is particularly notable in view of the fact that many patients sent to houses with special licenses were above the average age of those boarded-out, having already spent much of their lives in an asylum.

In contrast, the average annual mortality rate in asylums was, in 1884, for example, 8.2%.[63] However, the statistics are barely comparable since there were higher levels of "active disease" in establishments, and asylum inmates included many seriously physically ill patients.[64] Those in private dwellings had been selected partly on the grounds of their physical well-being. Nevertheless, this is not enough on its own to mitigate the impressive nature of the low death rate recorded for boarded-out patients. The disparity remained marked in the early years of the twentieth century. In 1906, for example, the proportion of

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[59] GBCLS 25th AR (1883), p159.
[60] This assertion was supported by Macpherson, among many, when he noted that the "freedom from irksome discipline, mixing with sane persons of their own rank in life, and on a footing of equality has a wonderfully beneficial effect, and sometimes results in complete recovery." GBCLS 43rd AR (1901), p163.
[61] GBCLS 13th AR (1870) and 55th AR (1913) *passim.*
[62] GBCLS 17th AR (1875), p258.
[63] GBCLS 26th AR (1884), p132.
[64] GBCLS 11th AR (1869), main report, pxxxv. Reflecting this, the Commissioners, commenting on the low death rate, announced "that it should be less than the mortality among asylum patients is not surprising considering the amount of active disease in such establishments."

deaths among patients resident in royal and district asylums was 10%, while that in private dwellings was only 3.9%.[65]

Comparisons of the cause of death of asylum residents and boarded-out patients yields striking differences. In 1884, Fraser observed that deaths from general debility and old age were more frequent among patients in private dwellings (27.5%) than among those in asylums (12.7%). Cerebral and spinal affections comprised 18.9% of deaths (compared to 38.7% in asylums), thoracic affections 30.2% and death from epilepsy and convulsions 6.4% of total deaths. In contrast to asylum statistics there were no deaths from general paralysis or suicide.[66] In most years, the most common cause of death was disease of the nervous system, accounting for 30% of all deaths.[67]

8.5 Asylums inappropriate for certain classes of the insane

In conjunction with the erection of county or district asylums across Britain, the belief had spread among physicians and the public, that as soon as an individual had become insane, regardless of the degree of mental disturbance, admission to an asylum was imperative. This was facilitated as new buildings were completed and extensions sanctioned freely. To some extent, this growth was attributed to superintendents, who, it was suggested, had:

> "very diligently inculcated the idea that they alone, by education, by experience and by general aptitude are qualified to take the medical superintendence of the insane and that restraint and separation from friends, in themselves is specially curative."[68]

According to advocates of domestic provision, this view was entirely erroneous and motivated by the determination of asylum physicians to retain control of the insane. However, as Commissioner Fraser declared, although treatment in asylums was "largely forced on us, as the best available treatment in the circumstances, we need not shut our eyes to its disadvantages and true nature".[69]

As early as the 1860s, a number of alienists had begun to argue that the facilities and cost of maintenance in asylums were wasted on a large proportion of the insane, and there was

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[65] GBCLS 49th AR (1907), main report, pxxi. The proportion of deaths among patients residing in lunatic wards was also low. In 1906, it was 4%. This was attributed to the results of careful selection of patients, those suffering from "grave physical infirmity" were not admitted.
[66] GBCLS 26th AR (1884), p132.
[67] GBCLS AR 40th AR (1898), p126.
[68] Hammond, W.A. (1879) *The non-asylum treatment of the insane*. New York: G.P.Putnam, p1.
[69] GBCLS 27th AR (1885), p131.

growing reaction against the indiscriminate policy of placing all insane persons in asylums. Morel, for example, considered that many patients were "inferior beings in a state of degradation and insensible to the architectural luxury of their dwellings."[70] To him, the prospect of a more natural environment was appealing. Rather than asylums being filled with violent patients exhibiting active delusions, as was the public's conception, the reality, in the view of many commentators, was "groups of patients seated round the fire or lolling about in a dreary sort of way."[71] Incurable patients with mild, chronic dementia or congenital mental defects who had been admitted to an asylum for want of an alternative, could gain nothing from the elaborate and expensive classification and organisation of asylums. Their very presence was held to reduce the status of asylums, denying physicians the opportunity to engage in what was perceived to be their proper task, that of curing the insane.

Maudsley, a powerful proponent of greater liberty for the insane, was an enthusiastic supporter of the boarding-out system in Scotland, although he had no direct impact on its implementation or development. He recorded his regret at its failure to become a significant movement in England and condemned "indiscriminate sequestration", simply because a person was mad. He was convinced that patients should only be locked away if they were a danger to themselves or the general public. This was clearly not the case for considerable numbers of asylum inmates throughout Britain, but as Maudsley declared, "the world has grown to the fashion of thinking madmen are to be sequestrated in asylums, and cannot now conceive the possibility of a different state of things."[72] The arguments of the Commissioners in favour of developing boarding-out, and, in addition, modifying the supremacy of the asylum, were underpinned by such similar beliefs that Maudsley's convictions are quoted here at length:

> "Let who will keep the asylums, it is necessary that they exist....I cannot but think that future progress in improvement of treatment of the insane lies in the direction of lessening the sequestration and increasing the liberty of them. Many chronic insane...will be allowed to spend the remaining days of their sorrowful pilgrimage in private families having the comforts of family life and the priceless blessing of the utmost freedom that is compatible with their proper care. The one great impediment to this reform at present undoubtedly lies in the public ignorance, the unreasoning fear and the selfish avoidance of insanity."[73]

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[70] Morel, M. (1865) The present state and future prospects of psychological medicine. An Address. *Journal of Mental Science*, **10**, p340.
[71] Wynter, A. (1870) Non-restraint in the treatment of the insane. *Edinburgh Review*, **131**, p436.
[72] Maudsley, H. (1867) *op.cit.*, p424.
[73] *Ibid.*, p434.

While Maudsley accepted that asylum treatment had advantages, especially in the inculcation of discipline, he argued that the patient's individuality was disregarded and that the inmate was perceived as just one among a crowd of insane who, generally, were not expected to recover.[74]

Such concerns were expressed forcefully and repeatedly by the Scottish Commissioners throughout their annual reports. While endorsing the general principles of asylum provision, the Commissioners were outspoken against indiscriminate admissions and were convinced that residence in any type of institution was unnecessary for up to 25% of the asylum population.[75] Thus Mitchell declared repeatedly that there was nothing in the condition of many patients which called for the constraints and discipline of an asylum.[76] His beliefs were reiterated by his successors at the Board of Lunacy, when in a memorandum to the General Board, he asserted that

> "the detention in an asylum of a person who does not need the loss of liberty and the more or less irksome restraints and discipline which such detention necessarily involves, and who derives no benefit from residence in an asylum, can only be justified on the ground that his remaining there adds to the comfort or suits the convenience of other people. Experience has shown that sometimes they have been allowed to have undue weight, and that many pauper lunatics have been detained in asylums who could have been at large without risk of injury to the public, with increased happiness to themselves, and with advantage to the ratepayers."[77]

Accompanying the increasing denunciation of the accumulation of chronic patients as detrimental to their well-being, was a growing belief that, as far as the safety of the public was concerned, "a very considerable number of persons labouring under acquired forms of insanity do not require to be cared for in asylums".[78] To the Commissioners, therefore, an important aim in the management of the insane received effect in boarding-out. They argued that the assembling of the insane in large establishments, and the constant association of maniacs and melancholics with each other, and with imbeciles and idiots, could not possibly be beneficial and that delusions were reinforced by the behaviour of surrounding patients. Quiet, harmless patients were locked in among loud, often violent lunatics. One example documented by the Commissioners over 20 years after the introduction of boarding-out concerned a helpless idiot, who was unable to walk and "unable to injure anyone were he capable of entertaining an idea of doing so."[79] However,

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[74] Maudsley, H. (1871) *op.cit.*, p327.
[75] Recorded, for example, in GBCLS 1st-10th AR (1859-1868), *passim*.
[76] Mitchell, A. (1864) *op. cit.*, p79 and (1868) *op. cit.*, p484.
[77] GBCLS 32nd AR (1890), p118.
[78] GBCLS 26th AR (1884), p126.
[79] GBCLS 22nd AR (1880), p134

he was locked in his ward, among forty lunatics of all classes. To the Commissioners "imbecility under such conditions presents a spectacle which would be ludicrous but for its inhumanity."[80] The Board of Lunacy regarded it a duty to provide, where possible, for the insane in a more natural environment, and this, it claimed, could be achieved by a systematised policy of boarding-out.

The view that large numbers of the insane could be suitably provided for outside an asylum continued to be expressed in the Commissioners' reports of the 1920s and 1930s. The proposition that all insane persons must be placed in asylums was countered by growing awareness of the greater costs of such a policy, the unwarranted confinement of chronic patients, and the concomitant prevention of the asylum being used as a hospital for the cure of insanity. While always maintaining the necessity for specialist institutions for recent, acute cases, the contention that they were the only suitable place for every insane person was widely and successfully disputed by the Commissioners, thereby adding credence to the alternative of boarding-out.

8.6 Advantages for asylums

8.6.1 Relief of overcrowding

Advocates of the boarding-out system constantly stressed the relief it brought to overcrowded asylums by the removal of large numbers of chronic patients.[81] Even when an asylum was praised highly by a Visiting Commissioner, it was often observed that conditions would be improved with a reduction in the number of patients. Pressure on space was felt in both district and royal asylums. Although district asylums had higher discharge rates to private dwellings, superintendents of royal asylums also recognised the merits of this solution and often recorded the relief attained by boarding-out; Edinburgh Royal Asylum being the most notable example. In this way, boarding-out received its strongest support from medical superintendents.[82] It is apparent that the continued growth in the number of registered insane led to demoralisation in asylums, with the energies of staff distracted by caring for chronic patients, who occupied valuable bed-space better used

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[80] *Ibid.*

[81] *Vide infra* Chapter 12 for an assessment of the attitudes of medical superintendents towards the boarding-out system.

[82] Enthusiasts of boarding-out emphasised the relief attainable by the removal from asylums of the large class of chronic cases that tended to accumulate, increasing expenses, distracting the energies of the staff, and occupying space better used for recent cases and it was "this that led many Committees of Scotch asylums to adopt the system of boarding-out." Norman, C. (1890) *op.cit.*, p471. *Vide infra* Chapter 12 for further discussion on the concerns of overcrowding.

for curable cases. Thus Parry-Jones contends that "asylums settled down as understaffed, overcrowded establishments, in buildings whose very size and appearance spoke of authority and repression".[83] These circumstances explain the growing enthusiasm among asylum physicians for an active boarding-out policy.

By the 1880s, constant attention was focused by Commissioners and superintendents on the overcrowding of asylums and potential solutions. This remained a prominent concern until the mid-1900s, after which time fewer references were made, despite continued difficulties in providing sufficient asylum accommodation. When boarding-out was still mentioned, its employment continued to be attributed to the relief of overcrowding, with recognition from a number of prominent alienists that, without this option, the problems of provision for the insane would have become insoluble. Clouston, for example, reflecting the views of many of his colleagues, contended that without such an active boarding-out policy, the asylum would have been so overcrowded by chronic cases that no new cases could be admitted.[84] Despite widespread recourse to boarding-out, overcrowding remained a major problem as admissions to asylums continued to rise, prompting fears that insanity was increasing throughout Scotland.[85] Certainly the increases were large, the population of Montrose Royal Asylum, for example, rose from 250 to 670 in the years 1857 to 1900, Edinburgh Royal Asylum rose from 467 to 758, and Crichton Royal Asylum from 384 to 902.[86]

8.6.2 Prevention of proliferation of asylum buildings

Reduction in the need for expansion in asylum buildings was one of the most frequently stated reasons for supporting the policy of boarding-out. While some expansion of asylums was inevitable in view of the increase in the registered insane, protagonists of boarding-out placed stress on the fact that the system availed itself of existing accommodation in the cottages of the peasantry. Articles in contemporary medical journals reflected growing concern at the seemingly inexorable growth in the number of asylums, and the extensions to existing buildings. Wynter observed that "asylums are becoming monstrous by gradual accretion."[87] He maintained that in such asylums, effective treatment was impossible, and

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[83] Parry-Jones, W.Ll. (1981) *op.cit.*, p207.
[84] MS AR (1891) Edinburgh Royal Asylum.
[85] However, as suggested in Chapter 1, this can be explained to some extent by the rise in population, and the changes made in the classification and registration of insanity.
[86] MS AR Montrose Royal, Edinburgh Royal and Crichton Royal Asylums, 1857 and 1900.
[87] Wynter, A. (1870) *op.cit.*, p449.

as increasing expenditure was lavished on additions, resistance to change was strengthened, particularly in the minds of medical superintendents anxious of their position. While referring directly to English asylums, his views were equally applicable to Scotland, when he observed prophetically:

> "As we see wing after wing spreading, and story after story ascending, in every asylum throughout the country, we are reminded of the overgrown monastic system, which entangled so many interests and seemed so powerful that it could defy all change, but for that very reason toppled and fell by its own weight never to be renewed. Asylum life may not come to so sudden an end, but the longer its present unnatural and oppressive system, as regards the greater number of its inmates, is maintained, the greater will be the revolution when at last it arrives".[88]

The Commissioners made it clear that without a boarding-out system, it would have been necessary to erect additional buildings in many asylums to accommodate those discharged to private dwellings. Other protagonists were confident that judicious selection of patients for boarding-out could obviate the need for extending asylums. The scope for alleviation was recognised by administrators and physicians alike. Reflecting this, in 1898, a conference was held at Stirling to attempt to check any unnecessary accumulation of patients. Concern was expressed about the growing expenditure for additional buildings, which had done little more than provide for existing patients. The majority of delegates accepted the recommendation that rather than continue adding to the building, renewed efforts to board-out should be instituted. In this way, the expense and trouble of increasing the asylum would be considerably modified.[89]

By 1900, most asylum annual reports listed reasons why patients should be boarded-out. It was desirable "from every point of view", not least in being the only way that ratepayers could be relieved from additional expenditure upon buildings and maintenance.[90] At Gartloch Asylum, for example, boarding-out was regarded as:

> "a certain relief to overcrowding and saves much building. The cases boarded-out alone since 1897 (153) would have needed the building of another three or four blocks had they been kept in the asylum."[91]

However, despite their preoccupation with this concern, medical superintendents and Lunacy Commissioners were aware that even with boarding-out, the need for increased

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[88] *Ibid.*

[89] Reported in MS AR (1898) Stirling District Asylum. The continued pressure on asylum accommodation is illustrated by the situation in Lanark at the turn of the century, following the construction of three asylums, Hawkhead, Hartwood, and Gartloch. Upon opening, all the beds were occupied immediately. This was attributed not just to an increase in the number of registered insane, but to the accumulation of chronic case; recoveries and deaths not being equal to cases of occurring insanity.

[90] MS AR (1904) Fife and Kinross District Asylum, p48. Numerous annual reports contained the same observations.

[91] MS AR (1904) Gartloch District Asylum.

accommodation could not be postponed indefinitely. At best, relief was temporary, but this did not diminish the enthusiasm of lunacy officials in their recommendations that, for this reason, certain classes of patients should be discharged to private dwellings.

8.6.3 Facilitation of the appropriate role of the asylum

One important incentive to board-out incurable patients came from the move towards the "hospitalisation" of asylums. This manifested itself in a determination to adopt, where possible, the methods employed in hospitals, for investigating, treating and nursing disease. These included the introduction of night nursing, removal of the more overtly prison-like features of an asylum, and the promotion of recovery, rather than just containment, of patients.[92] However, progress towards these aims was hampered by the concentration of incurable dements and idiots in asylums, demanding intensive care and attention, yet unable to benefit from any advances in hospital treatment. Warnings were issued by the Commissioners against misuse of asylums and the increasing recourse to them for patients whose presence in the family was considered inconvenient.[93] Boarding-out provided a partial solution, enabling asylums to escape from the growing criticism that they were merely places of refuge, rather than hospitals for the cure of disease. Although not every boarded-out patient was incurable, all were deemed unable to benefit further medical treatment. Their presence was seen to detract from the status of the asylum as an establishment concerned with the cure of insanity and many physicians concurred with Wynter's regret that as asylums grew larger:

> "the very atmosphere within the walls may be said to be saturated with lunacy. They are becoming centres for the condensation and aggravation of the malady, rather than places of cure."[94]

Annual reports of the Board of Lunacy indicated an increasing preoccupation with this issue, and the related question of whether the "magnificent and expensive" institutions were fulfilling their designed purpose.[95] In this context, Scull has argued that, as the nineteenth century progressed, asylums became:

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[92] *Vide infra* Chapter 12 for an assessment of the impact of the hospitalisation policy.

[93] This concern was raised in most annual reports of the Board of Lunacy and of asylums, among them, for example, CR for Stirling District Asylum (1872), p21, GBCLS 25th AR (1883), p162 and 165.

[94] In Wynter's view, such patients "beyond human help", converted asylums from "houses of cure into mere prisons." Wynter, A. (1870) *op.cit.*, p437.

[95] GBCLS AR, *passim*.

> "a dumping ground for a heterogeneous mass of physical and mental wrecks, epileptics, tertiary syphilitics, consumptives in the throes of terminal delirium, cases of organic brain damage, diabetes, ... and those who had simply given up the struggle for existence."[96]

This view has been challenged by Doody in her work on Fife and Kinross District Asylum.[97] Based on meticulous analysis of admission and discharge registers, she refutes the suggestion that the majority were long-stay chronic patients and that such institutions were largely receptacles for "the impossible, the inconvenient and the inept."[98] While there was a steady rise in asylum admissions over the period 1866-1901, less than one-fifth of patients remained after five years. Although 29% of admissions from 1874 to 1899 were unclassifiable, a modern diagnosis was applicable to the remainder, who were classified as follows: organic disorder (26%), schizophrenic (8%), affective (36%), neurotic (1%). In view of this, she concluded that at Fife and Kinross Asylum, there was "no evidence that chronically debilitated patients were detained", and that many were in fact seriously mentally ill. Her research supports the claims of medical superintendents who had long responded strongly to attacks on the expense and administration of asylums, insisting that asylums were places of cure, not repositories for the long term insane.[99]

Nevertheless, although some asylums, from their inception, had an active policy of removing incurable cases, the Lunacy Commissioners remained convinced that too many chronic patients resided in asylums and that therefore the majority of asylums "even of today are the home of chronic harmless patients and of senile dements and epileptics as well as hospitals for acute mental disease".[100] Such views had long been expressed by Maudsley, who was convinced that:

> "when more are put in families then will asylums instead of being vast receptacles for the concealment and safekeeping of lunacy, acquire more and more the character of a hospital for the insane and those who superintend them, give more time to scientific study of insanity, and to the means of its treatment, will no longer be open to the reproach of forgetting their character as physicians and degenerating into mere house-stewards, farmers or secretaries."[101]

By the turn of the century, however, patients suitable for boarding-out were still aggregated in palatial structures under expensive nursing conditions and chronic patients continued to be admitted rather than boarded-out immediately. Despite attempts to define and to refine

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[96] Scull, A. (1979) *op.cit.*, p252.
[97] Doody, G. (1992) *op. cit.*, and presentations at conferences at Gartnavel Royal (1993) and the Wellcome Institute, London (1994).
[98] Scull, A. (1993), *op.cit.*, p370.
[99] *Vide infra* Chapter 12.
[100] CR (1907) Paisley District Asylum, p8
[101] Maudsley, H. (1867) *op.cit.*, p431.

the role of the asylum, by 1900 incurable patients in asylums out-numbered curable cases by eight to one.[102]

Even without the movement towards developing hospital features, there was growing anxiety about the role of the asylum.[103] Dissatisfaction was evident among alienists in Scotland, and throughout the United Kingdom, concerned not only about the status of their asylum, but the necessary reflection this had on their own position. Among them, Yellowlees, for example, expressed his concern that the asylum should be recognised as a place for cure, not confinement. Thus, although advocating the erection of separate chronic asylums, rather than boarding-out, he declared:

> "the accumulation of incurable cases is perhaps the greatest defect of all, for it causes or aggravates all the others. It increases administrative worries, adds to the routine medical work, covers up from observation the new and curable cases, and tends to make the institutions a place of residence instead of a place of recovery; a shelter for wrecks instead of a place where vessels are refitted for service." [104]

The Commissioners were confident in their belief that boarding-out offered the best solution to these concerns. Mitchell's emphasis on the utility of boarding-out in helping to establish the "medical character of the asylums as hospitals for the cure of mental disease" was echoed by subsequent Commissioners.[105] In their view, the first aim of an asylum was to cure, the second, to provide a place of safekeeping for lunatics who were dangerous to themselves or others. However:

> "when asylums pass these two aims, they exceed their proper functions, and to the injury of the whole body of the insane poor. There is a feeling that these aims are being passed".[106]

8.7 Summary and conclusions

This chapter has indicated that the Board of Lunacy and many alienists recognised the benefits of boarding-out, both to certain classes of the insane and to the general public. The relative costs of institutional and domestic provision were stressed without fail in discussions on the various merits of the system, and there was widespread enthusiasm for a policy which, in relieving overcrowded asylums, facilitated the management of curable cases. The advantages of family life and the opportunity for patients to adopt the habits of

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[102] MS AR (1900) Perth District Asylum, p8.
[103] This is evident by a scan through contemporary medical journals, and the frequency with which the true nature of the asylum, and its designated role was debated at meetings, of, for example, the Medico-Psychological Association, and in annual asylum reports by medical superintendents.
[104] Yellowlees, D. (1890) Presidential Address. *Journal of Mental Science*, **36**, p487.
[105] Mitchell, A. (1868) *op.cit.*, p484.
[106] *Ibid.*

the general population were contrasted to the artificial routine of an asylum, and congregation with deluded, often violent patients. The appeal of a system which offered greater potential for contentment among patients was further enhanced by the realisation that repeated additions to existing asylums were rendered unnecessary. Allied to this was an increasing preoccupation with the role of the asylum, although its effect in encouraging boarding-out was varied. While many medical superintendents discussed the process of "hospitalisation" of asylum, there was less uniformity among them, in expressing this as providing a particular stimulus to boarding-out.[107] Superintendents were unanimous, however, in condemning the aggregation of helpless, harmless patients, even though some asylums failed to implement an active policy of discharge. Boarding-out was seen to offer numerous advantages, and if its main recommendation, in the eyes of many observers, lay in its financial benefits, the fact that it also offered the potential for greater well-being of as many as 2500 patients annually cannot be overlooked. The major reasons for implementing and developing boarding-out stand up to rigorous criticism. Nevertheless, Morel's warning should be remembered:

> "in our disposition to deprecate monumental asylums, let us not be carried to the opposite extreme. Neither colonisation, or family treatment can be applied indifferently to all the insane. Many will be unsuitable at all times...I do not reject family treatment, but the system to overrule all systems is the clinical one. Should I be called to the...superintendence of a colony I would not like to become a simple farmer or steward, but my wish would be to remain a student of medical science.[108]

While recognising the need for caution prior to any wholesale endorsement of the system, the conclusions of a Deputy Commissioner of 17 years and a medical superintendent for seven, are worth considering. Fraser expressed his belief that a mode of care where patients were under thorough central and local supervision was the most suitable way of providing for certain classes of the insane, at the same time as reducing the burden on ratepayers. With a confidence that was echoed by his colleagues on the Board of Lunacy, and by growing numbers of asylum superintendents, he maintained, therefore, that: "no system is perfect but this mode produces results superior to what could be attained for these patients by any other mode of care."[109]

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[107] The asylums of Edinburgh Royal and Stirling District, for example, both of which were particularly active in discharging patients to private dwellings, appeared to have emphasised this movement, as stimulating their enthusiasm to board-out, Other asylums, although equally active in advocating domestic provision, among them, Inverness and Woodilee did not discuss at any length the value of boarding-out in developing hospital features.

[108] Morel, M. (1865) *op.cit.*, p339.

[109] GBCLS 37th AR (1895), p100.

CHAPTER 9

REGIONAL DIVERSITY IN BOARDING-OUT

9. Overview

The system of boarding-out was practised in almost every parish in Scotland, albeit with great disparity in numbers. While there was a prominent tendency towards aggregations of special licensed houses in several areas, patients were also boarded in villages with no other insane person nearby. This chapter considers the extensive variation among districts in their activity in boarding-out.[1] Certain locations had almost no patients resident in private dwellings, while villages in the Highlands and central Scotland received large numbers of patients. Reasons for this disparity are explored. The significance of the nature of the district, whether rural or urban, in fostering an active boarding-out policy is also assessed. Boarding-out in the Highlands and Islands is examined in some detail; these regions had a high proportion of patients provided for in this way, in a system with markedly different characteristics to those in the rest of the country.

9.1 Introduction

Patients were boarded-out singly, or in special licensed houses in large towns, rural villages and isolated crofts across Scotland. Small country villages in agricultural areas were regarded by the Commissioners as particularly suitable. Special licensed houses run by small farmers flourished in such locations. The notoriety of aggregations in central Scotland led to the perception among international observers that boarding-out occurred only in particular areas. However, while certain counties accommodated a disproportionate number of patients, the system was in operation throughout the country. In 1887 for example, of 884 parishes in Scotland, 77 had no pauper lunatics chargeable to them. Of the remaining 807, only 261 had no patients in private dwellings. Thus, in 546 parishes, boarding-out was implemented in varying degrees, providing for patients in villages often

[1] The division of Scotland into 27 Lunacy Districts has been noted in Chapter 3. Counties and groups of parishes were combined into a single district.

some considerable distance to the parish of chargeability.[2] Similar figures were recorded in other years.

Throughout the nineteenth century, there were extensive discussions regarding the variation in the proportion of recorded insanity among various regions. In particular, the question whether insanity was more prevalent in rural or urban areas exercised the Commissioners for many years. While the proportion of the population registered annually as pauper lunatics was considerably higher in urban than rural parishes, the number remaining chargeable at the end of each year was much smaller for the former. However, the Board of Lunacy maintained that the relative proportion of paupers and pauper lunatics was almost equal in urban and rural areas and highlighted the difference in attitudes and circumstances, and not in mental condition, in various locations.[3] Distinction in the mode of provision was clear. The percentage of patients boarded in private dwellings was much higher for rural than for urban parishes. This was because persons chargeable to urban parishes, on first exhibiting signs of insanity, were almost invariably sent to an asylum. In contrast, those becoming insane, or being registered as otherwise defective, in rural areas, were permitted frequently to remain in private dwellings, under the care of their relatives.

There was substantial variation in the circumstances of the boarded-out insane in different parts of Scotland. The Commissioners recognised that where patients were accommodated in conditions parallel to those in surrounding houses, they were obliged to accept the standard and that when assessing the quality of provision, "it is necessary to employ not a national but a local standard".[4] Nevertheless, living standards in the Highlands and Islands were deplored regularly by the Commissioners, where conditions "continue without sensible amelioration".[5] Despite concern at witnessing and sanctioning conditions so far removed from their experience, subsequent Commissioners attempted to adhere to Mitchell's recommendation that:

> "the general standard is always taken into consideration...and it is generally regarded as sufficient if the lunatic's condition shows a reasonable approach to that of the poor but respectable portion of the general community...It is enough if he is not half naked and in rags, does not sleep in an pithouse or on the bare floor, if his meat is not thrown to him as if he were a dog and theirs is decently served, if he is not unwashed and filthy while they are clean."[6]

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[2] GBCLS 29th AR (1887), p112.
[3] GBCLS 17th AR (1875), p261.
[4] GBCLS 23rd AR (1881), p125.
[5] GBCLS 4th AR (1862), main report, plvi.
[6] Mitchell, A. (1864) *op.cit.*, p35.

Although patients were boarded in towns throughout Scotland, the Commissioners expressed clear preference for country cottages, in surroundings regarded as tranquil. Nevertheless, a recurrent problem prompted by the utilisation of rural surroundings was the difficulty of enforcing regular official visitation. The Board of Lunacy recognised that there were parishes in remote districts which were separated from officials "by mountains or arms of the sea...which are inaccessible even to the local authorities at certain seasons, for weeks and months."[7] Regular supervision in such areas was hard to maintain. The Commissioners argued, therefore, that patients should be boarded as near as possible to the homes of the local officials. Notwithstanding difficulties prompted by the distance and standards of living in certain rural localities, endorsement of boarding-out in these areas was strong. In conjunction with the advantages of living in a healthy climate, the opportunity for patients to be integrated into family life, untrammelled by the prejudices of their neighbours, was held to be more attainable in sparsely populated rural communities.[8]

9.2 Variation in placement of insane patients

Population distribution and access to asylums inevitably influenced the pattern of boarding-out. By 1821 there was clear disparity in population density; 42% of the population lived in the north, with 58% in central or southern Scotland. Fifty years later, the ten largest counties were Lanark (population 765,339), Midlothian, Aberdeen, Angus, Renfrew, Ayr, Fife, Perth, Stirling and Inverness (87,531).[9] It is necessary to retain a perception of a highly populated central and southern Scotland and particular growth in the urban centres of Glasgow and Edinburgh. This is contrasted with a comparative dearth of people, and asylums, north of the River Tay, and in particular, in the Highlands where the population fell in every census from 1851 to the beginning of the twentieth century.[10] Although urban areas such as Aberdeen and Dundee reduced the imbalance, it remained broadly true that the north of Scotland, and in particular the islands, was sparsely populated.

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[7] GBCLS 9th AR (1867), p246.

[8] An interesting request was made regarding the utilisation of the Island of Shuna for boarding-out patients, following a visit by Glasgow parish officials and the views of the Board of Lunacy were sought. The climate of the island was regarded as favourable, patients would benefit from the healthy atmosphere, and would be able to work outdoors in agricultural pursuits. The contrast between the crowded streets in Glasgow was emphasised. It was claimed that the island would be suitable for boarded-out patients, children or for "broken down worthy citizens". Although nothing came of the proposal, it serves to illustrate the recognition by parish officials of the advantages of remote, rural surroundings for insane persons. Utilisation of the Island of Shuna Joint memorandum, Motion, J.R. Inspector of Poor, Glasgow Parish Council and Wallace, A. Inspector of Poor, Govan Combination (1898) (Strathclyde Regional Archives).

[9] See Smout, T.C. (1987) *op. cit.*, particularly pp8-9 and 58-59, for an informative discussion of population trends.

[10] For example, during the period 1841-1911, the population of Glasgow rose from 275,000 to 784,000 and in Edinburgh from 164,000 to 401,000. Smout, T.C. (1987) *op. cit.*, p41.

Until the erection of district asylums from 1864, institutional provision was severely limited throughout the country. The royal asylums were all located in urban areas and as Rice has observed, although there were more asylums north of the River Tay, their numerical strength lay in the south. In 1857, 1288 patients were accommodated in the three southern royal asylums, while the four northern royal asylums had a total of 835 patients.[11] In addition the public asylum at Elgin provided for 43 patients.[12] There were only four poorhouses with lunatic wards and one private madhouse. In contrast, residents of central and southern Scotland had access to 13 poorhouses with lunatic wards and 22 private madhouses, as well as the asylums at Dumfries, Edinburgh and Glasgow.[13]

The disparity in the distribution of institutional provision remained marked following the growth of district asylums. It might be expected, therefore, that the proportion of patients boarded-out from rural areas north of the Tay would be far greater than that of patients chargeable to large towns in the rest of the country. However, this is not wholly accurate. Although the tendency to gravitate towards asylums was marked in areas where institutional provision was available and easily accessible, from the late-1860s, patients chargeable to urban parishes were also boarded-out in large numbers, often to locations in central Scotland. Nevertheless, where access was limited, the proportion of insane who had received sanction from removal to an institution, and remained under the care of their relatives, was high. In this context, Fraser emphasised that:

> "the expense and trouble of conveying a patient to the asylum is an inducement to provide home care as satisfactorily as it is possible to do in such districts. Then again, the thinness of the population admits of the residence in these districts of a class of lunatics who would not be tolerated in crowded and busy localities."[14]

Despite this, many asylum superintendents who approved of boarding-out unrecovered patients were more likely to recommend their discharge to locations in the vicinity of the asylum, thereby facilitating easier, and cheaper, return if necessary.[15]

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[11] Rice, F. (1981) *op.cit.* Rice offers a comprehensive overview of the development of the Scottish population, contemporary demography, growth of urbanisation, and patterns of employment, pp37 and 240.
[12] GBCLS 1st AR (1859), Appendix B.
[13] Rice, F. (1981) *op.cit. Vide supra* pp 21-22.
[14] GBCLS 23rd AR (1881), p122.
[15] In 1888, the cost of transporting a patient from Shetland to Montrose Asylum was £14. Superintendents and parish officials were reluctant to risk removing patients to private dwellings because there was no guarantee it could be permanent. Thus, Howden of Montrose Royal Asylum attempted to board-out patients chargeable to Caithness, Orkney and Shetland, in the vicinity of the asylum, thereby avoiding the expense of a journey to return patients if necessary. GBCLS 30th AR (1888), p109.

The Scottish system of lunacy provision was notable for its diversity. Reflecting this, Sutherland observed that:

> "whatever the explanation is for the striking anomalies between parishes, other than lack of interest and zeal, it is neither to be found in the varieties of mental disorder, nor in a difference in ethnic, social and economic conditions...in different counties and parishes...adjoining each other."[16]

The wealth of an area, its distance from an asylum and the attitudes of local officials were highly influential factors in determining the degree of implementation of boarding-out. Further, the Commissioners attributed the extensive variation partly to the extent of cooperation between parish and asylum authorities. While the activity of officials from many populous parishes resulted in the removal of a large proportion of incurable patients from asylums, repeated instances of alleged obstruction by medical superintendents were recorded by parish officials.[17] In 1873, Sibbald contrasted the activity of boarding-out in different regions. In Renfrewshire, 15% of pauper lunatics were boarded-out, in contrast to 50% of those chargeable to Wigtownshire, and 53% to Sutherland.[18] This diversity endured throughout the nineteenth and early-twentieth century (Tables 9.1 and 9.2).

Parish	Total insane	In private dwellings	% in private dwellings
Barony	785	188	23
Govan	605	98	16
Edinburgh	777	326	42
City of Glasgow	535	82	15
Dundee	584	120	20
Greenock	155	14	9
Leith	144	13	9
New Monkland	98	27	29
Old Monkland	89	14	15
Elgin	41	13	31
Stornoway	33	16	48
Fordyce	24	12	50
Kirriemuir	28	9	32

Table 9.1 Proportion of patients boarded-out in 13 parishes, 1895 [19]

While almost 50% of patients in the Highland regions were boarded-out in 1895, and a remarkable 42% in Edinburgh (although this fell in subsequent years), in most other urban locations, the proportion was under 10%. Four years later, in 1899, 22% of all pauper

[16] GBCLS 41st AR (1899), p131.
[17] The tension between the two authorities is examined at length in Chapter 13.
[18] GBCLS 15th AR (1873), p295.
[19] Source of data: Sutherland, J.F. (1897) *op.cit.*, p27.

patients in Scotland were provided for in this way and the Commissioners remained insistent that up to a third of all registered insane (private and pauper) could be boarded-out.[20]

Counties	Asylums (%)	Poorhouse lunatic wards (%)	Private dwellings (%)
Aberdeen	82	6	12
Argyll	81	-	19
Ayr	73	16	10
Banff	70	-	30
Berwick	71	-	29
Bute	81	-	19
Caithness	52	2	46
Clackmannan	81	1	18
Dumbarton	65	20	15
Dumfries	89	-	11
Edinburgh	76	1	23
Elgin	81	-	19
Fife	86	-	14
Forfar	73	10	17
Haddington	88	6	6
Inverness	55	2	42
Kincardine	76	17	7
Kinross	96	-	4
Kirkcudbright	90	-	9
Lanark	79	6	15
Linlithgow	71	18	11
Nairn	74	-	26
Orkney	67	-	33
Peebles	98	-	2
Perth	77	7	16
Renfrew	88	1	11
Ross	56	-	43
Roxburgh	88	-	12
Selkirk	92	-	8
Shetland	66	-	34
Stirling	80	1	18
Sutherland	66	-	34
Wigtown	64	16	20

Table 9.2 Percentage of registered insane boarded in asylums, poorhouse lunatic wards and private dwellings in each county of Scotland, 1908[21]

However, in many regions, little or no attempt was made to implement the system. Among them the counties of Aberdeen, Dumfries and Kincardine, described in 1882 as "districts in

[20] GBCLS 41st AR (1899), p141. Unless otherwise indicated, the figures recorded apply to pauper patients. Reliable figures are not available for private patients.

[21] Source of data: Report of the Royal Commission on the Care and Control of the Feeble-minded (1908)

which literally nothing is done in transferring patients from asylum to domestic care" continued to provide for the majority of their incurable patients in asylums or poorhouse lunatic wards in the 1900s[22] (Table 9.2).

The wealth of an area was highly significant in determining the extent of boarding-out. Where a district was prosperous and the general standard of wages high, there was less desire to supplement earnings by receiving insane lodgers.[23] Prospective guardians demanded a prohibitively high rate of board, almost equal to the rate of maintenance in the asylum. It was not surprising to discover in these areas, therefore, a "marked disinclination" among relatives to provide for persons "whose insane conduct must...prove a fruitful source of anxiety, inconvenience and...discomfort."[24] Further, without the incentive of economic benefits, the inducement to parish officials to expend the effort required in overseeing the policy was diminished. This was particularly apparent in the south-western districts of the country.

Notwithstanding the assertion from the Commissioners that there was little to distinguish between the characteristics of active and inactive parishes, difficulties were encountered among smaller parishes, where the duties of systematic visitation were felt to be a burden. To counteract this problem, it was suggested at the International Home Relief Congress in Edinburgh, in 1904, that smaller parishes be combined into larger units to facilitate an expansion of boarding-out.[25] It was recognised generally that in large urban districts, the system was more effective where the district comprised only one, or at most two, large parishes, thereby making administration more straightforward. The degree of activity in boarding-out from the City and St Cuthbert parishes of Edinburgh, confirmed this view, emphasising the strength of argument for centralised rather than devolved power.[26] In districts which were divided into numerous, often small parishes, organisation of boarding-out was problematic, while in urban parishes, the volume of cases often prompted the appointment of one official devoted exclusively to overseeing the policy. The difficulties encountered in Stirlingshire illustrate this. The district had one of the lowest number of

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[22] GBCLS 24th AR (1882), p140.
[23] *Vide supra* Chapters 5 and 7 for detailed discussion on the motivation behind receiving patients and the particular popularity and suitability of certain districts in central Scotland for the accommodation of boarded-out patients.
[24] MS AR, (1902), Roxburgh District Asylum, p29.
[25] Editorial. (1905) The Home Relief Congress. Review. *Poor Law Magazine*, **15**, 18-21.
[26] The exception to this was Inverness Lunacy District, which was made up of several parishes, and yet proved one of the most active areas in boarding-out from an asylum.

boarded-out patients chargeable to local parishes. The Commissioners recommended that all parish councils in the Lunacy District should join together, creating an organisation similar to those in Edinburgh or Glasgow.[27] One official, responsible to the District Lunacy Board would have the duty of overseeing all affairs relating to boarding-out. Without such simplification, it was recognised that the system would remain poorly implemented.[28] This proved to be an accurate warning, as the rate of boarding-out from Stirlingshire parishes remained comparatively low.

9.3 Diversity in boarding-out

Following the Registrar General, the Board of Lunacy classified parishes into three categories; 1: principal towns "in which the influences of busy city life may be supposed to operate", 2: large towns "where the population is not so closely aggregated and the influences of the surrounding country not so excluded", and 3: small towns and rural districts of under 2000 inhabitants "where out-door employment and a more tranquil current of life generally prevail".[29] The eight principal towns comprised: Edinburgh, Glasgow, Aberdeen, Dundee, Paisley, Greenock, Leith and Perth. The 18 large towns were Inverness, Arbroath, Forfar, Montrose, Dunfermline, Kirkcaldy, Stirling, Falkirk, Dumbarton, Port Glasgow, Ayr, Kilmarnock, Airdrie, Coatbridge, Hamilton, Galashiels, Hawick and Dumfries. These two groups were classified as urban, the rest of the country being regarded as rural.

9.3.1 Urban areas

In the years preceding widespread expansion of boarding-out, many patients were found in unsuitable town dwellings. Reflecting this, the author of "Gheel in the North" declared that:

> "it will not do to form a fancy picture of a sylvan retreat, a cottage-home remote from public view, for the majority are in towns and villages, and not necessarily the loveliest of the plain."[30]

The proportion of patients allowed to remain in such surroundings declined as the system developed and by the early 1870s, the discrepancy was marked. Patients in private dwellings amounted to, on average, only 14 per 100,000 of the population in the principal

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[27] The contrast between disparate and cohesive parishes was marked. Out of 777 pauper insane in the parish of Edinburgh, 42% (326) were boarded-out, and 23% of those chargeable to Barony parish, were boarded in private dwellings. MS AR Stirling District Asylum (1897), p29.
[28] GBCLS 39th AR (1897), p30.
[29] GBCLS 17th AR (1875), p261.
[30] Anon. (1866c) Gheel in the North. From a Correspondent. *Journal of Mental Science*, **11**, p282 (author identified as W.A.F.Browne).

towns, while as many as 85 per 100,000 were boarded-out in rural districts.[31] The Commissioners were never enthusiastic about conditions for patients in towns.[32] Reports by parish officials following visits to Clydebank and central Glasgow, indicate why. Patients were seen confined in "small stuffy rooms", often neglected, and clearly discontented. While some were reported to be provided for adequately, the consensus was that patients boarded in the country "had by far and away the best of it, being more healthy and contented."[33] This was thought to be because of their "more congenial surroundings." In contrast, in towns, the confinement in crowded tenements, continual noise and activity, lack of pure air and the consistent difficulty encountered in providing exercise and recreation were held to be detrimental to the mental and physical condition of patients. Many patients were forced to remain in one room, often confined to bed, despite intervention by official visitors. Lawson documented his concern that:

> "in some cases they are allowed to remain almost always indoors, occasionally, partly on account of their own indolence, and partly through want of control exercised by the guardians, they, though well enough to be up daily, try to remain constantly in bed. If they do go out of doors, it is often no further than to a narrow street or a squalid court, where they are exposed to annoyance and risk."[34]

It was also acknowledged generally that densely populated mining and manufacturing communities such as Renfrew, for example, were wholly unsuitable. Such areas were unlikely to yield suitable guardians in need of additional income as large-scale unemployment had not affected these locations in the nineteenth century.

Relatives of pauper lunatics chargeable to urban parishes were less able to take responsibility for the care of insane family members than those in rural areas. Many were obliged to leave the patient for long periods, while at work. This obstruction was avoided in farming communities, where patients were able to work alongside their guardian. Patients chargeable to urban parishes, therefore, were accommodated rarely within towns.[35] The majority were boarded some distance from their homes, frequently under the care of

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[31] GBCLS 17th AR (1875), p268. To Sibbald, the contrast in the proportion registered as pauper lunatics in private dwellings in one county compared with another was remarkable. For example, in the county of Fife only 38 per 100,000 persons were so registered, while in Wigtownshire it was as high as 124 per 100,000. GBCLS 15th AR (1873), p295.

[32] *Vide* GBCLS 32nd AR (1890), pp123-124, in which Lawson discussed at length the potential disadvantages of town life for insane patients.

[33] Glasgow City Parochial Board Minutes. (1906) D.HEW 1/2.

[34] GBCLS 32nd AR (1890), p123.

[35] Hogben observed that small settlements of pauper lunatics from large urban parishes were scattered all over the country from the Shetlands to Dumfries. Hogben, E. (1898) *op.cit.*, p689.

strangers in the special licensed houses of central Scotland.[36] Almost without exception, those allowed to board in towns lived with their relatives. Sanction for placing a patient with an unrelated guardian in a town was rarely sought and unlikely to be granted. Parish officials were warned by the Commissioners not to place patients in such circumstances, and wherever possible, for example following the death of a related guardian, to remove patients to private dwellings in the country.

The contrast in attitude among the general public in urban and rural areas was noted, the Commissioners maintaining that people from country districts were more sympathetic and suitable guardians. Further:

> "of all rural guardians, the Celt, when he or she has been drilled into, or naturally possess, habits of cleanliness and tidiness, is undoubtedly the best guardian of the insane in private dwellings." [37]

This was attributed to life in the Highlands, where patients and guardians lived and worked in close association and also to their "greater approachableness and imaginativeness" compared to the "somewhat hard and distant bearing of the people living in more southern parts".[38] The assertion of the Commissioners that "the conditions inseparable from density of population render it impossible that any great eccentricity of demeanour can be permitted in towns"[39] was given credence by numerous cases recorded where patients were taunted in the streets. People in the Highland regions were held to be more tolerant of the eccentricities and annoying behaviour of insane family members.[40] Nevertheless, such tolerance could have an adverse effect, in encouraging the retention of patients in private dwellings who were in need of asylum care. In contrast, active attempts to oversee a policy of boarding-out in densely populated areas were, with the exception of such towns as Edinburgh and later, Glasgow, neglected "or but languidly attempted."[41] Instead, there was a tendency to send patients to the district asylum, regardless of the degree of mental aberration. It is evident, therefore, that a larger proportion of the population were registered as pauper lunatics in urban areas.

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[36] *Vide supra* Chapter 5 which highlights the predominance in special licensed houses of patients from Edinburgh and Glasgow parishes.
[37] GBCLS 35th AR (1893), p108.
[38] *Ibid.*
[39] GBCLS 17th AR (1875), p261.
[40] GBCLS 38th AR (1896), p142.
[41] GBCLS 23rd AR (1881), p122.

9.3.2 Rural areas

It was widely accepted that the most suitable accommodation was to be found in rural districts. Evidence given to the Royal Commission on the Care and Control of the Feeble-minded (1908) stressed the particular suitability of small market gardens and crofts, where the only industry was agriculture. In such locations, there were plentiful opportunities for outdoor employment, the climate was regarded as healthy and peaceful and patients could wander freely, while remaining under the constant, unofficial supervision of the neighbours. The population of such villages was generally small, with a predominance of elderly couples and women living alone with sufficient spare room to receive boarders.

Nevertheless, conditions in small villages and hamlets throughout rural Scotland were often condemned as inadequate. Critics claimed that the standard of living was low and that many residents were untouched by developments in sanitary and general living conditions. Even Browne, occasional proponent of boarding-out, declared that many houses in rural areas were dilapidated and uncomfortable, but were protected from sustained criticism by their remoteness. However, official reports of the Board of Lunacy make it clear that ability to receive and retain patients was dependent largely on the adequacy of living conditions, the maintenance of which was ensured by regular official visitation. The development of boarding-out in small rural communities was endorsed fully by the Commissioners, and accepted gradually by parochial officials, despite the additional demands created by visiting patients at a distance.

9.4 Areas with minimal boarding-out

Districts where under 15% of patients were boarded-out were regarded by the Commissioners as having an inactive boarding-out policy. The majority of such areas were located in the wealthier parts of Scotland, many in the south of the country. Where districts were financially prosperous, with flourishing industry, the recruitment of guardians was obstructed by the lack of any real need for the supplement to income.[42] The Commissioners recognised that many people in these districts were:

[42] *Vide supra* 9.2.

> "so far above the reach of want that they have not the same inducement which exists in less favoured parts of the country to add to their meagre incomes by undertaking what appears at first sight a disagreeable task, the custody of pauper lunatics."[43]

Although almost every asylum experienced problems of overcrowding by the 1880s, institutional provision was adequate for the immediate needs of these districts, thereby reducing the impetus to board-out. The areas discussed in this section were among those which caused particular concern to the Commissioners, and have been selected to indicate the extent of inactivity in boarding-out in certain districts.

9.4.1 Forfarshire

Parishes throughout Forfarshire had a particularly small proportion of patients in private dwellings. In 1884, for example, 8% of their insane paupers were boarded-out.[44] (In the same year, Edinburgh City Parish boarded-out 28% of their insane.[45]) The area had easy access to two large asylums in Dundee and Montrose and to lunatic wards in the poorhouses of Dundee and Liff and Benvie. Towards the end of the century, in 1896, out of 576 pauper lunatics chargeable to the district, 371 (64%) were in asylums, 149 (26%) in lunatic wards and 56 (10%) in private dwellings.[46] The city of Dundee itself boarded-out only 8 of the 289 pauper lunatics chargeable to the parish.[47] The proportion boarded-out from Forfarshire was not always so low, although few patients were boarded in the environs of the district. Local parish officials showed greater enthusiasm at utilising villages in Fife, even though there was an adequate supply of suitable homes and guardians in the rural districts of Forfar.

9.4.2 Aberdeenshire

In 1880, the relative proportion of those boarded-out to those in institutions in Aberdeenshire was little more than one in five, with 84% of patients in institutions and 16% in private dwellings.[48] Many incurable, harmless patients were accommodated in poorhouse lunatic wards in Aberdeen and Old Machar. The Commissioners could not comprehend this lack of activity in boarding-out, declaring that:

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[43] Thus one family in Roxburgh, refused to receive a passive imbecile patient for 10 shillings a week, and demanded twelve shillings exclusive of extras. GBCLS 27th AR (1885), p134.
[44] Mitchell, A. (1884) Memorandum on present position of lunacy administration in Forfar and Aberdeen Lunacy Districts, p47.
[45] *Ibid.*
[46] Minutes of Parish Council, Dundee (1896).
[47] *Ibid.*
[48] GBCLS 22nd AR (1880), p118.

> "it is impossible to think that what has been found to be advisable and practicable by cities and large towns in other counties is objectionable and inadvisable in Aberdeenshire, particularly as Aberdeenshire possesses advantages long recognised as a district suitable for dealing with the insane in private dwellings".[49]

Not until 1890 was any systematic attempt made to implement boarding-out. Following limited trials, inspectors of poor from several parishes in the district adopted the system, and within a few years, the two parishes of Aberdeen removed patients to private dwellings "with zeal". In 1889, for example, only one pauper patient chargeable to Old Machar parish was boarded-out. Three years later, 17 were provided for in this way.[50] The Commissioners observed the keen interest displayed by parochial officials who had become "unanimously of opinion that the boarding-out system is of real advantage to the patients and to the ratepayers."[51] However, success was short-lived. In the early years of the twentieth century, the proportion of patients boarded-out from Aberdeen parishes returned to the previously low figures and in 1904, 38 parishes with a total of 161 registered insane made no provision for patients in private dwellings. Aberdeen City parish with 425 patients, boarded-out 8.5%, one of the lowest proportions in Scotland and figures for other large parishes including Peterhead, Fyvie, Fraserburgh and Huntly were similar, with an average of 9% of patients boarded-out.[52]

Parish officials declared that failure to maintain the impetus was due to the low rate of board in poorhouse lunatic wards, and to the high standard of living among potential guardians. The number of registered insane rose steadily throughout Scotland in the years following the institution of the Board of Lunacy. In Aberdeenshire, by 1884, the increase was 117%, although the total population had only increased by 25%. The number in asylums throughout the district had increased by 122%, and those in lunatic wards of poorhouses by a remarkable 463%. However, there was no recorded increase in patients boarded-out.[53] This contrasted unfavourably, in the opinion of the Commissioners, with the large numbers provided for in lunatic wards of poorhouses. Although throughout Scotland, 8% of the pauper insane were placed in such establishments, in Aberdeenshire, it was 29%.

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[49] GBCLS 31st AR (1889), p131.
[50] GBCLS 35th AR (1893), p106.
[51] *Ibid.* Parish officials estimated that within four years, £500 had been saved by the adoption of boarding-out.
[52] GBCLS 46th AR (1904), p162.
[53] Mitchell, A. (1884) *op.cit.*, Appendix E, p79.

The proportion thus accommodated in Forfarshire (20%) was similarly high.[54] Notwithstanding sustained pressure by lunacy officials, these two counties remained among the least active in boarding-out.

9.4.3 Lanarkshire

Lanarkshire, a thriving industrial region for manufacturing, mining and agricultural activity, contained nearly a quarter of the population of Scotland. It was well provided with institutional accommodation, the great majority of its pauper lunatics being boarded in asylums, although the district was "admirably suited" for boarding-out.[55] Existing homes for patients were reported to be comfortable and clean, prompting visiting officials from Glasgow to announce that:

> "this district [is] well suited for boarding-out. Beautiful scenery may be somewhat lost on our patients, but the fresh upland air and association with kindly well-to-do people cannot be otherwise than helpful to them."[56]

While the proportion of patients boarded-out by Lanark parishes was never large (being only 7% in 1886, compared to a national average of 20%[57]) the growing demands of the district placed extensive pressure on available asylums. An expansion of boarding-out, therefore, was recommended and instituted by Deputy Commissioners and the superintendent of Lanark District Asylum. This resulted in an increase from 99 patients boarded-out in 1879 to 230 in 1884.[58] There was no further progress towards expanding the system, however, and in 1897, only 26 patients were provided for in this way.[59]

9.4.4 Stirlingshire

Although special licensed houses in Stirlingshire accommodated large numbers of boarded-out patients chargeable to Glasgow and Edinburgh, local officials in Stirling did not display marked activity in implementing the system, and "with few exceptions there is very little interest displayed by the parishes in the boarding-out of the insane."[60] Patients were rarely removed from Stirling District Asylum to private dwellings, despite excessive overcrowding. Macpherson, when medical superintendent, conceded that:

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[54] Mitchell's lengthy memorandum on the state of lunacy provision in Aberdeenshire stressed the suitability of many poorhouse residents for life in private dwellings. *Ibid.*
[55] Printed minutes of the Parish Council, Glasgow City. (1898) D.HEW 1/2, p478.
[56] *Ibid.*
[57] House Committee Report (1886) Lanark District Asylum, Kirklands, p6.
[58] GBCLS 27th AR (1885).
[59] GBCLS 39th AR (1897), p125
[60] MS AR (1897) Stirling District Asylum, p27.

> "boarding-out...which is so extensively carried out in parts of the country, so that it is now one of the recognised features of the Scottish Lunacy administration, has become practically a dead letter in our district."[61]

In 1897, for example, 11.5% of patients chargeable to Stirling Lunacy District were boarded-out, compared to a national average of 23%.[62] The same explanations offered by the Commissioners for other inactive areas were put forward by Macpherson.[63] An additional reason lay in the dispersion of the 54 parishes of the district and the attendant difficulties in organising a unified system of provision for the insane.[64] Further, many villages had long been utilised by patients chargeable to other parishes in the aggregations in Stirlingshire. The continued lack of activity across the district lent urgency to the employment of alternative solutions. The possibility of erecting an additional asylum at Dumbarton was discussed, but rejected on the grounds of expense. A further alternative, the introduction of small cottages on the asylum estate, was implemented, with less expenditure of effort and funds. The Commissioners nevertheless maintained pressure on officials, insisting that the expansion of boarding-out was the cheaper and more successful long term solution.

9.4.5 Borders

Counties in the Borders had the lowest rate of boarding-out in the country. In 1900, 10.5% of patients chargeable to Haddington were boarded-out, in Galashiels 14% and in Selkirk 10%, all significantly below the mean for Scotland (20%, with large parishes reaching 33%[65]). The county of Peebles had the lowest percentage boarded-out of all the Scottish counties, with only 2.5% boarded-out in 1905.[66] By 1908, these proportions had fallen further (Table 9.3). In the previous ten years, the number of registered insane patients, and the asylum population had risen steadily in the Border counties while the number in private dwellings had declined by 7%. The Commissioners considered that of the 10 large parishes of the area, with the exception of Duns and Kelso, the proportion boarded-out was wholly inadequate.[67]

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[61] *Ibid.*, p28.
[62] *Ibid.*, p27.
[63] *Vide supra* 9.4.
[64] *Vide supra* 9.2.
[65] GBCLS 43rd AR (1901), p153.
[66] Anon. (1906) Family care of the insane. Lecture in Aberdeen. Review and discussion of Macpherson. *Poor Law Magazine*, **16**, p78.
[67] GBCLS 50th AR (1908), p163.

	Total insane	In asylums	In private dwellings	% in private dwellings
Counties				
Berwick	112	80	32	28.6
Dumfries	204	180	24	11.8
Peebles	37	36	1	2.7
Roxburgh	176	156	20	11.4
Selkirk	66	62	4	6.1
Towns				
Coldstream	8	8	-	-
Dumfries	59	54	5	8.5
Duns	13	7	6	46.2
Galashiels	39	33	6	15.4
Hawick	52	47	5	9.6
Jedburgh	16	16	-	-
Kelso	25	20	5	20
Melrose	21	21	-	-
Peebles	16	15	1	6.3
Selkirk	21	20	1	4.8
Total	865	755	110	12.7

Table 9.3 Distribution of insane patients in the five Border counties and in the 10 principal parishes of the five counties, 1908

In Roxburgh, 15% of registered pauper insane were in private dwellings at the turn of the century, with considerable variation in activity among parishes. In five, nearly a quarter of patients were boarded-out. In the remaining 18 parishes, there were no patients in private dwellings. In this context, the Commissioners remarked that:

> "these differences in the same county reveal curious anomalies as to the methods in operation in disposing of the insane, and the need for action which would tend towards uniformity."[68]

The frequency of boarding-out from the district asylum was sporadic. Johnstone, the medical superintendent, made repeated attempts to discharge incurable patients to private dwellings, seeking the assistance of Commissioners and inspectors of poor in selecting homes and patients. However, aware that suitable accommodation could be secured only at a greater cost than provision in the asylum, many inspectors proved reluctant to undertake the trouble and responsibility. Some inspectors asked Johnstone: "why are you so anxious to send the patients out? Our Board is quite willing to keep them in the asylum"[69] Despite such difficulties, a small number of patients were discharged annually to private dwellings

[68] GBCLS 42nd AR (1900), p140.
[69] GBCLS 27th AR (1885), p134.

at the enthusiastic instigation of Johnstone and in 1887, for example, of 25 patients discharged unrecovered from the asylum, seven were boarded out.[70]

It was recognised that the nature and activity of the population was adverse to the development of boarding-out and that "the social, and other conditions in the counties forming the Lunacy District do not favour any considerable extension to the system."[71] The manufacturing towns of Berwick, Roxburgh, and Selkirk offered profitable full employment, and the rural population of Dumfriesshire was the most affluent in the country. Further, many farm labourers were migratory and lacked sufficient accommodation for additional persons. Potential guardians were only induced to receive patients for maintenance payments that were equal or higher than the rate paid in the district asylum. In Dumfriesshire, for example, the maintenance charge at the Crichton Royal Asylum was "exceptionally low".[72] The Commissioners recognised that living standards for both guardians and patients were higher than anywhere else in the country, and that the fee paid, on average 1s7d above the aliment charged throughout Scotland, was not excessive. It is possible that the lack of activity could be related to the sustained scepticism of boarding-out in neighbouring English districts. Nevertheless, it appears more likely that boarding-out failed to flourish in these counties for reasons already addressed. In addition, a significant proportion of patients discharged from the asylum returned to the care of their families, who were able to maintain them without resorting to poor relief and were therefore outside the jurisdiction of the Board of Lunacy. Despite limited attempts to introduce the system in the Borders, it was acknowledged that the system was "more readily adoptable in many districts than ours, still everywhere where it is tried has been found to be laudable and worthy of imitation".[73]

9.5 Areas with high levels of boarding-out

Officials from the large urban parishes of Edinburgh and Glasgow were consistently the most active and enthusiastic at boarding-out, even though access to asylums was

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[70] MS AR (1887), Roxburgh District Asylum, p21.
[71] CR (1904), Roxburgh District Asylum, p55. Similarly Linlithgowshire, an area with fruitful agricultural activity, and minerals below the surface of the land, offered profitable employment for the labouring classes of the area. Here too, only a small percentage of their patients were accommodated in private dwellings. Commissioners made repeated exhortations to parish officials in such areas to increase the number of patients boarded-out.
[72] GBCLS 23rd AR (1881), p123.
[73] MS AR (1883), Roxburgh District Asylum, p24.

comparatively easy. Patients had been boarded-out from these parishes from the very start of the policy, although not placed in the towns. Thus, in 1884, the City of Edinburgh provided for 28% of their chargeable insane in private dwellings.[74] The sustained activity of parish officials ensured the system's integration into general parochial administration. The remarkable activity in boarding-out from these parishes is referred to elsewhere, and is therefore not discussed in detail here.[75] Consideration has also been given to the particular locations in Scotland where groups of patients were boarded together in special licensed houses in small villages.[76] Although many patients were boarded-out in aggregations in Stirlingshire, few chargeable to local parishes were provided for in this way. In contrast, the district of Fife, noted for the high proportion of patients from other parishes boarded in the area, also boarded-out many of their own patients locally. In 1874, for example, 29% of patients chargeable to Fife were boarded-out, falling only slightly to 26% a decade later.[77] Similarly, a high proportion of patients chargeable to Perthshire were boarded-out locally.

The growth and development of boarding-out from Elgin, Midlothian and Banffshire were all singled out for praise by the Commissioners. The most common feature among these counties was the co-operation of parish officials. Midlothian was also a particularly popular location for private patients. In fact, the proportion of private cases relative to pauper patients was greater than in any other county. In 1896, for example, 69 (29%) of 238 boarded-out patients were private.[78] In other areas, it was unusual to find more than ten private patients boarded-out under official control. In addition to this high number, approximately 33% of pauper insane chargeable to Midlothian resided in private dwellings in the 1880s and 1890s, making the area among the most active in boarding-out pauper patients.[79] Although following a less cohesive, almost haphazard system in places, districts in the Highlands and Islands also provided for large numbers of their insane residents in private dwellings. The experience and circumstances peculiar to these regions are examined below. There was, therefore, considerable variation in the number of patients

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[74] Mitchell, A. (1884) *op.cit*, p47. In 1900, 265 patients chargeable to Edinburgh were boarded-out under the care of strangers. Every patient was placed in a rural locality, 218 of them in villages in Fife. Lunacy Board Minutes: Edinburgh District. 1898-1913 (M/7).

[75] Reasons for the adoption and growth of boarding-out in Edinburgh and Glasgow, particularly in special licensed houses, is discussed in Chapter 5, and the enthusiasm of officials from these parishes is discussed in Chapter 13.

[76] *Vide supra* Chapter 5.

[77] GBCLS 16th AR (1874) and 26th AR (1884).

[78] GBCLS 39th AR (1897), p128. The Commissioners devoted sustained attention to the incidence of boarding-out in Midlothian, and the unusual number of private patients residing there. Sibbald in particular, focused on this area in his annual reports in the 1870s and 1880s.

[79] *Ibid.*

placed in private dwellings across Scotland by 1913. The disparity in the proportion of patients boarded in special licensed houses was particularly apparent, despite the enforced limitation of the number of licenses issued in such areas from 1877 (Figure 9.1).

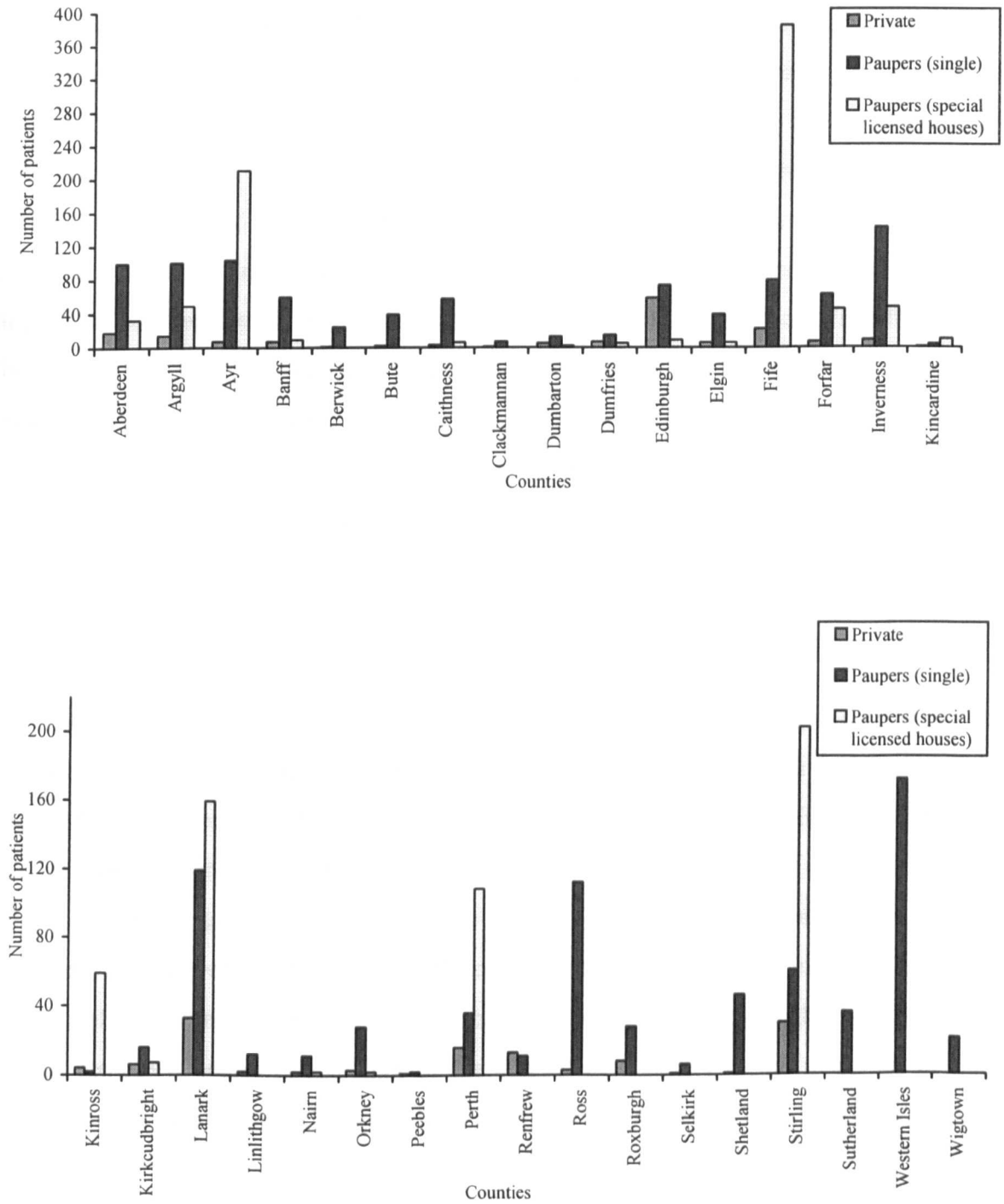

Figure 9.1 Number, distribution and location of private and pauper patients boarded-out in Scotland, 1913[80]

[80] Source of data: GBCLS 55th AR (1913).

9.6 Highlands and Islands

The unique nature and circumstances of the Highlands and Islands have long been a source of fascination for historians and numerous detailed works address the peculiar characteristics of these districts.[81] In particular, the discrepancy in wealth, patterns of work and bonds of community present stark differences between Lowland, and Central Scotland and the Highlands and Islands. Although under a centrally controlled lunacy administration from 1857, the nature of provision in the Highlands and Islands remained markedly different from that in the rest of the country. Problems created by the burden of lunacy varied across Scotland and the often cited problems incurred by overcrowded asylums and unhealthy tenements in the towns were not experienced in these locations. The proportion of patients boarded-out in the Highlands and Islands remained consistently high throughout the nineteenth century. Almost half the registered insane were provided for in private dwellings, the majority being granted exemption from removal to an asylum, with no previous asylum admissions. This was in stark contrast to patients in the special licensed houses of Fife, Perth and Stirling, who were frequently ex-asylum residents. This form of boarding-out with strangers, was, in turn, comparatively rare in the Highlands, with the exception of the aggregations at Inverness.[82]

Asylum provision remained restricted in these counties throughout the period, despite the erection of Inverness District Asylum in 1864. Where access to asylums was problematic, the number of patients residing in their homes was high. Most patients from districts such as Caithness, Sutherland, the Northern and Western Isles, therefore, were accommodated in private dwellings, generally under the care of relatives. Even by the turn of the century, following 50 years of supervision by a Board of Lunacy determined to remove all patients in need of treatment to asylums, the number boarded-out throughout the Highlands and Islands remained nearly double that of the rest of the country.[83] One inspector of poor declared to the Royal Commission on the Poor Laws and Relief of Distress (1909) that the

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[81] Among them, for example, Devine, T.M. (1994) *op.cit.*, and Levitt, I. (1988) *op.cit.* Annual reports by Commissioners frequently contained extensive descriptions of the living conditions experienced by Highlanders, particularly in the early reports, ie Appendix to 2nd and 3rd AR.(1860, 1861) Although not specifically a history of the Highlands, Mayes, M. (1995) *The Stormy Petrel. A life of Dr Kate Fraser, 1877-1957* includes vivid descriptions of life in the Highlands in the early 20th century. Glasgow: Wellcome Unit for the History of Medicine, Glasgow, Occasional Publications.

[82] *Vide supra* Chapter 5 and Appendix 6.

[83] 39% of patients from these areas were boarded-out in 1898. GBCLS 40th AR (1898), p126.

boarding-out of lunatics and orphans was carried out wherever possible with "the most gratifying results...from 40-50%...are cared for in this way."[84]

The proportion of patients residing under the care of relatives was striking. Of 166 patients boarded-out in Caithness, Sutherland and Skye in 1900, for example, 120 (72%) resided with relatives.[85] The picture for the rest of Scotland was markedly different, with an extensive increase in unrelated guardianship.[86] The rate of maintenance for patients in these areas was also considerably lower in these areas, a reflection of the lower cost of living, including cheaper rents and the fact that related guardians received less payment than strangers. Most patients boarded-out in the Highlands and Islands were residents of the area. One exception was an aggregation which developed in Islay, during the 1880s, for patients chargeable to the parish of Govan. Although separated by the sea from their relatives, few complaints were recorded and, when visits were requested, the Board of Lunacy granted relatives money for the fare. The Commissioners were convinced that the improved health and happiness of patients boarded there compensated for any disadvantages created by distance.[87]

Living conditions throughout the Highlands and Islands were criticised frequently by the Commissioners who considered that the "little progress in hygiene, ...leaves much to be desired, and falls far below" that of Lowland and Central Scotland.[88] The cost of poor relief was particularly high and obstacles unknown to residents in the rest of the country hindered progress towards improving living conditions. The "procrastinating habits of the people and the destructive effects of the climate" were held to account for the poor conditions of many dwellings, with difficulties in transporting material to renovate houses and hazardous communications for many winter months. A particular concern to Commissioners was the apparent sexual laxity among the population.[89] It was noted with distaste that "all sexes and ages sleep together in the beds", and that such habits had a "demoralising influence", leading to vice.[90] The tone of annual reports indicate that the living conditions, expectations, morals and mode of life throughout the Highlands and Islands, coupled with

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[84] Report of the Royal Commission on the Poor Laws and Relief of Distress (1909), *op.cit.*, p727.
[85] GBCLS 43rd AR (1901), p151.
[86] *Vide supra* Chapter 7 for discussion on the growth in the number of unrelated persons receiving patients.
[87] GBCLS 35th AR (1893), p93.
[88] GBCLS 40th AR (1898), p127.
[89] This concern is documented in Chapter 11.
[90] GBCLS 3rd AR (1861), p249.

the fact that many guardians and patients only spoke Gaelic, remained incomprehensible and impenetrable to the highly educated professional men from Edinburgh.[91] Nevertheless, exhortations to accept local habits appeared in successive reports, with the Commissioners stressing that "a good deal of forbearance" was necessary, and that many allowances must be made "in consequence of the peculiar circumstances and character of the people."[92]

Notwithstanding these objections, by the turn of the century, the Commissioners conceded that although there was perhaps less comfort, the general health of patients in the Highlands compared favourably with that of the boarded-out insane anywhere in Scotland.[93] Following Macpherson's first visit to the Western Isles, he recorded his "agreeable" surprise at what he saw.[94] He admitted that he had heard so much about the poverty of the Islands, that he had expected to find defective diet and care. However, the patients appeared to be robust and comfortable and, allegedly, standards never fell below those experienced by the general population. The need for extensive vigilance and regular visitation was nevertheless stressed continually, in view of the comparative isolation of patients and the lack of ready access to an asylum. Distinguishing characteristics and practices encountered in certain locations are outlined in the following sections.

9.6.1 Inverness-shire

Of all areas north of the River Tay, the Lunacy District of Inverness had the highest proportion of patients in private dwellings, many of whom were boarded in special licensed houses. Parochial officials and successive medical superintendents of the district asylum endorsed the policy and implemented it with enthusiasm. The activity of officials led to an unusually high proportion of patients, for a mainland district, being boarded-out from the parish; being almost equal to those placed in asylums. Their efforts were inspired largely by necessity because the asylum suffered from overcrowding and there were no poorhouse lunatic wards available to relieve the pressure. Nevertheless, other counties experiencing the same pressures failed to implement the system with such good results.[95]

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[91] While Fraser, in 1916, expressed willingness to learn the language, declaring, "I must learn Gaelic. It is so awful not to be able to speak, nor understand a word of what is being said. It sounds like German...." previous Commissioners more frequently condemned the poor standards of English, and were overtly impressed with conditions in English speaking districts. Mayes, M. (1995) *op.cit.*, p110.
[92] GBCLS 19th AR (1877), p126.
[93] GBCLS 43rd AR (1901), p151.
[94] GBCLS 44th AR (1902), p164.
[95] A notable example being the City of Aberdeen. *Vide supra* 9.4.2.

The parish of Inverness was heralded by the Commissioners as "one of the pioneers in boarding-out"[96], and the Northern District of Inverness was considered particularly well adapted for boarding-out. By the turn of the century, 44% of pauper insane in the district were boarded in private dwellings, the figure for the whole of Scotland being 21%.[97] There were many localities populated by crofters willing to accept the responsibility for harmless patients who were able to do useful work.[98] However, it was recognised that the removal of unrecovered cases from the asylum caused risks. Many parishes to which patients were chargeable were situated in remote districts and inspectors of poor often complained at the expense involved in removing a patient on trial to his own parish. It was preferable, therefore, to find a suitable guardian close to the asylum to minimise the expense of re-admitting the patient if necessary. The number of cases boarded-out on probation in Inverness, being assessed before permanent discharge, was exceeded by only one other asylum in Scotland.[99]

9.6.2 Northern Isles

a. Shetland

The Board of Lunacy regarded Shetland as "in many respects an exceptional county"[100] Patients registered as single patients resided with their relatives and, almost without exception, had never been asylum inmates. The Commissioners devoted considerable attention to the islands in the first twenty years of visitations, with annual reports containing lengthy assessments of conditions. This policy diminished during the 1880s, with little further specific references to Shetland. Although far removed from the mainland, most islanders spoke English and were considered by the Commissioners to be of "high mental capacity" and more intelligent than persons of the same social class in the Western Isles. A high proportion of male islanders emigrated to the mainland in search of employment: "indeed the county may be regarded as a nursery for seamen. The strongest and best educated of young men leave early and take service on vessels."[101] Housing was reported to be of poor standard, albeit superior to that of other islands. Living off a regular

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[96] GBCLS 46th AR (1904), p160.
[97] MS AR (1901), Inverness District Asylum, p11.
[98] MS AR (1905), Inverness District Asylum, p11.
[99] *Vide infra* Chapter 12.
[100] GBCLS 6th AR (1864), p221.
[101] GBCLS 11th AR (1869), p229.

supply of fish and imported meal, the diet of the population was considered adequate and an air of "rough contentment" was reported.

Shetland was an impoverished area, where the burden of poor relief was great. Maintenance costs in the mainland asylums were regarded by parochial officials and ratepayers as too high to countenance, except for the most severe cases. Sibbald drew attention to the reluctance of inhabitants to allow the removal of patients, because of the expense incurred and many unsuitable patients remained under domestic care, even following the Board's intervention. The Commissioners regretted that:

> "the difficulty attending the removal of patients from one locality to another frequently prevents such improvements being effected as the authorities would otherwise be willing to make...the time and labour required for removing a patient to Montrose...Asylum, is always a serious obstacle in the way of sending any but the most urgent cases."[102]

The poor-rate rose rapidly throughout Shetland as the century progressed, with increases in some parishes of 700-800%, over two decades. In the parish of Lerwick, for example, the rate rose from £40 in 1845 to £900 twenty years later. The possibility of granting a rate-in-aid for insane patients was considered, although, ultimately, never instituted. It was recognised by officials that the standard of lunacy provision demanded throughout Scotland was almost impossible to attain in Shetland. For example, the chairman of one parochial board responding to the recommendation that a melancholic patient receive aid, declared that "in our dealings with the poor we have always to consider our own impending ruin."[103] Mitchell concluded that, in such circumstances, it was inappropriate to enforce the precise implementation of his recommendations.[104]

The majority of parishes in Shetland were extremely remote from any medical officer, who frequently resided over 40 miles away, making close medical surveillance impractical. Guardians were located across all the islands of the county and several patients and guardians had never been seen by a medical officer before formal visitations were ordered by the Board of Lunacy. Despite advice from Commissioners to board patients in a clearly circumscribed area, to ease inspection, the majority continued to be dispersed widely.

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[102] GBCLS 15th AR (1873), p286.
[103] GBCLS 6th AR (1864), p299.
[104] GBCLS 6th AR (1864), p287. He declared that "the great difficulty, in attempting to improve the condition of the insane poor in these islands rests on the impossibility of burdening local funds with any additional expense."

Initial visits highlighted adverse living conditions for many patients. The Shetland cottage or hut was considered to be "of the rudest description," generally with a dunghill at the door and only a bed separating animals from humans.[105] In the view of the Commissioners, "nothing could possibly be more offensive or more tending to induce disease" than the sleeping accommodation they saw. Inadequate cleanliness, ventilation and drainage was universal. The condition of many patients was also a source of concern to visiting officials. Numerous patients were reported displaying the features that made them unacceptable for boarding-out; for example, those who were violent, dangerous or liable to wander. Mitchell maintained that a much larger proportion of imbeciles and idiots in Shetland appeared troublesome and dangerous than in other parts of the country. He was unable to explain this disparity, but observed that it resulted in increased removal of patients to asylums in a state of imbecility or idiocy, as opposed to other mental disorders.

One particularly unsuitable case, seen in the early 1860s, concerned a 16 year old congenital idiot, "dwarfish but well made", and unable to speak. He lived with his parents who Mitchell regarded as clearly unsuited to the responsibility. His father was old and blind, and his mother "a pithless, feckless..silly...crushed and useless little woman." They were in constant fear that the boy would set fire to the house or kill his brothers. His mother asked; "Do you not think, sir, that he is possessed of a devil?" [106] The patient was of filthy habits, unable to wash or dress himself and ate grass, cinders, raw fish and faeces. Further, his "sexual appetite" was "strong" and his conduct was such that women did not like to enter the house. Easily excitable, on one visit, he:

> "threw himself into the most grotesque and distressing contortions, leapt on a trunk, then pitched himself headlong from it; seized a red hot peat, held it for a few moments in his hand, then flung it from him; tore off a heavy window sill and cast it across the room, screaming and howling all the time." [107]

This episode had been prompted by a suggestion that he was washed. The poverty of the family had resulted in the degradation of the patient, who, Mitchell considered, under other circumstances could have been managed successfully in a private dwelling. His removal to an asylum after many years of such behaviour, was undertaken in 1863, although the Commissioners were reluctant to increase expenditure for an already impoverished parish.

