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FROM “PAUPER LUNATICS” TO “RATE-AIDED PATIENTS”:
REMOVING THE STIGMA OF MENTAL HEALTH CARE?
1888-1938

ALICE BRUMBY

A thesis submitted to the University of Huddersfield
in partial fulfilment of the requirements for the degree of
Doctor of Philosophy

March 2015

Abstract

Though the debate surrounding the extent to which pessimism dominated in the late nineteenth century asylum is extensive, the same debate in the twentieth century remains under-explored. Relatively few academics have offered a cross-century analysis that goes beyond the beginning of the First World War to analyse the twentieth century and none of these studies have explored how changes were implemented in the institutions in the West Riding of Yorkshire. This thesis attempts to redress this imbalance by offering an original analysis of a selection of developments and innovations that were carried out in the West Riding of Yorkshire between the years 1888-1938. Consideration is given to four specific innovations and an analysis is made of how successful these new developments were with relation to the eradication of the stigmas of pauperism and certification. Innovations relating to how to segregate mentally deficient children and adults and service patients will be assessed, along with the establishment of outpatient departments and the local implementation of the 1930 Mental Treatment Act. By offering an analysis of these developments this thesis contributes to our understanding of how successful these social and legal changes were in the administration of mental health care throughout these years.

Primarily this thesis is concerned with an analysis of these different innovations and an observation of the impact that these attempts at change had on the patients. Wherever possible close attention is given to the voices of the patients and their families in order to assess their roles in accessing the services provided. This thesis argues that these innovations represent significant legal and social changes in the administration and admission of the mentally ill over the years covered. Despite this however, this thesis identifies that these changes were all beset with many inherent problems, usually linked to a lack of finance and overcrowded institutions, which meant that they were all *significantly limited* in their capacity to change the system for all but a small minority of sufferers of mental illness and learning disability.

Acknowledgments

First and foremost I would like to thank *all* of the staff at the University of Huddersfield who have contributed to my education, and looked after me for the past eight years, since arriving as a very enthusiastic, and slightly naïve eighteen-year-old undergraduate. Thanks go especially to members of the History Department, to Dr Rebecca Gill and Professor Barry Doyle, for all their help, kind support, and words of encouragement. My biggest thanks go to Dr Rob Ellis, without whom this project would never have happened. From finding the funding, to cajoling me into actually finishing this thesis, his endless support, untiring commitment, infinite patience, sarcastic remarks, and ability to see the humorous and optimistic side in everything has made this thesis happen. Thank you.

Of course my thanks also go to the AHRC, for funding this project. To Delphi Tatarus and Joanne Bartholomew and all the staff at the Thackray Medical Museum that I worked with for the CDA. Thanks also go to the lovely people at the WYAS, who helped me to negotiate my way around the archives, and who never failed to offer their support and help.

Lastly my love and gratitude to my family and friends, too many to mention by name, for putting up with me for so many years and offering so much encouragement. My thanks especially to my University Girlies, Liz, Jo and Emma, for going through the journey with me, and to my good friend Emma Richards, who has proof-read this whole thesis. Finally my love and thanks to David, who has never ceased to believe in me and support me.

Without all this help, there would be no thesis.

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Notes on Semantics

Throughout this thesis attempts have been made to utilise the vocabulary that was used at the time. This has been problematized by the many changes in terminology during the years. Throughout the period 1888-1938 there were a number of key changes in semantics and many names of regulatory bodies changed. As such care has been taken to use the correct phraseology of the time period discussed. This means in some chapters both 'lunatic asylum' and 'mental hospital' are utilised side by side, for instance when discussing out-patient departments from the years 1890-1938.

List of Key Changes:

Previous name	New name	When did it happen
The Commissioners in Lunacy	The Board of Control ¹	1913 Mental Deficiency Act
West Riding Asylums Board	West Riding Mental Hospitals Board	1923/1924
Pauper Lunatic Asylums	Mental Hospitals	In Law 1930, Regionally 1923/1924
Pauper Lunatics	Rate-aided patients	In Law 1930, Regionally 1923/1924

Other Phrases Used:

Terms such as lunatic, mental deficiency, idiocy, imbecility and feeble-mindedness have been used to reflect nomenclature of the day. All of the terms above have been used in this thesis without inverted commas.

Though Wakefield Asylum is commonly known as the West Riding Pauper Lunatic Asylum (WRPLA) in many narratives, by the turn of the century this name was replaced with 'Wakefield Asylum' in order to avoid confusion with the other two West Riding Asylums at Menston and Storthes Hall. Confusingly Wadsley was often known as the South Riding Asylum. To avoid confusion, in this thesis 'Wakefield'; 'Menston'; 'Storthes Hall'; and 'Wadsley' will be used.

Abbreviated surnames have been used throughout in order to protect the patients' identities, in accordance with the 100 year case closure rule and the Data Protection Act (1998).

¹ The Board of Control was formulated in 1913 and the Board's powers and duties were outlined in the Mental Deficiency Act. Effectively their role was similar to the now disbanded Commissioners in Lunacy, only they had further powers to regulate services linked to mental deficiency in addition to the Lunacy Commissioners' previous powers which only linked to mental illness.

Abbreviations

BMJ	British Medical Journal
COS	Charity Organisation Society
GPI	General Paralysis of the Insane
JMS	Journal of Mental Science
NA	National Archives
SA	Sheffield Archives
WRCC	West Riding County Council
WRPLA	West Riding Pauper Lunatic Asylum
WYAS	West Yorkshire Archive Services

Key Legislation referred to in this Thesis:

1886 Idiots Act

1888 Local Government Act

1890 Lunacy Act

1912 West Riding Asylums Act

1913 Mental Deficiency Act

1917 Service Patient Scheme

1919 Ministry of Health Act

1927 Mental Deficiency Act

1929 Local Government Act

1930 Mental Treatment Act

Chapter One: Introduction

For some time now the historiography relating to asylums, psychiatrists, mental illness, and mental health care has ceased to be a marginal subject within the history of medicine. Much early work on the field was undertaken by writers such as Jones,¹ Scull,² Foucault³ and Porter,⁴ each offering their own interpretation of different responses to the ‘problem’ of mental illness and the rise of the asylum as the key approach to institutional care.

Early work by Kathleen Jones argued that the growing population of mentally ill people under care represented the success of the humanitarian values of the asylum. She argued that the growing dependency upon asylum care demonstrated that the construction of these asylums was a necessary humanitarian intervention to look after a group of vulnerable people who had hitherto gone unnoticed and untreated, or even *mistreated* within society. Written against the backdrop of the Mental Health Act of 1959, Jones’ monograph *Mental Health and Social Policy* argued that during the 1830s and 1840s “a series of pieces of social legislation were introduced, which embodied a common ethical principle... that the community had a responsibility for those who could not help themselves.”⁵

This optimistic explanation for the growth of the asylum has, however, been sub-

¹ K. Jones, *Lunacy, Law and Conscience, 1744-1845* (London, Routledge and Kegan Paul, 1955); K. Jones, *Mental Health and Social Policy* (London, Routledge and Kegan Paul, 1960); K. Jones, *A History of Mental Health Services* (London and Boston, Routledge & Kegan Paul, 1972).

² A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England* (London, Allen Lane, 1979); A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven and London, Yale University Press, 1993); A. Scull, *The Asylum as Utopia: W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry* (London, Routledge, 1990).

³ M. Foucault, *Madness and Civilisation* (New York, Pantheon, 1965); M. Foucault, *Mental Illness and Psychology* (Berkeley, University of California Press, 1987).

⁴ R. Porter, *Mind Forg’d Manacles: A History of Madness in England from the Restoration to the Regency* (London, Athlone, 1987).

⁵ Jones, *Mental Health and Social Policy*, p. 1.

jected to revisionism from other academics, who argued that “to present the outcome of reform as a triumphant and unproblematic expression of humanitarian concern is to adopt a perspective which is hopelessly biased and inaccurate.”⁶ Such fiery language encapsulates Andrew Scull’s monograph, *The Most Solitary of Afflictions*. An advancement upon his earlier *Museums of Madness*, this seminal piece of work argued against seeing the mid nineteenth century reforms and asylum building programme in a humanitarian light. His monograph scathingly suggested that a historian’s unbridled belief in reform suggests “a naïve Whiggish view of history as progress, and a failure to see the key elements of reform process as sociologically highly problematic.”⁷ Instead, Scull located the increase in people seeking institutional care and the development of the asylum structure within the context of a maturing capitalist system. He attributed the growing medicalisation of ‘mad doctors’ and the need for families to ‘dispose of’ their unproductive members to be the source of the growth of these ‘warehouses,’ which sprung up to store the mentally ill, an argument which has been subject to claim and counterclaim.⁸

Foucault saw the rise in these institutions as being part of a powerful relationship consisting of surveillance and discipline.⁹ He argued that the years between 1660 and 1800 represented what he referred to as the ‘great confinement’ throughout Europe. For Foucault the rise of the asylum, and the introduction of moral therapy in particular, represented the complete mastering of madness. For Foucault, chains, whips and straitjackets had finally been replaced by something much more severe. Moral therapy was seen as a type of imprisonment for the mind, as the asylum became an instrument of social control

⁶ Scull, *The Most Solitary of Afflictions*, p. 3.

⁷ *Ibid.*, p. 2.

⁸ K. Jones, ‘Scull’s Dilemma’, *British Journal of Psychiatry*, vol. 141, no. 3, 1982, 221-226; J. Crammer, ‘English Asylums and English Doctors: Where Scull is Wrong’, *History of Psychiatry*, vol. 5, no. 17, 1994, 103-115; H. Mersky, ‘Somatic Treatments, Ignorance and the Historiography of Psychiatry’, *History of Psychiatry*, vol. 5, no. 19, 1994, 387-391. For instances of counterclaim see A. Scull, ‘Psychiatrists and Historical “Facts”’: Part 1, The Historiography of Somatic Treatments’, *History of Psychiatry*, vol. 6, no. 22, 1995, 225-241. See also, A. Scull, ‘Psychiatrists and Historical “Facts”’: Part 2, Re-writing the History of Asylumdom’, *History of Psychiatry*, vol. 6, no. 23, 1995, 387-394.

⁹ Foucault, *Madness and Civilisation*.

and moral discipline. Certainly the idea that the asylum was an “instrument of social control,” has long been a powerful narrative in the historiography of asylumdom.¹⁰ Despite this however Roy Porter has argued against Foucault’s thesis by acknowledging that “Foucault’s Revisionism cannot be more than partially accepted, for it does not fit the facts, at least in England.”¹¹ Despite being interested in some of Foucault’s philosophical insights, Porter has highlighted some of the flaws that existed chronologically and historically in Foucault’s work.¹² He clearly identified how in the eighteenth century “the scale of sequestration... was hardly ‘great’ [and as such] the age of confinement in England was not the Georgian Era, but its successor.”¹³

Within the past two decades the historiography has moved substantially past earlier debates between Whiggish and Revisionist historians. Indeed, within his work, Peter Bartlett suggested that in fact there are many similarities between the structural approaches within these original branches of the historiography:

Th[e] factual structure is remarkably consistent between traditional ‘Whiggish’ and Revisionist accounts. Those versions differ not on the basic factual structure but rather on the interpretation to be put on those facts, or the subsequent implementation of the system.¹⁴

¹⁰ D. Ingleby, ‘Mental Health and Social Order’, in S. Cohen and A. Scull (eds), *Social Control and the State: Historical and Contemporary Essays* (Oxford, Basil Blackwell, 1983), pp. 141-190, p. 151. See also M. Ignatieff, ‘Total Institutions and the Working Classes: A Review Essay’, *History Workshop Journal*, vol. 15, no. 1, 1983, 167-173; F. M.L. Thompson, ‘Social Control in Victorian Britain’, *Economic History Review*, vol. 34, no. 2, 1981, 189-208.

¹¹ Porter, *Mind Forg’d Manacles*, p. 7.

¹² R. Porter, ‘Foucault’s Great Confinement’, *History of the Human Sciences*, vol. 3, no. 1, 1990, 47-54.

¹³ Porter, *Mind Forg’d Manacles*, pp. 7-8.

¹⁴ P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London, Continuum, 1999), p. 1.

It cannot be questioned that since the 1990s there has been an explosion of interest in, and multitude of academic writings adding to, the now much more complex historiography of the field of asylums, mental health care, mental illness and its treatment. This explosion of scholarship has led Scull to reassess the significance of his contribution within the study:

I have now passed from the status of the arch-revisionist of the field to the remarkably different position of being the very embodiment of orthodoxy, the Aunt Sally figure, against which a new generation of iconoclasts seeks to prove its mettle.¹⁵

To use Scull's turn of phrase, this 'new generation of iconoclasts' have sought to prove their mettle in a variety of different ways. Certainly in later studies the historiographical trend has led post-revisionist historians to provide in-depth and more detailed analysis on a much smaller and more intricate scale. Within this framework many historians have chosen to frame their research within a local, regional or even individual institutional context.

Within his work Peter Bartlett has attempted to reassess the very structures within which the growth of the Victorian Pauper Lunatic Asylum took place. Since Bartlett's pioneering monograph, which was released in the late 1990s, the locus of the historiography of mental health care has subtly changed. Bartlett's seminal thesis suggested that "the county asylum was essentially a Poor Law institution,"¹⁶ and as such, understanding mental health care and pauper lunatic asylums "is a matter of understanding the relation-

¹⁵ A. Scull, *The Insanity of Place/The Place of Insanity: Essays on the History of Psychiatry* (Oxon, Routledge, 2006), p. 3.

¹⁶ Bartlett, *The Poor Law of Lunacy*, p. 2.

ships between these institutions and how they related to the pauper insane.”¹⁷ As such Bartlett explained that the rise of the asylum was linked to the rise in the administrative provisions, which provided a framework for the successful operation of the asylum.

Other scholars have sought to situate the rise of the asylum contextually, as part of a long-term trend in providing care for the mentally ill, which originated long before the legislation of the nineteenth century was passed. Works on caring for the insane, and those with learning disabilities, as one contemporary edited volume identified, range in their purview and scope from antiquity to the present.¹⁸ As such, studies into the seventeenth and eighteenth centuries have revealed much to enlighten our views on societal care before the introduction of the public asylum regime in the nineteenth century.¹⁹ In *The Trade in Lunacy* William Parry-Jones offered a wide-ranging analysis of the functioning of the private madhouse during the eighteenth century. His work was undertaken in order to try to counter what he referred to as the “biased conception of the private madhouse,”²⁰ which has stemmed from the (over) exposure of malpractice that existed behind the walls of certain institutions. Similarly Porter’s analysis of the long eighteenth century suggested that “pre-nineteenth century practice was characterised by diversity and individualism” and as such humanitarian efforts and concerns to provide specialist care for the mentally ill existed side-by-side with cruelty and maltreatment.²¹ Following

¹⁷ Ibid.

¹⁸ P. Horden and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions and the Provision of Welfare Since Antiquity* (London, Routledge, 1998).

¹⁹ P. Rushton, ‘Lunatics and Idiots: Mental Disability, the Community and the Poor Law in North East England, 1600-1800’, *Medical History*, vol. 32, no. 1, 1988, 34-50; Rushton, ‘Idiocy, the Family and the Community in Early Modern North-East England’, in D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London, Routledge, 1996), pp. 44-64; A. Suzuki, ‘The Household and the Care of Lunatics in Eighteenth Century London’, in *The Locus of Care*, pp. 153-175; J. Andrews, ‘Identifying and Providing for the Mentally Disabled in Early Modern England’, in *From Idiocy to Mental Deficiency*, pp. 65- 92; J. Andrews, ‘Begging the Question of Idiocy: The Definition and Socio-Cultural Meaning of Idiocy in Early Modern Britain: Part 1’, *History of Psychiatry*, vol. 32, no. 9, 1998, 65-95.

²⁰ W. Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London, Routledge, 1972), p. 2.

²¹ R. Porter, *Mind Forg’d Manacles*, p. 32.

on from Porter's discussion of the long eighteenth century, Len Smith's *Cure, Comfort and Safe Custody* identified the continuities and crucially the breaks that followed into the early nineteenth century. Smith argued that the first half of the nineteenth century should be recognised as "a crucial period of transition in mental health care, reflecting the modernisation and growing sophistication of political, economic and administrative structures."²² Though not directly relevant to the timeframe of this thesis, all of these works are important in offering a broad historical overview of the developments and continuities that took place in psychiatric practice in the events leading up to the public asylum system taking root.

Though the early to mid-nineteenth century has been hailed as a time of great optimism and achievement in the embryonic psychiatric sector,²³ the rapidly increasing infrastructure of asylums and prevalence of insanity throughout the nineteenth century has attracted much debate in the historiography.²⁴ With regard to the growing demands on mental health services for care and treatment, it is commonly argued that the late nineteenth century symbolised the years of pessimism and decline in psychiatric services.²⁵ Even Kathleen Jones has acknowledged that by the late nineteenth century "the promise of 1845 was lost."²⁶ Within his work, Scull has popularised the argument that the rise in uncured chronic patients pointed to the end of the nineteenth and early twentieth century as being a period of stagnation within the walls of the asylum.²⁷ As Bartlett identified, "historians tend to view the asylum in the later nineteenth century as a failure, full of incurable cases and unable to fulfil the humanitarian promise of the reformers. The prom-

²² L.D. Smith, "*Cure, Comfort and Safe Custody*": *Public Asylums in Early Nineteenth-Century England* (London, Continuum, 1999), p. 2.

²³ Jones, *Mental Health and Social Policy*, p. 8.

²⁴ E. Hare, 'Was insanity on the increase?', *British Journal of Psychiatry*, vol. 142, no. 1, 1983, 439-455; A. Scull, 'Was insanity increasing? A response to Edward Hare', *British Journal of Psychiatry*, vol. 144, no. 4, 1984, 432-436.

²⁵ J. Melling and B. Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London, Routledge, 2006).

²⁶ Jones, *Mental Health and Social Policy*, p. 3.