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[105] GBCLS 2nd AR, (1860), p214.
[106] GBCLS 6th AR (1864), p224.
[107] *Ibid.*, p225.

Generally, recommendations made by the Commissioners were implemented, and, within a few years, Mitchell was able to declare that conditions had "undergone an unmistakable improvement".[108] The Board of Lunacy issued a list of suggestions, broadly similar to instructions for inspectors of poor, regarding the attainment of adequate standards. Increased visits from parochial officials and medical officers were advocated. Particularly unsuitable patients were sent to a mainland asylum. Allowances were increased and a more liberal supply of clothing granted. The erection of an asylum on the islands was recommended by the Board of Lunacy, but never achieved. Frequent, extensive visits by officials, however, did much to improve standards and, by the 1880s, conditions were broadly of the standard found throughout Scotland.

b. Orkney

Living conditions of patients in Orkney resembled those in the Shetlands. In the early years of the Board's control, the Commissioners made repeated reference to neglect and the inappropriate use of restraint, with reports of patients being chained to the bed for long periods. By 1864, however, Mitchell asserted that the condition of "the great majority of single patients" was satisfactory.[109] Further, in several areas, the visiting report books testified to the scrupulous attention bestowed on patients by local officials.[110] Nevertheless, Commissioners reported that, in common with other counties, there was a tendency to evade the legal requirement to intimate all insane paupers, thereby reducing the expense of administration. Despite poverty, and the problems in regulating and supervising boarding-out, it was generally accepted that patients were provided for adequately, if they were treated in the same way as the rest of the population.

9.6.3 Western Isles

Throughout Scotland in 1867, the proportion of patients in private dwellings was 28%, with 72% in institutions. However, in the Western Isles, only 37% of the registered insane were in any form of institution, leaving 63% as single patients.[111] Conditions were broadly similar to those throughout the Northern Isles, although the standard of living and habits of

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[108] *Ibid.*, p220.
[109] GBCLS 6th AR (1864), p226.
[110] Visiting Report Book: Stromness Parochial Board. 1905-1923 (CO6/18/13), Inspectors Visiting Report Book: Deerness. 1904-1919 (CO6/13/15).
[111] GBCLS 9th AR (1868), p247.

the people received greater censure from the Commissioners. The population was poor and the rates for poor relief particularly high. It was recognised that the condition of patients could not be measured by the standards applicable in wealthier districts and in this respect, the Board of Lunacy demonstrated sensitivity to local variation. The sparsity of the population and an apparently greater tolerance of eccentricities allowed all but the most dangerous patients to remain on the islands, thereby minimising the expense of removal to an asylum.

Living conditions were condemned frequently by the Board of Lunacy, which reported with some incredulity upon the absence of windows and furniture in the majority of houses and on the inadequate drainage and washing facilities. The low standard of living and the lack of comfort prevailing for all residents, were considered to be unfavourable for insane patients, diminishing the possibility of any amelioration in their mental condition. However, the nearest asylum was at Inverness and access to it was costly and hazardous, often impossible, in the winter months.

The majority of patients on the islands of, for example, Stornoway, Harris, Barra, North Uist and South Uist, received dispensation from removal to an asylum, despite suffering from a wide range of mental disturbance. However, it is probable that the existence of a large number of insane persons in each parish was kept secret from the Board of Lunacy, in case their living conditions were declared inadequate and heavy costs demanded for improvements. A higher proportion of single patients were classified as suffering from congenital rather than acquired insanity, when compared to the statistics recorded on the mainland.[112] In 1868, for example, there were 45 idiotic or demented patients residing in private dwellings in the Western Isles and only nine classified as suffering from mania[113] and such disparity continued throughout the century. It was argued that the number of insane persons would have been even higher in the islands, if a strict definition of lunacy was adhered to. The Commissioners maintained that, throughout the Western Isles, cases of arrested mental development were common, and that the average standard of mental capacity was lower among the resident population than in mainland Scotland. However:

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[112] The greater prevalence of idiotic and demented patients was commented upon frequently. In Long Island (the islands of Lewis, Harris, Barra, North and South Uist) it was reported that such patients, compared to those suffering from acquired insanity, predominated by ten to one. GBCLS 10th AR (1868), p248.
[113] GBCLS 9th AR (1867), p247.

> "the idea still lingers...that if a person, although weak-minded and unable to work for his living, is inoffensive and not dangerous, he is not, properly speaking, a lunatic."[114]

Despite the difficulties encountered by the Commissioners in controlling boarding-out in such distant locations, their influence had considerable impact. Gradual improvements in living conditions were recorded and requests that all insane patients be registered were largely heeded. While the Commissioners could maintain that an increase in registered insanity had resulted from their exhortations, the existence of the grant-in-aid was probably a more powerful impetus. Few parish officials could afford to ignore the prospect of half the maintenance costs of each insane patient being offset by the government. However, parish officials from South Uist maintained that, notwithstanding the assistance of the grant-in-aid, costs incurred by the parish, following the Board's intervention, would be higher than the sum awarded by the grant. Nevertheless, from 58 patients registered by the Board of Lunacy in the Western Isles in 1879, the number had risen to 93 ten years later, the majority of whom were congenital imbeciles or idiots, previously ignored by parish officials reluctant to incur the additional maintenance costs.[115] The general freedom and contentment of most patients was also recognised as an explanation for the small number being registered officially as insane. To local residents, accustomed to the presence of such imbeciles, their classification as insane appeared both unnecessary and unfair. Informal care was the preferred option. However, receipt of parochial aid was dependent upon notification of such patients and the attainment of certain designated standards.

9.6.4 Island of Arran

Preceding the creation of the Board of Lunacy, Arran had been much utilised for the reception of insane patients, under no formal legal supervision or control. Many non-pauper lunatics were boarded with unrelated persons, without a sheriff's warrant and under no form of medical care. Such boarders were kept solely for profit.[116] The nature of illness of many boarders was such that, had they been pauper patients, under the jurisdiction of the Board, they would not have received exemption to remain in private dwellings.[117] Several

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[114] GBCLS 16th AR (1874), p313.
[115] GBCLS 32nd AR (1890), p123.
[116] The defects in treatment and the lack of any supervision was discussed at length by the Commissioners in the 1860s. See for example, GBCLS 8th AR (1866), p250, 9th AR (1867), pp2 and 61.
[117] The Commissioners maintained that some patients "labour under forms of mental disease which makes it improper to detain them in private houses. Such cases, if paupers, would not receive the Board's exemption from removal." GBCLS 7th AR (1865), p239.

were reported to be suicidal, others were noisy and violent.[118] In many cases, their condition was considered to be markedly below that of pauper lunatics on the island, even though they paid higher rates of board and belonged to a higher social class. The Commissioners considered that in such cases, "it would be an advantage to many of them to sink into pauperism", thereby bringing them under formal supervision.[119]

A full inquiry into conditions for the insane in Arran was conducted in 1865.[120] At the time, there were 61 insane patients resident on the island, of whom 12 were paupers chargeable to Arran, and five were paupers chargeable to other parishes. The remainder were not in receipt of poor relief. The high proportion of private patients was unique to Arran; there were 13 belonging to the island and residing with relatives and 31 sent to the island as boarders, under no legal control. While a number of patients had acute mental disorders, the "intellectual disturbance" of many was "slight" and certainly not extensive enough to warrant certification of insanity.[121] There were cases of "ordinary dipsomania", who received no clear benefits from residence on the island because many managed to acquire alcohol, and the "treatment", such as it was, was unsuccessful.[122] The inquiry found no evidence of restraint or cruelty and the majority were found to be comfortably clothed and contented. The location of Arran was praised by the Commissioners, who emphasised the advantages of seclusion, the beauty of the surroundings and the healthy climate. Following the inquiry, close vigilance was maintained over patients. This was reflected in the general trend towards improvement recorded in annual reports and within twenty years of regular visitation, conditions were deemed satisfactory. Unsuitable cases had been sent to the asylum, allowances were increased, clothing granted with greater frequency and the selection of guardians made more judiciously than formerly. In addition, Commissioners reported with satisfaction that many private patients had been brought under the Board's jurisdiction. According to Mitchell, "progress has not been rapid, but since it has begun it has been steady and satisfactory."[123]

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[118] *Ibid.*
[119] *Ibid.*, p240.
[120] GBCLS 8th AR (1866), p249.
[121] *Ibid.*, p250.
[122] Following the intervention of the Board of Lunacy, however, there was a significant reduction in the number of dipsomaniacs sent there.
[123] GBCLS 9th AR (1867), p261.

In 1880, there was only one special licensed house in Arran, receiving two patients; the remainder were boarded singly. However, small aggregations had developed in Largiebeg and Dipping, prompting complaints about the accumulation of patients. A further special inquiry, therefore, was instituted in 1882, which resulted in six patients being returned to the asylum and 12 being removed to different guardians. These changes led to the dispersal of the aggregations and the reassurance of local residents.

Improvement in the quality of housing was attributed partly to the profits derived from receiving patients and the increased prosperity of the island. Nevertheless, there was a steady diminution in the numbers boarded, which was deemed desirable, in view of the overcrowding of the island during the summer, due to the influx of tourists. In some instances this had led to the comfort of patients being disregarded, especially when houses were let and local residents moved to specially erected barns. Although these barns were reported to be comfortable, they were disapproved of by the Commissioners who observed that "this practice, not by any means an ideal one, has gone on continuously since patients were lodged in Arran thirty years ago".[124] Reassured by a decline in numbers to more manageable levels, however, the Commissioners expressed enthusiasm for the advantages available for patients. The transformation from an island with a high proportion of private cases (72% in 1865) with a mental illness of dubious validity, to a flourishing environment praised highly by the Commissioners was marked. Condemned for years as unsuitable for the residence of the insane, by the 1870s, Arran had become a popular location for pauper and private patients from locations in the west of Scotland.

9.7 Summary and conclusions

The assessment of regional diversity has emphasised two very different methods of boarding-out. The majority of patients boarded-out from large urban parishes had been discharged unrecovered from asylums and placed in the care of strangers in rural communities. Patients from the Highlands and Islands, however, were more likely to reside with their relatives, having had no previous asylum admission. The expense and inconvenience of maintaining patients in overcrowded asylums in urban districts encouraged the system of boarding-out. Although embraced for entirely different reasons, a

[124] GBCLS 46th AR (1904), p162.

system of domestic provision flourished in the northern parts of the country, strengthened by two factors, the distance of most communities from any asylum and the expense incurred in transferring and admitting patients.

Boarding-out insane persons was an integral part of life in the Highlands and Islands and the great majority of parishes had at least some patients residing in private dwellings. It was rarely an active policy requiring the formality of commitment and removal of patients from asylums. Insane patients had lived in domestic settings long before the Board of Lunacy was established. The intervention of the Board did little more than oversee an existing arrangement and attempt, by regular supervision, to improve living conditions. In contrast, the system practised by urban parishes had the appearance of greater control and supervision. Advice concerning the expansion of the policy throughout a particular region was frequently sought from, and given by, the Commissioners. However, despite sustained encouragement, a high proportion of patients in the Borders, for example, remained in institutions and the extent of boarding-out in these counties was never comparable to that in the rest of the country. The consistent pressure exerted by the Commissioners on parochial officials and asylum superintendents in Lowland and Central Scotland, not always successfully, highlights the more tenuous and formal nature of boarding-out in these districts, Edinburgh and Glasgow being notable exceptions. Localities with impressive records of receiving patients from other areas were spread across the central belt of Scotland and villages, once utilised by a particular parish, remained an important focus for the placement of generations of patients.

The high number of patients in private dwellings in the Highlands and Islands was not attributable, therefore, to any particular recognition of the merits of boarding-out, rather, the system existed through necessity. Sufficient funds to accommodate patients in an asylum on the mainland did not exist. Further, the nature of the community, in isolated areas, often with extended family networks, made it more acceptable for insane relatives to remain under the care of their own families. While urban parishes, with an active record of boarding-out, were prompted by a need to relieve asylums of overcrowding, and a realisation that many patients were well suited to domestic care, there was little choice in the islands. Thus insane patients resided throughout the islands, under the care of relatives, regardless of any official, centralised policy by the Board of Lunacy.

There was considerable divergence, therefore, between large towns and rural parishes, in the degree to which the policy was implemented. This was a source of frustration to the Commissioners, who maintained that if one parish could board-out large numbers, there was no reason why this could not be imitated nationwide. Both Edinburgh and Glasgow City parishes had an active record of boarding-out over a long period, indicating that once the system had been instituted, it was likely to remain an integral and valued part of parish administration. The diversity must be attributed largely to the initial enthusiasm of local officials and to the availability and accessibility of institutional provision. The proportion of patients boarded-out varied significantly across Scotland, but the system was an available option for all parish officials. Whether they chose to implement such a policy was a different issue.

CHAPTER 10

CRITICISMS AND SHORTCOMINGS OF THE BOARDING-OUT SYSTEM

10. Overview

A system of lunacy provision which catered for up to 25% of the registered insane attracted considerable comment from those concerned with lunacy administration, including medical superintendents of Scottish asylums, parish officials and alienists from throughout the United Kingdom and worldwide. While criticisms were forthcoming, and enduring, many were easily refuted or dismissed. This chapter identifies the main objections to boarding-out and assesses their validity in light of the experience of the Scottish system.

10.1 Introduction

Although widely heralded as pioneering, many alienists, from the very introduction of boarding-out, were critical of the system. Among concerns expressed was the possibility that an active boarding-out system could overshadow the newly developing asylums. Critics also maintained that only very limited types of patients were suitable for such provision; that there were few opportunities for therapeutic intervention; that patients lacked stimulation, were vulnerable to potential ill-treatment by uneducated, untrained, and possibly ill-motivated, guardians, and that they were resented by the local community. Other objections were concerned with the risks posed by what was regarded to be inadequate supervision, public fears of the production and perpetuation of hereditary degeneracy and the fear that the presence of the insane could have a detrimental effect on the host family, especially children. This assessment of boarding-out tries to avoid the pitfalls described by one asylum superintendent, Campbell, when he observed that the system in Scotland had been much eulogised. Instead he recommended a "calm and judicial history of its working so far, its merits, difficulties, defects dealing with both patients and

the public..."[1] In his view, enthusiastic, glowing descriptions which avoided discussion of potential drawbacks engendered distrust of the system.

Annual reports of the Commissioners in Lunacy contained few criticisms of boarding-out and members of the Board remained firm protagonists of the system. One of the major defects of their reports was the marked tendency to highlight the beneficial aspects of boarding-out, in their zeal to encourage its expansion. However, the Commissioners did not wholly ignore potential disadvantages and the majority of their reports did address the problems inherent in the system.[2] There were discussions on the objections raised, although these were almost invariably dismissed as minor, and attempts were made to counteract them, often successfully. One exception to this concerned difficulties encountered in rectifying conditions among those boarded with relatives. The impotence of the Board in such cases and its limited powers of intervention in cases of maltreatment of private patients were railed against repeatedly.

It could be expected that medical superintendents would have a vested interest in publicising the disadvantages of a boarding-out system. However, while many were sceptical of the ability of boarding-out to offer an alternative to asylum care, most recognised the beneficial effects of removing chronic patients. If they felt their position, or the status of the asylum threatened, this does not appear in their annual reports. The Commissioners insisted that boarding-out was an adjunct to asylum provision, not intended to supersede it, and this conviction was accepted widely. Nevertheless, specific objections were forthcoming from medical superintendents in the early years of the system. These focused on insufficiency of supervision, lack of suitable guardians and difficulties in selecting patients from among the chronic, harmless insane. However, by the early twentieth century, the Commissioners were able to contend that "time has shown that [these objections] were not so real as doubtless they then appeared."[3] Further, although large numbers of patients were boarded-out from asylums, the main concerns of superintendents lay in the daily administration of the asylum, rather than in implementing a system of boarding-out.

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[1] Campbell, J. A. Reported in Anon. (1888) Notes and News. *Journal of Mental Science*, 34, p646.
[2] *Vide infra* Chapter 11.
[3] GBCLS 43rd AR (1901), p163.

Parish officials had a major role in overseeing boarding-out insane persons from their parish. Although they made adverse comments against the powers of the Commissioners in Lunacy and their overbearing nature, their opprobrium was largely confined to this, rather than to criticism of the system itself.[4] While some inspectors of poor were reluctant to take on the additional burden of implementing the policy, there were no specific criticisms of boarding-out, and, despite the extra work involved, the merits of placing patients in private dwellings were accepted increasingly widely. Reflecting this, in 1906, for example, at a discussion among inspectors of poor, following an address on boarding-out by a Lunacy Commissioner, the majority of delegates declared themselves to be in favour of the system and sought advice as to how they could implement it further.[5]

From the 1870s, articles on the system of boarding-out in Scotland were published in medical journals, increasing in frequency throughout the 1880s. The discussions such articles prompted, and the debates of the annual meetings of the Medico-Psychological Association, were documented in detail, most regularly in the Journal of Mental Science.[6] While largely descriptive, there were articles which included fierce criticism of the system, Tuke's assessment in 1870 of conditions at Kennoway being a notable example.[7] The authors of many other critical remarks regarding boarding-out remained anonymous.[8] However, the attitude of successive editors of the Journal of Mental Science appeared to be generally favourable towards the system, often offering firm endorsement of the reports of the Scottish Lunacy Commissioners. Similarly, the editors of the Edinburgh Review, in 1870, remarking upon certain criticisms made on both the system of boarding-out and the bias of annual reports of the Board of Lunacy, concluded that, after consideration of the system, "we fail to find any reason for this disingenuous attempt [to discredit the system]...we can see no sign of false colouring".[9]

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[4] *Vide infra* Chapter 13 for assessment of the role of parish officials and their attitude towards the Commissioners.

[5] Anon. (1906) Family care of the insane. Lecture in Aberdeen. Review and discussion of Macpherson. *Poor Law Magazine*, **16**, 81-89.

[6] *Vide supra* Chapter 2.

[7] Tuke, J.B. (1870) *op.cit.* The only other particularly critical articles appear to have been those by the anonymous author of Gheel in the North. (1866c) *op.cit.*, and Robertson, C.L. (1867) Presidential Address. The care and treatment of the insane poor. *Journal of Mental Science*, **12**, 287-306. There is no indication of any sustained attack on the system in later years.

[8] It does not appear that this anonymity was prompted by any desire for secrecy, but rather, reflected the nature of the reports. General conclusions were often drawn by the editors of journals or the chairman of meetings on behalf of individual speakers.

[9] Wynter, A. (1870) Non-restraint in the treatment of the insane. *Edinburgh Review*, **131**, p443.

Almost without exception, foreign alienists praised the system highly; their copious reports contained only minimal censure and their conclusions were generally glowing and strongly in favour of its adoption in their country.[10] English commentators were more restrained, although their doubts lay rather in its applicability to their country, with its more urban-based population and more extensive institutional provision, than in condemnation of particular aspects of the system.[11] Thus while one English physician, Rayner, observed that the Scottish experience was "such an irrefragable proof of the advantage of the system"[12] that he could add nothing further in its favour, lack of enthusiasm for boarding-out was observed frequently by the English Lunacy Commission. Among the more vehement critics was Robertson, superintendent of the Sussex County Asylum, who, although initially in favour of the Scottish system, later condemned it as "the most objectionable form of lay speculation in lunacy"[13] His attacks were firmly refuted by Mitchell in a lengthy article disparaging Robertson's status as an informed critic.[14] Notwithstanding adverse comments at meetings of the Medico-Psychological Association and in a limited number of articles, it is difficult to find sustained criticism of the system.

Criticism was voiced more frequently in the early years of boarding-out, due to its unfamiliarity to the medical profession and to unease about a policy which endorsed the residence of large numbers of insane patients in the community. Less than ten years after its inception, one anonymous commentator announced that the system had met with the "worst success, because misunderstood and badly executed".[15] As familiarity with the aims and results of boarding-out increased, such criticism became rare, and where apparent, was challenged at once by the Commissioners. Although a decline in the number of patients boarded-out was evident from the turn of the century, this was linked less to dissatisfaction with the system, than to difficulties imposed by war-time conditions and the change in classification of patients brought about by the Mental Deficiency and Lunacy (Scotland)

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[10] The attitudes and recommendations of overseas alienists are discussed in detail in Chapter 14. Féré, Marie and Stedman were among many eminent physicians who praised the system as practised in Scotland, and attempted to replicate its principles.

[11] *Vide infra* Chapter 14 for a discussion of the major objections held by English physicians.

[12] Reported in Anon. (1909a) *op. cit.*, p181.

[13] Mitchell, A. (1868) *op.cit.*, p490.

[14] *Ibid.* p491. Mitchell objected to the fact that Robertson made his criticisms without ever having seen the Scottish system in practice. He "has shown no wish to obtain a personal knowledge of the state of matters in Scotland."

[15] Anon.(Author of the Gheel Question) (1865a) A catechism on the necessity and possibility of a radical reform in the treatment of insanity. *Journal of Mental Science*, **10**, p11.

Act in 1913.[16] There was no sudden renewal of impetus towards censuring boarding-out and the system remained widely advocated by professionals in the field.

10.2 Limitation in type of patient suitable for boarding-out

Some physicians, including for example, Rogers[17], Cyon[18] and Howden,[19] maintained that only very specific categories of patients were suitable for care in private dwellings and that this devalued the policy of boarding-out. They argued that the number was so small that it was not worth implementing the system, although it is interesting to note that the German alienist, Griesinger, suggested that one-fifth of the insane could be provided for in this way.[20] In fact, the removal of incurable patients alone would have brought significant alleviation to overcrowded asylums. However, the classification of patients often involved severe difficulties, especially in the definition of incurability and harmlessness. As one anonymous commentator contended:

> "that any insane person should be legally recognised as incapable of amelioration is certainly a dangerous and retrograde movement."[21]

He considered that all patients were capable of improvement under careful training, making it unsafe to declare any patient incurable. Despite these concerns, their validity in censuring the selection of patients for care in private dwellings declined as the system developed and an increasing range of cases were boarded-out. The assertion of Lindsay that "each case should be dealt with apart altogether from its mere nosology, or from any rigid scientific or practical definitions"[22] was echoed increasingly by the Commissioners, in their conviction that the actual illness of a patient was less important than their ability to cope in the community.

Fears about placing women of child-bearing age in private dwellings were expressed repeatedly. Pregnancies and sexual assaults were reported frequently in the earlier years of the Board's control, particularly among patients living with relatives.[23] However, the

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[16] The decline in the number of boarded-out patients has been documented in Chapter 4 and reasons for this decline are considered in Chapter 15.
[17] Rogers, T.L. (1877) On the best means of providing for the care and maintenance of pauper lunatics of the demented and imbecile class. *Journal of Mental Science*, 23, p327 and reported in Anon. (1877b) Notes and News. *Journal of Mental Science*, 23, p444.
[18] Jolly, F. (1875) *op. cit.*, p51.
[19] Howden, J. Reported in Anon. (1870a) Notes and News. *Journal of Mental Science*, 15, p300.
[20] Recorded in Jolly, F. (1875) *op. cit.*, p51.
[21] Discussed by Lindsay, W.L. (1871) *op. cit.*, p523. *Vide supra* Chapter 4 for discussion of this point.
[22] Lindsay, W.L. (1871) *op.cit.*, p524.
[23] *Vide supra* Chapter 6.

Commissioners argued that what, to them, were limited occurrences (although there was, on average, one case of pregnancy reported annually even from the 1870s) did not warrant censure of the system as a whole or justify the forcible removal from private dwellings and retention in institutions of imbecile women of child-bearing age.[24] This view was accepted gradually, with the recognition that most congenitally defective patients did not require the restraints and routine of asylum life. Although pregnancies continued to be recorded as the system expanded, despite the close supervision of various officials, the Board declared with the optimism prevailing throughout their reports, that isolated incidents were not to be seen as a reflection on the stature of the system. Where the Board's supervisory recommendations were upheld, the Commissioners claimed that women were as safe as in the best-conducted asylums, where such assaults also occurred.[25]

Difficulties could arise when a patient appeared suitable for life in a private dwelling, being quiescent, clean, and harmless, but despite careful selection, failed to flourish, becoming unmanageable outside the asylum, or developing new features which made them inappropriate for domestic life. Lindsay, superintendent of Murray Royal Asylum, documented one such case which illustrates this.[26] Within a few days of being boarded-out in the country, one female patient threatened suicide and then tried to drown herself. Upon re-admission to the asylum she was reported to be in acute mania, which took several months to subside. She was then noted to be active, intelligent, industrious, and one of the best laundry assistants. Lindsay was certain however, that if she were discharged again, the outcome would be the same. He therefore advocated caution in placing the non-recovered insane in country districts where, in his view, there was "an absence of proper control or discipline, with defective sanitary arrangements."[27] Similar problems were reported as late as the 1900s, when patients who had appeared suitable for domestic care, developed dirty habits, or proved uncontrollable upon being boarded-out.

Relapse was recorded on some occasions even before patients were removed from the asylum; for example, in the case of one long-stay patient who had been selected for boarding-out, being quiet and harmless. At the asylum, he had been granted much liberty,

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[24] GBCLS 50th AR (1908), p163 and AR, *passim*.
[25] GBCLS 30th AR (1888), p113.
[26] MS AR (1861) Murray Royal Asylum, pp18-19.
[27] *Ibid.*

acting as an attendant, groom, and gallery assistant, and always "behaved with intelligence and propriety". It was presumed that he would be equally harmless and industrious out of the asylum, and, therefore, his removal on probation as an unrecovered patient was recommended. However, it was reported that:

> "the bare idea of leaving at once made him ill and caused the development of delusions that had long been apparently dormant, or generated new ones".[28]

Because of this, he was allowed to remain in the asylum. Lindsay suggested that the patient was aware that his position in an asylum would always be superior, in terms of diet, accommodation, society, exercise and general sanitary arrangements, and that this knowledge had made him react in that way. It was evident, therefore, that suitability for care in private dwellings could only be determined by a trial. Despite precautions being taken against a patient being boarded-out prematurely, the Commissioners acknowledged that some failures were inevitable, and that exacerbation of mental disturbance could occur. Further, host households might prove unsuitable for a particular case and it was recognised that "not infrequently a patient fails under one guardian, and yet does very well under another."[29] However, despite selection difficulties, the majority of patients were placed successfully. The Commissioners placed great emphasis on the ease with which they could be returned, or admitted to, an asylum, although critics (particularly medical superintendents) argued that the re-admission procedure was too lengthy, and the expense incurred prohibitive, especially when the patient lived at a distance from an asylum.

10.3 Maltreatment and exploitation by inexperienced, ill-motivated guardians

Possible maltreatment of patients was one of the major issues highlighted by critics, particularly in the earlier years of the system. Neglect, ill treatment and unjustifiable detention by "sordid and unscrupulous guardians" were all regarded as potential risks.[30] Even though few cases of real cruelty, as opposed to incidental neglect, were recorded, the criticism cannot be dismissed lightly. In 1865, it was noted with concern that "not a year passes yet when the Visiting Commissioners do not report cases of extraordinary neglect or cruelty"[31] and in 1866, eight cases of cruelty against patients were recorded.[32] Many

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[28] *Ibid.*, p18.
[29] GBCLS 28th AR (1886), p373.
[30] Norman, C. (1890) *op.cit.*, p473.
[31] GBCLS 7th AR (1865), p235.

guardians had no experience of caring for lunatics, although asylum attendants were often no better trained. Among approximately 40 cases of cruel behaviour documented by the Commissioners in the 1860s, several patients complained that they were struck by their guardians, one able-bodied idiot being beaten by his guardian who also "punishes him cruelly and forces him to work beyond his strength. By this treatment he is rendered vicious and unmanageable."[33] Other cases which were censured by the Board in the first ten years of boarding-out included the discovery of a man who had been chained to his bed for 30 years[34] and two brothers who were " found in an extraordinary state of misery" with one under mechanical restraint and the other secluded. To the Commissioners "it would not be easy to imagine a condition exhibiting greater cruelty, mismanagement and neglect."[35]

However, as far as can be ascertained on the basis of available sources, there is no indication of sustained maltreatment by guardians once the system was firmly established, and supervision procedures widely known. Such cases were seldom reported from the 1870s, and in 1882, Lawson felt able to announce that "with very few exceptions all visited were admirably provided for and to all appearances happy."[36] Notwithstanding this, as late as 1913, one patient was removed from a guardian who had whipped her and placed her in the cellar, as punishment for stealing.[37] Despite such occasional, comparatively rare, incidents, there is no evidence in the annual reports of the Commissioners or parish officials of overt cruelty towards patients, and it is likely that thorough supervision procedures ensured that such behaviour did not remain undetected.

Nevertheless, some alienists could not reconcile themselves to the practice of untrained, uneducated labourers and artisans controlling patients. Tuke considered this to be one of the major faults of the system, and, by way of illustration, he highlighted the difficulty that superintendents experienced in finding satisfactory attendants, who had to be trained for several months "to inculcate that consideration is due to the weaknesses of those under his or her care".[38] For many physicians, it was vital for those attending the insane to have special training. Thus, Browne, in his vitriolic appraisal of boarding-out, declared that:

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[32] GBCLS 9th AR (1867), p236. In all these cases the patients were removed to the asylum "as the proper and only remedy for the gross mismanagement they displayed."
[33] GBCLS 6th AR (1864), p235.
[34] GBCLS 10th AR (1868), p238.
[35] *Ibid.*, p238.
[36] GBCLS 24th AR (1882), p171.
[37] Boarded-out mental patients registers. (1914) D.HEW 7/4/4., p400.
[38] Tuke, J.B. (1870) *op.cit.* p532.

> "when civilisation and a higher standard of living and a keener appreciation of minor morals shall have penetrated more deeply into the substrata of society...and assimilated cottage interiors...to the infirmities, habits and requirements of the insane, the substitution of private dwellings for public hospitals for certain classes of the insane... may be useful, as well as practicable; whereas at present, it can only be regarded as an evil which it is a public duty to mitigate as much as...[is]possible."[39]

Defending the system of boarding-out with untrained persons, however, the Board of Lunacy argued that ordinary intelligence and kindliness were the major requirements for guardianship. It was also maintained that asylum trained attendants were generally unable "to regard an insane person from any other point of view but that of a patient, and consequently to be treated on the lines found necessary in the institution."[40] The great appeal of the system, continually emphasised by the Commissioners, was the opportunity it provided for insane persons to be integrated into family life.

A further, major, objection put forward was that only impoverished people would accept boarders, for entirely the wrong reasons.[41] This criticism was more easily substantiated. Critics, among the most vocal of whom was Robertson, maintained that most guardians were little above the level of pauperism, being simple artisans and farm-workers and that money was a crucial incentive. Echoing this, an editorial in The Lancet concluded that "Dr Robertson, we think justly, condemns the practice of placing patients in labourers' cottages, as a retrograde step. We entirely agree with him".[42] Another alienist, Ireland, cautioned that the limit of suitable guardians would soon be reached, and that persons who were "compelled by circumstances to take a madman or idiot into a narrow cottage must be poor and wretched unless philanthropists of the first water".[43] Further, those who placed stress on the dangers of pecuniary motivation expressed concern that guardians would not deal gently with chronic, severely demented patients if they had to clean up after them and provide constant care. In practice, however, severely dependent patients were not selected for, or allowed to remain in, private dwellings.

The fear that patients would be exploited by guardians was a recurrent observation of parish officials, certain medical superintendents and, less often, newspaper columnists. In a

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[39] Anon. (1866c) Gheel in the North. From a Correspondent. *Journal of Mental Science*, **11**, p286.
[40] GBCLS 43rd AR (1901), p164.
[41] *Vide supra* Chapter 7 which contains an assessment of the motives behind applications for patients.
[42] Reported in Anon. (1868a) Care and treatment of the insane poor. *Journal of Mental Science*, **13** (reprinted from The Lancet), p586.
[43] Reported in Anon. (1880) Overcrowding in pauper asylums and its remedies. Notes and News. *Journal of Mental Science*, **26**, p323.

lively debate on the merits of the system, Boyd, the Chairman of the Medico-Psychological Association in 1870, expressed his concern that utilisation of patient labour was, to some degree, slavery.[44] While he accepted that guardians might be well selected, he spoke of "the tendency in the human mind to develop itself in the direction of power" and warned that without strict supervision there was a very real danger that "the stronger man would oppress the weaker."[45] A letter sent to a Glasgow newspaper made the same point:

> "Sir, During a stay in Fifeshire, I visited several villages and hamlets in which harmless lunatics are boarded-out...and engaged in very light work...Physically unfit though the patients be, numerous keepers of them hire them out for labourers work to farmers and others, and receive in return a fee, of which the workers see nothing...The Woodilee Directors owe it to the ratepayers of Glasgow to take very decisive means to protect against a system of slavery, a number of defenceless imbeciles..." [46]

These concerns were borne out by some examples recorded in the reports of the Commissioners. It was clear that there was a marked disinclination by a number of unrelated guardians to accept unproductive patients and many stipulated explicitly that they would receive only useful boarders. There were several reports containing reproaches by guardians for being sent patients who were unable to work. Thus one guardian complained that one of her male patients was lazy, useless and quarrelsome and demanded that he be removed and a better worker sent.[47] Similarly, an "old and worthy" guardian who boarded three female patients complained that none of them were any help to her. In view of her recognised suitability as a guardian, the Commissioners approved the removal of one patient, to be replaced by a more useful patient.[48] This was an unusual concession to the wishes of a guardian and demonstrates the Board's capacity to be flexible in applying its stated guidelines. Its basic conviction, nevertheless, remained that patients were boarded-out to increase their own well-being and that any benefits attained from their labour were incidental and not part of any justified expectation. As Macpherson explained to a meeting of inspectors of poor:

> "the ideas held by a considerable number of guardians, usually working farmers, are preposterous...[they] expect patients to be up very early in the morning and to work all day...If they can't they are considered useless. Such guardians apparently regard inspectors of poor as beneficent genii who have come to this world purely for the purpose of supplying distressed agriculturalists with free labour and giving them a bonus of 7s a week in addition."[49]

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[44] Boyd, R. Reported in Anon. (1871) Notes and News. *Journal of Mental Science*, **16**, p300.
[45] *Ibid.*, p301.
[46] Letter in (untitled) newspaper, 30.8.93. by JPG, contained in inside cover of boarded-out mental patients registers, D.HEW 7/4/1.
[47] Boarded-out mental patients registers (1908) D.HEW 7/4/4., p437.
[48] Barony Parish Report by Visiting Committee, City Parish (1898) D.HEW 24.14, p4.
[49] Macpherson, C. (1903) *op.cit.*, p127.

A large proportion of boarded-out patients were, anyway, unable to do any competent work, and among those able to work, Lindsay, echoing Griesinger, estimated that the value of their labour was only one-fourth or one-fifth that of the sane.[50] In an attempt to counteract the risks of overworking patients, the Board of Lunacy recommended, in particular, placement on a croft or small farm, where no hired labour was required, but where moderate assistance would be appreciated. By the turn of the century, however, increasing numbers of patients were boarded on medium-sized farms, leading the Commissioners to express some concern that increasing ability for profitable labour was expected from the patients. Illustrating this, they cited instances when guardians had asked: "what is the use of sending us x? He is of no use about a farm."[51] Despite concerted vigilance by visiting officials, exploitation was impossible to eliminate completely, as the following case indicates. A man suffering from chronic mania, who, before his illness, was a successful shoemaker, had been boarded-out for 20 years, with a shoemaker. During an official visit, the Commissioner remarked upon the excellence of the patient's labour and suggested that the maintenance payment to the guardian be reduced, in view of the quality of work. However, the guardian managed to convince the parochial authorities that the patient "spoiled more leather than all his fine work was worth."[52] His allowance, therefore, remained unchanged, and his deception enabled him to make a considerable profit as he continued to receive both a regular sum for the patient, and profit from the patient's expertise at work, estimated to be approximately 20s a week.

While the annual reports of the Commissioners and parish officials indicate that the majority of guardians provided adequate care for their charges, the fear that some patients would be exploited was not, therefore, groundless, despite reassurances by the Board of Lunacy. It is clear, from the cases described, that some accusations concerning abuse of patients had substance.[53] However, while critics saw only a desire among guardians to benefit financially at the expense of offering suitable care, this is not reflected generally in official reports or in the small, and diminishing number of patients removed annually due

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[50] Lindsay, W.L. (1871) *op.cit.*, p520. Thus he maintained that "too much weight is apt to be attached...to the value of the labour of the chronic insane."

[51] GBCLS 54th AR (1912), p159.

[52] Macpherson, C. (1903) *op.cit.*, p127.

[53] However, it was not easy to prove, and therefore quantify, the extent of potential exploitation. When questioned by the Royal Commission on the Poor Laws as to whether farmers worked their patients unfairly, Spence, the Secretary to the General Board of Lunacy, indicated that although such allegations were made, he did not think any case was ever proved. Evidence given to the Royal Commission on the Poor Laws and Relief of Distress, Scotland (1909).

to ill-treatment or over-work.[54] Notwithstanding isolated cases, financial corruption and devious behaviour on the part of guardians was not regarded by the Commissioners as a serious problem and, on the basis of extant written communications of the Board of Lunacy, this confidence appears justified. The careful selection of guardians and the vigilance of visiting officials and neighbours reassured the Commissioners that the treatment of patients was comparable with standards of care in the family and surrounding neighbourhood. Thus it was concluded, and reflected in the case reports, that, with certain inevitable exceptions, the attitude of guardians towards their charges, "while not wholly altruistic was not a selfish one."[55]

10.4 Inadequate supervision

Although patients received quarterly visits from the parish medical officer and were seen at least annually by the Deputy Commissioners in Lunacy, as well as by other officials, those unconvinced of the efficacy of boarding-out emphasised the adverse effects of the lack of experienced supervision. Coxe, a former Commissioner in Lunacy, assured members of the Select Committee in 1877 that no insane patient would remain unvisited for two years, except for those residing in Orkney and Shetland. Nevertheless, other witnesses estimated that many were not visited for lengthy periods. A year earlier, for example, one Commissioner had visited 1066 of 1400 boarded-out patients, leaving 334 "for a long period to the tender mercies of the great unwashed", the visitations of a parish doctor and an inspector with no specialist knowledge of the insane.[56]

The efficacy of official supervision was also questioned. Critics argued that visits were "likely to be of a somewhat perfunctory character[57] and that a performance was put on for official visitors. As a result, the Commissioners failed to obtain an accurate representation of daily life.[58] It is impossible to ascertain whether the impression gained by the

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[54] In 1899, therefore, Sutherland was able to record that "no complaint of cruelty, neglect harsh or unfeeling treatment [or of] overtaxing the strength of willing workers has come under my notice. It is very probable that any real abuses would come to light, as patients are visited 7 or 8 times a year". GBCLS 41st AR (1899), p128.

[55] Sutherland, J.F. (1897) *op.cit.*, p41.

[56] Reported in Anon. (1877a) Dillwyn Committee Report. Reprinted from *Journal of Psychological Medicine*, 3(2), p7.

[57] Norman, C. (1895) *op.cit.*, p421 Although the Scottish system had not been implemented at the time of Stevens' visit to Gheel, his criticism was equally applicable to Scotland, as to other family care policies when he maintained that "the great drawback of Gheel and similar systems is and must be, want of proper supervision". Stevens. H. (1858) Insane colony of Gheel. *Journal of Mental Science*, 4, p434.

[58] *Vide supra* Chapter 6.13 which considers the extent to which patients may have been intimidated by the Commissioners and other official visitors.

Commissioners was a legitimate reflection of treatment and standards prevailing all year round. Although visits were unannounced, the element of surprise was difficult to ensure in a village community. Further, while patients were ostensibly under inspection quarterly, to many it seemed that "no such inspection will ensure the proper treatment of the idiotic for sixpence a day in the houses of strangers, undertaken for pecuniary profit."[59]

In response to such allegations, protagonists of boarding-out argued that not only were patients inspected regularly by officials, but guardians and their charges were observed daily by their neighbours. Indeed, the Board of Lunacy regarded the most effective supervision to be that of the general public, since they considered that abuse or neglect was unlikely to occur on a regular basis without discovery. The Commissioners remained confident that patients were as well-protected as they were in asylums and that many were capable of complaining. The latter was recognised as a valuable guarantee and with a few exceptions, patients were "able to attend to their personal wants, and have sufficient intelligence to complain should they not be kindly treated."[60]

10.5 Local opposition

The tolerant attitude of the general public towards boarded-out patients was often remarked upon. Communities became accustomed to the presence of the insane and came to appreciate the pecuniary benefits, which saved many guardians from resorting to parish relief. Few criticisms were levelled against patients boarded singly. In many areas, the Commissioners concluded that villagers were unaware of the presence of insane patients and that it was possible to walk through a village without being aware that any were boarded-out:

> "there is nothing to attract attention, and nothing to object to, in the great majority of the boarded-out insane. Lunatics with grotesque antics, with maniacal manifestations, or with untidy and objectionable habits are not selected for care in private dwellings."[61]

Nevertheless, the Commissioners conceded that it was "a very natural question to ask do these patients make themselves obnoxious in the neighbourhood?"[62] From responses by

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[59] Reported in Anon. (1868a) *op. cit.*, p586.
[60] Robertson, A. (1870) On boarding the insane in licensed private houses. *Journal of Mental Science*, **16**, p414.
[61] GBCLS 22nd AR (1880), p112 and 29th AR (1887), p125. Thus Fraser reported with satisfaction on the village of Balfron, where there were over 50 patients, who he saw "walking about, going messages, employed industriously and going to church. I have very rarely seen anything objectionable in their conduct or appearance". This opinion was endorsed by the Commissioners annually. GBCLS 22nd AR (1880), p112.
[62] GBCLS 29th AR (1887), p123.

clergymen, doctors, shopkeepers, policemen and other residents, the general conclusion reached was that patients were accepted with remarkable ease and that the prevailing attitude was sympathetic and friendly.

Despite this, there were occasions when objections were made by some residents in the neighbourhood against patients congregated together in a small village. Particular concerns were expressed regarding personal safety, the destruction of property by potentially violent lunatics, offences against public morals and the reduction in house prices. Tuke observed the apprehension among some villagers towards patients in Kennoway and reported complaints against the constant presence of "such depressing and melancholy objects."[63] Concern was also expressed in some official circles. For example, following an assault of boarded-out woman in Kennoway in 1889, the sheriff of Dundee took the unusual step of reprimanding Edinburgh Parochial Board for demoralising the neighbourhood by sending an idiot woman to be boarded-out in their district.[64] One of the most serious and vocal objections was made in 1895 by the Parish Council of Collessie, a rural district in Fife.[65] A petition was submitted by 18 people alleging that they suffered an "intolerable grievance" owing to the presence of lunatics in the village. They declared that "neither life nor property is safe, and that freedom as subjects of Her Majesty is thereby most seriously and oppressively curtailed." The petition was circulated widely and sent to the Scottish Secretary, the Local Government Board and the Lord Advocate. It was followed by a further appeal: "May it therefore please Her Majesties' Secretary of State to order the removal of this intolerable presence." A year earlier, in a neighbouring area, a boarded-out lunatic had murdered a child, but the Board of Lunacy maintained that the timing of the petition was a "mere coincidence", having no special reference to the assault. The complaints were seen to be of "a very general nature". While recognising the gravity of the offence, the Commissioners questioned whether it should jeopardise the stability of the system as a whole, especially in view of the fact that it was the first time such an event had occurred in 38 years of boarding-out, with approximately 2500 patients annually residing in private dwellings.[66]

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[63] Tuke, J.B. (1870) *op.cit.*, p529.
[64] Unidentified newspaper clipping inside jacket of Boarded-out mental patients registers. (1889) D.HEW 7/4/1. The nature of the assault is documented in Chapter 6.
[65] GBCLS 38th AR (1896), main report, pxliv. Also reported in Editorial. (1896a) The boarding-out of lunatic paupers. *Poor Law Magazine*, **6**, 127-130.
[66] GBCLS 38th AR (1896), main report, pxlv.

The outcry was reported in newspapers, documented in the Journal of Mental Science and even reached general medical journals, including the Lancet. Acting upon public concern, the Board of Lunacy assessed the conditions and numbers of patients in the village, but concluded that there were no grounds for any sweeping measures and that none of the patients needed institutional confinement. However, they conceded that, in view of the large number boarded there, no further patients chargeable to other parishes would be accepted.[67] Shortly after the appeals, a petition declaring support of the system, was submitted to the Board by residents of Collessie, which contained 104 signatures, a far greater number than the previous petitions. It requested that boarding-out be continued, for the following reasons:

> i.That the lunatics... are harmless and inoffensive, and are not a source of danger to life or annoyance to the great majority of residents in the neighbourhood; the fatality at the hands of one of them which took place recently... being regarded by us as a most exceptional occurrence, and most unlikely to recur, the lunatics being under constant medical and parochial supervision.
> ii. That the system is not carried on as a trade by the guardians of the lunatics in this parish, the fact being that the guardians have other, though in some cases scanty, means of livelihood, and board out lunatics only to eke out to a small extent such other means.
>
> With regard to the advantages of the system we are of opinion-
> i. That the removal of all such patients back to asylums would enormously increase the poor rates of the county, in respect of required extra accommodation and attendance at the asylums.
> ii. That the system is a means of helping many to eke out their livelihood, which in some cases would otherwise be small, and in this way also it helps to keep poor rates at a low figure.
> iii. That it is at present a source of revenue to the parish of Collessie to the extent of not less than £650 per annum, the great proportion of which is spent in the parish, to the advantage of the shopkeepers, merchants, tradesmen etc.
> iv. That the system is of immense advantage to the mental health of the patients themselves, giving them as it does an idea more of home and home comforts than they could possibly get by being constantly confined in an asylum, and thereby tending in some cases to their ultimate recovery.[68]

These petitions illustrate the polarisation of opinion in one small village. Although patients from other districts were no longer placed in Collessie, boarding-out continued there and no further disturbances were recorded.

One of the most enduring anxieties among local communities concerned depressed house prices, and the possibility that the presence of lunatics discouraged tourism. Although such claims cannot easily be substantiated, similar assertions were even made in a Gazetteer of 1886, which, in its reports on Kennoway, noted that:

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[67] *Ibid.*, pxlvi. A circular letter was sent to inspectors of poor restricting the growth of the number of patients residing in private dwellings in several parishes of Fifeshire, namely, Collessie, Auchtermuchty, Strathmiglo, Falkland, Kettle, Markinch, Kennoway, Wemyss, Kilconquhar and Leuchars. Only patients who were chargeable to the parishes, or who had connections there were to be granted sanction to board in private dwellings. GBCLS 38th AR (1896), p157.
[68] Editorial. (1896b) Objections to the boarding-out system. *Journal of Mental Science*, **42**, p353.

> "15-20 private houses were licensed for the reception of pauper lunatics, which has had the effect of greatly lessening the value of house property and keeping away respectable tenants".[69]

The most frequent complaints came from people who let houses or rooms to summer visitors. They protested that they could not do business if it were known that there were insane people nearby. Twenty years before the upheavals in Collessie, the inhabitants of Kennoway, one of the most well-known lunatic "colonies" in Scotland, submitted a petition to the Board of Lunacy, following the births of two children among boarded-out females in the village. Their main objections were:

> i. the presence of lunatics discouraged capitalists from speculating in house building,
> ii. due to a lack of vacant accommodation, summer visitors could not reside in the village, and that therefore the inhabitants lost the benefit and influence of good society,
> iii. their presence was highly detrimental to the morality of the young (they highlighted "numerous instances of exposure of the person and other unseemly disgusting acts"),
> iv. the insane themselves were poorly treated and inadequately fed,
> v. the whole system was "founded upon a mistaken philanthropy", the guardians having no more consideration for the imbeciles than to look upon them as "paying objects",
> vi. the value of house and land property declined and would continue to do so, for as long as the village was "degraded to the condition of a dwelling place for insane men and women."[70]

The petition requested that each parish provide for its own lunatics, rather than "oppress with their imbecile men and women neighbouring communities".[71] The petitioners were convinced that the prosperity of the parish was affected by the presence of the insane and that the "revolting practices" of patients were inevitably injurious to the morals of the community. Furthermore, they maintained that the signatures represented a unanimous expression of dissatisfaction among the residents of all 150 houses in the village. Despite the strength of feeling, the objections were countered firmly by the Board of Lunacy which reported that on the basis of thorough enquiries made on recent visits to the village, nothing about the appearance of any of the patients was objectionable and that it would be prejudicial to their well-being to interfere with their residence.[72]

The Commissioners were of the opinion that some complaints against patients were motivated by malice, rather than by genuine grievance. Several cases in which neighbours declared opposition to the residence of an insane patient proved to be little more than a reflection of existing disagreement between the parties. Such objections in Skye and the

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[69] Groome, F.H. (1884-85) *Ordnance Gazetteer of Scotland; A survey of Scottish Topography*. Edinburgh: T.C. Jack.
[70] Recorded in Fraser, J. (1878) On the disadvantages of boarding-out certain harmless lunatics and on the advantages of open-doors in asylums. *Journal of Mental Science*, **24**, p298.
[71] *Ibid.*, p299.
[72] GBCLS 22nd AR (1880), p124.

Outer Hebrides were attributed directly to bad feeling generated by agrarian disputes.[73] In one case, the complaint had been made by the crofter party, the other, "by those connected with the other side". The Commissioners maintained that both patients were complained about, not because of any deterioration in mental condition or behaviour, "but because good feeling between different classes in the neighbourhood had diminished."[74] Petty complaints against, for example, the behaviour of a chronic dement, who had thrown stones at people after being teased, were therefore dismissed as trivial by the Board.[75] Further, in some instances, aversion to the placement of lunatics in a village was evident when the experiment was new and residents opposed the concept without any specific complaints. In this respect, the Commissioners recorded several cases where opposition diminished, to be replaced by, if not enthusiasm for boarded-out patients, then at least acceptance of their presence.[76] Thus Sutherland maintained that:

> "instead of being regarded as intruders or strangers, they have come to be considered as an integral part of the population. Quite different and mistaken ideas of fatuous and demented people prevail in communities which have no experience of them, consequently the safer critics are individuals and communities who have experience of the working of the system. In every community there is a large section which has no pecuniary interest in the system, and its attitude is not only friendly but protective."[77]

Illustrating this, the Commissioners documented cases where villagers who had remonstrated against the presence of patients in their neighbourhood, on seeing how the experiment worked, applied themselves for boarders.

Although critics of the system contended that objections were raised frequently by the public, proponents insisted that relative to the number boarded-out complaints were rare. Many patients ran errands for neighbours, went to church, and walked about quietly. The Commissioners announced that there was rarely anything to object to in their behaviour, and nothing to justify the claims made against them. Given that among the strict criteria in selecting patients for boarding-out it was stipulated that they had to be clean, of tidy habits, and able to dress themselves, the confidence of the Commissioners that the presence of patients was not inexpedient was rarely misplaced. The Board of Lunacy acted promptly

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[73] Thus the Commissioners concluded that the cause of many complaints "seem to be as a result of the agrarian agitation which has made people less helpful to each other, and has necessitated a wider distribution of parochial relief." GBCLS 33rd AR (1891), p112.
[74] GBCLS 29th AR (1887), p130.
[75] *Ibid.*
[76] Lawson went further, claiming a transformation from discontent to a "public opinion decidedly in their favour." GBCLS 33rd AR (1891), p116.
[77] GBCLS 39th AR (1897), p121.

where there were complaints and their swift action in ordering the removal of unsuitable patients contributed to the successful development of the system of accommodating insane persons in small communities. Within a few years of the introduction of special licensed houses in a district, it is apparent that villagers adapted to their presence and appreciated the benefits the financial payment brought to the guardians. Pride, rather than dissatisfaction, was evident, where a small village was deemed suitable for the boarding-out of insane patients by the authorities from the capital of Scotland. This same acceptance was apparent following a visit made to Kennoway in 1995.[78] Older villagers, who remembered boarded-out patients, spoke of them with no malice or discontent. Instead a quiet fondness for them was revealed, and they appeared surprised at the suggestion that the presence of such boarders could have been objected to.

10.6 Detrimental effects on host family

An often cited objection concerned the fear that the presence of the insane could exercise a harmful influence upon those with whom they were placed. Monro[79] and Van Deusen[80], among other physicians, maintained that the residence of an imbecile patient in a household was an act of cruelty to all members of any family. This assertion was considered in depth by the Commissioners, who contended reassuringly, that:

> "the influence of the lunatics on their associates cannot be entertained as one of the primary considerations determining the disposal of them. The law requires that if he is dangerous or offensive, he must be sent to an asylum, but it does not recognise the existence of any other disagreeable accompaniments of lunacy which would entitle society to isolate the lunatic. If sanctioned by the Board for a private dwelling, it shows that he is not offensive to public decency or dangerous..."[81]

Nevertheless, the potential threat to the well-being of host families was of sufficient importance to merit inclusion on the agenda of successive Home Relief Congresses between 1901 and 1904.[82] Although there was agreement among delegates that the companionship of the insane in institutions could be prejudicial to the mental well-being of staff, they did not consider that this was necessarily true of those living in private

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[78] *Vide infra* Chapter 15 for a record of surviving memories of the "wee mad folk."

[79] Reported in Anon. (1871) Notes and News. *Journal of Mental Science*, **16**, p460.

[80] Van Deusen emphasised his concern regarding the "serious injury to impressible members of the family". Van Deusen, Dr. (1873) Provision for the care and treatment of the insane. Review. *Journal of Mental Science*, **19**, p146.

[81] GBCLS 25th AR (1883), p170.

[82] The proceedings of the International Congress held at Edinburgh on Home Relief are discussed in the *Poor Law Magazine*. (1903) **8**, 409-413. It was noted at the Congress held in Antwerp in 1902 that "an immense majority of the physicians ...were favourable to the... family care of the insane, but with certain reservations". However, this can be seen partly as a reflection of the personal interest of delegates choosing to attend such a congress. Morel, J. (1903) Progress of Psychiatry in 1902. *Journal of Mental Science*, **49**, p339.

dwellings, where the illness of patients was less severe. Further, the freedom available to patients meant that guardians did not have the same unremittingly close contact with them throughout the day. One Commissioner, Sutherland, estimated that, by 1908, 10,000 people had had some form of contact with the 2,780 patients in private dwellings in Scotland.[83] However, he claimed that in 14 years of inspections, only five cases of insanity had occurred in the families of unrelated guardians, and these, he held, were unlikely to be attributable to the presence of the patients.[84]

Concern for the well-being of the family was linked with the specific fear that children were affected adversely by growing up with an insane person in the household and several alienists questioned the long term effects on children. Among them Burnett announced:

> "I remember with horror even now, a single day spent in a home in Scotland where two defective members of the family were being cared for. It was days before I could think of it at all calmly.....Am I wrong? My thought is for the children."[85]

Hack Tuke, a consistent critic of certain aspects of boarding-out, expressed the clear view that it was unsuitable to board-out the insane in houses containing children or young women. He stressed that "we should not lose sight, as there is great danger of doing, of the interests from a moral point of view, of the families into which it is desired to introduce a lunatic." [86] In his opinion, the risk of moral injury to the family, especially to younger members, was often overlooked.[87] Despite their enthusiasm for boarding-out, the Commissioners did not dismiss these fears, rather they acknowledged that the selection of patients for the special circumstances in which they were placed, determined the success of the system. Patients who were irritable, unsympathetic to children, or likely to use offensive language in houses where there were young families, clearly jeopardised outcome. In a few cases, therefore, the removal of a patient was recommended due to these perceived risks, although such occurrences proved rare. Throughout the annual reports of the Commissioners between 1859 and 1913, removal due to these risks was reported on less than 20 occasions, out of an average boarded-out population of approximately 2500

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[83] GBCLS 51st AR (1909), pp151-152.
[84] *Ibid.*
[85] Burnett, A. (1895) *American Journal of Insanity*, **52**, p576.
[86] Tuke, D.H. (1889a) *op.cit.*, p511.
[87] Similarly, Crockett, an advocate of the boarding-out system in America in the 1930s questioned the advisability of placing patients in families with children. While she recognised that the persistent questioning of young children often roused schizophrenic patients out of their daydreams, she emphasised that homes with young children were to be used with caution until there was a greater understanding of the effect of the mentally ill upon them. Crockett, H.M. (1934) Boarding homes as a tool in social casework with mental patients. *Mental Hygiene*, **18**, p197.

patients.[88] However, when one Commissioner, Macpherson, began visits to patients, he reported that he had expected to find the association of the insane to be unhealthy to children. In fact, thorough inquiries among doctors, schoolmasters and parents had removed his doubts. He reported that guardians found such an idea amusing, and that many insisted that the presence of the insane in their homes was beneficial to their children, making them more considerate and kindly. In addition, it was observed that no doctor had ever come across any ill-effects on guardians or their children[89]

It was generally accepted among the Commissioners that instances where the presence of the insane was prejudicial to guardians or their families were rare, although they recognised the influence that patients could exercise on their neighbours. For example, in their view, the use of profane and obscene language by patients could be demoralising to guardians and their families. Nevertheless, the Commissioners announced with conviction, that there was no harmful influence from the presence of the insane in private dwellings, and, citing "many pleasing instances of great solicitude and devotion," concluded that, "the care of the weak produces a healthy altruism."[90] In addition, they alleged that caring for insane patients could produce an elevating effect on guardians and their surroundings, as it raised the standard of household order and cleanliness. As Lawson reported, houses were made bright and clean, either "from the unremitting efforts of a female patient whose delusions do not exclude her from a useful intimacy with the pail and the scrubbing brush"[91] or because:

> "however humble a Scottish home may be, the mistress...has too much pride to think with indifference of a periodical visitation, which might result in a condemnation of her housekeeping and her cleanliness; and the necessity of being prepared encourages habits of tidiness which, by emulation, may even spread to neighbours."[92]

The Board of Lunacy remained confident, therefore, that under a carefully supervised and controlled administration, no adverse influence on children or adults could be traced to the presence of insane boarders.

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[88] GBCLS AR *passim*. Instead, Fraser, reflecting the view of the Board of Lunacy, concluded that "on reviewing the private dwelling system as a whole, my opinion is that there is no harmful influence on the guardians from the presence of the insane in their houses, and this is the verdict of a host of guardians to whom I have spoken on the subject." GBCLS 35th AR (1893), p93.
[89] GBCLS 51st AR (1909), p158.
[90] GBCLS 35th AR (1893), p95.
[91] GBCLS 35th AR (1893), p93.
[92] GBCLS 22nd AR (1880), p133.

10.7 Unsatisfactory living conditions

Both opponents and supporters of boarding-out often drew attention to the depressed conditions in which many patients lived, particularly in the early years of the system.[93] The rudimentary and harsh nature of life experienced by the whole population was condemned as unsuitable for the insane who were thought to require extra protection and comforts. Browne, the celebrated author of "What asylums were, are and ought to be," argued that patients were better provided for in an asylum than in the community, where they were in wretched dwellings:

> "indifferently protected from the weather, poorly dressed, and nourished without treatment of any description, only inspected by officials at rare intervals, and intercourse with the uneducated, rough but maybe kind, household."[94]

Although it was widely accepted that boarding-out was a cheaper alternative to institutional care, critics argued that in effecting this economy, patients were subjected to inferior food, poor hygiene, absence of supervision and unsatisfactory accommodation. One physician, Campbell, challenged the assertion of Commissioners that a boarded-out demented patient was in more favourable conditions than an asylum inmate or a sane working man. He suggested, that the weekly expenditure of 3s cited in one annual report, on a boarded-out lunatic who received only a ¼lb of animal food a week, "would make one fear that he was undergoing a process of slow starvation."[95]

Lack of washing facilities were commented upon in the aggregations in central Scotland. Tuke, for example, noted that many patients were "in the full possession of the homelike influences of dirt and squalor."[96] He observed, with disapproval, that no patients bathed at Kennoway, and contrasted this to the leading axiom in asylums that personal cleanliness be "scrupulously attended to."[97] However, as Robertson (in a rare conciliatory remark on boarding-out) pointed out, baths were not found in every household and, "the Scotch and English peasantry did not wash either as a general rule."[98] Tuke went on contend that expressions such as free air, greater liberty and absence of restraint were "mere sentimental props", since the reality was "lunatics in hovels in a decaying village."[99] While the Board of

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[93] Living conditions encountered by visiting officials in these years have been documented in Chapter 4.
[94] Anon. (1877a) *op.cit.*, p6.
[95] Campbell, J.A. (1886) *op. cit.*, p646.
[96] Tuke, J.B. (1870) *op.cit.*, p528.
[97] *Ibid.*, p531.
[98] Robertson, C.L. (1871) Notes and News. *Journal of Mental Science*, **16**, p300.
[99] Tuke, J.B. (1870) *op.cit.*, p528.

Lunacy, with an almost blinkered resolve, determined that the accommodation and provision for the insane should resemble that of the general population, many, generally un-named, critics observed that the houses and habits of the poor were hardly known for their comfort, cleanliness, refinement or temperance.[100]

Critics also condemned the view that it was no hardship for pauper patients to be placed in what were regarded as the destitute and spartan homes of peasants because they were derived from the "lowest of the lower classes". They maintained that many pauper lunatics were of a respectable class, being artisans, domestic servants and ploughmen, who had become pauperised through the effects of insanity, and therefore it was unfair to regard pauper patients in the same category as ordinary paupers:

> "to say that what is good enough for a sane pauper is good enough for an insane is simply to ignore and cast overboard the results of the philanthropic efforts of the last forty years".[101]

However, such criticisms were dismissed by the Board of Lunacy. While the Commissioners invariably expressed concern over living conditions in some areas, their annual reports on boarded-out patients recorded evidence of a gradual improvement in the general standard of living throughout Scotland. In 1897, for example, Sutherland concluded, with satisfaction, that:

> "to the credit of the Scottish villagers and peasantry, as a whole, it must be said, having due regard to different ideas of hygiene prevailing in different parts of the country, that an inspection....leaves a favourable impression as to cleanliness and comfort."[102]

With such evidence serving to reassure the Board of Lunacy, it became accepted that, regardless of any criticisms put forward by unconvinced commentators, where patients were boarded under the same conditions as the rest of the population, little more could, or should, be expected.

10.8. Inadequate opportunities for therapeutic intervention

A number of physicians, usually medical superintendents, were of the opinion that the quality of care available in the cottage of an untrained crofter could not compare to the medical expertise of asylums. It was widely recognised that the ethos of greater freedom, and the gradual abolition of prison-like features led to improvements in the standard of

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[100] This issue was addressed at a meeting of the Medico-Psychological Association in 1871. Recorded in Anon. (1871) Notes and News. *Journal of Mental Science*, **16**, 300-302.

[101] Tuke, J.B. (1870) *op.cit.*, p530. The social class of patients has been discussed in Chapter 6 and indicates the validity of this claim.

[102] GBCLS 39th AR (1897), p119.

treatment in asylums. Despite the fact that boarded-out patients were regarded as incurable and unable to benefit from the routine and discipline of asylum life, the absence of efforts at cure and its potentially deleterious effect on patients was, nevertheless, often condemned. Monro, for example, maintained that the only place for the insane was in a specially designed institution, where they were removed from the environment in which they became ill, and subjected to the "wholesome discipline" of strangers.[103] Other physicians contended that even incurable patients could benefit; patients in asylums were relieved of the irritants and annoyances they would be subject to in their home and delusional patients could be distracted.

The Select Committee of 1877 had issued an exhaustive report on the condition of the insane, both in and out of asylums, throughout the United Kingdom.[104] The authors observed that while many insisted that patients were happier when emancipated from the restrictions of asylum life, this was an unreliable assumption, founded on a very narrow basis. They concluded that "to the melancholic, all surroundings are indifferent, consciousness bears the burden of misery, terror, remorse everywhere".[105] While proponents of boarding-out insisted that self control and intelligence flourished in freedom, to the Committee the real question was "not whether the insane can be made happier, but more reasonable in an asylum or out of it."[106] However, by employing the same argument, it can be held that patients unable to appreciate the activities and stimulation available in an asylum, and incapable of any further amelioration of their condition, were more humanely provided for outside an institution.

The absence of the refining influences of asylum life was emphasised repeatedly by asylum superintendents who perceived a lack of contentment among boarded-out patients, and a "total want of all ameliorating and humanising influences" in their homes, influences held to be available in asylums.[107] To support their argument, critics highlighted the variety of amusements and occupations in asylums contrasted to the lack of such activities in a crofter's cottage, where there were rarely any pictures, musical instruments, or books.

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[103] Anon. (1871) Notes and News. *Journal of Mental Science*, **16**, p461.
[104] Report from the Select Committee appointed to inquire into the operation of the Lunacy Law, so far as it regards security afforded by it against violations of personal liberty, with the Proceedings of the Committee. 1877. (373.) xiii.1.
[105] Recorded in Anon. (1877a) *op. cit.*, p12.
[106] *Ibid.*, p13.
[107] Tuke, J.B. (1870) *op.cit.*, p532.

Reflecting the view of a number of physicians, Tuke announced that boarded-out patients were under as much restraint as if they were within the walls of an asylum, yet receiving none of the concomitant benefits. His impression was that:

> "the restraint and authority exercised by persons of their own or even lower class sat heavier upon them and was accompanied by a feeling of degradation greater than if exercised by those whom they recognised as their superiors."[108]

Sixty years later, Pollock's detailed review of the Scottish system was also critical of its failure to provide adequate psychiatric provision and community activities.[109]

There is some evidence in the annual reports of the Board of Lunacy that a small proportion of patients missed the routine and organised activities arranged in asylums. Macpherson, for example, reported that some female patients, particularly the younger ones "prefer the asylum, as they miss the dances and other entertainments".[110] However, the volume of complaints was not thought to be significant enough to justify the criticisms levelled against this aspect of boarding-out. In response to physicians who advocated asylum treatment for all insane patients, on the grounds that only in asylums could satisfactory occupation and amusement be provided, protagonists of boarding-out questioned the therapeutic value of asylum-organised entertainment for certain classes of the insane.[111] They were convinced that varied amusements could not be appreciated by the severely impaired imbecile or chronic lunatic, but when boarded-out in the community, there was scope to enjoy the village band and other local entertainments. Reflecting the views of the Board of Lunacy, the physician, Hogben, while conceding that properly regulated recreation was "a powerful factor in the treatment of the insane", stated that:

> "maldevelopment and the impairment of the higher intellectual and aesthetic faculties have obliterated the capacity for enjoyment, such as is derived from concerts, dances and dramatic performances."[112]

The Commissioners therefore dismissed the concerns regarding the absence of amusements and therapeutic intervention as "more imaginary than real". Of greater importance, in their opinion, was the preservation of patients' individuality and much emphasis was placed on the fact that when boarded in private dwellings:

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[108] *Ibid.*, p527.
[109] Pollock, H.M. (1936) *op.cit.*, p422.
[110] GBCLS 22nd AR (1880), p145. Similar complaints were recorded in 34th AR (1892), p106, 54th AR (1912), p160 and *Vide supra* Chapter 6.
[111] For example, Lindsay, W.L. (1871) *op.cit.*, Turnbull, A. (1888) and annual reports of the Board of Lunacy, *passim*. Among the Commissioners, Sibbald and Lawson placed great emphasis on this point.
[112] Hogben, E. (1898) *op.cit.*, p691. He went on to declare that "though some of the patients are allowed to go about freely I have observed that for the most part they avoid mixing in any concourse of people. On the other hand the various incidents that make up life about a country place seem to afford them engrossing interest."

> "they are not like so many sheep in a flock, who are considered and cared for in the aggregate rather than singly. They do not feel lost in the crowd, as inmates of our large asylums sometimes complain. Above all they enjoy almost complete freedom, for the degree of surveillance required scarcely imposes any restraint on their liberty."[113]

10.9 Impact on asylum provision

10.9.1 Boarding-out as a challenge to the asylum

The assertion that those confined in asylums would be "fast bound in misery and iron" was criticised by certain observers, among them, Browne.[114] There was concern among medical superintendents that widespread use of non-institutional provision would encourage the belief that life in an asylum was uncomfortable and harsh. Thus, despite Clouston's conviction that boarding-out offered many advantages, he condemned the uncritical praise of numerous advocates, observing that some writers "would seem to suggest" that all the insane should be so treated:

> "Gloomy pictures have been drawn of asylums, and deep have been the tints in which the misery of their inmates has been depicted; while on the other hand have been represented bright cottage homes of which they would be inmates, happy families of which they would be members..."[115]

From a medical viewpoint, those in asylums were relieved from the worries of daily life, received greater comforts than they would in a private dwelling, were better supervised and cared for and had the opportunity to receive effective medical treatment. Advocates of boarding-out, it was argued, overlooked the inherent advantages of asylum provision, in their determination to stress the benefits of the greater freedom of home care. Wood, for example, considered it a "very serious mistake to ...encourage...a notion that there is something very horrible about an asylum."[116] In contrast, however, critics of institutional provision argued that it was in the asylum that delusions were confirmed, and encouraged, by witnessing other patients behave in deluded ways, while patients who were boarded-out were removed from such influences.

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[113] Robertson, A. (1870) *op. cit.*, p414. He also observed that boarded-out patients had the amenities of a private home "with the merry play of the elder children and the prattle of infants in the neighbourhood, which to them, being chiefly women... more than compensates for the somewhat ideal loss referred to."

[114] Anon. (1866c) Gheel in the North. *op.cit.*, p284.

[115] MS AR (1870) Cumberland Asylum. In Occasional Notes of the Quarter (1871)) *Journal of Mental Science*, **16**, p236.

[116] Anon. (1871) Notes and News. *Journal of Mental Science*, **16**, p460.

It might be expected that asylum superintendents would resent the removal of patients, who were often useful workers, leaving a residue of noisy, highly disturbed inmates.[117] However, objections on these grounds were rarely voiced and in most asylum reports, medical superintendents noted with relief the extra accommodation made available for curable patients by the removal of long-stay residents.[118] It is less straightforward to assess the effect of an active boarding-out policy on the private madhouse system (such as it was). Surviving records of private madhouses contain no discussion on the system of boarding-out and its effects. Although maintenance costs for pauper patients in private dwellings were markedly cheaper than those in private madhouses, it is more likely that direct and sustained censure from the Board of Lunacy had a greater impact upon their rapid decline than any challenge posed by the boarding-out of patients.[119]

The challenge to asylum provision was, in fact, only ever minimal, given that patients suitable for boarding-out had different mental characteristics from those needing asylum treatment. There was little basis for concern about declining asylum admission rates, and an accompanying reduction in the influence of medical superintendents, because throughout the century, admissions rose. As Cameron has shown, between 1869 and 1895, Scotland had a higher admission rate to mental institutions than England, per 100,000 of the population.[120] The Commissioners remained definite about the benefits of domestic care, stressing that it was intended to complement institutional provision. Emphasising this, they maintained that the care of the insane in private dwellings had been welded into a system which could be allied to the working of establishments, explaining that:

> "it is not a department to be compared with another department, but a supplementary development by which unrecovered, but harmless patients can be moved into private dwellings, as other patients are moved from one ward into another."[121]

In this way, boarding-out achieved for one class of patients what asylums did for another.

10.9.2 Exaggeration of extent of relief to asylums

One of the major advantages of boarding-out was alleged to be the relief it brought to asylums.[122] While the discharge of incurable patients to private dwellings undoubtedly

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[117] This concern was regularly put forward by Parker, medical superintendent of Gartloch District Asylum, who maintained that "the want of workers boarded-out is felt". MS AR (1904) Glasgow District Asylum, Gartloch, p10.
[118] *Vide infra* Chapter 12 for discussion of prevailing attitudes among asylum superintendents.
[119] This issue will be addressed in a forthcoming study of the Scottish "trade in lunacy". Parry-Jones, W.Ll. and Sturdy,H.
[120] Cameron, D. (1954) *op.cit.*, 180-186.
[121] GBCLS 31st AR (1889), p136.

alleviated, to some extent, the overcrowded wards, the proportion of patients suitable for such provision was inevitably restricted. Despite the opportunity created by an active boarding-out policy, a clearance of chronic cases in asylums was never achieved, and it soon became clear, even to the Commissioners, that the needs of the rising number of registered insane could not be met solely by extending the system. In numerous debates on how to respond to the increase, medical superintendents favoured the erection of chronic asylums and even the strongest protagonists of boarding-out accepted that little more than 15% of the asylum population could be provided for in this way.

As an outlet for the constant accumulation of chronic insane in asylums, therefore, boarding-out proved inadequate and its existence was not, as supporters maintained, the solution to the ever-increasing problems of providing for the insane in different countries. Difficulties in selection, limited applicability, and the obstacles encountered among officials when disposing of incurable patients diminished the significance of boarding-out as a supplement to asylum provision in the minds of many of its critics.

10.10 Propagation of hereditary degeneracy

Widespread anxiety among the general public and medical profession that lunacy was increasing was exacerbated by the fear that insane patients in the community could produce degenerate children, thereby increasing the proportion of insanity and idiocy in the country. In condemnation of systems of domestic care, Cyon was of the opinion that:

> "one must war hand and foot against the introduction of a system which ought rightly to be regarded as the system of artificial breeding of an imbecile population".[123]

Reflecting this, although an advocate of boarding-out, Jolly also observed the danger of sexual intercourse between sane and insane, leading to the generation of mental disorder.[124] The Commissioners attributed the frequency with which imbecile women gave birth in the early years of the system to insufficient surveillance of weak-minded females, and an ignorance of "right and wrong". The occurrence of pregnancies, they believed, could be largely prevented under the vigilant control of local officials. However, the greater proportion of pregnancies occurred among non-pauper patients, the control of whom was minimal. That the threat was very real was emphasised by estimates that at least two in five

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[122] *Vide supra* Chapter 8.
[123] In Jolly, F. (1875) *op.cit.*, p54.
[124] *Ibid.* pp54-55.

of surviving offspring were as mentally defective as their mothers.[125] Although the majority did not survive beyond a few weeks, their very existence was held to be a scandal to public morality and responsible for imposing a heavy burden on society. Nevertheless, concern regarding the propagation of hereditary insanity remained largely theoretical, and was never a major preoccupation of the Board of Lunacy in regard to the boarding-out system. Scotland did not have a higher rate of imbecile births than countries without a boarding-out system. With the strict guidelines laid down by the Commissioners, and enforced by parish officials, incidents of unwanted pregnancy and indecent behaviour by patients were largely eradicated by the turn of the century.[126]

10.11 Summary and conclusions

Many criticisms have been highlighted in this chapter. It may appear that all objections put forward were muted and easily counteracted. To some extent this is accurate, in that none of the objections were regarded as insurmountable. Although the nature of concern was often valid, no potential weaknesses were held to be so great as to jeopardise the continuation and expansion of the boarding-out system. Inevitably, therefore, this chapter has comprised little more than a list of major criticisms, the significance of which have then been disputed. However, this is more a reflection of the tenuous nature of the complaints and the ease with which the perceived problems were rectified, than a blinkered refusal to recognise disadvantages, in an attempt to stress the value of boarding-out. Despite the somewhat partisan nature of the evidence available, as far as can be ascertained, it does appear that the general conclusions reached by the Board of Lunacy regarding the safety of the system, both with regard to patients and the general public, can be sustained. In a ten year period between 1892 and 1902, for example, among a boarded-out population of nearly 3000 patients, there was one suicide and two fatal accidents from burns,[127] and in many years, no serious accidents of any kind were recorded by the Commissioners. Other sources available, including newspapers and the extremely detailed commentary on daily life found in parish records, indicate that there were no public revelations of corruption or brutal behaviour, occurring as a result of the boarding-out system, other than the ones recorded by the Commissioners.

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[125] Stewart, H.G. (1865) On hereditary insanity. *Journal of Mental Science*, **10**, 50-66.
[126] *Vide supra* Chapter 6 for assessment of the risks and incidence of pregnancy among boarded-out patients.
[127] GBCLS 34th AR-44th AR (1892-1902), *passim*.

In view of the number of patients boarded-out, often closely congregated in small communities, there were remarkably few objections against their presence, and those reaching the Board were assessed thoroughly, with a Deputy Commissioner investigating the protests in person. On no occasion was the complaint regarded with such gravity as to warrant a change in policy, although in certain localities, the Commissioners recommended a reduction in the number of patients boarded in one village. Nevertheless, from the outset of the boarding-out system, charges against the policy were consistent and, despite reassurances, many physicians remained unconvinced of its efficacy in offering a useful supplement to institutional provision. Boarded-out patients, it was alleged, were often dirty, badly dressed, neglected and overworked and the few official annual visits could do little to ameliorate their quality of life. Certainly, the extent to which guardians put on a show for visitors is impossible to ascertain. Further, it was argued that "even the romance of rurality" and the "associations of country life which have been cast around this scheme, must be sorely invaded, if not dispelled."[128] Not only were some patients boarded in and around towns, but the conditions in many villages were hardly comparable to the pictures of rustic charm so widely propagated in romantic Victorian literature.

Notwithstanding these criticisms, supporters argued that the moral and social objections to boarding-out were more sentimental and imaginary than sustainable. There is no indication of sustained criticism of such severity as to question the utility of boarding-out. Conclusions reached after many long discussions on the merits of the system held that the existence of certain shortcomings did not mean that boarding-out was imprudent. Among even the most vocal of critics was a recognition that carefully supervised and controlled, the policy could provide some relief to overcrowded asylums. For this reason, it was generally accepted as a useful component of lunacy administration. While each objection in turn was considered carefully, it was maintained by the Lunacy Commissioners and, to a lesser extent, medical superintendents and parish officials that the inherent advantages of the system outweighed any potential risks to the patient and the community in which they were placed.

[128] Reported in Anon. (1866c) Gheel in the North. *op. cit.*, p284.

CHAPTER 11

ROLE AND SIGNIFICANCE OF THE BOARD OF LUNACY

11. Overview

The successful development of boarding-out depended upon the activities of the Deputy Commissioners of the Board of Lunacy. The pressure they exerted upon asylum superintendents and parochial officials to board-out patients dictated the degree to which the system was implemented. This chapter provides a profile of the responsibilities and activities of the Board of Lunacy towards all registered insane patients and, specifically, those in private dwellings. The effects of the increased vigilance imposed by lunacy legislation concerning the implementation and expansion of boarding-out and the prevailing attitude held by the Commissioners towards the system are considered. Further, the nature of the relationship between the Commissioners and other officials involved in the care of lunatics is explored.

11.1 Introduction

The Board of Lunacy, created under the terms of the Lunacy (Scotland) Act, 1857, comprised a body of professional men, not all medical, appointed to oversee the administration of lunacy in Scotland. Membership of the Board was always small. In 1858, there were ten officials, including the Chairman, Secretary, two unpaid Legal Commissioners, two paid Medical Commissioners and two paid Medical Deputy Commissioners, supervising a total of approximately 10,000 patients. This contrasted favourably to the English Board of Lunacy, which had six officials responsible for overseeing the condition of 82,600 patients, prompting the observation that "either Scotland is ridiculously overmanned, or England absurdly undermanned, as regards official

medical visitation of the insane. We can only judge by results".[1] The Board retained the same structure for 56 years, being replaced in 1913 by the Board of Control. In turn, this was replaced in 1960 by the Mental Welfare Commission, consisting of a far larger group of officials, retaining the same responsibilities, although their power and influence has decreased. In 1995, the Commission consisted of 18 Commissioners, four medical officers, two nursing officers, two full-time and one part-time social workers and 21 other administrative staff.[2]

Andrews has suggested that the partnership of medical men, lawyers and administrators was "occasionally uncomfortable"[3] and, on the basis of extant source material pertaining to the Board of Lunacy, his assertion appears correct. In addition, the presence of legal officials as Commissioners led to criticisms of the Board's constitution with complaints that it was too legalistic in its approach to lunacy. Nevertheless, the duties of unpaid Commissioners were largely administrative and it was with the Medical Commissioners that responsibility lay for the practicalities of the care of the insane. While a number had been medical superintendents of asylums and retained close alliances with their previous asylums, others, including Mitchell, an extremely active proponent of boarding-out, had no direct experience of asylum life.[4] The Commissioners were responsible for assessing the care of all patients in asylums and other licensed establishments, while the Deputy Commissioners visited patients boarded in private dwellings. The Chairman, generally an experienced politician, was a figurehead, with no real experience of lunacy administration.[5]

The distinctive feature of the Scottish system of boarding-out was the degree of formal, centralised control exercised by the Lunacy Commissioners. Despite close imitation of the system in other parts of the world, the extent of control enforced in Scotland was not replicated elsewhere. Each Deputy Commissioner was responsible for visiting patients in private dwellings in one half of the country, seeing and assessing as many as 1000 patients a year. Their intentions were clear:

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[1] Tuke, J.B. (1889) *op.cit.*, p 606 McCandless has recorded the British Medical Journal's assessment of the two Lunacy Boards, in which the Scottish Commissioners were commended for taking a "broader and more expanded view" of the lunacy question than the English. McCandless, P. (1979) *op.cit.*, p560.

[2] Figure supplied by the Mental Welfare Commission for Scotland.

[3] To Andrews " the alliance between law and medicine was not always an easy one...tension...not infrequently broke the surface of the Commission's proceedings". Andrews, J. (in preparation) *op.cit.*

[4] See Appendix 12 for biographical details of Lunacy Commissioners.

[5] Andrews, J. (in preparation) *op.cit.*

> "we aim, in short, at extensive and general improvement; and we have every reason to hope that the result of our labours will gradually become manifest, in the steady diminution of those degraded cases which our own investigations and those of the Royal Commission brought to light". [6]

Although their work was primarily supervisory, the visits made were extensive and thorough, as the lengthy annual returns indicate. These included detailed statistics of the number, location, classification and treatment of patients.[7] It is clear by reading these reports that the Commissioners were aware of the unique nature of their achievement and frequent complimentary references to their influence were made in successive annual reports.[8] Therefore, although the first annual report of the Board of Lunacy, published in January 1859, contained extensive, largely negative, descriptions of existing institutions, and of the mainly unsatisfactory condition of single patients, within a few years, marked improvements in standards of care were recorded.

The activities and significance of the Scottish Board of Lunacy have received little research attention. This contrasts with the detailed assessment of English Commissioners undertaken by Mellett[9] and Hervey,[10] and a general familiarity with their existence evident in numerous works on British psychiatric history.[11] Henderson's account of Scottish psychiatry[12] contains almost no discussion of the work of the Board of Lunacy, and an article by MacNiven, a former Commissioner, although containing useful information, almost amounts to a hagiography of the Commissioners.[13] Recently, Andrews has attempted to redress the balance and his informative, comprehensive work locates the Scottish Commissioners in the context of British lunacy administration.[14] It includes an incisive view of their attitudes and expertise, while questioning the success of their

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[6] GBCLS 2nd AR (1860), main report, pxl.
[7] These returns are contained in the appendices of the Board of Lunacy's annual reports and take up between 10 and 25 pages each year. *Vide supra* Chapter 2.
[8] GBCLS AR, *passim.*
[9] Mellett, D.M. (1981) Bureaucracy and mental illness: The Commissioners in Lunacy, 1845-1890, *Medical History,* **25,** 221-250 and (1982) *The prerogative of asylumdom.* New York: Garland.
[10] Hervey, N. (1987) The Lunacy Commission, 1845-1860, with special reference to the implementation of policy in Kent and Surrey. (PhD Bristol University), and (1985) A slavish bowing down: the Lunacy Commission and the psychiatric profession 1845-1860. In *The anatomy of madness: Institutions and Society* (eds. W.F. Bynum, R. Porter and M.Shepherd), pp 98-131, London: Tavistock Publications.
[11] For example: Busfield, J. (1986) *op.cit.*, Jones, K. (1972) *A history of the mental health services.* London: Routledge & Kegan Paul, Scull, A. (1979) *Museums of madness: the social organisation of insanity in Nineteenth Century England.* London Allen Lane, (1981) *Madhouses, maddoctors and madmen: the social history of psychiatry in the Victorian era.* London: Athlone Press and (1993) *The most solitary of afflictions. Madness and society in Britain, 1700-1900.* New Haven and London: Yale University Press.
[12] Henderson, D. (1964) *op.cit.*
[13] MacNiven, A. (1960) The first Commissioners: Reform in Scotland in the mid-nineteenth century, *Journal of Mental Science,* **106,** 451-471.
[14] Andrews, J. (in preparation) *op.cit.* The author is very grateful to Andrews for access to the article before publication.

activities both regarding boarding-out and in the implementation of their general duties. Mayes' study of her aunt, Kate Fraser, is less detailed, although entertaining.[15] It contains previously unpublished extracts from Fraser's diary recording her experience as a Commissioner for the Board of Control (created in 1913) during and after the first World War and provides insight into the activities of the Commissioners.

11.2 General powers and responsibilities

The duty of the Board of Lunacy was to ensure that, as far as possible, Scotland had a lunacy system which provided for patients according to their individual requirements. Under Section 51 of the Lunacy (Scotland) Act, 1857, it was the responsibility of the Board to ensure adequate standards of care were attained for all registered insane patients. Although district lunacy boards were responsible for ensuring the maintenance of satisfactory conditions in district asylums, they had no control over royal or parochial asylums, lunatic wards of poorhouses or private dwellings. The duties of the Lunacy Commissioners were extensive and varied. In 1877, Mitchell estimated that, on average, there was one Commissioner to every 4400 patients.[16] In addition to regular inspection of registered patients, they had responsibility for all legal questions affecting the insane. They investigated and arbitrated complaints and sanctioned the admission of patients into institutions or private dwellings. They had the power to order district lunacy boards to provide asylums and to grant or withdraw licenses for private madhouses, parochial asylums and lunatic wards of poorhouses. The Commissioners issued regulations for the management of establishments, attempted to enforce the registration of any insane person, and had sole power to sanction the removal of patients from one private dwelling to another and of liberating asylum patients on trial.

Further duties included arranging the annual election of district lunacy boards, sanctioning the rates of board in establishments and examining the accounts of district lunacy boards. Each year, the Board was required to submit a report to the Secretary of Scotland detailing the living conditions experienced by all insane patients and documenting general annual expenditure. Although parochial boards were under the immediate control of the Board of

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[15] Mayes, M. (1995) *op.cit.* However, there are a few inaccuracies regarding the nature of the boarding-out system before 1913.

[16] Andrews, J. (in preparation) *op.cit.* In England, the proportion was far greater, with one Commissioner responsible for every 21,000 patients.

Supervision (later, the Local Government Board), they were under the control of the Board of Lunacy in all aspects relating to the care of pauper insane. Inspectors of poor, therefore, were obliged to inform the Board of Lunacy of every insane pauper in the parish.

The designated responsibilities of the Board in connection with boarding-out were: to assist in the proper selection of patients, guardians and locations; to establish, implement and oversee regulations for their treatment and supervision, ensuring the attainment and maintenance of adequate standards and to intervene with corrective measures where necessary. Boarded-out private patients were under the jurisdiction of the Board of Lunacy only if they were received for profit, if their mental illness was of a confirmed character, if they were confined to the house under restraint, or if they were under curatory by order of the Court.[17] Other private patients were not placed under any control, if a registered medical practitioner had certified that their illness was not confirmed and that they would benefit from temporary residence in a private dwelling for a period not exceeding six months. Although the Lunacy (Scotland) Act, 1857, directed that the majority of private patients should come under the jurisdiction of the Board of Lunacy, this was never achieved. In 1864, for example, only one in 15 private patients were under Sheriff's warrant, and therefore in compliance with the Lunacy (Scotland) Act, 1857. The Commissioners conceded, however, that applying for the sheriff's order involved trouble, and expense, as well as having "an odour of crime about it".[18]

The Board of Lunacy therefore had no official knowledge of a large number of insane persons residing in their own homes or with strangers, and it was among such patients that the most unsatisfactory conditions were recorded.[19] There were no particular means of discovering the existence of these patients, although advertisements were placed in newspapers explaining the requirements of the law regarding single patients and the penalties chargeable upon its violation.[20] In cases where the Board was informed of the patient's existence, visits were made, but apart from offering advice, they had no legal power of enforcement unless the patient was being abused. This lack of control was

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[17] As Mitchell observed, however, what constituted restraint or coercion was never wholly clear, and that therefore the provision of the Act demanding registration of such patients was largely useless. Mitchell, A. (1864) *op.cit.*, p5. *Vide supra* Chapter 1.

[18] Mitchell, A. (1864) *op.cit.*, p4.

[19] *Vide supra* Chapter 7 and GBCLS AR, *passim.*

[20] The response to this was considered disappointing; the Board was fully aware of numerous patients being confined illegally, but who were beyond the reach of Lunacy officials.

condemned by the Commissioners, who regarded their limited power as a failure of the Lunacy Act which not only affected the proper care of the insane and led to imperfect lunacy statistics, but indicated weakness in the degree of control of the Board of Lunacy. Thus, of 1658 boarded-out lunatics known to the Commissioners in 1865, only 21 (1.2%) were private patients, kept for profit with the sanction of the Board, even though failing to report such cases was an offence.[21]

Notwithstanding considerable frustration at their circumscribed role, the Board of Lunacy did not demand indiscriminate control over all boarded-out patients, and was prepared to accept that certain private patients did not require regular visitation. It was considered inappropriate to visit some because of their higher social position and, further, it was recognised that many were well cared for. Nevertheless, the Commissioners consistently expressed their regret and concern at their limited control, arguing that it was in the interests of the insane that more extensive powers existed for visiting private patients. A case reported by Mitchell, in the early years of boarding-out, exemplified the impotence experienced by the Commissioners in certain circumstances. In this instance, "the Board's efforts to ameliorate the patient's condition were finally defeated". M.M'A, a private patient with chronic mania, was visited by the Commissioners who reported evidence of prolonged restraint and cruel treatment. The patient had been tied down to her bed and forced to wear a strait-jacket for 12 years, resulting in permanent stiffening of her limbs. The Board made repeated efforts to remove her to an asylum and the case was brought before the sheriff-court several times, the first petition being presented in 1859. During the legal process, the patient remained under restraint and died in 1863. There had been no indication that positive action would be forthcoming and the Commissioners felt this to be "the most signal defeat which the Board has sustained in its efforts to improve the condition of patients found out of asylums."[22]

A further constraint on the power of the Board lay in the limited alternatives available to implement improvements in the condition of pauper patients residing under the care of relatives. The Commissioners often reported their frustration that their "good intentions"

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[21] GBCLS 7th AR (1865), main report, pi. In this year, 1865, there were 1039 registered private patients, of whom 1018 were in institutions.
[22] GBCLS 10th AR (1868), p239.

were sometimes obstructed by "the obstinacy and degradation of relatives".[23] Their only means of compulsion lay in enforcing the removal of a patient to an asylum or to the care of a new guardian, but they were often reluctant to order the forcible separation of an imbecile child from the mother. Further (and pre-empting any action by the Board), certain patients residing in unacceptable circumstances were removed from the poor roll by relatives to avoid implementation of any recommendations forthcoming.

Despite certain limitations, however, the Board of Lunacy had ultimate control over all registered insane patients and "the sheer enormity and scope of the Scots Commissioners work load is on its own impressive and worthy of recognition."[24] Their control over boarded-out patients was more extensive than over those accommodated in asylums. Their actions could result in the achievement and maintenance of adequate living conditions; the removal of a patient to a better home; increased maintenance and clothing allowances and increased vigilance of parish officials. Nevertheless, definite dissatisfaction at the constraints imposed upon them was manifest and is reflected in Lawson's declaration that:

> "it is to be regretted that the causes which operate in modifying the numbers of pauper lunatics in private dwellings are...so capricious, so arbitrary, so purely personal... There is no part of lunacy administration which is left so much as this to be determined by individual considerations. The will of a...superintendent, an inspector of poor, and of a guardian [is] modified by preconceived ideas and by prejudices and interests; the necessity for finding accommodation in an asylum balanced by the necessity for finding patients to fill one; the enthusiasm of those who approve, and the inactivity of those who disapprove..."[25]

11.3 Specific activities in relation to boarding-out

In the first two years following the creation of the Board of Lunacy, information was obtained on 4097 private and pauper patients residing in private dwellings, of whom 3527 were visited by the Commissioners and 570 reported on from information received by local officials.[26] Commissioner Macpherson claimed that the nature of the control and supervision undertaken "gives a completeness to the lunacy administration of Scotland which is peculiar to it"[27] and the evidence supports this assertion. The length and detail of official reports indicate that annual visits to boarded-out patients became increasingly

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[23] GBCLS 27th AR (1885), p140 and *vide supra* Chapter 7.
[24] Andrews, J. (in preparation) *op.cit.*
[25] GBCLS 26th AR (1884), p150.
[26] GBCLS 1st AR (1859) and 2nd AR (1860). In 1858, for example, Commissioners examined 1643 patients in 688 parishes in 30 different counties. GBCLS 1st AR (1859), main report, pxxxiv.
[27] GBCLS 27th AR (1885), p127.

thorough as the system developed. Much emphasis was placed on the efficacy of regular supervision. As the Commissioners announced:

> "we are far from maintaining that the condition of insane in private dwellings is in every respects satisfactory; but we believe it is more satisfactory in Scotland than any other country. At all events it is better known, and the reports of Commissioners show that it has greatly improved under methodical inspection, which is one of the most important features of the Scotch lunacy system". [28]

Nevertheless, they declared that it was not their intention, or practice, to intervene in the daily parochial administration of lunacy or to travel across Scotland "in the character of detectives."[29] In fact, they depended upon parish officials to fulfil their responsibilities and inform them of the existence of all insane paupers.

Repeated exhortations were made by the Commissioners to asylum and parochial officials to board-out suitable patients. Medical superintendents often sought their advice in selecting patients for discharge to private dwellings. In addition, they were also asked to give presentations on the system at local parochial board meetings.[30] The following activities are indicative of a typical work-load for Commissioners; in 1868, in the course of his visitations, Mitchell saw 203 inspectors of poor, and 85 parochial medical officers, and had interviews with 77 procurators fiscal, police superintendents, chairmen of parochial boards, and clergymen. Further, 243 letters were written to inspectors of poor, medical officers and the Secretary of the Board regarding peculiarities or problems encountered among certain patients.[31]

The length of the journey to often remote districts added to the arduous nature of the Commissioners' duties. Patients were boarded-out across the country, with long distances between them often demanding lengthy walks or rides over bog-land. Illustrating the extent of his travels, Fraser calculated that in his time as Deputy Commissioner, he was one of the few people in Scotland who had been in every parish in the country.[32] Access to some patients was possible only by boat, regardless of the weather or season and for much of the

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[28] GBCLS 16th AR (1874), pxlvii.
[29] GBCLS 16th AR (1874), p313.
[30] For example, Macpherson gave a paper on the family care of the insane at a meeting of Aberdeen, Kincardine and Banffshire parish officials in 1906. He recorded his pleasure at the large size of the audience. The diversity of their role is demonstrated by the varied requests made by officials. Thus Macpherson was asked to consider the boarding-out of children on the island of Iona, a practice he regarded as successful.
[31] GBCLS 10th AR (1868), p225.
[32] Marr, H. (1925) John Fraser's obituary. *Journal of Mental Science*, 293, p191.

year, communication between remote parts of the country was often impossible.[33] Thus a visit to Shetland was achieved only with "considerable fatigue and expense."[34] Similarly, visitation of patients in Orkney, regardless of the number of single patients boarded there, took a whole day. The arduous nature of the Commissioners' workload underwent no perceptible amelioration as the system developed. The diary of Kate Fraser, the first female Deputy Commissioner, contained interesting insights into the nature of her work, although there was often more detail about local conditions and weather than about the patients. Fraser listed her means of travel and the discomfort often experienced in lorries, boats and dog carts, reporting how, "often I have lain in the bottom of a motor boat under a tarpaulin while the waves washed over me...And I walked and walked!"[35] Similar conditions were experienced by other Commissioners, but notwithstanding the nature of their work, there is little evidence, in their writings, both as practising officials and upon retirement, of particular dissatisfaction or unhappiness, even if frequent remarks were made regarding the time incurred travelling across the country.

In assessing the condition and suitability of those in private dwellings, the Commissioners distinguished between patients who were discharged from asylums, whose fitness for domestic care was often doubtful and those whose suitability was assured. The inspection of the former category was viewed largely as an inquiry into the personality of the patient, while that of the second category was more an assessment of the surroundings in which the patient resided. The Commissioners emphasised that the greatest attention had to be focused on those newly boarded-out, the "less stable minority" often with a mental condition liable to sudden change.[36] As the system expanded and an increasing proportion of patients were discharged unrecovered from asylums, greater vigilance from the Commissioners was required. However, the marked increase in attention demanded for such patients was modified by a reduction in the need for close supervision of chronic quiet cases who had been boarded-out for many years. Further, annual visits to the same patients

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[33] Mitchell recorded using a one horse trap over moors, fens, bogs, fords, and rowing and sailing boats in the lochs of the Western Isles, noting that "much endurance and courage was required."

[34] GBCLS 2nd AR (1860), p213.

[35] Mayes, M. (1995) *op.cit.*, p96. Again she wrote: "the longest walk I had was one of five miles through the ups and downs of a Highland glen...It would have been a lovely walk had it not been that rain had fallen steadily for several days...and it was a perfect quagmire and almost impossible to follow the path. It was so wet underfoot that I took off my shoes and stockings and walked barefoot, putting them on again before entering the cottage in order to uphold the dignity of office." Mayes' book contains further detailed reminiscences of Fraser's experience as a Commissioner, and is recommended for that reason.

[36] GBCLS 35th AR (1893), p105.

and guardians over many years reduced the need for routine visitation. As the Commissioners recognised, their role in ascertaining the suitability of provision had, "by the consolidation of the system become less important."[37] The most frequent defects requiring intervention reflected injudicious management of patients and the effects of financial constraints, with sleeping accommodation and quality of clothing reported frequently as inadequate. Therefore, although the responsibilities of their office were great, visitations to private dwellings often required little more than recommendations of increased clothing, or financial allowances.

11.4 Attitudes towards boarding-out

The enduring endorsement of boarding-out by the Commissioners in Lunacy was the single most significant factor in the expansion of the system, and is in marked contrast to their open disapproval of private madhouses. Their unwavering support and enthusiasm for boarding-out was not inspired by dissatisfaction with the asylum system and there was never any stated intention to undermine the status of asylum care.[38] Thus Mitchell, insisted that the system in no way took the place of asylums, but was merely one of the various ways in which to provide for the insane poor. This perception of the role of boarding-out was echoed by his successors, who remained convinced that asylums were of primary importance, private dwellings being supplementary; "they complete the scheme, and become necessary as part of the whole".[39]

The publication of Mitchell's' influential book in 1864 had drawn worldwide attention to the system of boarding-out, although much of it was taken up with descriptions of filth, "abject misery" and the degree of suffering experienced by many of the insane in private dwellings.[40] However, his claim that as a direct result of intervention by the Commissioners, conditions in private dwellings had undergone substantial amelioration can be substantiated by the reports not only of the Commissioners but by parochial officials and medical superintendents. So extensive were these improvements that Mitchell was able

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[37] *Ibid.*

[38] An exception to this was the view expressed by Lawson in his forthright condemnation of the stronghold of asylums. To him, such places were "a necessary evil." GBCLS 26th AR (1884), p143. Such firm censure was not however, typically reflected in the official viewpoint of Lunacy Commissioners and Lawson too, conceded that in practical terms, "efficiency in management and treatment can only be arrived at by the aggregation of lunatics."

[39] Mitchell, A. (1864) *op.cit. Vide supra* Chapter 10 for debate concerning the perceived threat to the status of asylums.

[40] Mitchell, A. (1864) *op.cit.*

to recommend the widespread adoption of the system for certain patients, concluding that, "to transfer chronic, incurable cases to private dwellings would be the best thing for the patients, and the best thing for the country."[41] An article in the Scotsman even attributed the growth of boarding-out to Mitchell, declaring that:

> "it is beyond doubt that lunacy administration in Scotland has drawn its inspiration from Mitchell more than from anyone else...his work of 1864 did much more than merely sow the seed from which the system of private dwellings has been developed. The views which it enunciated were mature and they established the system virtually as it exists in Scotland today."[42]

However, this is unduly complimentary to Mitchell. Boarding-out was adopted seven years before the publication of his book. Further, the opinions voiced by Mitchell were in close accord with those of his colleagues, and a contemporary of Mitchell, another influential Commissioner, Sibbald, was an equally staunch advocate of boarding-out.[43] To the Commissioners, the advantages ensuing from the economic saving created by the postponement of asylum extensions, the reduced cost of maintenance and the increased comforts for patients, were supplemented by the recognition that these benefits were attainable at no risk to public safety. Reflecting the trend towards encouraging domestic features in the treatment of the insane, the Board of Lunacy stressed the importance of allowing patients to remain, where possible, in their own homes, or to be placed under the care of unrelated guardians of the same social class. Where removal to an asylum was considered necessary for the safety of the patient, or the general public, the Commissioners encouraged the abatement of "prison-like" features in asylums, in order to minimise the restrictions of medical treatment. The great advantage of the boarding-out system, they maintained, lay in the possibilities for patients to reside in "a way little removed in its character from the mode of life which they would have led had they not suffered from insanity".[44] Therefore, they pressed medical superintendents for the swift removal of patients from asylums to private dwellings when treatment had ceased to be beneficial.

While enthusiastic about the benefits attainable for chronic patients, their interest was also prompted by a recognition that a successful policy of domestic care improved conditions for patients remaining in asylums. They argued that the position of asylum residents was influenced by the removal of the accumulation of incurable cases, thereby allowing greater

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[41] *Ibid.*, p92.
[42] The Scotsman, 27th November, 1894, p17.
[43] Sibbald, J. (1861) *op.cit.* Reasons behind their firm endorsement of the system have been explored in Chapter 8.
[44] GBCLS 29th AR (1887), p141.

time and attention to be devoted to potentially curable cases.[45] The ethos behind the following statement, reiterated countless times by subsequent Commissioners, exemplifies the underlying principle behind the expansion of the system. Mitchell contended:

> "that all cases of insanity should be placed in an asylum is a proposition we cannot entertain, the welfare of the patients would not thereby be promoted, while the expense to the country would undoubtedly be greatly increased. All great aggregations of permanently diseased minds are evils which should, as much as possible, be avoided, as their tendency is undoubtedly to lower and degrade each constituent member of the mass."[46]

The benefits of boarding-out were stressed repeatedly by the Commissioners in their annual reports, at meetings of asylum superintendents and of parish officials and in articles in contemporary medical journals, most notably the Journal of Mental Science. Further, their endorsement was voiced at regular conferences held throughout Scotland and at international meetings.[47] Instances of amelioration in the condition of patients were announced with pride. Defects arising from the system, while never dwelt upon prominently, were also acknowledged, although the Commissioners were confident that none were so severe as to demand radical modification to the system. They dismissed, therefore, criticisms arising from the limited number of isolated unsatisfactory cases reported each year. Further, while they acknowledged that there were occasions where patients proved unsuitable for private dwellings, they argued that awkward, troublesome patients resided in even the best of asylums. In the same way that asylums were not judged by their disruptive patients, the Commissioners contended:

> "so the boarding-out system must not be censured on account of the bad cases. The condition of the mass is the true gauge by which to judge either of an asylum population or of the extramural insane."[48]

The defensive responses of the Commissioners to concerted attacks upon the practice of boarding-out highlights the proprietary nature of their support for the system. They emphasised the extent of their experience and the knowledge gained of the life of the poor throughout Scotland, maintaining that persons who condemned the system did so out of ignorance and that alienists with experience only of asylums were unfit to judge the system. To assess the policy with any degree of fairness, they argued that it was necessary to visit

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[45] *Vide supra* Chapter 8.

[46] GBCLS 2nd AR (1860), main report, pxli.

[47] For example at the International Home Relief Congresses, held at various European capitals in the early years of the 20th century.

[48] GBCLS 22nd AR (1880), p116. Nevertheless, constant concern was expressed towards the hereditary taint of mental disorder, and the propagation of a race of imbeciles. Therefore much attention was focused on the degree of sexual activity in various districts, and the risks facing vulnerable patients, notably imbecile women, Commissioners maintaining that the tone of morality among the poorer classes was a matter of grave import. *Vide supra* Chapter 9.

and talk to patients and guardians in the way they did each year. The implication is clear; criticism from anyone with less experience than themselves would not be tolerated or considered. Extensive exposure to patients in private dwellings, with the additional experience of knowledge of asylum life, reassured the Commissioners that their endorsement was based on sound principles. Although aware of certain concerns held by more dispassionate observers of boarding-out, the Commissioners announced with assurance that "a fuller knowledge of the facts is all that is required to dispel the doubts which are still...expressed as to the success of the system as at present administered."[49]

It is clear that the Commissioners regarded the system as a policy capable of becoming an integral part of any complete system of providing for the insane. Norman, superintendent of Richmond Asylum, Dublin, was accurate in his announcement that "the system meets with the unmixed approval of the Scotch Lunacy Board."[50] Its endorsement remained strong in the early years of the twentieth century, with continued belief that it was "only right and proper" that quiet, inoffensive patients should be given the opportunity of enjoying the surroundings and conditions experienced by sane persons.[51] In 1913, the Commissioners expressed their conviction that boarding-out had become "a permanent and established system, which could not, without enormous expense to the country be superseded".[52] This confident statement, while accurate in its assessment of the durability of boarding-out, also indicates the almost unqualified approval of the system by its official supervisors.

11.5 Relations with asylum and parochial authorities

11.5.1 Medical superintendents

The degree to which patients were boarded-out from asylums was influenced by the nature of the relationship between the Lunacy Commissioners, who had overall control over the system, and the officials immediately responsible for the care of the insane. Where asylum physicians were sceptical of the merits of the system, the number of patients discharged to private dwellings was low.[53] In response, the Commissioners criticised those

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[49] GBCLS 34th AR (1892), p102.
[50] Norman, C. (1890) *op.cit.*, p469.
[51] CR (1904) Midlothian and Peebles District Asylum, p32.
[52] Review of Lunacy Administration since 1857 in GBCLS 56th AR (1914), plxxxii. Similar enthusiasm was recorded several years later. Among many such endorsements, Fraser, writing in the 1930s observed that although institutional care was necessary for certain classes of patient, many could share happily in the life of the community.
[53] The dynamics of the relations between the two bodies is examined in greater detail in Chapter 12.

superintendents who allowed the accumulation of chronic patients. They attributed this to the continued indifference and open scepticism expressed by a number of asylum superintendents and parochial officials regarding the efficacy of boarding-out.

Nevertheless, praise, where merited, was unstinting and support for innovation was strong. The success of the open door system introduced by Tuke, for example, and the abolition of airing courts instigated by Sibbald, received warm endorsement from the Board, which recommended similar action in all Scottish asylums. The interest of Commissioners in encouraging boarding-out from institutions was enduring and they exerted constant pressure in this direction. Thus Keay, at Inverness District Asylum, was praised for his "persistent use" of boarding-out, which formed "such an admirable feature" in the administration of the asylum.[54] Equally when the Commissioners considered that the rate of boarding-out from certain asylums was too low, they made their concerns clear and encouraged greater activity in removing suitable patients. To the Commissioners, it could not be "too often insisted that the *only* effective way of moderating the population of Scottish asylums is by discharging those who do not need asylum care."[55] However, from the 1880s, a number of their reports on asylums contained little or no reference to boarding-out. This should not be seen as a reflection of loss of faith or enthusiasm in the system, rather, recognition that boarding-out from asylums had achieved sufficient stability and recognition to continue without constant haranguing from the Board.

In considering the relations between the Commissioners in Lunacy and asylum superintendents, Andrews' appraisal is particularly valuable.[56] In his view, the advice offered to the superintendents was often regarded by asylum superintendents as unnecessary intervention and, sometimes resented, albeit not overtly. Clouston, for example, observed a degree of friction among many asylum superintendents and Commissioners, which he attributed to extensive differences of opinion regarding lunacy administration. However, he conceded that "physicians have come to recognise what a great help the Commissioners are" and that they acknowledged the depth of experience gained by the Commissioners regarding the care and supervision of boarded-out patients. In

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[54] Attempts made to board-out from asylums were warmly praised, and the importance of continued efforts was stressed, as "it is well known that there is a class of chronic insane who are more suitably and more cheaply provided for in private dwellings than in any other way." CR (1909) Govan District Asylum, p6.
[55] CR (1908) Kirklands District Asylum, p38.
[56] Andrews, J. (in preparation) *op.cit.*

fact, he went so far as to assert that many medical superintendents regarded them as "a great bulwark and protection to them, exposed as they are to the suspicions and misinterpretations of the public".[57]

11.5.2 Parish officials

Relations between the Board of Lunacy and the Board of Supervision were frequently uncomfortable. Indeed, the relationship between Commissioners and parochial officials was one of the most vulnerable features of the boarding-out system. Intervention by the Commissioners in affairs previously accepted as the sole responsibility of the parish and the negative attitude towards lunatic wards in poorhouses caused resentment among parish officials. Nevertheless, the Commissioners had to depend upon the willingness of these officials to remove patients from asylums and to find suitable accommodation for them.

The work of inspectors of poor was scrutinised closely by the Board of Lunacy, which required detailed reports from them of the condition of all patients in private dwellings. The Commissioners recognised the effect of their control, conceding that "the hand of the General Board is felt by the parish council at every step which they take."[58] Parochial board reports contained numerous veiled references to what were perceived to be the domineering tactics of Lunacy officials. However, there is no evidence in annual reports that this had any impact upon the Commissioners. This is possibly due to the recognition that their reports were for official perusal, thereby limiting the likelihood of their use as a vehicle for the expression of minor discontents. Nevertheless, presentations by the Commissioners in various journals and at conferences rarely highlighted the uneasy relations between the two bodies, although frustration at the apathy of many parish officials was sometimes apparent. Brief comments, placed unobtrusively in reports from asylums, illustrated their dissatisfaction. In Argyll, for example, it was reported that supervision by parochial officials was "frequently defective, and the withholding of the [government] grant has been threatened in several cases, unless evidence of greater attention to this duty is found at the next visit."[59] The Commissioners maintained that the continued accumulation of chronic patients in asylums was partly due to the lack of enthusiasm, and at times "strenuous

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[57] Clouston, T.S. (1893) *op.cit.*, p11.
[58] Sibbald, J. (1904) *The relief of the poor in Edinburgh.* Glasgow: Reprinted from the Poor Law and Local Government Magazine. The term parish council was applied to the old parochial boards from 1894.
[59] CR (1880) Argyll and Bute District Asylum.

opposition" displayed by parish officials. As late as 1900, Macpherson was moved to comment upon "a disinclination on the part of many of the parish councils...to board-out their patients."[60]

The Commissioners also condemned the unnecessary admission of many patients to asylums. The majority were held to be due to failure on the part of inspectors of poor to find suitable guardians and to the ease with which pauper patients were admitted to asylums. Sutherland maintained that "hundreds" of parish officials "see their patients once, convey them to the asylum, shake hands with them and never see them again"[61] No further action was taken by them until pressure was exerted by the Board of Lunacy. There was justified wariness among the Commissioners at declarations from untrained parish officials regarding the mental condition of patients, which were often in contrast to their own assessments. This disparity reinforced the need, from the Commissioners' standpoint, for personal inspection of patients by medical men, and further emphasised the limited reliance that could be placed on reports by parochial officers. They illustrated their concerns by citing the example of M.G, a patient who, in 1860, was reported to the Board as "keeping well, only a little nervous". Following a visit by a Commissioner, M.G was declared to be in a state of mania and religious excitement, which had lasted intermittently for 15 years. Although the Commissioner concluded that her life was in danger by her behaviour, parish officials had deemed her a suitable person for continued residence outside an asylum.[62]

Despite such disagreements, the Commissioners' reports often contained warm praise for the activities of parish officials, particularly as the system expanded and was employed increasingly throughout Scotland. Lawson, for example, praised the efficiency and courtesy of inspectors of poor in certain districts, particularly those from Edinburgh and Glasgow City parishes, remarking on the "admirable feeling which, almost without exception, I have observed to exist between the patient and guardian, and the visiting officials".[63]

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[60] Reported in Carswell, J. (1911) Lunacy in relation to public health administration. *Poor Law Magazine*, **21**, 225-236. The Royal Commission on the Care and Control of the Feeble-minded, reporting in 1908, found the only defect in lunacy administration was the unwillingness of some parish councils to deal with boarded-out cases, and "a certain lack of unity between the administration of District Boards of Lunacy and parish councils." It was recognised that the main interest of parish councils related to expenditure, with little concern regarding the nature or prevention of insanity.

[61] GBCLS 45th AR (1903), p249.

[62] GBCLS 3rd AR (1861), p238.

[63] GBCLS 23rd AR (1881), p130.

While tension ran high at times between the Commissioners and other authorities dealing with the insane, their relationship was much more harmonious than that reported of the English Commissioners.[64] Despite their superior training and general education, the Commissioners tried to establish close links with parish officials. While some degree of dissatisfaction remained perceptible among parochial authorities, gradual recognition of the advantages of the system and an acceptance of the role of the Commissioners, enabled an expansion of the policy generally untrammelled by personal divisions.[65] Any resentment and apathy prejudiced the status of boarding-out. By the 1880s, the Commissioners expressed their confidence that relations between the two bodies had improved to the extent that cordial exchanges occurred. Reflecting this, Lawson reported with pleasure that:

> "there is now little trace of the old antagonism with which the earlier representatives of the Board had to cope in the advocacy and institution of the system... it is very striking to see over the last twenty years ...their zeal in support of a scheme in the success of which they had a vital interest; the great personal influence which ... is exercised in the rural districts by men of repute from a distance, in the removal of prejudice and misunderstanding, and in the inauguration of beneficial changes; the energy and success with which they have enlisted every local influence in the prosecution of their mission, have been prime elements in the success which crowned their labours".[66]

This was high praise for the former critics of the Board of Lunacy.

11.6 Effect of the Board of Lunacy in regard to boarding-out

11.6.1 Practical results

The Lunacy (Scotland) Act, 1857, had the effect of increasing vigilance and control over all registered insane patients, regardless of location. Although their role was essentially supervisory, there is no indication that the Commissioners existed merely to approve prevailing conditions. Further, although Andrews has suggested that the efficiency of the Commissioners was curtailed by the excessive demands placed upon them, there is no evidence to suggest that this was true in regard to boarding-out, where their main duties lay in ensuring that patients were provided for suitably by local officials immediately responsible for their care. The activity of the Commissioners can be illustrated by an assessment of the number of special licenses granted and revoked annually, thereby demonstrating the close attention paid to existing conditions. Taking 1912 as a typical year, 19 licenses were cancelled and a similar number of new licenses granted. Fourteen

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[64] Andrews, J. (in preparation) *op. cit.*
[65] *Vide infra* Chapter 13.
[66] GBCLS 22nd AR (1880), p132.

cancellations were due to the death of the guardians, two on account of "dissipated habits" on the part of the male guardians and two as a result of general untidiness and inadequate care which repeated intervention by the Board had failed to rectify.[67]

The Commissioners' exhortations to asylum superintendents to board-out patients were often responded to immediately. In 1887, Fraser visited Ayr District Asylum twice, advising Skae about the suitability of patients for discharge. He also visited the Governor of Cuninghame Poorhouse and 45 of the 48 inspectors of poor in the county, explaining the views of the Board of Lunacy regarding the system of boarding-out. As a result, 32 patients were discharged unrecovered to private dwellings from the asylum and five from the poorhouse.[68] Similarly, at Argyll and Bute District Asylum, a number of patients were boarded-out following recommendations by a visiting Commissioner. Accompanied by the medical superintendent, Lawson visited boarded-out patients in the district inquiring as to the forms of insanity under which they laboured, and to the way they were cared for. They also visited local inspectors of poor and potential guardians and houses. Over 40 patients were discharged from the asylum as a direct result of Lawson's intervention.[69]

The positive effect of the Commissioners' intervention is illustrated in the case of C.M, in 1865. When first visited, she lived with her grandmother, who sent her around the district to beg. It was reported that she was beaten and half-starved at home and teased by local boys. The Board ordered her removal to the care of an unrelated guardian, who lived near the inspector of poor. On a later visit, it was reported that she was kept clean, dressed tidily and attended church regularly. Further, she was no longer excitable, and was trustworthy enough to go shopping for her guardian, to whom she was strongly attached.[70] Similar achievements were reported annually. Among them, and representative of many others, E.M, was transferred to a new guardian. Her previous residence had been in a dirty hovel where she was "engaged in the meanest drudgery" under the care of "guardians...less competent than herself." In her new surroundings she was seen, by Lawson, to be:

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[67] GBCLS 55th AR (1913)
[68] GBCLS 29th AR (1887), p112.
[69] GBCLS 25th AR (1883), p163. Similarly in 1891, Fraser, frustrated at the limited efforts to board-out by parishes in Banff, visited every inspector of poor of the county pointing out how little had been done, and recommending concerted action. The result was impressive. In 1885, only one patient had been boarded-out in the county, five years later, 11 were thus accommodated. GBCLS 33rd AR (1891), p100.
[70] GBCLS 7th AR (1865), p253.

> "so completely changed that I would not have known her as the same person. She looked healthy and bright, was neatly clad and seemed quite at home in a scrupulously clean and comfortable cottage."[71]

This had been attained by simple action from the Board, incurring little expense or trouble.

Although there is inherent bias towards the system in the annual reports of the Commissioners,[72] there is no suggestion that the numerous examples of substantial amelioration of the mental and physical condition of patients following their intervention were exaggerated. The Commissioners also claimed that, indirectly, the improvements resulting from their recommendations helped to raise the standards of the community in which patients resided. This was a valid claim in connection with cases of moral impropriety where imbecile patients of the opposite sex shared a bed. Such conditions, in the Commissioners' opinion, could not fail to be prejudicial to the morality and sensibilities of the neighbourhood.[73] Their intervention served to reassure villagers and encourage the maintenance of decent standards. In this context, MacNiven is not unduly optimistic in his assertion that by demanding the attainment of what appeared to be high standards in the care of the insane, the Board of Lunacy did much to "revolutionise the public attitude towards the treatment of those suffering from mental illness."[74]

11.6.2 Assessment of Commissioners' role

The Commissioners were in no doubt about the utility of their role and the success of their work, stressing repeatedly the beneficial effect of their persistent influence. While an element of self-congratulation runs through the reports, satisfaction at the consequent improvements is apparent. Despite complimentary assessments of the Scottish Commissioners from observers worldwide, the English Lunacy Commissioners and contributors to the Journal of Mental Science were less wholehearted in their praise. Thus, it was suggested that many of the Commissioners had little or no experience of asylum management, yet felt able to intervene in the daily management of the insane and force implementation of their suggestions.

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[71] GBCLS 30th AR (1888), p121.
[72] The potential drawbacks of the limited range of sources and the necessary concentration in this thesis on annual reports of the Board of Lunacy has been discussed in Chapter 2 and is an important consideration.
[73] This issue was addressed in GBCLS 6th AR (1864), p228, and commented upon regularly throughout subsequent reports.
[74] MacNiven, A. (1960) *op. cit.*, p471.

A further criticism of the Commissioners concerned the high standards which they appeared to expect from villagers. While the Commissioners stressed repeatedly the need to judge living conditions by the standards of the community, it was they, rather than parish officials from more modest circles, who often needed reminding of this. However, despite certain exceptions, the favourable opinion with which the Commissioners bestowed upon themselves was echoed by a high proportion of observers. Their role in helping the general population to overcome fear surrounding the residence of insane persons in the community and in encouraging local officials to take an interest in the affairs of the insane were perceived widely as significant achievements. Urquhart, for example, highlighted their "broad and sympathetic policy":

> "which has not only been fruitful in the protection and promotion of the best interests of the insane, but has also done much to encourage and assist those who are more immediately engaged in carrying out their care and treatment".[75]

Equally enthusiastic praise was forthcoming from the American alienist, Copp, who contended that the Commissioners were "actuated by the highest motives" in their endorsement of boarding-out.[76] Similarly, Riggs stressed the efficiency of the safeguards established by Commissioners to ensure the proper care and control of the boarded-out insane. His praise was unstinting when he declared that it was "impossible to speak too highly of the wise and humane manner in which the Board of Commissioners fulfil their duties."[77] The conclusions of a later Commissioner would, therefore, have been endorsed fully by the early pioneers of a centralised lunacy administration, even if they cannot be accepted with such ease today. MacNiven praised the sense of mission and zeal of Commissioners in their consistent attempts to ameliorate the condition of the insane. He went on to assert that:

> "the Medical Commissioners...appear successfully to have combined the functions of administrators, clinicians, teachers and social workers. I venture to suggest that their record is a remarkable one and that they deserve honour and remembrance."[78]

11.7 Summary and conclusions

Detailed analysis of the official reports from the Lunacy Commissioners support a favourable assessment of the effects of their work. The Commissioners were essentially the arbiters of the boarding-out system and its implementation and development was dependent

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[75] Reported in Anon. (1908) Meeting of the Medico-Psychological Association. *Journal of Mental Science*, **54**, p625
[76] Copp, O. (1904) *op.cit.*, p60.
[77] Riggs, C. E. (1895) The boarding-out system in Scotland. *American Journal of Insanity*, **52**, p325.
[78] MacNiven, A. (1960) *op.cit.*, p471.

upon their enthusiasm and activity. Their support for the expansion of the policy was unwavering and it is clear from official lunacy, asylum and parish reports that the system became increasingly refined under their control. The dogmatism and fervour evident in early reports, with the drive to remove all unsuitable patients, allowing only a particular category of boarders, was replaced gradually by greater flexibility and complacency, although the degree of vigilance maintained over the system was always extensive.

The Commissioners were somewhat isolated in their roles as lunacy administrators. Mellett, and Hervey have both remarked upon the essential conservatism of the English Commissioners;[79] and the findings of the present study do not indicate that the Scottish Commissioners should be viewed any differently. Their positions were secure and, notwithstanding certain limitations upon their powers, their control of lunacy in Scotland was extensive. Nevertheless, a number of criticisms can be upheld. Armed with their clearly defined perceptions of right and wrong, the Commissioners travelled throughout Scotland endeavouring to ensure the attainment of their rather narrow standards.[80] It is evident that great stress was placed upon the minor details of a patient's life, attempting to establish a surface conformity, for example, in the importance placed upon patients being treated as equal members of the household. Their overwhelming emphasis was upon civilising the insane, and integrating them into the patterns of modern society. Where their ideals were not implemented, guardians and parish officials were, often unjustly, condemned for apathy and ignorance.

Assessment of the annual reports of Commissioners indicates that the charge that, at times, they were insensitive to local conditions must be accepted.[81] Although their reports emphasised repeatedly the importance of adapting standards to prevailing local circumstances, disapproval at certain aspects of daily life permeated their reports. The lack of bathing facilities, for example, and the general standard of hygiene in Highland communities appalled the sensibilities of the Board. Such condemnation was not apparent among parish officials more accustomed to local habits. In addition, there was no

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[79] Mellett, D. (1981, 1982) and Hervey, N. (1987) *op.cit.*

[80] *Vide supra* Chapter 4.

[81] This accusation was made repeatedly by parish officials and subsequent observers of the Lunacy Commissioners and is addressed in Chapters 9 and 13. However, there were several instances in which the Commissioners emphasised that "allowances must be made in consequence of the peculiar circumstances of the people." (Noted in Chapter 9. GBCLS 19th AR (1877), p126)

indication that conditions deemed offensive to wealthy and educated Commissioners, were in any way deplored by the local population, prompting complaints from parish officials that the standards demanded by the Board were impossibly high and unfair to the rate-payers of poor communities.

It is reasonable to assume that a number of cases described in annual reports were selected to lend weight to the Commissioners remarks and to propagate their ideologies. Thus the reports appeared to encapsulate firmly the legitimising view, with little room for innovation. A reviewer for the Journal of Mental Science remarked upon the careful compilation, and detailed nature of the official reports, observing with scepticism, a "*couleur de rose* tint spread over the pictures annually drawn".[82] Despite their potential polemic content, however, the lengthy reports contained extensive factual information regarding patients in private dwellings. Therefore, while retaining a degree of caution regarding the declarations of the Commissioners, sustained cynicism of their reports by subsequent readers serves only to negate the importance of official records as a useful indicator of prevailing conditions. While remaining aware that the Commissioners had a clear message to portray, on the basis of evidence available, it is possible to accept that the claims reflected accurately the modifications made to the boarding-out system.

The responsibilities of the Scottish Commissioners in their role as guardians of the boarding-out system were defined carefully and adhered to closely. Their vigilance, advice and encouragement concerning proper management of patients, and the pressure placed on parish officials to follow an active boarding-out policy, resulted in large numbers of patients residing comfortably in private dwellings, aided by the gradual improvement in housing conditions throughout the country. The consistent endorsement of boarding-out by the Commissioners enabled the steady growth of the policy, which, in turn, attracted worldwide attention to its pioneering nature and apparent benefits. To the Commissioners, who placed great confidence in the system they had developed, their role was clear:

> "to secure the proper care of pauper lunatics in private dwellings is one of the most important duties of the Board, and constitutes perhaps our greatest responsibility."[83]

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[82] Editorial. (1868) The state of lunacy in 1866. *Journal of Mental Science*, **13**, p466.
[83] GBCLS 2nd AR (1860), main text, pxxxvii.

CHAPTER 12

ROLE AND ATTITUDES OF MEDICAL SUPERINTENDENTS

12. Overview

The Commissioners in Lunacy represented the driving force behind the development and expansion of the system of boarding-out. However, without cooperation from medical superintendents of asylums in selecting patients for discharge, the success of the policy was threatened. This chapter focuses on the attitudes of superintendents towards the removal of patients to private dwellings and the motivations underlying their acceptance of the policy. To enable a thorough assessment of the significance of the asylum in implementing boarding-out, arguments propounded for the adoption of the system are examined from the perspective of the superintendents, with a consideration of possible drawbacks. Finally the extent of boarding-out from three asylums is discussed in detail.

12.1 Introduction

The discharge of unrecovered patients from asylums to private dwellings formed an increasingly significant part of the boarding-out system and by the mid-1880s, the greater proportion of boarded-out patients had been discharged from asylums.[1] This development can be attributed to a growing recognition among medical superintendents that the continued admission of all categories of insane or mentally defective persons diminished the curative capacity of asylums and to mounting concern at the institutionalisation of patients and the growth of the "asylum bred" lunatic.[2] In 1870, Wynter, the editor of the British Medical Journal, had declared that: "our whole scheme for the cure of lunatics has utterly broken down."[3] He maintained that individual treatment had given way to a system

[1] *Vide supra* Chapter 4 which describes the development of the boarding-out policy to include patients discharged from asylums.
[2] *Vide supra* Chapter 8.
[3] Wynter, A. (1870) Non-restraint in the treatment of the insane. *Edinburgh Review*, **131**, p437.

of "routine and general discipline", and that large public asylums could not be effective, because:

> "to drive weak and perverted minds into a crowd and there keep them as a class apart, is clearly against the teachings of common sense, and is opposed to scientific observation, and to keep them there unnecessarily is a crime".[4]

With the gradual adoption of the ideals of moral management and the recognition that certain classes of the insane could be accommodated outside asylum walls, his views found increasing favour. This was allied to concern at the escalating costs of lunacy provision. Parish officials and certain physicians, supported by politicians, highlighted the expense of asylum treatment. In 1907, one anonymous critic announced that in the past 50 years, the construction of asylums in Scotland had cost £4.5 million, making the cost per bed far greater than in Germany or France.[5] With up to 65% of the asylum population classified as chronic dements and thought to be unable to appreciate their surroundings, the palatial masonry was condemned by some commentators as unnecessary.[6] Reflecting this, the former Prime Minister, Lord Rosebery, when opening the district asylum in Edinburgh in 1905, condemned the extravagance of asylums, deploring the "tombs of the intellectually dead" for those who "represent sheer waste and decay."[7] To him, the cost was both enormous and appalling.

Despite the conviction of medical superintendents that the asylum should be regarded rather as "a hospital for the treatment of what is, in reality, a bodily infirmity, than as a lock up for those afflicted with some mysterious metaphysical malady"[8] it cannot be disputed that large numbers of patients throughout Britain were detained unnecessarily in asylums. An active boarding-out policy not only offered greater freedom for such patients, but increased the opportunities to foster cures among those able to respond to medical treatment.

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[4] Wynter, A. (1859) Non-restraint in the treatment of the insane. *British Medical Journal*, p152. Echoing this, Parry-Jones has observed that at best, institutional asylum offered "an ordered way of life excluding factors that made life outside alien...and intolerable. At worst it provided food, clothing, protection from physical maltreatment, some social contact and health care" However, "the price to pay for such security was loss of personal choice and autonomy...public asylums became so organised and regimented that systems of care, designed to be protective and nurturing, easily became patronising and enfeebling". Parry-Jones, W.Ll. (1988) *op.cit.*, p409.

[5] Anon. (1907) The cost of Scottish asylums. *Poor Law Magazine*, **17**, p82.

[6] *Ibid.*, pp82-85.

[7] Recorded in AR for Bangour District Asylum (1906) and in Anon. (1907) The cost of Scottish asylums. *Poor Law Magazine*, **17**, p83.

[8] MS AR (1883) Midlothian and Peebles District Asylum, p17.

This assessment focuses solely on the role and significance of asylums in boarding-out. The limited extant records of private madhouses contain no discussion of the policy, and focus entirely on their own establishments. For the same reason, lunatic wards of poorhouses are not discussed here. As far as can be ascertained, the only surviving reports on poorhouse wards are those of the Commissioners, which make no reference to the system of boarding-out. Patients accommodated therein were generally incurable, with characteristics indistinguishable from those boarded-out and in many districts, admission to private dwellings or lunatic wards was entirely dependent on the attitude and preferences of medical superintendents or parish officials. In addition, the directors and staff in both poorhouses and private madhouses were often unskilled and as such, their attitude towards this official policy is less significant than that of medically trained asylum superintendents.[9] No distinction is made in this chapter between district and parochial asylums, the extent to which superintendents in both establishments boarded-out patients was comparable and they are contrasted only to royal asylums.

12.2 Role of medical superintendent in boarding-out

Although medical superintendents had no direct control over implementing boarding-out, parish officials were dependent upon their judgement in selecting patients. It was among the chronic, harmless patients who had been allowed to settle in asylums, that the most suitable cases for boarding-out were often overlooked. Their removal at the instigation of medical officers was vital in controlling an ever-increasing asylum population. An uncooperative superintendent could hinder the development of boarding-out in their district and, indeed, those asylums with officials who were sceptical of the system tended to have lower rates of boarding-out, regardless of the attitude of parish officials. For example, Howden, superintendent of Montrose Royal Asylum, was convinced that asylums were necessary for the majority of the insane, announcing that "there is, I believe no position more adapted to their wants than the wards of an asylum."[10] This was reflected in the annual discharge rates of the asylum.[11] Although parish officials could remove their

[9] It must be noted, however, that certain proprietors, including for example, J.B.Tuke and A.Robertson (private madhouses) and J.Carswell (Barnhill poorhouse, Barony) were qualified and experienced alienists.
[10] MS AR (1864) Montrose Royal Asylum, p12.
[11] At Montrose Royal Asylum, where, in the 1870s, nearly a quarter of patients were private, only a small number of those in the pauper section were boarded-out, despite wards being so full that new admissions were refused.

paupers, despite disapproval of asylum staff, pressure from the asylum was nevertheless a significant impetus.

Once patients were boarded-out, the asylum had no further responsibility for them, although in some instances superintendents wanted further control. Lack of autonomy over boarding-out was resented widely and many superintendents expressed frustration at their comparative impotence to influence the implementation of the policy, maintaining that it should be under their supervision. Thus Fraser insisted:

> "if it were my duty to visit these...cases, I believe I could elaborate the system, and make it a constant and substantial relief to the asylum. Suitable custodians...would come under my notice, and I could select the fittest guardians for each particular patient. Unless this duty is put into my hands, I plainly forsee that the boarding-out of improved cases will cease, the asylum will become crowded and an extension of the building will be inevitable."[12]

Concerted attempts were made to retain control over patients and the system itself and such views were strongly held. For example, at a meeting of the Medico-Psychological Association,[13] Urquhart disagreed with Sibbald's belief that superintendents were not specially suited to superintend patients in private dwellings, declaring that:

> "such a dictum was a wrong to physicians of their specialty. They ought to be the centre of the lunacy administration in the district in which their work lay. They ought to have the power to place their patients in the positions that they thought best and should not lose interest in them because no longer actually in the asylum."[14]

Robertson, of Stirling District Asylum, was less proprietorial, arguing that the majority of patients selected for boarding-out no longer needed daily supervision by a skilled alienist and required only the comforts of home-life. His views were fiercely disputed by other medical superintendents.

However, the Board of Lunacy insisted that medical superintendents could not attend to the government of asylums and the care of those in private dwellings without neglecting one or the other, and that they were better occupied with the care of acute cases. The Board also considered that when patients were fit for boarding-out, they should be detached from the methods of care and the associations of asylum life. If superintendents had control over the system, there was the risk that patients would be boarded as near as possible to the asylum. In addition, the Commissioners held that it was unlikely that a steady supply of guardians

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[12] MS AR (1875) Fife and Kinross District Asylum, p13.
[13] Reported in discussion on paper by Turnbull, A.R. (1896) The mode of provision for the chronic pauper insane. Notes and News. *Journal of Mental Science*, **42**, p894.
[14] *Ibid.*

could be found close to an asylum. The grievances of certain medical superintendents, therefore, remained unresolved.

12.2.1 Impact of attitude of individual superintendents

Several asylums had no active policy of discharge to private dwellings, despite problems of overcrowding. Possible explanations for this lack of activity include obstruction by parish officials, difficulties created by the location of the asylum, and the personal inclinations of medical superintendents. The personality and ideas of the superintendent shaped the operational policies of the asylum, but even where they were firm advocates of boarding-out, other factors sometimes prevented its adoption. Most superintendents recognised the necessity for widespread implementation of boarding-out, accepting that many patients remained too long in asylums, leading to degradation in their mental condition, overcrowding and an unhealthy influence on curable patients, who received inadequate attention. The majority, therefore, echoed Rutherford's praise for an active boarding-out system when he emphasised:

> "the advantage of those who remain, in enabling the medical staff of the institution to concentrate their attention on the class most capable of benefiting by it; to the advantage of the asylum as a medical institution, by freeing the wards of chronic harmless cases requiring no special treatment, and by making room for more necessitous cases..."[15]

Nevertheless, reluctance by some superintendents to encourage boarding-out from their asylum was evident. Tuke attributed this to exaggerated claims for the system:

> "advocating it to the detriment of the character of the asylum treatment. If they had been content to say the system was good enough for such people these objections would not have arisen, but when it was said it was better, that set the asylum man's back up."[16]

The medical superintendents at both the Fife and Kinross and Argyll and Bute District Asylums were keen protagonists of boarding-out, but limited use was made of the policy. Officials from Fife and Kinross Asylum experienced continued difficulties in boarding-out.[17] With Sibbald as medical superintendent at the Argyll and Bute Asylum from 1862-1870, it might have been expected that large numbers of incurable cases would be discharged to private dwellings. In fact, his annual reports contained little discussion of boarding-out and, although he had written an extensive assessment of the system in 1861, praising its effects highly,[18] the number of patients boarded-out each year did not reflect the

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[15] MS AR (1889) Crichton Royal Asylum, p248.
[16] In Anon. (1871) Notes and News. *Journal of Mental Science*, **16**, p301.
[17] *Vide infra* 12.9.2.
[18] Sibbald, J. (1861) *op.cit.*

extent of his endorsement. Sibbald's successors, Rutherford and Cameron, rarely mentioned boarding-out, other than to observe the difficulties encountered in discharging patients.

In contrast, officials from the Edinburgh Royal Asylum pursued an active boarding-out policy. In 1867, Skae stressed that he did all in his power to board-out patients, "both in deference to the opinions encouraged by the Lunacy Board, and under the convictions...which I urged in my annual reports many years ago".[19] In fact, when compared to the later activity of the asylum, the statistics for the 1860s hardly support his claim, although small numbers discharged need not automatically imply lack of enthusiasm for the system; other factors could also be relevant. Skae's successor, Clouston, was among the most enthusiastic proponents of the system, and this is reflected in the steady number boarded-out annually under his guidance.[20] In Clouston's opinion, three things were necessary in providing for the insane:

> "a curative hospital, wards or an institution for the easily managed incurable, and a properly supervised boarding-out system, all working together, supplementary and complementary to each other. Such a system does the best for the insane and the best for the sane, through being the cheapest." [21]

It might be expected that where an asylum had a well-established policy of boarding-out for some years, the system would survive the departure of the medical superintendent, indicating that it was not simply a reflection of the individual whim of a physician. Most asylums did continue with the system once adopted by an enthusiastic superintendent. In this respect, the policy was perpetuated at the asylums of Inverness District (Keay, Aitken, Campbell), Edinburgh Royal (Skae, Clouston) and Stirling District (Skae, Robertson, Macpherson). However, there is one notable exception to this. Officials at the Murray Royal Asylum were among the first to recommend the system and there was much activity in the early 1860s under the superintendence of Lindsay, one of the great protagonists of boarding-out.[22] However, the implementation of his ideals did not out-last his departure. His successor, Urquhart, referred at times to the policy, but without the fervour and enthusiasm of Lindsay and the proportion of patients boarded-out from the asylum declined rapidly following Lindsay's retirement. A contributory cause was the growing selectivity of

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[19] MS AR (1867) Edinburgh Royal Asylum, p18.
[20] Despite his activity in overseeing the boarding-out system, his record of publications which included: The neuroses of development (1891), Clinical lectures on mental diseases (1896), and The hygiene of mind (1906), contained no lengthy assessment of the system.
[21] MS AR (1884) Edinburgh Royal Asylum, p13.
[22] See also Lindsay, W.L. (1871) *op.cit.*, 497-527.

admission at the asylum, with the increase of private patients, many of whom, when discharged unrecovered, were returned to their family or friends, rather than boarded-out formally.

The number of patients boarded-out from Gartnavel (Glasgow) and Montrose Royal Asylums was always low. This was related to the greater concentration of private patients in both asylums, but a key factor was the attitude of their superintendents regarding the supremacy of the asylum, and their scepticism regarding the inferior potential for treatment in private dwellings. Thus Yellowlees of Gartnavel Royal Asylum, while conceding that there were advantages to the system, contended that it "could afford but slender relief to the overcrowding in pauper lunatic asylums."[23] His extensive annual reports made no detailed reference to boarding-out, either to criticise or commend. His successor, Oswald, appeared to have been equally disinterested, although in his previous post at Gartloch Asylum, he had been active in encouraging the system.[24] This confirms the significance of the prevailing ethos of an asylum; and implies that where boarding-out was only resorted to on a small scale, as in certain royal asylums, the arrival of even the most enthusiastic of supporters was unlikely to modify policy.

The ability of superintendents to obstruct a smooth operation of the system was potentially great. It is apparent from their annual reports that some officials felt threatened by extensive boarding-out from their asylums.[25] Although Lindsay declared with confidence that boarding-out need not interfere with existing asylums, within a few years of the policy coming under official supervision, the Commissioners reported a lack of enthusiasm among a number of medical superintendents. However, there was some sympathy with their position and, despite certain misgivings, there was no suggestion in asylum annual reports of any real wish to obstruct the implementation of boarding-out. Although such intentions were recorded in a number of parish records, it is not surprising that superintendents did not document their lack of cooperation with official lunacy policy. Boarding-out was generally recognised as a useful supplement to asylum administration,

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[23] Yellowless, D. Reported in Anon. (1880) Overcrowding in pauper asylums and its remedies. Notes and News. *Journal of Mental Science*, **26**, p323. Yellowlees was however, an active participant in a number of the frequent debates at meetings of the Medico-Psychological Association, on the merits or otherwise of the system. He also addressed the question at length in certain articles, but more as a useful general policy than one specifically applicable to his asylum.
[24] See for example, MS AR (1899) Glasgow District Asylum, Gartloch.
[25] *Vide supra* Chapter 10.

and those officials who appeared inactive in implementing the policy, were not, necessarily, against it. It is more likely that many would have been indifferent. It was certainly possible for them to be lax in suggesting suitable cases, but, in practice, faced with increasing pressure on numbers, and the exhortation of the Commissioners, the extent to which a superintendent might obstruct the system was very limited.

There is no discernible pattern behind the endorsement or scepticism of boarding-out among individual superintendents either of royal or district asylums. Aware of its therapeutic advantages, and the relief it offered to the asylum, superintendents were obliged to act by continued pressure from the Board of Lunacy and the pattern in most asylums was of a steady, enduring employment of boarding-out, albeit not always affecting large numbers of patients. Where the proportion declined, it was more likely a reflection of external difficulties, or a lack of suitable patients, than the replacement of the medical superintendent. Edinburgh Royal Asylum was typical of those asylums which boarded-out patients for many years, despite a succession of superintendents, thereby highlighting the significance of accepted policy as against the impact of the individual. Further, although cooperation and enthusiasm from medical superintendents was desirable, the personal inclination of the individual was, it is suggested, of less importance than the attitudes of parish officials and Lunacy Commissioners.

12.3 Reasons for endorsement of boarding-out

12.3.1 Relief of overcrowding

Annual reports highlighted the anxiety of superintendents regarding the effects of overcrowding.[26] Not only was the capacity of the asylum to effect cures diminished, but it was also held to be unwise to congregate large numbers of the insane together. In addition, an overcrowded asylum was unable to develop the changes spreading throughout Scottish asylums from the 1880s, particularly the methods and features of general hospitals. Not all superintendents of overcrowded asylums boarded-out patients to alleviate the position, but where it was adopted, the strongest and most enduring impetus was a desire to facilitate a reduction in numbers.[27] Officials were anxious to keep numbers to manageable levels, not

[26] The difficulties caused by severe overcrowding have been considered in Chapter 8.
[27] Annual reports for Dundee Royal Asylum, for example, often complained at the overcrowded state of the asylum, but made little mention of the option of boarding-out. Patients were more usually sent to lunatic wards of the nearby

exceeding 400 patients. Representative of comments in many reports, it was recognised at Woodilee District Asylum that boarding-out "has always been advantageous to the asylum which, had we no [such] system...would have been very inconveniently crowded."[28]

Even during the period of rapid growth in institutional provision in the 1860s and 1870s, boarding-out was employed to relieve wards which, once built, were immediately filled. For example, only a year after the Argyll District Asylum was opened, overcrowding was so extreme that beds had been placed in lavatories.[29] From the 1880s, there was a clear emphasis on boarding-out, with almost all asylums resorting to this system to control their population, although it is notable that recourse to the policy fluctuated within each asylum.[30] Superintendents of asylums that one year boarded-out a large proportion of their unrecovered patients, explicitly to relieve the asylum, a year later expressed concern about overcrowding, yet made no reference to boarding-out as a solution. However, one explanation for this could be the impossibility of maintaining a regular supply of incurable patients for discharge each year.[31]

The impetus to board-out in order to relieve overcrowding applied to large and small, urban and rural asylums, and to a lesser extent, royal and district asylums.[32] Some distinction must be made between those royal asylums which either refused admission to, or had limited numbers of, pauper patients. Uniformity is evident to a surprising extent and it is difficult to identify the specific characteristics of asylums most likely to board-out for alleviation of overcrowding. Nevertheless, boarding-out was not, and never became, the only solution to overcrowding and therefore never represented a real challenge to the status of the asylum. Employment of the policy went a long way in alleviating overcrowding, but as Keay, superintendent of Inverness District Asylum, observed, "the effect of boarding-out

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poorhouse. Gartnavel Royal, Montrose Royal and Crichton Royal also had only a very small number of patients boarded-out. It is significant that these are all royal asylums with a high proportion of private patients.

[28] MS AR (1902) Glasgow District Asylum, Woodilee, p20.

[29] MS AR (1869) Argyll and Bute District Asylum, p7.

[30] Thus Skae, medical superintendent at Stirling district asylum, observed in 1870 that "with a judicious selection of patients for removal this course can scarcely fail to prove a persistent source of relief to the asylum". In 1875, however, only six patients were boarded-out, whereas 11 were sent to poorhouse lunatic wards. By 1887, albeit under a new medical superintendent, boarding-out was again being "sedulously carried out" with admission kept within manageable limits. This had been achieved at "an expenditure of effort on the part of the asylum authorities which no outsider could readily believe." MS AR (1870) and CR (1887) Stirling District Asylum.

[31] Several asylums had sporadic rates of boarding-out, among them, for example, Ayr District Asylum. CR (1900) and Woodilee District Asylum (MS AR 1902, 1903, 1905).

[32] As this chapter indicates, not all urban asylums had an active policy of boarding-out despite the pressure on numbers; for example, Glasgow Royal Asylum, Lanark District Asylum and Aberdeen Royal Asylum boarded-out only a very small number of patients at any one time.

so many patients has been, not to reduce the population, but to check its increase."[33] In the majority of asylums only between 3% and 4% of patients were discharged as unrecovered annually, and were either boarded-out in private dwellings, or returned to their family and friends. Little more than, on average, 2% of the asylum population were boarded-out each year. Other patients were simply removed from the poor roll (Table 12.1).

Asylum	Daily Population	Unrecovered and removed from poor roll (%)	Boarded-out (%)	Total (%)
Edinburgh	527	6.1	4	10.1
Gartloch	450	3	5.6	8.5
Woodilee	707	4.3	3	7.3
Perth	336	2.4	1.8	4.2
Fife and Kinross	479	2.8	1.2	4
Inverness	522	1.5	2.4	4
Ayr	448	2.9	1	3.9
Govan	403	2.5	1.2	3.7
Roxburgh	267	2.4	1.3	3.7
Dumfries	448	2.8	.9	3.7
Dundee	335	2.2	1.1	3.3
Stirling	576	2.2	1.1	3.3
Midlothian	241	1.8	1.1	2.9
Montrose	521	1.4	0.8	2.2
Argyll and Bute	414	1.3	1	2.2
Aberdeen	528	1.3	.5	1.8
Lanark	581	1.4	.2	1.6
Haddington	136	1.2	.4	1.6
Total	9013	2.6	1.7	4

Table 12.1 Average discharge rate of unrecovered pauper insane for 18 asylums, 1892-1902[34]

Boarding-out was, therefore, unable to solve the enduring problem of overcrowding, but it was successful enough for the Commissioners to make repeated recommendations for its adoption for that reason alone. Building extensions and increasing bed space were measures of temporary utility, whereas the removal of chronic patients was the only action which could permanently affect the situation. Other motivations were constant, as indicated below, but it is suggested here that the most over-riding impetus behind an enthusiastic

[33] MS AR (1902) Inverness District Asylum, p13.
[34] Source of data: GBCLS 45th AR (1903).

endorsement of boarding-out by medical superintendents lay in the recognition of its ability to control, to some degree, the growth within an asylum.

12.3.2 Humanitarian ideals

One consistent argument in favour of boarding-out was that certain patients were happier and more suitably cared for in a domestic setting.[35] However, the primary concern of superintendents was for the welfare of their asylum and for the patients within it. The impact of boarding-out upon patients was rarely mentioned, in contrast to repeated comments on this by the Commissioners. With the notable exceptions of Murray Royal and Stirling District Asylums, there was little discussion in annual reports of any consideration by superintendents of a patient's right to live with as much freedom as was compatible with their mental condition.[36] The report from Gartloch Asylum in 1908, is typical of many others when Parker, the superintendent, noted that boarding-out served the "good purpose of keeping down the growth of the asylum population, and...saves the expense of building,"[37] but made no mention of potential benefits for patients. Almost as an afterthought, some superintendents observed that care outside the constraints of an asylum was only "right and proper" for those who had ceased to need institutional provision, but such a statement was seldom to be found as sole justification for the policy. Rather, it was often claimed that the removal of chronic cases was beneficial both for the patients and for the asylum. This indicates that, to medical superintendents at least, this was not an overwhelming concern. The removal of incurable cases was certainly beneficial for the institution; that it could also be justified on humanitarian grounds was an added bonus.

12.3.3 Pressure from the Commissioners in Lunacy

Asylum superintendents were under pressure from the Board of Lunacy to board-out every suitable case. Most Scottish asylums were visited bi-annually by Lunacy Commissioners, who made lengthy reports of what they saw. Where an asylum was active in pursing the policy, the Commissioners were unrestrained in their praise.[38] Despite certain tensions,

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[35] *Vide supra* Chapter 8 for detailed discussion on the humanitarian aspect of boarding-out.

[36] Almost every year, the medical superintendent at Stirling praised the effect of boarding-out on patients who were seen to be "doing well", while Lindsay, at the Murray Royal, listed the advantages of suitable occupation, exercise, homely surroundings, the "society of kind relatives and friends" and a feeling of freedom. MS AR (1861) Murray Royal Asylum, p21.

[37] MS AR (1908) Glasgow District Asylum, Gartloch, p8.

[38] The Commissioners singled out Edinburgh Royal and Glasgow District Asylums as particularly active, praising the steady exodus of unrecovered patients who no longer required the costly appliances of an asylum.

relations were good between the Commissioners and superintendents, particularly those from the royal asylums.[39] However, before 1857, asylums had been largely autonomous. Therefore, an element of resentment at the Board's interference would not be surprising. Andrews illustrates this by noting that Fraser, when superintendent at Fife and Kinross District Asylum was admonished for the tone of his correspondence with inspectors of poor, and points out that he "could little have relished the Lunacy Board's wrist slapping activities.[40]

Notwithstanding a degree of friction, superintendents were generally co-operative in implementing the suggestions of the Commissioners. Scottish alienists were part of a small, select peer group, and many relationships were closely interlinked, with medical superintendents having trained under Commissioners who had formerly been superintendents in the same asylums.[41] Annual reports of asylums regularly included the comments of Commissioners, whose remarks on the general state of the asylum were often quoted with pride. Their satisfaction when their institution was reviewed well is clear. As boarding-out developed and medical superintendents became more convinced of its value, many sought advice from the Commissioners. Among them, Macpherson, when superintendent of Stirling District Asylum, met Lawson who

> "was so kind as to take me on two occasions to visit some of his boarded-out patients. I valued the privilege and the opportunity very much and was able to form a fresh and extremely favourable opinion of the system from the little I saw of it. You...should encourage Scottish superintendents to investigate the boarding-out system somewhat more extensively, for if many of them know as little about it as I did a very slight personal experience of it might open their eyes to its undoubted benefits."[42]

It seems likely that some medical superintendents succumbed to pressure from the Commissioners to implement the system out of a wish for a tranquil relationship with them, especially their former mentors, and to comply with their declared preferences. An asylum official who was reluctant to remove suitable patients met with censure from the powerful body of men who fostered the system of boarding-out with more pride than any other aspect of their administration. The Commissioners' reports often drew attention to

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[39] Andrews, J. (in preparation) *op.cit.*
[40] *Ibid.*
[41] For example, Sibbald, having been trained by Skae, was medical superintendent of Argyll and Bute District Asylum from 1862-1870, then Commissioner in Lunacy, and Fraser, from Fife and Kinross, followed the same route. Both went on to become among the most enthusiastic proponents of boarding-out. See Appendix 12 which contains biographies of leading Commissioners and medical superintendents, and clarifies the interconnection between the two groups.
[42] GBCLS 36th AR (1894), p95.

the "exceedingly small percentage of pauper patients...boarded-out in private dwellings"[43] and condemned the large numbers left to accumulate in asylums for many years. At Lanark District Asylum, for example, "the supineness of asylum and parochial authorities" was regretted.[44] The overall impact of the Commissioners in motivating superintendents was, nevertheless, limited, and those asylums with superintendents who were never firm advocates of boarding-out, did not adopt it solely because of recommendations by the Board of Lunacy.[45] This highlights the freedom of choice retained by superintendents and the consequent variation among asylums in the extent to which boarding-out was employed. However, combined with the recognition of advantages to be gained in removing incurable patients, the consistent pressure employed by the Commissioners ensured that the majority of asylums in Scotland at least attempted to board-out patients. The outcome depended on a wide range of external factors.

12.3.4 Improved recovery rates

Much attention was focused on statistics of admissions, discharges, recoveries and deaths in annual reports of asylums, with many superintendents comparing recovery rates across asylums. Many proponents of boarding-out suggested that the removal of incurable patients increased the likelihood of impressive recovery rates. In turn, this would be an important incentive for superintendents to adopt the policy. However, a number of superintendents argued that an active boarding-out policy actually lowered the recovery rate. It was inevitable that, after a trial period in private dwellings, some patients would prove unsuitable, and so have to be re-admitted, thereby diminishing the recovery rate. For example, while assessing the cure rates at Edinburgh Royal, Clouston reported that of 53 cases boarded-out or sent to poorhouses in 1888, 22 had to be re-admitted after a trial period, but, as he maintained,

> "it is a necessity of any properly worked boarding-out system that patients can be readily re-admitted to the asylum, and again tried out when their mental condition admits of it."[46]

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[43] CR (1903) Lanark District Asylum, p37.

[44] CR (1904) Lanark District Asylum. The Commissioners stated firmly when they considered that asylums should increase their activity in boarding-out. At Midlothian and Peebles District Asylum, in 1904, for example, Fraser emphasised that the asylum would "either have to stop having private patients or the ordinary method in Scottish asylums of preventing accumulation by removing quiet harmless patients to private care must be adopted." CR (1905) Midlothian and Peebles.

[45] Illustrating this, despite consistent recommendations from the Commissioners to implement the system, the proportion discharged to private dwellings from Gartnavel Royal, and Montrose Royal, remained low throughout the century.

[46] MS AR (1889) Edinburgh Royal Asylum, p25.

There is no indication that enthusiastic superintendents were deterred by potential relapses from suggesting suitable cases for discharge. Thus, Keay, of Inverness District Asylum, declared that, "no opportunity is lost sight of to give a patient a trial of living outside when a suitable guardian can be procured."[47] Their removal from the asylum, even if only temporary, reduced expenses for ratepayers at the same time as creating space for potentially curable cases. The majority of boarded-out cases were, in fact, able to remain in private dwellings for the rest of their lives.

Apart from the zealous recording of annual statistics, and noting the occasional re-admission of boarded-out patients, the reports of medical superintendents do not indicate any marked preoccupation with cure rates. Many reports made no connection between an active boarding-out policy and its potentially adverse effect on recovery rates and there is no evidence that incurable cases were boarded-out with the specific intention of enhancing cure rates. The motivations outlined above were far more alluring and effective in stimulating superintendents to encourage an active policy of boarding-out.

12.4 Changing perception of the role of asylum

Following the extensive growth of asylums across Scotland, alterations in their structure and ethos of care became perceptible, reflecting current trends in lunacy provision.[48] There was growing concern about the reputation of asylums and a determination that they should be viewed as curative institutions.[49] The writings of Home, a celebrated patient at Edinburgh Royal Asylum, exemplified much of the prevailing criticism of institutional life. In his experience, asylum attendants were:

> "a class of uneducated, coarse-bred cads about the rank of table helpers, bullying, tyrannising over and openly insulting the poor creatures committed to their charge who are in bodily terror of them." [50]

He deplored the routines of asylum life and the regimented adherence to rules and his dissatisfaction at the lack of classification is clearly apparent in his complaints at mixing

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[47] MS AR (1906) Inverness District Asylum, p12.
[48] For example, Clouston's plan for a hospital home begins with an enlightening description of some of the predominant changes occurring in the field of asylum provision. See Clouston, T.S. (1879) An asylum or hospital-home for 200 patients. Boston, Rand Abery & Co. pp3-4.
[49] *Vide supra* Chapter 8.
[50] Beveridge, A. (1993) John Home: If you want to demoralise a man in every way, put him in a madhouse. *Proceedings of the first European Congress on the history of psychiatry and mental health care* (eds. L.de Goei and J.Vijselaar), pp90-95. Rotterdam: Erasmus Publishing.

with a "herd of common lunatics."[51] Overcrowding had done much to damage the morale of those involved in asylum care and many alienists echoed Maudsley's concern regarding the custodial nature of the asylum. He argued that rather than hospitals for the insane, asylums had become "vast receptacles for the concealment and safekeeping of lunacy".[52] The desire to respond to such criticisms and to raise the status of the asylum contributed to a growing acceptance of boarding-out.

According to Finnane, the gradual progress towards asylums achieving legitimacy as the century progressed, was aided by the development of hospital features and an elaboration of nursing structures, which in turn elevated the status of asylum physicians.[53] In Scotland, movements towards improving conditions in asylums developed apace from the late 1860s.[54] Mechanical restraint and seclusion had largely fallen into disuse and the benefits of increased liberty acknowledged. The radical changes brought about by the open-door policy and the abolition of airing courts coincided with an increase in the removal of incurable patients to poorhouse lunatic wards and private dwellings. The movements were interlinked, the stimulus for change in the asylums coming from the growing therapeutic optimism of officials, encouraged by the removal of large numbers of incurable cases. The developing medical environment of the asylum encouraged superintendents to board-out as many cases as were suitable, to allow further advances to take place. It was suggested both at the time, and subsequently, that the movement towards developing hospital features in asylums was one of the most important departures made in Scottish lunacy administration in the nineteenth century.[55] Commissioners and medical superintendents noted with enthusiasm the extent to which these changes had altered the character of institutions; asylums had, they maintained, become less places of detention for dangerous persons and more hospitals for the curative treatment of disease.

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[51] *Ibid.*

[52] Maudsley, H.(1867) *op.cit.*, p501.

[53] Finnane, M. (1985) Asylum, family and the state. *History Workshop Journal*, 20, p143 and *vide supra* Chapter 8 for detailed discussion of these developments.

[54] The abolition of airing courts and the introduction of an open-door policy were the most innovative changes at this time. *Vide supra* Chapter 1 for an assessment of changing trends in provision for the insane.