²⁷ Scull, *The Most Solitary of Afflictions*, pp. 271-272.

ised cures never materialised...”²⁸

Echoing this perspective, Sarah York’s thesis identified that by the late nineteenth century “the therapeutic optimism that [had] surrounded the asylum in its early years slowly ebbed away as medical superintendents accepted the reality of asylum management and resigned themselves to the task of custodial containment.”²⁹ Similarly, in their work *The Politics of Madness*, Melling and Forsythe argued that “the asylum model had exhausted its potential for innovation long before the 1890 lunacy legislation” came into being.³⁰ More dramatically still Unsworth considered that in the late nineteenth and early twentieth centuries in Britain, the state of psychiatry was “custodial, stagnant and suspect.”³¹ The growing demand upon care and the inability to cure the chronically ill is in no way disputed within this thesis, nor is the idea that this growing underclass of chronic patients can be seen, at some levels, to represent a failure in psychiatry at this time. Despite this however, not all psychiatrists were so pessimistic.³² In his work, Frank Crompton suggested that although the late nineteenth century signifies “the retreat from a hopeful optimism associated with moral treatment to a therapeutic pessimism of the ‘hereditary’ later Victorian period, [this] is not readily apparent in the records that survive” at Worcester Asylum.³³ This particular debate is central to the backdrop of this thesis, and forms a key theme to be analysed throughout.

In addition to the plethora of studies on English Asylums, many works of interesting comparative value have also been conducted upon asylums and institutional spaces

²⁸ P. Bartlett, ‘The Asylum and the Poor Law’, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society: A Social History of Madness in Comparative Perspective* (London, Routledge, 1999), pp. 48-67, p. 48.

²⁹ S. York, ‘Suicide, Lunacy and the Asylum in Nineteenth Century England’, unpublished PhD Thesis, The University of Birmingham, 2009, p. 35.

³⁰ Melling and Forsythe, *The Politics of Madness*, p. 6.

³¹ C. Unsworth, *The Politics of Mental Health Legislation* (Oxford, Oxford University Press, 1987), p. 17.

³² See F. Lyman-Hills, ‘Psychiatry: Ancient, Medieval and Modern’, *Popular Science Monthly*, vol. 60, no. 1, 1901, 31-48.

³³ F. Crompton, ‘Needs and Desires in the Care of Pauper Lunatics: Admissions to Worcester Asylum, 1852-72’, in P. Dale and J. Melling (eds), *Mental Illness and Learning Disability Since 1850: Finding a Place for Mental Disorder in the United Kingdom* (Oxon, Routledge, 2006), pp. 46-64, p. 59.

for the mentally ill in countries, not only across the provinces of the United Kingdom,³⁴ but also offering cross-national and even trans-national insights. Collectively, the edited volume *Psychiatric Cultures Compared* “offered one of the first attempts in the history of psychiatry towards a more systematic comparison of national developments, which focuses upon, but is not limited to a number of major Western Countries during the twentieth century.”³⁵ Papers within this volume focus upon comparisons and contrasts within psychiatric practice in the Netherlands, America, Germany, France, Italy, Sweden and Japan.³⁶ These works have identified the importance of cross-cultural investigation and also provide the broader (inter)national framework, from which we can contextualise and situate the changes and developments occurring within various localities.

With regard to regional history within the past two decades there has been renewed interest in attempting to understand the structures and administrative hierarchies and micro-politics of nineteenth century lunatic asylums, in order to understand how they worked on a local and regional level. As Melling and Forsythe pointed out in their work a whole host of “actors and influences need to be acknowledged if we are to gain an accurate understanding of the social history of institutional provision for the certified.”³⁷ Adding to this work, other historians have attempted to assess the role of the asylum management in order to consider these hierarchies and shed some light upon the autonomy of particular institutions.³⁸ Rob Ellis’ work on The London County Council asylum cluster

³⁴ M. Finnane, ‘Asylums, Families and the State’, *History Workshop Journal*, vol. 20, no. 1, 1985, 134-148; H. Sturdy and W. Parry-Jones, ‘Boarding out Insane Patients: The Significance of the Scottish System 1857-1913’, in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum* (London, The Athlone Press, 1999), pp. 86-114.

³⁵ M. Gijswijt-Hofstra and H. Oosterhuis, ‘Introduction: Comparing National Cultures of Psychiatry’, in M. Gijswijt-Hofstra et al. (eds), *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam, Amsterdam University Press, 2005), pp. 9-34, p. 12.

³⁶ See the edited collection M. Gijswijt-Hofstra et al. (eds), *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century*. Additionally, the edited collection G. Mooney and J. Reinartz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York, Rodopi, 2009), contains papers on Australia, New Zealand and New York amongst others.

³⁷ Melling and Forsythe, *The Politics of Madness*, p. 207.

³⁸ B. Hayes, ‘Lancashire Public Asylum Provision: Regional Co-operation, Local Rivalry and Factional

at Epsom highlights how the opinions of members of the local Urban District Council made vocal through the local and national press could attempt to influence asylum management. He argued that, “negotiation and lobbying at a local level impacted on what was seen as an imposition of regional and national concerns.”³⁹ Furthermore, other works have been instrumental in our understandings of institutional power and decisions at the local, regional and national level. These include scholarship relating to the Lunacy Commissioners (later the Board of Control),⁴⁰ the Poor Law Guardians, and the relationships between the asylum and the workhouse.⁴¹ These works have all been central to an understanding of which groupings sought for, fought for, and eventually implemented the developments and innovations that this thesis deals with.

Linked to this scholarship upon understanding the workings of the asylum at a microcosmic level is the importance that has been justly re-attributed to the families, relatives and patients who utilised the mental health system. These attempts to reinsert lay actors into their experiences of mental health care have been wide ranging and have added to our understanding of the lunacy system in a variety of different ways. Newer stud-

Interest, 1889-1914’, in B. Doyle (ed.), *Urban Politics and Space in the Nineteenth and Twentieth Centuries: Regional Perspectives* (Newcastle, Cambridge Scholars Publishing, 2007), pp. 80-98.

³⁹ R. Ellis, ‘A Constant Irritation to the Townspeople’? Local, Regional and National Politics and London’s County Asylums at Epsom’, *Social History of Medicine*, vol. 26, no. 4, 2013, 653-671.

⁴⁰ N. Hervey, ‘A Slavish Bowing Down: The Lunacy Commission and the Psychiatric Profession, 1845-60’, in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness*, Vol. 2 (London, Tavistock, 1985), pp. 98-131; E. Murphy, ‘The Lunacy Commissioners and the East London Guardians, 1845-1867’, *Medical History*, vol. 46, no. 4, 2002, 495-524; Scull, *The Most Solitary of Afflictions*, pp. 280-281. For an analysis of the Board of Control with relation to these things, see M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c.1870-1959* (Oxford, Oxford University Press, 2001), pp. 79-109.

⁴¹ C. Smith, ‘Parsimony, Power, and Prescriptive Legislation: The Politics of Pauper Lunacy in Northamptonshire, 1845-1876’, *Bulletin of the History of Medicine*, vol. 81, no. 2, 2007, 359-385; R. Ellis, ‘The Asylum, The Poor Law and the Growth of County Asylums in Nineteenth-Century Yorkshire’, *Northern History*, vol. 45, no. 2, 2008, 279-293; B. Forsythe, J. Melling and R. Adair, ‘The New Poor Law and the County Pauper Lunatic Asylum – The Devon Experience, 1834-1884’, *Social History of Medicine*, vol. 9, no. 3, 1996, 335-355; B. Forsythe, J. Melling and R. Adair, ‘A Danger to the Public? Disposing of Pauper Lunatics in late Victorian and Early Edwardian England: Plympton St Mary Union and the Devon County Asylum’, *Medical History*, vol. 42, no. 1, 1998, 1-25; B. Forsythe, J. Melling and R. Adair, ‘The Politics of Lunacy: Central State Regulation and the Devon Pauper Lunatic Asylum, 1845-1914’, in *Insanity, Institutions and Society*, pp. 68-92. For an understanding of the workhouse see M. A. Crowther, *The Workhouse System, 1834-1929: The History of an English Social Institution* (Georgia, University of Georgia Press, 1982).

ies on the role of the family tend to be critical of Scull's notion that families in Victorian England "disposed" of their unwanted and unproductive family members, that "the asylum inevitably operated to reduce family and community tolerance."⁴² Notably David Wright and John Walton have described in some detail how families used the asylum facilities. In both their studies it has been suggested that contrary to what had been previously suggested by Scull, families used asylums as a stop-gap or temporary measure, often reclaiming their loved ones from the grasp of the asylum when they were in a better social and/or financial position to cope with their illnesses.⁴³ According to Wright, asylum accommodation constituted a legitimate way for a family of "reducing the number of dependents [during] economic crises."⁴⁴ He referred to this as "a process of strategic confinement rather than the 'dumping of unwanted family members.'"⁴⁵ More recently, Louise Wannell has utilised surviving correspondence from the families of patients who were admitted to the York Retreat to highlight how long after the admission of their loved ones, "families and friends remained significantly involved in asylum life and patient care."⁴⁶ Clearly historians are beginning to accept that institutions were not closed, medicalised dumping grounds, but instead were porous and contingent and occasionally even temporary spaces where patients, staff and families interacted. Despite this recognition however, there are still few studies that really attempt to understand these relationships as experienced on a daily basis.

Instrumental to the fabric of this thesis, therefore, is the concept that the asylum

⁴² Scull, *The Most Solitary of Afflictions*, p. 353.

⁴³ J. K. Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in W. F. Bynum, R. Porter, and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry* (London, Tavistock, 1985), pp. 132-146; D. Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, vol. 10, no. 1, 1997, 137-155; D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford, Oxford University Press, 2001).

⁴⁴ Wright, *Mental Disability in Victorian England*, p. 82.

⁴⁵ Ibid.

⁴⁶ L. Wannell, 'Patient's Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910', *Social History of Medicine*, vol. 20, no. 2, 2007, 297-313, 297.

could not and did not act alone in the process of institutionalising the insane, but instead was part of a process which took place between a variety of medical, legal and social discourses on insanity. Since Roy Porter's call for historians to attempt to create the history of medicine from below or "to get inside the heads of the mad,"⁴⁷ a number of historians have helped to enlighten our views of the lived experiences of the individual.⁴⁸ This idea of retrieving the voices of the mad and understanding the actions of the ordinary lay actors is a prime focus of this work. Within this thesis specific attention is given to the voices of patients, families and relatives who looked to the asylums to provide care, or who petitioned the asylum authorities for the release of their loved ones. Wherever these voices have been preserved within the casebooks, an attempt has been made to utilise them, in order to provide a unique understanding of the experiences of the 'ordinary' people. In comparison to many other works, this thesis places the patient experiences and understanding of their institutionalisation as key. The success of the innovations dealt with in this thesis is to some extent measured by patient experience and usage, rather than solely the analysis of medical professionals.

In addition to understanding why patients and their families utilised the asylum facilities, there has been considerable work carried out that has attempted to investigate the socio-economic identities of institutionalised patients. This primarily refers to detailed quantitative studies into the class, gender, age and ethnicity of groups of patients.⁴⁹ The Feminist movement of the later twentieth century helped to ingrain the idea of gen-

⁴⁷ Porter, *Mind Forg'd Manacles*, p. 229. See also R. Porter, 'Introduction', in R. Porter (ed.), *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*, (Cambridge: Cambridge University Press, 1985), pp. 1-22.

⁴⁸ See amongst others: P. Bartlett, 'The Asylum, The Workhouse and the Voice of the Insane Poor in Nineteenth Century England', *International Journal of Law and Psychiatry*, vol. 24, no. 4, 1998, 421-32; F. M. L. Thompson, 'Social Control in Victorian Britain', *Economic History Review*, 2nd Series, vol. 34, no. 2, 1981, 189-208.

⁴⁹ For a selection of work on ethnicity and asylums in colonial India see W. Ernst, *Colonialism and Transnational Psychiatry: The Development of an Indian Mental Hospital in British India, 1925-1940* (London, Anthem Press, 2013); W. Ernst, *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800-1858* (Oxon, Routledge, 1991); J. Mills, *Madness, Cannabis and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857-1900* (London, Palgrave-MacMillan, 2000).

der difference by arguing that “women in particular were the victims of repressive doctors and asylums.”⁵⁰ This characteristically feminist interpretation of mental illness suggests that the system of English psychiatry was “built on an ideology of *absolute and natural difference* between women and men.”⁵¹ Other scholars however have rejected the notion that there were any substantial gender differences with relation to insanity and asylums. In her work ‘The Female Malady?’ Busfield directly questions Showalter’s analysis, claiming that although the notion of the female malady “appears to have become part of feminist orthodoxy, [it] has little empirical support.”⁵² Similarly in her monograph, *Women’s Madness: Misogyny or Mental Illness?* Jane Ussher observes that, “Whilst feminist arguments are both persuasive and appealing in their rhetoric and veneration of the Victorian madwoman, they are simplistic in their analysis of the phenomena of madness.”⁵³ These scholars roughly agree that the available statistical information represents the fact that there was less difference than has often been suggested between the admissions and treatment of incarcerated men and women in pauper lunatic asylums during the nineteenth century. In light of this debate, the editors of the work *Sex and Seclusion, Class and Custody* put together an edited volume of essays discussing the relationships between gender and custodial care, stressing the need for research to “compare men and women, as well as, or rather than women [or] men in isolation”⁵⁴ This twofold

⁵⁰ R. A. Houston, ‘Class, Gender and Madness in Eighteenth Century Scotland’, in J. Andrews and A. Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Class and Culture in the History of British and Irish Psychiatry* (Amsterdam and New York, Rodopi, 2004), pp. 45-68, p. 45.

⁵¹ E. Showalter, *The Female Malady: Women, Madness and the English Culture, 1830- 1980* (London, Virago Press, 1996), pp. 167-168. My emphasis.

⁵² J. Busfield, ‘The Female Malady?: Men, Women and Madness in Nineteenth Century Britain’, *Sociology*, vol. 28, no. 1, 1994, 259-277.

⁵³ J. Ussher, *Women’s Madness: Misogyny or Mental Illness?* (Hertfordshire, Harvester Wheatsheaf, 1991), p. 92.

⁵⁴ J. Andrews and A. Digby, ‘Introduction: Gender and Class in the Historiography of British and Irish Psychiatry’, in *Sex and Seclusion, Class and Custody*, pp. 7-44, p. 9. For a selection amongst many works on gender see: O. Walsh, ‘Gender and Insanity in Nineteenth Century Ireland’, in *Sex and Seclusion, Class and Custody*, pp. 69-94; H. Marland, ‘At Home with Puerperal Mania: The Domestic Treatment of the Insanity of Childbirth in the Nineteenth Century’, in *Outside the Walls of the Asylum*, pp. 45-65; M. Levine Clark, ‘Dysfunctional Domesticity: Female Insanity and Family Relationships among the West Riding Poor in the Mid-Nineteenth Century’, *The Journal of Family History*, vol. 25, no. 3, 2000, 341-361.

approach to studying gender relations has been firmly adopted within this thesis.

Similarly many works have looked at aspects of class and how this altered a patient's experience of mental illness, institutionalisation and treatment. Charlotte Mackenzie's work gives a broad overview of the lives of the rich within a private institution during the years 1792 to 1917.⁵⁵ More recently however, studies that relate to pauper asylums and the Poor Law almost intrinsically identify the pauper population to be central to their studies.⁵⁶ As Forsythe, Adair and Melling note, "in seeking to explain the provision made for the pauper lunatics and the limitations of their treatment in the heroic age of mental treatment, scholars have recently drawn our attention to the key role of the Poor Law in the institutional containment of lunatics."⁵⁷ Such attention to the workings of the Poor Law on institutional provision naturally marginalizes the experiences of the fee-paying private patient in an attempt to understand the experiences of the predominantly working class, pauper majority. Again the edited collection *Sex and Seclusion, Class and Custody* has brought this scholarship together, and many authors have attempted to assess the complexities between the statuses of private and pauper patients. Notably in his papers on the English governess, Melling examines how the status of professional women in teaching occupations could change from private to pauper depending upon various factors including their employers' willingness to pay, the patient's type and duration of illness and the limited amount of funding available.⁵⁸ Though much attention has been

⁵⁵ C. MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London, Routledge, 1992).

⁵⁶ See for instance, Ellis, 'The Asylum, The Poor Law and the Growth of County Asylums in Nineteenth Century Yorkshire'; Murphy, 'The Lunacy Commissioners and the East London Guardians'; Forsythe, Melling and Adair, 'A Danger to the Public?', to name but a few.

⁵⁷ Forsythe, Melling and Adair, 'The New Poor Law and the County Pauper Lunatic Asylum'.

⁵⁸ J. Melling, 'Sex and Sensibility in Cultural History: The English Governess and the Lunatic Asylum, 1845-1914', in *Sex and Seclusion, Class and Custody*, pp. 177-222. See also, J. Melling, 'Buried Alive by her Friends: Asylum Narratives and the English Governess, 1845-1914', in *Mental Illness and Learning Disability Since 1850*, pp. 65-90. For more on the debates surrounding class, see also: Houston, 'Class, Gender and Madness in Eighteenth Century Scotland', in *Sex and Seclusion, Class and Custody*, pp. 45-68; and L. Walsh, 'A Class Apart? Admissions to the Dundee Royal Lunatic Asylum 1890-1910,' in *Sex and Seclusion, Class and Custody*, pp. 249-270.

given to patients' socio-economic and gender identities, as yet little work has been carried out that focuses directly upon the specific problems relating to the stigma of pauperism for the pauper class. This particular inconsistency is a gap that this thesis seeks to explore in some detail.