[55] Walmsley has attributed much of the survival of the asylums to their adaptation of the movement. Walmsley, T. (1991) *op.cit.* For a full discussion of this, one of the most informative articles is Robertson, G.M. (1922) *op.cit.*, 321-332. Also useful is Macpherson, J. (1896) The hospital treatment of the insane in asylums. *Journal of Mental Science*, 42, 778-787.

At Gartnavel Royal Asylum, Yellowlees, although never specifically advocating a formal policy of boarding-out, was among the most vocal proponents of hospital features in the asylum. To facilitate this, he announced that:

> "when the restrictions of asylum life can be wisely and safely dispensed with...patients should be restored to their friends. The institution is a hospital for the treatment of disease, and ought never to become merely, or mainly, a home for the silly and eccentric. A true asylum physician can never degenerate into something like a benevolent hotel keeper."[56]

His successor, Oswald, shared his conviction, maintaining that the objectives of an asylum were "to provide scientific treatment and care, and to promote the study of the causes of mental disorder with a view to cure and ultimate prevention."[57] Forty years later, Robertson, a forceful enthusiast of the hospitalisation movement, suggested that the atmosphere of the asylum had changed, to become "more human, more sympathetic and more medical. Its influence is all pervading and dominant."[58] In conjunction with the hospitalisation movement, further developments in theory and practice became apparent. In 1879, Clouston was appointed to the first lectureship in mental diseases at Edinburgh University. Yellowlees, one year later, became the first lecturer in mental diseases at the University of Glasgow. From 1896, observation wards and pathological laboratories were introduced. These developments in the role of the asylum undoubtedly had an impact on the criteria for asylum admission. In this context, the outlet offered by boarding-out was recognised and employed gratefully by most superintendents, aware that the capacity to admit new cases was dependent, to some considerable extent, on the removal of chronic patients. Their removal enhanced the potential for further advances in asylum provision, which, in turn, enabled the status of the asylum to rise from "a convenient place for inconvenient people"[59] to a hospital where the main objective was to effect recoveries.[60] The aim expressed by Clouston in 1885 was echoed increasingly widely in asylum reports throughout Scotland:

> "We must try and attain as close a combination of the *hospital* idea for cure and the *home* idea for comfort as possible. Our primary object is to cure disease, nothing else will avail if we do not provide the best means of doing this. If we are not a medical institution we are nothing."[61]

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[56] MS AR (1887) Gartnavel Royal Asylum, p10.
[57] MS AR (1912) Gartnavel Royal Asylum, p17.
[58] Robertson, G.M. (1922) *op.cit.*, p333. However, he contended that the asylums would only become "special hospitals in the true sense of the term" when there were greater numbers of medical officers, who had received a special training in psychiatry, and "when the laws cease to place a prison-stigma on asylums and their inmates."
[59] Scull, A. (1980) *op. cit.*, pp37-57. Also discussed at length in Scull, A. (1993) *op. cit.*
[60] Although it was towards the end of the century that sustained attention was given to this particular reason for adopting boarding-out, as early as 1857, Lindsay at Murray Royal Asylum was advocating principles that were to become enduring aims. He encouraged the adoption of home treatment for harmless and industrious patients, observing, "the greater relief from such cases, the greater space was at our disposal, and the greater our ability to admit fresh and urgent cases. The institution thus becomes more extensively useful". MS AR (1857) Murray Royal Asylum.
[61] MS AR (1885) Edinburgh Royal Asylum, p23. Statements such as these can be found in annual reports of most Scottish asylums, spread over a period of many years, but with greater frequency and urgency, from the 1880s.

12.5 Location of the asylum

There is no indication that the location of an asylum had any bearing on the degree of endorsement of the system by its superintendent or on the extent of boarding-out from the asylum.[62] Although the district asylums of Glasgow and the royal asylum in Edinburgh, which were located in highly industrialised, urban areas, had active boarding-out policies, the asylums of Dundee, Aberdeen, Montrose, Lanark and Glasgow Royal, had consistently low numbers of patients discharged to private dwellings. In areas where asylum provision was deficient, many patients remained outside institutional care, for example, in the Highlands and Islands. Correlation between the location of an asylum, and the extent of boarding-out can only be tentative, since many other more complex factors were involved. The influence of local conditions will be assessed briefly, drawing on the experience of the Argyll and Bute District Asylum as an illustration.[63]

The difficulties encountered in implementing a system of boarding-out from Argyll and Bute Asylum (the Commissioners "pet asylum"[64]) were frequently attributed to obstruction created by the location of the district.[65] Despite Sibbald's enthusiasm, the experience in Argyllshire had not been "altogether satisfactory."[66] Although he recommended that patients should be placed with families living near the asylum, to facilitate their supervision, local circumstances prevented the successful development of the policy. Particular emphasis was placed on the problems of access to and from the asylum experienced by a widely dispersed population. The expense of removing patients to distant homes, and then, if the experiment proved unsuccessful, returning them to the asylum was often considerable. Faced with difficulties in persuading persons "above the average in intelligence and civilisation" to receive patients, Sibbald conceded reluctantly that the only practical solution for providing for the continually increasing requirements of the county was by adding to the asylum building.[67] Forty years later, the location of Argyll and Bute

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[62] There is a closer correlation between location and the extent of boarding-out in regard to the activity of parish officials. Urban parishes often had a high number of patients boarded-out from asylums to distant country districts. However, this was independent of the policy of individual asylum superintendents. *Vide supra* Chapter 5 which explored the particular utilisation of special licensed houses for patients discharged from asylums in Edinburgh and Glasgow.

[63] Chapter 9 has examined the regional variation in boarding-out in greater detail.

[64] In Anon. (1875) Notes and News. *Journal of Mental Science*, **21**, p303. The reviewer went on to claim that "all the favourite ideas of the Scotch Board have been carried out there".

[65] Annual reports of MS and CR. Argyll and Bute District Asylum, *passim*, particularly in the late 1860s and throughout the 1870s.

[66] MS AR (1868) Argyll and Bute District Asylum, p8.

[67] *Ibid.*

Asylum was still the focus for explanation as to why so few patients were boarded-out. From 1892-1901, the average annual proportion of pauper patients discharged unrecovered from the asylum was only 2.2%, almost half the national average of 4.3%.[68] Although the Commissioners praised the consistent efforts of superintendents who, in their view, were "influenced by broad and liberal views in the discharge of patients",[69] lack of cooperation on the part of parish officials and continued difficulty in finding suitable guardians near the asylum, consigned most attempts to failure.[70] Notwithstanding firm endorsement of the system by successive medical officials, the difficulties occasioned by what the Commissioners and medical superintendents attributed to the location of the asylum, prevented the successful implementation of their aims.

12.6 Relations with parish officials

The degree of enthusiasm or obstruction displayed by parish officials in boarding-out patients was of utmost significance to asylum physicians. Inspectors of poor had the legal power to remove unrecovered patients, while the medical superintendent had authority only to discharge recovered cases. Even physicians who were firm advocates of the system were constrained, being able to do little more than recommend patients for removal. There were frequent complaints against the apathy of parochial officials and, where they were obstructive or indifferent, this was generally reflected in the rates of discharge from the asylum.[71] In contrast, asylums which had active boarding-out policies, such as Woodilee and Edinburgh Royal, experienced the wholehearted cooperation of local parish officials.

Medical superintendents and Commissioners alike noted with frustration the apathy of certain parish officials. As early as 1861, Lindsay had endeavoured to indicate to inspectors of poor the advantages of such transfers. Only in a few parishes, where assurance had been given of ready re-admission in case of relapse, and where the asylum had supervised the procedure, was the experiment made, prompting Lindsay to remark with regret that:

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[68] CR (1904) Argyll and Bute District Asylum, p39.
[69] GBCLS 37th AR (1905), p57 The proportion per 100,000 of the population of pauper patients in the asylum was 415, the highest of any Lunacy District in Scotland. Stirling, by contrast had 183.
[70] For example, in 1904, Fraser remarked on the "physical difficulties caused by distance and inadequate means of transit which have a deterring influence in preventing trial being made as regards home care of improved or unrecovered patients." CR (1904) Argyll and Bute District Asylum, p39.
[71] This was apparent at Lanark District Asylum, where the low rate of boarding-out was invariably attributed to the lack of enthusiasm of parish officials. For example, CR (1907) Lanark District Asylum, p37.

> "Inspectors at a distance, with whom we have had opportunity of communicating only by letter, have shown little, if any, disposition to bestir themselves in the matter: nor do we believe they will until compelled".[72]

Superintendents continued to report indifference among parish officials even at the turn of the century.[73] When confronted with asylums with low rates of boarding-out, the Commissioners appeared more willing to accept the explanations of superintendents, than those of parish officials. Many asylum reports contained complaints that rural inspectors of poor perpetuated a misuse of asylums, being too ready to resort to them for any form of mental unsoundness, and regarding them as:

> "not only as the place for the treatment of the insane but also as a hospital for the treatment of any form of nervous disease with which mental enfeeblement may be associated, or as a home for aged persons whose faculties are failing."[74]

In view of this, the Commissioners declared that, at times, many superintendents were anxious to extend boarding-out, but could not get the parish officials to take an interest.[75]

However, superintendents sometimes defended parish officials, reporting that they experienced no difficulty in working with them and that indeed, many welcomed being advised as to the suitability of cases to be boarded-out. Howden, for example, reported that he experienced no difficulty in working with inspectors of poor and had found them receptive to advice.[76] Where re-admission rates from private dwellings were low, superintendents praised the judicious selection of guardians by inspectors of poor and expressed their gratitude at the assistance provided towards maintaining steady numbers in the asylum.[77] Thus in 1905, on the death of Ferrier, inspector of poor in Edinburgh, Clouston's praise was unstinting, when he declared that to him, "the parish council owes its successful boarding-out system of the quiet and manageable insane."[78]

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[72] MS AR (1861) Murray Royal Asylum, p21.

[73] Among many critical remarks, see CR (1903) Argyll and Bute District Asylum, p38 and CR (1905) Lanark District Asylum, where efforts to induce inspectors of poor to board-out had proved unsuccessful, and "despite the enthusiasm of the medical superintendent" there was no positive response by the majority of parish officials to the request of the District Board that unrecovered patients were removed to private dwellings.

[74] GBCLS 24th AR (1882), p140.

[75] Sutherland concluded that it was this indifference which resulted in many large parishes having only 5% of their patients boarded-out, while other large parishes, such as Edinburgh, Inverness, Old Kilpatrick, Rathven and Forfar had boarded-out 30-50% of their patients. GBCLS 48th AR (1906), p161.

[76] Anon. (1888) Notes and News. *Journal of Mental Science*, 34, p645.

[77] Thus while visiting Woodilee Asylum, in 1909, Fraser observed that by the active co-operation of the parish officials, 23 chronic and harmless patients had been provided for in rural districts. GBCLS 34th AR (1892), p92.

[78] MS AR(1905) Edinburgh Royal Asylum, p19.

The powers of the superintendent were, nevertheless, guarded jealously. They insisted that they should be the sole judges of selection and that it was inadvisable to grant this responsibility to laymen. Some of the failures of boarding-out were alleged to be due to faulty selection of patients by parochial officials without the advice of a medical authority.[79] For the system to work well, close collaboration between parochial officials, and medical superintendents was necessary. Although not stated overtly, annual reports of superintendents indicate that many had tense relationships with parish officials who were inferior in class and expertise.[80] However, they were obliged to forge good relationships with parish officials, since in regard to boarding-out, asylum staff were impotent without active cooperation from the parish. Where this was manifest, the number of patients boarded-out was high, indicating the importance of the relationship between the two bodies in determining the effectiveness of boarding-out from the asylum.

12.7 Difficulties incurred by asylums which boarded-out.

12.7.1 Concentration of disturbed patients

Concern was expressed by certain physicians about possible adverse effects of an active boarding-out policy on the asylum. Parker, medical superintendent at Gartloch Asylum, reflected the views of many superintendents when he declared: "I believe in boarding-out, but the disadvantages are apt to be lost sight of in the more obvious advantages."[81] One anxiety voiced frequently concerned the concentration of noisy and dangerous patients following the removal of patients to private dwellings. Such patients were generally the most useful inmates and:

> "if each year they are weeded out, the district asylum would become the receptacle of either the most excited, or the most utterly degraded class of lunatic."[82]

The fear was that this close grouping of noisy, troublesome patients would generate the need for more care and attention.[83]

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[79] *Vide infra* 13.6.

[80] While there are no explicit attacks on the social class or education of parish officials, the regular criticisms and veiled remarks in several annual reports give credence to this assertion. See for example, Edinburgh Royal Asylum (1866), Inverness District Asylum (1875, 1904) Argyll and Bute District Asylum (1903) and Midlothian and Peebles District Asylum (1905).

[81] MS AR (1904) Glasgow District Asylum, Gartloch, p10.

[82] MS AR (1867) Fife and Kinross District Asylum, p14.

[83] Similar concern was expressed at Dundee Royal Asylum, where rather than board-out, patients were removed to lunatic wards of poorhouses. The concentration of violent, noisy cases "produced for a time so thorough a change...as to give rise to much, and well-founded anxiety." MS AR (1866) Dundee Royal Asylum, p17.

Although active in discharging patients to private dwellings, the most frequent and heated concerns about the consequences of the system were expressed at Gartloch Asylum, particularly in the 1900s. Parker acknowledged many advantages to boarding-out, but continued to question:

> "how much more friction there is when a large number of irritable and excitable people are living together at close quarters, than they would have been had the natural growth of asylum wards gone on and no boarding-out resorted to".[84]

He contended that without boarding-out, irritable, easily excited cases would be distributed over a larger number of wards, with more quiet, apathetic and demented patients around them as "padding". In turn, this would produce fewer quarrels and less noise and excitement. Each successive annual report at Gartloch Asylum devoted much attention to this dilemma, but while other medical superintendents shared these concerns and feared for the degradation of the asylum, apart from noting the problem, few considered it at length.

12.7.2 Loss of unpaid assistance in the asylum

Another disadvantage highlighted in annual reports, notably from the 1890s, was the loss of useful help around the asylum. The Commissioners were aware of some reluctance among superintendents to part with "what appeared excellent material":

> "there is a natural reluctance...to part with good workers and opposition to their removal is sometimes regarded as justifiable on the ground that if they were discharged it would be necessary to substitute paid labour."[85]

Although this attitude was understandable, it was "far from satisfactory or conclusive".[86] Staff at Gartloch, Edinburgh Royal, Stirling, and Inverness District Asylums all recorded their regret at this loss of labour, with many of their best workers having been discharged to private dwellings. As Keay noted, when resident in the asylum, such patients "made themselves useful about the place, required little or no looking after and were cheaply maintained".[87] Those remaining were anxious, troublesome patients (or recent admissions) who required more care and attention, were not useful and, therefore, cost more to keep. Despite the strength of these claims, an exploitative element is perceptible. The work undertaken was usually for the benefit of the asylum, to enable running costs to be reduced and, in contrast to boarded-out patients who worked on farms, payment was rarely made.

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[84] MS AR (1904) Glasgow District Asylum, Gartloch, p10.
[85] As a result, individual parishes could, through their own remissness, be placed at a disadvantage by the detention of useful unrecovered patients, "in order that the institution may be run as economically as possible." MS AR (1907) Midlothian and Peebles District Asylum, p32.
[86] *Ibid.*
[87] MS AR (1902) Inverness District Asylum, p13.

There is no evidence of any misgivings about the employment of patients, just as there was none apparent in English asylums, notably Wakefield, where the invaluable assistance of patients was enlisted and designated as therapy.[88] However, although several physicians referred, quite openly, to the loss of patient labour, it was accepted that this was outweighed by the advantages of boarding-out.

12.7.3 Higher expenditure for the asylum

Financial advantage to the ratepayer was an accepted incentive for boarding-out, but when this threatened to raise asylum costs, enthusiasm among its officials was, understandably muted. While the Board of Lunacy strenuously advocated the removal of suitable cases, it was recognised that if this increased the rate of board paid for asylum patients, the economic justification would become invalid. This suggests that boarding-out was endorsed by asylum superintendents, until it appeared possible that the asylum could suffer. The loyalty of superintendents lay firmly with their asylum, and if its reputation was threatened, anxiety about a policy which detracted from smooth administration was apparent. There was, therefore, a perceptible reluctance to continue boarding-out in large numbers in Aberdeen, where, in 1904 the opening of the new district asylum had taken numerous patients from the Royal Asylum.[89] It was accepted that where there were vacant beds, the creation of more vacancies by continuing to board-out increased the maintenance costs, as no reduction in staff was possible.

Parker recorded a steady rise in numbers discharged to private dwellings from Gartloch Asylum. In 1908, for example, 34 patients were boarded-out, equivalent to the population of a ward for chronic cases. The savings achieved from this were considerable. However, it was not a straightforward cost-effective measure, because, as Parker observed, as long as there were empty beds, or if the asylum population was stationary,

> "boarding-out increases the cost of the care of the patient by taking a cheaply kept, or possibly profitably kept, patient away and paying 7/- per week for him outside, while the profit on his work is lost, and the difference between the cost of his maintenance and the average cost of patients' maintenance is added to the cost of the remaining patients." [90]

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[88] For example, Annual reports of the Directors of Wakefield Asylum, *passim*. Discussed in Sturdy, H. (1992) *Quality of care in early-nineteenth century lunatic asylums: 1810-1835. A retrospective audit*. Unpublished BA dissertation. Durham University. The encouragement of employment as a central feature of moral management in asylums and the belief in its therapeutic benefit is also discussed in Scull, A. (1993) *op. cit.*, pp 89, 102 and 288.

[89] MS AR (1906) Aberdeen Royal Asylum, p26.

[90] MS AR (1906) Glasgow District Asylum, Gartloch, p8.

He concluded that if a patient who was able to work on the farm was boarded-out, the parish would pay 7s per week for him, whereas his board and care in the asylum cost 2s.[91] It was further argued that a concentration of disturbed cases created the need for a larger staff. At Edinburgh Royal Asylum, Clouston observed that as a result of boarding-out, the feeble and paralysed cases were greater in number in proportion to the whole: "in consequence, our staff has had to be strengthened, and the amount of extra diet increased."[92] Other asylum physicians reported similar experiences, among them, the superintendents of Stirling, Gartloch and Woodilee Asylums, all of which had an active policy of boarding-out.

There was considerable unease, therefore, over the financial consequences of the system for asylums. It was argued that boarding-out, by reducing the numbers in the asylum, had the effect of raising the cost per head, as the expenses of administration and treatment were divided over a smaller number. Building accounts increased to provide staff accommodation, although to balance this larger maintenance outlay there were some savings in the capital expenditure on buildings. There was no dispute over the overall economy of boarding-out, it was accepted that patients could be maintained in private dwellings at a lower cost than if in an asylum. The fear, so far as it existed, lay in the consequent increased costs of asylum administration.

12.7.4 Risk of blame to medical superintendents

Although less prominent than other concerns, there is evidence of some restraint among superintendents in their recommendation of cases for boarding-out, because of the risk of being blamed if patients proved unsuitable. This is well illustrated by Lindsay, superintendent of the Murray Royal Asylum, who observed that asylum physicians were aware that regardless of how well patients behaved in an asylum, and how suitable they appeared to be for boarding-out, the change from the routine and discipline of asylum life could be followed by unexpected effects. This was not easily preventable, but it was the asylum official who was "subject to public reprehension, yet he has no control, and is generally ignorant of the circumstances in which a non-recoverable patient be placed."[93] It

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[91] *Ibid.*
[92] MS AR (1890) Edinburgh Royal Asylum, p13.
[93] MS AR (1861) Murray Royal Asylum, p13.

was natural therefore that asylum officials should be "chary in assuming responsibility" for recommending patients for boarding-out. While he accepted that superintendents had to incur a certain amount of responsibility, Lindsay argued that this should be shared by parochial officials and Lunacy Commissioners.

An integral aspect of boarding-out was the provision for re-admission of individuals who had seemed quiet and controllable in the asylum, but proved unable to cope outside. After removal to a private dwelling the authority of the medical superintendent over a patient ceased. Superintendents were not kept informed of the patients' progress and often knew nothing until a patient returned, following relapse. Maclaren, superintendent of Stirling District Asylum, observing the frequency with which guardians returned patients to the asylum, recorded that:

> "too often we are disappointed to find one who, though unrecovered, had for long required almost no attention or supervision, sent back from a private dwelling as unmanageable and dangerous, prove on re-admission perfectly quiet, but less cleanly or less industrious than he was prior to his release". [94]

In Maclaren's view, it was clear that no amount of care on the part of superintendents in the selection of cases could prevent such mistakes and that, therefore, re-admission was often inevitable. Although risk of blame was not a strong deterrent to the implementation of boarding-out, it was, nevertheless, another contributory factor leading to a certain caution of the effects of the system.

12.8 Probation as a preliminary to boarding-out

A widely adopted form of probationary discharge from asylums was that preceding final release into the community, thereby enabling assessment of the degree of recovery.[95] Many asylums which boarded-out incurable cases also resorted to the related system of discharge on probation, as a means of testing the fitness of patients for care in private dwellings. This form of probation is considered here.

As early as 1865, the Commissioners commented on the success of discharging patients, while retaining their names on the asylum register, thereby facilitating an uncomplicated

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[94] MS AR (1887) Stirling District Asylum, p35.

[95] Mitchell reported on many patients discharged successfully from the asylum, after a period of probation. Thus one "whose discharge I had thought a very doubtful step, began to work...and when I last saw him, some years after his discharge, I found him so much improved as to make it difficult to detect even a trace of his old malady...He informed me that he was married and expected a child". GBCLS 11th AR (1869), p295.

return to the asylum if necessary. Between 1862 and 1869, there were 636 probationary discharges, of whom 91 were returned to asylums before the expiry of the period.[96] From the 1880s, this form of discharge was resorted to increasingly, with patients allowed out "on pass" for four weeks. This could be authorised by a superintendent, without incurring the expense of a medical certificate or a sheriff's order. Parishes were then relieved of the expense of maintenance in the asylum. As Johnstone, medical superintendent of Roxburgh District Asylum (where 40% of inmates were, at some stage, given trial in their homes) observed, removal on probation provided:

> "an admirable means of securing for poor and friendless persons that after-care and assistance of which they often stand so sorely in need, on returning to the outside world."[97]

It was at the Inverness District Asylum that the system of probation before boarding-out was employed most frequently and with the greatest success.[98] Every patient was sent out on a year's probation, with a view to testing their fitness for domestic care before final discharge. It was expected that certain cases would prove unsuitable, but in the majority of trials, this method of discharge proved successful and was praised by the Commissioners as "an admirable feature in the administration of this asylum."[99] Between 1900 and 1904, 160 patients were discharged unrecovered, of whom 140 were on probation, a much higher number than liberated from any other Scottish asylum in the same way. Only 22 were re-admitted within the probationary period.[100] Nevertheless, it was recognised that such active discharge of unrecovered patients could only be temporary. The available population of suitable cases decreased every year; the potential risk being taken only for those patients who had been resident in the asylum for some time.

A more limited system of discharge on probation was in operation at Woodilee Asylum, where patients were tested for suitability for domestic care, while remaining within the confines of the asylum. Patients who were doubtful subjects for boarding-out were given a trial by living in asylum farms and homes before being sent from the asylum. The benefits of this experiment were praised widely:

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[96] GBCLS AR 4th-12th AR (1862-1870), *passim*.
[97] MS AR (1904) Roxburgh District Asylum, p28.
[98] See for example, the commendation of the Commissioners in their reports for Inverness District Asylum (1903), pp32-33, and (1906) p12, where it was noted that "no opportunity is lost sight of to give a patient a trial of living outside", and (1908), p12.
[99] CR (1906) Inverness District Asylum, p22.
[100] MS AR (1904) Inverness District Asylum, p10.

> "the homes, as it were, form a stepping stage between the asylum and boarding-out with the result that many cases now boarded-out from this asylum have done remarkably well."[101]

It is evident that the employment of some form of probation complemented and, in many cases, facilitated, the successful adoption of discharge to private dwellings from asylums. Medical superintendents who had doubts about the safety and applicability of the boarding-out system found a compromise solution in the use of discharge on probation.

12.9 Profile of three asylums

This section focuses on the variation of activity in boarding-out from three institutions. The first, Midlothian and Peebles District Asylum had only a very small number of patients boarded-out annually. The Fife and Kinross District Asylum exemplifies asylums which were anxious to board-out, yet were, for various reasons, comparatively inactive. Finally, the experience of Woodilee Asylum illustrates widespread acceptance and enthusiasm for the system. There were no unifying factors among these asylums which could explain their inclinations and, although the institutions selected are all district asylums, Gartnavel Royal or Montrose Royal Asylums would have been equally effective examples of asylums with limited activity in boarding-out. Similarly, Edinburgh Royal Asylum could have been selected to illustrate an enthusiastic employment of the system. Throughout this chapter, these asylums have been referred to frequently and therefore are not discussed here.

12.9.1 Midlothian and Peebles District Asylum

Although the asylum opened in 1874, it was not until the early-twentieth century that annual reports referred to the policy of boarding-out, and the discharge figures suggested that very few patients were discharged in this way, although the district of Midlothian had a high number of patients residing in private dwellings.[102] The problem of overcrowding was often mentioned, but few solutions were offered. Mitchell, the medical superintendent, included an excerpt from a Parliamentary Blue Book at the end of his annual report of 1903, which referred to the limited employment of boarding-out in several asylums, including his own.[103] In this, it was noted that the asylums of Midlothian, Montrose, Lanark, Argyll and Haddington were the least active in boarding-out their unrecovered

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[101] MS AR (1907) Glasgow District Asylum, Woodilee, p18.
[102] *Vide supra* Chapter 9.
[103] Recorded in MS AR (1903) Midlothian and Peebles District Asylum, p35.

patients. Although superintendents often attributed a lax policy of boarding-out to indifference among parochial officials, the government report did not consider the poor statistics to be due to any failure by the parishes. Indeed they maintained that it was:

> "difficult to see that any special reasons of real weight could be given to account for the small number of patients discharged unrecovered ...from these asylums which could not be applied with equal weight, to asylums such as Edinburgh, Riccartsbar [Paisley], Perth, Banff, Elgin and Fife, all of which show a high or fairly high proportion of patients boarded-out." [104]

The figures issued supported the assumption that many asylums had an accumulation of patients who could have been discharged without injury to themselves or others.

In the year of this report, 1903, only one patient was boarded-out from the asylum, although 15 were discharged unrecovered to the poorhouse lunatic wards or to their friends.[105] A year later, this had not increased; of 21 discharged unrecovered, only one was boarded-out under the care of a guardian. When Commissioner Fraser visited the asylum in 1904, he expressed concern at the particularly small proportion of pauper patients boarded-out. The average discharge of unrecovered patients from the asylum, per annum, was 2.9%, compared to a national average of 4.3%.[106] Unlike other asylums, Midlothian and Peebles District Asylum was therefore less able to control the growth of its population.

In the Commissioners' reports for the asylum, emphasis was continually placed on the importance of boarding-out to offset the steady population increase. Unless there was an increase in numbers boarded-out, there was a risk that the asylum would have to refuse admission to private patients. Attempts were made to comply with continued recommendations. A list of patients suitable for boarding-out was constructed and the Commissioner then visited inspectors of poor to discuss available accommodation in private dwellings. Despite this move, however, the system never achieved prominence, attributable in part to the obstacles created by the inactivity and indifference of parochial authorities. In addition, at no time did asylum superintendents wholeheartedly embrace boarding-out. On a few occasions, the medical superintendent remarked upon the limited adoption of the system, when recording the annual increase in admissions and consequent overcrowding, but beyond that, little action was taken. There are no comments in the comprehensive annual reports which provide any insight into this lack of enthusiasm for

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[104] *Ibid.*
[105] *Ibid.*, p35.
[106] MS AR (1904) Midlothian and Peebles District Asylum, p32.

the policy, although perhaps implicit in the minds of the medical superintendents was concern that any change in asylum policy would threaten its very existence. The merits so often propounded in other establishments fell, in this asylum, on an unreceptive audience.

12.9.2 Fife and Kinross District Asylum

The scale of boarding-out from the Fife and Kinross District Asylum was always limited, despite enthusiastic endorsement of the system by successive medical superintendents.[107] The district of Fife, however, had the highest proportion of boarded-out patients in Scotland, particularly in special licensed houses in the villages of Kennoway and Markinch. The majority of patients accommodated were from the City parishes of Glasgow and Edinburgh, rather than from the nearby Fife and Kinross Asylum. Alternatives to provision in the asylum were necessary and there were no poorhouse lunatic wards in the counties of Fife and Kinross. The only relief available to the asylum, therefore, was in boarding out suitable cases.

Pressure from the Commissioners to implement the system was consistent almost from the opening of the asylum in 1866. Mitchell had visited the asylum in 1867, and recommended patients for boarding-out. Tuke, the medical superintendent, accepted his advice, recognising that unless some chronic patients were removed annually, district asylums would be forced to double in size within 30 years.[108] An active boarding-out policy would not only obviate the need for the enlargement of existing asylums, but reduce the annual expenditure of lunacy districts. Tuke's successor, Fraser, made frequent references in correspondence and annual reports to the advantages of boarding-out,[109] but his continued failure to see the policy flourish appeared, at times, to have diminished his enthusiasm. This was reflected in an article in the Journal of Mental Science, in which he recorded that his efforts to board-out patients had been fruitless.[110] Similarly, in his annual report for

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[107] Fraser became a Deputy Commissioner and one of the strongest advocates of the system, J.B.Tuke, while recording many objections to the system (Tuke, J.B. (1870) *op.cit*) argued that if well supervised, and controlled it could form a valuable adjunct to asylums, and offer much needed relief and Turnbull, A.R. (1888) *op.cit.*, documented many positive features.

[108] He observed that 50% of admissions were discharged cured, 25% died, leaving a residuum of 25%; a yearly increase was thus inevitable. Tuke, J.B.(1870) *op.cit.*, p533.

[109] Thus he announced that after studying the history of the asylum, he would "endeavour to prevent any further extension of the building during my term of office. I saw before me in the boarding-out system, and in the suitability of one or two wards of the poorhouses ... ample means of keeping down the population. I consider the present size of the asylum sufficient for the district." Letter from Fraser, to District Board of Lunacy for Fife and Kinross-shires. (1874)

[110] Fraser, J. (1878) *op.cit.*

1875, he observed that although eight patients had been boarded-out that year, the "smallness of this number is to me a matter of regret." The difficulties and delays in getting patients boarded-out were seen to be so great, "that I almost despair for the future."[111] His continued zeal for the system, nevertheless, was very prominent in his reports during his long service as a Commissioner.

Notwithstanding persistent efforts by successive medical superintendents to promote the removal of suitable patients, the asylum population increased steadily. Each year a number of patients were removed, but the proportion remained small, and did little to alleviate overcrowding. Superintendents attributed the lack of any enduring success largely to the obstruction and apathy of parish officials. A further explanation was the fact that Fife and Kinross had the lowest rate of board among Scottish asylums. In 1873, it cost £26 per head, per annum, falling to £20 in 1886.[112] One effect was the increased reluctance to remove cases suitable for boarding-out. Turnbull, medical superintendent between 1881 and 1899, had often been informed, when urging the removal of such cases, that it was of no advantage financially to the parish to have them removed, and that the responsibility and trouble to parochial authorities was much increased. Thus, "by adding to the admissions and by lessening the inducement to remove chronic cases, a low rate of board tends to increase the numbers resident in the asylum."[113]

Although a number of meetings were called by asylum and parish officials in attempts to reduce overcrowding, the most feasible solutions reached were the establishment of lunacy wards in poorhouses and the enlargement of the asylum building. The ready-made option of boarding-out was frequently neglected and often dismissed entirely. The rate of boarding-out from Fife and Kinross Asylum therefore remained sporadic throughout the nineteenth century. However, the policy does appear to have been implemented with greater success in the 1900s. Between 1900 and 1902, 129 patients were boarded-out, the highest number recorded in a two year period.[114] The asylum also operated the system of putting cases "on pass" for up to 28 days, which met with some success in the 1900s. Inevitably, a few patients proved unsuitable and had to be sent back to the asylum. Thus, of

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[111] MS AR (1875) Fife and Kinross District Asylum, p13.
[112] MS AR (1886) Fife and Kinross District Asylum, p15.
[113] *Ibid.*
[114] MS AR (1902) Fife and Kinross District Asylum, p26.

532 patients in the asylum in 1902, 168 (31%) had been tried either at their own homes or in private dwellings under suitable guardians, but had to be re-admitted.[115] This is an impressive figure, indicating the genuine, if frustrated attempts of superintendents. It was recognised widely by the Commissioners and medical superintendents that obstruction by parish officials was largely responsible for the limited success of the policy. This helps to explain the paradox that, although the asylum was under the superintendence of some of the most enthusiastic proponents of boarding-out, it was among the least active in implementing the policy.

12.9.3 Woodilee District Asylum

Barony Parochial Asylum, Woodilee, which in 1898 became a district asylum of Glasgow, had one of the most active records of boarding-out. The high rates of discharge to private dwellings matched that of another Glasgow district asylum, Gartloch. In 1886, it was noted at Woodilee Asylum that an unusually large number of patients, 76, had been boarded-out. This had followed the adoption of a resolution of the District Board, inaugurating the boarding-out system which led to 45 cases being discharged to private dwellings in the first year. The Convenor of the House Committee, in listing the ensuing benefits, was able to declare that "the necessity of providing additional accommodation on the female side has been obviated."[116]

The medical superintendent, Blair, often recorded his satisfaction that the policy was implemented so actively by parish officials and praised the standard of care attained by many guardians. His enthusiasm was reflected in the discharge figures of the asylum; the statistics for the closing years of the century are impressive. In a 15 year period between 1885 and 1900, 356 patients were boarded-out. By 1900, 185 remained in private dwellings, while 103 had been returned to the asylum. Despite the latter, it was stressed that "this fact need not have any deterrent action in giving a trial to those patients who are believed to be suitable for care in private dwellings."[117]

The enduring interest in boarding-out held by the superintendents of Woodilee Asylum is evident in an examination of their annual reports. The majority of asylum reports contained

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[115] CR *Ibid.*, p47.
[116] D.White, Convenor, Barony Parochial Asylum, Woodilee, House Committee Report (1886) p10.
[117] CR (1900) Glasgow District Asylum, Woodilee, p15.

perhaps a page, at most, every few years discussing boarding-out, while annual reports at Woodilee offered extensive assessments of the introduction and development of the system and explanations for the endorsement of the policy. Notwithstanding this enthusiasm, a sharp decline in boarding-out was discernible by the mid-1900s and in fact, the asylum population rose by 28 in 1907, due partly to a relaxation of effort to discharge suitable cases.[118] Although the proportion of boarded-out insane was deemed creditable, the Commissioners considered that maximum employment of the system had not been attained. They accepted that the decline in boarding-out could be explained by a desire to utilise the accommodation provided by recent extensions of the asylum. However, the number of patients boarded-out from Woodilee did not increase for some years and, in 1908, only four cases were removed to private dwellings.[119] Nevertheless, the recognition that boarding-out was the only way in which the rapid growth of the patient population could be kept in check remained in force and, despite evidence of fluctuation in the 1900s, officials at Woodilee Asylum continued to rank as among the most enthusiastic in advocating the policy.

12.10 Summary and conclusions

The development and expansion of boarding-out was largely dependent upon the suitability of patients selected for private dwellings. To this extent, therefore, the role of medical superintendents was important. Indeed, Fraser, in his capacity as Visiting Commissioner, when analysing the causes of the increase in boarded-out patients in the 1870s and 1880s, highlighted the actions of medical superintendents as one of the main forces operating in favour of the expansion.[120] Annual reports of superintendents have provided extensive insight into their activities and opinions regarding boarding-out. Not only was the policy mentioned with great regularity, but many superintendents took the opportunity to discuss its merits and drawbacks at length. Nevertheless, in focusing on the role played by asylum superintendents in boarding-out there is a danger of attributing too much significance to their actions. Medical superintendents were, first and foremost, concerned with the reputation and administration of their asylums, rather than the various merits and dilemmas of a policy of care within the community of patients they were no longer responsible for.

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[118] CR (1907) *Ibid.*, p28.
[119] CR (1908) *Ibid.*, p30. Blair, a keen proponent of the system, had by this time left the asylum and been replaced by Marr.
[120] GBCLS 23rd AR (1881), p120.

The fact that a useful outlet was found by boarding-out prompted considerable approval by asylum physicians, but, in many cases, that was the extent of their interest.

Reasons put forward for adopting boarding-out remained constant, namely, relief of overcrowding; increased opportunities for superintendents to attempt curative treatment rather than just containment of the insane; postponement of extensions to asylum buildings; economic advantage to ratepayers; and, although at times appearing more as an afterthought, the increased happiness and well-being of patients. These considerations combined to offer a powerful incentive to superintendents to implement the system. National and international trends had no perceptible influence on the actions of superintendents in boarding-out patients, although, in the prevailing theoretical climate, allowing greater freedom was fashionable. Aware of current debates and developments in England and overseas, and at times participating in discussions with foreign alienists regarding the merits of the system, it was the realities of asylum life which provided the basic impetus to board-out. Although from the early 1860s, superintendents encouraged the removal of suitable patients, there are only casual references to the policy in the annual reports at this time. The greatest activity was apparent in the 1880s and 1890s. Nevertheless, motives behind encouraging the system did not change, although the development of hospital features increased in importance from the 1880s. The predominant reason was to relieve overcrowded wards, and sometimes this was the only objective cited.

There is clear evidence of greater enthusiasm for boarding-out among officials of district asylums. In general, the royal asylums, although often overcrowded, boarded-out only a small proportion of their patients. Edinburgh Royal Asylum was an exception to this, a tribute to the cooperation between asylum staff and parish officials. Part of the explanation for this lies in the growing selectivity applied to admissions to royal asylums and in the increased number of private patients. The erection of district asylums throughout Scotland, with many, by the early years of the twentieth century, located near the royal asylums,[121] served to reduce the pressure upon the latter asylums to continue admitting pauper patients.

There is no indication of any decline in the policy in the 1900s, and in fact, many asylums which had previously had only limited recourse to the system, appeared by the turn of the

[121] For example the district asylums of Dundee (opened 1903), Aberdeen (1904) and Edinburgh (1904)

century, to have adopted it with great fervour. Boarding-out never represented a real challenge to the supremacy of the asylum, even if its extensive use challenged the way asylums were administered. Reasons justifying its employment did not change and it is the enduring nature of ensuing benefits that is so notable. Despite the recognition of certain drawbacks, the relief brought about by large scale removal of chronic cases was generally welcomed. The majority of asylum superintendents, therefore, accepted the advantages inherent in such a system, and where appropriate, cooperated with the inspectors of poor.

CHAPTER 13

ROLE AND ATTITUDES OF PARISH OFFICIALS

13. Overview

The attitude and activity of individual parish officials was an important factor in the expansion of the boarding-out system. It was their responsibility to remove patients from asylums and to select suitable guardians and houses. This chapter examines their workload, responsibilities and attitudes towards the system. The relationship with officials from the Board of Lunacy and with medical superintendents of asylums was often fraught with tension. Many parish officials resented the sustained intervention of the Commissioners in Lunacy and the extent to which this affected the implementation of boarding-out is considered. In addition, the degree to which local officials could obstruct the growth of the system in their individual parish is assessed.

13.1 Introduction

Parish officials had responsibility for a wide range of areas, including employment, public health, railways, burial grounds, school rates, sewage, care of pauper children, poorhouse management and for all persons claiming poor relief. The Commissioners in Lunacy, however, had clearly designated interest in the well-being of all registered insane persons in Scotland, both private and pauper. Each parish was required by law to provide assistance for all destitute persons chargeable to a parish. This was administered by separate parochial boards, under the control of the Board of Supervision. Assistance granted included provision in the poorhouse, an allowance to those remaining in their own homes, boarding-out in private dwellings, or reception into specialist institutions. The additional workload presented by boarding-out insane paupers was not always welcomed.

As a result of the Poor Law Amendment Act, 1845, poorhouses (the Scottish equivalent of English workhouses) were erected throughout the country. They were used to

accommodate pauper lunatics, although they were unlicensed and the staff untrained. The Board of Supervision was aware that many paupers thus detained were wholly unsuitable for such provision, since they were often actively insane, disruptive and potentially dangerous. Despite this recognition, by 1850, it concluded that:

> "for a large class of incurable and harmless pauper lunatics, especially such as have no near relation with whom they can reside, a well regulated poorhouse affords the place of refuge most conducive to their own happiness and welfare and most advantageous to the community."[1]

This approval was undoubtedly influenced by the fact that the cost of maintenance in a poorhouse was half that of asylum provision. However, it was also maintained that patients in poorhouses were cared for by experienced warders, and had "as good if not better chance of recovery than in large and dignified establishments."[2] The validity of both assertions is, however, questionable.

The Commissioners were justifiably critical of the provision for the insane in poorhouses, condemning the high death rate and "parsimonious treatment of inmates" by parochial authorities. Although some poorhouses containing insane paupers were closed by the Board of Lunacy, the pressing need for accommodation obliged the Board to grant new licenses to certain poorhouses for the reception of the insane. The Lunacy Act of 1862 therefore sanctioned the residence of pauper lunatics, who were unable to benefit from asylum treatment, in specially licensed poorhouse wards, entirely separated from other paupers. The bias of the Board of Supervision in favour of lunatic wards was strongly pronounced, particularly in the early years of the Board of Lunacy, although most parishes also boarded-out suitable patients in private dwellings. This discrepancy was not altogether unexpected, as poorhouses were controlled by the Board of Supervision and asylums and boarding-out by the Board of Lunacy. In addition, patients in lunatic wards required little supervision from inspectors of poor, in contrast to the heavy workload involved in visiting the boarded-out. Parish officials condemned the growth of specialist institutions for the treatment of the insane, maintaining that:

> "insane paupers are better and more cheaply boarded in poorhouses...than by sending them to large princely establishments, now rearing their aristocratic heads over the length and breadth of the land...It cannot be looked upon as an ornament to a district to have itself studded with madhouses every here and there, as seems to be the tendency of the time, however much architectural beauty these buildings may be made to embrace."[3]

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[1] In Ferguson, T. (1948)The dawn of Scottish social welfare. Edinburgh, London. Melbourne and Toronto: Nelson & Sons Ltd, p208.
[2] Something about idiocy and insanity. (1865) *Poor Law Magazine*, **8**, p148.
[3] *Ibid.*, p147.

Further, they argued that utilising poorhouses enabled the care of all paupers to be undertaken in one form of establishment. The erection of the new district asylums advocated by the Board of Lunacy was criticised by parochial boards as unnecessarily extravagant and their condemnation of the "palatial" asylums remained consistent. Over fifty years after the introduction of district asylums, they argued that the pauper insane could be maintained at a much lower rate in poorhouse lunatic wards, concluding that:

> "unfortunately the Board of Lunacy have set their face against lunatic wards of poorhouses...because there is a little jealousy with the Local Government Board or something like that."[4]

The two official bodies responsible for the care of insane paupers were, therefore, diametrically opposed in their ideals. Tension was exacerbated by the control held by the Board of Lunacy over parish officials in the implementation of boarding-out. This removal of power remained a constant irritant to parish officials who contended that the system in place before 1857 was satisfactory and that they were best equipped to regulate it. The general disapproval of lunatic wards by the Board of Lunacy added to the tensions experienced. Nevertheless, cooperation increased steadily as the system of boarding-out expanded and confidence in its merits spread.

Boarding-out pauper children was widely resorted to throughout Scotland, with large urban parishes sending a high proportion of their pauper children to rural areas every year. There was even an Association for the Advancement of Boarding-out for Children. This system, which has been discussed extensively by Macdonald,[5] preceded that of boarding-out insane patients, the development of which can be attributed partly to the success experienced by the City parish of Edinburgh in boarding-out their children.[6] The benefits were held to be applicable both to children and insane patients; one observer, Miss Thackeray, declaring:

> "the lessons that the boarding-out of pauper children may teach us in regard to the boarding-out of insane adults seem to me to be of great importance. ...What is possible in the case of these children is equally possible in that of the chronic harmless insane...In many respects the insane are in the position of children, equally helpless, equally trustful, equally docile, calling for the same kind and degree of care..."[7]

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[4] Report of the Royal Commission on the Poor Laws and Relief of Distress, Scotland (1909) p210.
[5] Macdonald. H. (1994) *op. cit.*, and in Boarding-out and the Scottish Poor Law, 1845-1945. *Scottish Historical Review.* Forthcoming (October 1996). Another informative work on the boarding-out of pauper children is that by Anderson, W. (1871) *Children rescued from pauperism: the boarding-out system.* Edinburgh: John Menzies.
[6] *Vide supra* Chapter 5.
[7] Miss Thackeray. (1870) Little Paupers. *Cornhill Magazine.* Recorded in Lindsay, W.L. (1871) *op. cit.*, p502.

Enthusiasts insisted that it was an improvement on keeping children in poorhouses and it was recognised that, just as certain insane persons did not require institutional confinement, many children were more suitably provided for under domestic care. Insane patients were sometimes placed with boarded-out children, but this was rare.[8] Nevertheless, many parishes accommodated a considerable number of boarded-out persons, both children and the insane. In fact, in some areas, inspectors reported that guardians who usually welcomed patients, refused to take them, when it was discovered that they could get children, two or three of whom paid as well as one patient and demanded less attention.[9] Parish officials endorsed the boarding-out of children with enthusiasm, in contrast to the apathy displayed by many in relation to insane patients. This can partly be explained by the fact that the parish held sole control over the provision of care for pauper children. In addition, it is clear that the residence of children, rather than insane persons, living at large in the community, was more readily accepted.

13.2 Development of Poor Law provision

Prior to the Lunacy (Scotland) Act, 1857, the most notable legislation affecting the condition of the insane poor was the Poor Law Amendment Act, 1845, which can be regarded as the most important piece of Scottish Poor Law legislation until the Local Government (Scotland) Act, 1929. Before this Act, there had been no uniformity or control over the system of governing parish affairs. The relief of the poor relied largely on charity, church collections and, in larger parishes, on assessment. In general, survival depended on begging. The Act of 1845 provided for the creation of a Board of Supervision, thereby ensuring the supremacy of centralised administrative control. The responsibilities of the Board, like those of the Board of Lunacy, were primarily supervisory, although in contrast to the latter Board, its officials had few powers of compulsion, leading to considerable variation in the activities and standards of care offered by different parishes. The duty of the Board of Supervision was to ensure that each parish complied with the new requirements of the Act and to supervise the administration of relief. It was also responsible for the erection and maintenance of poorhouses.

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[8] At Kennoway in 1870, for example, a pensioner was the guardian of a boarded-out child and two insane patients. GBCLS 12th AR (1870), p255.

[9] Lists of children boarded-out by Barony parish: includes lists of boarded-out patients, 1896. (D. HEW 24. 12)

The administration of each parish in Scotland was managed by a democratically elected body, the parochial board, whose main responsibilities lay in managing the affairs of all sane and insane paupers, except those in asylums. A total of 800 such boards were established. It is evident that the Poor Law Amendment Act had considerable impact not only on the development of poor relief, but on the condition of insane paupers, who, for the first time, were recognised officially as having separate needs. As Mackay has asserted, "it is upon the Act of 1845 that the system rests."[10] Other Acts, in his view, simply modified the established details of administration. The Local Government (Scotland) Act, 1894, replaced the Board of Supervision and the parochial boards, creating, in their place, parish councils. Among the principal duties of the new councils was the administration of the Poor Law, Lunacy, and Burial Ground Acts. However, the Board of Lunacy retained ultimate control over the affairs of all registered insane.

13.3 Responsibilities

In the years following the legislation of 1845, until the introduction of the Board of Lunacy, parish officials and sheriffs had responsibility for all insane paupers in Scotland. In 1858, these amounted to 4737, an increase of over 100% since 1845.[11] The removal of this autonomy was resented openly by many parish officials. Thus, while the great majority of registered insane were maintained out of poor rates, parochial boards had no direct control over their provision and no influence in the administration of the Lunacy Acts. The Board of Lunacy and the newly created District Lunacy Boards oversaw the administration of the insane, although local inspectors of poor were obliged to ensure that the provisions of the Act were implemented. Inspectors had regular contact with all insane paupers in private dwellings and were responsible for their well-being. The mode of provision, however, was controlled by the Commissioners and parish officials were forced to comply with the designated policy of the Board of Lunacy.

Despite some objections from the Lunacy Commissioners, parish officials continued to have responsibility for the cost of maintenance of their insane poor, although this was modified in 1875, with the introduction of the Government grant-in-aid.[12] The principal

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[10] Mackay, G. (1907) *op.cit.*, p8.
[11] Kinnaird, Lord. (1859) Notes on the Lunacy Bill for Scotland. *Poor Law Magazine*, **2**, p6.
[12] *Vide supra* Chapter 4 for conditions under which the grant-in-aid was awarded.

executive officer of the parochial board was the inspector of poor; each parish also had a medical officer, who acted as advisor to the parochial board in all medical affairs. Nevertheless, these officials had no autonomy over lunacy administration, their role approximating more that of caretaker.

In the majority of parishes, the inspectors of poor were the only public figures with any substantial knowledge of lunacy administration. Their duties were onerous; they dealt with applications for poor relief, paid aliment to those entitled to it, visited them regularly and kept the parish accounts and records of all applications for relief, those granted and those refused. The inspector had to attend meetings of the parish board, where he produced extensive statistical returns. Further, he dealt with every case of insanity reported to him. The Board of Lunacy required detailed returns annually relating to every pauper lunatic chargeable to each parish, as well as forms recording whenever a patient became, or ceased to be, chargeable. Such additions to their workload caused some discontent among local officials who complained that "the Lunacy Board appears to have had a desire to devise a form for every possible and impossible case."[13] The claim that the duties of the inspector were "so numerous and difficult that a good inspector must be a man of intellect, education, tireless energy, tact and benevolence" appears justified.[14] The salary was generally low, particularly in small parishes and many inspectors had additional occupations, for example, frequently, as schoolmaster.

The Commissioners recognised the need to allow parochial officials some authority in the disposal of their chargeable insane, and conceded that as parochial boards were entrusted by law with the care and treatment of their poor:

> "to deny them the power of removal of unrecovered patients from asylums, simply because their maintenance was defrayed from public rates instead of from private sources, would be equivalent to placing a large amount of irresponsible power in the hands of superintendents of asylums, on whose will and opinion their discharge would then practically be almost entirely dependent."[15]

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[13] Anon. (1859a) The Board of Lunacy and its actings. *Poor Law Magazine*, 1, p389.

[14] Poor Law officials emphasised the significance of the role of inspector of poor, arguing that if inspectors were aware of the importance of their office, they were more likely to discharge their duties effectively. It was asserted that he was "not in the position of a mere clerk...[but] fills a situation of great trust and responsibility, requiring education, training and the constant exercise of faculties of a high order." Shaw, J. (1868) On the spirit in which the duties of an inspector of poor should be discharged. *Poor Law Magazine*, 1, p334.

[15] GBCLS 12th AR (1870), main report, pxxxvi.

Lunacy legislation therefore granted statutory power to parochial officials to order the removal of any of their pauper patients from asylums, providing they were not dangerous, offensive or otherwise unsuitable for discharge. They were then placed in private dwellings, after a minute had been approved at a parish meeting. The Board of Lunacy had to be informed of the action within 14 days of the patient's removal, with notification of the location of the house and the character of the guardian. In this way, the Commissioners were able to appear magnanimous, although they retained the power to order the return of any patient to an asylum, if it was considered that their treatment was unsatisfactory. The inspector of poor had the responsibility of finding suitable accommodation and guardians. In some parishes, inspectors were instructed to advertise for guardians in the local newspaper.[16] However, the population of the majority of parishes was small enough to enable the inspector to have considerable knowledge of the character and suitability of potential guardians. Once placed in a private dwelling, the patient was visited twice annually by the inspector, with additional visits from other members of the parochial board. Inspectors had to ensure that visiting books recording the condition of the house, and the quality of care bestowed were provided in all houses where patients were boarded.[17] Recommendations were often very specific and provide evidence of the scrupulous attention and concern bestowed on many patients. Detailed suggestions for improvements included the supply of clogs to patients, which were deemed easier to wear; hats for protection when working in the sun and for regular attention to be paid to dentition and eyesight. Inspectors even examined the condition of patients' nails, indicating the thoroughness with which they undertook their duties.

The overall cost of maintenance for the insane incurred by each parish was determined by the number of patients boarded-out, since institutional care, even in poorhouse lunatic wards, was significantly more costly. The solution to the increasing burden of pauper lunacy therefore lay "primarily in the hands of the parochial boards".[18] However, while the Board of Supervision accepted that the main responsibility for removing patients to private dwellings rested with the parish, this was not always welcomed. Members argued (and in

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[16] For example, in the parish of Dundee (Dundee Lunacy Board Minutes, 1885) and in the Orcadian newspaper, where an advert was placed requesting "a person in the country to board and take care of an old woman who is in a state of dotage but otherwise in good health. Apply immediately to the inspector of poor, Kirkwall." F.Watson, Northern Health Services Archivist. (1996) Personal communication.

[17] See Appendix 13 for a detailed description of the specific duties of inspectors of poor towards patients in private dwellings.

[18] Editorial. (1892) Pauper Lunacy in Scotland. *Poor Law Magazine*, 2, p511.

doing so, agreed with medical superintendents and some Commissioners) that parish officials were "unskilled in the mysteries of lunacy"[19] and did not possess any specialist skills to determine whether a patient was suitable for removal from an asylum. Because of this, they concluded, it was unfair to expect them to take on the responsibility of discharging patients who could then prove unsuitable.

Despite, this, the actions of inspectors of poor were of the utmost importance in the implementation of boarding-out. According to Commissioner Fraser, although medical superintendents had an important influence on the policy of boarding-out from asylums, their duty was largely to recommend suitable patients for discharge and, "the success and extension of the...system is largely, if not mainly, in the hands of the inspectors of poor."[20] Inspectors were able not only to initiate the removal of their insane paupers from asylums, but also to refrain from placing every patient, indiscriminately, in institutions. The extent to which they co-operated with medical superintendents in implementing their recommendations for discharge had a marked impact on the success of the policy.[21] Their visits to asylums, therefore, were viewed favourably by the Board of Lunacy. The crowds of patients in each ward often meant that suitable cases for boarding-out were overlooked by the medical superintendent and as a result of the vigilance of inspectors, most notably those from Edinburgh and Glasgow, a greater number of patients were thus removed.

The work-load of Motion, the "able and energetic" inspector of poor for Glasgow parish, illustrates well the duties of inspectors in boarding-out patients.[22] Glasgow parochial authorities were praised regularly by the Commissioners for their sustained and successful activity in boarding-out which was facilitated by a general acceptance of the policy by local officials. Motion, for example, maintained that assessing the suitability of patients in asylums for boarding-out had become an integral part of parish administration. His assistant visited pauper patients in Glasgow's asylums regularly, seeing both patients and medical officials, and reporting on the condition of each patient, their cleanliness, speech,

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[19] *Ibid.* Among Commissioners who claimed that parish officials were inadequately skilled in treating the insane, Macpherson noted that many inspectors failed to grant liberal supplies of clothing. They "do not seem to appreciate the fact that the insane as a rule are of comparatively lower vitality than their neighbours and require warmer clothing for the maintenance of their health...often I have had to insist upon increased supplies of clothing". GBCLS 38th AR (1896), p135.

[20] GBCLS 23rd AR (1881), p121.

[21] *Vide infra* 13.6.

[22] Reported in GBCLS 44th AR (1902).

and behaviour and whether noisy, epileptic, or otherwise unsuitable for discharge. Motion then made up a list of those potentially suitable for boarding-out and discussed each case with the medical superintendent. Once the patient's suitability had been ascertained, and satisfactory homes and guardians found, the duties of regular visitation then commenced.

The medical officer of the parish was also involved in the care of boarded-out patients. His duties included the examination of all disabled paupers, the vaccination of children and the certification of lunatics. The fee for certification was one guinea. In addition, once lunatics had been certified, the medical officer visited once every quarter, but unlike the inspectors, who received no additional remuneration, a fee of 5d was paid for each visit. This was a frequent point of contention at parish meetings.[23]

13.4 Attitudes to boarding-out

13.4.1 Obstruction and apathy

When the Commissioners first began to supervise boarding-out, they recorded their frustration at the apathy of inspectors of poor in implementing the policy. They announced that although many parishes had patients suitable for boarding-out, local officials made no attempts to remove them from asylums, because the workload of inspectors increased significantly when patients were sent to private dwellings. It was far easier to allow them to remain in asylums, thereby avoiding the task of finding suitable accommodation and undertaking regular visits. Among a number of parish officials there appears to have been a lack of understanding of the characteristics of lunacy, with many sharing the belief that all insane persons should be confined in asylums. This was reinforced when they came into contact with certain patients who were of disturbing appearance and behaviour. One Commissioner reported that when visiting a patient, R.A, the inspector of poor declined to approach the house, making the excuse that if the patient saw him, he would lock the door. R.A, whose appearance was considered offensive, was seen "gazing at a New Testament, and appeared dark and dirty, and unshaved in person; haggard, emaciated and anaemic."[24]

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[23] However, Bruce, a member of the General Medical Council for Scotland with 20 years experience as a parochial medical officer, asserted that visiting doctors should be well paid. He was concerned that if payment was inadequate the work of the local doctor would be too perfunctory. Royal Commission on the Care and Control of the Feeble-minded (1908), Vol. III, p199.

[24] GBCLS 4th AR (1862), main report, plviii.

The Commissioners accepted that such an appearance was unsettling for untrained laymen, many of whom desired no contact with such cases.

Another form of obstruction came from inspectors of poor who thwarted the Commissioners' attempts to admit patients to asylums from private dwellings. This was motivated largely by concern that their duration of stay would be lengthy and that the cost to the parish would be high. The Commissioners often commented on the difficulties experienced when attempting to remove from private dwellings patients who were not suitable for domestic care. However, they recognised that this could be attributed to the hesitation of medical officers to grant a certificate of insanity, due to insufficient specialist knowledge, rather than deliberate obstruction. For example, in 1862, the Commissioners recommended the removal to an asylum of a female pauper patient, labouring under religious melancholia, who stated that "her soul is lost" and that she "despairs of salvation". She had run away from home and twice attempted suicide by starvation. Her mother was in an asylum, having cut her throat, and her father, having also cut his throat, had died. Despite a serious risk that the patient was in danger of killing herself, the parochial medical officer refused to grant the necessary certificate, asserting that there was nothing in her appearance indicating insanity. Eventually she was admitted to an asylum, although the medical officer remained unconvinced that she was "a proper person to be placed in the asylum".[25] In such cases, the intervention of the Board of Lunacy was vital for the well-being of the patient and the neighbouring community, but, nevertheless, it was resented strongly by parish officials.

In addition to obstruction created through ignorance, there were times when inspectors of poor refused to act, through lack of support for the system. This was particularly frequent when the system first developed, but, even as late as 1904, examples of antagonism among parish officials were reported. The Commissioners, notably Fraser, Turnbull and Macpherson, stressed their willingness to assist both medical superintendents and parish officials in selecting suitable patients for boarding-out. Despite this, Macpherson reported several instances of indifference and even hostility by inspectors of poor, regarding any proposals for the boarding-out of unrecovered patients and although several inspectors promised to act, no response was forthcoming. To Macpherson:

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[25] GBCLS 3rd AR (1863), main report, pxxiv. *Vide supra* Chapter 11 for similar example.

> "the attitude is much to be regretted... if there was energetic and concerted action by the superintendent and inspector of poor, a large number could be placed in private dwellings."[26]

Lack of co-operation of a more subtle kind was manifest on a number of occasions when the Commissioners attempted to improve the living conditions of patients boarded in their own homes. On occasion, inspectors of poor offered to place the patient in an asylum and, when this was rejected by relatives, the patient was removed from the poor roll. The Board of Lunacy expressed concern that the offer was made with the expectation that it would be rejected, thereby preventing receipt of poor relief. In this way, patients deserving of relief and in need of proper treatment were removed from official jurisdiction. The Commissioners could not legitimately authorise residence in private dwellings where patients were discovered in unsatisfactory circumstances, even if this was the only way to keep the patient on the poor roll. To do so would allow the perpetuation of unsuitable treatment. It was suggested (but never enacted) that the solution lay in granting the sheriff compulsory powers of removal in all cases where the Board considered the patient was unsuitably provided for in their own home.

Complaints were made by inspectors regarding the arduous task of regular visitation. These were particularly understandable in the more isolated parishes, such as in regions of the Highlands where the distances to be covered by visiting officials were extensive. Further, the charges demanded by medical officials were felt to be excessive, particularly to those in sparsely populated parishes. The prevailing view among parochial authorities was that the insane did not need any greater supervision or visitation than other paupers. Nevertheless, lunacy officials emphasised the need for close and regular supervision, particularly in areas of poverty, because:

> "in no other social duty are indifference and neglect more apt to appear, than in the care and treatment of an insane fellow creature, especially where poverty prevails and the lunatic is felt to be a burden."[27]

In general, boarding-out was implemented with greater success and enthusiasm in areas where there were no poorhouse wards licensed for lunatics.[28] In Aberdeen, for example, there was ample accommodation for insane paupers in the poorhouses of Aberdeen and Old

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[26] GBCLS 46th AR (1904), p173.
[27] GBCLS 22nd AR (1880), p127.
[28] Exceptions to this were the large urban centres of Glasgow and Edinburgh, which had licensed lunatic wards for the accommodation of the harmless insane, yet also had a high proportion of patients boarded-out.

Machar and, directly related to this, few patients were boarded in private dwellings.[29] Similarly, in Dunfermline, parish officials were reluctant to develop the boarding-out system at the expense of their "well regulated poorhouse." Although Dunfermline had a good record for boarding-out children, officials asserted that insane patients were more suitably provided for in a poorhouse, where they were properly supervised and where "there would be less likelihood of a lunatic becoming obstreperous and running away."[30] The chairman of the parish council was unimpressed following visits to boarded-out patients, declaring that many were in a comatose state, showing no interest in anything and would be more suitably provided for in a well equipped poor-house. Further, they would benefit from the experience of trained staff, and be better fed and clothed than was possible on the allowance granted for boarded-out patients. It was concluded, in Dunfermline parish at least, that "the system of boarding-out lunatics is somewhat dangerous."[31]

13.4.2 Gradual acceptance of the policy

By the 1880s, the Commissioners observed among parish officials an increasing thoroughness of supervision and a greater willingness to co-operate with the boarding-out system, despite instances of obstruction and indifference. In many parish reports, the desperate need for accommodation for lunatics is conveyed clearly. With overcrowded asylums and poorhouses, constant problems were encountered in the disposal of the pauper insane and the prospect of boarding-out was often welcomed. Illustrating this, the parish of Barony boarded-out only a very small number of patients until 1886; in 1868, 14 patients were provided for in this way and in 1878 this had fallen to 12. This prompted condemnation from the Commissioners for being "one of those parishes which did practically nothing about boarding-out".[32] Active opposition by some parish officials was also reported. However, following continued exhortation by the Commissioners and recognition that asylums in Glasgow were unable to accommodate the increasing numbers of registered insane (the asylum at Woodilee, which opened in 1873, had been filled rapidly) the system was adopted by the parish in 1886. In 1878, 3% of paupers from the parish were in private dwellings, but, ten years later, this had risen to 14%.[33]

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[29] *Vide supra* Chapter 9.
[30] Report of the Royal Commission on the Poor Laws (1909) *op.cit.*, p372.
[31] *Ibid.*
[32] GBCLS 30th AR (1888), p109.
[33] *Ibid.*, pp109-110. Circulars were also issued to asylum and parish officials by a committee of the parochial board in 1885, inquiring into the experience and practice of the officials in regard to boarding-out harmless, incurable patients. On

Inspectors of poor often accompanied the Commissioners on their visits to single patients. In this way, Mitchell met over 200 inspectors a year and he was able to observe:

> "a great and increasing desire on their part to meet the wishes of the Board. A wider and more correct knowledge of the views of the Board, and the better understanding that it is not their wish to place every class of the insane poor in asylums have no doubt led to this increased readiness on the part of parochial authorities to carry out the recommendations of the Board."[34]

With increasing frequency as the century progressed, the Commissioners' reports contained praise for the activity and scrupulousness of many inspectors and satisfaction that the propriety of removing patients to private dwellings had become accepted widely by parochial authorities.[35] The high number of patients boarded-out from the City parish, Edinburgh, for example, was attributed almost entirely to "the energy and ability which the inspector of this parish has exercised in its development and care".[36] In 1883, 29% of the total number of lunatics chargeable to the parish were in private dwellings.[37] This proportion was considered to be attainable in most urban parishes. Surviving parochial records indicate that towards the end of the century, only a small minority of parishes retained any prejudice against the system, or attempted active opposition. Fraser summed up the position when he noted that:

> "opponents of this class are becoming belated and discredited. It is evident that the great expansion of the system of dealing with pauper lunatics in private dwellings has been accompanied by an increasing smoothness and spontaneity in action, mainly because those who have to do with the carrying out of it have confidence in its advantages and practise it with generosity towards their insane poor and with keen supervision over the guardians.[38]

Visiting Committees of laymen appointed by the parish regularly accompanied their inspector of poor to visitations of single patients. The pleasant and sympathetic manner in which the inspectors fulfilled their duties was commented upon. One Glasgow Committee member observed that "I was glad that what I expected to be a formal affair turned out to be a pleasure to me instead of a harsh duty."[39] Patients and guardians alike were reported to

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the basis of "instructive replies" and the encouragement of the Commissioners, the system was adopted formally the following year.

[34] GBCLS 8th AR (1866), p235.

[35] The attitude of parish officials in Glasgow is illustrated by the result of a motion put forward that stated: "in the interests of economy and stricter supervision, boarding-out in the future be confined within a radius of 50 miles of the parish." However, several officials spoke in support of the system as it was, and the motion was defeated by 27 to 2. Minutes of Parish Council: Barony (1895) D.HEW 2.3. By the turn of the century, Glasgow City parish had over 500 patients boarded-out in the country.

[36] GBCLS 23rd AR (1881), p121.

[37] GBCLS 25th AR (1883), p165.

[38] GBCLS 36th AR (1894), p102. Other Commissioners were equally satisfied with the transition in attitude. Many were particularly effusive; for example, Marr praised the inspectors, "of whom it may truly be said that the interests of their patients are their first consideration, and much energy and conscientiousness were seen devoted to this end by individual inspectors." GBCLS 54th AR (1912), p146.

[39] Lists of children boarded-out by Barony parish: includes lists of boarded-out patients (1910) D.HEW 24.23.

welcome the inspector and "many seemed deeply attached to him, and all welcomed him as an interested friend."[40] Reports of inspectors of poor were usually short, concise and frequently full of praise for the guardians and their treatment of patients. Many officials concluded that they could not praise too highly the manner their patients were looked after:

> "The homes were all that could be desired, comfortable, clean, and well-aired, many of them set in scenes of great beauty, which, for all we know, may be appreciated by the unfortunate patients in some half-conscious way. After visiting all our districts over a number of years we have come to the settled conviction as to the utility of the boarding-out system...it affords better opportunities of restoration where mental health is possible, and where this fails, the free life and occupation in the open-air, and the kindly influence of family life, all tend to an improved condition, and something as near happiness as is possible to mental disorder."[41]

Concern at the steadily increasing cost of provision for lunatics obliged parish officials to adopt the most economical measures. With responsibility for large numbers of paupers, it was in the interests of each parish to achieve the lowest possible expenditure. Those which boarded-out patients were able to make extensive savings, since the cost of provision in asylums, private madhouses, and even in poorhouse lunatic wards was far greater than that for care in a private dwelling. As the Board of Lunacy emphasised, "economy, one of the proper objects in parochial administration, is attained by this method"[42] Returns for the City Parish, Edinburgh detailed the average cost of maintenance for patients boarded with strangers. In 1880, this amounted to £19 a year, whereas in asylums, the cost was £27 per annum. The total costs of providing for pauper lunatics had escalated sharply. In 1868, 5769 insane patients were maintained by poor rates, but by 1890 this had risen to 12,303, an increase of 113%.[43] While it was recognised that provision for the insane had improved considerably, the attitude of parish officials was, necessarily, mercenary and as one commentator, Lamond, declared, "the question regarded from a Poor Law point of view is reduced simply to one of cost."[44] Recognition that significant savings could be made by implementing the system helped ameliorate many of the initial fears and prejudices of parish officials. Safeguards authorised by lunacy officials lent further reassurance to officials previously sceptical of boarding-out.

The number of conferences concerned with the boarding-out system, held regularly from the 1880s, indicates the general recognition of its importance. The Commissioners were

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[40] *Ibid.* (1911) D.HEW 24.24.
[41] Parochial report by Visiting Committee: Glasgow City, Barony parish (1898) p7.
[42] GBCLS 23rd AR (1881), p121.
[43] Lamond, R.P. (1893) *The Scottish Poor Laws.* Glasgow: Hodge & co, p136.
[44] *Ibid.*, p142.

invited to parish meetings to lecture on boarding-out.[45] They declared it to be the duty of every parish council to take an interest in the matter. Reports of discussions following lectures contained informative, lively debate, with many officials expressing their enthusiasm for an extension of the system. Few were openly critical. Meetings of the Ayrshire Poor Law Association held to discuss the system, for example, were well-attended by officials who were in favour of an extension of the policy. At one such meeting, a motion was passed unanimously that "the boarding-out of suitable lunacy cases should be more generally adopted throughout the county,"[46] and that parish councils should board-out patients wherever practicable. Therefore, while many inspectors were initially unconvinced of the merits of boarding-out, it is apparent that by the 1880s, increasing numbers recognised its potential advantages and embraced the system with enthusiasm, encouraging its further employment. Despite some reservations, by the turn of the century, boarding-out had become an integral part of poor law administration, with every city and large town in Scotland (with the exception of Aberdeen) implementing the system to varying degrees.[47]

13.5 Relations between parish officials and the Commissioners

Fierce antagonism was shown by many parish officials towards Lunacy Commissioners, particularly in the years following the creation of the Board of Lunacy. The Poor Law Magazine, the mouthpiece for parish officials, printed numerous articles questioning the role of the Board and arguing for a return of parish control.[48] Although hostility was more apparent in the 1850s and 1860s, it remained perceptible even at the turn of the century. The sudden loss of autonomy and the intervention in what previously had been their province, provoked impassioned outbursts of resentment by officials, to whom:

> "the idea of the Lunacy Commissioners being sole judges as to the necessity of confining a patient, or placing such uncontrolled power in their hands is preposterous; and still more absurd is it to imagine that the Commissioners should superintend all lunatics and fatuous persons, not in confinement, unless with the aid of such a staff as would be ruinous."[49]

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[45] Among many lectures and conferences addressing the boarding-out system, Macpherson gave a lecture in Aberdeen to inspectors of poor, which was followed by a lively discussion. Invitations to attend were extended to officials in Inverness, where it was decided that in view of the importance of the subject, the inspector be authorised to attend. Anon. (1906) Family care of the insane. Lecture in Aberdeen. Review and discussion of Macpherson. *Poor Law Magazine*, **16**, 74-89. Other importance conferences included one held at Stirling in 1898, discussing with asylum and parish officials the increasing difficulties of accommodation for all registered lunatics. MS AR (1898), Stirling District Asylum, p23.

[46] GBCLS 52nd AR (1910), p174.

[47] Over a five year period, 1895 to 1900 the proportion of patients boarded-out from Glasgow, the largest parish in Scotland, rose from 270 to 347, from Govan, 98 to 130, and from Paisley, 19 to 35. GBCLS 43rd AR (1901).

[48] Anonymous articles included: (1859a) The Board of Lunacy and its actings (1862) What is the use of the Commissioners in Lunacy? and (1862) How stories about lunatics are got up.

[49] Anon. (1859b) Powers of the Board of Lunacy. *Poor Law Magazine*, **2**, p8.

It was maintained that the Board of Supervision had been "considerate and patient in all its deliberations,"[50] and that interference and criticism from the new Board of Lunacy was unwarranted. In addition, the Lunacy (Scotland) Act, 1857, was regarded as crude, cumbersome and in need of amendment. The report on which the legislation was based was thought to be "prodigious and appalling" and concocted in secret in an attempt to implicate the Board of Supervision, the sheriffs and parochial boards "with dereliction of duty."[51] Cases were fabricated by "rude, untaught policemen" who were arbitrarily appointed sole judges of who were insane. In view of these accusations, the conclusions reached by the Report's authors were considered to be:

> "so extravagant...that a suspicion is ready to generate that they have been too long connected and associated with the unhappy subjects of this peculiar malady."[52]

Finally, the Act, it was charged, was passed hurriedly through Parliament, before the public had time to ascertain the validity of assertions, on the basis of highly coloured and erroneous data, which created an additional, heavy burden on rate-payers.[53]

The annual reports of the Board of Lunacy conveyed none of this antagonism. In fact, many reports contained complimentary remarks about the efforts of parish officials.[54] The Commissioners asserted control over lunacy administration at a national and local level and were confident in their apparently unassailable position. Verbal attacks from parish officials, although frequent and acrimonious, did not bring about policy change and inspectors of poor were obliged to implement the system of boarding-out, under the direction of the Board of Lunacy. However, sustained criticism from the Commissioners, regarding the suitability of parochial provision, and the effectiveness of local officials did little to ameliorate the uneasy alliance between the two authorities. To parish officials, the Board of Lunacy was both expensive and unnecessary. Further, there was criticism of the extravagant expenditure lavished on the large number of asylums erected, when there was adequate space in existing parish-run establishments. Lord Kinnaird, one of many high profile critics of the Commissioners, declared that:

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[50] Anon. (1861) Experience of the Lunacy (Scotland) Act. Discussion. *Poor Law Magazine*, **3**, p5.
[51] Anon. (1859) Topics of the month. *Poor Law Magazine*, **1**, p75.
[52] *Ibid.*
[53] It was also suggested that the Act had been hurried "in such a way as to lead one to suppose the Commissioners were afraid of the searching inquiry then being made by the Board of Supervision and parochial boards into the accuracy of their Report." *Ibid.*
[54] *Vide supra* Chapter 11. In 1864, for example, Paterson reported with satisfaction that most of his recommendations had been attended to, and that "inspectors of poor discharge their duties with humanity and intelligence. I make recommendations and generally found every disposition on the part of parochial authorities to carry them out as far as practicable." GBCLS 6th AR (1864), p238.

> "I do not believe that Scotland will submit to be under the dictatorship of two medical men who, however great their talent and experience in this peculiar malady, cannot but be, to some extent, carried away by their own views, anxious...to act upon them, without sufficient regard to the cost which this would entail."[55]

The general attitude among parish officials was that the care of the insane was most suitably provided by parochial boards and that there was no necessity for the Board of Lunacy. The strength of feeling was so high that meetings were called to discuss the new Board, and motions were passed declaring that the Act was erroneous and should be amended and that the Board of Lunacy, with its "useless, costly and obstructive machinery", should be disbanded.[56] Parish officials contended that the Commissioners made false charges of inefficiency and mismanagement against the Board of Supervision and parochial boards, in order to assure their continuance in office. The result of their efforts, they maintained, were evident in their bitter attacks on the activities and capabilities of local officials in their annual reports.[57] In accordance with this, one critic, "Scotus", asserted that the Board of Supervision "enjoys in a rare degree the confidence of the parochial boards and the public. It is essentially a popular board", while in his view, the Board of Lunacy had always been unpopular. He contended that its name and duties were "distasteful to the feelings and jar on the sentiments of the people," and by its very nature could never "enjoy the sympathy "of the public.[58] Over 30 years after the establishment of the Board of Lunacy, many parish officials still argued that it should be abolished, on grounds of economy, and that there was insufficient work to occupy both Boards. In their opinion, the success of the two Boards was markedly different:

> "one has steadily promoted economy with beneficial results, the other has constantly promoted extravagance. Expediency would therefore justify merging the smaller and less useful in the greater and more economical board."[59]

Lunacy officials were determined to remove all unsuitable cases from domestic care, while parish officials, often with an eye on economic considerations, claimed that many did not need treatment. There was repeated criticism by local officials who regarded the policy of the Board of Lunacy to be an insensitive one of forcing chronic, demented paupers into asylums, especially those who had lived happily within a village for many years. Letters were written claiming that it was "preposterous and cruel to drag idiots who have hitherto

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[55] Kinnaird, Lord. (1859) Notes on the Lunacy Bill for Scotland. *Poor Law Magazine*, **2**, p7.
[56] Anon. (1862c) How stories about lunatics are got up. *Poor Law Magazine*, **5**, p273.
[57] Reports which, incidentally, were held to be marvellously dull productions.
[58] Scotus. (1870) Review of the Scottish Poor Laws: Examination of their policy, history and practical action. *Journal of Mental Science*, **15**, p440.
[59] Lamond, R.P. (1893) *op.cit.*, p146.

been harmless, from parents and relatives who are willing to take charge of them, and who have done so till now."[60] The expense incurred by forced removals was condemned by officials concerned that patients, once admitted to asylums, "far removed from the long familiar objects that formed their little world...will drag out a long and weary existence."[61] This divergence of attitudes is well-illustrated in the case of one insane pauper from the Highlands, reported to be "as simple as a child and harmless as a lamb."[62] He had been dressed in "the garb of the fairer sex", which was regarded as offensive to public decency by the visiting Commissioner. To parish officials, he appeared content and well treated by his neighbours. In the eyes of the Commissioners, however, he was being treated inappropriately, albeit not cruelly, and would benefit from removal to an institution.

The scorn with which many Commissioners were regarded is conveyed colourfully in the writings of one inspector of poor, who observed that:

> "The Commissioners write at length on the boarding-out system, and prove (to their own satisfaction at least) its benefits on the score of cheapness, reducing their calculations to the nicety of a half-penny. It is easy work this, on paper. It is very enjoyable to travel the country and philosophise in this way, but if these gentlemen had personally to carry out the matter in practice, they would, I doubt not, find it not quite so smooth as it is to write on paper. I have on more than one occasion been amused and annoyed at the visits of these Commissioners, amused at the vague and stupid category of inquiries put to the patients, and annoyed at finding the latter put into a condition of excitement that should not have occurred. I could never see the force of the Board of Lunacy's existence..." [63]

Loss of control over provision for the insane remained one of the main reasons behind continued hostility towards the Board of Lunacy and there was sustained resentment following suggestions for improvements in conditions for boarded-out patients. However, although tension between the two bodies remained evident throughout the century, parish records in the 1880s and 1890s indicate that despite these grievances, local officials reached an uneasy acceptance of the Board of Lunacy. This was facilitated by recognition from the Commissioners that parish officials had become increasingly competent in selecting and supervising patients in private dwellings, enabling the Commissioners to announce that, "the views of the Board are now so generally known and accepted that their need for interference...becomes gradually less."[64] The greater freedom allowed to each parish contributed to a diminution of open hostility by the officials, which in turn led to the

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[60] Anon. (1859a) The Board of Lunacy and its actings, including letter from "Philology". *Poor Law Magazine*, **1**, p385.
[61] *Ibid.* (Letter from "Philology") p380.
[62] *Ibid*, p381.
[63] Anon. (1896) Letter by a "Rural Inspector." *Poor Law Magazine*, **6**, p224.
[64] GBCLS 36th AR (1894), p102.

expansion of boarding-out throughout Scotland, albeit with markedly divergent degrees of enthusiasm and success.

13.6 Relations between parish officials and superintendents

Although never as acrimonious or as enduring as the resentment directed at the Lunacy Commissioners, tension also existed between parish officials and asylum superintendents.[65] On occasion, parish officials insisted that they made regular attempts to remove patients from asylums, but were obstructed by superintendents who, they alleged, did not want to lose valuable workers or take the trouble of training new patients, to replace those removed.[66] From the viewpoint of parish officials it appeared that to the superintendent:

> "the asylum is his world...he naturally desires to reign paramount, internecine warfare occasionally arise between him and lay authorities. Usually the medical superintendent is the victor."[67]

The attitudes of parish official and asylum superintendent towards the management of individual cases did not always concur. Superintendents were authorised to grant a certificate whereby a patient could be liberated safely without risk to himself or the public. Occasionally, this was granted but the inspector of poor failed to remove the patient. This situation is illustrated by the discord over one patient at Stirling District Asylum, who was in fair physical health, although slightly rheumatic. In 1909, her case notes showed that she was "much enfeebled in mind, frequently excited and noisy." Two years later, having become quiescent, the medical superintendent recommended her removal, but the parish council refused and no further action was taken.[68]

Parish officials in turn were critical of what they regarded to be the misguided attitudes of asylum staff, complaining that:

> "the tenderest care, warmest sympathy, the most generous expenditure are reserved for the lunatic poor, many of whom are quite unable to appreciate the kindness and care bestowed on them, and the cost of whose housing and maintenance is out of all proportion to the necessities of the case."[69]

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[65] *Vide supra* Chapter 12.

[66] In several parish council reports for the village of Houston, near Glasgow, it was claimed that inspectors visited asylums to check the suitability of their patients for boarding-out, but were generally told by the asylum superintendent that none were ready. This was unlikely, in view of the considerable proportion of chronic harmless patients found in every asylum. Minutes of Parochial Board: Houston and Killellan, 1852-1912 (CO2/23/3-5) *passim.*

[67] Anon. (1868) Discussion. *Poor Law Magazine*, **2**, p97.

[68] Visitors Report Pocket Book: Dollar parish council, Stirling (1911) XK2/2/33.

[69] Motion, J. R. (1904) The care of the pauper insane in Scotland and its cost. *Poor Law Magazine*, **14**, p127.

In this way, patients suitable for boarding-out were often retained in asylums, although parish officials exonerated themselves by attributing the delays and obstructions to the lack of cooperation of medical superintendents. Somewhat surprisingly, this was acknowledged as a problem by sympathetic Commissioners, who, otherwise, were more supportive of the superintendents. One Commissioner, Macpherson, when addressing a meeting of inspectors of poor, accepted the complaint that superintendents were frequently unhelpful, but attempted to explain this by noting that many of them saw nothing of the success of boarding-out, but only saw those returned to the asylum as unsuitable, often in a worse condition than when discharged. Because of this, "they are apt to judge the system by what they see." Macpherson urged parish officials not to allow their judgement to be overruled by asylum staff: "you probably knew the patient before he went to the asylum, know his former characteristics and can judge what he will do again."[70] Many superintendents, he explained, felt genuinely that patients were better cared for within an asylum.

Annual reports from asylums recorded increasing co-operation from the parish, and even when this was sparse, it was attributed by medical superintendents more to apathy and indifference than to direct hostility towards the superintendent. Remarks in parish reports indicate that this was an accurate assessment. While the volume of articles from parish officials condemning the Board of Lunacy is remarkable, those criticising the activities and attitudes of asylum staff were, by comparison, rare. However, this does not imply that the opinion of local officials towards asylum staff was necessarily one of respect and deference. Rather, their energies were devoted to attacks on the central body of lunacy administration and, although condemnation of the expenses of asylum provision was consistent, there was no specific resentment against medical superintendents themselves.

13.7 Summary and conclusions

The role of the parish was vital in the successful implementation of boarding-out. Inspectors of poor had more specific duties and greater responsibility over the system of boarding-out than asylum superintendents and, notwithstanding certain resentments, the majority of parishes did board-out patients, when appropriate. In the long term, the animosity felt towards the Board of Lunacy was no bar to the successful discharge of their

[70] Macpherson, C. (1903) Boarding-out of pauper lunatics. Paper read before the Society of Inspectors of Poor. Reported in *Poor Law Magazine*, **13**, p129.

responsibilities. The frequency with which boarding-out was discussed in the Poor Law Magazine reflects the general recognition by the Board of Supervision and its local officers, of the merits of the system. Nevertheless, the regular visits to patients and the task of selecting suitable houses and guardians added considerably to the numerous duties of inspectors of poor and the advantages extolled by the Commissioners were of little regard to an overworked inspector of poor. The additional work involved was countered, however, by an awareness that the cost of boarding-out was lower than maintenance in an asylum, one of the paramount obligations of any parish official being to ensure that costs of caring for the indigent and insane poor were kept to a minimum.

Parish officials tended to be less critical than the Lunacy Commissioners of the conditions in which they found many boarded-out patients. Living in the same community and frequently knowing both patients and guardians well, the inspector of poor had greater insight into the real quality of life experienced by patients. The Commissioners freely admitted that the habits and language of those in the Highlands were, at times, incomprehensible.[71] Inspectors of poor, however, displayed greater flexibility, for example, in recognising that the Celtic population required to be dealt with in a different way from patients in urban areas.[72]

Inspectors of poor played a key role in the boarding-out system. Although the final sanction came from the Board of Lunacy, initial investigations and actions were taken by the parish to which patients were chargeable. Despite instances of apathy and obstruction in certain parishes, boarding-out developed and expanded in Scotland, largely as a result of the actions of their officials. Parishes with very few or no patients boarded-out tended to be administered by officials who remained sceptical, or merely disinterested in the system. Without their co-operation in selecting guardians and patients and their subsequent supervision, boarding-out could not continue. While officials from the large City parishes of Glasgow, Edinburgh and Paisley experienced great pressure in accommodating all their registered insane, the activity in boarding-out from these parishes was attributed more to the diligent input of the inspectors of poor, than to the high numbers of patients requiring

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[71] See for example the diaries of Kate Fraser, where she observed the problems of the language barrier. Mayes, M. (1995) *op.cit.*, Chapters 10 and 11.

[72] The importance of this was discussed by inspectors of poor in Inverness, in the late 1890s, for example, when they emphasised what they regarded to be the unique characteristics of Highlanders. Inverness Parish Council Minutes. 1897-1899 (CR6/1).

provision. Other parishes, where district asylums were equally overcrowded, did not have the same degree of activity. Therefore, although there was certainly some correlation between pressure on numbers and impetus to board-out, the actual extent of boarding-out was determined by the attitude and activity of individual parish officers. Further, while the original impetus and sustained pressure to board-out insane patients came from the Board of Lunacy, the ultimate success of the system was dependent upon the enthusiasm and cooperation of asylum superintendents and, most crucially, parish officials.

CHAPTER 14

COLONIES AND FAMILY CARE SYSTEMS IN THE UNITED KINGDOM AND WORLDWIDE

14. Overview

Insane persons throughout the world have long resided in the community, cared for by relatives, or paid guardians, under informal, private arrangements. However, from the 1860s, prompted by increasing prominence given to methods of non-restraint and freedom for the insane, physicians adopted organised, closely supervised policies of domestic provision. An evaluation of the Scottish system of domestic provision is not possible without an appraisal of related systems worldwide. In the absence of any extensive studies of international family care policies, this chapter explores the implementation and development of such systems, European and transatlantic, assessing the impulse behind their adoption, the proportion of patients affected and the degree of success attained. Considerable attention is devoted to activities in the rest of the United Kingdom, questioning the nature of the marked divergence in attitude towards an organised domestic system of care. The interchange of ideas between different countries is explored, and throughout the chapter, comparisons to the Scottish policy, where evident, are observed. Finally, the degree to which the Scottish system influenced international policy is assessed.

14.1 Introduction

The early years of the nineteenth century witnessed a marked growth internationally in asylum provision and a concomitant move towards the institutionalisation of the insane. Reflecting this, Mangen has suggested that:

> "by the mid-nineteenth century, most pauper lunatics in Europe were no longer in the community. Almost synchronously the European states had solved the problem of containment, the seclusion of the mad in institutions of their own became the treatment of first choice."[1]

[1] Mangen, S.P. (ed.) (1985) *Mental health care in the European Community.* London, Sydney, Dover, New Hampshire: Croom Helm, p6.

Overcrowding, therefore, became a severe problem in all developed countries, as chronic patients accumulated in wards, with no hope of cure or discharge. However, increased prominence given to the ideals of enlightened physicians, notably Tuke, Conolly and Griesinger, contributed to a growing acceptance that certain patients could be suitably provided for within the community, if closely supervised. The colony at Gheel, in Belgium, which had provided for the insane in the community for centuries, became the focus for alienists seeking alternatives to wholesale institutionalisation. By the 1860s, reports of visits to Gheel were published internationally, offering reassurances that certain insane patients could be provided for outside the asylum. Thus, formal attempts at domestic provision were implemented worldwide, prompted by necessity and a tentative confidence that such an alternative was safe and potentially beneficial.[2] Nevertheless, a number of powerful alienists remained unconvinced of its merits. Among them Billod, in the 1860s[3], and Van Deusen in the 1870s[4], recorded their scepticism, highlighting in particular, popular apprehension of the insane and the lack of official control. To Van Deusen, any advantages to patients were more than counterbalanced by dangers facing their guardians. Others argued that the system was no more economical or beneficial than the best run asylum.

The three dominant methods of extra-mural provision for the insane were: 1. systems of colonies attached to asylums; 2. independent colonies and 3. boarding-out in private families. All were different from the Scottish system, having no central supervisory body, and frequently being grouped around an asylum. Andrews has suggested that lunatic colonies on the continent were viewed as "dumping grounds" for chronic patients; for example, those boarded at Dun-sur-Auron, in France, were discharged from asylums as incurable.[5] However, patients who were quiescent, but potentially curable, were also placed in colonies.[6] The classification of patients and the characteristics of guardians were broadly comparable to those in Scotland. Notable differences lay, therefore, in the distribution of the insane and the nature of guardianship. While patients in Scotland were removed from asylum authority, and placed in the houses of related or unrelated guardians throughout the

[2] Although some countries made no formal attempts until the 1890s, there was a clear impetus towards such endeavours, from the 1860s, in the same way as the move towards institutionalisation had affected the treatment of the insane in the majority of countries during the first half of the nineteenth century.
[3] Anon. (1863) Discussion on the colonisation of the insane. *Medical Critic and Psychological Journal*, **3**, p578.
[4] Van Deusen, Dr. (1873) Provision for the care and treatment of the insane. Review. *Journal of Mental Science*, **19**, p146.
[5] Andrews, J. (1994) personal communication.
[6] The colonies of Gheel and Lierneux, for example, accommodated acute cases.

country, prominent systems elsewhere provided for patients in clearly circumscribed areas, often with asylum attendants as guardians, under the supervision of an asylum official.

The colonial asylum, or villa system, providing for domestic care, but on markedly different lines than in Scotland, was exemplified at Alt-Scherbitz in Germany, where patients were lodged in detached cottages in asylum grounds. Such a system cannot strictly be viewed as boarding-out, or family care, as it was more commonly known in Europe and the United States. Nevertheless, these cottages and agricultural farms were regarded widely as the way forward for lunacy provision. At Clermont and Fitz-James in France, colonies were run on similar lines. In the United States also, the villa system was adopted widely, its development seen as a logical extension of the open-door policy.

The religion or wealth of industrialised countries had less impact in determining lunacy provision than the pressing practical demand for a solution to overcrowding. Non-institutional provision developed both in countries which were prominently Catholic or Protestant; colonies of insane patients flourished in certain areas of Italy and France, but also in Holland, Belgium and Germany. Further, although American observers suggested that wealthy persons were less likely to receive patients into their households[7], such systems existed in areas of Germany and France not known for their poverty. Proximity to a country with an active boarding-out policy had little impact, as the contrasting activities in England and Scotland demonstrate. Rather, the pressures facing institutional provision and growing confidence in the theoretical benefits of care in the community, must be looked to as the major explanation behind the development of such systems. As the author of "the Gheel question" declared in 1865, the system of family care was applicable to all countries, rich and poor, and far from being a utopian ideal, contained "principles which are imposed on us by science, sound understanding, experience, and necessity".[8]

There was mutual sustained interest in international systems of domestic provision during the second half of the nineteenth century. Major medical journals which contained discussions on family care almost invariably referred to the systems practised in Gheel and Scotland. The open dissemination of information created a broad awareness of

[7] Stearns, H.P. (1881) *op. cit.*, p31.
[8] Anon. (1865a) *op.cit.*, p14.

international systems, stimulating lively debate across borders; the volume of articles describing the Scottish system illustrates the interest with which it was embraced. Further, summaries of annual reports from the Board of Lunacy detailing the condition of boarded-out patients were published in French, American and German journals, along with works by prominent proponents of the system. The most notable studies on family care systems were those by Alt, Tamburini, and, covering a later period, Bufe.[9] However, there has been no subsequent attempt to collate descriptions and assessments of the international movement in the nineteenth century. This chapter, therefore, is largely descriptive, outlining details of the implementation, growth and impact of such policies on individual countries.[10] Linking their adoption with the Scottish system illustrates broad similarities between attempts, with the success of boarding-out in Scotland highlighted repeatedly as the ideal to imitate. In the 1870s, at a time when many countries had not yet adopted such systems, Lindsay, of Murray Royal Asylum, had "little doubt that the adjunct cottage plan of treatment will yet form part of the asylum system of every civilised country."[11] This chapter investigates the accuracy of his remark.

14.2 Boarding-out in England, Wales and Ireland

Despite the activity in Scotland, a cohesive, centrally-organised system of domestic provision failed to flourish in England, Wales or Ireland. This study has indicated that one of the major motivations behind boarding-out in Scotland was relieving overcrowded asylums. Similar concerns about overcrowding were voiced throughout the United Kingdom, but the option of accommodating patients in private dwellings was rarely advocated. While the Lunacy Act, 1845, had ordered the compulsory establishment of asylums in all counties throughout England and Wales, by 1865, the Lancet, reflecting the dominant concerns of physicians, questioned what solutions were proposed for accommodating the growth of pauper insane: "are the existing county asylums to be enlarged time after time until they become as monstrous and unmanageable as the metropolitan ones are?"[12] Problems created by overcrowding appeared to be insoluble.

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[9] Alt, K. (1899) *op.cit.*, Tamburini, A, Ferrari, G.C, and Antonini, G. (1918) *op.cit.*, and Bufe, E. (1931) International ubersicht uber den stand der Familienpflege. *Zeitschrift für psychische hygeine*, 4, 98-110.

[10] The greater attention devoted in this chapter to certain countries, most notably France, Germany, and America was influenced in part, by the greater accessibility of pertinent records, notably the prominent medical journals for each country, but prompted also by a recognition that these countries, along with the striking experiment in Belgium, were among the most active in implementing domestic provision for their insane.

[11] Lindsay, W.L. (1871) *op.cit.*, p514.

[12] Anon. (1865c) *op.cit.*, p621.

Physicians throughout the United Kingdom could not fail to be aware of the system developing with such apparent success in Scotland. Vigorous debates at Annual Conferences assessed arguments for its introduction and from the late 1860s and over the next thirty years, the Journal of Mental Science contained lengthy descriptions and discussions of the Scottish system. Although by no means written exclusively by Scottish physicians, there was a perceptible decline in English contributions from the mid-1880s, signifying a general, if not always unanimous, agreement to remain firmly within the boundaries of an institutional system of care. While there was considerable support for boarding-out by a number of prominent physicians, including Maudsley, Stallard and Bucknill, lunacy administrators proved unable, or unwilling to implement a potentially valuable adjunct to institutional care.[13] In 1867, for example, the proportion of patients boarded-out in Scotland was well over twice that in England, prompting Stallard to suggest that, "one or other of the systems must be wrong, if 27% of pauper lunatics of Scotland can be treated at home, so must they in England."[14] A number of alienists maintained, somewhat implausibly, that the proportion of patients in domestic care was comparable to that north of the Border, despite the official bias in Scotland in favour of boarding-out. Coxe, for example, contended that while there was:

> "a great deal of talk about the Scotch system of boarding-out, in reality there is as much boarding-out in England, the only difference is that it is part of the Scotch system of lunacy to place every pauper lunatic under the jurisdiction of the Commissioners, whereas in England this is not the case."[15]

With the exception of Chancery lunatics, those in the community received little systematic supervision or regulation.[16] Any knowledge the Commissioners had of pauper cases was gleaned solely from reports by untrained parish officials. Such a position cannot be compared to the formal policy prevailing in Scotland.

Notwithstanding consistent hostility for an organised system of boarding-out, a related experiment of small cottages in asylum grounds proved popular. Robertson, while a vocal

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[13] Other powerful advocates of a boarding-out system included the editors of the Lancet and the British Medical Journal. As McCandless has observed , Wynter, editor of the British Medical Journal from 1858-1860 was a great enthusiast, maintaining that treatment in large institutions could not be a success. The Lancet proposed the adoption of a system on the lines of Gheel in England as early as 1858, with the BMJ following a few months later. McCandless's article follows the pressure exerted by these bodies, and their ultimate failure. McCandless, P.(1979) *op.cit.*

[14] Stallard J. (1869) Pauper lunatics and their treatment. *Transactions of the National Association Promotion of Social Science*, **70**, p470.

[15] Coxe, J. (1878) Discussion. *Journal of Mental Science*, **24**, p481.

[16] Chancery patients were seen quarterly by Visitors who could insist on their removal, if improper treatment was evident. To Bucknill, Chancery patients experienced "untold blessing" when boarded in private dwellings. Bucknill, J.C. (1880) *The care of the insane and their legal control.* London: Macmillan, pxxii.

critic of boarding-out, dismissing the possibility of implementing a Gheel model as "utterly impracticable", endorsed the cottage asylum system. He maintained that the accommodation of patients under the care of a married asylum attendant, in the grounds of the building "stands midway between the asylum wards and the private dwellings, and combines...the advantages of both."[17] While patients remained under the control and discipline of asylum superintendents, they also received the benefits of domestic life. Other superintendents concurred, placated by the greater autonomy they retained over patients.[18]

14.2.1 England

Long before any official discussion on the merits or otherwise of allowing patients to live in the community, patients from a "superior social position" had avoided the stigma of asylums by remaining in their homes, or residing in the private houses of medical men. Nevertheless, while as many as 28% of private patients were boarded in the community, a practice explored in detail by Hervey, only a minority of paupers were similarly accommodated.[19] Although there was no magistrates' order to legalise their detention, no one in England was allowed to keep a patient in an unlicensed house, and persons receiving patients had to be in receipt of medical certificates, under the authority of the Boards of Guardians. Notwithstanding these legal requirements, the Board of Lunacy conceded that many patients were kept in private dwellings for profit, "not in that happy state of liberty and comfort" reported in Scotland.[20]

However, sporadic attempts were made by various superintendents to encourage systems of domestic care. Incurable patients were discharged to the care of their friends from asylums in Surrey, Gloucester and Suffolk. A more widely known experiment was undertaken by Bucknill at Devon County Asylum, prompted in part by consistent pressures of overcrowding, and the need to find alternative accommodation while extensions to the asylum were underway and by a belief that non-institutional provision could be beneficial to certain patients.[21] Thus, in 1856, he boarded 42 patients by the seaside. Following initial

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[17] Robertson. C.L. (1865) On the several means of providing for the yearly increase of pauper lunatics. *Journal of Mental Science*, **10**, p487.
[18] For example, Toller, E. (1865) Suggestions for a cottage asylum. *Journal of Psychological Medicine*, **10**, p343.
[19] Hervey discusses the condition of single patients in England. In this he concludes that the English Lunacy Commission "were not keen to be involved in the secret world of lodgings care". Hervey, N. (forthcoming) *op.cit.*, East, E. (1886) *op.cit.*, contains a lengthy discussion on treatment for single patients.
[20] Anon. (1865d) *op. cit.*, p377.
[21] Parry-Jones, W.Ll. (1981) *op.cit.*, p209.

concern among the neighbourhood, when meetings were held, and petitions lodged, residents accepted their presence. Patients were also placed with cottagers in the neighbourhood of the asylum, remaining under the supervision of asylum superintendents.[22] This experiment was considered successful, if short-lived. Bucknill's endorsement of the system echoed views held in Scotland, when contending that:

> "it is in the development of this system...that the greatest promise lies of the largest possible amelioration of the unhappy lot of those afflicted with mental disease."[23]

His advocacy of widespread adoption of domestic provision as an adjunct to the asylum system remained, however, almost a solitary plea. An exception to this was the successful experiment undertaken at Sussex County Asylum. Over a period of 18 years, Williams, the medical superintendent, discharged almost 15% of all admissions to the care of friends, thereby postponing the necessity of erecting additional buildings, and reducing the county's poor rate. While recognising the importance of retaining close supervision over such patients, Williams urged the amendment of lunacy laws to encourage the facilitation of boarding-out.[24] Despite strong prejudices in the minds of many, particularly from the middle and upper classes, against the release of insane patients into the community, in his opinion, the system was worthy of further development.[25]

14.2.2 Wales

The condition of the insane in private dwellings in Wales has been largely overlooked, not only by recent authors, but by nineteenth-century alienists. Michaels, in her study of asylums in North Wales, observed that before 1848, the vast majority of the insane resided in the community as single patients.[26] However, just as in Scotland at this time, this was less a result of designated policy than a reflection of the dearth of alternative provision; there was no asylum in North Wales during the first half of the nineteenth century. Patients were therefore either sent to private madhouses, prisons, or remained in their homes.

Notwithstanding the growth of county asylums, large numbers of patients continued to be accommodated in the community throughout the nineteenth century. Some reports suggest

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[22] Bucknill, J.C. (1861) Presidential Address. *Journal of Mental Science*, 7, 1-23. In a useful article, Philo has documented the experiment of Bucknill, and assessed the objections put forward: Philo, C. (1987) "Not at our sea-side": community opposition to a nineteenth-century branch asylum. *Area*, 19(4), 297-302.
[23] Bucknill, J.C. (1880) Care of the insane and their legal control. London: Macmillan & co, p120.
[24] Report from the Select Committee appointed to inquire into the operation of the Lunacy Law, 1877 (373.) xiii.1, p183.
[25] Williams, S.W.D. (1872) Our overcrowded lunatic asylums. *Journal of Mental Science*, 18, 515-518.
[26] Michaels, P. (1994) Seminar given at Wellcome Unit for the History of Medicine, Glasgow.

that the proportion was comparable to that in Scotland. In 1889, for example, 25% of all insane patients were in private dwellings.[27] Ten years later, in the counties of Anglesey, Cardigan, Carmarthen and Caernarvon over 30% were provided for in this way.[28] However, these figures are misleading. Such patients were, as in England, under no official control or regulation and, therefore, not formally boarded-out.

The social and economic circumstances of the population were almost identical to conditions held to be eminently suitable for the development of a boarding-out system. In central Scotland, the creation of aggregations of insane patients had been facilitated by the willingness of impoverished residents of rural communities to accept patients into their homes. In Wales, despite this similarity, no such organised system developed. Patients who remained outside the constraints of asylum provision went unsupervised and unreported. There is no evidence that medical journals or groups of foreign visitors displayed any interest in such *ad hoc*, often wholly unsuitable, arrangements. Thus, despite large numbers of insane patients remaining outside the jurisdiction of the asylum, the dismissive references by Lunacy Commissioners and medical commentators regarding a formal policy of domestic provision indicate that the scepticism and apathy displayed towards boarding-out in England was no less apparent in Wales.

14.2.3 Ireland

An organised system of boarding-out failed to be established anywhere in Ireland in the nineteenth century. In stark contrast to medical journals published in England, the prominent medical journal, the Transactions of the Royal Academy of Medicine in Ireland contained no discussion of domestic care until the 1890s, when two persuasive articles advocating the adoption of the policy were published by Norman, superintendent of the Richmond Asylum. Dublin.[29] While he accepted that for a large proportion of the insane, asylum treatment was necessary, he remained highly critical of the "unhealthy surroundings" of asylum society. Adopting similar arguments to those adhered to by Scottish proponents, highlighting humanitarian, utilitarian, and economic benefits, he expressed confidence that the system could be adopted successfully in Ireland because:

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[27] GBCL 43rd AR (1889).
[28] Sutherland, J.F. (1897) *op.cit.*, p48.
[29] Norman, C. (1890) *op.cit.* and (1895) The domestic treatment of the insane. *Transactions of the Royal Academy of Medicine in Ireland*, **8**, 412-425.

> "our people are kindly disposed to the afflicted. They are very domestic in their habits and many of them are unfortunately poor enough to be willing to undertake any honest method of assisting themselves in the struggle for existence".[30]

Notwithstanding his sustained enthusiasm, boarding-out did not become a recognised policy in his lifetime. Asylum officials throughout Ireland displayed little interest in the idea and extensions to asylum buildings remained the favoured solution to overcrowding.

14.2.4 Factors influencing against boarding-out

Scottish observers, and the few English proponents of the system, were critical of the prevailing apathy in the rest of the United Kingdom. Parry-Jones has highlighted the fear of the insane embedded in English consciousness, with scandals of eighteenth century abuses in the "trade in lunacy", and concerns prompted by the madness of George III remaining dominant in the public mind.[31] Further, fears of wrongful confinement, publicised so prominently by Perceval, with his Alleged Lunatics Society, created among the public a disinclination for involvement in the affairs and treatment of the insane. Scottish physicians suggested that there was an undercurrent of dissatisfaction in lunacy administration in England, as opposed to a general sense of security and confidence in Scotland. The comparative lack of scandals and exposure by Select Committees in Scotland, when contrasted to England (with the exception of the Royal Commission Report of 1857), probably countered the widespread fear and disdain expressed towards the insane in England, thereby creating within Scotland greater tolerance of those residing in the community. The deeply entrenched prejudices against freedom for the insane contributed to the continuing dominance of institutional provision, at the expense of more innovative experiments. The major obstructions to the development of boarding-out are examined in turn.[32]

14.2.4.1 Negative attitude of Lunacy Commissioners

Hostility from the Board of Lunacy made the successful implementation of domestic provision an impossibility. Commissioners reports contained almost no mention of the

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[30] Norman, C. (1895) *op.cit.*, p423. Over ten years later, his enthusiasm was undiminished. Giving evidence to the Royal Commission, he announced that "the sooner the legislation is adopted the better, as some system of family care for the insane is in all probability inevitable." Royal Commission on the Care and Control of the Feeble-minded (1908), p118.

[31] Parry-Jones, W.Ll. (1972) *op.cit.* Scandals recorded in Select Committee reports of the early-nineteenth century further discouraged popular confidence in the treatment of the insane.

[32] Constraints of space prevent full discussion of the arguments presented. Both Parry-Jones and McCandless address this issue, but the clearest evidence of English attitudes are found in Commissioners reports for England and debates of the Medico-Psychological Association recorded in the Journal of Mental Science.

system, except to declare that the higher wages of English workers meant that the majority would not be inclined to receive patients for additional income. Their own scepticism and "near-phobia of abuse" was, in fact, more responsible for the general apathy. To Parry-Jones, such concerns had a paralysing effect on the policy.[33] Thus the Commissioners declared in 1873, with the knowledge of the flourishing system in Scotland, that:

> "the risk of placing patients to board with strangers is so great that in the existing state of the law, we think it would be unwise materially to extend the practice."[34]

They argued that boarded-out patients would be unsuitably provided for by unqualified, potentially mercenary, abusive guardians. By contrast, in asylums, patients were well cared for by trained officials, and offered the luxuries readily available in the community only to the wealthy. In addition, it was generally accepted that the Lunacy Commission was "too weak to add to its burden" by ordering extensive supervision of patients in the community.[35] Adequate supervision would have required a far greater number of Commissioners than were needed in Scotland.[36]

Impassioned attempts by Norman to convince the authorities in Dublin to adopt a system of boarding-out proved futile. Finnane has pointed to a general suspicion of innovation among inspectors in Ireland.[37] This was evident in their reaction to the prospect of boarding-out. Among their reasons for doubting the safety of such a policy, they highlighted the general lack of respect for the law which could lead to regulations being ignored. Obstruction from Commissioners, asylum and poor law governors proved insurmountable. Similar scepticism and disapproval was reported among officials in England. Illustrating this, Whitwell recorded the apathy he encountered among Boards of Guardians in Suffolk in his attempts at boarding-out. The expenditure of effort demanded produced a negative response: "they appear to see only the small local side of the matter and not realise the larger side...the comfort to the patient, economy to the county...". Whitwell's experiment was successful for two years, until the passage of the Lunacy Act, 1890, which "entirely and hopelessly killed" it. Patients were to be re-certified periodically by the asylum's

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[33] Parry-Jones, W.Ll. (1981) *op.cit.*, p213.
[34] GBCL 27th AR (1873), p18.
[35] Anon. (1909b) Boarding-out. Occasional notes. *Journal of Mental Science*, **55**, p93.
[36] Thus Rayner, a physician, suggested that "the reason they were frightened of it in England was feebleness in point of numbers and therefore in the working power of the Lunacy Commissioners". If the Lunacy Commission had been numerically equal to its duties, he contended that they would have encouraged asylum superintendents to implement an active boarding-out policy. Anon. (1909a) *op. cit.*, p181.
[37] Finnane, M. (1981) *Insanity and the insane in post-famine Ireland.* London: Croom Helm, p72.

medical officer. Many had been boarded in locations distant from any railway line, or aggregations of people and access to patients for certification became too problematic for the continuation of the experiment.[38]

The English Lunacy Commissioners firmly denied suggestions by the Chairman of the Royal Commission on the Care and Control of the Feeble-minded in 1908 that Scotland was more advanced and "better for pushing on experiments in lunacy administration".[39] The Secretary to the English Board stressed that the question of introducing boarding-out had been discussed incessantly, but that it was generally agreed that the best policy was continued extension of asylum buildings.[40] Despite recognition that large institutions could be injurious to good management and patient care, dissatisfaction with asylum provision was not strong enough to inspire any radical shift in policy.

14.2.4.4 Negative attitude of physicians

Many alienists deplored domestic provision as utopian and unrealistic and there was agreement that the public would be unwilling to take on the burden of caring for the insane. Further, the standard of living in the homes of the lower classes were regarded by some as physicians as wholly inappropriate for patients. The prospect of boarding-out inoffensive pauper patients in prevailing conditions was "altogether repugnant."[41] One of the strongest attacks came from Robertson, superintendent of Sussex County Asylum. In 1865, he had appeared to be in favour of a limited introduction of the system. However, two years later, his opposition was vehement when he questioned:

> "how far removed from sober truth are the pictures of rural bliss....which are yearly chronicled in the appendix to the Scotch Lunacy Commissioners Reports",[42]

although, as Mitchell observed, he made his judgement without ever seeing the system in practice. Robertson argued that representations of "rural bliss" were distorted, that the Commissioners glorified a system where ignorant, greedy guardians had a disproportionate degree of control over vulnerable patients, and that the system was a "retrograde step in the care and treatment of the insane."[43] The extension of detached blocks in asylum grounds

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[38] Royal Commission on the Care and Control of the Feeble-minded (1908), p450.
[39] *Ibid.*, p43.
[40] *Ibid.*, p13.
[41] Parsey, W.H. (1876) The President's Address. *Journal of Mental Science*, **22**, p357.
[42] Reported in Mitchell, A. (1868) *op.cit.*, p491.
[43] *Ibid.* p497. Robertson doubted the motivation of guardians in Scotland, arguing that "cupidity, fear and ignorance were strong motives of action with the masses." To him, the insane required the safeguards which public asylums alone could

was preferable to such a system.[44] Another alienist, Balfour, while acknowledging that a balanced system of asylums and private care could be successful, urged caution:

> "once admit that chronic and harmless lunatics should be removed from the asylum and placed under private care and...you implant into the country a source of evil for the present and the future which nothing will get rid of."[45]

Others agreed that instituting a policy of domestic provision would be a regressive step, which would do little to advance lunacy provision, or ameliorate overcrowding. Thus Rogers declared that, "the proportion of [suitable] cases is so limited that it does not practically affect the question of future provision for the insane poor."[46] Such an assessment was, in fact, unfairly dismissive, as the experience in Scotland makes clear.

While some influential alienists and observers advocated the adoption of non-institutional provision, their ideas had little impact. Among the most prominent was Maudsley who maintained that a boarding-out policy would increase the comfort of patients and relieve asylums.[47] Others contributed to lively debates on the validity of extending the system. Sankey, for example, declared that boarding-out was a procedure he thought England might "very advantageously copy" from Scotland.[48] However, as Busfield has contended, Maudsley's suggestions "ran counter to the institutional bias of the nineteenth-century poor law and so had little chance of adoption".[49] Hervey too has argued that "the whole trend of psychiatry was towards an almost exclusive dependence on an institutional base."[50] The dominant mood was deep hostility to such a system; the belief that the asylum was the only suitable place for the insane remained unassailable. Parry-Jones is justified, therefore, in his contention that:

> "the concept of a cottage, family, or colony system never gained ground in Britain...opposition from leading asylum psychiatrists and those responsible for overseeing lunacy in the country was always too great."[51]

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offer.

[44] The argument between Mitchell and Robertson documents well the advantages and opposing concerns voiced by alienists throughout the United Kingdom. Robertson. C.L. (1865) On the several means of providing for the yearly increase of pauper lunatics. *Journal of Mental Science*, **10**, 470-491, and (1867) Presidential Address. The care and treatment of the insane poor. *Journal of Mental Science*, **12**, 287-306.

[45] In Anon. (1880) Discussion. *Journal of Mental Science*, **26**.

[46] Rogers, T.L. Reported in Anon. (1877b) Notes and News. *Journal of Mental Science*, **23**, p444.

[47] Maudsley, H. (1867) *op.cit.*, p430. *Vide supra.* Chapter 8 for more detailed assessment of Maudsley's attitude.

[48] Anon. (1909a) *op. cit.*, p181.

[49] Busfield, J. (1986) *op.cit.*, p277.

[50] Hervey has detailed how powerful alienists attempted "through the activities of the Metropolitan and National Lunacy Commission to curtail, if not eliminate the practice of single care." Hervey, N. (forthcoming) *op.cit.*, To McCandless the idea of community care was rejected "virtually without trial". McCandless, P. (1979) *op.cit.*, p571.

[51] Parry-Jones, W.Ll. (1981) *op.cit.*, p212. Among them was D.H.Tuke, who condemned experiments such as those by Bucknill as "utopian and absurd".

14.2.4.3 Financial considerations

A lack of financial saving and the high demands made by potential guardians were highlighted as an obstacle to the development of boarding-out. The maintenance costs paid in Scotland was considered too low to be acceptable in England. Chapman, for example, argued that the difference between the English and Scottish system was "very much a question of money," and that suitable caretakers could not be found in England willing to take on the burden of an insane boarder.[52]Robertson also declared that the system would not provide the savings achieved in Scotland; "they manage it...for sixpence a day. I have failed to obtain necessary comforts for chronic lunatics for one shilling a day".[53]

An additional explanation may be sought in the impact of the Government grant-in-aid, introduced throughout Great Britain in 1874, providing four shillings a week towards the maintenance of every pauper lunatic. While boarded-out patients in Scotland received the grant, it did not extend to those outside asylums in England and Wales, thereby creating a strong disincentive to adopt domestic provision. Nevertheless, the Scottish Commissioners dismissed the financial arguments of their English counterparts, considering such reasons to be merely excuses. Further, as Blandford stressed, domestic treatment was not necessarily costly. The position of Chancery patients indicated that suitable cases could be provided for at a moderate cost. Boarding-out, therefore, was suitable for all patients who were easily manageable, not just the wealthy. Claims that certain counties were too impoverished[54] found little favour with experienced Scottish officials, who concluded that no country was too poor, or too wealthy to create favourable conditions for a system of family care.

14.2.4.4 Unsuitable general conditions

There was general consensus among physicians, enthusiasts and critics alike, that England was too densely populated to allow the successful development of a system whereby vulnerable, possibly disturbed, patients were allowed to roam at large. For example, superintendents in Yorkshire had been in favour of the system, but were forced to conclude

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[52] In Anon. (1889a) Notes and News. *Journal of Mental Science*, **34**, p619.
[53] Robertson, C. (1867b) *op.cit.*, p214 To Robertson, "in a rich and thickly peopled country like England, where labour is abundant and wages high, the number of cottagers who would consent to receive boarders are not so numerous as in Scotland."
[54] See, for example, comments of the physicians Yellowlees and Jones, in Anon. (1909a) *op. cit.*, p176.

that its adoption was not practicable, "mainly on account of the character and density of the population."[55] Hack Tuke suggested that no more than 10%, and probably under 8% of patients could be boarded-out, in contrast to up to 25% in Scotland.[56] In Ireland, the risk of pregnancy among vulnerable patients, the difficulty in finding clean homes, the temptation of "profiteering" and the threat to property values, were considered too real to allow boarding-out to flourish. One inspector of lunatics, O'Farrell, although in principle in favour of the policy, recognised that his country was not well suited for it:

> "the people have rather a fear, an objection, to insanity close to them in their homes...What they call in Scotland "sexual accidents" in Ireland would create a tremendous sensation."[57]

The fear and prejudice reported among villagers in Scotland, when a systematic policy of boarding-out was first established, was considered potentially so great in England as to prevent general acceptance of patients residing in the community. Illustrating this, one medical superintendent, Parsey recommended the adoption of boarding-out in rural districts near an asylum. His enthusiasm was not reciprocated by the asylum committee, which received his suggestion "with great repugnance", declaring "why, you are not going to let loose all your lunatics among us!"[58] However, while it was reported to the Royal Commission in 1908, that "English people would not like such a system", Sutherland argued that this should not obstruct any attempts to implement boarding-out.[59] Similar objections in Scotland had declined once the system had become established. Nevertheless, the claim of Elkins, an asylum superintendent, seems plausible, when he attributed the general lack of enthusiasm to a misunderstanding of the behaviour of the chronic insane and to the fact that people in England, and particularly in London, were "so self satisfied that... it was impossible to cast the eyes further out and see and profit by what had been done in Scotland and elsewhere."[60]

14.2.5 Interim conclusions

The scepticism and apathy displayed south of the Border was remarkable, in view of the widely heralded success of boarding-out in Scotland and the international attention it

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[55] Tuke, D.H. (1889b) On the provision for the insane poor in the future. *Journal of Mental Science*, **35**, p321.
[56] *Ibid.*
[57] Royal Commission on the Care and Control of the Feeble-minded (1908), p82.
[58] Parsey, W.H. In Anon. (1877b) Notes and News, *Journal of Mental Science*, **23**, p446. C.L. Robertson too, recorded the prejudices in the minds of many, particularly the middle and higher classes against the discharge of lunatics.
[59] Royal Commission on the Care and Control of the Feeble-minded (1908), p50.
[60] Elkins. In Anon. (1909a) *op. cit.*, p180.

received. Consideration of social differences between the countries does little to explain the diversity. While the density of population and greater individual wealth were highlighted as obstacles to the development of boarding-out, similar conditions prevailed in parts of Scotland. However, patients were simply removed to more amenable districts, where employment was low and the population sparse. Such locations existed throughout the United Kingdom. Further, there were marked similarities in population distribution and economic strengths, particularly in Wales and Ireland, and yet the system never became more than a highly debated theoretical issue.

The greater availability and ease of access to institutions in the rest of the United Kingdom is likely to have been a major determinant. The legislation of 1808 and 1845 encouraged, then ordered, substantial growth in asylum provision. In addition, large numbers of the insane, both private and pauper, were provided for in private madhouses, which declined rapidly in Scotland, as the century progressed. Although the Lunacy Act, 1890, had restricted further expansion, there were still 70 establishments in operation in England by 1900, contrasted to only three in Scotland. The ethos of custodialism was more deeply entrenched in England than across the Border, where until the 1860s, asylum provision had long been limited to the wealthy and those in urban areas. Sutherland was, therefore, accurate in observing that, even by the turn of the century:

> "it does not seem as yet, to have struck the English mind, fond of public institutions, with imposing architectural features, that the remedy [to overcrowding] is to be found in an adoption of the policy followed so successfully in Scotland."[61]

There was, somewhat surprisingly, no element of competition between the countries. Boarding-out in Scotland was widely accepted as successful, but there was no move from English physicians to imitate this accomplishment.[62] Thus, the superintendent of Monmouth Asylum suggested in 1882 that "the English system was too severe and perhaps the Scotch too free...[we] need a happy union of the two"[63]. Proponents declared that boarding-out was successful throughout the world, and that it was impossible therefore, to single out England as the one country where such a system could not work.

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[61] Sutherland, J.F. (1897) *op.cit.*, p49.

[62] However, a minority of physicians argued that Bucknill should be attributed with creating the system. Thus Mickle, the President of the Medico-Psychological Association complained that "it was not realised how much work the English Commissioners did. It was to be remembered that the Scots had the benefit of the working of the English Lunacy Act for ten years before theirs was drawn up and they had the advice of two of the English Commissioners. The boarding-out system had really been begun in England by Bucknill, and not in Scotland". In Turnbull, A.R. (1896) The mode of provision for the chronic pauper insane. Followed by discussion. Notes and News. *Journal of Mental Science*, **42**, p894.

[63] Anon. (1882) Asylum reports. *Journal of Mental Science*, **28**, p108.

The ambivalence and widespread rejection of boarding-out was, therefore, attributable largely to official scepticism. Although the greater number of alternatives, private madhouses, workhouses, and increasingly, villa systems, minimised the urgency to imitate Scotland, such methods were utilised in conjunction with boarding-out across the Border. Reasons put forward by officials for their lack of activity in implementing domestic provision, were regarded by proponents as weak justification for their own apathy. Finnane's conclusion for Irish failure is equally applicable to England and Wales. Boarding-out was never implemented successfully, because it was never able to surmount "the obstacles of administrative caution and political inertia."[64]

14.3 Gheel

There is such an extensive literature describing and assessing the lunatic colony at Gheel, in Belgium, that further description is unnecessary. For a concise, informative discussion of the colony and its relevance to the United Kingdom, Parry-Jones[65] is the most useful. Prominent international medical journals of the nineteenth century contained regular discussions and descriptive articles on the colony and its applicability to other countries.[66] The introduction of a system of providing for large numbers of the insane outside an asylum under formal control and supervision was attributed to Gheel. As Sutherland maintained:

> "Belgium for centuries has given an object lesson to all civilised nations by the system of boarding-out in the commune of Gheel, the Mecca of alienists and appropriately termed the "paradise of fools."[67]

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[64] Finnane, M. (1981) *op.cit*, p142.

[65] Parry-Jones, W.Ll. (1981) *op.cit.*,

[66] Among those recommended for further reading are: Stevens, H. (1858) Insane Colony of Gheel. *Journal of Mental Science*, **4**, 426-437, Duval, J. (1860) *Gheel ou une Colonie d'aliénés vivant en Famille et en Liberte*. New York:Ballière Brothers, Paris Guillaumin et Cie Librairies, Sibbald, J. (1861) *The Cottage System and Gheel. An Asylum Tract*. London: J.E.Adlard (Also in *Journal of Mental Science*, 1861, **7**), leGrand du Saulle (1860) Gheel, ou une colonie d'aliénés vivant en famille et un liberte. *Annales Médico-Psychologiques*, 333-336, Coxe, J. (1862) A recent visit to Gheel. *Medical Critic and Psychological Journal*, **2** 184-192, Anon.(Author of the Gheel Question) (1865a) A Catechism on the necessity and possibility of a radical reform in the treatment of insanity. *Journal of Mental Science*, **10**. 5-21, Wiedemeister, Fr. (1865) Was leistet das zu Gheel ausgeführte System für die Heilung der Kranken? *Allgemeine Zeitschrift für Psychiatrie*, **21**, 122-141, Kitching, Dr. (1867) On the Gheel Question. *Journal of Mental Science*, **12**, 131-133, Maury Deas, P. (1876) A Visit to an insane colony. *Journal of Mental Science*, **22**, 66-77, Mundy, J. (1862) The Gheel Question. *Medical Critic and Psychological Journal*, **2**, 399-412, Neuschler, E. (1867) A Visit to Gheel. *Journal of Mental Science*, **12**, 20-43. Transl with remarks by J. Sibbald, Webster, J. (1867) The Insane Colony of Gheel Revisted. *Journal of Mental Science*, **12** 327-40, Tuke, D.H. (1886) On a Recent Visit to Gheel. *Journal of Mental Science*, **31**, 481-497, Cleaves, M. (1891) The Colony of the Insane at Gheel, Belgium. *Journal of Mental Science*, **37**, 227-238, Sibbald, J. (1897) Gheel and Lierneux, the Asylum Colonies for the Insane in Belgium. *Journal of Mental Science*, **43**, 435-61.

[67] Sutherland, J.F. (1897) *op.cit*, p51.

Gheel was located in the Campine near Antwerp. Following the rise of the legend of St Dymphna, the daughter of an Irish king, martyred there in the seventh century, insane persons visited her shrine in large numbers, gradually creating a colony. Run largely by the Church for centuries, by 1852, it had been placed under the Belgian Government, and non-ecclesiastical officials appointed. The colony was divided into four sections, each with a separate medical officer. Throughout the nineteenth century, there were over 1000 patients residing in the village, distributed among 11,000 inhabitants.[68] The occupations of those receiving patients was as varied as in Scotland, although some guardians were of a higher social class, prompting Coxe to observe that "patients are received indiscriminately by all classes of the community".[69]

One of the major distinctions between Gheel and the Scottish system lay in the mental characteristics of the patients. In Scotland, the majority were certified as harmless, chronic and clean. However, not all patients at Gheel were fatuous or imbecile. For example, in 1862, of every 100 admitted, 13 suffered from melancholia, mania (42), monomania (4), dementia (34) and epilepsy (7).[70] Patients who were homicidal, suicidal or offensive were excluded. Parigot, the first medical director, established a system of classification in the 1850s, whereby patients who were quiescent and capable of employment were placed in villages and larger hamlets. Those who were noisy and unmanageable were boarded in remote hamlets to avoid public disturbances. Such patients would not have been boarded-out in Scotland.

There was sustained criticism of Gheel throughout the nineteenth century, although the strength of attack declined somewhat with the advent of stricter supervision. One consistent complaint concerned the excessive restraint of patients. Guntz, visiting in 1853, for example, reported the common presence of chains, prompting him to announce that "had I not known where I was, I should have supposed myself in a convict colony."[71] Over 30 years later, in 1886, Hack Tuke noted that patients were strapped down in pierced chairs. Other objections focused on inadequate classification and medical superintendence, lack of amusement, and frequently, the inability of guardians to comprehend the language

[68] The number of patients rose from 284 in 1804 to 1000 in 1847. Roosens, E. (1979) Mental patients in town life, Gheel, Europe's first therapeutic community. Sage Library of Social Research, 90.
[69] Coxe, J. (1862) *op.cit.*, p185.
[70] *Ibid.*, p190. Subsequent visitors also commented upon the high proportion of noisy, dirty and excitable cases.
[71] *Ibid.*, p191.

of their boarder. The standard of housing was also condemned, Tucker observing in 1883 a "universal wretchedness and sordid misery."[72] Further, the personal liberty extolled so frequently, was, to many, "delusive and unreal". Falret, while maintaining that the inconveniences had been exaggerated, accepted that the distinguishing features of the colony, unrestrained personal freedom and a domestic life, had been overstated. To him, "Gheel has more to gain by approaching the asylum system, than the asylum system in approaching Gheel".[73]

Notwithstanding sustained criticism, the status of the colony rose in the 1880s, following the appointment of Peeters as medical director; suicides were rare, and the incidence of pregnancy among patients was low with on average one case reported every five years[74] (a lower rate than that achieved in Scotland). As criticism from international observers abated, greater attention was focused upon the beneficial nature of the extended freedom granted to patients. The cost of maintenance for patients boarded in this way was one-third less than that in asylums and, as Neuschler conceded fairly, despite a number of deficiencies, the colony was "an example of very good, in some cases the best kind of treatment for the insane."[75]

14.4 Belgium

A colony for insane patients was established in Lierneux, in the Walloon district, near Liège, following the same system as that of Gheel. Patients boarded at Gheel resided with Flemish speaking guardians. However, the language barrier had proved an insurmountable difficulty to patients from the Walloon provinces. In an attempt to resolve this, in 1884, four patients were sent from Gheel to Lierneux, a thinly populated area selected for its remote nature. Further, the inhabitants were poor and lacked any specialised industry to support them; circumstances recognised as favourable in Scotland. Following initial protests about the distribution of insane patients in their community, the colony grew

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[72] Tucker, G.A. (1887) *Lunacy in many lands.* Sydney: C.Potter, p18.
[73] Falret, J. (1862) Report on Commission appointed to examine Gheel. *Medical Critic and Psychological Journal*, **2**, p366.
[74] Norman, C. (1890) *op. cit.*, p466.
[75] Neuschler, E. (1867) *op.cit.*, p35. Mentally ill patients are still sent to Gheel today. The colony, the "State Psychiatric Hospital-Center for Family Care" is controlled by the Ministry of Public Health. (Parry-Jones, W.Ll. (1981) *op. cit.*, p205). In 1980, for example, 1363 patients were boarded among 1007 foster families. 45% were over the age of 55 and two-thirds were male. The majority of patients are classified as subnormal.

rapidly. By 1896, 420 patients were resident in Lierneux.[76]

Guardians were only allowed to receive patients of the same sex. Deperon observed that many of the patients appeared wholly unsuitable for such provision, being:

> "mostly unhappy beings reduced to a merely vegetative life, idiots on the lowest rung of the ladder, paralytics in the last stage, patients whom up to the present we have felt bound to admit in our wish to people our young colony."[77]

Notwithstanding this, observers offered generally favourable assessments of the colony, and as Féré announced, the experiment demonstrated that "it does not need centuries to make a Gheel."[78] Not surprisingly there were more similarities between Lierneux and Gheel, than with the Scottish system, most notably in the distribution of patients, who were more closely congregated than was the practice in Scotland. On arrival patients were placed in the infirmary, which "corresponds in every way to the infirmary at Gheel" before being boarded with selected families.[79] Although the colony never attained the prominence or achieved the worldwide interest shown in Gheel and Scotland it nevertheless offered more suitable provision for patients from the Walloon province than transportation to the larger, more distant colony where their language could not be understood.

14.5 Germany

Germany, both before and after unification in 1871, had one of the most active policies of boarding-out. Regular discussions of family care were contained in the influential psychiatric journal, Allgemeine Zeitschrift für Psychiatrie. From the 1880s, lengthy reports on existing boarding-out systems were printed almost annually.[80] There were no general,

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[76] Sibbald, J. (1897) *op. cit.*, p451. Although private patients were boarded there, they were a minority. In 1895, for example, there were 343 "indigent" patients and six private cases.

[77] Deperon, in Norman, C. (1895) The domestic treatment of the insane. *Transactions of the Royal Academy of Medicine in Ireland*, **8**, p419.

[78] *Ibid.*

[79] Sibbald, J. (1897) *op. cit.*, p452.

[80] Articles included the original work of German alienists, foreign reports, discussions of other systems, and records of visits abroad. The volume of articles on the subject was extraordinary. Prominent alienists paid particularly close attention to the subject, ie: Griesinger, Wahrendorf, and Alt. Articles by Mitchell and Sibbald were translated in full. Useful descriptive studies of the Scottish system include Ripping, Dr. (1875) Reisebericht ueber eine psychiatrische Reise in England und Schottland. *Allgemeine Zeitschrift für Psychiatrie*, **31**, 253-274, and Siemerling, Dr. (1886) Ueber Schottische, Englische und Franzosische Irrenstalten, *Archiv für Psychiatrie und Nervenkrankenheiten*, **18**, 577-598. More general works on the system of family care include: Griesinger, W. (1866) Ueber die familiale Irrenverpflegung, *Allgemeine Zeitschrift für Psychiatrie*, **22**, 390-393, Cyon, E. (1868) Ueber Irrenpflege und Irrenstalten. *Virchow's Archiv*, **42**, 419-441, Sioli, Dr. (1890) Ueber die Familienpflege der Geisteskranken. *Allgemeine Zeitschrift für Psychiatrie*, **46**, 507-517, Falkenberg, W. (1898) Ueber Familienpflege Geisteskranker. *Allgemeine Zeitschrift für Psychiatrie*, **54**, 553-87, Alt, K. (1897) Beitrag zur Wärterfrage mit Berucksichtigung der familiaren Irrenplege. *Monatsschrift für Psychiatrie und Neurologie*, **I**, 435-455, Alt, K. (1899) *Ueber Familiare Irrenpflege.* In *Sammlung zwangloser Abhandlungen aus dem Gebiete der Nerven-und Geisteskrankenheiten.* Halle:Verlag von Carl Marhold. Klinke-Brieg, Dr. (1903) Ueber Familienpflege, *Allgemeine Zeitschrift für Psychiatrie*, **59**, 238-9, Brosius, Dr. (1866)

cohesive laws regulating the care of the insane. Policy and practice varied across states. The movement towards confining patients in asylums, prominent in the first half of the nineteenth century in the United Kingdom, was less marked in Germany, where by 1850, only one third of insane patients resided in asylums. The remaining patients were accommodated in their homes, under no formal control. Despite this, Griesinger, a firm proponent of family care, contended that an organised system was:

> "specially suitable and the only proper provision, for a certain proportion of the insane. It furnishes what the most splendid and best conducted institutions in the world can never furnish, a life entirely among the sane, a return from an artificial and monotonous existence to what is natural and social, to the blessings of family life"[81]

The success of the system in Scotland and Gheel convinced him that it was practicable. His consistent condemnation of the indiscriminate admission, and maintenance of patients in asylums was comparable to that of Scottish Commissioners.[82] Alt, an equally prominent alienist of the late-nineteenth century, and a proponent of family care, regretted that Griesinger's suggestions were derided by many as "the unrealisable idea of an enthusiastic and impracticable idealist."[83] Nevertheless, although he never implemented or witnessed mass adoption of his ideals, family care was adopted gradually across the majority of German states.

The first attempts at boarding-out had been made in 1764, wholly by chance, at Bremen under a Dutch military doctor, Engelken, who used opium in treating the insane. Visiting patients lodged in surrounding villages, thereby creating a colony, which continued in place even after the use of opium had declined. In the 1860s, a conference of alienists, following visits to Gheel, and influenced by Griesinger, concluded that the introduction of a "cottage system" would be advantageous, if undertaken in connection with existing asylums. A number of alienists, therefore, began placing patients in villages near asylums, thereby making the first moves towards developing a systematic policy of family care.

Schmidt-Michel in a detailed discussion of family care has contended that the adoption of

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Ueber das familiale System der Irrenbehandlung, *Allgemeine Zeitschrift für Psychiatrie*, **22**, 438-445 and Bufe, E. (1931) International Übersicht über den Stand der Familienpflege. *Zeitschrift für psychische Hygiene*, **4**, 98-110 (more useful for a description of family care systems in the late 1920s)

[81] Griesinger, W.(1864) The care and treatment of the insane in Germany. *Journal of Mental Science*, **9**, p28.

[82] He announced that many patients were capable of existence outside an asylum, declaring that "their emotions decay in the uniformity and monotony of the establishment and tend ever more towards stupidity as a necessity of their seclusion in the asylum." Griesinger, W.(1864) *op.cit*, p23. Such assertions were made by Commissioners throughout the nineteenth and early-twentieth century.

[83] Alt, K. (1899) *op.cit.*, p34.

the system was accomplished in five distinct periods, the first three of which come under the period discussed in this study.[84] To him, the years 1850-1880 were taken up by theoretical discussion. This is borne out by the prominence of debate in the Allgemeine Zeitschrift für Psychiatrie, with little evidence of any widescale development of policy. Between 1880 and 1914, the option of removing certain patients was instigated in almost every asylum in the country. Following the establishment of family care as an accepted option, during the war and subsequently, the system declined, recovering to a pre-war position by 1935, until eradicated finally with the advent of National Socialism. With new laws regarding sterilisation, and the widespread euthanasia of the insane, there was no place for a humanitarian system of family care. Nevertheless, both before the first World War and preceding the fall of the Weimar Republic, family care was practised widely in Germany, particularly in the north. The advantages propounded in Scotland were echoed, with emphasis on the greater economy, alleviation of asylums, and humanitarian provision for chronic patients. The policy was regarded as a valuable alternative to institutional provision for up to half the population of asylums, developing rapidly from the 1880s, stimulated by increasing asylum admissions, and the encouragement of Alt and Wahrendorf, the "fathers of family care."

Patients remained on the asylum register, under the regular contact and supervision of asylum superintendents, in the immediate vicinity of the asylum, a practice in stark contrast to the Scottish system. The mental classification of patients, however, was as diverse as that in Scotland, the majority being chronic, harmless and quiet. Epileptics were accepted only if subject to rare attacks.[85] Those confined to bed, or in need of special care were not accepted. The majority were over the age of 50, with an equal proportion of male and female patients. To Roesen, female patients who were "little old mothers who...sit in the asylum knitting are highly suitable for family care."[86] However, at Ilten, the classification of certain patients was clearly opposed to the Scottish practice. Wahrendorf accepted "fresh cases of psychosis and also deep insanity and serious bodily illness".[87] Similarly, at Berlin, among those boarded-out were patients guilty of violence, homicide, serious assault, and

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[84] The pattern described by Schmidt-Michel did not appear as clear cut from an analysis of nineteenth-century German psychiatric texts, but the book is thoroughly recommended for information on family care up to the present day. Konrad, M. and Schmidt-Michel, P.O. (1993) *Die zweite Familie. Psychiatrische Familienpflege. Geschichte, Praxis, Forschung.* Bonn, Psychiatrie Verlag.

[85] Müller, H. (1914) Die Familienpflege in Waldbrol. *Allgemeine Zeitschrift für Psychiatrie*, **71**, p164.

[86] Roesen, L. (1912) *op.cit.*

[87] Wahrendorf, Dr. (1882) *op.cit.*

fire raising. Such patients would not have been considered for domestic care in Scotland. Sutherland appears justified in his assertion that the large number of insane criminals reflected badly on the system, where "there is clearly not the same stringency in regard to this as obtains in Scotland."[88]

The majority of guardians were of the same social class as those in Scotland; workmen, craftsmen, tradesmen or small farmers. As in Scotland, once it became apparent that patients were not troublesome or dangerous, applications for patients rose. In Waldbrol, for example, Müller observed that demand for patients far exceeded the number available.[89] Preference was originally given to relatives or friends, although many were placed with asylum attendants. By the 1890s, the trend of placing patients with unrelated guardians, so marked in Scotland, was reported throughout Germany. In Berlin, in 1891, 164 patients were boarded with relatives while 250 were under the care of strangers.[90]

Bremen had the longest tradition of family care, if instigated by unorthodox means. The first official attempt, however, was implemented at Ilten in 1880, by Wahrendorf, a keen advocate, declaring "I will stand up for this system as long as I live."[91] To him, the system implemented was not comparable to that at Gheel, which, although valuable, was not in his view, an ideal prototype. By 1912, 22% of registered asylum patients were boarded-out at Ilten.[92] The next decade saw the policy adopted across the country, with notable success in the following states: Dalldorf, Bunzlau (with 8% in family care) Eichberg (14%) Kortau, Lubeck, Herzberge, Leipzig, Ellen (25%) Lengerich, (21%), Uchtspringe, Zwiefalten, Weissenau, Hildburghausen, Silesia, Brandenburg, Saxony, Waldbrol (16%) and Merxhausen (6%).[93] Rather than list every city which implemented boarding-out, only brief mention of some will be made, stressing any major differences.[94] In Saxony within ten

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[88] Sutherland, J.F. (1897) *op.cit.*, p53.
[89] Müller, H. (1914) *op.cit.*, p164.
[90] Bothe, A. (1893) reported in Sibbald, J. (1895) *Lunacy administration in Berlin and in Scotland.* Lewes: Southern Counties Press, p13.
[91] Wahrendorf, Dr. (1882) Über den bisherigen Stand der familialen Irrenpflege in Ilten im Anschluss an die dortigen Anstalten. *Allgemeine Zeitschrift für Psychiatrie*, **38**, 340-347.
[92] *Ibid.*
[93] Müller, H. (1914) *op.cit.*, **71**, p164. The percentages apply to numbers boarded-out in 1912.
[94] The following articles are recommended for further information regarding the experiment in these regions: Engelken, Dr(1886) Bericht über die familiale Verpflegung Geisteskranker zu Ellen im Jahre 1884. *Allgemeine Zeitschrift für Psychiatrie*, **42**, 173-179, Alt, K.(1906) Uchtspringe: zehn Jahre Familienpflege in der Provinz Sachsen. *Allgemeine Zeitschrift für Psychiatrie*, **63**, 610-613, Müller, H.(1910) Die Familienpflege in der Stadt Leipzig. *Allgemeine Zeitschrift für Psychiatrie*, **67**, 276-292, Roesen, L.(1912) Die Entwicklung der Familienpflege an der Brandenburgschen Landesirrenanstalt Landsberg a.W.und ihr weiterer Ausbau. *Allgemeine Zeitschrift für Psychiatrie*, **70**, 761-778, Specht, G.(1911) Ueber die familiale Verpflegung der Geisteskranken in Bayern, *Allgemeine Zeitschrift für Psychiatrie*, **68**, 305-

years of the system's adoption, 475 patients were boarded-out, initially with their families or asylum staff, but subsequently, with unrelated guardians also.[95] At Gardelegen, the system was adopted enthusiastically. Patients remained on the asylum register, in common with the practice elsewhere, and were regarded as belonging to Uchtspringe Asylum. By 1904, 119 predominantly female patients were boarded-out.[96] In contrast, at Zwiefalten, difficulties were recorded in finding suitable patients. Family care was never fully established there, and the number of patients fluctuated dramatically across the years. Although 191 patients were boarded-out between 1896 and 1911, by 1912 only 6 remained.[97]

The marked similarity of the experiment at Dalldorf, Berlin, to the Scottish system warrants detailed discussion.[98] The policy was introduced in 1884 to prevent overcrowding. Unlike the majority of German experiments, patients were not confined to any specific area, but rather were scattered throughout Berlin and its suburbs, boarded with relatives or strangers, and visited monthly by superintendents. Similar urban locations were generally avoided by Commissioners in Scotland. Patients were ordered to visit the asylum monthly, to be seen by a medical officer, and to receive pocket money.[99] According to Norman, of Richmond Asylum, Dublin, the system was "a remarkable and very successful experiment" which was:

> "a much better system than that in use in Scotland where the unhappy lunatic boarded-out is seen by no-one who has any particular knowledge of insanity, but the Assistant Commissioner in Lunacy who visits once a year...and once a quarter by the Parish Doctor."[100]

Boarding-out developed gradually, evolving from a minor appendage of asylum provision to "a vigorous and independent department of Berlin lunacy administration".[101] In 1887, 34 patients were boarded-out. By 1899 this had risen to 209 (6% of asylum inmates). The system was heralded widely as a great success, to the surprise of Scottish alienists.[102]

10, Gutekunst, Dr.(1912) Die Entwickelung der familialen Verpflegung der Königl.Heilanstalt Zwiefalten. *Allgemeine Zeitschrift für Psychiatrie*, **69**, 430-447, and Müller, H.(1914) Die Familienpflege in Waldbrol *Allgemeine Zeitschrift für Psychiatrie*, **71**, 164-165.

[95] Alt, K. (1906) *op.cit.*, pp610-611.

[96] Tamburini A. (1913) *op.cit.*, p782.

[97] Gutekunst, Dr. (1912) *op.cit.*, p432.

[98] A detailed comparative analysis of the Berlin and Scottish systems is found in Sibbald, J. (1895) *op.cit.*, Also useful is Bernhardt, P. (1914) Dalldorf: Aus der Berliner Familienpflege. *Allgemeine Zeitschrift für Psychiatrie*, **71**, 351-352.

[99] Bernhardt, P. (1914) *op.cit.*, p351.

[100] Norman, C. (1895) *op.cit.*, p421.

[101] Sibbald, J. (1895) *op.cit.*, p206.

[102] Bothe, A. (1893) *Die Familiale Verpflegung Geisteskranker (System der Irren-Colonie Gheel) der Irren-Anstalt der Stadt Berlin.* Berlin: Springer and Bothe, A. (1893) Ueber Familienpflege Geisteskranker nach den in Dalldorf mit dieser Einrichtung gemachten Beobachtungen. *Allgemeine Zeitschrift für Psychiatrie*, **49**, 650-668 contain detailed discussions on the merits of the system.

Because of this success, family care was also adopted in the new asylum for the district, at Herzberg, in 1893. By the turn of the century, one-fifth of patients in Berlin were provided for in families.

Following initial scepticism regarding the efficacy of family care, the majority of alienists adopted the system with enthusiasm, recognising it to be a valuable supplement to asylums. Nevertheless, and although Alt disputed claims that the percentage of suitable patients and guardians was so small as to render the system futile, the relief attainable by asylums was, in fact, limited. Although many German physicians visited Scotland to assess the boarding-out system, and descriptive articles were published frequently, an assessment of the dominant topics in the Allgemeine Zeitschrift für Psychiatrie indicated that the attention devoted to Gheel was more sustained. Nevertheless, the system, particularly in Berlin, bore remarkable similarities to the Scottish policy. Patients were placed singly or with one other patient, in the houses of related or, and increasingly, unrelated guardians. Scottish Commissioners however, were critical of certain points, notably those which diverged from their system. For example, Sutherland condemned the aggregations of patients in the vicinity of the asylum. Scottish patients, in contrast were located in districts across the whole country. To Sibbald, the great defect was in the mode of superintendence. In Scotland, the insane were under one authority, the Board of Lunacy, while in certain states in Germany, no differentiation was made between sane and insane paupers. Further, in Scotland, medical superintendents had no responsibility for those in private dwellings, while, in Germany, their supervision was undertaken solely by superintendents. Sibbald was critical of this, maintaining that "no mere extension of asylum administration can develop into a comprehensive system for dealing with the insane in private dwellings".[103]

Despite a number of clear distinctions between the two systems, boarding-out flourished in Germany, as in Scotland, even if never becoming an integral part of German lunacy administration.[104] The benefits propounded were identical to those highlighted by the Scottish Commissioners, just as criticisms too, were comparable. Claims that family care had great significance had much credence, with almost every psychiatric institution attempting the policy between 1880 and 1930 with varying degrees of success.

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[103] Sibbald, J. (1895) *op.cit.*, p215.
[104] Family care declined most markedly in the south, for example Bavaria, Wurtemberg and Baden.

14.6 Austria and Hungary

From 1854, Mundy, the "apostle" of the family system, argued for the adoption of a system of family care in Austria. He wrote extensively on the merits of the subject, travelling internationally to observe various methods of domestic provision. However, although there was some success, family care never attained the prominence or acceptance seen in Germany. In 1898, in the neighbourhood of the Mauer Oehling Asylum, a village was built on the same plan as at Uchtspringe.[105] Eight cottages were erected, each for two families of guardians, and three patients. All patients were certified as incurable and harmless, and, as in Germany, returned to the asylum once a month to be weighed and bathed.

A further attempt at establishing colony systems was undertaken at the asylum of Ybbs, in Lower Austria. The guiding ethos differed substantially from that in Scotland, the colony serving more as a place of recovery for those incapable of work, than a source of long-stay domestic provision for incurable patients. A more formal system of boarding-out patients from asylums was authorised in 1901.[106] However, by the end of World War I, family care had become almost non-existent in locations where it had formerly flourished. At the turn of the century, for example, over 300 patients were boarded-out from Mauer Oehling. By 1929, only ten were thus placed.[107]

Towards the end of the nineteenth century, a system of family care was initiated in Hungary by Konrad. A small proportion of suitable patients were removed from Nagyszeben Asylum and placed with guardians. Such patients were visited regularly by asylum physicians.[108] A more widely adopted policy was the development of colonies attached to asylums. Following positive assessments of international systems of domestic care in the 1890s, colonies were established in six asylums. One was largely following the style of Gheel, the other five were of the annexe plan. With severe disruption during World War I, three of the colonies were lost. Nevertheless, by 1929, over 18% of the insane population were boarded in this way. At Cepel, near Pesth, a limited system of family care lasted many years, enduring through the War. Bufe has asserted that the system in Hungary flourished with greater success than the well-documented attempts in Germany. However,

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[105] Alt, K. (1899) *op. cit.*, p30.
[106] Tamburini, A. (1913) *op.cit.*, p575.
[107] Bufe, E. (1931) *op.cit.*, p106.
[108] Howells, J. (1975) *World History of Psychiatry.* London:Bailliere Tindall, p298.

without further evidence, it is impossible to substantiate such a claim. The policy of boarding-out in Germany was widely known among nineteenth-century alienists and cited with some frequency, in contrast to a dearth of discussion regarding the system in the Austro-Hungarian empire.

14.7 France

In France, boarding-out never attained the popularity witnessed in Germany or Scotland. Nevertheless, a related policy of encouraging colonies of patients within limited areas, akin to the Gheel system, flourished towards the end of the century. The Revue Scientifique and the Annales Médico-Psychologiques contained regular discussions of the benefits of alternatives to institutional provision,[109] with sustained attention focused on the colony system from the 1860s.[110]

Compulsory legislation ordering the erection of asylums throughout France was instituted comparatively early (1838), when contrasted with similar legislation in England and Wales (1845) and Scotland (1857). The same problems created by overcrowding were experienced, but there was widespread cynicism about family care. Non-institutional provision in France took its inspiration from Gheel. Esquirol, in 1821, and de Tours, in 1845, recorded their enthusiasm for the colony, while maintaining that it was not replicable in France. In the 1860s, de Boismont also maintained that any such development must be on a limited scale, due to the lack of "born philanthropists" seen at Gheel[111] and should be at some distance from large cities or manufacturing towns. Notwithstanding the potential for development in rural districts, de Boismont argued that the low moral standards of the population rendered the safety of the experiment extremely doubtful. These reservations were echoed by contemporaries. Among them, Ferrus condemned all attempts at interfering

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[109] The article by Féré, C.H. (1894) Le Patronage familial des aliénés en France. *Revue Scientifique*, 4^{e} série, 1, 235-240 is perhaps the most detailed about the family care system. Other informative articles included: leGrand du Saulle (1860) Gheel, ou une colonie d'aliénés vivant en famille et en liberté. Etude sur le meilleur mode d'assistance et de traitement dans les maladies mentales. *Annales Médico-Psychologiques*, 3^{e} série, 7, 333-336, Rodiet, A. (1908) L'organisation actuelle des colonies familiales d'aliénés en France. *Annales Médico-Psychologiques*, 10^{e} série, 7, 266-268, Rodiet, A. (1913) Des inconvenients, imperfections et dangers des colonies familiales d'aliénés. *Annales Médico-Psychologiques*, 10^{e} série, 4, 59-63, Dalmas et Vinchon (1921) Le role de l'habitude dans la colonisation familiale des aliénés. *Annales Médico-Psychologiques*, 11^{e} série, 1, 294-309.

[110] Discussion sur la colonisation des aliénés (1862b) *Annales Médico-Psychologiques*, 4^{e} série, 1, 674-689, Dumesnil, (1863) Revue des Journaux de medecine. *Annales Médico-Psychologiques*, 4^{e} série, 2, 387-402.

[111] de Boismont, B. (1862) De la colonisation appliquee au traitement des aliénés. *Annales Médico-Psychologiques*, 3^{e} série, 8, p249.

with the present system and was not impressed by his visit to Gheel, announcing, "je crois, pour moi, qu'il est impossible de faire quelque chose d'aussi detestable."[112] In particular, the lack of trained supervision was emphasised by alienists, who remained unconvinced that the advantages of domestic surroundings compensated for the risks.[113]

Nevertheless, a number of colonies were established in connection with asylums. The colony of St Luke, attached to Pau Asylum, was opened in 1860. Patients were sent there to work on the land during the day, returning to the asylum every night. Within a few years, cottages were built on the estate for a small number of patients. At the same time, a more widely known colony, Fitz-James, was established for Clermont Asylum. Although these colonies provided greater freedom and a reduction of institutional features, they remained closely involved with asylums.

In 1864, an official system of boarding-out, placing patients in houses often at a distance to the asylum, was introduced with some caution. A Government Commission of 1862 had recommended the adoption of the system of committing patients, who presented no danger to the public, to the care of friends in their own houses. Two years later, with the explicit intention of relieving overcrowded asylums, 100 patients were sent from l'Antiquaille Asylum, Paris, to board with individual families. Despite widespread concern among alienists, the merits of boarding-out were recognised gradually. One physician, Garnier was confident that "without doubt this example will become promptly contagious, and this will be much to be commended..."[114] In fact, this small-scale system did not represent an explicit boarding-out policy, and its employment throughout France remained limited. However, domestic care in a colonial form with no attachment to asylums was adopted from the 1890s. Encouragement from Féré, a keen advocate of family care, particularly as practised in Scotland, combined with the widely reported success of the colony at Lierneux, Belgium, overcrowding in asylums in and around Paris, and the decline of the wine-growing region in central France, advanced the implementation of these colonies.

Two particular family care colonies flourished in the late-nineteenth century, south-east of Bourges; Dun-sur-Auron, established in 1892, and Ainay le-Château, in 1900. Preceding

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[112] Reported in Sibbald, J. (1861) *op. cit.*
[113] Falret, too, declared that France could not look after its insane patients in this way. Falret, J. (1862) *op.cit.*
[114] Anon. (1865e) Insane colonies in France. *Journal of Mental Science*, **10**, p298.

their establishment, the Department of the Seine sent a deputation to Scotland to assess the system of boarding-out and its applicability to France.[115] Marie, the first Director of Dun, and an enthusiast of the Scottish system, in line with the declaration of Scottish Commissioners, recommended that not more than four patients were placed in one house.[116] The mental and demographic characteristics of patients were broadly similar to those in Scotland. Because French law precluded the settlement of insane patients under public care in any places except asylums, preference was given to "the various types of dementia, or to the chronic psychoses of people past the prime of life".[117] Patients suffering from acute or recent insanity were not selected. Physicians recorded their recognition that the success of the experiment and the safety of families depended upon an assurance that all patients were incurable and harmless. Concerns voiced in Scotland regarding the suitability of women of child-bearing age were echoed in France, and the majority of female patients were over 40 years. Most patients were incapable of paid employment, although many did housework, and looked after children. There was a general fear that if patients were employed, they would jeopardise job-security for the rest of the population. The physician Puteaux contended that such a risk was unlikely, since Dun was "a colony not of work but of rest".[118] One major difference between these colonies was that Dun provided almost entirely for women, while Ainay mainly accommodated male patients.[119]

Although Féré reported initial problems in the selection of guardians, as "those who offered their services first were not the fittest but the most necessitous",[120] the demand for patients rapidly became greater than the supply of suitable cases.[121] Thus it was reported in 1906 that "an industry has been created in the region: that of...foster parent, of nurse and this

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[115] Féré and Marie were among the steady stream of alienists from throughout the world who visited Scotland to assess the pioneering practice of boarding-out. The Government of France also sent over a number of delegations. A Commission appointed by Paris Municipal Council to study the water question in Scotland, also, somewhat surprisingly, enquired into the system of boarding-out.

[116] Marie had been given a travel grant by the Council of the Seine to look at the boarding-out system in Scotland in the early 1890s, and subsequently adopted much of what he saw.

[117] Marie, A. (1898) *British Medical Journal*, p69.

[118] Norman, C. (1895) *op.cit.*, p419.

[119] Thus at Dun, in 1894, there were 8 male patients, and 115 women. Féré, C.H. (1894) *op.cit.*, p235. This distinction remained true throughout the 20th century. Jodelet's assessment of the colony of Ainay illustrates the preponderance of male patients there. Her book, containing interviews with guardians, while informative and detailed for the late 20th century, contains little useful discussion of the development of the colony, and makes no reference to Féré and other "founders" of the system, or international influences. Nevertheless, as a discussion on the role of the colony today the book is unique. Jodelet, D. (1991) *Madness and social representations. Living with the mad in one French community.* Ed. Duveen, G. Trans T. Pownall, University of California Press.

[120] Féré, C.H. (1888) L'assistance des aliénés dans les maisons privées en Ecosse. *Revue Scientifique*, 3^{e} série, **15**, p529, This article contains detailed descriptions of the Scottish system, with a favourable assessment of its strengths.

[121] Féré, C.H. (1894) *op.cit.*, p235.

industry is arresting the local exodus."[122] Occupations of guardians included tailors, publicans and agricultural workers; persons of a similar social class to those selected in Scotland. According to Féré, inhabitants of small towns were "better fitted than mere peasants to be hosts for patients from Paris".[123]

Patients boarded in the two colonies came from within 300 km of Paris, and were placed with unrelated guardians within a clearly delineated area, in contrast to the Scottish system where patients from all areas of Scotland were boarded in private dwellings across the whole country. Although the concept of a colony system was incompatible with the Scottish policy of dispersal of patients, many regulations resembled those in Scotland; among them, for example, guardians were ordered to allow patients to take their meals with family. However, patients were selected and supervised by the asylum physician and the guardian-boarder relationship was more formal than in Scotland. Even supporters of the system accepted that patients were treated as paying boarders, rather than as members of the household and in 1904, it was announced at Dun that "the patient is primarily regarded as a source of profit."[124] Notwithstanding this, observers concluded that, in general, patients were treated with kindness and guardians took pleasure in presenting their boarders in good condition.