Linked to this scholarship on assessing individuals' identities, there has been a surge of interest in the plight of children who were institutionalised in the nineteenth and twentieth centuries.⁵⁹ In her work Dee Hoole refers to this as an attempt to recreate the "forgotten and often hidden history of children within Poor Law asylums."⁶⁰ Studies that focus upon the plight of children in asylums often emphasize different attempts to separate mentally deficient children from adults within the asylum system.⁶¹ Other historians have chosen to review specific institutions that were not connected with lunacy such as Earlswood Asylum,⁶² (a national asylum for idiots;) the Western Counties Idiot Asylum,⁶³ or Sandlebridge Boarding School.⁶⁴ Collectively these studies all seek to analyse the plight of mentally deficient children and adults who found themselves incarcerated both before and after the Mental Deficiency Act of 1913.⁶⁵ Works focusing entirely upon mental deficiency and learning disabilities have increased dramatically during the past two decades and this increased knowledge has led to the ability to analyse them as a sep-

⁵⁹ J. Melling, R. Adair and B. Forsythe, 'A Proper Lunatic for Two Years: Pauper Lunatic Children in Victorian and Edwardian England. Child Admissions to the Devon County Asylum, 1845-1914', *Journal of Social History*, vol. 31, no. 2, 1997, 371-405; C. J. Wardle, 'Historical Influences on Services for Children and Adolescents before 1900', in H. Freeman and G. E. Berrios (eds), *150 Years of British Psychiatry*, Vol. 1 (London, Gaskell, 1991), pp. 279-293.

⁶⁰ D. Hoole, 'Idiots, Imbeciles and the Asylum in the Early Twentieth Century: Bevan-Lewis and the Boys of Stanley Hall,' unpublished PhD thesis, University of Aberdeen, 2012, p. 3.

⁶¹ *Ibid.*

⁶² D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford, Oxford University Press, 2001).

⁶³ D. Gladstone, 'The Changing Dynamic of Institutional Care: The Western Counties Idiot Asylum, 1864-1914', in *From Idiocy to Mental Deficiency*, pp. 134-160.

⁶⁴ M. Jackson, *The Borderland of Imbecility* (Manchester, Manchester University Press, 2000). For a more general discussion see K. Day and J. Jancar, 'Mental Handicap and the Royal Medico-Psychological Association: A Historical Association, 1841-1991', in *150 Years of British Psychiatry*, Vol. 1, pp. 268-278.

⁶⁵ For a detailed analysis of the 1913 legislation see J. Owen, 'Social Darwinism and Social Policy: The Problem of the Feeble-Minded 1900-1914', unpublished PhD thesis, Institute of Historical Research, 1997.

arate, yet incorporated chapter within this thesis.⁶⁶ Inevitably, all of these works have been instrumental in understanding a multitude of individual, regional and national responses to the problem of mental deficiency, idiocy, imbecility and feeble-mindedness. As this summary identifies however, there has been a tendency to compartmentalise experiences of mental health care within the existing historiography. Many scholars have offered an approach to history that centres upon separate demographic and conceptual categories. By looking at the provision for learning disabilities side-by-side with developments in mental health care, this thesis will provide a truer picture of the complexities regarding these separate, but often interlinked conditions. Furthermore, by creating a case-study approach to all aspects of mental health care my work will attempt to reconstruct the shape of the entire patient body, by interrogating the interactions between gender, class, age and illness in a holistic manner.

The majority of approaches to analysing the history of mental health care listed above, be it ‘Whiggish,’ ‘Revisionist,’ or ‘Post-Revisionist,’ have attempted to understand and locate the meanings and experiences of madness and learning disabilities from within the walls of the asylum or respective institution(s). Lately however there has been an attempt to add to our understanding of insanity and learning disabilities by moving outside of the walls of the asylum.⁶⁷ In his influential study, first published in the early 1960s, Goffman suggested that asylums represented ‘total institutions,’ which were characterised by “the barrier to social intercourse with the outside” world.⁶⁸ To Goffman, symbols such as “locked doors, high walls [and] barbed wire” represented the totality of

⁶⁶ Most noticeable here are two edited collections, which have brought together many historians working within the field. See D. Wright and A. Digby, *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities*. See also P. Dale and J. Melling, *Mental Illness and Learning Disability since 1850*.

⁶⁷ P. Bartlett and D. Wright, ‘Community Care and its Antecedents’, in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (London, The Athlone Press, 1999), pp. 1-18.

⁶⁸ E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (London, Penguin, 1991), p. 15.

the institution, identifying a prison for its inmates.⁶⁹ More recently however, scholarship has sought to contest and challenge this assumption, by suggesting that the walls of the asylum were more permeable than our previous understanding suggests. Papers within Mooney and Reinarz's edited collection *Permeable Walls* identified that it was not only nurses, doctors and visitors, but also patients who could often find hospital walls porous. Some patients were allowed to leave and re-enter the institution in a variety of ways, not least for outings and recreational activities.⁷⁰ Similarly Bartlett and Wright's collection *Outside the Walls of the Asylum* serves as a reminder that patients received care in many ways, and often institutional treatment formed only part of a patient's overall care. Their work identified that the findings of many monographs on patient admissions into particular institutions "imply that situations of 'care' in the community existed long before a crisis precipitated institutional confinement and continued after discharge."⁷¹

In recent years then, the focus of the historiography has shifted from an emphasis upon the institution to institutional relationships with a variety of individuals, be it the Poor Law, the families of the insane and the patients themselves. For the most part, however, most histories are still largely dependent on Victorian records for their insights into the lived experiences of the insane.⁷² Though primarily this thesis also hinges on primary sources from Victorian institutions, there has been a direct attempt within this thesis to build upon the chronology of the current historiography. The vast majority of the work mentioned above focuses upon the eighteenth and nineteenth centuries as the key historical moments in asylum care and as yet few studies have provided a history of the asylum in the twentieth century after the First World War. Even the most recent works from 2014 and 2015 have continued the historical trend towards the examination into nine-

⁶⁹ Ibid.

⁷⁰ G. Mooney and J. Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York, Rodopi, 2009).

⁷¹ Bartlett and Wright, 'Community Care and its Antecedents', p. 3.

⁷² Ibid., pp. 2-3.

teenth century asylums and Victorian institutions for the mentally ill. Both Anna Shepherd's *Institutionalising the Insane in Nineteenth Century England*⁷³ and Mark Stevens' *Life inside the Victorian Asylum* further contribute to our knowledge of nineteenth century health care.⁷⁴ Furthermore Thomas Knowles and Serena Trowbridge's edited collection *Insanity and the Lunatic Asylum in the Nineteenth Century* continues this trend in the scholarship into 2015.⁷⁵ The volume provides "literary, medical, social historical and cultural essays on asylums of the United Kingdom, Ireland, France and the United States in the nineteenth century."⁷⁶

In comparison to works upon the nineteenth century however, as yet scholarship on the role of the asylum in the twentieth century is still in its infancy. Within his hugely influential work, Bartlett offers a few suggestions as to the connections between the nineteenth and twentieth centuries, arguing that little changed between the two centuries. His vision of the similarities between these years is fundamental to the ideas behind this thesis, and as such, here he has been quoted at length:

The point here is not that nothing had changed; if anything quite the reverse. The economic and political context, the nature of the family and institutional frameworks have all varied markedly. The history of mental health legislation demonstrates the force of legislative inertia, and a history of cut-and-paste law-making over periods of considerable change. The point is instead that the

⁷³ A. Shepherd, *Institutionalising the Insane in Nineteenth-Century England* (London, Pickering & Chatto, 2014).

⁷⁴ M. Stevens, *Life Inside a Victorian Asylum: The World of Nineteenth-Century Mental Health Care* (Barnsley, Pen and Swords Ltd, 2014).

⁷⁵ T. Knowles and S. Trowbridge, *Insanity and the Lunatic Asylum in the Nineteenth Century* (London, Pickering & Chatto, 2015).

⁷⁶ *Ibid.*, p. 1.

study of the nineteenth-century administrative networks has much to say about the roots of the twentieth century statute. The nineteenth century none the less presented a remarkably similar set of options to the twentieth when confronted with an insane person: provide a cash hand out to live in the community (called out-door relief in the nineteenth century); admit to an asylum (now a psychiatric hospital); or, admit to a different form of social service housing boarding out or workhouse care in the nineteenth century, nursing home provision and group homes in the twentieth... Without wishing to press the point too far, the similarities are striking.⁷⁷

Thus Bartlett suggests that changes in mental health care over the years represented little more than a semantic shift and a differentiation within technical terminology, rather than any meaningful difference in patient experience. He suggests that whilst there have been many changes in semantics over the years, with relation to many aspects of mental health care he states that “the job itself has remained remarkably unchanged.”⁷⁸ Bartlett’s work offers these suggestions, but crucially offers no analysis of the twentieth century beyond this primary hypothesis. Indeed, in his work where these ideas are proposed, his focus only extends from the years 1834 to 1870. A considerable part of this thesis therefore acts as a response to Bartlett’s supposition that changes in mental health care merely represented changes in semantics; consequently testing this hypothesis is a common theme throughout the following chapters of this thesis.

Although there is an assumption by some scholars that little changed in psychia-

⁷⁷ Bartlett, *The Poor Law of Lunacy*, p. 5. My emphasis.

⁷⁸ *Ibid.*, p. 4.

try throughout the early years of the twentieth century, few academics have actually offered a cross-century analysis that goes beyond the beginning of the First World War to justify this claim. As a critical response to the lack of scholarship on institutions in the later twentieth century, Louise Westwood argues in her work that:

The history of the care of the insane has concentrated on legislation and the private and public asylums of the eighteenth and nineteenth centuries. The rules on confidentiality and the destruction of records make twentieth-century records more difficult to access and therefore some interesting developments have been under researched, which has perpetuated the view that twentieth century care, prior to the First World War, followed a nineteenth century pattern.⁷⁹

Much of Westwood's work focuses upon small-scale changes in the mental health system that took place at a local level. This notion that 'interesting developments'⁸⁰ took place in the late nineteenth and early twentieth centuries challenges the accepted view within the historiography, which has suggested that little changed in psychiatric practice from the late nineteenth and into the early stages of the mid twentieth century. Three years after Westwood's work was published Hofstra *et al.*'s edited collection was released which offered an overview of the twentieth century across a range of cultures and countries. The volume generically argued that, "over the course of the twentieth century...the main

⁷⁹ L. Westwood, 'A Quiet Revolution in Brighton: Dr. Helen Boyle's Pioneering Approach to Mental Health Care, 1899-1939', *Social History of Medicine*, vol. 14, no. 3, 2001, 439-457, 439.

⁸⁰ *Ibid.*

function of mental institutions shifted from shelter and care to treatment and cure.”⁸¹ However, together these papers seem to suggest that it was “the 1950s [that] appear to mark a turning point” in psychiatric practice within these countries, rather than the earlier part of the twentieth century.⁸²

Collectively these works offer the beginnings of an important debate within the historiography. Though these works are now nearly ten years old, little else has been added since to our understanding of this debate regarding twentieth century psychiatry. This thesis seeks to create some clarity between these apparently conflicting and contradictory ideas, by offering a detailed examination of a selection of the differences and similarities in mental health care during the late nineteenth and early twentieth centuries. In her work, Westwood refers to the ‘interesting developments’ that took place; in my work I label these developments as ‘innovations,’ which I will identify had the potential to be unsuccessful as well as successful. By offering an analysis of how significant these changes were, this thesis aims to offer new insights into what is evidently a crucial and missing part of the historiography of early twentieth century psychiatry. At the conclusion of his monograph, Bartlett invites new historians to “ask the degree to which twentieth century mental health and its administration remain the Poor Law of Lunacy?”⁸³ This thesis in part aims to address this question and seeks to understand not only the extent to which mental health care remains the Poor Law of Lunacy, but also analyse how successful these innovations were in changing the experiences of mental health care for those using its services in the early twentieth century.

This thesis therefore seeks to identify and analyse the successes and failures of a series of initiatives that took place in the spheres of mental health care, psychiatric prac-

⁸¹ Gijswijt-Hofstra and Oosterhuis, ‘Introduction: Comparing National Cultures of Psychiatry’, in *Psychiatric Cultures Compared*, pp. 9-34, p. 13.

⁸² Ibid.

⁸³ Bartlett, *The Poor Law of Lunacy*, p. 251.

tice and the changes in caring for people with learning disabilities between the years 1888-1938. This range of new innovations was designed to alter the administration and admission of patients suffering from different types of mental afflictions and learning disabilities. These various initiatives took two forms. Firstly, gradual ideas were conceived and implemented for the steady eradication of the *stigma of pauperism* from patients who were receiving treatment for their mental disorders. Secondly, developments were also carried out which attempted to remove the necessity of the *stigma of certification* for many patients in need of treatment. With respect to the eradication of pauperisation, pauper lunatic asylums, which were conceived and built during the nineteenth and early twentieth centuries, were legally rebranded as mental hospitals in 1930.⁸⁴ Poor Law administration including accommodation, relief and finance began slowly to be eradicated from certain aspects of mental health care, firstly from those labelled mentally deficient, secondly for mentally afflicted service-patients who were in need of psychiatric treatment and care after serving in the Army or the Navy during the First World War and finally from all the services of mental health care itself.⁸⁵

At the same time as the attempts to eradicate pauperism from mental health care, a series of innovations were being carried out with regards to the *eradication of certification* for certain sufferers of mental illness in the incipient stages of the disease. These began with localised attempts at establishing outpatient departments and culminated in the 1930 Mental Treatment Act. For the first time this new Act allowed rate-aided patients to admit and discharge themselves from mental hospitals by written application.⁸⁶ Each of these initiatives relate to the social and legal segregation, and categorisation of different types of mental illness and learning disabilities and the administration of the mental

⁸⁴ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

⁸⁵ Local Government Act 1929, [19 GEO. 5, Ch17].

⁸⁶ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

health system. With relation to the new initiatives to eradicate these stigmas a special report of a sub-committee of the West Riding Mental Hospitals Board commented in 1926:

We heartily endorse the recommendations that the lunacy code should be re-cast... certification should be the last resort and not a necessary preliminary to treatment; and that the procedure for certification should be simplified, made uniform for private and rate-aided cases alike and [be] dissociated from the Poor Law... We welcome the proposal to extricate all lunacy legislation from the Poor Law.⁸⁷

Clearly it was understood that the requirement of certification under the lunacy legislation was often a prohibitive barrier for patients requiring treatment. Firstly to be certifiably insane was to be officially branded with the stigma of 'insanity'; and this stigma of certification was often compounded by the fact that most patients would have had to receive their help through the Poor Law, which legally rendered them Pauper Lunatics. Secondly, certification meant that many patients in early stages of illness were ineligible for treatment, until their conditions deteriorated further. Alienists working within the field often argued that late admittance to the asylum and treatment led to the growing population of hopeless chronic cases, who languished in the asylum uncured until their deaths.⁸⁸ In 1926 Professor Joseph Shaw-Bolton, medical superintendent of Wakefield Mental Hospital, angrily attacked the Lunacy Laws, by condemning the inefficiency of "the present happy-go-lucky method of submitting a mental case to the investigation of

⁸⁷ WYAS, C416/1/64, Minute Books of the West Riding Mental Hospitals Board (1927), pp. 106-112.

⁸⁸ P.W. MacDonald, 'Presidential Address on the Early Symptoms of Mental Disease and the Prevention of Insanity', *British Medical Journal*, no. 1660, October 1892, 885-887, 885.

the experts only after it has become difficult or impossible to blunder along any longer.”⁸⁹ The attempts to extricate the stigmas of pauperism and certification from mental health care therefore were important attempts to try to persuade potential patients to undergo treatment at an earlier stage of their illnesses when they were considered to be more treatable.

Primarily this thesis is concerned with an analysis of these different developments and an observation of the impact of these initiatives on the users and potential users of the services offered. Therefore the analysis offered in this thesis seeks to provide answers to some of the questions raised by the ‘pessimism debate’ in the twentieth century. *What were* the differences made to the provision of mental health care in the late nineteenth and early twentieth centuries? Did these changes make any lasting difference to the experience of institutionalisation and illness from the patients’ point of view? Had the asylum model “exhausted its potential for innovation long before the 1890 lunacy legislation” came into being?⁹⁰ To what extent is Bartlett correct in thinking that many of the changes represented nothing more than a semantic shift towards a new set of institutional terminology?

Local Institutions and Available Sources

This thesis presents a case study of a local area in order to provide some answers to these questions and address some of the gaps that relate to twentieth century mental health care within the current historiography. In the past many scholars undertaking postgraduate work in the field of mental health studies have chosen specifically to focus their attention

⁸⁹ WYAS, C85/1/12/14, Annual Reports, Medical Superintendent’s Report (1926), p. 86.

⁹⁰ Melling and Forsythe, *The Politics of Madness*, p. 6.

upon one particular asylum or mental hospital. This approach provides us with detailed, individual micro-histories of one particular institution within a clearly defined time frame.⁹¹ However in attempting to assess the representativeness of their institutional studies, other academics have chosen to compare two relatively local asylums in order to get a more nuanced picture.⁹² Though this work focuses upon one specific locality – the West Riding of Yorkshire – it analyses a range of institutions within that locality in order to provide a more holistic approach to mental health care. For the purposes of this research, a case study approach is useful to be able to analyse various developments in psychiatric practice with a view to observing how they affected specific demographic groups such as gender, class and age. Such an approach also provides an opportunity to examine the patient and the institutions in the context of family, community and regional culture.

By creating a case study of the West Riding of Yorkshire, my work will contribute to and extend the emerging scholarship that has been carried out on the first West Riding Pauper Lunatic Asylum in Wakefield, which has received much attention from historians in recent years.⁹³ The key debate centres itself upon the extent to which pessimism existed in psychiatric practice in the nineteenth century. Rob Ellis' thesis began this debate, by adding to our understanding of the uses of the asylum in the years 1844-1888. His thesis concluded that merely trying to categorise the asylum as a place of cure or house of detention is too simplistic and that both custody and cure was part of the asy-

⁹¹ D. Wright, 'The National Asylum for Idiots, Earlswood, 1847-86', unpublished D.Phil. thesis, University of Oxford, 1993; D. Hoole, 'Idiots, Imbeciles and the Asylum in the Early Twentieth Century: Bevan-Lewis and the Boys of Stanley Hall', unpublished PhD thesis, University of Aberdeen, 2012.

⁹² R. Ellis, 'A Field of Practise or a Mere House of Detention? The Asylum and its Integration, with Special Reference to the County Asylums of Yorkshire, c.1844-1888', unpublished PhD thesis, University of Huddersfield, 2001; P. Bartlett, 'The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England with special reference to Leicestershire and Rutland', unpublished PhD thesis, University of London, 1993.