There were some similarities between the two colonies in France and the aggregations of special licensed houses in central Scotland, where large numbers of patients were boarded together in one village. Further, the town of Dun had remarkably similar characteristics to locations in central Scotland, with a declining population, closed iron mines, no special industry and low pay for the employed. Conditions were eminently suitable for the establishment of a colony. The number boarded there rose rapidly; in 1892, there were 24 patients, a year later, 108 and, in 1897, 500 patients were accommodated there.[125] The two colonies of Dun and Ainay, located 12 miles apart, were the only major centres of family care in France although colonies were established at Levet which was linked to Dun, and in the small villages of Bussy, Osmery and Ourouer, in the neighbourhood of the larger

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[122] Jodelet, D. (1991) *op.cit.*, p37.
[123] Féré, C.H. (1894) *op.cit.*, p235.
[124] 90 years later, Jodelet reported that 41% of foster parents were out of work. Jodelet, D. (1991) *op.cit.*, p44.
[125] GBCLS 39th AR (1897), p123. The colony at Dun-sur-Auron was of a similar size to aggregations in Fife, where nearly 400 insane patients were boarded. However, Dun had a much higher ratio of insane patients to the sane population compared to Fife, and were "not spread over so wide a belt of country as Fife." Sutherland, J.F. (1897) *op.cit.*, p51.

colony at Ainay. The number of patients provided for in these colonies were substantial, particularly when contrasted to the aggregations of central Scotland. In 1905, for example, 660 patients were boarded at Dun, 86 at Levet, 438 at Ainay and 200 at the sub-colonies at Bussy, Osmery and Ourouer.[126]

Despite sustained objections to family care colonies in France, practical application of the policy served to reassure some critical observers. Féré and Marie were among the most prominent supporters, emphasising the therapeutic advantages to patients. Other physicians stressed the greater economy of the system, which, although offering less of a saving than that attainable in Scotland, was cheaper than asylum rates. Nevertheless, despite increasing acceptance by professionals, Féré recorded his regret that:

> "the system has not sufficiently attracted the attention of the powers that be in our country where the industrial and agricultural crisis renders it peculiarly applicable in these days."[127]

Castel has condemned the system practised at Dun and Ainay as "more of a deportation of patients from overcrowded Parisian asylums than an attempt at new forms of care in the community."[128] However, this is to minimise the innovative nature of these colonies. While prompted by the prospect of relieving asylums, the benefits of a family care policy were endorsed increasingly, although the colony system in conjunction with the local asylum, seen at Clermont and St Luke attained greater acceptance. Even though family care in a colonial form was only implemented on any significant scale nearly forty years after its introduction in Scotland, and at least ten years after its extension throughout Germany, the numbers provided for in this way mean that the system cannot be dismissed as an unsuccessful experiment. At its peak, approximately 1500 patients were placed under family care, and even if never implemented nationally, the volume of pertinent literature illustrates the interest and attention focused on its potential as an alternative to wholesale institutionalisation.

14.8 Italy

The Italian alienist, Tamburini wrote extensively on family care, observing that it was more developed in other countries than his own.[129] Legislation of 1848 did not provide for the

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[126] Cunyngham Brown, R. (1908) *op.cit.*, p542.
[127] Féré, C.H. (1889) The insane in private dwellings in Scotland. *Poor Law Magazine*, **17**, p288.
[128] Castel, in Mangen, S. (ed.) (1985) *op.cit.*, p144.
[129] Tamburini, A. (1918) *op.cit.*,p560.

inspection or supervision of patients outside institutions. However, Biffi, physician to a private asylum near Milan, and one of the most authoritative alienists in Italy, had become a keen advocate of the Gheel system and its introduction into Italy, following a visit there in the early 1860s. He recommended non-institutional provision, not just for the chronic insane, but also for certain curable cases, to relieve pressure on asylums.[130] Nevertheless, he accepted the potential difficulties of establishing colonies, in a country unused to domestic provision, although he maintained that large areas of wasteland near Milan were eminently suitable for such an experiment. Any colony would be complementary to asylum provision. This annexe-type of insane colony was only ever employed on a small scale, rarely catering for more than 40 patients throughout the country. By the turn of the century, there were three agricultural colonies connected to asylums.

On the basis of available evidence, it does not appear that particular attention was devoted to the system practised in Scotland. Nevertheless, the system of placing up to two patients with individual families had more lasting success, and was regarded as an effective method of caring for harmless, usually elderly patients. One such attempt was made in Florence, in 1865, when patients were sent from Boniface Asylum and placed under the care of farmers.[131] By 1898, 450 were thus boarded, rising to 800 in 1913.[132] At Reggio Emilio, in the early twentieth century, 31 patients were placed with unrelated guardians within three years,[133] and, by 1910, in the province of Lucca, 140 patients were boarded-out.[134] Tamburini, making the same point as the Scottish Commissioners, announced that more favourable conditions prevailed among those boarded with strangers. The majority of patients were chronic, tranquil and clean, although a limited number of patients suffering from epilepsy and hysterical insanity, usually females, were also considered suitable.[135]

Families of asylum attendants residing near the institution, were favoured as guardians, facilitating ease of supervision. In common with experience in other countries, observers recorded a reduction in suspicion of insane patients residing in the community.

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[130] Reported in Arlidge, J. and Lond, M.B. (1865) Della Colonizzazione dei Pazzi. Review of S. Biffi. Foreign Psychological Literature. *Journal of Mental Science*, **10**, p422.
[131] Alt, K. (1899) *op.cit.*, p30.
[132] Tamburini, A. (1918) *op.cit.*, p580.
[133] *Ibid.*, p579.
[134] *Ibid.*, p577
[135] Tamburini, speaking at the International Congress for the Care of the Insane (1902) Recorded in Morel, J. (1903) Progress of Psychiatry in 1902. *Journal of Mental Science*, **49**, p338.

Applications for patients often exceeded the places available for such care. The "homo-familial" system whereby patients were boarded with their relatives was not considered a success, and by the turn of the century, attempts to sustain the policy had been abandoned in the majority of districts.[136] Although Tamburini recorded more satisfactory results among patients boarded with strangers, in what he classified as the "hetero-familial" system family care never attained lasting popularity and was not resorted to uniformly across the country. In 1898, for example, 1416 patients were provided for in this way, comprising 4% of the registered insane.[137] Although a number of districts made enthusiastic attempts to implement the policy and despite endorsement by a number of influential alienists, confidence in the system remained muted.[138]

14.9 Spain

Comelles has observed that the Spanish state failed to develop a system of psychiatric care at a level comparable to that of neighbouring states.[139] From 1835, the construction of an asylum in Madrid was requested, but no government action was taken until 1852, when a national asylum was erected at some distance from the capital. Ten provincial asylums were also established over the next two decades.[140] However, by this time, the growth of private madhouses had flourished across Spain, notably in Catalonia. Many patients also remained in their own homes, under no official control.

Legislation passed in 1885 decreed that all persons connected with insane patients in the community must report the existence of any patient to the mayor within 24 hours of their reception. Further, they were responsible for any damage caused by or to the patient arising from inadequate supervision. This indicates some attempt to assert control over existing *ad hoc* domestic care provision. However, there were few organised attempts at family care systems. At Saragossa, an agricultural colony resembling Gheel had been established in the eighteenth century. Sibbald reported that, at the time of Pinel, the colony had an excellent

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[136] *Ibid.*

[137] Tamburini, A. (1918) *op.cit.*, p577.

[138] The comparative apathy towards non-institutional provision stands in marked contrast to more recent action in Italy, where following the passing of Law 180, in 1978, no patient could be admitted to an institution.

[139] Comelles, J.M.(1991) Psychiatric care in relation to the development of the contemporary state; the case of Catalonia. Trans DiGiacomo, S. *Culture, medicine and psychiatry,* **15**, p197.

[140] Burdett, H.C. (1891) *Hospitals and asylums of the world; their origin, history, construction, administration, management and legislation.* London: J. & A. Churchill.

reputation, which had long since diminished.[141] Thus, in 1860, Desmaisons described it as "un batiment moderne de la plus triste apparence" where only ten of the 300 patients were occupied in any form of agricultural labour.[142] Other attempts were restricted to the accommodation of up to four patients into a family, supervised by medical and local authority officials. This was rarely implemented and organised care in the family, or in asylum colonies only ever catered for a very small minority of the insane throughout Spain.

14.10 The Netherlands

Family care was introduced in Holland in the 1880s, in close connection with the asylums of Veldwijk, Bloemendal and Dennenoord, although initially, the system applied solely to wealthy patients who were boarded in the immediate vicinity of the asylum under the care of former asylum attendants.[143] Although Dutch asylums all experienced the problems of overcrowding, legislation of 1884 restricted the residence of insane patients in the community and for many years, patients were only allowed to board with asylum attendants.[144] Throughout the nineteenth century, however, a "considerable contingent" of patients were accommodated at the nearby colony of Gheel.[145]

In 1889, the medical superintendent of Ermelo Asylum instituted the first significant attempt to board-out patients of all classes. Positive reports encouraged its adoption as official policy by the government and, within a year, the State Asylum at Medemblik introduced the system.[146] Other asylums followed suit, although Dutch law stipulated that no more than 10% of the asylum population could be boarded-out at any one time and that accommodation was to be reserved in the asylum for them, in the event of exacerbation of their mental condition. Only patients who had been in the asylum for six months were eligible for boarding-out. A Scottish Commissioner, Cunyngham Brown, contended that the Dutch system was adopted solely as a "therapeutic means of approved value."[147] However, it is more likely that the dual incentives of greater economy and relief of overcrowding played a greater part in its development. As in Scotland, patients were placed

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[141] Sibbald, J.(1861) *op.cit.*, p55.
[142] *Ibid.*
[143] Cunyngham Brown, R. (1908) *op. cit.*, p537.
[144] Tamburini, A. (1918) *op.cit.*, p573.
[145] Cunyngham Brown, R. (1908) *op. cit.*, p537.
[146] Cowan, Dr. (1902) Discussion. *Journal of Mental Science*, **48**, p136.
[147] Cunyngham Brown, R. (1908) *op.cit.*, p538.

in private dwellings under the care of unrelated guardians, but there were marked differences in the administration of the system. Contact between the asylum and the boarded-out patient remained intact. Clothing was supplied by the asylum and patients were bathed and then examined every week at the asylum by the medical director. Supervision was more extensive than in Scotland, with patients being visited daily by an asylum official and weekly by a physician. In line with Scottish policy, family care was also viewed as a preliminary stage to returning to daily life for convalescent patients and a Government grant paid a proportion of maintenance costs for boarded-out pauper cases.

Although this form of family care operated widely throughout Holland, the experiment was rarely recorded in international surveys and does not appear to have been visited, or discussed, by Scottish observers.[148] The colony at Gheel, operating on a far larger level, superseded any attention that may have been focused on attempts in neighbouring countries. Nevertheless, boarding-out became an integral, if comparatively unheralded, part of Dutch lunacy administration. Asylum superintendents offered warm support and the Government became convinced of its efficacy. By 1899, the Minister of Interior had granted approval to allow the system to be connected to State asylums. Physicians concurred in the belief that the policy was "a therapeutic means of the first order."[149] Thus, Van Dale, of Ermelo Asylum, announced with confidence that "Holland will proceed rapidly along the path of this humane and beneficent reform."[150]

14.11 Scandinavia

In Sweden, the majority of patients remained at home or in refuges for the poor rather than in any formal boarding-out system. Not until the turn of the century were asylums built on any scale[151] and preceding their erection, private asylums flourished. Qvarsell has argued that family care could not develop in a country where there were extensive distances between asylums and patients, rendering adequate supervision impossible. Further, he maintained that there was a lack of unity among relatives, unlike the situation in Catholic countries. In large industrial cities, there was often only one adult to take the responsibility

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[148] The system was discussed in some detail at the International Congress for the Care of the Insane held in Antwerp in 1902. Recorded in Morel, J. (1903) Progress of Psychiatry in 1902. *Journal of Mental Science*, 49, pp336, 339, 342 and also in Tamburini, A. (1918) *op.cit.*, 573-574 and Cunyngham Brown, R. (1908) *op.cit.*, 537-539.
[149] Tamburini, A. (1918) *op.cit.*,p573.
[150] Van Dale. Recorded in Morel, J. (1903) *op. cit.*, p339.
[151] Qvarsell, R. (1991) History of Psychiatry in Sweden. *History of Psychiatry*, ii.

of care.[152] In such an environment, a closely organised system of family care was unattainable. One anonymous American observer recorded a curious method of boarding-out. Writing in 1894, he recalled the report of a man, who forty years earlier, saw insane persons passed from house to house. Legislation had provided that the insane should be boarded for one week in turn by property owners of a given township. Farmers received at least four patients annually, a number of whom were "quite obstreperous". The observer reported that "all accepted the task as a matter of course, and the patients were then passed on to the next neighbour."[153] In view of the absence of any detailed assessment of family care systems in Scandinavia, it is not possible to verify this assertion. Although there were a number of small communities providing family treatment, it is apparent that boarding-out was never adopted wholeheartedly and patients either remained in their own homes, or were admitted to an asylum.

Family care in Denmark existed more as a remnant of tradition than through any recognition of its merits. Many patients were sent to the countryside to unrelated guardians. If they became excited, an isolation room was erected in the barn. In a situation similar to that in Sweden, members of each parish were called upon in rotation, to take in patients, "with little pleasure or skill".[154] One asylum superintendent, Helweg, was firm in his approval of the Scottish system concluding that "if a State desires to do something for all its lunatics...the Scotch system may be very good".[155] He estimated there were about 3000 patients in private dwellings in Denmark in need of supervision.[156] Although there was no organised family system, married warders were allowed to keep patients and, by the turn of the century, experiments were undertaken to develop the policy. Nevertheless, employment of family care systems was always limited and *ad hoc* arrangements between families and paid guardians remained more common.

In Norway, legislation of 1848, incorporating ideas from other countries, made reference to the care and supervision of patients in families, and established central government responsibility. According to Bøe, the legislation drew on the example of Scotland when

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[152] Qvarsell, R. (1994) Paper at History of Psychiatry conference, London.
[153] Anon. (1894) Discussion. *American Journal of Insanity*, **51**, p106.
[154] Alt, K. (1899) *op.cit.*, p29.
[155] Dicussed in McDowall, T. (1883) Danish Retrospect. *Journal of Mental Science*, **29**, p308.
[156] *Ibid.*, p305.

establishing the Norwegian Kontroll-Kommisjon.[157] Although four state asylums were erected between 1854 and 1900, institutional provision remained inadequate and incurable, harmless patients were placed under the care of guardians in the vicinity of the asylum. A similar system provided for patients to be "rented out" to farmers, or put on "legd", a policy whereby the poor of any village were provided for in turn by the other inhabitants.[158] Such persons remained in one house for up to a month. In 1859, 10,000 people were provided for in this way, including the insane. This method declined in the second half of the century, to be replaced by lisitasjon, a method of hiring patients, where auctions were arranged, with those giving the lowest price receiving the patient. Guardians, often very poor themselves, were openly motivated by the prospect of pecuniary gain, an inspiration which, in Scotland, was condemned regularly by the Commissioners.[159]

Boarding-out in Norway appeared poorly organised and the limited extent of supervision and the pecuniary motivations of guardians gave the system an unsatisfactory reputation. Patients were supervised by asylum physicians, but visits were made at most twice a year, and no other official bodies undertook supplementary supervision. Although the number of patients provided for in this way declined with the growth of asylums, private care remained in force throughout the twentieth century, on a far larger scale than that practised in Sweden and Denmark.[160] Patients were also accommodated in small colonies usually connected to asylums although an attempt at introducing colonies at Gaustad in the 1870s proved unsuccessful due to the geographical distance between the asylum and the colonies. Nevertheless, by 1900, there were 89 colonies, accommodating 644 patients.[161]

14.12 Switzerland

Colonies for the insane were established in cantons throughout Switzerland in the 1860s. Boarding-out resembling the Scottish system, however, was not adopted until the turn of the century, and then only on a limited scale. Physicians were sceptical of a system which placed patients beyond asylum supervision, although there was some enthusiasm for agricultural colonies, or cottages in the neighbourhood of an asylum. In 1864, for example,

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[157] Bøe, J.B. (forthcoming) De Utsatte Psykiatriske pasienter i privatpleie på Jaeren, 1950-1970.
[158] Personal communication from K. Ludvigsen, in Norway.
[159] The extent to which potential guardians were motivated by financial reasons has been discussed in Chapters 7 and 10.
[160] Personal communication from K. Ludvigsen, in Norway.
[161] Tamburini, A. (1918) *op.cit.*,p575.

at Einum near Hildesheim, 40 male patients were boarded on a farm near the asylum. In the same year, a colony for 25 patients was established at Margarethenberg.[162]

Annual reports of Swiss asylums in the 1880s and 1890s contained descriptions of family care systems in Scotland, Belgium and Germany, and alienists praised the Scottish system for its discriminating and sophisticated care. A number of physicians visited Scotland to see the system in practice, recommending its adoption into Switzerland. Among them, Moor and Fahr advocated the establishment of the system in villages around the convent.[163] The cantons of Berne, Waldau and Munsingen adopted the system for certain chronic patients.[164] In 1908, similar attempts were made in Zurich, around the clinic of Rheinau. A year later, a Canton Inspection was established, with responsibility for the selection of guardians and the care of patients.[165] Ausfeld has maintained that family care developed into a popular and widely utilised alternative to asylum provision, although, stimulated by the need to relieve overcrowded institutions, a number of unsuitable patients were boarded-out. Economic advantages were widely extolled and asylum physicians, having retained control over patients, endorsed the policy, with its regular supervision, adapted closely from the Scottish system.[166] Despite the similarities with boarding-out in Scotland, however, and the enthusiasm of Swiss physicians towards the system, there is no indication that the closely related Swiss experiments were known to the Scottish Commissioners.

14.13 Russia

Provision for the insane in Russia throughout the nineteenth century remained highly inadequate. Only dangerous or severely disturbed patients were admitted to asylums. Nevertheless, physicians attempted to follow Western models in initiating reforms, travelling widely to assess various systems for treating the insane, viewing the Scottish boarding-out system, and agricultural colonies in France and Germany. Similar systems were subsequently implemented.[167] Family care was introduced on a limited scale from

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[162] Anon. (1870) Psychological Retrospect. *Journal of Mental Science*, **15**, p104.
[163] Ausfeld, R. (1977) *Anfänge der sozialpsychiatrischen Bestrebungen im Kanton Zurich. Dargestellt anhand der Jahresberichte des Zürcher Hilfsvereins für Geisteskranke von 1875-1975.* Zürcher medizingeschichtliche Abhandlungen Neue Reihe, **120**, Zurich, p26.
[164] Tamburini, A.(1918) *op.cit.*, p576.
[165] Ausfeld, R. (1977) *op. cit.*, p34.
[166] The influence of the Scottish system on the development of family care in Switzerland is discussed at length in Ausfeld, R. (1977) *op. cit.*, 26-36.
[167] For example, following a visit to Alt-Scherbitz in 1885, Serbskii appealed for the establishment of similar colonies in Russia.

1873 at Ekaterinaslav, and Rjasan Asylums, and in three villages near Moscow, "imitating Kennoway, Dun-sur-Auron and Gheel".[168] The first colony is reported to have been established in 1887, in Nikaulitsch, by Bajenow, an asylum director.[169] Although the system was well received by the majority of alienists, dissatisfaction at the presence of insane patients was recorded among the wealthier classes. The colony was disbanded after one year, and a new site selected in 1892, by the asylum of Villa Noeff, near Moscow, accommodating 15 patients. Colonies were also established on the banks of the Volga, and at Liakovo, a small agricultural colony flourished.[170] A colony at Devitzo, received 25 patients from the 300 in the asylum in 1895 and in addition, a German observer, Snell, reported favourably on Semenowskaje near Moscow, where patients resided in the cottages of farmers.[171] A supervisor lived in the village, thereby ensuring constant supervision for the 18 patients. Guardians and patients were selected by the asylum superintendent.

The system, drawing closely upon the Scottish model, was heralded as a successful component of provision for the insane. In 1905, Narbouth, a physician from St Petersburg had toured areas of central Scotland in the company of Scottish Commissioners. Following his visit to boarded-out patients, he concluded that "the instructive visits were not only delightful but will show their effect on the future welfare of my countrymen".[172] The establishment of such a system was not directly linked to overcrowding, but more unusually, out of recognition of its inherent benefits and stimulated by the success experienced in other countries. Although a number of alienists rejected the viability of such a system, by the 1890s, out of 200,000 lunatics, over 30,000 (15%) were boarded-out.[173]

14.14 United States of America

From the 1880s, to the turn of the century, the American Journal of Insanity and the Boston Medical and Surgical Journal published numerous articles discussing domestic provision for the insane and, in particular, the Scottish system of boarding-out.[174] American

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[168] Howells, J. (1975) *op. cit.*, p311.
[169] Tamburini, A. (1918) *op.cit.*, p571.
[170] *Ibid.*
[171] Alt, K. (1899) *op. cit.*, p27.
[172] GBCLS 48th AR (1906), p170.
[173] Morel, J. (1903) Progress of Psychiatry in 1902. *Journal of Mental Science*, **49**, p339.
[174] For example, Stedman, H. (1884-5) Boarding-out of insane persons *Boston Medical and Surgical Journal*, **114**, 319-320, Stedman, H. (1890) The family or boarding-out system, its uses and limits as a provision for the insane, *American Journal of Insanity*, **47**, 327-338, Alder Blumer, G. (1899) The care of the insane in farm dwellings, *American Journal of Insanity*, **56**, 31-40, Moulton, A.R.(1892) Boarding-out the insane. *Boston Medical and Surgical Journal*, **126**, 402-403,

superintendents had long favoured a strong asylum system, firmly opposing the principle of diffusion, prompting Lindsay to declare that their "views carry so much weight that their opposition has so far prevented all material progress in the direction of boarding-out".[175] Nevertheless, asylum overcrowding prompted appraisal of international methods of dealing with the insane. Following visits to Scotland, to see the system in practice, its adoption was advocated warmly, although certain states, such as California, where "custody was paramount from the start", displayed no enthusiasm to board-out chronic cases.[176] However, the Scottish Commissioner, Sibbald, reported in 1888 that:

> "several gentlemen connected with lunacy administration in America, during their visits to Scotland, have made careful inquiry into what is being done here in the matter of boarding-out, and some of them accompanied the Deputy Commissioners in order to see for themselves how lunatics under private care are treated. They were favourably impressed with what they saw, and have since been advocating the introduction of the system into their own country."[177]

Despite widespread interest in the system, it was only the state of Massachusetts which adopted such a policy on any significant scale.[178] The attempt to implement boarding-out there was notable, modelled wholly on the Scottish system.[179] Indeed, one physician, Sanborn wrote of the years in which "I introduced and managed the Scotch system in Massachusetts."[180] As early as 1862, asylum reports recommended the transfer of incurable patients to private dwellings to relieve overcrowding, but despite extensive debate in the 1860s and 1870s regarding the benefits of domestic care, the Board of State Charities ordered the continuance of existing policy.[181] Boarding-out was not adopted as official policy until 1885. In the first five months of that year, 32 patients were boarded-out, and early reports of their progress were favourable.

Copp, O. (1904) Characteristics of the Scotch Lunacy System. *American Journal of Insanity*, **61**, 55-69, Gibson, G. (1925) The boarding-out system in Scotland. *American Journal of Psychiatry*, **71**, 253-264.

[175] Lindsay, W.L. (1871) *op.cit.*, p499.

[176] Fox, R.W .(1978) *So Far Disordered in Mind. Insanity in California, 1870-1930.*Los Angeles:Berkeley. p18.

[177] GBCLS 22nd AR (1880), p115.

[178] Greater activity was seen in the development of the colony system, attached to asylums. Such annexes were first instituted at Willard Asylum, New York, in the 1880s, providing for many who were unsuitable for boarding-out. The growth of farm colonies attached to asylums was also welcomed.

[179] Articles relating to the system in Massachusetts include: Anon. (1887) The boarded-out insane. Reporting 8th Annual Report of the Massachusetts Board of Lunacy and Charity. *Boston Medical and Surgical Journal*, **119**, 242, Moulton, A.R. (1897) The insane poor in private dwellings in Massachusetts. *Boston Medical and Surgical Journal*, **127**, 616-617, Mitchell, A. (1897) The insane poor in private dwellings in Massachusetts. *Boston Medical and Surgical Journal*, **137**, 457-460. Also in *Journal of Mental Science*, (1898) **44**, 439-445, Copp, O. (1902) Some results and possibilities in family care of the insane in Massachusetts. *American Journal of Insanity*, **59**, 299-313, and Copp, O. (1907) Further experiences in family care of the insane in Massachusetts. *American Journal of Insanity*, **64**, 361-375.

[180] Sanborn, F.B. (1898) Letter to editor. *Boston Medical and Surgical Journal*, **138**, p287.

[181] Morrisey, J.P. and Goldman, H.H. (1980) *The enduring asylum. Cycles of institutional reform at Worcester State Hospital.* New York: Grune & Straton, p57.

Sustained attention was focused on the personality of the guardians, the majority of whom were female. Their social status was often higher than those in Scotland.[182] Copp analysed their status in 1902: farmers (39%), housekeepers (28%), physicians (4%)(not recorded in Scotland) and merchants (4%). Carpenters and school teachers were also registered. Despite following the Scottish system so closely, one major difference lay in the selection of patients. No patient was boarded-out unless they had previously been in a State institution. They were generally middle-aged, and up to 80% were female. Among patients boarded-out in 1902, Copp classified 32% as suffering from manic depression, a higher proportion than in Scotland; 15% from delusional insanity; and 28% from dementia. Patients with eccentricities, obscene or vulgar speech, or immoral tendencies were not boarded-out. From 34 patients in 1886, numbers rose to 175 in 1892, before declining to 129 four years later. The decline was not attributed to lack of enthusiasm, rather, according to official reports, to a dearth of suitable patients.[183]

Although there was concerted attack from certain quarters, often reported anonymously in the Boston Medical and Surgical Journal, many alienists embraced the system with enthusiasm, while recognising that the number boarded-out was too small to give much relief to institutions. As Mitchell declared, "the experiment has never been on anything but a quite insignificant scale."[184] In this context, Grob has observed that in Gheel only one patient in 50 was in hospital, while in Massachusetts, less than one in 50 were free from confinement. To Grob, therefore, the system had little impact on the country, in view of the limited numbers affected.[185] Such an assessment, however, is unduly dismissive of the innovative nature of the attempt. The Scottish system of boarding-out was adopted in part due to a prevailing belief in the "Scotchman's thrift and the belief that his methods would net the greatest savings in dollars and cents."[186] In addition, the advantage to patients of individual care and the relief to asylums prompted a solid body of support for the system. While Copp admitted that he could not define its applicability with any clarity, he was convinced that "it holds a distinctive place and may be made a valued auxiliary in any

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[182] Only 14% were related to the patient. No patients were maintained at the State's expense if boarded with relatives. To American observers, this obviated the abuses recorded in Scotland.

[183] Mitchell questioned the accuracy of this assertion, contending that other causes, including a misunderstanding of the real purpose of the system were more responsible for the decline. His arguments are outlined in Appendix 14.

[184] Mitchell, A. (1897) *op.cit.*, p457.

[185] Grob, G. (1966) *The state and the mentally ill. a history of Worcester State Hospital in Massachusetts 1830-1920.* University of North Carolina Press, p247 .

[186] Crockett, H. (1934) Boarding homes as a tool in social casework with mental patients. *Mental Hygiene,* **18** , p192.

adequate system of care of the insane."[187]

Wisconsin was the only other American state to introduce the Scottish system to any extent in the nineteenth century. A small number of patients were discharged from asylums, mainly to relatives and entered in asylum records as "absent on leave." Proposals to extend the system to unrelated guardians across the rural counties were never implemented. Widescale attempts were not witnessed until the 1930s, when among other states, New York adopted a system of family care in 1931, Pennsylvania followed suit one year later.[188]

Although the Scottish system was praised widely, conditions in the United States prevented wholesale employment of boarding-out. This was not prompted by specific prejudice towards the Scottish system; a number of alienists maintained similarly, that the system prevailing at Gheel was no more suited to America. One physician, Earle, announced that:

> "the active and enterprising Yankees, with bridle upon steam and a halter upon lightning, yet still whistling and chafing for greater speed are not the quiet Flemish, plodding through plains of sand in the horse-cart ruts of ages."[189]

On the contrary, it was the success of the colony system attached to asylums, with extensive supervision and control which detracted from the novelty and value of a dispersed boarding-out system. Difficulties in selecting suitable patients and guardians remained prominent and enthusiasts regretted that:

> "although we modelled it after the Scottish system we find it very difficult to get places for boarding them out...Whether the Scotch are more decent people, kinder and better men and women, or less excitable I don't know."[190]

The nature of the criticisms and concerns are remarkable for their similarity to those voiced across the world. In Scotland, Germany and Gheel, such objections had little impact. In the United States, they were sufficient to condemn the policy to little more than a bold, if ultimately futile, early attempt at community care.

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[187] Copp, O. (1902) *op.cit.*, p312.

[188] As Deutsch observed, "despite the impressive arguments in its favour, the family care system has not been adopted on a considerable scale in New York or other states." Deutsch, A. (1937) *The mentally ill in America: A history of their care and treatment from colonial times.* Garden City: Doubleday, Doran, p448.

[189] Earle, P. (1868) The care and treatment of the insane poor in the United States. *Journal of Mental Science*, **13**, p373. Similarly, Bannister maintained that "until the country has become much older, and has a larger settled rural population of a certain social class than it now possesses, it is doubtful whether the boarding-out plan will be anywhere general or remarkably successful." Bannister, H.M. (1898) The progress of psychiatry in America. *Journal of Mental Science*, **44**, p409.

[190] Alder Blumer, G. (1893) In *Commitment, detention, care and treatment of the insane* (eds G. Alder Blumer and A.B. Richardson), International Congress of Charities. Baltimore: Johns Hopkins Press, p178.

14.15 Australia

The family care systems of Gheel and Scotland were well known in Australia, and recognised as a valuable, although potentially problematic, adjunct to institutionalisation. In New South Wales, Western Australia and Queensland, unrecovered patients were boarded-out from the asylum with relatives or friends, who received a monetary allowance. Such patients were easily re-admitted if necessary, without recourse to extensive official documentation. One physician, Sinclair, declared with satisfaction that, "this is boarding-out in a most useful form...it avoids the risk of the patient being taken merely as a revenue producing individual".[191] Single patients were also boarded in licensed houses where they were visited by a medical official. Sinclair recognised that the conditions of life were in stark contrast to those in Scotland, but maintained that:

> "the experience of Scotland and other countries is so encouraging that despite local difficulties it should be tried, and if introduced in a small and tentative manner, and confined to suitable localities, it will take root."[192]

Despite favourable reviews of the Scottish system, other physicians were more sceptical. Among them, Beattie Smith reported his uncertainties. Following an experiment to board-out patients with asylum officials, he concluded that the results were unsatisfactory, with patients being regarded as servants, who were "taken for what could be got out of them".[193] Similar scepticism was apparent following an attempt in Victoria in the 1890s. The Government had authorised the "astounding step" of providing for 1500 insane patients in cottages, at some distance from the metropolis. However, many regarded this "City of the Simple" as an unwise experiment.[194] Further, conditions which favoured the development of such a system in Gheel and Scotland were absent in Australia. Not only were working people unlikely to want an insane patient out of a need for financial remuneration, but the sparse population and the nature of bush life posed insurmountable obstacles to effective medical supervision of patients.[195] Thus, while boarding-out was practised on a limited scale, the number of patients residing in the community at any one time remained small.[196]

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[191] Sinclair, E. (1909) Presidential Address, *Journal of Mental Science*, **55**, p228.
[192] *Ibid.*
[193] Beattie Smith, W. (1909) The housing of the insane in Victoria. *Journal of Mental Science*, **55**, p482-489.
[194] Manning, F. (1889) Address in psychological medicine. *Journal of Mental Science*, **35**, p160.
[195] *Ibid.*, p161.
[196] Other colonies included one founded at La Plata in Latin America, in 1884, and in Lujan, 1899, Oliva, 1908 and Torres, 1915. In 1908 a system of foster home care was created by Franco Da Rocha in Sao Paulo, and in Japan, for several centuries, a colony in the city of Iwakura, near Kyoto, had flourished, on the same principles as Gheel. Bufe, E. (1931) *op.cit.*, p104.

14.16 Reciprocal influences between Scotland and other countries

14.16.1 Impact of Gheel on the Scottish system

There is no doubting the impact of Gheel upon European and American alienists. The constant stream of visitors and subsequent articles testified to this. However, while the idea of allowing patients to reside in the community under supervision was welcomed, few alienists considered that an analogous system could be instituted elsewhere. It was generally recognised that the unique nature of the system and its longevity was attributable to acceptance borne of familiarity, as generations of townspeople witnessed the freedom given to the insane. Deas, for example, maintained that :

> "to found anything like a Gheel in this country would be utopian, impossible, such a system could only grow up, and that under most exceptional circumstances. But ...boarding-out offers a solution for that deadlock which leads to the building of one huge asylum after another..."[197]

A number of Scottish Commissioners visited the colony in the 1860s, praising its underlying principles, if not the quality of care and provision. From this, Rice has argued that the Commissioners were prompted to implement the system seen there.[198] In addition, McCandless has attributed the expansion of boarding-out to the influence of a visit to Gheel in 1860 by Coxe and Sibbald, suggesting that they were convinced that the system, despite some defects, had sufficient merit to warrant its adoption in Scotland. This assumption, however, overlooks the provisions of legislation passed three years earlier in 1857, authorising a system of boarding-out under the strict supervision of the newly created Board of Lunacy.[199]

The longstanding ideals displayed at Gheel reflected trends in the care of the insane from the mid-to-late-nineteenth century. In this way, the significance of the colony lay in its early endeavours to implement a policy of domestic provision. Physicians declared that from the time that Gheel became known to alienists, it was "continually cropping up like a ghost that cannot be laid."[200] The theoretical ideals, if not the actual practice, behind it were imitated throughout the world. As Winslow indicated:

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[197] Deas, M. (1876) *op.cit.*, p75.
[198] Rice, F. (1981) *op.cit. Vide supra* Chapter 4. Halliday, however, in 1828 had proposed establishing "Gheels" on the Heaths of Middlesex and Midlothian. He was largely ignored.
[199] Sibbald, J. (1861) *op.cit.*, Although enthusiastic regarding the potential benefits of Gheel, this is not to link his support for boarding-out with direct attempts to adopt a Gheel system.
[200] Hill, R.G. (1870) Non-restraint in the treatment of the insane. *Edinburgh Review*, **131**, p441.

> "it was in this direction that nearly every eminent authority in psychological medicine is inclined to tread. "Family life" is the new watchword that is being uttered by the best teachers on Mental Pathology throughout Europe."[201]

Thus, Parry-Jones has suggested that Bucknill's experiments in Devon were directly associated with the model of Gheel.[202] However, while Bucknill pointed out the similarities between his experiment and Gheel, his numerous publications made little reference to the colony (or indeed to the Scottish system). Although some English superintendents mentioned Gheel when discussing the possibility of instituting non-asylum provision, this reflected less a desire to imitate, than simple awareness of its existence and potential benefits. Alienists argued that there was little of practical value to other countries, except in the demonstration that extensive freedom was possible for certain classes of the insane.[203]

Nevertheless, certain Scottish medical superintendents did discuss the colony. For example, among proposals put forward for the relief of overcrowding at Stirling District Asylum, the establishment of independent colonies, such as Gheel, was suggested.[204] Although ideas and experiments did filter across countries, the innovators of a centralised boarding-out system were located firmly in Scotland. The activities of alienists overseas appeared to have little direct impact on the attitudes of Scottish medical superintendents. The majority concurred, rather, with the views of the powerful Board of Lunacy.

Despite aggregations in central Scotland being hailed as Gheels of the North, Scottish alienists, therefore, took care to disabuse others of this interpretation, pointing out the many differences in the selection and distribution of patients, and arguing that the only similarity lay in the congregation of the insane outside the asylum.[205] It is evident that there was a general misunderstanding of the true nature of the system; in the short time available, overseas visitors were directed to the districts which contained the greatest number of patients and rarely travelled to remote areas. However, this concentration on certain villages led to widespread belief that an essential feature of Scottish policy consisted of

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[201] Winslow, F. (1859) Pauper Lunacy. *Journal of Psychological Medicine*, **12**, p342.
[202] Parry-Jones, W.Ll. (1981) *op.cit.*, p209.
[203] Such an assertion is still reiterated. Srole has asserted that "an entire heterogeneous population can spontaneously function as a natural therapeutic community, for those heretofore terminally consigned to hospital wards." Srole, L. (1977) Geel, Belgium, the natural, therapeutic community. 1475-1975. *New Trends of Psychiatry in the Community* (ed. G.Serban) Cambridge Massachusetts: Ballinger, p129.
[204] MS AR (1897) Stirling District Asylum, p27.
[205] Mitchell, in 1870, while accepting that it was possible to implement a system on the lines of Gheel, declared that small aggregations dispersed throughout the country were more desirable than the accumulation of large numbers in a small area. GBCLS 12th AR (1870), p251.

"colonies" of the insane such as Gheel. This misleading impression continued and, for example, Parry-Jones argued that it is:

> "a misconception to view the Scottish boarding-out regime as a specialised system of family care... the boarding-out of single lunatics, both private and pauper, had been and remained common practice in England and Wales. The main difference in Scotland was the aggregation of relatively large numbers of lunatics in one locality."[206]

This is to concede too much importance to the aggregations of special licensed houses and to neglect the nature and extent of official control. Although by the 1880s, a large number of patients in Scotland were boarded-out in such houses, nearly 50% of all boarded-out patients remained dispersed throughout the country as single patients, an integral part of the system. Patients at Gheel, however, were located in a clearly delineated area. Hack Tuke was, therefore, accurate in his assertion that although observers maintained that "Scotland already presents an example of the system pursued at Gheel, this is only true in a modified sense."[207] The number residing in Scottish aggregations was minimal when contrasted to the inmates at Gheel. Further, patients who were dirty or troublesome, all paralytics and the majority of epileptics were excluded by the Commissioners, in contrast to the greater tolerance of such cases at Gheel. To Hack Tuke, despite sustained criticism of certain aspects, boarding-out was more systematised and better supervised in Scotland, and "if we entertain misgivings as to its advantages, we must entertain still greater misgivings as to the planting of a Gheel in this country."[208]

With the exception of the potential influence of Gheel, the experiences of other countries had little formative impact upon Scottish policy. While aware of similar policies operating around the world, there was no steady stream of Scottish visitors to assess these other systems. Complacent in its pioneering position, the path taken by commentators was very much towards Scotland. Nevertheless, this is not to dismiss the importance of Gheel. The colony provided a useful example of the success of domestic provision on a large scale, even if few countries attempted to replicate its existence in an identical form. As Parry-Jones has stated, "it is indisputable that it provided a prototype for an alternative approach in the care of the chronic insane to that offered by the asylum system."[209]

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[206] Parry-Jones, W.Ll. (1981) *op.cit.*, p210.
[207] Tuke, D.H. (1886) *op.cit.*, p495.
[208] *Ibid.*
[209] Parry-Jones, W.Ll. (1981) *op.cit.*, p207.

14.16.2 Worldwide impact of the Scottish system

The number and frequency of references to the Scottish system in European and American journals is exceptional. Notwithstanding the greater age and fame of Gheel, it is rare to find an article on family care which does not refer to boarding-out in Scotland. The majority of these reports were favourable, often resulting in direct attempts to initiate such a system. It was in Massachusetts that the most direct impact of the Scottish method was seen, but on the continent, particularly in Berlin and in Switzerland, the system was widely recognised as of great significance and worthy of imitation.

Contemporary journals reported the frequent visits to Scotland of physicians from around the world. Editors of the Journal of Mental Science observed that Colonial, European and American specialists were commissioned by their Governments to visit Scotland:

> "in order to see the modus operandi and these have returned with such favourable accounts that other nations are following suit".[210]

Thus, physicians from as far away as New Zealand, Romania, and Russia made regular visits to see boarding-out in practice.[211] American observers also were, almost without exception, enthusiastic proponents of the Scottish system, advocating its adoption in their country. Riggs, for example, endorsed it without reservation, asserting that "nowhere else has boarding-out been so extensively and so successfully tried as in Scotland".[212] However, despite widespread, sustained enthusiasm for the Scottish system, certain aspects of the policy were criticised, although with less vehemence and less regularity than that directed at Gheel. Ripping, a German alienist, condemned the inadequate supervision, and the selection of impoverished guardians, maintaining that it was only in infertile, unproductive areas that the system could flourish.[213] Sixty years later, an American physician, Sandy, deplored the possibility of patients being boarded-out "without having had a desirable period of close observation, diagnostic study and intensive treatment".[214] In his view, the system in Germany with its close links to the asylum appeared to be better. Such criticisms

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[210] Sutherland, J.F. (1897) *op.cit.*, p59.

[211] Among the many visits recorded were those by Peeters, commissioned by the Belgian Government, Siemerling from Germany (1886) Meyer, from Germany. See report in Meyer, E. (1905) Care of the insane in England and Scotland. *Poor Law Magazine*, 8, p287) Narbouth, from St Petersburg, members of the Romanian Government in 1900, and Braesco, medical superintendent of Jassy Asylum.

[212] Riggs, C. (1895) *op.cit.*, 328-329. Similarly, Moulton declared that: "as the system of treating lunatics in Scotland has certain prominent features considered of great value, I believe so far as circumstances will permit, advancement in this country should be along the lines found advantageous there." Moulton, A.R. (1892) *op. cit.*, p402.

[213] Ripping (1875) *op.cit.*, p265.

[214] Sandy, W.C. (1935) Boarding-out of mental patients. *Pennsylvania Medical Journal*, 39, p156.

were rare. The system of boarding-out in Scotland was heralded widely as an innovative and successful experiment which merited close replication overseas. The Scottish system was feted with equal enthusiasm to the Gheel colony and imitated around the world. One physician, Stedman, recorded his regret that so few American physicians had visited Scotland, in contrast to the many visits to Gheel, because in his opinion, the Scottish approach was "a well nigh perfected department in its lunacy system."[215]

One marked divergence between the Scottish and other systems lay in the independence from asylum administration in Scotland. This severance of asylum influences was never fully achieved on the continent, and the tendency towards aggregations of the insane, in a circumscribed area (often with a central infirmary) became typical. Rather than select Scotland or Gheel as the archetypal influence behind activities in other countries, it is perhaps more realistic to stress their combined impact. Alienists adopted aspects of the colony, and the more dispersed boarding-out system, either with an asylum as the central focus, or with patients distributed across the country. What is certain is the enduring and far-reaching impact the Scottish system had upon the development of family care throughout the world. Even where it was not imitated directly, it was closely assessed and widely referred to. The pride of Scottish Commissioners in their development and control of such a pioneering system was justified by the scale of interest provoked. It is apparent, therefore, that the belief of the German alienist, Jolly, was echoed internationally, with his declaration that "in the Scottish family system there lies an advance in lunacy administration...the fundamental principles may be adopted with confidence from Scotland".[216]

14.17 Summary and conclusions

This brief survey of international family care highlights the widespread activity in the second half of the nineteenth century towards adopting additional methods of providing for the insane. While not definitive, this assessment has undertaken an extensive survey of international methods of family care, in the absence of any other framework of material to draw on. There was lively debate regarding the effects of such systems. International congresses were devoted to the theme, journals devoted considerable space to descriptions

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[215] Stedman, H. (1890) *op. cit.*, p328.
[216] Jolly, F. (1875) *op.cit.*, p60.

of various systems, and frequent visits were made to countries with active family care policies.[217] Interest in the subject was first evident from a small number of individual countries, including France, Belgium and Scotland from the 1850s, mounting to widespread activity across nations by the 1890s, with the notable exception of England.

The nature and development of family care systems has often been misunderstood; Maletz, for example, reporting incorrectly that Germany adopted a system of domestic provision in 1911.[218] Similar inaccuracies are seen in other brief studies, prompted by the lack of any systematic study of international, national or even local, family care policies. The majority of countries which endeavoured to implement such systems acted long before 1900. More recently, Pernice has suggested that "at the turn of the century, family care centres increased rapidly in...European countries (France, England, Scotland, Italy, the Netherlands and Belgium)".[219] The developments traced in this chapter have indicated the error of this interpretation. The system in Scotland cannot accurately be described as forming a family care centre, patients were dispersed widely across the country. Further, the international enthusiasm for domestic provision did not extend to England. Its proximity to Scotland, and the widely heralded success of the latter country made no impact upon sceptical asylum-oriented physicians and there was never any sustained attempt to implement a system of family care in England in the nineteenth or early-twentieth century.

The closely controlled and supervised Scottish system was, however, replicated by alienists worldwide, distance proving no obstacle to imitation. By 1900, similar systems were in place worldwide. The international attention devoted to Gheel, and to a similar extent, to Scotland, provided the dominant impetus behind the movement towards domestic provision. Differences between international systems do not detract, in any way, from the influence of Scotland, because, as Cunyngham Brown declared, the choice of policy was determined less by the intrinsic merits of any one system as by "the nature of the country, the character of the inhabitants and the form of administration obtaining at the time".[220] The

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[217] At the International Congress for the care of the insane held at Antwerp in 1902 the question of family care was the main topic. In 1904, the Home Relief Conference was held in Edinburgh, in recognition of the pioneering nature of Scottish lunacy administration. Notes on the preparations and proceedings of the International Congress in Edinburgh are contained in the Poor Law Magazine for 1903 and 1904, *passim*.

[218] Maletz, L. (1942) Family Care. A method of rehabilitation. *Mental Hygiene*, **26** 594-605.

[219] Pernice, A. (1995) Family care and asylum psychiatry in the nineteenth century: the controversy in the *Allgemeine Zeitschrift für Psychiatrie* between 1844 and 1902. *History of Psychiatry*, **6**, 55-68.

[220] Cunyngham Brown, R. (1908) *op.cit.*, p537.

sustained attention focused on Scotland, and the attempts to implement the "Scotch system" remain one of the most remarkable aspects of the boarding-out policy. The endorsement of an American observer was reflected widely, when it was announced:

> "the brand "made in Scotland" goes nowadays. Golf has spread like wildfire, and Scottish influences are in evidence everywhere...Is it not time to give a fair trial to boarding-out as practised North of the Tweed...The Scotsman is nothing if not shrewd and cautious. There must be something in it for him as well as for the patient".[221]

Mangen has suggested that the historical significance of nineteenth-century attempts at domestic provision lies "in their role as models for the future, rather than in the speed of their implementation, or the original extent of their diffusion."[222] In this context, it is constructive to trace the continuing development and influence of the Scottish boarding-out system into the twentieth century.

[221] Alder Blumer, G. (1899) *op. cit.*, p39.
[222] Mangen, S. (ed.) (1985) *op.cit.*, p5.

CHAPTER 15

COMMUNITY CARE IN THE TWENTIETH CENTURY

15. Overview

This chapter provides a historical overview of the boarding-out system from 1913 to 1995, exploring the gradual change in the nature of its application. Current moves towards the related policy of care in the community can be traced to a reforming movement in psychiatric hospitals, which acquired momentum in the 1950s and 1960s, boosted by the introduction of psychotropic drugs. However, preceding this, there had been a gradual change in orientation, with sustained attempts to improve the quality of life for those in hospital, by implementing rehabilitative measures. The development of provision for the mentally ill in the community is outlined and the enduring belief in the need for asylum in the 1990s is assessed. In addition, the foregoing assessment of boarding-out between 1857 and 1913 enables analogies to be drawn with the late-twentieth century debate concerning the appropriate balance between institutional and community care of the mentally ill.

15.1 Introduction

Widespread attention has been focused on the nature and quality of psychiatric provision in the late-twentieth century from professionals, the media and the general public alike. Within the past two decades, health service providers throughout Europe have made a clear policy commitment to reducing the size and role of psychiatric hospitals with a new emphasis placed on community-based resources. This is dependent upon the provision of primary care by GPs, with specialist psychiatric services available for patients with acute illness, and those requiring long-term care. Concerns that the running down of institutional accommodation places both patients and public at risk, increases with each reported suicide or murder committed by recently discharged psychiatric patients. Parallels between the prevailing attitude towards the mentally ill today, and the fear and prejudice encountered when patients were boarded-out in the nineteenth century are evident.

This chapter explores the continued growth of boarding-out in Scotland, under the new name of guardianship. Such a system is not to be confused with the more *ad hoc*, but increasingly widely employed, policy of community care. In both methods of provision, patients are accommodated outside large institutions and located in private homes, hostels, or half-way houses. However, the very nature of guardianship offers more support of a personal nature to those patients regarded as particularly vulnerable. Supported lodgings schemes, which provide for mentally ill persons in family homes under the care of an individual guardian are currently being introduced in several districts of Scotland, by the Scottish Association for Mental Health. These schemes, which are funded by the Scottish Office, are administered by social services.[1] At present, similar policies are rarely employed in England and Wales, although in recent years, experiments such as the Adult Placement Scheme in Hackney, are gaining in popularity, albeit affecting only a minority of patients.

International experiments of family care policies continued in the twentieth century, with notable success in Germany in the 1950s onwards. In Ireland, family care was adopted following the passage of the Mental Treatment Act, 1945. Domestic provision was also extended in the United States. During the nineteenth century, Massachusetts was the only state to adopt the policy on any significant scale. In the 1930s and 1940s, as the deleterious effects of long-term institutionalisation became more apparent, and pressure on bed-space remained undiminished, family care was introduced in many states for incurable, quiet and easily managed patients.[2] Numerous articles documented the progress of the system, and are particularly notable for the marked similarity in the nature of their endorsement, to that recorded in Scotland.[3] Notwithstanding concerted attacks from certain quarters, family care became an important addition to the prominent policy of confining the insane in

[1] *Vide infra* 15.6.2.

[2] Other disorders included manic depression, mental defectiveness, and alcoholic psychoses. Molholm, H.B. and Barton, W.E. (1941) *op.cit.* The nature of questioning as to the suitability of patient and guardian were almost identical to those asked in Scotland in the nineteenth century. The mental condition of the patient was closely assessed, and personal habits, religious interests, and physical needs were all observed. Guardians were questioned as to the number of rooms in their house, its location, plumbing, and cleanliness. Further they were asked what their reason was for wishing to receive patients. Their social and educational background was also considered.

[3] Useful descriptive studies include: Crockett, H.M. (1934) Boarding homes as a tool in social casework with mental patients. *Mental Hygiene*, **18** 189-204, Crutcher, H.B. (1938) Family care of the mentally ill. *Mental Health Publication of the American Association for the Advancement of Science*, **9**, 179-184, and (1940) Family care of mental defectives. *American Journal of Mental Deficiency*, **45**, 127-133, and Molholm, H.B. and Barton, W.E. (1941) Family Care, A community resource in the rehabilitation of mental patients. *American Journal of Psychiatry*, **98**, 33-41.

institutions in the United States. Following the advent and rapid implementation of "decarceration" however, its benefits were largely forgotten.[4]

Grob's assertion that "if a knowledge of the past does not offer a precise prescription for the future, it can nevertheless yield insights...that provide a context against which to measure and evaluate contemporary policies and issues,"[5] lends support to the contemporary relevance of the present study of a pioneering system of care in the community. By recording briefly the developments in psychiatric provision this century, the enduring similarities in trends of care, both towards and away from institutionalisation, can be seen. What becomes markedly clear is the recurrence of the very problems that, it was hoped, each new step would ameliorate. The mounting concern and widely publicised "scandals" relating to care in the community have prompted a general recognition that radical change is long overdue. Bucknill's warning in 1860 remains wholly apposite:

> "The tide of public opinion has set strongly against asylums; soon however, it will be slack water, and then a few outrages will probably turn the prejudices of the fickle public against the liberty of mad folk. A few striking examples either way are sufficient to turn the direction of public opinion."[6]

15.2 Boarding-out in Scotland, 1913-1995

The policy of placing vulnerable mentally ill or defective persons with official guardians continued to be utilised in Scotland following the Mental Deficiency and Lunacy (Scotland) Act, 1913. However, from a system which provided for up to 25% of all registered insane in the 1890s and 1900s, the proportion provided for in this way in the twentieth century appears minimal. Further, the mental classification of boarded-out patients underwent a gradual transformation, with an increasing tendency to accommodate the mentally defective in private dwellings, while the mentally ill were admitted in growing numbers to psychiatric hospitals. Notwithstanding a decline in the number of those placed under guardianship, this form of provision for certain chronic patients has remained in force, even if barely comparable to the system championed by the Lunacy Commissioners in the nineteenth century. The more widely known trend towards a policy of care in the

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[4] The process of decarceration is most notably documented by Scull, A. (1984) *Decarceration*. Revised edition, Oxford: Polity Press.

[5] Grob, G. (1994) *The mad among us: a history of the care of America's mentally ill.* New York: Free Press, p3.

[6] Bucknill, J.C. (1860) Annual reports of lunatic asylums, *Journal of Mental Science*, 6, p511.

community, although providing for patients outside the constraints of institutions, rests on an entirely different basis, with less formal control and selectivity of those affected.

15.2.1 1913-1950

Lunacy Commissioners expressed concern at the diminution in numbers boarded-out in the 1910s and 1920s. In 1914, Macpherson noted his regret that "for the first time in many years I have to report a considerable falling off in the number boarded-out."[7] As a result of the Mental Deficiency and Lunacy (Scotland) Act, 1913, changes in classification led to patients who had been boarded-out as insane being certified as mentally defective, and therefore not appearing in the Board of Control statistics for boarded-out lunatics.[8] Nevertheless, admissions to asylums were reported to be rising at an alarming rate, partly due to improvements in the status of mental hospitals and to changes in the law relating to hospital admission. Reflecting this, Robertson maintained that the "hospitalisation" of the asylum system led directly to the demise of boarding-out, with the reform of institutional care and a reduction in many long condemned characteristics.[9] Thus, it is contended that the decline of boarding-out was not precipitated by any tangible dissatisfaction with the system, rather it was the continued progress in provision for the mentally ill, and the changing conditions brought about by World War I, which led to an ultimately irrevocable challenge to its status.

The decline was most apparent among cases transferred from asylums in large parishes. Between 1875 and 1914 the number boarded-out had increased from 1399 to 2768.[10] This was followed by a considerable reduction in patients accommodated in this way, over the next three decades (Figure 15.1). Both forms of admission to private dwellings, from asylums, and from home, underwent marked decline. In 1910, for example, 133 patients received sanction from removal to an asylum, thereby becoming single patients, while in 1919, only 27 were thus admitted. Similarly, in 1910, 156 patients were discharged unrecovered from asylums to private dwellings and this fell to 53 in 1919.[11] The decrease in patients removed in this way was perceived to be particularly serious, because from the

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[7] GBCLS, 56th AR (1914), p142.
[8] Under the terms of this Act, the Lunacy Commission was replaced by the General Board of Control.
[9] Robertson, G.M. (1922) *op.cit.*, pp321-332. The basic impetus behind and characteristics of the hospitalisation movement has been discussed in Chapter 12.
[10] GBCLS 18th AR (1876) and GBCLS 56th AR (1914).
[11] GBCLS 53rd AR (1911) and GBC 5th AR (1920), main report, pxxxvii.

1880s onwards it was from asylums that the greatest number of boarded-out patients had originated.

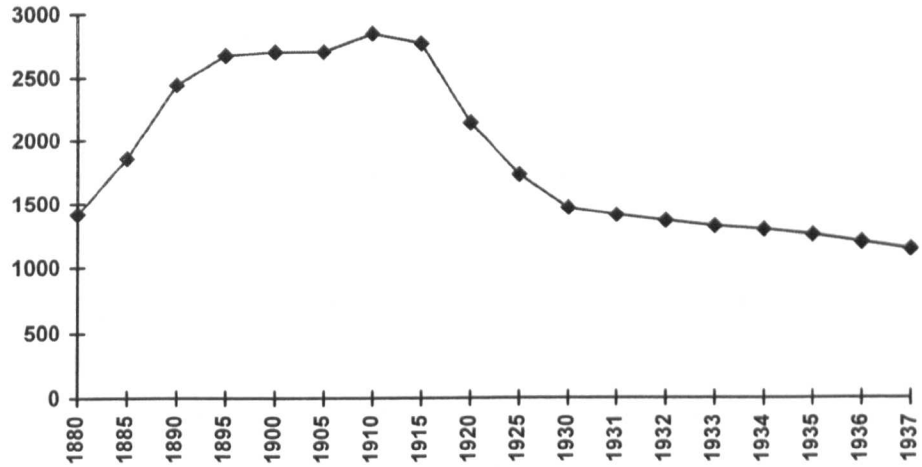

Figure 15.1 Rise and fall in the number of insane patients boarded-out, 1880-1937[12]

The Commissioners attempted to reverse this trend, emphasising the surplus of accommodation in many areas and the adequate supply of willing guardians, who, it was feared, would disappear if not utilised. As Cunyngham Brown explained:

> "Good guardians cannot be manufactured in a day, elderly guardians die, and unless their successors, the younger generation in the household, are encouraged to keep their special licensed houses in being, the experience and tact in handling the insane in private dwellings which has been acquired and transmitted from mother to daughter during this past half century will be lost to the country for ever."[13]

However, there was considerable disorganisation of local authorities during the war years. Attention was focused more on coping with war conditions, rather than overseeing provision for the insane. The normal distribution of the population was altered and, in addition, restrictions on food and fuel, and rising living costs compelled many guardians to part with their patients, many of whom had resided with them for years.[14] The system never recovered fully from the decline during the war, although it became a popular form of provision for ex-service men. By 1925, 1789 insane patients were boarded-out, a reduction of 1120 over 12 years, although added to these figures were 874 mental

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[12] Source of data: AR of GBCLS (1880-1913) and GBC (1914-1937) *passim*.
[13] GBC 1st AR (1914), p149.
[14] In 1920, the Board of Control issued a circular to inspectors of poor and Clerks to the District Boards of Control regarding the "alarming decrease" in the numbers boarded-out during the war. Local authorities were urged to increase the maintenance paid to guardians, arguing that more adequate remuneration was necessary, in view of the enhanced cost of living. In this way, one cause of the decline could be eradicated.

defectives, now classified as distinct from the insane.[15] A post-war scarcity of housing, particularly in rural Scotland, reduced previous enthusiasm for, and ability to accommodate patients within the family. Further, the financial saving attainable to parishes declined, with a rise in maintenance payments to guardians, but no increase in the Government grant-in-aid to the parish.[16]

An additional reason for the decline in the number of patients boarded-out was thought to be the greater apathy among parish officials, upon whose activities the success of the system was largely dependent. The work-load of public assistance officers (previously inspectors of poor) had increased markedly in the 1920s and 1930s, creating difficulties in finding time to make the statutory visits, "far less think out ways and means of improving conditions".[17] The less troublesome option of removing patients to asylums, thereby not incurring the responsibilities of visitation, was resorted to with increasing frequency. In addition, asylum superintendents failed to board-out patients as readily as in previous years. With increased wages demanded by staff, the ability of patients to work acquired enhanced value, creating a reluctance among superintendents to lose their useful patients.[18]

The rise in the number of mental defectives boarded-out is the most notable feature of the system in the twentieth century. Commissioners contended that family care was often "an ideal way of dealing with defective patients",[19] although it was recognised that high-grade defectives required more care and supervision than other cases. Such patients, therefore, were not boarded in the same houses as those classified as insane, and no more than two were boarded together. In 1918, for example, 525 mentally defective and 2449 insane patients were boarded-out. By 1938, 1587 mentally defective patients were provided for in this way, contrasted to 1087 classified as mentally ill.[20] The disparity rose further by the 1950s and in 1957, 2551 mentally defective and 307 mentally ill patients were boarded-out.

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[15] GBC 5th AR (1920), main report, pxl.
[16] However, the saving was still considerable. In 1920, the annual cost of provision for a pauper in an asylum was £38, in contrast to £24 for those in private dwellings. *Ibid.*, pxli.
[17] GBC, 21st AR (1936), pxxxi.
[18] Gibson, G. (1925) *op.cit.*, p258.
[19] GBC, 24th AR (1939), pxxix.
[20] *Ibid.*

The condition of mentally ill persons deemed suitable for care in private dwellings also underwent some transformation, with schizophrenic patients, those suffering from delusions and hallucinations, as well as those who were reported to be "moody and irritable" being boarded-out. Such patients were rarely granted sanction for residence in the community in the nineteenth century. In a further departure from previous policy, elderly patients were generally considered to be unsuitable.[21]

Despite the post-war decline in numbers, patients continued to be boarded-out throughout the first half of the twentieth century. By 1935, the Board of Control was able to report that "more interest is being taken in the boarding-out system than was the case some years ago", with a rise in applications from suitable guardians.[22] Report books and registers for the 1930s and 1940s indicate that large number of patients were boarded-out annually, the majority still being sent to rural areas from Glasgow and Edinburgh, and to a lesser extent from Greenock, Paisley, Aberdeen and Dundee (officials from the latter two parishes having been condemned repeatedly in previous years for their inactivity).[23] The advantages extolled so frequently in the nineteenth century remained pertinent. Eighty years after the system first came under formal control, the conviction of the Commissioners remained strong and the enthusiasm of one Commissioner, Chapman, in 1936, was echoed widely:

> "I am firmly convinced of the benefit to be derived from the boarding-out system, not only to the patient but to the general community. It provides useful employment, interest and a home life for the patient, widens the outlook of those who come into contact with him and helps to remove that all too prevalent opinion of the general public that the only place for the mentally afflicted is the asylum."[24]

15.2.2 1951-1980

The use of guardianship has declined over the last forty years, although it is still utilised for overseeing the condition of vulnerable persons.[25] Formally defined as the placing of adult

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[21] Stone, J.A.W. and Evans, A.E. (1938) The boarding-out of mental patients in the Scottish Highlands. *Journal of Mental Science*, 84, p390.

[22] GBC, 20th AR (1935), pli.

[23] In 1958, patients were still sent to special licensed houses. General Board of Control, Residence sanctions 1916-1958. (MC6/12, 13) The high proportion of patients boarded-out in Inverness has been documented in Chapter 9. The region retained its popularity in the twentieth century. In 1936, 21% of registered patients were boarded-out from institutions in the county, while the average proportion for the whole of Scotland had declined to 6.6%. GBC 21st AR (1936).

[24] GBC, 21st AR (1936), pxxix. Similarly, Ferguson Watson stressed the value of the system as a useful "safety valve" which provided the opposition that prevented the asylum system from becoming a monopoly. "Let us see that this well tried, humane and practical scheme, is not allowed to wither, to decay, by indifference and neglect." GBC 10th AR (1925), p263.

[25] Richards, H. and Mc.Gregor, C. (1992) *op.cit.*, contains a useful general description of the development of guardianship this century. The use of guardianship was endorsed in the Mental Health Act (1959) for England and Wales, as a way of protecting vulnerable disordered persons. However, it was only ever in limited use.

mentally disordered persons with unrelated guardians in private homes, patients continued to be provided for outside institutions, under regulated supervision. In 1955, the General Board of Control stated that:

> "the Scottish system of boarding-out patients in private dwellings has stood the test of almost a century and during these years many tributes have been paid to the devoted and sympathetic care given to patients, and the kindly and vigilant supervision afforded by doctors and local authority welfare officers."[26]

That this was possible can be explained by the accuracy of Henderson's assertion that every Commissioner known to him since 1907 (and in fact, from the creation of the Board in 1857) was "wholly in favour" of the system. This was apparent in their continued advocacy for its employment.[27] The Dunlop Commission of 1957 recommended the continuance of guardianship. By this time, the emphasis was upon local authority officials having responsibility for acting as guardians. Their authority was held to be comparable to that of a parent. Under the terms of the Mental Health Act, 1960, Commissioners were authorised to make regular visits to all persons under guardianship and make recommendations for improvements where necessary. Immediate responsibility rested with the local authorities, which continued to select patients and guardians and pay the maintenance costs.

No distinction was made between mentally defective or mentally ill patients in the admission to guardianship. However, the trend towards a predominance of mentally defective patients, first perceptible in the 1930s, continued apace, although the proportion thus provided for remained small. Immediately prior to the legislation of 1960, almost 1000 out of 40,000 mentally defective patients were under official guardianship. Others were placed informally and remained with their families, or were accommodated in hospitals.[28] Patients sent from Glasgow constituted the majority of those boarded-out, and rural locations continued to be the most popular placement location.[29] However, with the increasing professionalisation of psychiatry, mounting concern at the lack of formal supervision by trained staff became evident. Patients were visited by local authority mental health officers three times annually, a local authority physician annually, and a Mental Welfare Commissioner bi-annually. Thus, each patient was seen by an official six times a

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[26] *Ibid.*, p14.
[27] Henderson, D. (1964) *op.cit.*, p98.
[28] Certain councils preferred informal procedures, regarding formal placement as stigmatising.
[29] This had changed dramatically by 1988, when 68% of those under guardianship lived in urban areas, and 32% in rural areas. Richards, H. and Mc.Gregor, C. (1992) *op.cit.*, p70.

year, for approximately 30-60 minutes but this was regarded, by some, as inadequate protection against potentially exploitative or incompetent guardians.

Recommendations for the employment of psychiatric social workers to oversee patients, and improvements in arrangements for social activities were put forward and ultimately implemented by officials anxious to ensure the continuance of the system. In some areas, clubs were established for patients to meet weekly. Henderson advocated the decentralisation of administration, whereby each hospital made individual arrangements for boarding-out in their own area.[30] This would allow medical staff to continue treatment and enable hospital officials to become sufficiently aware of the system and its potential benefits. Local authorities now provide for and oversee the maintenance and welfare of patients, as enshrined in the NHS and Community Care Act, 1990, although the Mental Welfare Commission retains the right of inspection over all patients under guardianship.

Despite continued centralised control and supervision, by 1966, the number under guardianship had fallen to 973, of whom only 250 were with unrelated guardians. This marked decline can be linked to a steady rise in hospital admissions for mentally handicapped persons. Such patients were regarded by the Commission as most in need of regular visitation. In addition, many mentally defective people were given informal status following the Mental Health Act, 1960, and, although supervised informally by local authorities, were not under the surveillance of the Mental Welfare Commission. This prompted renewed concern at the possibility of abuse and fear that such procedures were superseding an organised boarding-out policy. The assertion of the Commissioners that, "there is a risk that the system by its very nature could result in exploitation of the patient" was plausible.[31]

Growing concern among mental health professionals led to a series of extensive surveys conducted by the Mental Welfare Commission, published in 1970, 1972 and 1975. The first report, "No Folks of their Own" was an assessment of the standard of care received by

[30] Henderson, D. (1964) *op.cit.*, p102.
[31] No Folks of their Own. A Report on one aspect of community care of the mentally handicapped (1970) Mental Welfare Commission for Scotland. Edinburgh: Her Majesty's Stationary Office, p1.

147 male persons boarded-out with strangers, 76% of whom were over the age of 40.[32] The Commissioners concluded that while the majority were well cared for, the standards observed for 20% were "doubtful" and for 21% "unsatisfactory".[33] There were few complaints from the boarders; most were reported to be happy and settled, although loneliness, financial constraints, and more rarely, complaints about overwork were recorded.[34] In general, guardians spoke warmly of their charges, fulfilling the long-standing concern of Commissioners that patients be integrated fully into family life. The report observed, however, that a minority of guardians regarded the patient more as a hired hand. In such cases, patients ate alone and spent the evenings in their room.[35] It was in these households that open resentment at official visitation was apparent. The Commission recommended that no patient be placed informally with unrelated guardians and stressed the benefits of the system to those under formal supervision. Despite certain concerns regarding the standards attained in some families, the report concluded that this "does not negate the value of boarding-out as a useful and well tried means of integrating certain mentally disordered persons in the community."[36] Following the report, the establishment of hospital assessment centres was proposed to facilitate patient selection,[37] although this was never implemented. However, public concern was captured by increasing disclosures about guardianship. In 1970, the BBC conducted an inquiry into the condition of mentally handicapped men, boarded-out in farms on Islay, and for a time, a profusion of related articles were printed in newspapers.[38]

The second major report by the Commission, "A Duty to Care" (1972) stressed the dramatic decline in patients residing under guardianship. In 1960, 2442 were thus provided for; 11 years later, this had fallen to 608.[39] Concern regarding the untraceable number of

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[32] 88 of the patients came from Glasgow, demonstrating the continued popularity for boarding-out patients from large towns to rural districts.

[33] *Ibid.*

[34] Complaints included "I get awful lonely", "I want away", "I can't have a bath", "She is very fiery." Others, however, declared "nae complaints av'a", "it is a good place, you get as much as you want to eat" and "they make you just like themselves, you can go with them anywhere, and sit with them."

[35] Positive comments included: "to part with him would be like a death in the house", "A good toy, a great company to me", "Nobody would harm Willie, for Willie would harm nobody", and the source of the title of the report, "they're poor souls aren't they with no folks of their own?" Other guardians were more callous: "What can you expect of a person who is daft?", "I don't like them in with the children", "They kind is all moody", "he is twisted".

[36] No Folks of their Own. (1970) *op.cit.*, p18.

[37] The extensive debate on this is detailed clearly in the Memorandum by Mental Welfare Commission for Scotland on male patients boarded-out formally with unrelated guardians in Scotland (1968).

[38] Related papers (1968) (HO5 19/2/11/3/5).

[39] Richards, H. and Mc.Gregor, C. (1992) *op.cit.*, p20.

those living under informal guardianship was once again apparent. The third report, "No Place to Go" (1975), highlighted the existence of unsatisfactory living standards, incompetent guardians and inadequate supervision by local authorities. These criticisms continued to find expression in subsequent annual reports.[40]

Memories of the system of boarding-out remain strong in the minds of elderly residents of once active boarding-out centres. On a visit to the village of Kennoway in 1994, the author found that memory of the "wee mad folk" remained vivid.[41] One surviving guardian, a retired music teacher, had taken in patients from 1953, and still had two, with learning disabilities, both over 70 years old. Despite residing with her for over forty years, both were to be moved to sheltered accommodation within a few months. Mrs K's attitude towards her charges appeared bereft of affection or compassion, although she maintained that she had enjoyed having them. However, it was important to her that they "knew their place" or she felt they would take over her life. The prevailing emotion among villagers appears to have been one of acceptance and affectionate nostalgia for the "boarded-out folk", and some quiet pride at the notoriety of their village. Anyone asking for the village would be informed, even in the 1960s, that "that's where the dafties live." Patients were offered food by various families, received presents at Christmas, and were regarded as "everybody's friend," although a number of them appear to have been subjected to sustained teasing, usually by young boys.[42] The overall impression, however, is one of patients becoming assimilated into village life and being treated, mainly, with gentle benevolence.

15.2.3 1981-1995

The Mental Health (Scotland) Act, 1984 clarified the nature of guardianship as "the power to require the patient to reside at a place specified by the authority or guardians." Power was given to guardians to ensure the patient received medical treatment, education or training. The guardian could be either an unrelated individual, or, increasingly, the local authority, if the patient was residing in a home or hostel. In 1987, 72% of those under

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[40] Mental Welfare Commission Annual Reports, 1985-1995, *passim*.

[41] Personal communications on a visit made to the village of Kennoway in 1994. A small number of women were still caring for boarded-out patients. One such boarder was washing her guardian's car, when the visit was made.

[42] A 72 year old man was able to recount with great clarity the characteristics and activities of their boarded-out folk. For example, one boarder, Johnny was "a wee twister", who frightened some people, and chased him as a boy, while others had breakfast with his family once a week.

guardianship had local authority guardians, while 28% were boarded with private individuals. Between 1985 and 1991, the number of persons residing under guardianship did not rise over 71, despite a sudden increase from 45 patients in 1989 to 71 two years later.[43] In 1989, for example, only 14 new cases were admitted to guardianship.[44] Boarding-out, or guardianship is rarely discussed at present. From a position of international recognition and widespread acclamation, the policy is imperfectly understood, and seldom resorted to, in the 1990s.

However, some inherent benefits to the system are still recognised. The Royal College of Psychiatrists and MIND have openly endorsed boarding-out as a useful alternative to hospital provision and so "why it should fall into desuetude is not entirely clear."[45] Nevertheless, the option of placing patients under guardianship is met with increasing unease and criticism from local authority officials. The costs incurred in achieving and maintaining adequate standards of care and supervision are not regarded as commensurate with the benefits attainable.[46] While a small number of mentally disordered persons continue to reside with guardians, the majority of these are accommodated in institutional settings, in direct contrast to the ethos of the system in the nineteenth century.[47] In 1988, for example, 60% of those under guardianship lived in some form of institutional care, with 23% of them in hostels, 19% in residential care and 19% in hospitals. Only a small minority resided in their own homes, or in the house of an unrelated guardian, although the importance of a guardian being easily accessible and recognisable to the patient has long been recognised. As the Mental Welfare Commission acknowledged in 1989, the strength of the policy, demonstrated by years of success, lay in the personal responsibility and contact between guardian and ward.[48] There is now some concern that the increasing use of local authorities as guardians, diminishes the essential success of the policy, by removing personalised attention and reducing personal responsibility for the patient.

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[43] Richards, H. and Mc.Gregor, C. (1992) *op.cit.*, p26. In 1988, 59% of those under guardianship were male. Only 6% were under 26, while 73% were between 25-65. The average length of guardianship was four years, although 9 patients had been under guardianship for over 21 years.

[44] Weatherhead, A.E. (1991) *op cit.*, p341.

[45] Richards, H. and Mc.Gregor, C. (1992) *op.cit.*, p27.

[46] It has been suggested, most plausibly, that the policy has become unpopular "because it presents local authorities with financial and resource implications which cannot be met." Richards, H. and Mc.Gregor, C. (1992) *op.cit.* p37. Chapter 2 of this book assesses current critiques of the policy, and questions reasons for its decline in popularity.

[47] Commissioners highlight a marked trend towards using guardianship "to facilitate the moving of people from their own homes, or from hospital into residential or nursing home care." Annual Report (1993-1994) Mental Welfare Commission for Scotland, p14.

[48] Annual Report (1989) Mental Welfare Commission for Scotland.

Changing patterns of payment for those responsible for the daily care of mentally disordered persons and continued changes within local authority services can be looked to for further explanations for the decline in popularity of guardianship. A number of social work departments do not encourage its employment, choosing to regard institutional provision, or community care with no formal carer, as adequate. The White Paper of 1981 focused on the powers of guardianship being "wide, ill-defined and paternalistic to the extent of being out of keeping with modern attitudes to care of the mentally disordered,"[49] while Weatherhead has highlighted the growing doubts among professionals regarding the criteria for guardianship, the increasingly faceless, impersonal nature of the policy, the limited power given to guardians and the concern regarding the availability of alternatives if it proves unworkable.[50]

The concerns so dominant in the minds of nineteenth-century Commissioners remain prevalent 100 years later. Thus, the Commission's report for 1992 notes the risks of sexual exploitation and promiscuity, insufficient support and supervision and ineffective guardians.[51] Further, conditions reported among the most unsuitable and needy patients, bear remarkable similarities to those documented in annual reports in the 1860s and 1870s. Cases have been recorded where vulnerable, often deluded, persons were discovered in conditions of squalor, comparable to those condemned in the nineteenth century. One house was reported to be filthy and fouled with dog urine. Another contained rotting food, covered in flies. In this case, the social work department was reluctant to help, maintaining that he was lazy rather than mentally ill. Following the intervention of the Commission, his circumstances improved.[52]

Nevertheless, Mental Welfare Commission reports for 1993 to 1994 indicate that the number remaining under guardianship has stabilised, with an increase in applications for those over the age of 65, prompting Commissioners to express their confidence that, despite the decline in numbers, "guardianship continues to be used as a short-term interventionist strategy as well as for longer term management."[53] Of 81 people under guardianship in 1994, 46 were mentally handicapped, 5 suffered from mental illness, 25

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[49] Richards, H. and Mc.Gregor, C. (1992) *op.cit.*, p28.
[50] Weatherhead, A.E. (1991) *op.cit.*, pp341-343.
[51] Annual Report (1992) Mental Welfare Commission for Scotland.
[52] *Ibid.*
[53] Annual Report (1993-1994) Mental Welfare Commission for Scotland.

from dementia and 5 from both mental illness and mental handicap. The majority (29), resided in Strathclyde, 15 lived in the Grampian region, and 12 in the Highlands. Other patients were dispersed across the country.[54]

The option of placing vulnerable, often elderly, and usually mentally handicapped patients under the care of official guardianship remains in use in Scotland, to a limited extent. Where closely regulated and supervised, guardianship offers many of the benefits of the boarding-out system. However, the policy today is poorly clarified, often misunderstood and rarely implemented. If it is to survive as a viable form of provision, it is generally accepted that amendment to current legislation is necessary. In its place, a less controlled, more widely publicised policy has become the dominant method of caring for the mentally disordered, namely "care in the community."

15.3 Development of community care in Britain

There is an extensive literature detailing the gradual implementation and development of community care over the last forty years. Both clinicians and historians of psychiatry have devoted sustained attention to the radical transformation in policy for the care of the mentally ill. It would be superfluous, therefore, to focus in detail on the growth of community-based psychiatry. Community care is not an extension of the boarding-out system, but, having traced the origin of boarding-out, it will be useful to trace the roots and function of a policy which also provides for the mentally ill in the community, albeit a different patient population. Further, to facilitate a comparative assessment between current policy and the nineteenth-century boarding-out system in Scotland, it is necessary to trace the development of community care this century and to explore the inter-relationship between the two policies. The division of this section to cover three distinct periods reflects the nature of the development of community care, with particular activity in the 1950s and 1970s, although a clear move towards such a policy was perceptible from the 1930s.

15.3.1 1920-1950

Increasing overcrowding and accumulation of chronic patients by the turn of the century had led to renewed concern that the asylum was inadequate as a place of cure. Attendants

[54] *Ibid.*

were often poorly trained, confinement and isolation was common and little effective treatment was available. Gradual advances in asylum provision were apparent in the 1920s, as the movement towards developing hospital-like features became widespread, and the link between general and psychiatric hospitals strengthened. New asylums were built on the villa system, the open-door policy was re-introduced, occupational therapy was encouraged and increasing accent was placed on the potential for cure. Admission became easier with the creation of the new category of voluntary patient, following the passage of the Mental Treatment Act, 1930. The development of psychiatric out-patient clinics and observation wards was encouraged, and their expansion did much to improve public perception of the psychiatric hospital, although problems brought about by overcrowding continued to be documented. Towards the end of the 1930s, however, further innovations were recorded, among them, insulin coma therapy (introduced in Edinburgh in 1936), followed swiftly by a largely national adoption of electro-convulsive therapy. Such procedures, coupled with the growing practice of rehabilitation and the increasing employment of group therapy, helped to restore therapeutic optimism and, with the introduction of the National Health Service in 1948, mental hospitals were brought under the control of the Ministry of Health alongside general hospitals.

15.3.2 1951-1970

The movement towards confidence in the curability of mental illness was strengthened by the introduction of psychotropic medication in the 1950s. The acute symptoms of psychoses were suppressed, enabling disturbed patients to be managed outside a hospital. The extension of psychiatric units in general hospitals flourished[55] and new therapeutic communities were established, based on a reduction in traditional hierarchy and a rise in patient autonomy. After World War II, industrial and occupational therapies had been used widely to help chronically disabled patients in the move from hospital to sheltered accommodation or home. At that time, many longstay patients were suffering from handicaps largely attributable to years of institutional living and were responsive to vigorous new methods. With the increasing dominance of patients with severe mental

[55] The two psychiatric hospitals of Oxford and Cambridge, Littlemore and Fulbourn, were particularly active in developing group homes under Mandelbrote and Clark. Coupled with the introduction of neuroleptic drugs, successful attempts were undertaken to rehabilitate patients in the community. Mandelbrote, B.M. (1972) Therapeutic communities and community psychiatry. In *Psychiatric aspects of medical practice* (eds. B.M. Mandelbrote and M.G.Gelder), pp70-87. London: Staples Press.

disturbance, new difficulties emerged. The importance of the concept of rehabilitation cannot be overestimated. As Dyer has maintained: "rehabilitation is at the centre of debate on ways of providing mental health services and the movement towards community care."[56] The provision of group homes, half-way houses and hostels were hailed as breaking down the barriers between hospital and community and restoring dignity to patients after years of impersonal hospital existence.

The reorientation of mental health provision into the community was apparent by the mid-1950s.[57] Enshrined in the Mental Health Acts in England and Wales (1959) and in Scotland (1960), was the belief that the majority of mentally ill patients did not require in-patient treatment, although the hospital retained its place as the central component of provision for the most severely ill.[58] Admissions to psychiatric hospitals continued to rise, but the majority of cases were short stay and the number of compulsory admissions declined dramatically.[59] Into the vigorous, positive environment of out-patient clinics, day centres, general hospital units and psychopharmacotherapy, came the seminal work of Goffman, Szasz and Laing. Sustained criticism of institutions as anti-therapeutic, and attacks on psychiatry and the "myth of mental illness" were heralded as the new ideology.[60] However, despite the growing momentum away from institutional provision, there was no official government declaration of action until the renowned "water tower" speech of 1961, by the Health Minister, Powell, in which he forecast the "elimination of by far the greater part of this country's mental hospitals as they stand today."[61] Endorsement from the Government for community-based provision has become, subsequently, one of the integral features of mental health care policy.

Although the development of psychotropic drugs had a marked impact on the care of the mentally ill, it did not, in itself, herald the advent of community care. Scull is not alone in pointing to financial motivations, as the expense of segregation became increasingly

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[56] Dyer, J.A.T. (1993) Rehabilitation and community care. In *Companion to psychiatric studies.* 5th edition (eds. R.E. Kendell and A.K. Zealley), Edinburgh, London: Churchill, Livingstone, p927.
[57] Bennett, D. (1991) The drive towards the community. In *150 Years of British Psychiatry, 1841-1991* (eds. G. Berrios and H. Freeman), London: Gaskell, pp325-327 *passim.*
[58] Dyer, J.A.T. (1993) *op.cit.*, p927.
[59] Bennett has estimated that "the number of compulsorily detained patients declined in the early 1960s to one-tenth of the number in the late 1950s." Bennett, D. (1991), *op. cit.*, p327.
[60] The impact of their work is assessed in Jones, K. (1993) *Asylums and after, a revised history of the mental health services.* London: Athlone, pp164-180.
[61] Powell, E. (1961) Address to the National Association for Mental Health, London.

difficult to justify. While Jones is accurate in asserting that, "the adoption of drugs and ECT facilitated the acceptance and implementation of community care policies"[62], its development can be seen as "just the present phase of the continuously changing view of how the mentally ill should be cared for"[63], a view which has already undergone substantial modification since its adoption. The vigour of the new movement obscured problems created by fragmented staff structures, the loss of spacious hospital grounds and the build-up of a core of the most severely disabled patients. From the 1970s, the adverse consequences of the radical actions of the 1950s and 1960s became patently clear.

15.3.3 1971-1990

The process of "de-institutionalisation" has continued to develop over the last two decades, although the movement towards implementing the policy has always been slower in Scotland. In recent years, however, the prevailing mood of optimism has altered to one of concern that the pendulum has swung too far, that patients may need "asylum" and that care in the community is little more than empty rhetoric without sufficient financial input to maintain the impetus. From the cautious enthusiasm of the 1950s and 1960s, through to sustained activity in the 1970s, renewed in recent years, the policy has attracted numerous detractors as well as protagonists. Wholesale decanting into the community has become a prominent component of provision for the mentally ill internationally.[64] The most extensive experiment was in Italy where, following the passage of Law 180 in 1978, the psychiatric hospital was entirely rejected. Although widely acclaimed in contemporary international journals, disaffection with the policy became apparent within a few years. Jones suggests that the Italian experience demonstrates that effective substitutes must be in place before hospital closures. She deplored the citing of the policy "as a lever for change" in Britain, where it has been held up as a successful illustration that the mental hospital can be abolished with little additional services. To her, "the real lesson is that this has been tried in Italy and failed".[65]

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[62] Jones, K. (1993) *op. cit.*, p365.
[63] Bennett, D. (1991) *op.cit.*, p321.
[64] The American experience, initiated slightly earlier than that in Britain, has been widely documented. Grob. G. (1994) *op. cit.*, is particularly informative.
[65] Jones, K. and Poletti, A. (1985) Understanding the Italian experience. *British Journal of Psychiatry*, **146**, p347.

Nevertheless, the policy was heralded as inspirational in Britain, where the legacy of the past forty years had established positive attitudes towards widespread care in the community. Targets for bed reduction were announced following the publication of a White Paper in 1975[66] and greeted with enthusiasm, prompted in part by a spate of accusations in the early 1970s regarding overcrowding, cruelty and neglect in psychiatric hospitals.[67] There was also the belief that a closely controlled, adequately financed policy of community care could be more effective than continued institutionalisation for large numbers of chronic and acutely mentally ill persons. The impetus towards community-based provision continued to gain momentum under the Conservative Government from 1979, with the powerful motivation to implement cost-effective policies. It was broadly recognised that the costs of maintenance of buildings, many of which were over 150 years old, was counter-productive.[68] However, and perhaps unexpectedly, the cost of such provision has proved to be only marginally cheaper than hospital care, as an increasingly disabled population is discharged into the community, demanding the employment of greater resources and attention.[69]

The experience north of the border has been largely neglected in general studies of the development and impact of community care.[70] Although the passage and provisions of mental health legislation was either parallel to, or one year later than that of England and Wales, the reduction of in-patient beds has been less marked in Scotland. In 1985 for example, psychiatric hospitals in Scotland had 319 in-patients per 100,000 population, contrasted to 160 per 100,000 in England and Wales.[71] Nevertheless, the number of available beds has declined by almost a third over the last two decades.[72] Thus, in 1987, the Greater Glasgow Health Board announced its strategy for the development of "a

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[66] Better services for the mentally ill. (1975) Department of Health and Social Security. Cmnd 6233.
[67] Jones, K. (1993) *op. cit.*, pp190-193.
[68] Burrell, an architect, has publicised an alternative to the mass closure of psychiatric hospitals, recommending that the former hospital site is transformed into a small town, or "district centre" thereby bringing the community to the hospital, diminishing the stigma and prejudice faced by the mentally ill and making good use of valuable land. His recommendations have not been acted upon. Burrell, J. (1986) *The psychiatric hospital as a new community.* London: Burrell-Foley Associates.
[69] Research by TAPS on the closure of three longstay hospitals, Friern Barnet Claybury and Netherne showed that expenditure for the maintenance of patients was broadly comparable whether accommodated in hospital or in the community. Leff. J.P. (1993) Evaluation of the transfer of care from psychiatric hospitals to the community. In *Principles of Social Psychiatry* (eds. D. Bhugra and J. Leff), pp526-533. Oxford: Blackwell Scientific Publications.
[70] The implication of the dearth of information regarding community care policies in Scotland is discussed in McCollam, A. (1994) *The Minister regrets: This information is not held centrally.* The closure of Scotland's psychiatric hospitals. Briefing paper no. 2. SAMH.
[71] Barham, P. (1992) *op. cit.*, p36.
[72] For example at Hartwood psychiatric hospital in Lanarkshire, bed space has declined from 1600 to 400 in the space of 20 years. Information and Statistics Division, Scottish Office, Edinburgh.

comprehensive network of community based services" with a corresponding reduction in the number of psychiatric hospitals.[73] Such services are being developed with the involvement both of the voluntary and, more controversially, the private sector.

With the continued upsurge in the numbers discharged into the community came the realisation that the policy was inadequately co-ordinated and financed. A House of Commons report in 1985 was highly critical of the standard of provision available under community care, a slogan which, in their view, was "virtually meaningless."[74] The report recommended a rise in expenditure on community-based facilities and better public education. The Times, in the same year, ran a series of articles highlighting the "sordid boarding houses" that had become the only available accommodation for many vulnerable, mentally ill persons.[75] Throughout the 1980s, there was a gradual transfer in public concern from the abuses in mental hospitals, to realisation that neglect was common in the community. Warnings against the cyclical nature of mental health policy were given greater credence, with increasing recognition that the potential abuses of a "trade in lunacy" were replicable in the late-twentieth century, with the growth in private provision for the mentally ill coupled with what appeared to be official neglect. In this context, Turner cautioned that:

> "in abandoning useful buildings (and prime building land) for an evanescent philosophy, persuading exhausted relatives to go on putting up with impossible behaviour, could easily become a backward path to the world of the wandering Tom O'Bedlam".[76]

15.4 Community care in the 1990s

After much delay and disagreement between central and local government, the National Health Service and Community Care Act was passed in 1990[77] and was broadly welcomed by "almost all involved in the mental health field."[78] There is, however, a paucity of comparative assessments of life in a psychiatric hospital and life in the "community". The analysis by Leff of 615 patients discharged from three hospitals in the south-east between 1985 and 1991[79] and the more recent study by Shepherd et. al. of patients in 20 community

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[73] Community care plan. (1992) Greater Glasgow Health Board, p13.
[74] Jones, K. (1993) *op.cit.*, p225.
[75] Wallace, M. The Times, 16.12 85.
[76] Turner, T. (1985) *op.cit.*, p711.
[77] The progress towards the passage of the Act is discussed in Jones, K. (1993) *op.cit.*, p185.
[78] Annual Report (1993-1994) Mental Welfare Commission for Scotland, p22.
[79] In this, Leff and his colleagues concluded that the majority of patients reported satisfaction with their new freedom. Leff. J.P. (1993) *op.cit.* On a smaller scale, Shepherd has recorded the results of his observation of 20 patients living in supervised hostel accommodation. Approximately one-half of the patients were found to have settled in well. Shepherd,

homes in London[80], are exceptions to this. Government departments have been censured for failing to co-ordinate policy and guarantee adequate financial assistance. The Mental Health Foundation has estimated that there is a shortfall of approximately £540 million annually in funding the provision for the mentally ill.[81] The provision of day-care centres remains deficient, with a general unwillingness among local authorities to commit further resources to extensions in community-based provision. The inadequate supply of hostels and public sector homes further adds to the increasingly low perception of community care.

While Bottomley (Health Minister 1992-1995), maintained that the aim of Government policy was to get patients out of "bleak old Victorian institutions", there is now increasing pressure on policy makers to facilitate the admission of severely disturbed patients to hospitals where necessary.[82] Towards the end of 1994, the Government admitted to flaws in its policy, accepting that the balance of mental health provision had swung too far, although their support for the development of locally based services remained undiminished. The long-standing policy of closing all existing psychiatric hospitals by the year 2000 has become increasingly unrealistic and it has been announced that hospitals will close "when and only when community services are ready".[83] Thus while the number of available beds in England and Wales has fallen from 140,000 in 1961 to 28,000 in 1994, further closures are no longer envisaged until additional services are established.[84]

The divergence in activity between Scotland and the rest of Britain remains marked. In Scotland the number of psychiatric, psychogeriatric and adolescent beds has fallen from 18,300 in 1970 to 11,387 in 1994.[85] The decline, while clearly perceptible, is barely comparable to that in England and Wales. The major difference may be, as Barham suggests, that "Scotland takes claims for the retention of mental hospitals more seriously

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G. (1990) Community Care: A historical overview. In *Community care, People leaving long-stay hospitals* (eds. S.Sharkey and S. Barna), pp13-23. London: Routledge.

[80] Shepherd, G., Muijen, M., Dean, R. and Cooney, M. (1996) *Inside residential care*. The Sainsbury Centre for Mental Health.

[81] Reported in The Independent, 30.9.94.

[82] The prospect of Community Treatment Orders has raised vocal debate about the element of compulsion, prompting fears of infringement of civil liberties, without a concomitant degree of responsibility accepted by any health care agencies. MIND, for example, argue that a person who is well enough to cope in the community should retain the right to accept or refuse treatment.

[83] John Bowis, Junior Health Minister. Reported in The Independent 30.9.94. Such statements are reiterated frequently in policy documents of the Department of Health.

[84] *Ibid.*

[85] Database Institution code directory. Scottish Health Services Common services agency. Accurate figures for 1995 are not yet available.

than England and Wales."[86] The Scottish Association for Mental Health maintain that the comparative lack of action in Scotland was prompted partly by the experience of England and America, which illustrated the "importance of a coherent strategy with clearly specified objectives, targets and time-scales".[87] There is strong feeling among voluntary and professional groups that Scotland still has the opportunity to avoid a repetition of mistakes made in England and Wales and that "Scotland has the opportunity to be the jewel in the crown of UK mental health services."[88] In the past five years, however, the move towards reducing in-patient beds has gained momentum and in 1994, the Scottish Office announced that the number of long-stay beds are to be cut by two-thirds by the year 2000.[89]

Notwithstanding guarantees from the Scottish Office and the Department of Health that the severe shortfall of community-based accommodation throughout Britain will be rectified, the conclusions of the Seebohm Committee in 1968, tempered by the realities of experience, remain pertinent today:

> "the widespread belief that we have community care of the mentally disordered is, for many parts of the country, still a sad illusion and, judging by published plans will remain so for years ahead". [90]

It is generally accepted, however, that the move towards greater community provision will continue to grow. Attention is focused currently on the Mental Health (Patients in the Community) Act (in force from April 1996), which will tighten controls over the severely mentally ill in the community, introducing a "supervised discharge order", to be enforced by community psychiatric nurses or other designated officials. Many psychiatrists and mental health groups remain sceptical about the effect of such a policy, arguing that the legislation is unlikely to satisfy anyone. One objection lies in the responsibility placed on health professionals for the actions of patients over whom they have no control. In addition, critics maintain that the Act will undermine the civil rights of patients and may encourage them to lose contact with professional services.[91] There is still controversy over the best

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[86] Barham, P. (1992) *Closing the asylum. The mental patient in modern society.* London: Penguin, p36.
[87] McCollam, A. (1995) *Counting the cost. Resourcing mental health services in the community.* The closure of Scotland's psychiatric hospitals. Briefing paper no.4. Scottish Association for Mental Health.
[88] Report of Scottish Association for Mental Health, June 1995.
[89] Six hospitals are scheduled for closure within the next few years, including Gartloch in Glasgow (350 beds) and Kingseat, in Grampian (312 beds). Decisions are being made governing the fate of a number of other large hospitals in Scotland. McCollam, A. (1994) *On the Brink.* The closure of Scotland's psychiatric hospitals. Briefing paper no. 1. SAMH, p1. Half of Edinburgh Royal Hospital has closed and plans are in place to establish new buildings at Stobhill General Hospital for patients previously accommodated at the hospital at Woodilee, Glasgow. Information and Statistics Division, The Scottish Office (1995).
[90] Interdepartmental report (Ministry of Health) of the Committee on local authority and allied personal social services (Seebohm Report 1968).
[91] Reported in the national press, for example, The Times and The Guardian, 27.6.95.

means of providing for the severely mentally ill, but although the policy of community care has been under increasing attack, few advocate wholesale return to the asylum era. The search for a balanced alternative continues, but what is widely accepted is the paramount need for some form of "asylum" for vulnerable members of society.

15.5 Concept of asylum in the late-twentieth century

The gradual realisation that the policy of community care has failed many of the most vulnerable patients has prompted renewed focus on available alternatives. In recent years, psychiatrists have devoted considerable attention to the concept of asylum, as applicable to the 1990s. Among them, Parry-Jones has highlighted the significance of the definition and implementation of the "modern form of asylum for those patients who continue to require it".[92] A recent definition focused on the traditional meaning of safety and protection for those in need:

> "a safe place of refuge or shelter, providing protection and support which may or may not involve total or partial withdrawal or removal from the rest of society. It may or may not involve treatment."[93]

While the majority of professional bodies are in favour of a co-ordinated, well-financed policy of care in the community, it is recognised that there will always be a residual body of the most severely disabled people in need of protection. Psychiatrists are in general agreement of the continued need for asylum, although it has been emphasised that negative experiences of community care do not justify wholesale censure of the policy.[94] Nevertheless, the lack of adequate practical assistance for sufferers and their families, have prompted renewed calls for added guidance and help for those discharged into an often uncaring community. Thus, Wing has cautioned that:

> "community care will come to deserve the odium now attached to the worst practices of former times if the tradition of asylum practised in the best of the large hospitals is not acknowledged...and given high priority in service planning".[95]

While recognising the value of greater independence for patients, the need for good support systems and easy recourse to some form of asylum for specialised, intensive treatment is of paramount importance.[96] Parry-Jones is clear that the new millennium will see the

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[92] Parry-Jones, W. Ll. (1991) International innovations in prevention and development. In *Deviance in inner cities* (eds. W. Ll. Parry-Jones and N. Queloz) Geneva: World Health Organisation, p89.
[93] The need for asylum in society for the mentally ill or infirm. The third King's fund forum, Consensus statement. (1987)
[94] Debate in Hall, P. and Brockington. I.F. (1990) *The closure of mental hospitals.* London: Gaskell.
[95] Wing, J.K. (1990) The functions of asylum. *British Journal of Psychiatry,* **157**, p822.
[96] Campbell has argued that "asylum is a precious concept whose realisation has often been feeble, overwhelmed by numbers and easily subverted or lost. Our mental hospitals embodies the right to sanctuary in a more accepting,

reconceptualisation of the asylum, but not in the form of the large psychiatric hospital or in the total dispersion into hostels in inner cities and sea-side resorts.[97] In contrast, Dick has stressed the importance of not casting back to the asylum for solutions, but looking elsewhere, recommending that we "remove the asylum from our minds...there is a distinction between asylum as a prison and asylum as a place of rest."[98] Other psychiatrists question whether the functions of asylum can be fulfilled without the existence of the asylum proper. Dangerous patients have been locked in prisons due to the lack of any suitable alternative, a position reflecting that in operation before the growth in asylum provision in the mid-nineteenth century. It is it evident that some of the lessons of past experience remain largely unheeded. The cyclical nature of asylum provision, with the balance oscillating repeatedly between neglect, reform and indifference, a regular feature of the past two centuries, is still evident today. The movement towards confinement of the mentally ill in institutions at a distance from the general public, while criticised by reformers in the mid-nineteenth and again in the mid-nineteenth century, has become an increasingly attractive solution for the potential neglect and isolation of some patients today.

15.6 Parallels between boarding-out and twentieth-century community care

An increasing number of articles on mental health published in prominent medical journals have adopted a historical perspective. This may be attributable to the search for explanations for the apparently cyclical nature of provision for severely disabled psychiatric patients in a period of crisis in confidence. In recognition of this, Parry-Jones has suggested that an awareness of the historical dimension of psychiatric provision:

> "highlights the risks of getting caught up by the emotive outbursts against psychiatric hospitals and colluding in the demand for change. One lesson that historical analogies spell out is the need to search for some common denominator that will illuminate present problems and the current pressures for innovation, often in the guise of reform, in the broader perspective of the whole history of confinement."[99]

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knowledgeable and humane way than many still grimmer alternatives available to destitute people with mental illness." Hall, P. and Brockington, I.F. (1990) *op.cit.*, p130.

[97] Thus he has warned that "in our current haste to develop new models of care, it is essential to retain a balanced view of institutional asylum and the means for its optimal provision in the 1990's." Parry-Jones, W. Ll. (1991) *The private madhouse movement in the early nineteenth century.* Unpublished lecture, p13.

[98] Dick, D. (1990) in Hall, P. and Brockington, I.F. *op.cit.*, p134.

[99] Parry-Jones, W.Ll. (1991) *op.cit.*, p13.

The continually shifting trends in the care and treatment of the mentally ill over the last two centuries is one of the most arresting aspects of the history of provision for the mentally ill.[100] An exploration of recurrent features in community-based provision highlights the cyclical trend discernible in methods of management of the mentally ill and the lack of integration of the successful features of past provision into mental health policy in the late-twentieth century. However, making a direct comparison of policies between centuries has many pitfalls. The system of boarding-out was developed in a society with different pressures and expectations. Further, the demands for mental health provision encountered by lunacy administrators in the nineteenth century have undergone marked transformation. Despite widespread employment of psychotropic drugs and other treatment developments, the rising longevity of the population, and increasing demands created by vulnerable psycho-geriatric patients, has placed new pressure on those responsible for overseeing the national mental health needs. In addition, the policy of community care covers a wide spectrum of provisions, including group homes, hostels and return to the family home. The accommodation utilised for boarding-out was more circumscribed.

Nevertheless, there are definite similarities between the system of boarding-out patients in Scotland in the nineteenth century, and the policy over recent decades of providing for patients in a non-institutional setting. While criticisms of both policies have common features, for example, in the opposition from the general public at the close proximity of mentally ill patients, concerns about inadequate regulation and supervision and risk of personal attack, the beneficial aspects of domestic provision in the nineteenth century do not appear, generally, to have been replicated in the current mode of care (although there are exceptions to this with positive assessments of the growing number of Adult Placement Schemes across the country).

Despite widespread endorsement of a domestic system which offered greater freedom for certain patients, the nineteenth-century asylum retained its position as the principal form of provision. Boarding-out was always perceived as an adjunct to asylum care, rather than a potential replacement. In contrast, in the 1990s, the movement towards the abolition of the asylum as the primary accommodation for the mentally ill has developed apace. Since

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[100] As Allderidge has observed, "we have all been going round in circles for at least...750 years. There are very few, if any, ideas on the...care of the mentally disordered that have not been round at least once before." Allderidge, P. (1979) Hospitals, madhouses and asylums. Cycles in the care of the insane. *British Journal of Psychiatry*, **134**, p321.

1961, detractors of the asylum have become increasingly vocal. Community care is held by its protagonists to offer those advantages which were widely extolled by proponents of boarding-out in nineteenth-century Scotland and is regarded as a viable substitute, rather than supplement, to hospital care, in the search for the best and most economical mode of provision.

While an assessment of current mental health policy is outside the remit of this study, an exploration of the common features between boarding-out and community care brings into sharp focus the marked contrast between their attainments. Evaluation of the successful features of boarding-out highlights the merits of simplicity. Patients who no longer required asylum treatment were placed in long-term residential care under a closely organised system. Such patients were kept on a national register, regularly supervised and, if accommodation or treatment was inadequate, remedial action was taken. Acutely disturbed, potentially dangerous patients were detained in the asylum. Arrangements made for patients discharged into the community 100 years later, however, are more variable.

15.6.1 Criteria for residence in the community

Although reluctant to dismiss patients as incurable, physicians in the nineteenth century recognised that many in asylums were incapable of receiving further benefit by prolonged residence. While previously there had been a predominance of congenitally insane patients being boarded-out, by the 1890s, the proportion of patients suffering from congenital and acquired insanity had become almost equal. Such distinctions between mental illness or handicap are less relevant in the current trend towards non-institutional care. Community-based provision for those with learning disabilities has caused little controversy. It is the decanting of chronically ill patients in need of close supervision that has prompted concern.

Patients were selected for boarding-out only if they fulfilled certain criteria.[101] The policy of community care has a much broader application and caters for a wider range of mental conditions among the patient population. While many are long-term chronically mentally ill (as in the boarding-out system), with little prospect of significant improvement, a high proportion of patients are floridly mentally ill. In 1987, for example, among residents of a

[101] *Vide* Chapter 6 and Appendix 9.

Salvation Army hostel in one area of London, 35% had chronic schizophrenia, and four out of five were experiencing hallucinations and delusions "that seriously interfered with their social functioning."[102] In contrast, manic patients, or those classified as suffering from dementia praecox were rarely boarded-out in the nineteenth century. Many of those residing in the community in the 1990s have become "revolving-door" patients. Upon relapse of their mental condition, temporary re-admission to hospital is authorised.[103] While this did occur in the nineteenth century, the majority of patients were able to reside in the community for prolonged periods, if not permanently. Those liable to frequent relapse were not selected. A further distinction is apparent in the ages of patients. Although a small number of young people were boarded-out, the majority were middle-aged or elderly, being regarded as easier to occupy and less troublesome. In recent years, patients of an increasingly wide age-range reside in the community, receiving out-patient care.[104] A more positive result of the movement away from hospital provision has affected elderly psycho-geriatric patients, who are no longer left in long-stay wards until their death. Public sector and privately run nursing homes have become the most usual form of accommodation.

Despite sustained pressure on beds in the nineteenth century, patients in need of asylum provision were admitted with little difficulty. Similar pressure on bed-space is evident in the 1990s, but return to hospital care is more problematic. This has been illustrated with increasing, and alarming frequency, prompting calls from members of the judiciary, pressure groups and the general public for explanations from the Government for the lack of beds for acutely ill patients.[105] The former Health Secretary, Bottomley, for example, was ordered on a number of occasions to appear in court to explain why beds were not available. The case history of Ben Silcock, with his repeated attempts to be re-admitted to hospital, testifies to the harshness of resource rationalisation.

5.6.2 Nature of guardianship

Persons receiving boarded-out patients had no specialist knowledge or training in the treatment of insanity. One of the main aims of the Board of Lunacy was that patients were

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[102] Murphy, E. (1987) Community care. *British Medical Journal*, **295**, p1506.
[103] Barham, P. (1992) *op. cit.*, p29.
[104] The age range of patients assessed in the TAPS study, discharged from two hospitals in north London was between 18 and 100. The average age was 60 years. Reported in Barham, P. (1992) *op. cit.*, p22.
[105] A scan through recent newspapers alone indicate the public perception of the severity of the situation.

integrated into family life. Formal training, therefore, was perceived as unnecessary. A distinguishing feature of the boarding-out system was the number of unrelated guardians providing for insane patients. This was because there was no pressure to retain or receive patients, and so while many families insisted on caring for their mentally ill relatives, those who were unable or unwilling had the option of declining to do so. This element of choice has not been embodied in recent policy.[106] Faced with inadequate alternatives, pressure to retain a mentally ill family member has become a serious problem of community care policy in recent years. Many mentally ill patients are now cared for by relatives, who receive little professional assistance, lending credence to the claim that the concept of the community providing care "means, in reality, disabled people caring largely for themselves, perhaps with the help of a relative who is undertaking the care at great personal cost".[107]

The option of placing patients with unrelated guardians for a fee has been relatively unexploited, although in recent years, supported lodging schemes have been developed by various local authorities. One example in Wales, involved the care of three long-term schizophrenic males by a woman who "sees to their cleanliness...sorts out their anxieties" cooks for them, and ensures they take their medication. For this, she was paid by the Social Services a sum adequate to cover basic maintenance costs. Her duties towards her lodgers had marked similarities to the responsibilities encountered in special licensed houses in the nineteenth century and it is this form of care that proved so effective in boarding-out.[108] In Scotland, the supported lodgings programme undertakes a matching process to attempt to ensure compatibility between carer and lodger, assesses the suitability of carers and offers pre-placement training. A "home to home supported lodgings scheme" has been introduced in Tayside, following a period of development for two and a half years. Carers have now been recruited and referrals for clients are now underway. In Grampian, a similar policy, "Room to care" has been in operation for over four years and caters for more than 60 clients.[109] Nevertheless, such policies have not become widespread and provide for only a small proportion of mentally ill people. The burden of care among untrained, often busy,

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[106] Hoenig, J. and Hamilton, M. (1967) The burden of the household in an extramural psychiatric service. In *New aspects of the mental health services* (eds. H. Freeman and J. Farndale), pp612-635. Oxford, London, Edinburgh: Pergamon Press Ltd.

[107] Murphy, E. (1987) *op. cit.*, p1506. See also O'Callaghan, M. (1990) Community care means never having to say you're sorry. In *Community Care, People leaving long-stay hospitals* (eds. S. Sharkey and S. Barna), London: Routledge, p74.

[108] Letters, The Guardian, 3.10.95.

[109] Information from the Scottish Association for Mental Health, Tayside branch.

families has prompted calls for more support systems to be established for carers, as critics insist that the responsibility of caring for a mentally ill person is better assumed, or at least shared, by the psychiatric hospital and social services.

The risks of abuse and neglect of the insane in private dwellings, highlighted in the nineteenth century, continue to be cited today, with a steady stream of reports in the media on the abuse of the mentally ill in their own homes. Cases have been recorded where patients are neglected or subjected to financial, physical and verbal abuse. While such incidents occur in all societies, the persistence of such abuses in the nineteenth century, resulted in the removal of the patient. However, it appears that there are inadequate means of detecting and remedying such abuse today.

15.6.3 Therapeutic opportunities

The prospect of rehabilitation has been one of the driving forces behind the expanding policy of community care. In the nineteenth century, there was no explicit attempt to provide curative treatment or rehabilitation for boarded-out patients, beyond the recommendation that guardians instil decent habits in their charges. Nevertheless, the Commissioners cited numerous instances of marked improvement in both the mental and physical condition of patients.[110] This was attributed to the more humanitarian environment, where patients were allowed to enjoy the freedom of domestic life and offered the opportunity of useful employment. The Commissioners announced that patients' needs were met simply by the provision of basic necessities and home life, resulting in limited rehabilitation. One of the major differences in ethos between the two policies, therefore, lies in therapeutic expectations: recovery was neither expected, nor worked towards, among boarded-out patients. Within community care, it has been envisaged that continued medication and participation in therapeutic activities could lead to modification in mental condition more successfully than could be achieved by long-term institutionalisation.[111]

15.6.4 Quality of provision

Much emphasis was placed by proponents of boarding-out upon the attainment of certain standards of care. Guardians whose houses did not meet the strict requirements of the

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[110] *Vide supra* Chapter 8.
[111] See for example, Mandelbrote, B.M. (1972) *op.cit.*

Board of Lunacy were not granted sanction for the reception of patients, and overcrowding or insanitary living conditions led to the patients' removal.[112] The majority of mentally ill patients today are suitably provided for in group homes or local authority hostels. In terms of the physical quality of accommodation, mental hospitals, which are generally old institutional buildings in poor repair, are often inferior to many community homes. Nearly 90% of residents surveyed by Shepherd et. al. were satisfied with their accommodation, compared with only 50% of those in hospital.[113] However, the maintenance of basic standards of accommodation in recent years has sometimes proved problematic, and over the last forty years, attempts have been made to place mentally ill patients in diverse, sometimes unsuitable, settings in the community.[114] A significant residue of often the most severely disturbed patients are reported to reside in inappropriate surroundings, often in inner cities, with little money, prospect of occupation, or company.[115]

15.6.5 Extent of inspection

One of the most frequent criticisms of community-based provision concerns the adequacy of supervision of vulnerable patients. Psychiatrists have voiced their anxieties that too many patients are able to evade regular contact with health-care professionals. Similar concerns were expressed repeatedly in the nineteenth century by critics of boarding-out, even though patients received regular, thorough visits from official bodies.[116] Further, the close-knit community was held to act as a form of unofficial control so that abuse or neglect would have been apparent to neighbours and residents. Despite the designated responsibilities of social workers and community psychiatric nurses, it appears that it has not been possible to implement the same degree of vigilance on a widespread scale in recent years.[117] Although many mentally ill persons are able to achieve and appreciate independence from official control, there will always be a minority in need of regular assistance and supervision. The introduction of Community Supervision Orders has been recommended by the Royal College of Psychiatrists as a partial solution for the inadequate control of severely mentally ill patients. However, this has been rejected in the new Mental

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[112] GBCLS, AR *passim*, 1859-1913.
[113] Shepherd, G., Muijen, M., Dean, R. and Cooney, M. (1996) *op.cit.*
[114] O'Callaghan, M. (1990) *op. cit.*, pp78-84. The importance of sending patients to what were regarded to be healthy rural communities was emphasised regularly in annual reports, among them for example, GBCLS 17th AR (1875), p261, and 32nd AR (1890), p123. Chapter 9 has discussed the particular benefits of rural locations for boarding-out patients.
[115] Murphy, E. (1987), *op. cit.*, p1506.
[116] *Vide supra* Chapters 4 and 10.
[117] O'Callaghan, M. (1990) *op. cit.*, p75.

Health (Patients in the Community) Act 1995, in favour of a less forceful policy providing for supervision applications.

15.6.6 Murder and suicide among patients in the community

Comparative assessment of the behaviour of boarded-out patients and those residing in the community today must be tentative. The nature of their mental illness and the age group is markedly different. Patients in private dwellings who attempted suicide or were regarded as potentially violent were returned to the asylum immediately. Nevertheless, some points can be usefully made. The number of murders, assaults and suicides committed by boarded-out patients was low in proportion to the total number in private dwellings. Between 1858 and 1913, for example, only two murders were committed by patients.[118] Suicide was also an unusual occurrence; with approximately one case certified as such every ten years. Assaults committed by boarded-out patients were recorded occasionally, but they were infrequent and never severe enough to pose a threat to the boarding-out system. Of greater concern was the risk of sexual assault or other abuse of, rather than by, mentally ill persons.

Such fears, while still voiced by a minority, are lost among the increasing alarm which currently follows each murder committed by psychiatric patients. The recent Confidential Inquiry into Homicides and Suicides by the Mentally Ill recorded 39 homicides in a 33 month period up to March 1995, committed by people who were either undergoing psychiatric treatment, or who had been in contact with psychiatric services within 12 months of the attack.[119] In an 18 month period between June 1993 and December 1994, the Inquiry also collected data on 240 cases of suicide.[120] No direct comparisons can be made, however, with the nineteenth-century boarded-out population. Further, the number of suicides or murders committed by patients discharged from asylums in the nineteenth century as recovered or relieved have not been identified and it is important to bear in mind that it is these patients, deemed fit for discharge, who compare more closely to the discharged patient population today.

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[118] *Vide supra* Chapter 6.

[119] Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. (1996) Royal College of Psychiatrists, p8. The cases of homicide were identified from Home Office files between July 1992 and December 1993 and September 1994 and March 1995.

[120] *Ibid.*, p17. Between September 1993 and September 1994, 107 patients (approximately two a week) killed themselves within 12 months of their discharge from a psychiatric hospital. The Guardian, 24.1.95.

The unsatisfactory conditions exposed in psychiatric hospitals in the 1960s and 1970s, which contributed to the growing demand for their closure, have been superseded in the 1980s and 1990s by "scandals" in the community, which have prompted renewed recognition of the need for some form of asylum.[121] Graphic headlines in newspapers have focused public attention on the failures of current policy. For example, in January 1995 The Guardian led with the attention-grabbing headline "stab victim sacrificed to care failures". In contrast, the two murders committed by boarded-out patients were reported in the Scottish press, but there was little of the furore that has become common-place in the media today. The detailed coverage given to inquiries into killings by mentally ill patients is a reflection of the prevailing concern of the public, which is clearly not being assuaged by continued Government assertions that the policy is working, and that all that is needed is more effective mobilisation of existing resources. Calls for compulsory treatment with comprehensive care plans continue to gain momentum. However, the introduction of supervision registers of 3000 severely mentally ill persons (established October 1994) and the Mental Health (Patients in the Community) Act, 1995 indicate that the search has begun for an equilibrium between individual confinement and public and personal safety.

15.6.7 Public opinion

In the nineteenth century, vehement objections were raised by some members of the general population at the presence of the insane in their village. Petitions were raised against the system, regarded by some villagers as "a perfect curse to the place." Common complaints included declarations that the moral health of the community was at risk, that house prices would be affected, and that tourism in the summer would be threatened.[122] Similar concerns continue to be expressed in the 1990s. Assumptions that "the community" would be accepting and supportive have proved largely inaccurate. Residents protest at the establishment of hostels and half-way homes, citing the same anxieties regarding the ill-effect on children and property prices if the location was inhabited by people with severe or

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[121] Among recent well-publicised cases of murder committed by psychiatric patients, Barratt (aged 24) stabbed an 11 year old girl to death (1991), having been released from a psychiatric hospital 48 hours earlier; Inweh (aged 22) killed a 23 year old girl working in a MIND hostel (1992); Clunis (aged 30), stabbed Zito to death (1992), three months after his release from a psychiatric hospital; Robinson killed an occupational therapist, Robinson (unrelated) (1993), after a 15 year history of violence; Rous killed Newby a voluntary worker, at a Cyrenian hostel (1993); Buchanan (aged 23), beat a stranger, Graver, to death (1994), having been discharged from hospital 17 days earlier as untreatable. Buchanan had been discharged 13 times between 1983-1992, and Laudat, who killed a fellow day care user (1994), having previously been convicted of violence offences.

[122] *Vide supra* Chapter 10 which illustrated the strength of opposition to the residence of the insane and the extent to which complaints were ever justified.

obtrusive mental illness. An NHS Trust in Surrey, for example, which, in 1995, announced plans to establish sheltered accommodation for patients leaving psychiatric hospitals may be forced to compensate home-owners for the alleged drop in value of their houses.[123] However, as the Scottish Association for Mental Health have insisted, there is no indication that prices are adversely affected. In Glasgow, two areas were assessed, one with mental health accommodation projects nearby, and one without. House prices rose in both areas.[124] Further reassurance has come from a recent survey, which indicated that only 20% of residents of Lambeth were concerned that house prices would fall and that the safety of children would be jeopardised by the presence of former psychiatric patients in supported houses in the neighbourhood. Thirty-five percent of respondents thought that their presence would have no discernible effect and 22% considered that the effects could be positive.[125]

The Royal College of Psychiatrists has called for an end to "stigmatising images of mental illness", which have a damaging effect on already distressed families.[126] Nevertheless, a survey by MORI in April 1995 indicated that the public fear of the mentally ill has risen as result of closing psychiatric hospitals. The Times reported that the image of a mentally ill patient as an "axe-wielding maniac" has grown in the public mind, in response to well-publicised cases of violent crimes.[127] Thus, seven in ten people believed that the closure programme had put the public at risk of violence, and 25% thought that the mentally ill were noisy and aggressive.[128] In fact, notwithstanding recent, highly publicised murders committed by former psychiatric in-patients, there is little evidence that mentally ill people are more violent than the population at large. It is far more likely that they will harm themselves than other people. Nevertheless, popular misconceptions are hard to erode. The fears prevalent among villagers in the nineteenth century have altered little among the general public today; the presence of the mentally ill in a community is rarely welcomed.

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[123] Patrick, H. Letter to The Guardian, 27.9.95.
[124] *Ibid.*
[125] Wolff, G., Pathare, S., Craig, T., Leff, J. (1996) Who's in the lion's den? The community's perception of community care for the mentally ill. *Psychiatric Bulletin*, **20**, pp69-70.
[126] Announced at launch of petition by Royal College of Psychiatrists in April 1995. To date, little research has been undertaken regarding the impact of media representations on attitudes towards mentally ill patients.
[127] The Times, 18.4.95.
[128] The Royal College of Psychiatrists has reported that employers are still wary of giving jobs to people with mental illness. Over 25% of employers said they would not employ someone who had suffered from mental illness in the past. Reported in *British Medical Journal*, **311**, 9.9.95.

15.7 Summary and conclusions

Although the option of placing mentally handicapped people under formal guardianship is still resorted to in Scotland in the 1990s, the system of boarding-out has been superseded by the separate, national policy of community care. The dominant impetus behind the development of community-based provision in Britain came from increased therapeutic optimism for the treatment of mental illness, with newly developed policies for rehabilitation, the "pharmacological revolution" and, ultimately, Government endorsement. Widespread disillusionment with the role of the large psychiatric hospital facilitated further the implementation of non-institutional provision. However, it is now widely accepted that a successful community-based service cannot be achieved by closing hospitals and that "the future of services for the chronically mentally ill in Britain is very unclear".[129] Coordinated, well-financed and flexible policies need to be established. Medical journals contain recommendations as to the best way forward, but there are few suggestions to modify a policy increasingly recognised by psychiatrists as unworkable in practice. The prophetic fears of Pollock, a physician in the 1930s, have been largely realised. He maintained that if psychiatric hospitals were abolished, the following would happen: hospitals would be utilised under other names; suicides and murders in the community would increase; prisons would be filled with persons suffering from psychiatric disorders; the population of homeless mentally ill people would rise and private nursing homes would proliferate.[130]

Some direct analogies can be drawn between the policy of care in private dwellings in nineteenth-century Scotland, and community care in twentieth-century Britain. However, the failings of provision for the mentally ill today, so graphically documented by the media, appear to be more serious than any shortcomings attributed to the more limited policy of boarding-out. Boarded-out patients were granted the freedom of residing in a domestic setting, but were visited regularly by official bodies, who took firm action where necessary. Asylums remained generally accessible to all patients, admission was unproblematic and, although overcrowding was an enduring reality, beds were available; acutely ill patients, or those unsuitable for domestic care, were easily re-admitted. It is not certain that the current policy of community care offers such provision.

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[129] Holloway, F. (1990) Caring for people- a critical review of British Government policy for the community care of the mentally ill. *Psychiatric Bulletin of the Royal College of Psychiatrists*, **14**(11), p645.

[130] Pollock, H.M. (1936) *Family care of mental patients. A review of family care in America and Europe*. Utica State Hospital Press.

Despite grounds for public disquiet and lack of professional confidence in current policy, it was inevitable that the transition into the community would be beset with obstacles and failures. In sounding a note of caution, one psychiatrist has stressed that:

> "zeal for what is new and for that which we intuitively feel to be both desirable and enlightened does not excuse us from an obligation to evaluate all innovations as they are introduced. It would be tragic...if those who extol the virtues of community care so vigorously and at times uncritically, merely encourage it into being discredited, as a result of an escalating number of clinical tragedies...The end result would be the loss of society's tolerance and a hasty reversion to institutional care of the worst kind...the history of health care teaches us that such a cycle has in the past been the rule rather than the exception."[131]

While the indiscriminate reliance on the asylum has been condemned, it is now regarded as irrefutable that there will always be severely mentally disordered people in need of special protection. Asylums have survived because of their multiple functions; while removing the patient from potentially aggravating influences, the asylum can also be seen as a sanctuary for the chronically mentally ill. Rather than advocating a return to mass asylum provision, physicians are increasingly searching for a balance between confinement and community care. The asylum, with all its benefits and drawbacks, is likely to undergo some form of re-creation.[132] Until then, the most appropriate method for providing for the mentally ill remains an enduring question. The warnings of alienists in 1873 remain apposite, particularly in view of the firm endorsement by the government of current policy:

> "it well becomes the medical officers of asylums to look ahead and prepare for what is coming...the final shape in which the lunacy affairs of the kingdom will be regulated may probably depend on the accident of political parties".[133]

What was sought in the 1870s, remains elusive today, in the recognition that "we ought to have passed into a further stage of the care and treatment of the insane than mere asylum management, or even lunatic colonies and the boarding-out system."[134] The form that stage will take has yet to be defined.

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[131] Morgan, H.G. (1992) Suicide prevention: hazards on the fast lane to community care. *British Journal of Psychiatry*, **160**, p153.

[132] Powell's "warning" has proved accurate. In 1962 he announced of the Victorian asylums, "do not for a moment underestimate their power of resistance to our assault" These "doomed institutions" are still visible, albeit in decaying form, 30 years on, and are once again become an attractive proposition to those disillusioned with current policy.

[133] Anon. (1873) Reviews. *Journal of Mental Science*, **19**, p559.

[134] *Ibid.*

CHAPTER 16

CONCLUSIONS

This study has described and assessed the implementation and development of provision for the insane in the community in nineteenth-century Scotland, highlighting both its pioneering nature and its impact upon domestic care policies worldwide. Although much reliance has been placed on official sources, with inherent constraints and potential bias, it is postulated that, given the limitations of available records, it has been possible to achieve a comprehensive portrayal of the system of boarding-out, its benefits and drawbacks, the characteristics of patients and guardians and prevailing attitudes towards the system. The discussion of international systems of family care serves to emphasise the significance of the Scottish policy, while the final chapter, outlining the continuation of a system of guardianship over the twentieth century, drawing analogies with the current policy of care in the community, allows attention to be focused on the enduring nature of the system, its strengths and weaknesses, in the light of subsequent developments.

The reports of the Board of Lunacy, which have been drawn upon heavily, cannot be accepted without question. They contained an element of propaganda and, in general, their continued assertions of the numerous benefits of the system went unchallenged in Scotland, enabling Lawson to announce, with some justification, that with favourable legislation, suitable social conditions, and the enthusiasm of the Commissioners, the system had become "consolidated into an organisation having no real parallel, amongst the institutions of any other country."[1] The focus of the Commissioners was necessarily utilitarian and pragmatic; a system which offered valuable savings to annual lunacy costs was worth welcoming, even if there were apparent drawbacks. However, when considering the extent to which their consistent praise of boarding-out was merely powerful, self-serving rhetoric, in endorsing a system for which they were responsible, it must be recorded that a

[1] GBCLS 22nd AR (1880), p132.

significant number of patients were removed from private dwellings annually, having been proved to have been unsuitable or inadequately cared for. If the Board of Lunacy had been determined to foster the system regardless of outcome, the population of boarded-out patients would have been largely static.

Similar caution has been exercised, of necessity, when assessing reports from asylum and parish officials. Although medical superintendents often devoted sustained attention to the system of boarding-out, their preoccupation lay largely with the daily administrative affairs of the asylum. Any assessments of boarding-out were invariably concerned more with the impact a successful policy might have on the asylum, rather than on the nature of the system itself. Notwithstanding this, and although almost inevitably influenced by the pressure placed upon them by their mentors at the Board of Lunacy, many asylum reports contained detailed descriptions of the policy in practice and warm recommendations for its widespread adoption. Parish officials displayed less immediate interest in the system, viewing their duties of visitation to patients as merely one of their many official responsibilities. However, among inspectors of poor, an increasing acceptance of boarding-out is also evident, and their reports, albeit more dispassionate than those of asylum superintendents, are a useful indicator of prevailing attitudes of parish officials.

Boarding-out developed rapidly throughout Scotland, facilitated by only minor legislative enactment.[2] As Hack Tuke, sometime critic of boarding-out concluded, the success of the policy depended entirely upon the careful selection of patients and guardians, the provision of suitable accommodation and frequent and efficient inspection.[3] The number of patients provided for in this way over the years 1858-1913 highlights the significance of the system, and the amelioration it brought to the recurrent difficulties created by the steady increase in asylum admissions from the 1860s, and the resulting overcrowding. The marked improvements in the mental and physical condition of boarded-out patients, recorded frequently by parochial officials and Lunacy Commissioners, were held to be testimony to the benefits of the system, which, the Commissioners contended, had become "permanent and established...[and] which could not be superseded without enormous expense".[4]

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[2] The Act of 1862 sanctioning special licenses for guardians and the government grant-in-aid of 1875 being the only notable legislation after the Lunacy (Scotland) Act, 1857.
[3] Tuke, D.H. (1889a) *op. cit.*, p510.
[4] GBCLS 56th AR (1914), main report, plxxii.

Further, the limited number of severe accidents and assaults against patients over a period covering more than half a century were emphasised by the Commissioners, who remained convinced that such results indicated that "large numbers can be adequately provided for in the homes of the people, and this method is a humane and enlightened one".[5]

It is possible to trace the longitudinal development in the system of boarding-out over the nineteenth century, and to observe a decline in the ferocity and validity of attacks against the policy. The usual criticisms in the early years focused on the neglect, injudicious treatment and restraint of often severely disturbed patients, by untrained, frequently mercenary guardians. However, instances of abuse or neglect recorded in the annual reports of the Board of Lunacy were, with the exception of the early years of the system, isolated occurrences. By the 1880s, the Commissioners expressed their confidence that, with close official supervision, such abuses could not remain undetected. Increasingly favourable reports from parish visitors give credence to their claim and indicate that the detailed recommendations of the Commissioners were largely implemented. Concurrently, criticisms by commentators that patients were received only for financial gain, and were generally neglected or exploited by poverty-stricken, uneducated crofters, declined in urgency.

In addition, the claim that boarding-out was applicable only to the most restricted range of congenitally weak-minded patients or chronic dements and, therefore, of only limited value, became increasingly inaccurate as the system developed and patient selection became more flexible. Boarding-out proved to be an adaptable policy, catering for a wide range of mentally disordered patients. While it was generally recognised that the majority of patients should be quiet and harmless, those suffering from acquired forms of insanity, including mania or melancholia, if quiescent, were increasingly given trial. It was among such patients that the most marked improvements were often seen. This was because, as Lawson observed, patients who were quiet and harmless in an asylum could be "little more than quiet and harmless out of it. A dement will remain a dement though perhaps he may take a greater interest in out-door life than he did in asylum monotony."[6] In contrast, it was alleged that patients who were more unsettled when in an asylum, often drew benefit from

[5] GBCLS 35th AR (1893), p103.
[6] GBCLS 26th AR (1884), p144.

mixing with the normal population, resulting in a modification of their more acutely disturbed behaviour. By the 1880s, therefore, certain patients suffering from acquired forms of insanity, who would have been in long-term asylum confinement, were given trial in private dwellings. Where this proved unsuccessful, they were returned with little difficulty to an asylum, although as the Commissioners recorded with satisfaction, the great majority proved in fact to be suitable for domiciliary care.

A further development, linked inextricably with this transformation in the mental condition of boarded-out patients, was the increasing proportion of asylum inmates discharged unrecovered to private dwellings. Between 1860 and 1864, only 27% of patients had been admitted to the roll of single patients in this way.[7] However, between 1908 and 1912, the proportion had more than doubled, with 58% of patients being boarded-out from asylums.[8] This was attributed to the conviction of the Board of Lunacy that, to inoffensive patients, and to those recovering from acute psychoses, boarding-out offered an effective means of assessing the extent of recovery, and that if it was the case that "the special mental hospital is the only proper entrance to the asylum" it was also true that boarding-out provided "the only proper exit".[9] A similar transformation as a result of the Commissioners' exertions was the rapid growth in the proportion boarded with strangers, rather than with relatives. Unrelated guardians were regarded widely as offering higher standards of care. Thus, between 1860 and 1864, only 23% of patients were placed with strangers, rising to 66% in the years 1908 to 1912.[10]

The attitude and assertions of physicians elsewhere in the United Kingdom had little impact upon the Scottish system. Few English alienists supported a policy of boarding-out, although the enthusiasm of Maudsley was a notable exception. The system developed in Scotland without perceptible intervention or support from the rest of the United Kingdom. Even Maudsley's endorsement, although welcome, made no marked impact upon policy. With its advantages increasingly apparent, boarding-out became an integral part of lunacy administration in Scotland, despite vocal and repeated attacks from observers in England.

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[7] GBCLS 56th AR (1913), Review of Lunacy Administration since 1857, plxxviii.
[8] *Ibid.*
[9] GBCLS 49th AR (1907), p550.
[10] GBCLS 56th AR (1913), Review of Lunacy Administration since 1857, plxxviii.

Foucault's argument that tolerance for the deviant within the community was diminishing throughout the nineteenth century has little to support it when applied to the boarding-out system in Scotland.[11] Public concern about the presence of the insane, although clearly apparent when patients were first placed in a community, declined steadily as it became evident that they were, in general, neither dangerous nor offensive to public decency. The actual expansion of boarding-out in any district indicates the gradual acceptance of the insane, with applications for boarders often in excess of the number of available placements. In addition, advocates of the system emphasised the educative effect the presence of the insane had upon the community. The Board of Lunacy maintained that mental defect became regarded less to be feared, and more deserving of sympathy and understanding. This may indicate undue optimism on the part of certain observers. Such an outlook has not been attained even today, but it is apparent that, historically, some local populations were increasingly willing to accept insane boarders. Towards the end of the century, the editors of the Journal of Mental Science were able to announce that the boarding-out system had become an approved and integral part of the lunacy administration in Scotland and that "every good Scot accepts it as, on the whole, an eminently satisfactory solution of difficulties with which a nation is brought face to face in dealing with the mass of chronic lunacy."[12]

A number of questions are prompted about the reasons underlying the particular and remarkable success of the policy in Scotland. It could be suggested that the Scots were a more philanthropic people, who were willing to care for vulnerable persons, or that for some indiscernible reason, less fear and disdain was felt towards the insane in Scotland than in other countries. Lawson, for example, subscribed to this view, and attributed the ease with which the policy was adopted in part to the "staid, unostentatiously affectionate character of the people, traditionally noted for their attachment to the weak."[13] A further explanation could lie in the comparative poverty of the nation and the resulting willingness of an impoverished population to receive insane boarders, but this does not stand up to rigorous appraisal. Wealthier countries, most notably Germany, implemented a similar policy of boarding-out with marked success in the late-nineteenth century. Clouston

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[11] Foucault, M. (1967) *Madness and civilisation* (Chapter 9: The birth of the asylum). London:Tavistock Publications.
[12] Editorial. (1896b) Objections to the boarding-out system. *Journal of Mental Science*, **42**, p352.
[13] GBCLS 22nd AR (1880), p134.

suggested that the geographic smallness of the country, which enabled Commissioners to know each asylum and its local circumstances in some detail, and the lack of any prominent scandal or lunacy law suit, contributed to the extension of a policy which was dependent upon extensive supervision and the acceptance of the insane in the community.[14] In fact, the most convincing explanation relates to the nature, extent and effectiveness of the supervisory control exercised by the Board of Lunacy, and their unwavering endorsement of the principle of domiciliary care. Boarding-out flourished in Scotland not because of any particular differences between Scotland and other countries, or specific characteristics of its indigenous population, but because of the enduring enthusiasm and control exercised by the Commissioners. The system was well organised, meticulously assessed at regular intervals, and had the public endorsement of lunacy administrators. The dilemma of international physicians as to whether Scots were "more decent, less excitable" people can be answered, therefore, with some degree of confidence.[15] Without the consistent encouragement and pressure from the Board of Lunacy, it is certain that boarding-out in Scotland would have remained little more than an *ad hoc*, poorly controlled, way of providing for the insane.

Advocates of the system declared, with an accuracy that was never fully tested, that an active policy of boarding-out would be "virtually a death-blow to the existence of monster establishments" seen in England, such as Colney Hatch and Wakefield, each with populations in the mid-nineteenth century of over 1500 patients.[16] Lindsay, for example, was confident that boarding-out "would effectually prevent the further development of the monastic or barrack asylum system."[17] In practice, growth of asylums was never prevented; admissions continued to rise throughout the century and additions to asylum buildings were frequent and extensive. But this does not negate the impact of boarding-out in reducing the rate and extent of asylum expansion. It would be unrealistic to expect domestic provision to accommodate more than a comparatively small proportion of the insane, leaving large numbers every year to remain in confinement. Boarding-out was perceived only as a complement to asylum provision, being merely one of many methods of accommodation. Thus, when questioned by the Royal Commission, in 1908, as to which system he

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[14] Clouston, T.S. (1893) *op.cit.*
[15] Alder Blumer, G. (1893) *op.cit.*, p178. *Vide supra* Chapter 14.14.
[16] Lindsay,W.L. (1871) *op.cit.*, p516.
[17] *Ibid.*, p517.

preferred, one Commissioner, Macpherson, explained: "you cannot separate the systems, boarding-out system is purely supplementary to asylums...you cannot do without asylums".[18]

Even the most enthusiastic supporters of boarding-out recognised certain inherent disadvantages to a system which placed insane people at a distance from the control and discipline of an institution. Further, the lack of modern amenities such as lighting, heating, adequate nutrition, baths, and organised recreation, all available in asylums, was deplored by critics. Despite the validity of some of these claims, there seems to be no reason to modify the generally positive reputation of boarding-out. There was consensus among Commissioners and medical observers alike that many of the objections were more theoretical than real, and even when valid, the advantages of home life and the opportunity for patients to enjoy personal liberty and be treated as part of a family, was held to be sufficient compensation. This recognition of balance, that boarding-out had a role to play in lunacy administration, although not necessarily any greater than the other forms of provision, ensured the success of the system. Lindsay's assessment, therefore, is pertinent, when he declared that "the family system is not an unmixed benefit, nor is the asylum system an unmixed evil. Both systems possess advantages and also disadvantages."[19]

Despite its limitations, the assertion that boarding-out offered "the most convenient, the most natural, the best and most economical, means of treating the majority of the chronic insane" was accepted widely almost from its introduction.[20] Endorsement of the system's main achievements remained strong 80 years after patients were first placed in private dwellings under official supervision. Among other enthusiasts, Thompson, a Deputy Commissioner in the 1930s, announced that he had been deeply impressed by the boarding-out system, which, in his view, should be developed further. The fostering of a system which encouraged "a root principle of human life, namely the life in the family", Thomson believed, must lead to improvements in the mental condition of patients. Echoing the belief

[18] Royal Commission on the Care and Control of the Feeble-minded (1908), p45.
[19] Lindsay, W.L. (1871) *op.cit.*, p527. Similarly, an English physician, Hayes Newington regretted that "there was an idea...that boarding-out was either definitely good or bad. It was regarded as a ...bone of contention...the truth lay between the two." In Anon. (1909) The boarding-out of the insane in private dwellings. Discussion in Notes and News. *Journal of Mental Science*, **55**, p181.
[20] Lindsay, W.L. (1871) *op.cit.*, p516.

held by Lunacy Commissioners in the nineteenth century, he concluded that "it is on this principle that the boarding-out system is working, and it is a sound and proper principle."[21]

Despite the increasing recourse to organised systems of family care across the world, Scottish lunacy administrators were right to maintain that no other country had such large numbers of insane patients residing in private dwellings under such extensive control and protection from the State.[22] Nevertheless the policy of boarding-out patients throughout the country never attained the prominence of the open-door system or of ideals of moral management. Although the Scottish Board of Lunacy endorsed the system wholeheartedly, enthusiasm among medical observers was always more cautious. Only a limited number of asylum superintendents championed boarding-out, even if the majority put it into practice. By contrast, the earlier movement towards abolishing the employment of mechanical restraint, popularised by Conolly, although widely criticised initially, was almost universally adopted. Increasing freedom within asylums was implemented across the United Kingdom, usually with enthusiasm.[23] Despite its more circumscribed appeal, the system of boarding-out can be seen as a natural progression of a lunacy administration which, recognising the advantages of more humanitarian treatment of the insane in asylums, also acknowledged an active policy of non-institutional provision as a valuable supplement.

It is inevitable that certain areas of interest remain comparatively unexplored. Due to the limitations of records on boarded-out patients, little further analysis can be undertaken of patient case histories, an area of particular appeal to the growing number of clinicians with an interest in the historical background of their discipline. Nevertheless, future research on the Scottish system would benefit from greater focus on the nature of the social environment in which patients were placed. The possible influence of the flourishing system of boarding-out on the rapid decline of private madhouses across Scotland in the second half of the century warrants separate consideration.[24] In addition, the extent to which boarding-out created the opportunity for asylums to represent themselves as places

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[21] GBC 18th AR (1933), p328.
[22] GBCLS 56th AR (1914), main report, plxxii.
[23] In this environment, too, recommendation for the establishment of convalescent homes for the insane poor fell on a receptive audience. See for example, the suggestions by Hawkins, H. (1871) A plea for convalescent homes in connection with asylums for the insane poor. *Journal of Mental Science*, **16**, 107-116.
[24] This is being addressed in a forthcoming assessment of the Scottish "trade in lunacy." Parry-Jones,W.Ll. and Sturdy,H.

of cure, rather than of confinement, should be assessed further, particularly in view of Scull's insistence that the asylum in the nineteenth century was merely "a dumping ground...for a heterogeneous mass of physical and mental wrecks".[25] This detailed, descriptive, study of boarding-out provides concrete evidence challenging Scull's theory. The very existence of a system in Scotland, if not elsewhere, which endeavoured to remove such patients from the constraints of asylums, counters his claim. Boarding-out offered the benefits of domestic life, and greater freedom for selected patients, while removing the accumulation of chronic cases from asylums. In turn, this enabled greater concentration on the development and implementation of methods of cure for asylum patients potentially receptive to such treatment.

A system which catered for almost a quarter of registered pauper insane patients and a significant proportion of private cases warrants greater research attention than it has so far been awarded. Boarding-out offered an early form of care in the community, closely regulated and supervised, or, to echo the assessment of Henderson, "the first medico-social experiment in the community care of the mentally afflicted",[26] its most important characteristic being centralised administration of policy. As a contribution to the on-going debate regarding the best mode of provision for the mentally ill, it has been established that the innovative system of boarding-out in Scotland in the nineteenth century had much to recommend it. Johnson's declaration regarding the role of history appears particularly apposite when set in the context of current concerns:

> "to judge rightly of the present, we must oppose it to the past; for all judgement is comparative, and of the future nothing can be known...The present state of things is the consequence of the former; and it is natural to inquire what were the sources of the good that we enjoy, or the evils that we suffer. If we act only for ourselves, to neglect the study of history is not prudent. If we are entrusted with the care of others, it is not just."[27]

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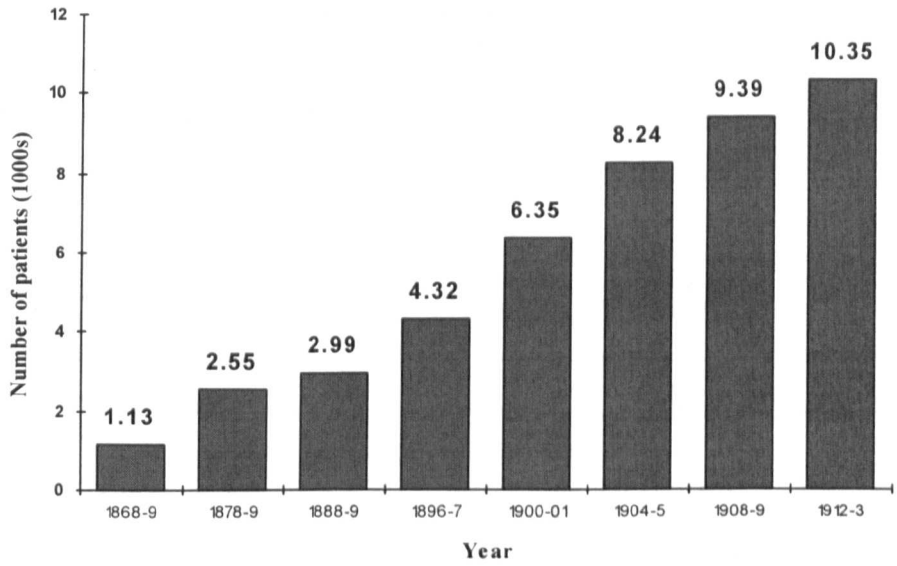
[25] Scull, A. (1979) *op. cit.*, p252, and (1993) *op. cit.*, pp370-374.
[26] Henderson, D. (1964) *op.cit.*, p98.
[27] Johnson, S. (1759) Rasselas. London: Printed for R.and J.Dodsley and W. Johnston, pp115-116. Noted in MacNiven,A. (1960) The first Commissioners: reform in Scotland in the mid-nineteenth century. *Journal of Mental Science*, **106**, p471.

APPENDIX 1

NUMBER OF PATIENTS IN DISTRICT ASYLUMS



Average number of patients resident in district asylums from 1868-1913

REGISTER OF BOARDED-OUT PATIENTS, 1886-1887

21 Sister Mrs. Mc. Donald 82 Main St Coatbridge

LUNACY REGISTER.—OUT-DOOR.

Name, Margaret V. Gallocher

Residence, 13 Society St Camlachie with father

Asylum Record, 26439 Settlement, Barony

Date of becoming Chargeable, 12th March 1885 Age, 24 1885 Birthplace, Co. Down Ireland.

Date of Sanction by Board of Lunacy, 19th March 1885 No. of Sanction, 6665.

Religion, R.C. Aliment allowed 32/8½ p.w.

DATES OF MEDICAL OFFICERS' AND INSPECTORS' VISITS, CHANGES, AND SUBSEQUENT PROCEEDINGS.

1886 July	2	Visited by Messrs Hobbs & M. Thomson, Members, and Mr Anderson Assistant Inspector. found all Satisfactory
Nov	12	Clothing Supplied 2 Shifts 2 Petticoats 1 Dress, 1 Shawl 1 Boots 2 Summits 14
1894 May	28	Patient Removed to the house of John Jamieson Wee Oldhall Dunlop.
"	29	Intimation Genl G B of Lunacy Dr Wylie & Inspector of Poor Dunlop.
"	23	Sanction of G.B of Lunacy to board this patient in the house of John Jamieson Wee Oldhall Dunlop
June	28	Sanction 7890 from G.B of Lunacy.
1901 March	12	Intimation to Roman Catholic Clergyman at Kilmarnock
April	16	Intimated to G.B. of Lunacy that aliment is increased to 8/ Weekly from 1/5/190
1901 Oct	29	Wrote Dr John Cumming Govt, Brae House, Stevenston to visit this Patient in room of Dr Robertson, Dunlop.
1910 Nov.	29	Removed to house of Mrs Mary Todd, Borland House, Dunlop, as Mrs Jamieson, died on 21st inst.
Dec	8	Intimation to G.B. of Lunacy, Inspector of Dunlop, Sister, & R.C. Clergyman.
	23	L. 8300 from G.B. of Lunacy sanctioning residence.
1911 March	11	Removed to house of Thomas Sturdie, Wee Oldhall, Dunlop, as she is restless.
	18	Intimation to G.B. of Lunacy, Inspector of Dunlop, sister, & R.C. Clergyman.
	30	L. 2213 from G.B. of Lunacy sanctioning residence.
1918 Oct	26	L. 2010 from G.B. of Control that Guardian complains about patient stealing money out of drawer, & eggs. No complaint of this kind before
1919 Feby	20	Wrote G.B. of Control that she seems to be doing better.

Bro: Jas. 4 Brench St. Briseton.

LUNACY REGISTER.—OUT-DOOR. 106

Name, Walter Cumbell

Residence, 277 North Woodside Road ~~with Mother~~ 21/2/00. Mrs Mary Finlayson Calgieveg, Braco

Record, 6/1443 Settlement, Barony

Date of becoming Chargeable, 2nd December 1887. Age, 23 Birthplace, Roland St Caithness

Date of Sanction by Board of Lunacy, 12 December 1887. No. of Sanction, 4690

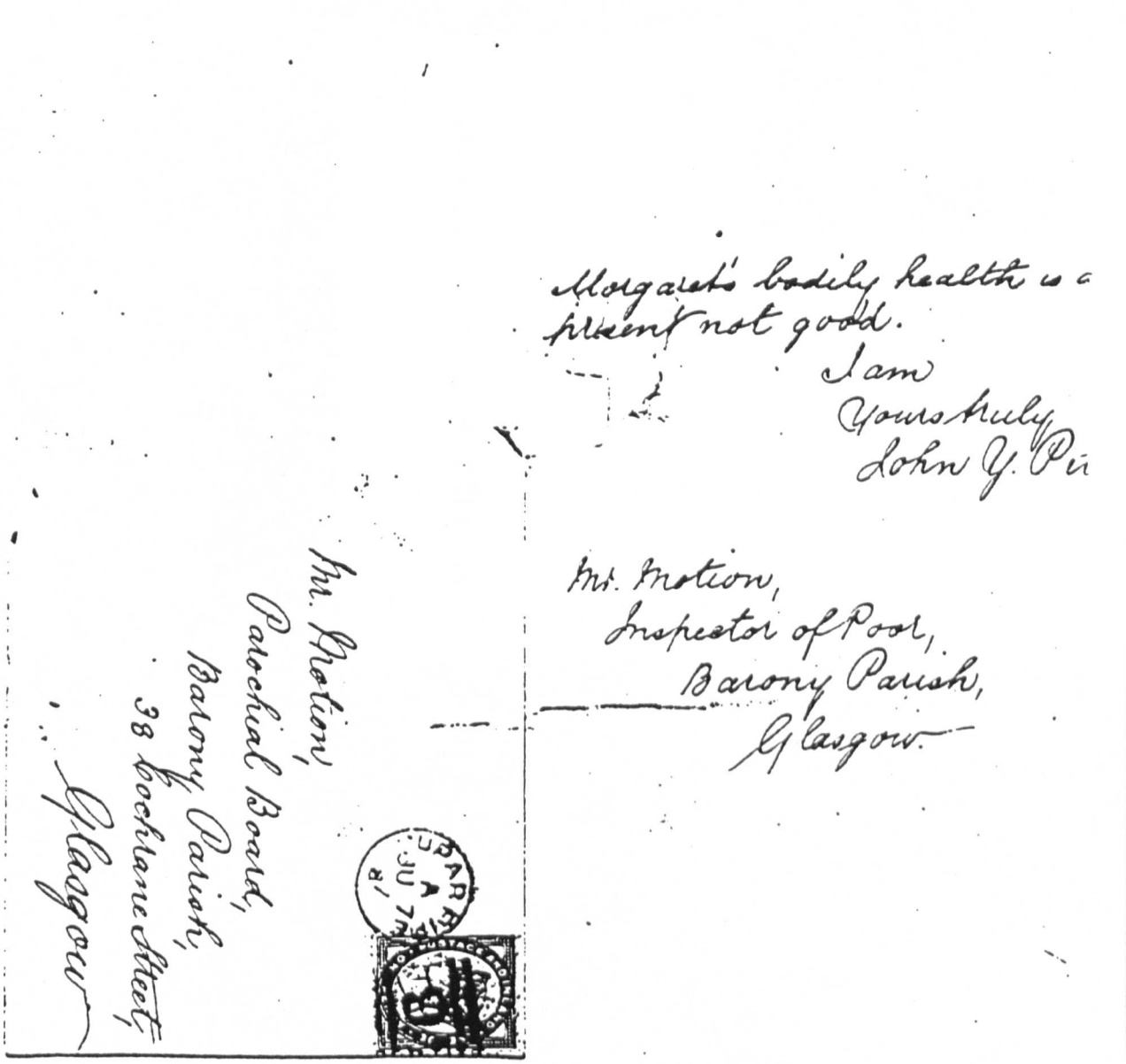
Religion, Prot. Aliment allowed, 4/ per week.

1887		DATES OF MEDICAL OFFICERS' AND INSPECTORS' VISITS, CHANGES, AND SUBSEQUENT PROCEEDINGS.
Dec	17	13408, Sanction of Board of Lunacy Obtained
June 1900	20	Wrote Dr Cowie as to Visitation
Feby	21	Removed from 15 Doncaster St, where he had been living with his niece, his mother having died, and boarded with Mrs Margt Finlayson, Calgieveg, Braco.
		Intimations sent Dr Todd, Dr Porter, Blackford
		Inspector of Poor, Ardoch.
	22	Intimation sent General Board of Lunacy.
March	11	L. S/1366 from Gen: Board sanctioning residence in Calgieveg.
May 1900	4	Removed from Calgieveg to Woodilee Asylum.
	10	Intimations sent Dr Porter & Inspector of Ardoch.
	14	Do Gen: Bd of Lunacy "Patient helpless on account of Paralysis"
April 1906	22	Boarded with Miss Margaret Meek, Hyndford Bridge, Lanark
	25	Intimation to G.B. of Lunacy, Dr Kelly, and Inspector of Lanark.
May	4	Wrote brother.
	7	L. S 2199 from G.B. of Lunacy sanctioning residence. No 12,732.
Dec 1912	14	Removed with Guardian to Rosevale, Hyndford Bridge, Lanark.
	24	L. 8890 from Dr Kelly that Patient ill with Cardiac weakness and Dropsy.
	26	Intimation to G.B. of Lunacy.
	27	Wrote brother.
	29	L. 30 from William Meek that patient died this morning.
	30	Intimation to brother.
	"	L. 8995 from G.B. of Lunacy sanctioning residence.
	31	Dr Kelly certifies that Patient died on 29th inst., that he last saw him on 28th inst. and that cause of death was "Cardiac Weakness. Dropsy" of 2 months duration.
Jany 1913	4	Intimation to G.B. of Lunacy and Inspector of Lanark.

Ceres, 6th June 1884.

Dear Sir,

At one time I thought that Margaret Bowie or McLachlan would have improved by being boarded out. But I have now come to the conclusion that she is not a fit subject to remain boarded out, for she is too frequently uttering oaths, using filthy language, and cannot with safety be let go outside the house alone, even to the garden. She is also becoming a source of annoyance to her companion, and the other inmates of the house, so much so indeed that Mrs. Lister informs me that she can't have Margaret much longer for a boarder.



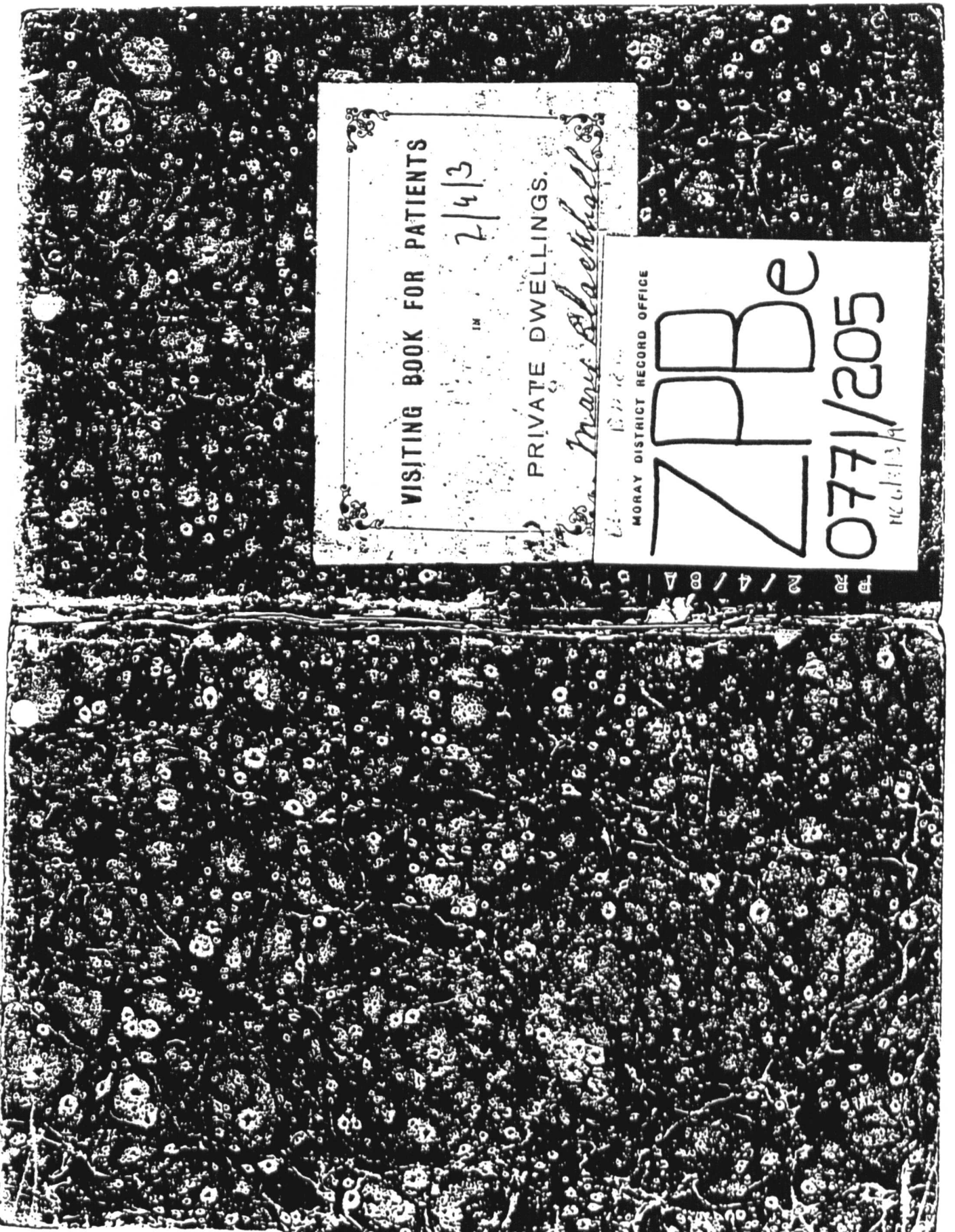
Margaret's bodily health is a
fitent not good.

I am
Yours truly
John Y. Pi

Mrs. Motion,
Inspector of Poor,
Barony Parish,
Glasgow.

Mr. Motion,
Parochial Board,
Barony Parish,
38 Cochlane Street,
Glasgow

VISITING REPORT BOOK



NOTICE.

It is required that every Lunatic residing under the Sanction of the Board of Lunacy in any Private Dwelling shall be visited at least once in every three months (unless the Board shall, on special application, otherwise regulate such visits) by a Medical Man, who shall at every such visit enter in the Visiting-Book for Patients in Private Dwellings, which shall be kept in the house in which the Lunatic resides, a report of the mental and bodily condition in which he found the Lunatic, with any suggestions or recommendations for improving the condition of the Patient which he may think desirable.

In the case of Pauper Lunatics, such intimation is required to be made by the Parochial Medical Officer; or, if the Patient be resident beyond his own Parish, by a Medical Man appointed by the Parochial Board of the Parish to which he is chargeable.

The Inspector of Poor is also required to inspect, personally, at least twice in the year, at their places of residence, all Pauper Lunatics resident in Private Dwellings in his Parish, and all those belonging and chargeable thereto who have not been placed under the superintendence of the Inspector of the Parish of residence, and shall satisfy himself that all the requirements of the Lunatic are specially provided for. And he shall record such visits, with the condition in which he found the Patient, in the Visiting-Book kept in the house in which the Lunatic resides.

2 REPORT-BY MEDICAL OFFICER.

To be filled up Quarterly.

Name of Patient, Mary Blackhall

State of Mental Health, Idiotic

State of Bodily Health, Fair

State of House, Good

State of Bedding, Good

State of Clothing, Good

State of Personal Cleanliness, Good

Suggestions and Recommendations,

(Signature) Danl. Dewar M.B. &c
pro G. Forbes M.D.

Date July 9th 1877

REPORT BY MEDICAL OFFICER. 3

To be filled up Quarterly.

Name of Patient, Mary Blackhall

State of Mental Health, Idiotic

State of Bodily Health, good

State of House, Clean

State of Bedding, good

State of Clothing, good

State of Personal Cleanliness, good

Suggestions and Recommendations,

(Signature) Geo. Forbes, M.D

(Date) Oct 4th 1877

6 REPORT BY MEDICAL OFFICER.

To be filled up Quarterly.

Name of Patient, Mary Blackhall

State of Mental Health, weak

State of Bodily Health, good

State of House, Clean

State of Bedding, good

State of Clothing, good

State of Personal Cleanliness, good

Suggestions and Recommendations, I recommend that she get a woolen jacket as the one she has is quite worn out.

(Signature) Geo. Forbes, M. D

(Date) 12th April 1876

7 REPORT BY INSPECTOR OF POOR.

To be filled up Half-yearly in the case of Pauper Patients only.

Name of Patient, Mary Blackhall

State of House, Good, & Tidy Woman

And giving a general Character,

State of Bedding, Good

State of Clothing, Good

State of Personal Cleanliness, Good

Duties of Guardian, if satisfactorily performed, Very Satisfactory

Articles of Clothing, Bedding, etc., required, Would require a Coat as well as a Jacket

(Signature) William Thomson

(Date) 29th & 4th May 1876

10 REPORT BY INSPECTOR OF POOR.

To be filled up Half-yearly in the case of Pauper Patients only.

Name of Patient, Mary Blackhall

State of House, Good guide & clean

State of Bedding, Good

State of Clothing, Good

State of Personal Cleanliness, Good

Duties of Guardian, if satisfactorily performed, Very Satisfactory.

Articles of Clothing, Bedding, etc., required, a pair of Shoes as the one's she has are worn done.