⁹³ Over the years, many writers have referred to the WRPLA in their works. Amongst the most notable are: Smith, "*Cure, Comfort and Safe Custody*"; Scull, *The Most Solitary of Afflictions*; A. L. Ashworth, *Stanley Royd Hospital Wakefield. One Hundred and Fifty Years* (London, Berrico, 1975); M Levine-Clark, 'Dys-functional Domesticity'.

lum's remit. In response to the growth of the asylum in these years he argued that although "many families turned to the asylum [they did so] only on the understanding that their kin would be returned to them restored."⁹⁴ In response to this, in their works other scholars have focused specifically upon particular aspects of change within Wakefield Asylum. Mike Finn's thesis focused upon the Medical Superintendent Crichton-Brown and the advancement of brain science during the years 1866-1876. His work looked at "how and why the ostensibly unpromising site of a Victorian asylum was made into a flourishing school of research."⁹⁵ Finn's thesis argued that the West Riding Pauper Lunatic Asylum "was of signal importance in the development of nineteenth century medical science, laying the foundations for modern neuroscientific study of the brain."⁹⁶ Also focusing upon the role of science at Wakefield, Jennifer Wallis' thesis, submitted in September 2013, has added to our understanding of medicine, science, technology and the patient's body in the late nineteenth century.⁹⁷

Moreover, Dee Hoole's thesis has provided an analysis of Wakefield Asylum's Superintendent, Dr Bevan-Lewis, between the years 1884-1910 and the provision for mentally deficient boys at Stanley Hall Home.⁹⁸ Though all of these works have proved extremely useful to put into context and piece together the earlier history of the asylum, Hoole's analysis specifically has provided an informative stepping-stone for the research provided in this thesis. Her optimistic assessment of Stanley Hall Home jarred with the evidence of provision that I found, especially after Hoole's research draws to a close in 1910. Similarly her brief introduction to the outpatients department in the nineteenth cen-

⁹⁴ Ellis, 'A Field of Practise or a Mere House of Detention?', p. 281.

⁹⁵ M. Finn, 'The West Riding Lunatic Asylum and the Makings of Brain Sciences in the Nineteenth Century', unpublished PhD thesis, The University of Leeds, 2012.

⁹⁶ *Ibid.*, p. 6.

⁹⁷ J. Wallis, 'Madness Incarnate: The Making of the Patient's Body in Late 19th-Century Asylum Practice', unpublished PhD thesis, Queen Mary, University of London, 2013.

⁹⁸ Hoole, 'Idiots, Imbeciles and the Asylum in the Early Twentieth Century.' See also D. Hoole, 'The Problem of the Mentally Disabled Child in Late Victorian Society: A Study of Pauper Lunatic Boys within the West Riding Pauper Lunatic Asylum at Wakefield in 1901', unpublished MA Dissertation, The Open University, 2005.

tury raised many questions that this thesis seeks to explore in more depth, especially regarding how outpatient provision changed and adapted into the twentieth century.

All of the scholars listed above have sought to find more positive developments within the local asylum at Wakefield, and thus in psychiatric practice more broadly. However, all the work that has been carried out so far focuses predominantly upon the nineteenth century. Though Hoole's work offers an analysis of the West Riding Pauper Lunatic Asylum until Bevan-Lewis' retirement in 1910, much more research needs to be carried out to inform our knowledge of mental health care in the twentieth century. As yet, there are few studies that offer a deep historical analysis of the developments that occurred within the West Riding Pauper Lunatic Asylums beyond the First World War. In stark comparison to Wakefield Asylum, the documents relating to Storthes Hall have been almost entirely neglected in historical study. Ann Littlewood's book *Storthes Hall Remembered* offers some historical insight; however much more work remains to be done if we are to be able to locate Storthes Hall within the wider history of asylums during this period.⁹⁹ It is not unrealistic to suggest that the fact that Storthes Hall – opened in 1904 – remains neglected by historians reflects the fact that to date, twentieth century mental health care also remains an understudied topic. This thesis will attempt to address some of these gaps by undertaking a local study, which extends across conventional chronological boundaries to examine the period from 1888 to 1938.

The first West Riding Pauper Lunatic Asylum was opened in Wakefield in 1818 for 150 patients after the permissive legislation of the 1808 County Asylums Act was passed. Over the course of a century, and significantly after the compulsory legislation of the 1845 and 1890 Lunacy Acts and subsequent Amendment Acts, a further three separate asylums were built in order to accommodate the growing number of insane people in

⁹⁹ A. Littlewood, *Storthes Hall Remembered* (Huddersfield, The University of Huddersfield, 2003).

the West Riding of Yorkshire. The subsequent asylums were created at Wadsley (Sheffield) in 1872, Menston (Leeds) in 1888 and Storthes Hall (Huddersfield) in 1904. After the Local Government Act of 1888 control over asylums was passed from the Magistrates to the Local Authorities.¹⁰⁰ Thus the local council or county council was responsible for their local asylum until the passage of the West Riding of Yorkshire Asylum Act of 1912, when the West Riding Asylums Board was officially created. After 1912, this newly created umbrella Board helped to impose more unity upon the individual asylums as its primary responsibility was to oversee developments within the region as a whole.¹⁰¹ In addition to this network of asylums were various other layers of care for patients with specific illnesses and disabilities. These included homes for the mentally deficient as well as outpatient departments and the Ministry of Pensions Hospital.

This thesis argues that irrespective of the pessimistic tendency in psychiatric practice there were undoubtedly changes that occurred in the administration and admission procedures of the mentally ill at these institutions during the late nineteenth and early twentieth centuries. As the numbers of mentally ill institutionalised in asylums continued to rise, increasing attempts were made to categorise and segregate specific types of patients with specific types of mental illnesses and learning disabilities both locally and nationally. Across all four of the West Riding Asylums attempts were made to make them more specialised. New epileptic blocks were built at all four of the West Riding Asylums. An Acute Hospital was opened in Wakefield in order to house the new patients who were admitted under observation and also patients with acute forms of mental illness. This practice was subsequently repeated at the other asylums. Stanley Hall Home was officially opened as an annexe to Wakefield Asylum in January 1901 for idiot and

¹⁰⁰ Local Government Act 1888, [51 and 52 VICT. Ch41].

¹⁰¹ WYAS, C416/1/1/1, West Riding Asylums Act (1912); WYAS, C416/1/1/2, West Riding Asylums Act (1912).

imbecile boys. Outpatient clinics were established during the 1890s and were successfully run at the four asylums, catering for patients who required some help or assistance, but who were not in need of institutional care. In addition to these new centres of care, a Ministry of Pensions Hospital was opened as an annexe to Storthes Hall operating between the years 1924 and 1931, specifically for mentally disabled ex-servicemen.

These attempts at specialisation were not accidental, but instead formed part of an organised campaign to segregate patients into specific categories, within the context of institutional care. This process of segregation should be viewed in the context of the Victorian and Edwardian vision of specialisation, which hinged around a patient's prescribed illnesses and prospects of recovery. As was noted in the Annual Report of the Superintendent of Wakefield Asylum in 1898:

We should thus secure at Wakefield separate accommodation for the chronic community at the old asylum; for recent and acute cases at the new hospital [acute block]; for idiot and imbecile cases, a new home; and lastly for quiet farm workers at the cottage residents.¹⁰²

Clearly the late nineteenth and early twentieth centuries represented a time of change and increasing specialisation in the field of mental health care. As such this thesis attempts to explore a variety of institutions that formed part of this new trend in providing specialist care for groups of people with specific illnesses or learning disabilities. Despite analysing a range of institutions in the West Riding, a variety of methodological factors have placed Storthes Hall and Wakefield Asylums at the centre of this study. Firstly Stanley

¹⁰² WYAS, C85/1/12/10, Annual Reports of the Medical Superintendent (1891-1899), p. 11.

Hall Home was an experiment established at Wakefield Asylum, specifically for dealing with mentally deficient children. No similar or comparable attempt at innovation appears to have taken place at either Wadsley or Menston. Instead, the cases of mental deficiency at these two asylums were often transferred to the specialist centres at Wakefield,¹⁰³ or to the Mansion, which was another institution for mental deficiency, opened as an annexe to Storthes Hall in the late 1920s.¹⁰⁴ Furthermore the Ministry of Pensions opened their hospital as an annexe to Storthes Hall, rather than at one of the other asylums. The fact that these two schemes were operated at Wakefield and Storthes Hall makes them interesting centres to focus this research.

Additionally other practical reasons – such as availability of primary documents – have guided this choice. Although detailed records survive pertaining to the admission of patients following the 1930 Mental Treatment Act at both Storthes Hall and Wakefield, they do not survive for Menston. Similarly, no records appear to have survived relating to the outpatients department that was set up at Wadsley in 1890. The fact that detailed primary source material exists for both Wakefield Asylum and Storthes Hall and not at Wadsley or Menston has inevitably steered the focus of this research. Nevertheless at strategic points, Menston and Wadsley are brought in for further comparative effect. In addition, this work makes use of documents relating to other institutions in the West Riding of Yorkshire which form part of the innovations that this thesis focuses upon; it has particular reference to an institution set up after the Mental Deficiency Act of 1913, Meanwood Park Colony. By analysing various institutions within the specific locality of the West Riding of Yorkshire, this thesis will provide a more holistic approach to analys-

¹⁰³ See WYAS, C85/1/12/11, Annual Reports (1901-1905), pp. 4-5.

¹⁰⁴ Unfortunately very little source material survives with regard to this particular institution. There are occasional references in the West Riding Mental Hospitals Board Minute Books especially with regard to the establishment of the institution. Also the staff service register exists giving an insight into who worked there. Regrettably however no records of the patients who were admitted there can be found and as such this institution does not form part of the analysis of this thesis.

ing these innovations in mental health care. Primarily this study seeks to create a more complete and complex regional picture than that which can be offered by a history of a single institution.

This thesis focuses upon specific developments intended to reform the social and legal administration of the lunacy system, rather than on the specific medical treatments of the insane. It seeks to look at both local interpretations of national legislation and also at independent localised attempts to deal with key issues. In the process it will examine the relationships between these initiatives and the patients, their families and the institutional staffs affected, providing new insights into the impact increased classification and specialisation had on the class, gender and age profiles of patients who used these services.

Chapter Two seeks to add to the growing historiography of the Mental Deficiency Act and institutional provision for children and adults with learning disabilities. Rather than seeing the 1913 Act as a piece of legislative social control, I argue that it can be observed as an experiment to remove deserving cases from the stigma of the Poor Law and pauperisation, by administering their care and treatment in different accommodation and through a different administrative body. This chapter assesses the fundamental and inherent problems of the act, including a chronic shortage in both governmental funding and institutional accommodation, topped with the confusing ambiguities with regards to who was responsible for the implementation of the act. Moreover, it will identify how the Education Authorities, the Local Committee for the Care and Control of the Mentally Deficient, and the Poor Law Authorities were all interrelated under the act, in a diverse variety of ways.

After seeking to understand the broader perspective, this chapter then offers an in-depth case study of how these ambiguities worked on a local level. This chapter seeks to

analyse two very different and separate, yet ultimately similar institutions within the West Riding of Yorkshire; namely Meanwood Park Colony for the Mentally Defective and Stanley Hall Home for Idiot and Imbecile Boys situated in the grounds of Wakefield Asylum. In her work, Dee Hoole considered Stanley Hall *before* the introduction of the 1913 Act.¹⁰⁵ This chapter looks beyond this chronology to offer an analysis of the home *after* the 1913 Act. By comparing the case files of the patients admitted to firstly, a mental deficiency colony, and secondly, the Poor Law accommodation of a lunatic asylum, this chapter seeks to understand what groups the Mental Deficiency Act catered for and why, and thus which cases were likely to remain in ‘second-rate’ Poor Law accommodation. The inclusion of a chapter on patients who were considered to be ‘mentally deficient’ adds to our understanding of the mixed loci of care provided by asylums in the late nineteenth and early twentieth centuries. This chapter serves as a reminder that patients with learning disabilities were often indiscriminately mixed with those with mental illnesses, even after the 1913 Act. To ignore their presence in the asylum, or initiatives specifically linked to their care, would offer an unrepresentative picture of the patient body.

Chapter Three explores attempts to remove the stigma of pauperism from another ‘deserving’ group within society by analysing two very different, yet inevitably interconnected schemes that were set up as a response to war-induced neurosis. At present, historical interest in the Great War and concepts relating to shell-shock and trauma suffered during the conflict remain an entirely separate study to that of civilian mental illness. The majority of the work upon mental disablement and the First World War, in Britain, retells the tale of the ‘shell-shocked Tommy’ on the front line who had become mentally and often also physically disabled as a response to his trauma. Frequently these works have

¹⁰⁵ Hoole, ‘Idiots, Imbeciles and the Asylum in the Early Twentieth Century’.

focussed upon class relations and treatment of shell shock,¹⁰⁶ and also on gendered representations of shell-shock as 'effeminate' or else akin to malingering.¹⁰⁷ Other writers have however tried to situate the 'phenomenon' of shell-shock within a wider historical framework, rather than merely perceiving it as a peculiar episode that occurred solely during the First World War.¹⁰⁸ More recently Fiona Reid and Peter Barham have sought to establish what happened to the mentally disabled serviceman *after* the armistice and into the interwar years.¹⁰⁹ Despite this however, although their works assess the role of the asylum system in the post war world, there is little attempt to assimilate the experiences of the service patient with the pauper lunatic, and this is a gap that this thesis seeks to address.

Both the 1917 Service Patient Scheme and the Ministry of Pensions Hospital in Kirkburton were instituted in an effort to separate, in both physical space and the public imagination, the mentally afflicted war-serving veteran from the non-serving pauper lunatic. In this respect, both of the schemes can be accurately observed as endeavours aimed at protecting the mentally ill ex-serviceman from the double disgrace of both pauperism and lunacy. By comparing the treatment and experiences of ordinary pauper lunatics in asylums during the war with the experiences of the mentally disabled war veteran after the war my work highlights the inherent double standards of asylum treatment in the

¹⁰⁶ E. Leed, *No Man's Land: Combat and Identity in World War I* (New York, Cambridge University Press, 1979); P. Leese, *Shell Shock, Traumatic Neurosis and the British Soldiers of the First World War* (London, Palgrave, 2002).

¹⁰⁷ G. Mosse, 'Shell Shock as a Social Disease', *Journal of Contemporary History*, vol. 5, no. 1, 2000, 101-108; J. Bourke, 'Effeminacy, Ethnicity and the End of Trauma: The Sufferings of 'Shell-Shocked' Men in Great Britain and Ireland, 1914-39', *Journal of Contemporary History*, vol. 35, no. 1, 2000, 57-69; J. Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (London, Reaktion Books, 1996); Showalter, *The Female Malady*. See also J. Meyer, *Men of War: Masculinity and the First World War in Britain* (London, Palgrave Macmillan, 2011).

¹⁰⁸ E. Jones and S. Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Sussex, Psychology Press, 2005); B. Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (London, Pimlico, 2002); R. Cooter and S. Sturdy, 'Of War, Medicine and Modernity', in R. Cooter, M. Harrison and S. Sturdy (eds), *War, Medicine and Modernity* (Gloucestershire, Sutton, 1999), pp. 1-21.

¹⁰⁹ F. Reid, *Broken Men: Shell Shock, Treatment and Recovery in Britain, 1914- 1930* (London, Continuum, 2011); P. Barham, *Forgotten Lunatics of the Great War* (London, Yale University Press, 2007).

early twentieth century and provides an insight into the lives of institutionalised ‘shell-shocked’ servicemen throughout the 1920s. Again, the core focus of this chapter is to gain an understanding of the effect that these particular schemes had in their implementation. Similar to Chapter Two, this chapter will also conclude that the two tier system for the ‘deserving’ and ‘undeserving’ left fundamental flaws to the successful administration, admission and ultimately treatment of different types of mental disorders.

The final two chapters of my thesis move away from attempts to deal with the stigma of pauperism, and instead address the attempt to remove the necessity of and therefore stigma of certification from patients who could not afford private care. Chapter Four compares two outpatient clinics, which were set up at Wakefield Asylum and Clayton General Hospital. It discusses the main reasons for the establishment of these clinics, namely the need for early treatment without certification; the function of the clinic; its role in managing patients’ access to institutional care, and also patients’ attitudes towards the clinic and their treatment therein. This can be seen as part of the hierarchical referral system that was developing at this time in which GPs increasingly referred patients to outpatient clinics, which in turn determined whether institutional care was required. This chapter will seek to analyse the successes and limitations of these clinics in their outpatient work. Similar to the chapters above, this chapter also concedes that although these clinics constitute an innovative development, which sought to alter the practice of psychiatry, they too were limited in their capacity to provide change for all but a small majority of the public.

The final chapter of the thesis also looks at experiments in changing the role of certification in mental health care by analysing the 1930 Mental Treatment Act, which, amongst other things, for the first time allowed rate-aided patients to apply to a mental hospital for treatment without the need for certification. It suggests that despite the rheto-

ric used by professionals at the time and despite the praise bestowed upon the act by certain historians, the achievements of the 1930 Act were limited in its formative years. Rather, the findings identify that this piece of legislation was yet another innovation set up for a small minority of people who utilised these facilities during the interwar years. Far from being an all-encompassing national scheme, the permissive nature of the act meant that for many patients, very little changed with regards to admission, institutionalisation and discharge from and into Britain's mental hospitals after the passing of the new legislation.

Collectively then, this thesis will seek to bridge a gap within the current historiography by assessing the significance and impact of some of the changes that took place during the late nineteenth and early twentieth centuries. It aims to shed light upon the disparity of ideas evident between authors such as Bartlett and Westwood with regards to the stagnation or innovation involved in twentieth century psychiatry. As such, this thesis seeks to track a series of separate but inevitably related initiatives which were established to alter the process of admission for patients suffering from different forms of mental disorder. Two of these initiatives were created specifically to relieve the stigma attached to pauperism (the Mental Deficiency Act and experiments for ex-service patients) and two were specifically designed to eliminate the need for certification (outpatient clinics and the Mental Treatment Act). The chosen developments are particularly important, as the joint stigmas of pauperism and certification were the two most common explanations given by psychiatrists for the problems inherent within the mental health system.¹¹⁰ As Scull identifies, "the stigma of confinement [or certification] in county asylums was compounded with an association with the Poor Law."¹¹¹ The very existence of these ini-

¹¹⁰ MacDonald, 'Presidential Address on the Early Symptoms of Mental Disease and the Prevention of Insanity', 885.

¹¹¹ Scull, *The Most Solitary of Afflictions*, p. 309.

tiatives highlight that there were some significant and fundamental attempts to change the system of administration and mental health care throughout this period. Overall however, my thesis identifies that although there were significant legal and social changes in the administration and admission of caring for people who were mentally ill or those with learning disabilities over the years covered within my thesis, the developments, although innovative in their establishment, were all *limited* in their capacity to change the system for all but a small minority of sufferers of mental illness.

Chapter Two

Mental Deficiency and the Stigma of Pauperism

*“The less eligibility principle of the workhouse and the stigma of pauperism were wholly inappropriate and inhumane when dealing with individuals who needed permanent care through no fault of their own.”*¹

Although traditionally the historiography relating to mental deficiency has been considerably understudied in comparison to its counterpart of mental illness, since the mid-1990s important steps have been taken to redress this imbalance. The publication of David Wright and Anne Digby’s edited collection of essays *From Idiocy to Mental Deficiency* significantly helped to open up the relatively new historiographical field of the history of learning disabilities.² The publication has been widely praised for generating “considerable insights into both continuities and discontinuities in historical constructions of disabilities and the provision of care.”³ Works in this collection range from the early modern period⁴ to Anne Digby’s interesting introduction to modern day problems.⁵ Despite this however, the historiography today can still be categorised into a relatively small number of discussions, the most prominent of these being centred upon the care and control debate.

Historians researching into the field of idiocy and imbecility in idiot asylums, for

¹ M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c.1870-1959* (Oxford, Oxford University Press, 2001), p. 11.

² D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London, Routledge, 1996).

³ M. Jackson, *The Borderland of Imbecility* (Manchester, Manchester University Press, 2000), p. 9.

⁴ J. Andrews, ‘Identifying and Providing for the Mentally Disabled in Early Modern England’, in *From Idiocy to Mental Deficiency*, pp. 65-92. See also J. Andrews, ‘Begging the Question of Idiocy: The Definition and Socio-Cultural Meaning of Idiocy in Early Modern Britain: Part 1’, *History of Psychiatry*, vol. 9, no. 4, 1998, 65-95, ‘Part 2’, 179-200.

⁵ A. Digby, ‘Contexts and Perspectives’, in *From Idiocy to Mental Deficiency*, pp. 1-21.

instance, tend to promote particular nineteenth century institutions' voluntary and philanthropic characteristics. Within his work, Gladstone perhaps rightly suggests that such voluntary institutions, which were set up for people who were classified as idiots, "were established within a climate of optimistic expectations of improvement."⁶ Other historians studying idiot asylums optimistically identify how families "did not necessarily take a fatalistic view of the potential of their child" and that both voluntary organisations, parents, and later the government responded with similar notions and attempts at education.⁷ These histories identify that children and adults suffering from idiocy and imbecility who were admitted to these institutions were not considered to be a deviant sub-group. Instead Wright suggests that their conditions were more commonly identified with an individual's "lack of self-help skills,"⁸ or linked to "concerns of [an individual's] self-sufficiency" in general.⁹

Although these works have suggested that society could be sympathetic to the conditions of idiocy and imbecility in the mid to late nineteenth century, other works have suggested that the opposite was true for individuals considered to be 'feeble-minded' in the twentieth century. Many historical narratives surrounding the feeble-minded have focussed primarily upon the language of eugenics, control, and twentieth century preoccupations with conceptions of individual deviancy, predominantly focusing upon sexual and criminal behaviour. Much of the historiographical (and indeed contemporary) controversy over the legislation that was finally enacted in the Mental Deficiency Act of 1913 was that it extended care and control over a group of people whose behaviour deviated away from Edwardian society's acceptable standards and expectations. In

⁶ D. Gladstone, 'The Changing Dynamic of Institutional Care: The Western Counties Idiot Asylum, 1864-1914', in *From Idiocy to Mental Deficiency*, pp. 134-160, p. 139.

⁷ D. Wright, 'Childlike in his Innocence,' Lay Attitudes to 'Idiots' and 'Imbeciles' in Victorian England', in *From Idiocy to Mental Deficiency*, pp. 118-133, p. 130.

⁸ *Ibid.*, p. 123.

⁹ *Ibid.*, p. 124.

order to substantiate this thesis most historians quote the Act's rights to extend its reach to women who, whilst receiving Poor Law relief, had given birth to an illegitimate child. Within her work, Walmsley argues that the act was just another way that "women were targeted for sexual regulation," in the Edwardian era.¹⁰ The historiographical discourse then is one that places the feeble-minded, sexually active woman at the forefront of the contemporary Edwardian anxiety about the health and efficiency of the nation.

It was not merely the sexually deviant or promiscuous behaviour of women however, but also the criminal propensity of young men, which came to be framed within the act and which has subsequently been observed within the historiography of the feeble-minded. As Thomson informs us, "the Mental Deficiency Act provided a way to extend control over some individuals without sending them into the adult penal system."¹¹ Within his work he argues that such action was taken as a means for providing care to those who needed it, but who had previously fallen outside the nation's legal obligation to help. As such Thomson vehemently disagrees with the accepted historiographical view, popularised by writers such as Desmond King, that the act was "heavily influenced by the eugenic movement both in Britain and America."¹² Instead Thomson argues that eugenics was only one of a myriad of factors, and certainly not "the primary source behind British social policy," relating to the mentally deficient in the early twentieth century.¹³

Despite being sympathetic with parts of Thomson's thesis, Mark Jackson argues that there are "limitations to Thomson's account." He suggests that these limitations centre upon the fact that "although billed as a survey of policies between 1870 and 1959, Thomson's narrative includes only cursory coverage of the forty years before the Mental

¹⁰ J. Walmsley, 'Women and the Mental Deficiency Act of 1913: Citizenship, Sexuality and Regulation', *British Journal of Learning Disabilities*, vol. 28, no. 2, 2000, 65-70, 65.

¹¹ Thomson, *The Problem of Mental Deficiency*, p. 253.

¹² D. King, *In the Name of Liberalism: Illiberal Social Policy in the United States and Britain* (Oxford, Oxford University Press, 1999), p. 1.

¹³ Thomson, *The Problem of Mental Deficiency*, p. 10.

Deficiency Act of 1913 and of the post Second World War period.”¹⁴ Furthermore, Jackson argues that Thomson “has not explored precisely how feeble-mindedness was constructed by different actors or examined the various sites in which the borderland of imbecility was assembled.”¹⁵ Instead, Jackson’s work seeks to look at the ways in which “a complex mix of local and national interests interacted in both the production and the consumption of rhetoric and policies, [and] the manner in which people identified as mentally defective contributed to those processes.”¹⁶ Therefore, within his work, Jackson sets out to “trace the process whereby the feeble-minded were reconfigured as particularly pathological, replacing the social residuum or underclass as the major source of social disorder.”¹⁷

It would be reasonable to suggest that the variety of historical narratives relating to the mentally deficient is linked to the fact that many historians have sought to undertake studies that seek to understand particular micro-political and social histories of *single* institutions. The problem here is twofold: firstly, this approach limits the ability to compare individual experiences of institutional care, and secondly, there has been a tendency to look in depth at institutions which focused predominantly upon one particular designation of deficiency, for instance Earlswood Asylum (a national asylum for idiots),¹⁸ the Western Counties Idiot Asylum,¹⁹ or Sandlebridge Boarding School,²⁰ which was established predominantly with a view to segregating the feeble-minded. The problem with the proliferation of individualised micro-studies is that they have left many questions unanswered about the interesting interrelations and correlations between spe-

¹⁴ Jackson, *The Borderland of Imbecility*, p. 9.

¹⁵ *Ibid.*, p. 10.

¹⁶ *Ibid.*, p. 10.

¹⁷ *Ibid.*, p. 10.

¹⁸ D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford, Oxford University Press, 2001).

¹⁹ Gladstone, ‘The Changing Dynamic of Institutional Care’.

²⁰ Jackson, *The Borderland of Imbecility*.

cific places of institutional care. One such gap in our knowledge relates to how the Mental Deficiency Act altered policy and practice at a local level, specifically with relation to the interactions between new specialised mental deficiency institutions and Poor Law accommodations with relation to who was incarcerated within them, and why.

In her doctoral thesis Dee Hoole looks at the relationship between Stanley Hall Home and the Superintendent of the Wakefield Asylum, Dr Bevan-Lewis, between the years 1884 and 1910. Similarly to David Wright's description of Earlswood Asylum, her analysis suggests that during these years Stanley Hall can be seen to be an innovative institution, which "went beyond its perception as a custodial establishment and practised new approaches to care."²¹ As her analysis ends in 1910 – the year in which Bevan-Lewis retired – this thesis offers no analysis of Stanley Hall after the introduction of the 1913 Mental Deficiency Act.²² This is important as it raises many questions about the continuation of the home after this legislation was passed. Was Stanley Hall really as innovative as Hoole suggests when it was first established? What happened to Stanley Hall *after* the legislation of 1913? How did Stanley Hall compare with new institutions established under the 1913 Act? And importantly, after the Act was passed, which groups of people continued to be admitted there and why? This chapter aims to provide some insight into some of these gaps within the historiography, specifically by looking into the relationship between mental deficiency services set up by the 1913 Mental Deficiency Act, and the Poor Law Authorities. Indeed, to date, although some historians have briefly acknowledged the flaws of the Act with relation to its confusing and often interconnecting relationship with the educational establishment,²³ nobody has looked at the history of mental deficiency in relation to its problematic and confusing role with the Poor Law au-

²¹ D. Hoole, 'Idiots, Imbeciles and the Asylum in the Early Twentieth Century: Bevan-Lewis and the Boys of Stanley Hall,' unpublished PhD thesis, University of Aberdeen, 2012, p. i.

²² *Ibid.*, p. 4.

²³ Thomson, *The Problem of Mental Deficiency*, p. 39.

thorities.

Within his work, Thomson argues that local Mental Deficiency Committees were set up under the 1913 Act because “the less eligibility principle of the workhouse and the stigma of pauperism were wholly inappropriate and inhumane when dealing with individuals who needed permanent care through no fault of their own.”²⁴ This statement however does not explain why so many people considered to be mentally defective were left abandoned within the ‘stigmatising’ walls of Poor Law institutions; nor does it explain why the Board of Control sometimes advocated and sometimes abhorred the practice of keeping the mentally deficient in Poor Law accommodation.

The legislation, proposals and remit of the Mental Deficiency Act on a national level have been well documented by historians, and there is no attempt to reiterate this history here or to rehash the same sources to reach yet another conclusion as to whether this Act was designed with a view to control, penalise and punish society’s delinquent and deviant, or to care for a group of educationally and medically disabled people. Instead this chapter seeks to understand how the Government Boards and various Local Authorities responsible for the Act’s implementation dealt with people labelled as mentally deficient at a local level. Firstly this chapter will look again at the establishment of Stanley Hall, and re-assess whether we should observe it as a custodial or curative institution. Following this, my work will look at mental deficiency institutions after the passing of the 1913 Act. It will examine the fundamental problems of the act with regards to complex administration, and a lack of accommodation and finance on both a national and local level. Finally this chapter will compare Stanley Hall with Meanwood Park Colony for the Mentally Deficient in Leeds, a certified institution specifically established to meet

²⁴ Ibid., p. 11.

the requirements of the new act.²⁵ The focus will be on observing whether any generalisations can be inferred between the types of patient and cases incarcerated within two completely different, yet in many ways similar institutions for the mentally defective in the West Riding of Yorkshire in the late nineteenth and early twentieth century. By comparing two institutions in order to get a broader picture of local implementation of the act, this work will mirror more recent scholarship, which also considers the relationships between different mental deficiency institutions.²⁶ Overall, this chapter aims to question whether attempts to accommodate the Mental Deficiency Act into practice can be observed as a failed experiment in removing mental deficiency services from the ambit of the Poor Law authorities, and in doing so seeks to address specific gaps within the current historiography of mental deficiency.

Legal Policy and Local Practice: Caring for the Mentally Deficient before 1913

Speaking in strictly legal terms, the notion that the mentally defective were a distinct and separate category of people from the mentally ill with different needs and requirements is a relatively new concept. Prior to the 1913 Mental Deficiency Act, providing provisions

²⁵ Although there were a number of certified institutions which were eventually opened in the West Riding, in Bradford, Halifax, Huddersfield and Leeds, Meanwood Park Colony in Leeds was by far the biggest, and opened comparatively early in 1919. With regards to this thesis the institution at Huddersfield would also have been worthy of study. The institution was called 'The Mansion' and was created as an annexe to Storthes Hall Mental Hospital in 1928. Despite being an annexe of Storthes Hall however, the institution was run by the West Riding Mental Deficiency Committee and was a Certified Mental Deficiency Institution. Ref: WYAS, C85/1/15/3, Annual Reports of the Board of Control (1929). Unfortunately however, other than references in the annual reports of the Board of Control and also the West Riding Mental Hospitals Board, there are no sources which have survived for this institution with regards to the patients who were admitted therein, therefore a comparative study of this institution is impossible. The few records that have survived pertaining to this institution are a few registers of the staff who worked there.

²⁶ I. Hutchison, 'Institutionalisation of Mentally-Impaired Children in Scotland, c.1855-1914', *History of Psychiatry*, vol. 22, no. 4, 2011, 416-433.

for people with differing types of learning disabilities had an ambiguous status in law.²⁷ The 1845 Lunacy Acts catered for idiots and lunatics without making too much distinction between their different needs. Collectively the Acts provided a space for curative and custodial care for idiots within the public lunatic asylums, but offered no legal or medical distinction between lunatics and idiots.

By the mid-1860s however it was becoming a well-established medical certainty that the mentally deficient, i.e. those categorised as either idiots, imbeciles or feeble-minded, were a distinct sub-group, with different needs and requirements to the mentally ill. In 1866 Duncan and Millard, who were the consulting surgeon and superintendent of Eastern Counties Asylum respectively, wrote their *Manual for the Classification, Training and Education of the Feeble-Minded, Imbecile and Idiotic*. Their work signalled the beginning of a growing fear of the ‘increase’ of the mentally defective in society and highlighted the medical distinction between these classifications and that of lunacy. Their work argued that:

The number of idiots, imbeciles and ‘feeble-minded’ is very great in the United Kingdom; those in asylums, schools and unions form but a fraction of the whole, and they abound in all classes of society, from the wealthiest to the poorest.²⁸

As hinted at in the above reference to ‘schools,’ in addition to the medical distinction there was often also an age distinction between the mentally ill and mentally handicapped within society and asylums. Frequently children who showed signs of (often quite se-

²⁷ For a report on the ambiguities of terminology and nomenclature throughout various Acts of Parliament see NA, ED 50/116, Minutes of the Board of Education (1928).

²⁸ Duncan and Millard, *A Manual for the Classification, Training and Education of the Feeble-Minded, Imbecile and Idiotic* (London, Longmans, 1866), p. viii.

vere) deficiency were institutionalised within asylums from their early childhood. With reference to this, also in the 1860s, a young James Crichton-Browne (later Medical Superintendent at Wakefield Asylum)²⁹ wrote of “the importance to be attached to the physical, mental and moral training of infancy and childhood.”³⁰ Collectively this distinction in age and the specific desire to give *training* to a group of people with distinct learning needs led to a growing desire to create new spaces for their care.³¹

Despite the growing medical and social discourse however, there was no alteration to the statute for a further two decades. Indeed, the first Parliamentary Bill aimed distinctly at ‘idiocy’ as a separate medical and legal classification to ‘lunacy’ came to fruition with the Idiots Act in 1886. This permissive Act empowered Local Authorities with the right to build separate idiot asylums if they considered it a necessity to do so. However, although this Act was intended to have “a beneficial effect in simplifying the admission of cases into suitable institutions,”³² it has long been recognised that this particular piece of legislation, probably due to the permissive nature of the Act, made little difference to the way that the majority of idiots were institutionally provided for.³³ Further, just four years later, the Lunacy Legislation of 1890 again complicated and confused the two conditions of mental illness and mental deficiency, as similarly to the legislation of 1845, it again blurred and confused legal and medical distinctions. Once again the act catered for lunatics, idiots and persons of unsound mind without any direct distinctions between the three categories.³⁴ Hence it is often observed that the 1886 Idiocy

²⁹ J. Todd and A. Ashworth, ‘The West Riding Asylum and James Crichton-Browne, 1818-76’, in H. Freeman and G. E. Berrios (eds), *150 Years of British Psychiatry*, Vol. 1 (London, Gaskell, 1991), pp. 389-418.

³⁰ J. Crichton-Browne, ‘Psychological Diseases of Early Life’, *Journal of Mental Science*, vol. 6, no. 1, 1860, 284-320.

³¹ K. Day and J. Jancar, ‘Mental Handicap and the Royal Medico-Psychological Association: A Historical Association, 1841-1991’, in *150 Years of British Psychiatry*, Vol. 1, pp. 268-278.

³² Anon., ‘The Report of the Royal Commission on the Blind, Idiots, Imbeciles and Feeble Minded Children’, *The Times*, 27 July 1889.

³³ Thomson, *The Problem of Mental Deficiency*, p. 12.

³⁴ Lunacy Act 1890 [53&54 Vict., c.5].

Act had little impact on a national level, except perhaps to affirm the work of the handful of Charitable Idiot Asylums, which themselves had been established many years earlier.³⁵

As with the national picture, it seems that the legislation of 1886 made little difference in the West Riding of Yorkshire. The West Riding of Yorkshire provided no locally run institutions or comparable independently run charitable solutions for the institutional education and care of idiots and imbeciles. Though there is evidence that some children were sent to the Northern Counties Asylum, the majority of these people remained in more traditional settings of care, either the workhouse, the home, or else the asylum.³⁶ During the mid-1890s however, steps *were* taken to address the problem within the walls of the West Riding Pauper Lunatic Asylum (Wakefield), by the Asylum Sub-Committee.