(Signature) William Thomson

(Date) 14th October 1878

REPORT BY MEDICAL OFFICER. 11

To be filled up Quarterly.

Name of Patient, Mary Blackhall

State of Mental Health, weak

State of Bodily Health, good

State of House, clean

State of Bedding, good

State of Clothing, good

State of Personal Cleanliness, good

Suggestions and Recommendations, ?

(Signature) Geo. Forbes.

(Date) Dec 3rd 1878

APPENDIX 4

PARLIAMENTARY GRANT-IN-AID

Circular letter from the General Board of Lunacy to inspectors of poor in regard to claims upon the parliamentary grant for pauper lunatics in the case of patients living under the Board's sanction in private dwellings.[1]

A copy of this was given to every medical officer who visited boarded-out patients.

Sir, The Board have under careful consideration the conditions under which parochial boards in Scotland are permitted to share in the Government grant for the relief of the local rates for the maintenance of pauper lunatics, and I am instructed to call your attention to the following points, the importance of which does not seem to be always fully appreciated:-

The grounds required to justify a claim upon the grant, in the case of pauper lunatics not in asylums, are that the nature of provision made for the patients by the parochial board shall be satisfactory, and that the supervision exercised over them shall be sufficient.

In regard to the nature of the provision, it is necessary that the patients shall be comfortably housed and fed, that they shall in every way be treated as well as the other members of the household of which they are members, and that every reasonable effort shall be made to improve their condition and contribute to their happiness.

In regard to the efficiency of the supervision it is necessary not only that the inspectors of poor and visiting medical officers shall ascertain that the patients are provided for and treated so as to satisfy these requirements, but that they shall also record their visits in the Visiting Books prescribed by the Board of Lunacy, the inspector of poor making such record half yearly and the medical officer quarterly. Patients resident in other parishes than those to which they are chargeable must either be visited regularly by the inspector of poor of the parish of chargeablity, or arrangements must be made for their regular visitation by the inspector of poor of the parish of residence. It must also be arranged that patients living at a distance from the parish of settlement, must be visited by a medical officer quarterly and recorded.

Improper treatment, neglect of a patient, or inadequate supply of food or clothing, although it may be the fault of the person under whose immediate charge the patient is placed rather than of the parochial officials, will invalidate the claim of the parish to share in the grant.

[1] GBCLS 21st AR (1879), p100.

APPENDIX 5

KENNOWAY: PROFILE OF A COLONY IN 1870[1]

Kennoway was reputed to be a quiet, healthy village, only a few miles from the sea, with a population, in the 1870s, of approximately 700. Observers claimed that the village, with a "magnificent outlook to the Firth of Forth" was cleaner and more pleasant than the majority of sea-side villages, and far healthier than villages in the iron and coal districts.[2] Among the residents were labourers, artisans, small farmers, miners, carpenters, masons and merchants. Many had been hand-loom weavers, until the introduction of power looms. House rents were low, due largely to a decreasing population. Many villagers had land and kept cows and pigs. Although there were complaints regarding the number of pauper lunatics boarded in the village, the Commissioners contended that "it would be quite possible to walk through the village without knowing that there was a single pauper lunatic boarded in it."[3]

i. Number in special licensed houses

Thirty-one patients were boarded-out in Kennoway between 1863, when the first license was granted, and 1870. Of the patients, unusually, one female patient had been discharged recovered after four years, and one male boarder left of his own accord and was later certified sane. A further patient had been returned to the asylum as unsuitable. A small number had died, leaving, in 1870, 24 patients in the village, although this number rose considerably throughout the 1870s. Only two of the houses were licensed for the reception of four patients, because, as the Commissioner, Mitchell, observed, "when there are four [patients] the house is apt to assume too much the appearance of an establishment." Seven houses had two patients and two houses only one. Although Kennoway became well-known for the number of patients accommodated in special licensed houses, some patients were also boarded there as single patients. Eighteen patients were chargeable to the City parish of Edinburgh, one was from Kennoway itself, with the remainder from central Scotland. While the number of parishes sending patients to the village increased administrative problems for parish officials, the steady activity indicated widespread recognition of the suitability of Kennoway for receiving harmless patients, although patients from Edinburgh City parish always made up the greater number of boarders.

ii. Description of houses and their occupiers

Villagers with more space and furniture in their houses than their neighbours were the most likely to apply for a license. The houses were similar to those occupied by working families

[1] This portrait is taken largely from the extensive description in Mitchell's annual report for the Commissioners in Lunacy. GBCLS 12th AR (1870), p252-263.
[2] GBCLS 29th AR (1887), p123
[3] *Ibid.*, p125.

throughout Scotland, rather than "cottages in the romance-of-rurality sense".[4] Of the 11 houses licensed for the reception of patients, most had two apartments, with beds in each. A number also had a scullery. The floors were made of compound (cement made of engine ashes, lime and sand) the type of floor common to the houses in this part of Fifeshire. Many houses were well furnished, and had carpeted floors. Fires were lit in the rooms occupied by the patients. One house was equipped with a mahogany chest of drawers, a large mirror, many framed pictures and ornaments, two arm chairs and two curtained beds. The walls were covered with bright, clean, kitchen utensils.

The appearance of the majority of houses gave "evidence of comfort and a rough plenty," and, although occasionally, the need for greater tidiness was remarked on by visiting Commissioners, as one patient announced:

> "You cannot have tidiness *always* sir, in any working man's house- much less in one with as much *stir* as we have here". I asked her what stir they could have, and she said, "oh, getting the meals ready, and washing and cleaning up the house, and looking after the beasts and the land."[5]

The Board of Lunacy was satisfied if the guardians were "kindly and sensible people" of the same social class as the patients, and willing to treat the patient in the same way as the rest of the family. The majority of guardians were considered to be industrious and competent.

The guardian in the first house was an unmarried woman of middle age. She owned both the house she lived in and the adjoining one, and also rented land where she kept two cows. A young woman, who had been adopted by her having been first boarded-out as a child, lived with her, helping in the field work. The guardian received 5s weekly for her patient.
Two patients boarded in the second house, at a cost of 6s a week each. The guardian was a pensioner who lived with his wife, but no other family member. Their house was rented for £3 per annum. They kept two pigs and poultry.
A widow, over the age of 50, owned the third house in which she lived with her granddaughter and two patients, each accommodated at the rate of 5s weekly. She was reported to be "an active, cleanly, respectable and industrious woman. Her whole time is given to household duties, the care of the patients, knitting and sewing." As with the other guardians she had a garden and kept pigs.
The fourth house visited by Mitchell was owned by a shoemaker, who with his wife had a license for the reception of four patients, each paying 5s weekly. They possessed two other houses and considerable land, the cultivation of which occupied most of their time.
The fifth house was rented by former shopkeepers, who had previously kept lodgers. They had four patients, at 5s weekly.
The guardians of the next five houses all had two patients each, at a rate of 5-6s weekly. Their occupations were: a surfaceman, a house-carpenter, a pensioner, formerly a weaver, and two unmarried sisters who were weavers. The pensioner received both boarded-out lunatics and children, a rare combination not usually accepted by the Board.
The final house was occupied by a farmer, his daughter, son-in-law and grandchild. Between them they farmed approximately 50 acres, had four cows, and some young cattle, five pigs, and three horses. Only one patient was boarded there.
It is apparent, therefore, that the position of all the guardians was respectable and that none were on the confines of pauperism.

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[4] GBCLS 12th AR (1870), p255.
[5] *Ibid.*, p254.

iii. Profile of patients

Of the 24 patients residing in Kennoway in 1870, 10 were male and 14 female. The discrepancy in favour of female patients became more apparent in later years. The residence of patients of both sexes in the same house was not sanctioned. The patients were all registered as pauper insane and were mostly from the labouring classes, many of them being of the same class as their guardians, others slightly below the ordinary tradesman and labourer. They often declared that the conditions and comforts in the licensed houses were superior to those in their own homes. One pauper patient had been a governess. The Commissioners observed that her presence at Kennoway was far more desirable than her continued existence in an asylum, where she would be surrounded by 20 or 30 paupers in a day-room. Mitchell noted that it was "because of her superior position and in order to make her surroundings more in accordance with it" that she was sent to Kennoway.

There was little difference between the ages of those at Kennoway and those in asylums. The mean age of the patients was 46.5 years, the eldest being 61 and the youngest 30. The mean age in asylums was 44.4 years.[6]

As was the case with the majority of boarded-out patients in the first 25 years of operation of the system, the most common mental disorders were chronic mania or dementia. Three or four were congenital imbeciles or idiots; all were considered incurable. The bodily condition of the patients was varied. While the Board stipulated that the patients had to be in reasonable health, many were in a weak state. The parochial medical officer of Kennoway reported that physical complaints of patients included: tendency to anasarca, near blindness, biliousness, oedema of the lower limbs, chronic bronchitis and asthma.

Doubts had been expressed as to the suitability of some patients sent to Kennoway in the earlier years of the system, although no sexual incidents or assaults had yet been recorded. Mitchell reported, with some surprise, that patients he considered "worse fitted for management in private dwellings", had benefited from domestic treatment. One patient, had been subject to occasional fits of excitement, when she became talkative, confused and restless. When Mitchell visited, she had resided in the village for seven years and was easily managed. During her periods of excitement, the guardian reported that "we do nothing, we let her alone. The doctor gives her a dose of castor-oil and she gets into her usual way after a few days." Another patient was considered unsuitable due to a habit of gesticulating in the street, stopping suddenly when walking and turning around three or four times. There was some concern by visiting Commissioners that children would follow and torment him. Despite some official reluctance to have the patient boarded-out, within a few years, the Board were informed that he had almost given up the habit, that he took an interest in the cow and land and nursed the children. His guardian declared that they "had grown to like him" and that they would not exchange him for any patient in the village. Notwithstanding the success of some cases regarded initially as inappropriate, Mitchell argued that many were boarded-out who were unsuitable for life in private dwellings. He conceded, however, that the experiment at Kennoway widened his views as to the proportion of chronic insane who could be properly and easily managed without the aid of public institutions.

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[6] *Ibid.*, p261.

iv. Quality of provision

The quality of provision in the houses was declared to be at least equal to, and often superior, to conditions in houses occupied by working people. When Tuke visited Kennoway in 1870, he was highly critical of the lack of cleanliness among patients and villagers alike.[7] Mitchell, however, was less censorious, observing that it was rarely necessary to demand greater attention be paid to the personal cleanliness of patients. His standards were clearly more flexible and in line with conditions accepted among crofters and other workers. He observed that:

> "they are washed and kept clean just as their guardians are, and as working people generally are. There are no baths, but one would not expect them, there are tubs for the more general washing which occurs on Saturday night. The necessity for cleanliness is strongly urged...the guardians are left to do it in the way they have been accustomed to adopt for themselves.[8]

The bedding provided was sufficient, consisting of a straw mattress, cotton sheets, a feather pillow and Scotch blankets. Because the patients were in a chronic state of lunacy, it was recognised that they were of low vitality and the importance of warm clothing was stressed. Thick shawls for female patients and blue jerseys for the men were recommended. Those who attended church were also provided with smarter clothes. The intention was that the patients be clothed as closely as possible, in the same way as the villagers. The Board was anxious to "avoid all appearance of a uniform, so that the patients may not be recognised by any peculiarity of costume." The diet of patients was considered to be of a satisfactory standard, reflected by the improvements in the physical condition of the majority of patients after their arrival in Kennoway. Indeed, the Commissioners often recorded their surprise at the quality of the dinner supplied. Further, the appearance of the patients reassured them that they were not underfed. If the food provided was insufficient, sickness would be more prevalent and the death rate higher. The average age of death for patients was 78 years and the low death rate served to indicate that living conditions for patients in the village were not unfavourable to life.

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[7] *Vide supra* Chapter 10 for his concerted attack on conditions at Kennoway.
[8] GBCLS 12th AR (1870), p258.

APPENDIX 6

BOARDING-OUT IN INVERNESS[1]

In the late-nineteenth and early-twentieth century, the parish of Inverness had one of the highest percentage of insane patients boarded-out, both singly and in small aggregations. In 1910 for example, within a radius of 16 miles of Inverness District Asylum, 132 patients (51 male, 81 female) resided in private dwellings. 38 of these were boarded with relatives and 84 with strangers. 66% had been inmates of the asylum. 69 patients resided within 3 miles of the asylum. The aggregation north of the Caledonian Canal, where in 1901, 34 patients were boarded-out is described below. The majority of the 22 houses receiving patients were between one and three miles from the town, although one group of five houses was seven miles distant, on high ground above Loch Ness. The description of patients is relatively detailed, when compared to much existing data on demographic and mental characteristics, and is most illuminating in highlighting the marked variation in mental condition.

1. A comfortable slated house with three apartments, occupied by a guardian, his wife, three young children and one female patient. The patient was between 30 and 35 and had been there for four years. She was reported to be a good worker, who assisted in household work and in the care of the children. Although excitable and inclined to scold, she was easily managed and attached to the children. She had a "fair sized comfortable attic room".
2. A thatched house, occupied by a guardian, his wife, four children and two female patients who had been there for over six years. One was a congenital imbecile, capable of doing housework, the other had been insane for ten years and in an asylum for four. She had "grand delusions and an intolerable temper", and was therefore an unusual case for boarding-out. However, she had improved under her present care, and was thought to be pleasant, agreeable and useful. The patients slept in a room which had just been added to the house.
3. A long narrow gabled house with three rooms, which were scrupulously clean. The guardian was an old woman, who lived with her sister and received two male patients, one of whom had resided there for 20 years, the other for 12. The first patient suffered from dementia. He was able to work on the farm, but required care to ensure his cleanliness. The other was "a stout, healthy dement...a willing worker, improved much in intelligence." Both appeared content.
4. A three-roomed house which was the home of a guardian, her daughter, occasionally her son and three female patients. The appearance of the house was criticised as being rather dilapidated, and structural improvements were ordered if the guardian wished to keep the patients. However, the patients, one of whom had been there for 30 years, and regarded herself as the housekeeper, spoke warmly of the guardian.
5. A thatched house of four apartments, occupied by a guardian, one son, one daughter and two middle-aged male patients. The house was clean and tidy. One of the patients, who had resided there for 8 years, was demented and occasionally noisy at night but reported to be

[1] Description taken from GBCLS, 43rd AR (1901) and 52nd AR (1910).

polite, obedient and useful about the croft. The other had been there for six years, and was frequently in and out of the asylum. Although quarrelsome and difficult to manage when living with his relatives, he was now clean, tidy, easily humoured and able to work under supervision.

6. A thatched house of four apartments, occupied by a guardian, his wife, four children and two male patients, aged 34 and 44, both of whom had been in the asylum. One had been insane since a child, and appeared healthy and happy. The other was less obviously suitable, being irritable on occasion and suffering from delusions. However, he was able to work, was managed with tact, and was therefore able to remain outside the asylum.

7. A thatched house with three rooms for a guardian, his wife, three children and one female patient, aged 42, who had been in the asylum twice, and discharged in a condition of deep dementia eight years ago. She was reported to have become cheerful and talkative, "kind to the children, and willing to be useful". Although still suffering from delusions, she reportedly caused no annoyance to the family.

8. A thatched house with three apartments in good condition, and clean and tidy. A guardian, his wife, one daughter and three elderly female patients resided there. One was boarded-out after 13 years in the asylum, and had lived in the house for 23 years. She was a maniac with delusions of suspicion, which had become less prominent, and she was able to converse with her guardians. Another patient, a congenital imbecile had lived there for 22 years, and was "a great chatterer and comparatively useless". The third was 80 years old, and had lived there for nine years after being in the asylum for 14 years. She suffered from hallucinations of hearing, but was well behaved and industrious. Two patients shared one room and the other had a bed in the kitchen.

9. A slated house of modern build, with five apartments, for a guardian, his mother, sister, and one male patient, who had lived there for 12 years. He was reported to be a good-natured dement, who was " subject to bronchial attacks" and so unable to do outdoor work. He was usually found sitting in the most comfortable chair at the kitchen fireside.

10. A slated house with three apartments, occupied by a guardian, his son, his son's wife and two young children and one 42 year old male patient who had lived there for six years. Commissioners reported that he was "sullen and suspicious", but had gradually become "more talkative and agreeable" and useful about the home.

11. A thatched house with four rooms, which were clean and comfortable, occupied by a guardian, his two daughters, a man-servant and two male patients. One had arrived 16 years ago having been in the asylum for five years. He had delusions of persecution, heard voices and was often violent. (Very unusual mental condition for boarding-out) However, although on occasion noisy at night he was quiet during the day, and was given much freedom, going shopping alone to Inverness. The other, a stout elderly dement had lived there for 18 months, was sulky at times, but generally manageable.

12. A thatched house, with two apartments for a guardian, her two daughters and one 67 year old female patient. She had been discharged from the asylum eight years ago after 20 years. Initially she was reported to be "excitable and extravagant in her conduct, dancing on the public road..." However, when visited she was quiet, polite and well behaved, and "might almost be regarded as a case of complete [mental] recovery" although had recently developed a disease which required surgical intervention.

13. A superior five-roomed house, occupied by a guardian, his wife, son, daughter and one 52 year old male patient, who had lived there for seven years after 15 years in the asylum. He was demented and childish, but seen to appreciate his freedom, and wandered about the neighbourhood, doing odd jobs.

14. A slated house of three rooms lived in by a guardian, his wife, two sons and one 65 year old female patient, who had lived there for six years. She was reported to be "very

emotional and melancholic", and suffering from rheumatism. She was no help in the home, and remained in bed for much of the day, but was grateful for the kindness with which she was treated.

15. A four-roomed house with a corrugated iron roof occupied by a guardian, his wife, son, daughter and a young female imbecile, both of whose parents died of phthisis. She had lived there for one year and already improved markedly; "she is plumper and healthier looking, and has also become more intelligent." She was also becoming useful.

16. A three-roomed house which had recently been repaired. All the floors were lined with wood. It was occupied by a guardian, his wife. The house was licensed for two patients, but only one patient resided there, having been there for seven years after five years in the asylum. He was able to work but was demented and often became excited and "gesticulates and lectures in a loud voice in Gaelic." The Commissioners recognised that he would be unsuitable for boarding-out in a densely populated district, "as his antics and speechmaking would be a nuisance, and would expose him to annoyance and teasing by the youth of the district." However, the area was isolated and he was reported to appreciate his liberty.

17. A four-roomed thatched house, for a guardian, her daughter and son in law, and two female patients, one of whom was an elderly imbecile, cleanly and domesticated, who was trusted to take care of the house in the absence of the guardian. The other was 42, and had been in asylum several times. She was reported to be reticent and in recent years had become increasingly irritable. The Visiting Commissioner considered that she may get excited during climatic changes and require further asylum care.

18. A five-roomed slated house in a state of some decay. This was occupied by a guardian, his wife, four children and two female patients. The house was criticised as being untidy and dirty, but the patients beds were clean, and there was a good supply of food. One patient had lived there for 10 years and was firmly attached to the family. The other one had arrived only recently. Although there were many positive features about the quality of guardianship, Commissioners regarded the house to the most unsatisfactory one. Without marked improvement, the license would cancelled.

19. In this old thatched house of three rooms, a guardian, his wife, an orphan pauper child and one female patient aged 42 lived together. (An unusual combination) The patient had lived there for nine years, having been in the asylum for three years. She was demented and at first was reported to be "haughty and overbearing in her attitude to the guardian". She was able to work on the farm, but complained on occasion at being sent as a servant to a farm. She was the only patient in the aggregation who did not sleep alone but shared her guardian's bed at her own request.

21. An old thatched house, with three rooms for the guardian, her son, daughter and one female patient aged 69 who suffered from chronic mania. She had been there for 11 years, having been boarded-out elsewhere for over ten years after 12 years in the asylum. She was demented and somewhat incoherent, muttering to herself when alone. However, she was able to answer questions correctly and was on most friendly terms with her guardian.

22. A four-roomed house with corrugated iron roof over the thatch. This was the home of a guardian, his wife, four children and two female patients, one of whom had resided in an asylum for 12 years, and the other for nine years. The first patient enjoyed home life, and had improved physically, and to a lesser extent, mentally. The other, a blind idiot, was less suitable and was reported to be increasingly degraded in her habits. Her return to the asylum was recommended, as she was in need of greater attention than could be expected in a private dwelling.

APPENDIX 7

DESCRIPTION OF SPECIAL LICENSED HOUSES IN THE COUNTIES OF LANARK, PERTH AND FIFE, 1906

i.Lanark and Lesmahgow[1]

Sex	Age	House	From asylum	Years/ months boarded -out	Physical Health	Mental Condition	Remarks
F	67	Mr Steel	Yes	6y	Good	Chronic mania	Active, useful, well pleased with home
F	38	"	Yes	2y	Stout and Healthy	Slight Dementia	Works well, pleasantly in the house
F	66	"	Yes	35y	Frail and failing	Congenital imbecility	Still able to go about a little
F	41	Miss Day	No	6y	Good	Congenital imbecility	Bright, happy, active and useful
F	24	"	Yes	6y	Good	Congenital imbecility	Can do no useful work, clean and happy
F	21	"	No	4y	Fairly good	Congenital imbecility	Happy in her home
M	36	Mr Scott	Yes	3m	Healthy	Dementia	Fair worker, cleanly and easily managed
M	22	"	Yes	1y	Healthy but stuperose	Dementia praecox	Cleanly, shows no objectionable propensities
F	44	Mrs Adams	Yes	8y	Good	Dementia	Amiable and working well about the house
F	20	"	No	6m	Stout and healthy	Congenital imbecility	Of pleasing appearance
F	71	"	Yes	2y	Good	Melancholia	Bright and cheerful
F	44	"	Yes	8y	Delicate	Dementia	Very helpless
M	22	Mr Watson	Yes	9m	Good	Dementia	Guardian has engine shop, and patient was an apprentice engineer. Is very useful to guardian

[1] All information taken from Report for the Royal Commission for the Care and Control of the Feeble-minded (1908)

Sex	Age	House	From asylum	Years/ months boarded -out	Physical Health	Mental Condition	Remarks
M	50	"	Yes	9m	Good	Dementia	Useful quiet man in the engine shop and farm
M	51	Mr Wylie	Yes	4y	Good	Dementia	Usefully employed in garden and field
M	37	"	Yes	9m	Good	Dementia	Cleanly in habits and tractable
M	60	Mr Donaghy	Yes	18m	Good	Dementia	Good tempered and kindly, does some work about the byres
M	39	"	Yes	2y	Fair	Dementia	Willing and useful at most of the work on the farm
F	18	Mrs Whitefield	No	4y	Fair	Congenital imbecility	Improved in health and slightly in intelligence, easily managed.
F	32	"	No	4y	Good	Dementia	Clean and tidy, active and happy.
F	39	Mr Dale	Yes	1y	Good	Chronic mania	Does a fair share of the housework and goes out a good deal
F	32	"	Yes	14y	Good	Congenital imbecility	Well cared for, can do some housework
F	70	Mr Struthers	Yes	4y	Good	Melancholia	Is a good seamstress and likes to work.
F	59	"	Yes	4y	Good	Chronic mania	Pleasant and chatty, evidently quite at home.
F	23	Mrs Pringle	Yes	9y	Good	Imbecile	Clean, tidy and useful
M	25	"	Yes	9y	Fair	Imbecile	Brother of above, useless
M	59	Mrs Kelly	Yes	4y	Good	Chronic mania	Works well in the fruit fields
M	73	"	Yes	7y	Good	Dementia	Useful indoor worker.

ii. Port of Menteith, Kilmadock and Kincardine, Perthshire

Sex	Age	House	From asylum	Years/ months boarded-out	Physical Health	Mental Condition	Remarks
F	42	Mr McOnie	Yes	19y	Good	Dementia	Takes her food alone, being somewhat impulsive at meals
F	15	"	No	1m	-	-	Not yet reported on
F	57	"	Yes	4y	Moderate	Chronic mania	Dreamy, discontented, anxious to get to home and friends
F	73	"	Yes	7y	Good	Chronic mania	Helpless and useless
F	60	Mr Kerr	Yes	6y	Good	Congenital imbecility	Agreeable, useful, quick in temper, but never irritable
F	82	"	Yes	11y	Frail	Dementia	Manifests a keen interest in many things and in full possession of her faculties
F	51	"	Yes	8y	Good	Dementia	Vigorous but not useful
F	63	Mrs McFarlane	Yes	8y	Good	Chronic mania	Cheerful but incoherent, diligent with the needle
F	43	"	Yes	27y	Good	Congenital imbecility	Comfortable and contented
F	59	"	Yes	21y	Poor	Dementia	Suffering from phthisis
F	68	"	Yes	8y	Good	Dementia	In good spirits and talkative
F	51	Mr Dymock	Yes	7y	Good	Dementia	Good knitter and houseworker
F	67	"	Yes	3y	Good	Dementia	Talks very rambling and incoherent, useless
F	41	"	Yes	4y	Good	Dementia	Good houseworker
F	52	Mrs Gardner	Yes	8y	Good	Dementia	Good tempered but indolent and useless
F	45	"	Yes	3y	Good	Chronic mania	Energetic hard working woman, noisy and exciteable temperament
F	65	"	No	15y	Good	Chronic mania	Has delusions and hallucinations, but is active and industrious
F	57	"	Yes	1y	Good	Dementia	Cleanly in habit, but unproductive

Sex	Age	House	From asylum	Years/ months boarded -out	Physical Health	Mental Condition	Remarks
F	61	Mrs McFarlane	Yes	2y	Good	Dementia	Fairly useful
F	57	"	Yes	21y	Good	Chronic mania	Active worker, can look after her own interests
F	58	"	Yes	20y	Poor	Chronic mania	In failing health
F	45	Mrs McKenzie	Yes	13y	Good	Dementia slight	Useful woman, who acts as deputy guardian
F	35	"	Yes	5y	Good	Dementia	Quiet, good natured and cleanly, talks a gibberish quite her own
F	56	"	Yes	15y	Fair	Dementia	Useless silent
F	51	"	Yes	1y	Good	Dementia	Clean and orderly in her habits, a German Jewess
M	29	Mr Mason	Yes	1y	Good	Chronic mania	Young strong man
M	51	"	Yes	1y	Good	Chronic mania	Well nourished, robust looking and amiable, conversation incoherent
F	53	Miss Drummond	Yes	14y	Good	Dementia	Great talker, incapable of any useful work
F	61	"	Yes	3m	Good	Dementia	Harmless, well behaved and easily managed
F	16	Mrs Hardon	Yes	2y	Good	Congenital imbecility	In good health
F	51	"	No	1y	Good	Dementia	Deaf and almost blind.

iii. Markinch and Kennoway, Fife

Sex	Age	House	From Asylum	Years/ months boarded -out	Physical Health	Mental Condition	Remarks
M	55	Mr Beveridge	Yes	2 y	Good	Chronic mania	Very cheerful and very fat, says it is result of being too well fed
M	71	"	Yes	2.5y	Feeble	Dementia	Quite blind but very contented
M	45	"	Yes	16y	Good	Dementia	Healthy, useful, contented
M	57	"	Yes	6m	Good	Congenital imbecility	Good natured, lazy, comparatively useless
M	54	Mr Wood	Yes	17y	Good	Chronic mania	The nurse of the household, at best when in charge of children
M	40	"	Yes	10y	Good	Dementia	Constantly engaged about the horses, likes his work, a very careful driver
M	31	"	Yes	6m	Good	Congenital imbecility	Willing and obedient, cleans out byres helps look after cattle
F	71	Mis Thomson	Yes	25y	Good	Dementia	Assists in housework, washes and knits
F	80	"	Yes	24y	Fair	Dementia	Much in bed, but gets up a little every day
F	92	"	Yes	24y	Good	Congenital imbecility	Cheerful and talkative
F	62	Miss Adamson	Yes	7y	Good	Dementia	At times noisy and abusive, but never strikes
F	70	"	Yes	6y	Fairly Good	Chronic mania	Unsociable, refuses to work, cleanly, never threatening
F	66	Miss Brown	Yes	11y	Good	Dementia	Evidently quite at home
F	61	"	Yes	13y	Good	Dementia	Something of a spitfire, and very garrulous
F	53	"	Yes	20y	Good	Congenital imbecility	Bright cheerful member of a happy family

Sex	Age	House	From asylum	Years/ months boarded -out	Physical Health	Mental Condition	Remarks
F	54	"	Yes	3y	Good	Dementia	Easily managed and obliging, useless
F	73	Mrs Scobbie	Yes	3y	Good	Dementia	Talks much to herself, at times incoherently
F	55	"	Yes	5y	Good	Dementia	Of use to guardian as a nurse and with knitting
F	59	Mrs Houston	Yes	19y	Good	Dementia	Boisterous, but good tempered, cannot work
F	67	"	Yes	13y	Good	Dementia	Dour, sullen looking woman, useful and quite friendly with guardian
F	39	"	Yes	4y	Good	Dementia	Talks a good deal, conversation incoherent at times. A good knitter
F	28	Mr Hutchinson	Yes	12y	Fair	Imbecility	Amiable, useful in little ways
F	45	"	Yes	8y	Good	Chronic mania	Quiet, concentrated, obliging
F	40	"	Yes	11y	Fairly good	Dementia	Useless, requires to be dressed by guardian
F	91	Miss Honeyman	Yes	14y	Feeble	Chronic mania	Still able to be up every day
M	44	Mr Clark	Yes	18m	Good	Dementia	Strong healthy, fairly useful, very incoherent
M	37	"	Yes	3y	Good	Dementia	Attends to the pigs, breaks sticks and works in the garden
F	67	Miss Russell	Yes	21y	Poor	Dementia	Stupid and useless

APPENDIX 8

Occupation and mental classification of patients boarded-out from Woodilee District Asylum, 1875, 1880, 1885 and 1890[1]

Year of admission: 1875

Sex	Age (yrs)	Age at first attack (yrs)	Occupation	Duration of existing attack (yrs)	Bodily condition	Mental disorder	Date of discharge
Male	33	19	Waiter	4½	Good	dementia	23.2.88
M	19	14	-	4	G	dementia	08.11.88
M	35	22	Labourer	13	G	dementia	08.3.94
M	35	25	Labourer	10	G	dementia	08.11.88
F	46	33	Servant	13	G	dementia	02.9.89
F	34	30	Weaver	3½	G	dementia	25.2.88
F	49	N/k	Unknown	20	G	dementia	10.10.90
F	35	N/k	Unknown	2	G	chronic mania	02.4.91
F	58	34	servant	4	G	dementia	10.10.91
F	35	30	Unknown	4½	G	dementia	13.4.89
M	27	19	Unknown	8	G	dementia	02.4.86
M	38	32	Barber	2	G	dementia	31.8.05
M	35	23	Clerk	12	G	dementia	02.4.86
M	46	40	Labourer	6	G	dementia	10.4.89
F	39	38	Housewife	1	G	mania	11.11.86
F	28	26	Cotton spinner	2	G	dementia	14.7.86
M	39	37	Dyer	2	G	dementia	22.9.88
M	37	31	Hawker	6	G	dementia	22.9.88

[1] Register of admissions, discharges and deaths for Woodilee Asylum

Sex	Age (yrs)	Age at first attack (yrs)	Occupation	Duration of existing attack (yrs)	Bodily condition	Mental disorder	Date of discharge
F	31	24	Dom.servant	7	G	dementia	08.7.87
F	52	45	Mill worker	7	G	dementia	11.11.86
F	42	28	Housewife	13	G	dementia	23.4.86
F	28	18	Weaver	10½	G	dementia	07.6.94
F	46	38	Dom.servant	8	G	dementia	24.4.86
M	43	17	Clerk	21	G	dementia	23.2.88
M	37	25	Seaman	12	G	dementia	12.4.94
M	43	23	Bootcloser	12	G	dementia	12.4.94
M	32	20	Cloth Lapper	13	G	dementia	28.6.94
M	36	31	Mill mechanic	6	G	dementia	08.3.94
M	28	18	Labourer	10	G	dementia	26.10.88
M	25	21	Labourer	4	G	dementia	26.5.94
M	45	44	Bookseller	7	G	mania	12.6.94
M	35	35	Labourer	8	G	dementia	11.5.93
M	29	19	Moulder	1½	G	dementia	18.3.96
M	32	25	Unknown	7	G	dementia	02.4.86
M	36	26	Flesher	3	G	melancholia	19.4.90

Year of admission: 1880

Sex	Age (yrs)	Age at first attack (yrs)	Occupation	Duration of existing attack (yrs)	Bodily condition	Mental disorder	Date of discharge
M	30	30	Labourer	1	G	mania	26.9.94
M	19	17	Shopboy	1	G	mania	25.8.03
M	16	0	None	1	G	imbecility	12.6.86
F	21	21	Servant	3months	G	imbecility	26.3.87
F	25	24	Servant	1m	G	dementia	09.4.86
F	30	0	Imbecile	1	G	imbecility	13.1.90
M	20	20	Collier	1week	G	mania	06.4.94
F	40	39	Servant	8m	G	dementia	14.7.86
F	36	36	Millworker	3m	G	dementia	07.1.87
F	20	15	Bookfolder	1m	G	dementia	07.7.88
F	21	21	Housewife	1m	G	mania	23.4.86
M	27	23	Kemp dresser	1m	G	mania	06.7.91
F	44	40	Servant	1m	G	mania	24.8.94
F	38	36	Housewife	1½	G	mania	15.6.93
M	22	22	Miner	N/k	G	dementia	06.4.89
F	56	56	Housewife	1week	G	melancholia	13.9.89

Year of admission:1885

Sex	Age (yrs)	Age at first attack (yrs	Occupation	Duration of existing attack (yrs)	Bodily condition	Mental disorder	Date of discharge
F	32	N/k	Millworker	4	G	dementia	18.11.96
F	45	44	Millworker	1	G	mania	20.7.95
F	39	N/k	-	N/k	G	imbecility	29.12.95
F	35	N/k	Domestic	1	G	melanch	09.4.85
M	33	32	Beltmaker	1	G	mania	23.4.98
F	30	N/k	Servant	10	G	mania	22.10.90
F	21	N/k	Domestic	1	G	mania	13.4.89
M	32	31	Salesman	N/k	G	mania	08.3.94

Year of admission:1890

Sex	Age (yrs)	Age at first attack (yrs)	Occupation	Duration of existing attack (yrs)	Bodily condition	Mental disorder	Date of discharge
F	26	25	Domestic	5m	G	mania	22.10.90
M	26	24	Coalminer	N/k	G	dementia	07.11.07
F	31	30	Housewife	N/k	G	mania	04.7.01
F	30	30	Weaver	1m	G	acute mania	15.2.04
F	31	19	Domestic servant	N/k	G	acute mania	24.10.18
F	57	56	Housewife	1m	G	dementia	09.6.91
F	34	34	Bookfolder	1m	G	acute mania	20.3.96
F	15	9	Nil	N/k	G	imbecility	28.6.92
F	50	50	Domestic	N/k	G	mania	25.2.96

APPENDIX 9

ASSESSMENT OF SUITABILITY[1]

Method by which patients were selected for removal from an asylum to private dwellings

Is the patient habitually dirty?

Is he noisy, cantankerous or otherwise troublesome?

Is he suicidal, dangerous, or offensive to public decency?

If so, when was the tendency last shown?

Is he liable to epilepsy with excitement?

Is he liable to recurrent attacks of mania or melancholia?

Is he labouring under progressive organic brain disease?

Is he liable to wander or escape?

Is he liable to refuse food?

Is he known to be addicted to drink?

Is he in fair bodily health?

Is he quiet at nights?

Is he a worker, if so, what?

Have relatives or others urged for his removal?

Does he go out on parole?

[1] GBCLS 27th AR (1885), p133.

APPENDIX 10

Murder committed by boarded-out patient

J.McD, a 40 year old pauper lunatic had been boarded-out for over ten years with his cousin, following his escape from Argyll District Asylum in 1891. He accompanied his cousin on fishing trips, and assisted in his work. Commissioners described him as "a powerfully built man, with a considerable amount of mental confusion, and a dour look." However, he was reported to be on friendly terms with his family and "caused no trouble whatever."

In 1903, the Board of Lunacy was informed that the patient, John, had murdered his cousin, while away on their boat. John declared that his cousin had fallen over a cliff and was killed, and that he had carried his body to the boat and covered it up with bags. However, the injuries on the victim's head were inconsistent with his version of events, and it was recognised John had killed him with a hatchet. When examined by the sheriff at Inverary, he was considered to be fully coherent and none of the legal officials regarded him as insane. Nevertheless, a plea of insanity was tendered at the Circuit Court, and he was ordered to be confined during His Majesty's Pleasure, at the lunatic department of Perth prison.

The murder was a surprise to his family, villagers, and the local doctor. Neighbours described John as a quiet inoffensive man, living "on the most friendly terms with his guardian". The mother of the victim announced that she had never heard an angry word between them and declared that "if Johnnie did it he did not know what he was doing." Commissioners too reported their surprise at the events. John had been regarded as a "good case for boarding-out", being healthy, industrious, and "so far as one can learn, freer from excitement and liability to outbursts of passion than most men of his class who are regarded as sane." Commissioners concluded that his return to the asylum in previous years would not have been warranted, and that it may in fact have been impossible to find two medical practitioners who were willing to certify him as insane. The only explanation for the murder seemed to be that the cousins must have quarrelled. The occurrence, while regretted by Commissioners, was not seen as an indictment on the system of boarding-out. As Macpherson announced:

> "I do not see, looking back, that any human foresight could have avoided this lamentable catastrophe...even if it were right and practicable to remove all persons of unsound mind to asylums it would not prevent such murders, as they take place occasionally in asylums".[1]

[1] GBCLS 45th AR(1903), p158

APPENDIX 11

RAPE OF BOARDED-OUT PATIENT

Contained within the Procurator Fiscal reports, for Tobermory, Argyll in 1869 was the trial of James McFadyn, a boatman of Tyree, 22, accused of raping Ann McPhail, a 38 year old congenital idiot. The Board of Lunacy was informed that she had delivered a still-born child. She was unable to hold a coherent conversation and suffered from both illusions and delusions. The surgeon reported that she had a strong erotic tendency "and has often expressed this desire to me". She had been boarded-out for three years. following the death of her mother. At the trial, the inspector of poor observed that he had had much contact with her, and although sharp at times, she was clearly an idiot, who was not responsible for her actions. He announced that for many years she declared that she wished to be "in the family way" and often put clothes up her dress to make her appear bulky. The inspector was told many times that she was pregnant, but did not believe her. Witnesses told how she had delusions, "imagining foolish things talking about men and sweethearts and about having children."

Evidence was given by the patient's guardian and other members of the household. The guardian's daughter, Catherine MacKinnon, speaking in Gaelic, reported that her father and brother, being sea-men, were often away. She told the court that she remembered the accused entering the house one night, when she and Ann McPhail had gone to bed. "I was suspicious that McFadyen had come for no good purpose." He had been drinking. Catherine reported that she told him "if he was not a dog he would not go near a woman like Ann", but he denied having "connection" with her. Ann, however, informed Catherine that she had been attacked, and that it had happened before. Other witnesses gave evidence declaring that they had never seen the accused with the patient. McFadyen himself announced that he was not aware whether she was a lunatic or an idiot:

> "I had no connection with her in my life and did not touch her in any way. I was quite sober...I have heard that she was saying two years ago that she was in the family way by me. She did not say so to myself but to others."

When giving her own testimony, Ann declared that the accused used to visit her day and night, usually when the house was empty. "I objected to his coming into the bed but he said he would do me no harm. In a short time however, he took hold of me and had connection with me" Speaking with surprising clarity for a certified idiot, she announced that she always resisted his attempts, and "threatened to tell." The court was informed that she was very ill during childbirth and nearly died. The Board of Lunacy ordered the inspector of poor to send her to an asylum. It was an achievement that the case was ever brought to trial however, and particularly notable that the patient was allowed to, and was able to testify. Correspondence relating to the court case was lengthy and detailed and it is disappointing that the verdict on the case is not recorded.[1]

1 TPF/1869/12 Tobermory Procurator Fiscal Reports. Island of Mull.

APPENDIX 12

BIOGRAPHIES OF LUNACY COMMISSIONERS AND MEDICAL SUPERINTENDENTS[1]

The following brief biographical details that follow are to enable the reader to identify the physicians referred to throughout the thesis and to see the links between them. Listed publications are not complete records of the author's published work, but reflect the general interests.[2]

William A. F. Browne (1805-1885)
M.D. Edinburgh University, 1826
Medical superintendent, Montrose Royal Asylum, first medical superintendent of the Crichton Royal Asylum (1839-1857)
First Commissioner in Lunacy (1857-1872)
President of Medico-Psychological Association (1866)
Keen proponent of the work of G. Combe and in the significance of phrenology
Ceased to be a Lunacy Commissioner in 1872 following the loss of his sight
Publications: *What asylums were, are and ought to be* (1835), *Cottage asylums* (1861), *Endemic degeneration* (1862), *Epileptics, their mental condition. A lecture* (1865)
Frequent contributor to Winslow's Psychological Journal.

Thomas S. Clouston (1840-1915)
M.D. Edinburgh University, 1861
Trained with Sibbald and Yellowlees, as assistant to Skae. Appointed medical superintendent of Cumberland and Westmoreland Asylum at Carlisle, aged 23 (1863)
Medical superintendent, West House, Edinburgh Royal Asylum (1873)
Appointed first lecturer in mental diseases at Edinburgh University (1879)
Important contribution to the understanding of adolescent psychoses. First person to describe Juvenile General Paralysis
Editor of Journal of Mental Science (1872-1879)
President of Medico-Psychological Association (1888)
Responsible for founding the Pathological Laboratory of the Scottish asylums (with J.B.Tuke)
Retired 1908, Knighted 1911
Publications: *An asylum or hospital home for 200 patients* (1879), *Textbook on mental disease*, *Morison lectures on the neuroses of development* (1891), *Clinical lectures on mental diseases* (1896), *The neuroses of development* (1891), *The lunacy administration of Scotland* (1893), *The hygiene of mind* (1906), *Unsoundness of mind* (1911) *Before I wed* (1913).

[1] Only the biographies of medical superintendents who are discussed at some length in the thesis are included here
[2] The information has been taken from the Medical Directory, Dictionary of National Biography, obituaries in the Journal of Mental Science, entries in the National Union Catalogue and Boyle, A. (ed) (1983) The Royal Society of Edinburgh: 100 Medical Fellows, elected 1841-1882. Scotland's Cultural Heritage. Vol. 4. Edinburgh: University of Edinburgh.

James Coxe (1811-1878)
M.D.Edinburgh University, 1835
Interest in physiology and pathology of the mind
Contemplated setting up a private asylum in Edinburgh, before being appointed to the Royal Commission to inquire into conditions for the insane (1855). Subsequent report written by him
Became a Commissioner on the creation of the Board of Lunacy. Wrote the first 15 reports
Firm advocate of boarding-out, and encouraged the promotion of improvements in provisions for the insane in private dwellings
Amendments passed to the Lunacy (Scotland) Act, 1857, in 1862 and 1866 following his recommendations
President of Medico-Psychological Association (1872)
Publications: Editor of A.Combe's *The physiology of digestion* (1849), *The principles of physiology* (1852), Revised Combe's *The constitution of man* (1860) (with R.Coxe), *A recent visit to Gheel* (1862), *Lunacy in France* (cont as Lunacy in Gheel) (1862), *On the condition of the insane in Scotland* (1863), *On the causes of insanity and the means of checking its growth* (1872), *Lunacy and its relation to the State* (1878).

Robert Cunyngham Brown
M.D. Durham University, 1898
Pathologist at Chester Asylum
Junior house surgeon then senior assistant house surgeon Huddersfield Infirmary, clinical assistant at the National Hospital for Paralytics and Epileptics, deputy medical officer HM Prison and State Criminal Lunatic Asylum, Parkhurst
Appointed Special Commissioner to the British Medical Journal in 1904 to report and study boarding-out systems, and visited colonies in France, Germany, Belgium and Holland
Gave evidence before the Royal Commission on the Care and Control of the Feeble-minded (1908)
Deputy Commissioner of the Board of Lunacy (1912-1915)
Entered Army Medical Service (1915)
Seconded to Ministry of Pensions (1918)
Deputy Director of Medical Services, Canada
Publications: *Diffuse Encephalitis* (1892), *Prof. Edinger's theory of the causation of some nervous diseases* (1897), *Boarding-out the insane in private dwellings* (1908).

John Fraser (1845-1925)
M.B. Edinburgh University, 1870 (9 medals)
Assistant Physician, Perth District Asylum, assistant physician, Fife and Kinross under J.B.Tuke, superintendent of Fife and Kinross District Asylum
Appointed Deputy Commissioner of Lunacy (1877-1894)
Became Commissioner in Lunacy (1894) on Mitchell's retirement
Senior Commissioner (1899-1910) on Sibbald's retirement
Advocated the employment of female nurses in male wards
Retained a particular interest in the boarding-out system
Publications: *On the disadvantages of boarding-out certain harmless lunatics and on the advantages of open-doors in asylums* (1878).

James Howden (1830-1897)
M.D. Edinburgh University, 1852
Assistant medical officer of Edinburgh Royal Asylum, under Skae, superintendent of Montrose Royal Asylum, 1857-1897
Active antiquarian Vice President of Montrose Natural History and Antiquarian Society
Instituted a Register of Pathological Lesions (1861) Published subsequently
Instituted a detailed record of meteorological observations (1865) for over ten years attempting to relate rainfall, wind direction and temperature to outbreaks of various diseases and to the incidence of epileptic seizures in the asylum
Publications:*Analysis of post-mortem appearances in 233 insane persons* (1871), *The religious sentiment in epileptics* (1873), *On the treatment of insanity* (1888), *Description of the new hospital at the Montrose Royal lunatic asylum* (1889)

John Keay
M.D. Glasgow University, 1888
Medical superintendent, Mavisbank Private Asylum, senior assistant physician, Crichton Royal Asylum, assistant medical officer, Woodilee District Asylum, house surgeon and house physician, Glasgow Royal Infirmary, medical superintendent, Inverness District Asylum
Publications: *Case of insanity in adolescence* (1888), *Case of delusional insanity* (1891), *Chloroform in mental disease* (1893).

Robert Lawson (1815-1894)
M.B.Edinburgh University, 1871 M.D.1888
Medical superintendent, Wanford House Asylum, Exeter, assistant to professor of practical medicine and medical psychology, Edinburgh 1871-1872, pathologist and assistant medical officer, West Riding Asylum (1874)
Deputy Commissioner for 18 years (1878-1894)
Publications: *Notes on asylums* (1875), *Symptomatology of alcoholic brain disease* (1878), *Traumatic epilepsy* (1876), *Epilepsy of Othello* (1880).

William L. Lindsay (1829-1880)
M.D. Edinburgh University, 1852, FRSE 1861
Assistant physician, Cholera Hospital, Edinburgh, assistant physician, Crichton Royal Asylum (1853), medical superintendent, Murray Royal Asylum (1854-1879)
Encouraged the widespread adoption of boarding-out from asylums Reactionary attitude towards the non-restraint system which he called "Conollyism"
Produced a new classification of insanity
Wrote articles on toxicology. Special interest in comparative psychology and the mental development of lower animals. Keen botanist
Retired 1879
Publications: *On insanity and lunatic asylums in Norway* (1858), *The family system as applied to the treatment of the chronic insane* (1871) *Insanity in the lower animals* (1871), *The physiology and pathology of the mind in lower animals* (1871), *The theory and practice of non-restraint in the treatment of the insane* (1878), *General History of the Royal Murray Institution in Perth* (1878)

Charles Macpherson
M.D. Glasgow University, 1888
Deputy Commissioner in Lunacy (1896-1919)
Publications: *Boarding-out of pauper lunatics* (1903)

John Macpherson
M.D.Edinburgh University, 1896
Senior assistant physician, Edinburgh Royal Asylum, house surgeon, Northern Infirmary, Inverness, medical superintendent, Stirling District Asylum
Lecturer on mental diseases at the Royal School of Medicine, Edinburgh
Deputy Commissioner (1900-1909)
President of Medico-Psychological Association (1910)
Publications: *Mental affection* (1899), *The hospital treatment of the insane in asylums* (1896), *The administration by parish councils of their powers and duties under the Mental Deficiency and Lunacy Amendment Act, 1913* (1913).

Hamilton C. Marr
M.D. Glasgow University, 1895
Junior assistant at Woodilee Asylum, then Crichton Royal Asylum, senior assistant Woodilee Asylum, senior assistant Crichton Royal Asylum, medical superintendent, Woodilee Asylum (1901)
Deputy Commissioner, 1910
MacIntosh lecturer, Psychological medicine, St Mungo's Glasgow
Secretary for Scottish Medico-Psychological Association
President of Medico-Psychological Association (1927)
Publications: *Case of general paralysis of the insane occurring early in life* (1899), *Five years experience of a reception house for recent cases of insanity* (1908), *Lunacy in Scotland* (1896), *Hypochondria and illegitimacy, in Encyclopaedia of religion and ethics* (1913), *Feeble-minded and backward children* (1913).

Arthur Mitchell (1826-1909)
M.D. Aberdeen University, 1848
Deputy Commissioner in Lunacy (1857-1870)
Morison lecturer on mental diseases (1861-1871)
Commissioner in Lunacy (1870-1875)
Member of the Commission on Criminal Lunacy, England (1880)
Member of Departmental Committee on criminal lunacy in Ireland (1885)
Chairman of the Commission on Lunacy, Ireland (1888-1891)
Secretary and Fellow of Society of Antiquaries, Scotland
Knighted (1887)
Publications: *On various superstitions in the North West Highlands and Islands of Scotland, especially in relation to lunacy* (1862), *The insane in private dwellings* (1864), *The care and treatment of the insane poor, with special reference to the insane in private dwellings* (1868), *The insane poor in private dwellings in Massachusetts* (1897).

Landel.R.Oswald

M.B.Glasgow University, 1888
Trained under Yellowlees
Appointed medical superintendent of the newly built Glasgow District Asylum, Gartloch; medical superintendent at Gartnavel Royal Asylum
Lecturer in Mental Diseases at Glasgow University (1901)
Established a Department of Mental and Nervous Disease in the Western Infirmary Glasgow (1908) and the first psychiatric out-patient department in Scotland at the Western Infirmary (1910)
Largely responsible for establishing the Western Asylums Pathological Laboratory in the grounds of Gartnavel
Retired 1921
Publications:*Haematoporphyrinuria following the administration of sulphonal* (1895).

George Paterson

M.D.Edinburgh University, 1833 FRCP 1837
Fellow and Secretary to the Royal College of Physicians, Edinburgh
Senior physician and lecturer on clinical medicine, Royal Infirmary, Edinburgh
Surgeon to the railways
Deputy Commissioner (1862-1877).

Alexander Robertson (1833-1908)

M.D. Glasgow University, 1855
House surgeon, then physician, Glasgow Royal Infirmary, consultant physician Glasgow District Lunatic Asylum, assistant physician then Director, Gartnavel Royal Asylum; assistant physician, Glasgow Old Men and Women Homes
Professor of medicine, St Mungo's College Glasgow (1889)
President of the Pathological and Clinical Society, Glasgow
Publications: *Notes of a visit to American asylums* (1869), *On boarding the insane in licensed private houses* (1870), *On the unilateral phenomena of mental and nervous disorders* (1875), *On insanity* (1881), *Percussion of the skull* (1881).

George M. Robertson (1864-1932)

M.B.Edinburgh University, 1885
Worked in pathology laboratories of Edinburgh University, assistant to Clouston at Edinburgh Royal, medical superintendent Perth District Asylum (1892), Stirling District Asylum (1899) and Edinburgh Royal Asylum (1908) succeeding Clouston, resident physician Edinburgh Royal Infirmary
Active in improving status of the mental nurse
Established psychiatric out-patient departments at the Royal Infirmary and Jordanburn Hospitals and a Psychiatric Clinic for children
Established a number of nursing homes, and Jordanburn Hospital for enfeebled male patients isolated from main hospital
Interest in hypnotism, disciple of Freud
Lecturer on mental diseases (1908-1909)
Instituted a post graduate course for the Diploma of Psychiatry (1912)
First Chair of Psychiatry, Edinburgh (1913)
President of Medico-Psychological Association (1922)
President of Royal College of Physicians (1925-1927)

Publications: *Hypnotism at Paris and Nancy* (1892), *The treatment of acute, delirious insanity* (1893), *Sanity or insanity* (1895), *Employment of female nurses in the care of insane men in asylums* (1902), *The hospitalisation of the Scottish asylum system, Presidential Address* (1922), *Psychotherapeutics* (1922).

James Rutherford (1840-1910)
M.D. Edinburgh University, 1863
Studied pathology and mental diseases in Vienna and Berlin (1863)
Locum tenens Murray Royal Asylum, 1863,
Resident house physician, Edinburgh Royal Infirmary (1864), general practice in Linlithgowshire (1865), assistant medical officer, Winson Green Asylum, Birmingham (1867), assistant medical officer, Montrose Royal Asylum, clinical assistant, West Riding Asylum, Wakefield, medical superintendent, Argyll and Bute, Woodilee and Crichton Royal Asylums (1870-1884)
Attended Edinburgh, Berlin and Vienna Universities. Honorary member of Medico-Psychological Associations in France, Belgium, Italy and America
Advocated outdoor employment and development of the open-door and parole methods
Publications:Trans and ed Griesinger's *Manual of mental diseases* (1867).

John Sibbald (1833-1905)
M.D. Edinburgh University, 1854
Short period in private practice, then assistant physician under Skae at Edinburgh Royal Asylum, medical superintendent at Argyll and Bute District Asylum (1862-1870)
Colleagues of Clouston and Yellowlees
Enthusiastic supporter of the boarding-out system and the cottage system of asylum construction
President of Royal Medical Society, Edinburgh 1855-1856
Editor of Journal of Mental Science (1871-1872)
Deputy Commissioner in Lunacy (1870-1878)
Commissioner in Lunacy (1878-1899)
Abolished use of airing courts at Argyll and Bute District Asylum
Knighted 1899
Publications: *The cottage system and Gheel* (1861), *Clinical instruction in insanity* (1871), *Insanity in its public aspect* Three of the Morison lectures for 1877 (1878), *Lunacy administration in Berlin and in Scotland* (1895) *Gheel and Lierneux, the asylum colonies for the insane in Belgium* (1897), *On the plans of modern asylums for the insane poor* (1897), *The relief of the poor in Edinburgh* (1904).

John F.Sutherland (1854-1911)
M.D.Edinburgh University, 1880
Deputy Commissioner 1895-1911
Keen general interest in the boarding-out system
Resident Physician to British Hospital in Paris, also medical officer to H.M.Prison, Glasgow and Barlinnie
Member and Secretary to the Commission on habitual offenders
Publications: *The insane poor in private dwellings* (1897), *The insanity of inebriety from the legislative and medico-legal standpoint* (1898), *The jurisprudence of intoxication* (1898), *Geographical distribution of lunacy in Scotland* (1901), *Recidivism* (1908).

John B.Tuke (1835-1913)
M.D. Edinburgh University, 1856
Surgeon to colonial forces, New Zealand (1856)
Senior medical officer in Maori War (1860-1863)
Assistant physician, Edinburgh Royal Asylum, under Skae, first medical superintendent Fife and Kinross District Asylum, (1866-1873) Private practice in Edinburgh, visiting physician to Saughton Hall Private Asylum (1873)
Lecturer in mental diseases (commenced 1874)
Helped found Pathological Club of the Scottish asylums, Edinburgh (with Clouston)
Knighted (1898)
MP for Edinburgh and St Andrews University from 1900
Publications: *On the morbid appearances met with in the brain of 30 insane persons* (1869), *The cottage system of the management of lunatics as practised in Scotland, with suggestions for its elaboration and improvement* (1870), *Lunatics as patients, not prisoners* (1889), *Insanity of Pregnancy, puerperal insanity and insanity of lactation* (1865), *The insanity of over-exertion of the brain* Morison Lectures (1894).

Adam Turnbull (1853-1916)
M.D. Edinburgh University, 1875
Resident physician, Edinburgh Royal Infirmary (1876), assistant physician, Edinburgh Royal Asylum, under Clouston (1876) medical superintendent, Fife and Kinross District Asylum (1881-1916)
Secretary to Scottish division of Medico-Psychological Association (1869-1872)
Keen advocate of the developing hospital features in asylums, the training of nurses and the extension of the boarding-out system
Publications: *The attitude of the medical profession in regard to lunacy legislation* (1885), *Some remarks on boarding-out as a mode of provision for pauper insane* (1888), *Female nursing in asylum sickrooms* (1896), *The mode of provision for the chronic pauper insane* (1896).

Alexander R.Urquhart (1852-1917)
M.D. Aberdeen University, 1877
Medical superintendent at: Hatton Asylum, Warwick, Perth District Asylum and Ticehurst Asylum, Murray Royal Asylum (1879-1913)
Hospital wings were built at Murray Royal Asylum under his superintendence
Encouraged musical and theatrical performances among patients and staff, advocated structural improvements in asylums, and added recreation hall, a new chapel and 2 new villas to the Murray Royal Asylum
Honorary member of Psychological Societies in France, America, Italy and Belgium
Recognised as an authority on the Lunacy Laws of Scotland
Joint editor of Journal of Mental Science
Helped compile the first edition of the handbook for attendants on the insane
President of Faculty of Physicians and Surgeons, Glasgow (1892-1894)
President of the Medico-Psychological Association (1898)
President of the Psychiatric Section of the British Medical Association (1905)
Morison Lecturer to the Royal College of Physicians of Edinburgh (1907)
Played a prominent part in the movement for improving the status of the mental nurse
Publications: *On Egyptian asylums* (1879), *Three Australian asylums* (1880), *Microcepahlic idiocy* (1880), *Descriptions of new hospital wings at Murray Royal Asylum*

(1890), *Insanity* (1909), *Lunacy administration in Scotland, with special reference to the Royal Asylums* (1910)
Published articles in Germany and Spain.

David Yellowlees (1835-1921)
M.D. Edinburgh University, 1857
Trained by Skae at Edinburgh Royal Asylum, assistant physician then superintendent, Glamorgan County Asylum (1863-1875) resident surgeon and resident physician Edinburgh Royal Infirmary, medical superintendent, Gartnavel Royal Asylum, (1874-1901), became Honorary Consultant Physician, Gartnavel Royal
Licentiate of Royal College of Surgeons Edinburgh, Fellow of Faculty of Physicians and Surgeons of Glasgow
Morison Lectures (1879)
First lecturer in Mental Diseases in the University of Glasgow (1880)
President of Medico-Psychological Association (1890)
On the Directing Board for the Association for the Relief of the Incurable, the Bramhill Home for Incurables and the Lanfine Home for Consumptives
Helped establish the Glasgow Association for the Care of Defective and Feeble-minded Children
Retired 1901, due to failing eyesight
Publications: *Homicidal mania: a biography* (1862), *Insanity and intemperance* (1874), *On the criminal responsibility of the insane* (1874), *Presidential Address* (1890).

APPENDIX 13

REGULATIONS FOR INSPECTORS OF POOR[1]

1. Procedure for placing pauper lunatics in private dwellings under sanction of the Board and conditions of sanction

i. Pauper lunatics who do not require asylum treatment may, on becoming chargeable, remain in private dwellings under suitable guardianship, with the sanction of the Board, which is granted on the application of the inspector of poor, accompanied by two medical certificates.

ii. Alternatively, they may be removed from establishments for the insane and be placed under suitable guardianship in private dwellings. When the patient remains a pauper, application for the Board's sanction must be made after the patient has been discharged and need not be accompanied by any medical certificate unless such be specially called for.

iii. Pauper lunatics sanctioned by the Board to live in private dwellings must be comfortably housed, sufficiently fed and clothed and otherwise suitably provided for. They must be placed under the charge of properly remunerated, efficient and trustworthy guardians, whose duty it shall be to carry out carefully the Board's directions.

iv. Every pauper lunatic whose residence in any private dwelling has been sanctioned by the Board, must be visited within three weeks after such sanction has been granted, and at least once every three months thereafter, by a medical man appointed to perform that duty by the parish council of the parish to which the lunatic is chargeable, unless the Board shall on special application by the inspector of poor, otherwise regulate such visits.

v. The medical officer shall at every such visit enter in the visiting book for pauper patients in private dwellings which shall be kept in the house in which the lunatic resides, a report of the mental and bodily condition in which he found the lunatic, with any suggestions or recommendations for improving the condition of the patient which he may think desirable.

[1]GBCLS 22nd AR (1880), p156, and 15th AR (1873), p303.

vi. Any medical person who shall make any such entry without having visited the patient within seven days previous to such entry is liable to a penalty not exceeding ten pounds for every such offence.

vii. Suggestions or recommendations for improving the patient's condition recorded by the medical officer shall be at once reported by him to the inspector of poor of the parish to which the lunatic is chargeable, who shall either see that they receive immediate effect, or shall report to the Board his reasons for not carrying them out.

viii. It shall be the duty of the inspector of poor of the parish to which an out-door lunatic is chargeable to visit the patient at least twice a year, and to record the visit on its proper page in the book in which the medical officer's visits are recorded; and in the event of the lunatic residing beyond the parish to which he is chargeable, it shall be the duty of the inspector of poor of the parish of chargeability to assure himself that these visits are regularly made and recorded.

ix. If a pauper lunatic whose residence in a private dwelling has been sanctioned by the Board, is regarded by them for any reason as having become unfit for residence in a private dwelling, or if any of the conditions as to accommodation, guardianship, treatment or visitation is not observed, the Board may withdraw their sanction and require the patient's removal to an asylum, and any pauper lunatic who has been removed from an asylum and boarded out shall be sent back to it within fourteen days after the inspector of poor receives the order of the Board to that affect.

x. No pauper lunatic residing in any private dwelling shall be removed from the poor roll unless by Minute of the parish council or of a duly authorised committee thereof, and unless sufficient evidence be produced to the parish council or its committee that his care and treatment will be provided for in a manner in which they regard as satisfactory. When a pauper lunatic who has been removed from an asylum is ordered by the Board to be sent back, the patient's relatives cannot remove his name from the poor roll without the Board's sanction.

xi. When a pauper lunatic in a private dwelling ceases to be chargeable as an outdoor patient by recovery, death, removal from the poor roll or removal to an asylum or other establishment for lunatics or is removed to another house or placed under another guardian, or when escape or other serious occurrence happens, or when the alimentary allowance is increased or reduced, intimation thereof must be given to the Board within fourteen days.
In making intimation of such occurrences the following requirements should be kept in view:
1. Notice of recovery must be accompanied by a medical certificate of sanity

2. Notice of death must be accompanied by a statement of the cause of death.

3: Notice of removal from the poor roll must be accompanied by a copy of a Minute stating the reason for such removal.

4. Notice of removal to an establishment for lunatics should be given by a letter stating briefly the reason which made removal from private care necessary.

5. Notice of removal from one private dwelling to another, or from one guardian to another should be accompanied by a short statement of the cause which has made the change desirable.

6. Escapes, serious accidents and other matters gravely affecting the well being of patients should be reported to the Board by the inspector of poor by a letter giving particulars.

7. Changes of allowance should be reported by letter stating briefly the reason of the alteration.

8.A separate notice must be sent in the case of each patient.

2. Private patients in private dwellings

A person of unsound mind, living with relatives or others who receive no remuneration for the patient's maintenance may reside in a private dwelling without an order of the sheriff or the sanction of the Board.

If the patient's mental derangement has endured for a period of one year, and is of such a nature as to require compulsory confinement to the house, or restraint or coercion of any kind, the occupier of the house shall report the facts to the Board, and shall state the reasons which render it desirable that the patient should remain under private care.

3. Temporary residence of patients in private dwellings

A person suffering from incipient or transitory mental disorder may be temporarily received and kept for profit in any private dwelling, without an order of the sheriff or sanction of the Board. This can not exceed six months, and the occupier must be authorised to receive the patient under a certificate granted.

4. Permanent residence of insane persons

Authority for the reception and permanent residence in a private dwelling of a person of unsound mind to whom the provisions of 1 and 2 are inapplicable, who is maintained out of private funds, and for whose maintenance or care the occupier of the house is remunerated, shall be obtained by application to the Board of Lunacy. Such application is unnecessary if the patient has been received into the house on a sheriff's order; but the fact that such order has been obtained must be intimated to the Board.

Notice of the reception, removal or death of every patient authorised by the Board or sheriff to reside in a private dwelling, must be given to the Board by the occupier of the house within three days of its occurrence; and in case of removal, the patient's mental condition at the time of leaving, and the place to which he has been removed shall be specified.

Every such patient shall be visited as often as the Board may require by a medical man, who shall enter a record of his visit in a visiting book which is supplied by the Board free of charge. The patient will further be visited and reported on by an officer of the Board at such times as they may direct.

Not more than one insane person can be legally received into any private dwelling unless the occupier hold a Special License.

5. Regulations by General Board of Lunacy under which special licenses for the reception of not more than four pauper lunatics are granted.

License is granted free of charge under the following conditions:

1 The application for the license is to be made by the occupier of the house and must be signed by the inspector of poor of the parish to which the pauper lunatics to be accommodated are chargeable, and no pauper lunatic chargeable to any other parish shall be placed in a specially licensed private dwelling without the consent of the inspector on whose application the license was granted which consent shall be intimated to the Board.

2. Not more than four pauper lunatics can be legally received into any specially licensed private dwelling, but the Board will not grant a special license for the reception of more than two pauper lunatics into any such house except on the recommendation of a Commissioner or Deputy Commissioner.

3. Each specially licensed private dwelling shall receive patients of one sex only, unless the Board shall in special circumstances sanction otherwise. A separate bed shall be available for every patient and no patient above 12 years of age shall occupy a bedroom with an adult of the opposite sex.

4. The occupier of every specially licensed private dwelling shall inform the Visiting Commissioner, medical officer and inspector of poor at their visits of all lodgers who are living in the house, or who have been received into it since the previous visit. No lodger of the opposite sex from the patients, if above 14 years of age, shall be received into any specially licensed private dwelling.

5. An inspector of poor, before removing a patient to a specially licensed house shall assure himself that he is not by doing so infringing any of the special conditions of license as to the number and sex of patients and that he is not encroaching upon the right in the house of any other inspector. In other respects the procedure for removing patients to such houses and for obtaining

the Board's sanction does not differ from that to be followed in providing for single patients in private dwellings singly.

6. All regulations are equally applicable to those private dwellings which are specially licensed.

7. In all cases in which an inspector of poor has made provision for a pauper lunatic chargeable to his parish, in a specially licensed private dwelling not situated within such parish or within the statutory distance from it, he shall, if he does not himself undertake the duty of visitation, at once provide for his being regularly visited by the inspector of poor of the parish in which the pauper lunatic has been placed.

8. The Board would at the same time strongly urge upon inspectors of poor the propriety of themselves visiting periodically all lunatics chargeable to their parishes who may be boarded out in specially licensed private dwellings, wherever such houses may be situated in order to satisfy themselves of the efficiency of the guardianship and of the continued fitness of the lunatic for residence in such a house; the date and particulars of such visits as well as of the visits paid by the local inspector should be duly recorded in the visiting book provided for the purpose. in all cases where a number of specially licensed private dwellings are situated in the same locality, the board will consider it necessary to insist upon periodical visits by the inspector of poor of the parish of settlement, and they would in such cases also strongly recommend visitation by a committee of the parish council.

9. Special licenses may be cancelled at any time, for any reason which the Board shall deem sufficient.

APPENDIX 14

BOARDING-OUT PATIENTS IN MASSACHUSETTS

Remarks offered by Lunacy Commissioner Mitchell on the 18th Report of the State Board of Lunacy and Charity, 1897.[1]

In 1886, 34 patients were boarded-out in Massachusetts. This rose to 175 in 1892, before declining to 129 in 1896. In making the following remarks, Mitchell observed that in his opinion, there was a general misunderstanding of the real purpose of the boarding-out system, and that some difficulties had been created unnecessarily and greatly magnified. To him, the experiment was never on anything more than "a quite insignificant scale." Responding directly to observations made by the State Board, he therefore put forward his view of the system, its advantages, potential drawbacks, and made specific recommendations. The concise and informative nature of his report has led to a decision to quote his words verbatim. The remarks made by the State Board are in bold.

i.Mental and Bodily Condition

1.persons of the quiet and chronic class.
2.chronic cases of good physical health and quiet tidy habits.
3.entirely tractable.
4.simply requiring to be comfortably clothed, housed and fed.

In Scotland, patients are certified to be 1. incurable, 2. harmless and 3. not in need of such special nursing as cannot easily be found out of institutions. This is regarded as enough. As a permanent provision is contemplated, incurability is assumed to be a feature of the patient's condition... Transferences from asylum to private care, made to complete or confirm convalescence, are not regarded as a mode of providing for the insane, but as a means of treatment; they are temporary, and called Liberations on Probation.

ii. Advantages

1.The patient enjoys home comforts and pleasures and a measurable return to his former habits of life.
2.The flickering remnants of mental activity are stimulated by the presence of old familiar habits, and the patient is happier than in the hospital.

This accords exactly with 40 years Scottish experience. If it is true of any single patient that his happiness and enjoyment can be thus increased, the State has no right to deprive him of that blessing, even if it cost a little more, instead of a good deal less. Admittedly some lunatics do enjoy life more out of asylums than in them, in their old familiar roughish environments than in the great formal day-rooms and dormitories of a public institution, with the irksome discipline and methods which exist there. If there are, as is admitted, some patients who can be thus benefited, it becomes a duty to ascertain how many there are, and to ask ourselves whether long connection with asylums does not tend to make us

[1] Mitchell, A. (1897) The Insane Poor in Private Dwellings in Massachusetts. *Boston Medical and Surgical Journal*, 137, 457-460.

bad judges of what patients among the incurable could with advantage live under private care in natural non-institutional surroundings.

iii. Character of families in which patients should be placed and asylum training of guardians

1.In families without young children, and one or both of whose heads have had hospital training.

2. In families in which enough of the hospital system appears to help ordinary family government.

In the experience of Scotland the presence of young children in the homes of the guardians is often a decided advantage to the patients. It is a common experience to find a boarded-out lunatic an excellent and trustworthy nurse.

Asylum-trained guardians do not ordinarily prove so satisfactory as persons who have had no special training, but who have shown good common sense and kind-heartedness in their relations to their children, relatives and neighbours. There is nothing which is so much disliked in Scotland as the appearance in the homes of the boarded-out of any trace of asylum methods of management. Every effort is made to render the life of such patients a true home and family life- the patients being as nearly as possible members of the family in which they live. This is generally found to be quite possible; and the patients share the interests, the pleasures, and the sorrows of their guardians.

iv. Difficulty in securing without delay in case of illness the care which can be at once obtained in asylums

There is a difficulty of securing in case of illness the same care that can be obtained without the slightest delay in the hospital.

It is difficult to believe this is seriously advanced as an obstacle in the way of boarding-out suitable cases.

The care referred to is evidently medical care. The guardians may fall ill as well as the boarders, and there would be no greater difficulty in obtaining the attention of a medical man in one event than the other. It is no hardship that the patients and guardians should be on an equality in this matter. A residence would not, of course be chosen because it was far from a doctor...but in a general sense there is nothing in the condition of suitable patients to prevent their living in the circumstances in which people of their class usually live.

v. Risk of guardians doing their work for the sake of gain

1. There is a risk that persons will take patients for the sake of gain.

2. In agreeing to receive boarders the motive of personal gain necessarily exists to some extent.

No-one could expect that persons would receive insane boarders into their families without the hope of some advantage from doing so. Indeed they ought not to so without that hope. They ought to be sufficiently remunerated. Proper payment tends to secure good work in this as in other things. It is not a work of charity, though kindliness should appear in it, and be required. The word *gain* has associations which give it an unpleasant ring, but the motive of gain or advantage is quite a proper motive, and in good administration there is no difficulty in preventing abuses and excessive gains.

vi. Risks to the young persons from association with the insane

1. The companionship of a person afflicted with insanity is extremely unsuitable for young and unformed minds, and is sometimes even attended with dangerous results.

2. The influence on children is far from good.

No evidence of such injurious influence has presented itself in Scotland. It must be remembered that the insane who are under private care, are believed to be incurable and harmless, and are often feeble in body as well as mind.. They are objects of sympathy, and the young, as well as the old, are led to treat them with kindness and consideration. There is an educational advantage to the young from having two or three imbeciles boarded in a village, in whose well-being the State shows an active and kindly interest...so far as the experience of 40 years work in Scotland goes, there is no evidence of any injury to the young.

vii. The risk of overworking patients

1.There is a danger that too much work may be imposed on them.

2. There is a risk of the imposition of tasks too severe for strength.

Of course such a danger must exist. The risk however is not great. And it will not be difficult under a good administration to make arrangements which will render the risk exceedingly small. The existence of this, as of any other risk, ought not to be ignored, but nor will it be found to be of such magnitude as to constitute any obstacle to the development of the system of boarding-out... either in New England or Old Scotland.

viii. Patients in families lose the amusements of patients in asylums

Patients in families are necessarily deprived of almost all the advantages of social life, the amusements and entertainments which form so large a feature of ordinary hospital routine.

The dances, theatrical performances, concerts and games of asylum life become proper, or rather necessary, as a relief to the dull monotony and *routine* of that life, and are needed for patients, officers and attendants alike. But going back to family life is a going back to true social pleasures and enjoyments. These are longed for by asylum inmates... No sane person would exchange them for asylum dances and concerts. The thousand and one familiar things constantly going on around patients in families constitute a far greater source of enjoyment than the scenic and got-up entertainments of asylums, and fill their lives with truer delights... It has been abundantly proved that it is possible to give patients a life closely approaching to real family life and the happiness of many of the insane poor has in that way been much increased.

ix. Private care best suited for convalescents

1. Care in private dwellings seems to apply most happily to those who are on the road to recovery; they are convalescent homes for them.

2. Convalescent cases receive the most benefit under private care, for them the system is best suited.

There is a complete misunderstanding here of what is properly enough called the *system* of boarding-out. It is a method of providing for the care of the incurable and harmless, and it concerns itself with arrangements and conditions which are expected to be lasting. Of course, recoveries are often hastened and confirmed by removing patients, who are improving, from asylums to care in their own homes or in the homes of persons unrelated to them, and every good Lunacy Law should make it easy to liberate patients on probation for some definite period with this good end in view.

But it is an altogether different feature of the lunacy administration of a country which proposes to provide for a considerable number of harmless, incurable lunatics in private dwellings, instead of leaving them in asylums.
The number of pauper lunatics in Scotland satisfactorily provided for in private dwellings is 23%. Scotland is nearly twice as populous as Massachusetts and the proportion of the insane to the population is nearly the same.
...It seems proper to ask whether convalescent insane patients are more fit than others to be exposed to the risks of being under the care of persons without hospital training, of being without the means instantly of having a doctor, of being kept for gain, of being overworked, etc.

x. Strain on guardians of attendance on patients

1. The guardians may tire of the strain which this constant and unremitting attendance occasions.
2. They can never leave home together without first securing some reliable neighbour to take charge in their absence.
If suitable patients are selected...there will not be any such "constant and unremitting attendance" as to cause any strain which will be a subject of complaint...The presence of an insane member in a family will no doubt sometimes, perhaps often, make it as difficult for both guardians to leave home as if there were young children in the family. But it will not be more difficult [than with children].

xi. Women shrink from association with persons of impaired intellect

Most women shrink from near association with persons of impaired intellect.
This is a very surprising statement. It is not true of the women in Scotland They are as capable and fearless as they are kind, in nursing persons of impaired intellect. They often devote themselves most lovingly and intelligently to the care of a helpless imbecile or dement.
It is not easy to believe that what is said here of Scottish women could not be said with as much truth of the women of Massachusetts.

xii. The demand for boarders exceeds the supply

It is a significant fact that the demand for insane boarders invariably exceeds the supply.
This is a most important statement, and shows the possibility of making care in private dwellings a part of any whole scheme for providing for the insane poor, if well directed efforts are earnestly and continuously made. This of course assumes that the proportion of incurable and harmless patients in the whole body of insane poor does not differ radically from that in Scotland, and there is nothing to show that any such difference exists.

xiii. Boarding-out is objectionable as leading to the removal from asylums of useful and profitable workers

1. The boarded-out are those easiest to care for in the hospital.
2. The number of paid employees in our hospitals is so small that much of the work must be done by patients with the result not only of a considerable saving to the State, but of being a wise adjunct to the treatment of patients. Thus the greatest number eligible for boarding-out are either quiet patients, doing no work, and requiring the minimum of hospital care, or else chronic cases, helpful to themselves and others, whose departure reduces the working force of the hospital.

This view of the question is full of error. It ignores the obligation of the State to do for the insane poor what is best for them, and to make their life as happy as possible. As regards a certain number of them, it may safely be said that every person, having special experience in the care of the insane, holds that they are happier out of, than in asylums. All physicians, act on that view and so do all laymen. Every insane person is not sent to an asylum. Only those are sent who, in addition to being insane, require care and treatment in institutions. It is recognised that it would not be right to subject some insane persons to the loss of liberty and irksome discipline which asylum life necessarily involves...it is also clearly wrong to detain persons in asylums who after residence there have passed into corresponding states of insanity. ...They ought not to be kept in asylums when they have ceased to need such provision, and when they can be provided for otherwise in a way which adds to their happiness. This should be a guiding view in State lunacy administration, even if the other way of providing for such persons led to some increase of cost. But it so happens that it diminishes cost and leads to saving.

It is not easy to believe that any one would seriously hold that it was right to keep persons in asylums because they worked well and profitably... This would be almost equivalent to holding that it would be proper to detain patients unnecessarily in asylums for gain to the asylum authorities, that is for gain to the State.

But it is desirable to point out that the removal of quiet patients who are good workers and are able to help themselves and others, has not the effects which it here alleged to have. This has been abundantly proved. When such patients are removed it is found that other patients can be induced to work. The set of good workers being sufficient, no serious effort is made to lead non-workers to become workers. They are not wanted, and a refusal to work is too easily accepted as a thing that cannot be got over. In this way the removal of the incurable and harmless does good to those who are left and tends to increase the number of recoveries.

xiv. Overseers of the poor hinder the growth of the system

1. Before removing patients to private care the consent of the overseers of the poor must first be obtained and they prefer to care for them in their own almshouses. This is a serious obstacle to the success of the system.

2. During the year ending March 1896, 86 persons were discharged to the overseers of poor, most of whom were eligible for boarding in families.

3. Were small towns forbidden by law to make their almshouses receptacles for the insane, the number of those boarded-out would be largely increased.

All this points to the necessity of fresh legislation.

1 All the insane poor, *however provided for*, should be as much under the care of the State as those who are in asylums.

2 No almshouse should be allowed to receive insane inmates, which is not licensed to do so by some State authority.

These remarks offer detailed insight into the system of boarding-out as perceived by one of its pioneers in Scotland. While inevitably placing much stress on the positive aspects of the system, the observations made are both informative, and interesting, and help contribute to an understanding of the comparative lack of success in boarding-out the insane in Massachusetts.

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