Stanley Hall Home for Idiot and Imbecile boys was officially opened in January 1901.³⁷ The home, which was merely an annexe of Wakefield Asylum itself, was set up with similar intentions to the voluntary idiot asylums that had been successfully pioneered in England forty years earlier.³⁸ The home was to be financed however, not by voluntary contributions of individual private subscribers, like the voluntary idiot asylums, but through Poor Law finances. This meant that the Medical Superintendent Bevan-Lewis, in conjunction with the Asylum Sub-Committee, were responsible for the decisions relating to the custody, care and treatment of the boys therein. In turn, the roles of Bevan-Lewis and the Asylum Sub-Committee were subsequently overseen by the Commissioners in Lunacy, and thus the boys were treated as any other lunatic or person of unsound mind, under the rules of the 1845 and 1890 Lunacy Acts and subsequent

³⁵ Wright, *Mental Disability in Victorian England*.

³⁶ WYAS, C488/7/2/12, Male Casebook Reports (1897-1905).

³⁷ WYAS, C85/1/12/11, Annual Reports (1901-1905), p. 4.

³⁸ See Wright, *Mental Disability in Victorian England*.

amendment acts.

In her work Hoole strongly emphasizes Bevan-Lewis' contribution to the founding and successful running of Stanley Hall.³⁹ However, the Annual Reports of the Commissioners in Lunacy identify that the Lunacy Commissioners themselves frequently suggested that the West Riding Asylum Committee should consider setting up such a home in one of their asylums. In 1896 the Commissioners in Lunacy suggested in their Annual Reports that:

During our inspection of the three asylums for the West Riding, we have seen fifty idiot children, of whom thirty-six were males and fourteen females in very undesirable association with adult lunatics. In [Wakefield] there are twenty, at Wadsley twenty-one, and at Menston nine. We think it very desirable that some other provision should be made for them at one of the newer asylums, and we hope that the Asylum Committee will take the matter into their early consideration.⁴⁰

Similar comments were frequently included by the Lunacy Commissioners in their Annual Reports in the years between 1890 and 1899. These comments suggest that the 'innovative idea of Bevan-Lewis' might actually have been linked to, if not prompted by, the persistent petitions of the Lunacy Commissioners and their gradual influence on the Asylum Committee. Interestingly however, the quote above suggests that the Lunacy Commissioners felt that such a home or ward would be best suited in 'one of the newer

³⁹ Hoole, 'Idiots, Imbeciles and the Asylum', p. i.

⁴⁰ WYAS, C85/1/12/10, Annual Reports (1891-1899), Report of Lunacy Commissioners, 1896, p. 38.

asylums,' which falls into contrast with the reality, which consisted of a house being utilised at the *oldest* asylum, in Wakefield. This fact is yet another pertinent reminder that the advice of the Lunacy Commissioners was not always followed strictly.⁴¹

In addition, when explaining the history of Stanley Hall during a strand on 'The Problems of Mental Deficiency' at the *National Conference on the Prevention of Destitution* in 1911, Alderman B Crowther from the West Riding County Council spoke of the origins of Stanley Hall Home. Interestingly in his talk, he made no mention of Bevan-Lewis' direct involvement with the scheme, nor does he mention the persistent prompting of the Lunacy Commissioners.

Some years ago in going through their asylums they found that they had quite a number of boys mixed amongst elderly men who were thoroughly imbued with the vicious habits of the other people. They then went to Lancaster and saw their method of procedure, with the result that they decided to separate the boys from the men and employ a teacher... It was marvellous to see the great improvement that had been effected with regard to the boys, who had seemed quite unteachable. They had been taught to read and write and do certain classes of work.⁴²

Crowther's words indicate that there was a level of success at the home, and that employ-

⁴¹ For more on this see, N. Hervey, 'A Slavish Bowing Down: The Lunacy Commission and the Psychiatric Profession, 1845-60', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness*, Vol. 2 (London, Tavistock, 1985), pp. 98-131.

⁴² Alderman B. Crowther, Speaking at the *National Conference on the Prevention of Destitution: Report of the Proceedings of the National Conference on the Prevention of Destitution* (London, Orchard House, 1911), pp. 582-583, p. 582.

ing a teacher and having a prescribed timetable of lessons and classes had some positive effect upon the boys admitted. The timetable reproduced below highlights a ‘desired’ curriculum for the boys to follow, which was published in the Annual Report of Wakefield Asylum in 1901.

Table 2.1: Timetable for Stanley Hall School, 1901⁴³

	Monday	Tuesday	Wednes- day	Thursday	Friday	Saturday
10.30	Musical drill	Repetition poetry	Musical drill	Kindergar- ten	Musical drill	Grace, Prayers, Hymns and Scriptures
10.45	Naming Animals	Picture lesson	Numbers	Drawing	Sand Building	
11.00	Writing	Drawing	Writing	Observation lesson	Colour lessons	
11.30	Kindergarten	Counting	Object Lesson	Writing	Reading	
11.45	Marching	Arithmetic	Marching	Colour les- son	Marching	
AFTERNOON						
2.00	Clock lesson	Kindergar- ten	Repetition	Half Holi- day	Letter writing	
2.20	Speech lesson	Colour	Sense Lesson		Clay modelling	
2.40	Reading	Writing	--		Sense Lesson	
3.00	Cube building	Drawing	Sand building		Arithmetic	
3.20	Conversa- tional	Object lesson	Figures			
3.40	Singing	Form lesson	Songs			

Source: WYAS, C85/1/12/11, Annual Reports (1901-1905), pp. 18-19.

Despite Crowther’s words however, the casebooks of the boys suggest that although quite a high percentage attended the school in some form or another, many did not gain much from their experiences there. Frequently the casebooks suggest the failure of boys to apply themselves to their studies. Examples are common and include eight year old

⁴³ WYAS, C85/1/12/11, Annual Reports (1901-1905), pp. 18-19.

Alfred T who “goes to school, but learns very little;”⁴⁴ Horace E who “goes to school regularly, but is lazy and careless,”⁴⁵ and Arthur H who “goes to school every day but is not much use there.”⁴⁶

The notion that schooling might be necessary, useful or desirable was a contentious issue when the home was first established. Many of the boys admitted to the school were thought to be “of such tender years as to render their association with the older boys undesirable,”⁴⁷ which immediately limited the number of children who could attend the school. Furthermore some of the older boys were considered to be of such a ‘hopeless chronic nature’ that the idea of training was considered to be a ‘waste of time.’ Many of the boys who were admitted to Stanley Hall in its early years were considered to be completely untrainable. Cases included eight year old John R, who was described as a child who “seems to have no understanding, [he is] blind, stunted in growth and helpless, unable to stand or walk... he requires everything to be done for him in the way of feeding and being kept clean.”⁴⁸ Equally seven-year-old William B was described as having “no natural feeling. His only method of conveying his few wants is by clapping his hands, bursting into tears and flinging himself down on the floor.”⁴⁹ Cases of patients with such a high degree of disability appear frequently throughout the casebooks, and highlight that for such patients, schooling was certainly not of the highest necessity. Consequently the idea of employing a teacher to attempt the training and educating of the boys at Stanley Hall had been a matter of some contention. A few months before the first boys were admitted to Stanley Hall, Bevan-Lewis explained that this particular institution should probably not attempt:

⁴⁴ WYAS, C85/3/6/167, Male case book reports, Stanley Hall (1888-1912), patient record no. 5.

⁴⁵ *Ibid.*, patient record no. 93.

⁴⁶ *Ibid.*, patient record no. 102.

⁴⁷ WYAS, C85/1/12/11, Annual Reports (1901-1905), pp. 4-5.

⁴⁸ WYAS, C85/3/6/167, Male case book reports, Stanley Hall (1888-1912), patient record no. 417.

⁴⁹ *Ibid.*, patient record no. 13.

Educational methods on any large scale... but rather to regard the function of such a building as that of a ‘custodial asylum,’ somewhat in the sense expressed by the Lunacy Commissioners... in which they suggested that such an asylum should be of an inexpensive character, and should not aim at too much in the way of attempts at education and development, but should be mainly a receptacle for unimprovable [sic.] idiots, in which they would be fed, kept clean, clothed, and treated with kindness, *leaving to other, and more specially equipped institutions the training and development of imbeciles of a higher degree of intelligence.*⁵⁰

(Emphasis original)

This statement is highly significant, and to some degree contradicts the thesis of Dee Hoole, that Stanley Hall “went beyond its perception as a custodial establishment and practised new approaches to care.”⁵¹ The final part of the above statement, which was italicised by Bevan-Lewis himself, identifies that as early as 1900, the purpose of Stanley Hall was to be a ‘storage tank’ rather than an institution which ranked training and schooling as the highest priorities. From the beginning, the Commissioners of Lunacy were appealing for such provision. In their first inspection of Stanley Hall in 1901, they commented: “We hope that attention will be directed chiefly to physical exercise and in-

⁵⁰ WYAS, C85/1/12/10, Annual Reports (1891-1899), Report of Medical Superintendent, 1900, p. 11. Original emphasis.

⁵¹ Hoole, ‘Idiots, Imbeciles and the Asylum’, p. i.

dustrial training which, we think are, in the case of idiots, the most helpful methods of development.”⁵²

Clearly the home established at the West Riding Pauper Asylum created as many questions and problems as it solved. Bevan-Lewis’ statement that Stanley Hall should leave “*to other, and more specially equipped institutions the training and development of imbeciles of a higher degree of intelligence*”⁵³ was highly problematic. In the late nineteenth century and into the early twentieth century there were very few institutional establishments set up and designed specifically with a view to the training and development of imbeciles of a ‘higher degree of intelligence’. At this stage nothing along those lines existed in the West Riding of Yorkshire, and before the new legislation of 1913, the very provision of such accommodation was in many ways legally ambiguous. Collectively the evidence above is suggestive that Stanley Hall was not quite as innovative as Hoole suggests. Though in the early twentieth century it was an important institution with regard to the attempt to segregate mentally deficient children from mentally ill adults, it still represented a custodial institution, which placed a greater emphasis upon issues of containment rather than cure or education.

As the nineteenth century came to a close, many professionals realised that a new solution to the ‘problem of the mentally deficient’ was necessary, as sporadic local attempts to separate various types of mental deficiency from lunacy, like at Stanley Hall, were struggling to keep up with the growing demand for places. The increasing number of chronic and incurable idiots and imbeciles housed within public lunatic asylums, workhouses, prisons and reformatories, not to mention those considered to be ‘in danger but not under any current supervision’ became a major concern to the Edwardian elites.

⁵² WYAS, C85/1/12/11, Annual Reports (1901-1905), Reports of the Commissioners in Lunacy, 1901, p. 47.

⁵³ WYAS, C85/1/12/10, Annual Reports (1891-1899), Report of Medical Superintendent, 1900, p. 11.

Subsequently, due to mounting pressure on the Government for action and after repeated appeals, the Royal Commission on the Care and Control of the Feeble-Minded was set up in 1904.⁵⁴

The Commissioners who took evidence and deliberated from 1904-1908 eventually concluded that mental deficiency was a serious problem which needed to be dealt with and that the existing systems for care were completely inadequate. This statement again suggests that there were many problems with the isolated and unconnected custodial institutions that preceded the 1913 Act, such as Stanley Hall. As has been noted in more detail elsewhere, the 1908 report was in favour of dealing with the problem by creating new specialised residential institutions and segregated colonies for the mentally deficient for either long-term or life-long care.⁵⁵ The Commission's *Report* published in 1908 stated:

Of the gravity of the present state of things, there is no doubt. The mass of facts that we have collected, the statements of our witnesses, and of our own personal visits and investigations compel the conclusion that there are numbers of mentally defective persons whose training is neglected, over whom no sufficient control is exercised, and whose wayward and irresponsible lives are productive of crime and misery, of much injury and mischief to themselves and to others, and of much continuous expenditure, wasteful to the community and to individual families.⁵⁶

⁵⁴ WYAS, C488/1/2, West Riding Asylum, Minute Book (1905-1907), p. 1835

⁵⁵ Thomson, *The Problem of Mental Deficiency*, p. 33.

⁵⁶ Royal Commission on the Care and Control of the Feeble-Minded, *Report of Royal Commissioners, Inspectors and Others, Vol. VIII, Dealing with Lunacy under the Poor Law: Methods of Procedure* (London,

The 1908 report, partly quoted above, suggested that any act should be about ‘training’ as well as ‘control.’ The key binaries of training and control stand in contrast to Bevan-Lewis’ official picture of Stanley Hall as a custodial institution. However, despite the report’s criticism of the existing systems of care, it was soon found that it could be difficult to juggle the competing dualities of providing adequate training at the same time as providing adequate control. Indeed, which of these objectives would become the most important factor of the act was frequently under debate. During a debate in the House of Commons in 1912, one Liberal MP seemed to forget about aspects of training altogether, and merely focused on aspects of control as part of his *defence* of the bill. As part of the debate, it was explained that the proposed bill did not intend to extend *any* control over *certain* types of mental defectives, and it was argued that:

It is not intended that defectives who are properly looked after in their own homes, or who are harmless defectives shall be brought within the scope of the Bill; but simply that defectives who are at present either themselves suffering or inflicting suffering upon other people should come under the proper authorities. Really I think as much as anything this is a Bill to put persons who are at present under inappropriate restraint under appropriate restraint.⁵⁷

This indicates that from the outset, the Mental Deficiency Act fell victim to the same

HMSO, 1908), p. 3.

⁵⁷ Speech by Mr Cawley, *Mental Deficiency Bill*, 19th July 1912, http://hansard.millbanksystems.com/commons/1912/jul/19/mental-deficiency-bill#S5CV0041P0_19120719_HOC_346 (accessed 10/05/2011).

ideological problems as those that were uncovered by those responsible for the establishment and running of Stanley Hall in Wakefield. The problem affecting any attempt at 'dealing' with the mentally deficient was in many ways circular: not all defectives who it was thought needed control were trainable, and not all 'trainable defectives' specifically needed to be put under control. This paradoxical element of the 1913 Act was to have profound consequences on local institutions and the local running of the Act, which culminated in a two-tier approach to care for defectives with different behavioural characteristics. This section has shown some of the problems relating to Stanley Hall *before* the new legislation of 1913 was passed. The following sections will identify how the continued and practically unchanging role of Stanley Hall *after* 1913 suggests that there were real difficulties with the implementation of the 1913 Act as well as fundamental problems with the establishment of new mental deficiency accommodation, nationally and also locally in the West Riding of Yorkshire.

Mental Deficiency Institutions After 1913

In many ways it is evident that the Mental Deficiency Act had similar benefits and problems as those that were inherent within the establishment of Stanley Hall, particularly the issues relating to the complexities surrounding the need to control and educate those who were deemed to be mentally defective. However, there were also other aspects of the new act that made the approach taken by Bevan-Lewis at Stanley Hall look outdated. Firstly, under the new act, the impetus for establishing, building (or buying) and funding new colony-style institutions was supposed to come from the Local Authorities or charitable institutions rather than the Poor Law Authorities. In the West Riding of Yorkshire, the first real steps towards the establishment of a mental deficiency colony along the lines

envisaged under the terms of the Act were taken in Leeds. Following the end of the war, in 1919 Leeds City Council rented Meanwood Park specifically for the purposes required in the 1913 Act. The Leeds Mental Deficiency Committee officially ran the colony, and the first patient was also admitted in 1919. However one of the main problems of colony provision being run by the Local Authority meant that Meanwood Park only catered for the people of Leeds. Thus, despite being a comparatively large institution, with residential accommodation for sixty-seven males and one hundred and seventeen females, Meanwood Park did nothing to relieve the pressures upon other towns and cities within the region.

In Wakefield and the surrounding towns in these early years no such new provision for the mentally defective was made. This meant that Stanley Hall, which continued to be run by the West Riding Asylums Board, was still the sole source of care for the majority of persons considered to be mentally defective in the West Riding of Yorkshire. After 1913, the fact that Stanley Hall was linked to a pauper asylum would often prove to be an issue of contention between the Board of Control and the West Riding Asylums Board.⁵⁸

One of the main arguments for the lack of provision provided by Local Authorities was that of a lack of finance. The financial stringency imposed by the war years and its after-effects meant that many Local Authorities did not see the need for, let alone wish to comply with, new legislation that compelled them to establish new institutional colonies specifically for the mentally deficient. The evidence is clear that the slow response from Local Authorities in setting up these institutions was not unique to the West Riding of Yorkshire. In December 1914 the Home Secretary made the following statement in the

⁵⁸ WYAS, C85/1/15/6, Annual Reports of the Board of Control (1919), p. 208; WYAS, C85/1/15/7, Annual Reports of the Board of Control (1920), p. 64; WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1930), p. 103.

House of Commons regarding the apathy of most Local Authorities towards the implementation of the Act:

The response made by the Local Authorities was very slow, and many of them delayed for weeks and some for months, the essential preliminary step of setting up a committee to administer the Act as required by law. The Board [of Control] continues to use all of its influence towards expediting the action of the local authorities... No local authority has as yet provided a certified institution either alone, or in conjunction with other local authorities.⁵⁹

Plagued by a chronic lack of approved institutional accommodation and persistent underfunding, it would appear that the Act was only ever going to be a partial success from the outset and that places like Stanley Hall would continue to be required. The First World War provided yet another serious challenge to the commencement of the creation of separate provision for the mentally defective, away from the Poor Law Authorities. In their first report, the newly formulated Board of Control commented that:

While the act was still in an early stage, the outbreak of War in August threw a most serious obstacle in the way of its further progress, not only by diverting into other channels the energies of the local authorities and other parties concerned, but also by financial stringency, which has rendered obligatory the curtail-

⁵⁹ NA, ED 50/113.

ment of capital expenditure within the narrowest limits.⁶⁰

By the end of 1918, the Board of Control were complaining that the outbreak of war had retarded their efforts to care for the mentally defective by some years as there was still not enough cash or institutional spaces for those who were considered to be in need of accommodation.⁶¹ By the early 1920s the Treasury again forced the Local Authorities and the Board of Control to limit their expenditure with regard to the Mental Deficiency Act. A notification sent around the Local Authorities in 1921 announced:

The Board [of Control] must therefore request that Local Authorities will limit their operations in order to ensure that all fresh liabilities incurred are covered by the amount of the approved estimate as respects both the current and the ensuing years.⁶²

The lack of money to create new approved mental deficiency accommodation led to the necessity to utilise older institutions to retain the cases already certified under the Lunacy Acts as well as to provide residential care to people ascertained as mentally defective under the new Act. This can be seen locally by the continued and unchanging function of Stanley Hall during these years. In 1920, the Board of Control explained the necessity for improvisation when looking for enough institutional places to care for the mentally deficient:

⁶⁰ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 55.

⁶¹ WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), p. 43.

⁶² NA, ED 50/119 (1921).

The existing financial stringency has rendered the provision of certified institutions by local authorities impracticable for the present and to enable the Mental Deficiency Act to be worked at all, it is *absolutely necessary to fall back on Poor Law institutions...* as we have said in our previous reports, we hope that the extended use of Poor Law accommodation may only be a temporary necessity.⁶³

It is clear from the negative language used that the Board of Control evidently considered Poor Law accommodation for its mental defectives to be second rate, having to “fall back” on it when there was nothing else available. The fact that they hoped that the use would “only be a temporary necessity”⁶⁴ until enough certified institutions run by the Local Committee for Mental Defectives and Local Councils could be established suggests that it was hoped that Poor Law accommodation would only be a short-term solution. This further suggests that after 1913 Stanley Hall was considered to be outdated in comparison to the newer form of institutional care, and the continuing use of Stanley Hall is suggestive of the failure of the new Act in acquiring enough residential space for the region’s mental defectives.

From the outset, this particular failure of the Act was anticipated and the Board of Control were forced to relinquish their moral views and accept that certain classes of the mentally defective would be more economically accommodated in Poor Law institutions. This process began as early as 1914, whereupon after the outbreak of War, the Board attempted to justify the staggering percentage of cases who had been certified under the Lunacy Acts, which were still accommodated within Poor Law institutions, specifically

⁶³ WYAS, C85/1/15/7, Annual Reports of the Board of Control (1920), p. 64.

⁶⁴ Ibid.

in this reference to those who resided in the workhouse.

With a few isolated exceptions, these cases are well and suitably cared for. They are idiots, imbeciles, harmless dements and cases of senile decay. Many of them are usefully employed about the house or in the gardens. Some have been in the workhouses, all, or nearly all their lives and look upon it as home; any change would be a hardship for them... Speaking generally, we do not think that a more suitable or economic refuge could be found for these harmless old people and we can again record with pleasure that we have almost invariably found them happy, contented and treated with evident kindness and sympathy.⁶⁵

This extract identifies that whilst finances were so stringent, and thus available accommodation in certified houses at a premium, the Board of Control were willing and even contented to see such untrainable cases remain institutionalised within the workhouse. It would appear that a lack of finance, leading to a lack of approved or certified institutional space left the Board of Control's vision of 'appropriate accommodation' for all to be an ideological illusion, and places were often given to younger cases that were deemed 'trainable.'

The notion that it was the trainability of defectives that was the first priority in specifying which institution that they were sent to, or rather, that they were left in, is fully apparent in the Board's analysis of middle-aged imbecile and feebleminded women who were to remain in the workhouse, often for life. For these women it was considered

⁶⁵ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 46.

to be:

Too late for any special training, though in most cases training would have been possible and beneficial. There is however much more employment in the workhouses for women than for men. Women are seldom idle; they are employed in the kitchen, laundry and housework. In the view of the fact that *for many years to come colony accommodation will be limited and should be reserved for younger and more trainable women*, we anticipate that women over child bearing age will continue to be maintained in workhouses.⁶⁶

Despite the inevitable stigma of pauperism and being institutionalised within the walls of a workhouse, the Board of Control campaigned for a “greater variety” to be “introduced into the lives of all mentally deficient persons who have to remain in the workhouse.”⁶⁷ They called for the mentally deficient to be allowed to “go out oftener under supervision, that their day rooms [c]ould be more homely and comfortable and that regular entertainments and amusements could be instituted in the evenings.”⁶⁸ These desires indicate perfectly the disparity between the image of the workhouse of who it was supposed to cater for under the principles of 1834, and the reality of what it had actually become by 1914, indicated by which groups of people were actually incarcerated within it, not the able-bodied, but the aged, sick, frail and infirm.⁶⁹ All of this identifies many problems with

⁶⁶ Ibid., p. 47. Emphasis mine.

⁶⁷ Ibid., p. 47.

⁶⁸ Ibid., p. 47.

⁶⁹ For more on conditions in the Workhouse see: M. A. Crowther, *The Workhouse System, 1834-1929: The History of an English Social Institution* (Georgia, University of Georgia Press, 1982). See also H. Bosanquet, *Poor Law Report of 1909: A Summary Explaining the Defects of the Present System and the Princi-*

the Mental Deficiency Act. The fact that there were not enough institutions to meet demand meant that many patients were forced to remain in the older institutions.⁷⁰ This meant that Poor Law accommodation like workhouses and Stanley Hall were still being utilised for the region's mental defectives, despite the fact that these places were considered to be little more than storage tanks by the Board of Control, and also by many who managed these institutions, such as Bevan-Lewis in the case of Stanley Hall.

Mentally Deficient Children and Suitable Places of Care after 1913

Although the Board of Control were at least content that many older patients were to remain within the walls of Poor Law accommodation, their opinions upon the 'correct' and suitable places of institutional treatment for children was very different. In their Annual Reports of 1914 they explained:

It is hard on a young girl that the whole of her life should be an alteration between the washhouse and the day room. The latter is often of the dullest description, with bare walls, a few benches and a table. Generally there are few, if any books, little music and no games. Everything that youth loves is absent. This is quite right if the object is to drive out the able bodied, but quite wrong if it is to make the feeble-minded settle down happily for

pal Recommendations of the Commission so far as relates to England and Wales (London, Macmillan, 1909); C. Booth, *Poor Law Reform* (London, Macmillan, 1910).

⁷⁰ This debate mirrors the older debate as to which patients were suitable for workhouse or asylum accommodation. For more on this debate see R. Ellis, 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century', *Social History of Medicine*, vol. 19, no. 1, 2006, 55-71.

life. The contrast is marked between the lack of variety and change in the workhouse and the life of a well organised colony where something is arranged for every evening.⁷¹

This shows that despite the desire of the Board of Control that circumstances within the workhouse should be adapted to suit the needs of the new class of inmates that resided there, conditions were for the most part bleak, and were evidently considered by the Board to be inferior to the “well organised colony.” Although Poor Law accommodation was considered adequate for the old-aged, harmless and un-trainable defectives, the Board of Control made absolutely clear that they hoped that:

*All defective children without exception, will, in future be reported to the Local Committee for the Care of Defectives, whose statutory duty it has now become to provide for them.*⁷²

Thus the hope was clearly to see these children removed from Poor Law accommodation, be it the workhouse or lunatic asylum and instead transferred to the new specialist institutions and colonies. However, the Board of Control’s desire that “*all defective children without exception*” would be removed from Poor Law accommodation was only ever a pipe dream. On the 1st January 1931, it was admitted that, “the number of patients under fifteen years of age in mental hospitals was 691 (402 males and 289 females).⁷³ Although it was not specifically stated, the likelihood is that the majority of these children would

⁷¹ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 50.

⁷² Ibid. Emphasis mine.

⁷³ WYAS, C85/1/15/4, Annual Reports of the Board of Control (1930), p. 79.

have been suffering from some form of mental deficiency and would have been categorised as either feeble-minded or else suffering from idiocy or imbecility.

In the West Riding of Yorkshire, as in the rest of the country, many children with learning disabilities continued to be maintained in Poor Law accommodation. This is especially true for the boys admitted to Stanley Hall. Importantly Stanley Hall *never* applied for and thus was never recognised as a new Mental Deficiency Colony under the new legislation. It remained under the administration of the West Riding Asylums Board, later the West Riding Mental Hospitals Board, and continued to be overseen by the Medical Superintendent of Wakefield Asylum and subjected to the (occasionally quite critical) Annual Reports of the Board of Control.⁷⁴ Those receiving institutional care in this building continued to be paid for through the Poor Law rates, and certified under the lunacy legislation. Therefore from the outset of the new legislation of 1913, Stanley Hall was no longer a ‘new and innovative’ institution, and thus in the eyes of the Board of Control was perceived to be different to the new Mental Deficiency Colonies that were established in the West Riding.

After the 1913 Act was passed Stanley Hall could no longer claim to be a new and innovative solution for the treatment and custody of the mentally deficient. As a result, its purpose became ambiguous and subsequent superintendents of Wakefield Asylum were forced to adapt the initial ideology of the home to suit the new classes of patients who were being sent to the asylum after the Act. The extract quoted below is taken from the Annual Reports of Wakefield Asylum in 1924, written by Joseph Shaw-Bolton, the Medical Superintendent. It identifies the many uncertainties that the 1913 Act created with regard to Stanley Hall specifically, and by extension to the duties of asylums and other Poor Law accommodation and relevant Local Authorities with regard to the men-

⁷⁴ See for instance WYAS, C85/1/15/7, Annual Reports of the Board of Control (1920), p. 64.

tally deficient.

Stanley Hall continues one of the most successful departments in the institution, in spite of the fact that juvenile admissions are now of a very low ebb. It is a curious fact that certain of our local authorities seem now to regard juvenile cases as ineligible for treatment here and still fail to provide suitable treatment for them elsewhere. The immediate result is that certain types of mental disease fall between the Lunacy Acts of 1890 and the Mental Deficiency Act of 1913 and are, in consequence, worse off than when we treated them here under the former Act.⁷⁵

Although Shaw-Bolton provided no figures to back up his point, the number of young people in the institution had been curtailed to the point where the home could no longer be said to represent the same ideals with which it was established. It was no longer a home for boys, but instead arguably became a home for adult males categorised as incurable idiots. In the same year as Shaw-Bolton's report, The Board of Control commented that of sixty-five male patients in Stanley Hall when they visited, only thirty patients were under the age of sixteen years old.⁷⁶ Although it could be argued that the reduction of the number of juvenile cases sent to Stanley Hall suggests that the Board of Control were beginning to have their way with regards to their ideas pertaining to suitable accommodation for children, it is clear that some children remained within the walls of Stanley Hall. It would seem that this new practice meant that by the mid-1920s the earliest intentions of splitting up the boys from the men had completely lapsed back into a

⁷⁵ WYAS, C85/1/12/14, Annual Reports (1923-1927), Report of Medical Superintendent, 1924, pp. 79-80.

⁷⁶ *Ibid.*, p. 111.

system of shared accommodation between adults and children. Even more importantly however, Shaw-Bolton's statement that "certain types of mental disease...are, in consequence, worse off than when we treated them here under the former Act"⁷⁷ suggests that some children were perhaps now not receiving *any* institutional care and attention. This statement is highly significant, and is evidence that in some ways the Mental Deficiency Act actually made caring for certain types of mentally defective children *more* difficult than before it was passed. The evidence suggests that this may have been the case at Stanley Hall.

Thus far this chapter has identified that the new impetus on training above mere custody and control meant that places like Stanley Hall were not considered to be particularly innovative after the 1913 Mental Deficiency Act. However, as was mentioned above, a number of people considered to be mentally defective were not considered to be trainable, and this led to massive problems with the implementation of the new act. The rest of this chapter will consider the inadequacies of the 1913 Act in the West Riding of Yorkshire, with regard to the patients who were institutionalised during these years. It will identify that Stanley Hall continued along the lines of its original policy by offering a location for those who were not considered to be 'trainable' and hence were unwanted by the new institutions. By offering an explanation of how the act was implemented and co-ordinated on a national and local level, it will become clear how such a two-tier approach to care was allowed to develop.

⁷⁷ Ibid., pp. 79-80.

The 1913 Act: Implementation and Co-ordination

Shaw-Bolton's comment above that "certain of our local authorities seem now to regard juvenile cases as ineligible for treatment here and still fail to provide suitable treatment for them elsewhere,"⁷⁸ suggests a certain amount of confusion with regard to the attitudes of the Local Authorities about where to send patients requiring institutional treatment and custody. The fact that workhouses, Stanley Hall and by extension the West Riding Asylums Board and other lunatic asylums across the country were legally still allowed to admit, institutionalise and care for mentally defective persons after the 1913 Mental Deficiency Act was passed highlights one of the most confusing elements of the new legal framework. This fact created a two-tier approach to care, which was made necessary due to the substantial lack of finance and appropriate mental deficiency accommodation available.

Arguably the complex rules relating to whose job it was to implement the Act locally was a major barrier to its success. As Thomson explains, "the complexity of the rules and regulations of the Act, and the ambiguities over the definition of mental deficiency, placed considerable influence in the hands of those who interpreted and implemented policy on the ground level."⁷⁹ The problem with this was that under the new legislation, influence and responsibility was somewhat confusingly divided between three separate groups. These groups consisted of:

- (a.) The *Education Authorities*, who, from the passage of the Elementary Education (defective and epileptic children) Act of 1899, were permitted to establish special schools and classes, and whose

⁷⁸ Ibid., pp. 79-80.

⁷⁹ Thomson, *The Problem of Mental Deficiency*, p. 242.

job it would later become in 1914 to select children who were underachieving at school for special schools.⁸⁰

(b.) *Local Committees for the Care of the Mentally Defective*, who were set up under the 1913 Act. In practice, these usually consisted of a sub-committee of the Local Authority, i.e. the local council or county (borough) council.

(c.) The *Poor Law Authorities*, who were technically still legally responsible for the idiots and imbeciles under their care who had been certified under the Lunacy Legislation of 1845 and 1890 and related amendment acts.

This collage of competing authorities clearly led to problems in the day-to-day implementation and running of the Act. As Thomson points out, “The most serious limitation resulted, not from modifications to the [1913] Act itself, but from the passage of the Education Act [1914], which provided a separate system of care for all the educable mental defectives under the age of seventeen.”⁸¹ This separate system of care became a really complex issue for those involved in implementing the system on both a local and a national scale. In trying to figure out what exactly the new legislation of 1914 meant for them, the Board of Education considered:

⁸⁰ Between the years 1899 and 1938 there were various pieces of legislation passed, which firstly permitted and later made it mandatory for Local Education Authorities to provide schooling for certain mentally and physically disabled children under their care. The brief overview below is taken from the National Archives website:

- Elementary Education (Defective and Epileptic Children) Act 1899 enabled local authorities to provide for the training of physically and mentally disabled and epileptic children
- Special Schools Education Act 1914 made these powers mandatory for mentally disabled and epileptic children
- Education Act 1918 made these powers mandatory for the physically disabled
- Education Act 1921 extended compulsory education for children with these disabilities to the age of 16

For more information see: <http://www.nationalarchives.gov.uk/records/research-guides/special-education.htm> (Accessed 26/04/14)

⁸¹ Thomson, *The Problem of Mental Deficiency*, p. 39.

In considering how we should proceed, we must, I think bear in mind that the Local Control Authorities and the Local Education Authorities are not identical bodies. Where the Local Education Authority is a County or County Borough the two authorities are simply different committees of the same council; but where the Education Authority is a Borough, or Urban District, the Control Authority is an entirely separate body, namely the County Council... In the last resort we can hardly refuse to allow the Local Education Authority to carry out the duty of providing education for mentally defective children placed upon it by parliament simply because a different authority has not performed other duties placed upon it by a different Act of Parliament.⁸²

Despite the involvement of the Education Authorities however, as mentioned above, it was the duty of the new Local Mental Deficiency Committee to ascertain the number of individuals in need of care under the new law. By way of explanation of how this partnership might work, the Board of Control commented:

The Local Authority should appoint a sufficient number of energetic officers with tact and some previous knowledge of the work of enquiry and recording... These officers should be in constant communication with the persons and authorities from whom information as to defectives can ordinarily be obtained. Amongst the

⁸² NA, ED 50/113, Minutes of the Board of Education (1915).

most useful of them are the Education and Poor Law Authorities, associations established for assisting defectives, Penitentiaries and rescue homes, reformatory, industrial and Poor Law Schools, remand homes, places of detention, probation officers and the governors of H.M. Prisons. As it is the duty of the Local Education Authority to ascertain what children in their area between the ages of seven and sixteen are defective and to notify suitable cases it follows that the most fertile source of information... will be the Local Education Authority and its officers. There should therefore be the closest co-operation between the staff of the Mental Deficiency Committee and that of the Local Education Authority.⁸³

The casebooks of Meanwood Park Colony seem to suggest that in some cases this system of collaboration between the Local Education Authorities and Leeds Committee for the Mentally Deficient seemed to work well. Patients were frequently admitted to Meanwood Park Colony after their attendance had finished at a local special school in the area. Sixteen year old Francis B for instance attended Lovell Road Special School for mentally defective children from February 1919 to December 1926 and was admitted to Meanwood Park just two months later in February 1927.⁸⁴ Similarly ten year old Alfred B attended Leeds Special School for mentally deficient children from November 1923 to September 1926 and was subsequently admitted to Meanwood Park just a few months later in early January 1927.⁸⁵ Whilst both of these cases, and many more besides, identify a straightforward collaboration between the Education Authorities and the Local Com-

⁸³ WYAS, C85/1/5/15, Annual Reports of the Board of Control (1918), pp. 43-44. For more on this relationship see NA, ED 50/114, Printing of Mental Deficiency (Notification of Children) Regulations (1914).

⁸⁴ WYAS, C904 (16), Case book reports, Meanwood Park (1924-1932).

⁸⁵ Ibid.

mittee for the Care of the Mentally Defective, the age of Alfred B does suggest that there were inconsistencies between the ages of children that the Education Authority would, could and should deal with.

In other cases however, the system of collaboration between these two groups seemed to be much less efficient, and patients were frequently discharged from special schools and had to wait months before they were admitted to Meanwood Park Colony. Although the reason for the delay is not explained, we can assume that the delay was linked to a number of factors including a lack of institutional residential space, and a lack of communication between the various authorities. Cases include patients like twenty-seven year old Claire K, who had previously attended the Leeds Hunslet Hall Special School for Mentally Deficient Children from June 1911 to July 1917. Despite leaving school in 1917 however, she apparently was allowed to continue a normal life away from mental deficiency services until she was finally admitted to Meanwood Park in 1929.⁸⁶ Claire's case was by no means unusual and many patients were seemingly without institutional treatment for similar lengths of time. Mary Elizabeth T for instance finished her special school attendance in August 1920, having attended Leeds Hunslet Hall Special School since 1913. Similarly however, she too appeared to get lost in the 'institutional system' and was not admitted to Meanwood Park until 1927. These cases and many similar ones identify the continuation of the fears of the Board of Education, who in 1915 stated that "a school was almost worse than useless unless an institution existed in which children needing further institutional treatment could be transferred when they leave school."⁸⁷ Further, the Admission Register highlights that although some patients were admitted to Meanwood Park Colony with the consent of their parents, most were sent on

⁸⁶ Ibid.

⁸⁷ NA, ED 50/113, Minutes of the Board of Education (1915).

the authority of a magistrate, Justice of the Peace, or else the local judicial authority.⁸⁸ In this respect, the process of institutionalisation would mirror that of a patient who had been certified under the 1890 Lunacy Acts.

Although these cases highlight that there were frequently problems between the working collaboration of the Education Authorities and the Local Mental Deficiency Committee, in theory, the relationship was reasonably straightforward. Despite all the various complications and uncertainties, the fact that *hypothetically* the Education Authorities stopped being in charge when their children reached school leaving age makes this relationship much less ambiguous than that of the Poor Law Authorities, who were in charge of all mental defectives certified under their care, regardless of their age.

Certainly the Act was much more confusing with regard to the power and responsibilities of the Poor Law Authorities for those certified as idiots under the Lunacy Laws. In their report of 1914, The Board of Control tried to explain the relationship:

The Mental Deficiency Act although did not directly interfere with the duties and powers of the Poor Law Authorities with regard to their mental defectives, provided the means whereby these authorities could transfer many of the cases to the Local Committee for the Care of the Mentally Defective.⁸⁹

The problem with this was that asylum and workhouse accommodation provided much cheaper institutional care than the new mental deficiency colonies. Therefore the fact that the wording only stipulated that the Poor Law Authorities “*could* transfer many... cases” (my emphasis) and with nothing to suggest that the new Local Committee for the Care of

⁸⁸ WYAS, C904/5/1, Admission Register for Meanwood Park Colony (1919-1945).

⁸⁹ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 46.

the Mentally Defective “*must*” find a “suitable” place for these cases, it is easy to see the potential problems in the implementation of the act on both a national and local scale. Many patients were simply never admitted or transferred to the new accommodation.

At Stanley Hall patients suffering from very similar conditions as those admitted to Meanwood Park were admitted to the institution having received very different treatment before their institutionalisation. Those who had received any treatment or care within a special school or other mental deficiency institution were in the minority. Instead many children arriving at Stanley Hall were transferred from other West Riding Lunatic Asylums and the main block of Wakefield Pauper Lunatic Asylum itself. These children and adults had been admitted to the original asylums after being certified in the same way as lunatics under the various statutes of the lunacy legislation. Instead of being admitted after receiving some form of education in a special school, many patients appear to have been sent to the asylum straight from their families. Examples include six year old John L who had been notified to the Poor Law Relieving Officer by his aunt, who appeared to be his custodian. John’s institutional journey saw him removed firstly to the workhouse in Sheffield, before being transferred to Wakefield Asylum in 1917 and finally admitted to Stanley Hall two years later in 1919.⁹⁰ Similarly, the uncle of seven year old Edward P began the process of Edward’s incarceration. In contrast however, Edward was sent straight to Wakefield Asylum, and was transferred to Stanley Hall within five days of his arrival at the asylum.⁹¹ Other patients were transferred from the workhouse itself, like eight year old Walter K who was admitted from Keighley Union Infirmary and transferred to Stanley Hall in 1919.⁹² The fact that very few patients admitted to Stanley Hall

⁹⁰ Although patients were often removed from Sheffield Workhouse to Wakefield Asylum, in this case John was probably admitted to Wakefield on account of the fact that Wadsley Asylum had been converted into Warncliffe War Hospital for the duration of the First World War. WYAS, C85/3/6/186, Male case book reports, Stanley Hall (1908-1924), patient record no. 453.

⁹¹ WYAS, C85/3/6/186, Male case book reports, Stanley Hall (1908-1924), patient record no. 445.

⁹² *Ibid.*, patient record no. 449.

had any previous institutional training may have been a factor that helped to prevent their admission to a certified institution for the mentally defective. The case books and admission registers suggest that despite all the different pieces of legislation and policy, local practice was exceptionally varied, and many patients with similar designations of deficiency received very different experiences of care, both before and during their institutionalisation to respective institutions. The evidence shows that where a mentally deficiency institution had been provided by the local authorities, the new legislation could and frequently did work well, as was the case in Leeds. However, where no such provision had been created the legislation had little effect, and institutionalisation at Stanley Hall continued in much the same way as it had before the 1913 Act was passed.

Rejection and Selection: The Desirable Patient for a Mental Deficiency Colony

Unsurprisingly difficulties often arose with relation to who was responsible for providing institutional care to patients with different types of mental deficiency. Perhaps the most serious issue facing the 1913 Act was that the Poor Law authorities would frequently find that the cases that they had transferred to specialist certified institutions through the Local Committee were often deemed ‘unsuitable’ and sent straight back to the Poor Law authorities, under the guise of the 1890 Lunacy Legislation. As early as 1914, the Board of Control were lamenting “We have found a considerable number [of defectives] who have been placed in [mental deficiency] institutions, “found unsuitable,” and returned to the workhouse.”⁹³

The continuation of this practice meant that even half a decade after the Act had been implemented, in 1918, the majority of low-grade cases, (i.e. the worst cases of idio-

⁹³ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 50.

cy and imbecility) had “to be sent to asylums, regulated to Poor Law Institutions under section 24 of the Lunacy Act, or remain undealt with.”⁹⁴ The practice of new colonies sending ‘undesirable’ patients back to the Poor Law Authorities was one that continued long after the establishment of the Act. In 1927 the Board of Control were desperately trying to convince:

The Local Authorities [that they] should now recognise that managers of private institutions will not accept or retain difficult and troublesome cases. We have knowledge that cases are constantly refused [admission to private institutions]. If a defective has been in prison, if a defective girl has had an illegitimate child or is reported to be sexually immoral or if defectives are violent tempered or epileptic or faulty of habits, *it is almost impossible to find any institution willing to accept them.*⁹⁵

This quote from the Board of Control highlights one of the biggest disparities of the Act. Indeed, the 1913 Mental Deficiency Act gave powers to local authorities to place under control, either in an institution or under Guardianship, any defective including idiots, imbeciles, and those labelled feeble-minded or moral imbeciles who were:

Found neglected, abandoned, or without visible means of support... undergoing imprisonment or penal servitude... detained in an institution for lunatics or a criminal lunatic

⁹⁴ WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), p. 57.

⁹⁵ WYAS, C85/1/15/12, Annual Reports of the Board of Control (1927), p. 43. My emphasis.

asylum... a habitual drunkard... been notified by the Education Authorities [as unable to benefit from education]... or who is in receipt of Poor Law relief whilst giving birth to an illegitimate child.⁹⁶

It would seem therefore, that in direct contradiction of the remit of the law, many of the defining characteristics of these peoples' mental deficiency were actually 'unwanted' by private institutions, as they were considered to be 'undesirable' patients. This identifies a major disparity between the original ideology of the Act, and its actual implementation.

The ability of many mental deficiency colonies to be able to select and reject patients was linked to their voluntary status as charitable institutions and also the lack of 'suitable' accommodation established by councils and county councils through the Local Committees for Mental Defectives. Throughout their reports on mental deficiency, the Board of Control and the Board of Education recognised the disparities between the limited accommodation made available by Local Authorities in comparison with that made available from voluntary and philanthropic organisations. As early as 1914, the Board of Education commented that "institutions and homes provided by religious and philanthropic associations, and by individuals have come forward in considerable numbers" in comparison to the slow rate of the local authorities.⁹⁷ By the first of January 1919 this disparity had grown further and the Board of Control were complaining that "of the fifty-six institutions certified, eleven had been established by Local Authorities and forty-five by various philanthropic associations or religious societies."⁹⁸ This evidence highlights that rather than being the 'normal' type of institution established under the 1913 Act, as it

⁹⁶ NA, ED 50/116, Copy of the Mental Deficiency Act (1913).

⁹⁷ NA, ED 50 113 (1914).

⁹⁸ WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), p. 44.

was hoped, in the early years Meanwood Park was actually quite an unusual institution. The problem with the disproportionate number of charitable or religious institutions being established was the tendency for voluntary institutions to take the ‘best’ cases and reject the worst. This was especially true as patients admitted into voluntary institutions were frequently voted in by subscribers to the institution, on a democratic election-style system.⁹⁹

As early as 1914, the Board of Control noted that, “It is natural that voluntary institutions should seek to select cases that they provide for and avoid difficult cases.”¹⁰⁰ However, this situation often meant that the local authorities, who were without their own certified accommodation, were frequently forced to appeal to managers of philanthropic associations who then had the opportunity to decide whether or not the patient was “suitable for [their] care.”¹⁰¹ Due to this inefficient system and the increasingly awkward situation, the Board of Control urged the Local Authorities to provide their own institutional residential care, so that all patients needing care could be admitted to ‘appropriate accommodation.’ As early as 1918 the Board of Control warned that:

Unless this is done, the present tendency to the multiplication of small institutions will increase and result in a continued lack of provision for low-grade cases, unsatisfactory classification, inefficient teaching and manual training and an unnecessarily high maintenance rate.¹⁰²

This routine whereby new mental deficiency colonies selected only the ‘best’ and most

⁹⁹ Wright, *Mental Disability in Victorian England*, p. 194.

¹⁰⁰ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 50.

¹⁰¹ WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), p. 44.

¹⁰² *Ibid.*, p. 45.

trainable cases continued into the 1930s and increasingly seemed to include new institutions set up by the Local Authorities *in addition to* charitable and private institutions. By 1930 the practice in which many new institutions merely resorted to the Poor Law Authorities in order to ‘discard’ their unwanted cases was still quite apparent. In response to this custom the Board of Control reported:

We are also of the opinion that the managers of certified institutions should use every endeavour to provide suitable staff and accommodation for their tiresome and difficult cases, and should not take recourse to getting rid of difficult patients by certification under the Lunacy Acts: 111 defectives have been transferred from certified institutions to mental hospitals during 1930.¹⁰³

As the evidence from the Board of Control quite clearly identifies, the ability for private and charitable institutions to select and reject cases according to a patient’s behavioural characteristics identifies very serious problems with the 1913 Act. In practice, the result of ‘undesirable’ patients being either sent back to pauper accommodation – workhouses or asylums – and the desirable patients being looked after in the new certified accommodation created a two tier approach to care, where medicine and education seemingly took a back seat to a patient’s behavioural characteristics.

¹⁰³ WYAS, C85/1/15/4, Annual Reports of the Board of Control (1930), p. 79.

Rejection and Selection: The Local Picture

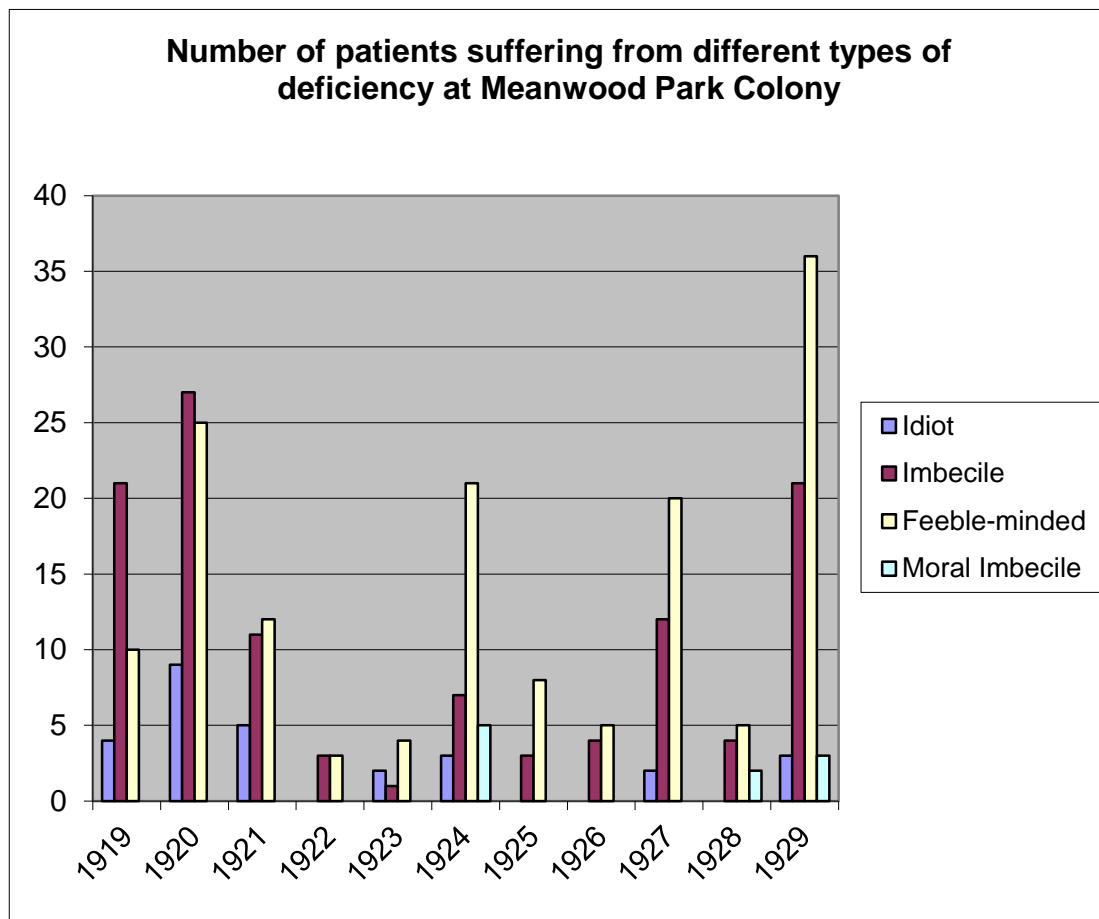
Similarly to the national picture, an equivalent picture can be seen when one observes the local practice and the classifications and categorisations of patients admitted to Meanwood Park Colony in comparison with the patients who continued to be admitted to Stanley Hall. As mentioned previously, Meanwood Park was not a private institution, but instead set up by the Mental Deficiency Committee and, in effect, run by the Local Council. In this respect Meanwood Park constituted an exemplary institution under the criteria of the 1913 Act and the recommendations of the Board of Control. Despite this however, certain generalisations can still be identified with regard to the classifications of defectives admitted by the Leeds Mental Deficiency Committee.

The Admission Register for Meanwood Park, which exists for the years 1919 to 1945, includes a catalogue of certain key facts about each individual admitted, including the date of their admission; their age; sex; condition in life; under whose authority they were sent there; bodily condition; and type of deficiency. Under this final category, a patient's 'type of deficiency' usually stipulated whether their 'defect' was idiocy; imbecility; feeble-mindedness or moral imbecility, and whether or not the person was epileptic.¹⁰⁴ This last category, which documents the patient's 'type of deficiency', is fascinating with regard to understanding the ability of a mental deficiency colony to be able to select and reject patients based upon their classification of disability and behavioural characteristics. The predominance of the imbecile and feeble-minded classes admitted above the class of idiots on a yearly basis is quite striking. This is interesting as those diagnosed as imbeciles and feeble-minded were usually considered to be more trainable than idiots, since those diagnosed with 'idiocy' were often suffering from severe forms of disability, as will be seen in the next section. Table 2.2 below shows the classification

¹⁰⁴ WYAS, C904/5/1, Admission Register for Meanwood Park Colony (1919-1945).

of defect of the patients admitted to Meanwood Park Colony in the first ten years.

Table 2.2: Number of patients suffering from different types of deficiency at Meanwood Park Colony.¹⁰⁵



Source: WYAS, C904/5/1, Admission Register for Meanwood Park Colony (1919-1945).

Table 2.2 evidently identifies that despite officially accepting all classifications of defectives, there was a clear preference in the institution towards what was considered to be the ‘high-grade’ cases, which were the higher-grade imbeciles and the feeble-minded. It should also be noted at this point that the lack of admissions of people considered to have been ‘moral imbeciles’ follows a national trend, which has been accounted for by some historians by the inability to provide a proper definition for this condition, which

¹⁰⁵ A small minority of patients within the register during these ten years are unclassified, and therefore are not part of this graph. As such this table does not represent the total number of cases admitted to Meanwood Park during these years.

therefore generated a general degree of confusion, and resulted in few cases being certified as such.¹⁰⁶ Thus, according to a survey of the Local Government Board in 1912, “of 31,824 defectives only 727 were classified as moral imbeciles.”¹⁰⁷

Perhaps the most obvious reason for the lack of idiots admitted to Meanwood Park Colony can be attributed to the perceived lack of trainability of many low-grade defectives in comparison with higher-grade imbeciles and feeble-minded persons.¹⁰⁸ The vague terminology utilised within the Royal Commission on the Care and Control of the Feeble-Minded separated idiots from the feeble-minded predominantly by social terms. Under the terms of the report, idiots were considered to be “unable to guard themselves from common physical dangers,”¹⁰⁹ whereas the feeble-minded were considered to be incapable “of competing on equal terms with their normal fellows or managing themselves and their affairs with ordinary prudence.”¹¹⁰ In other words, as was to be summarised later; “whereas the former is incapable of earning his own living, the later may be capable of earning a living under favourable circumstances.”¹¹¹

This tendency for the Committee to only admit a relatively small number of idiots into its accommodation, defied the hopes of the Board of Control for such institutions run by the Local Authorities. It also identifies major problems with the successful implementation of the 1913 Act. If the practice on both a local and national scale was to prioritise the treatment of one particular classification of illness over another and the ‘manageable’ over the ‘un-manageable,’ then the Act created a two-tier system, leaving children and

¹⁰⁶ Jackson, *The Borderland of Imbecility*, p. 158.

¹⁰⁷ Survey carried out by the Local Government Board in 1912, as quoted by Jackson, *The Borderland of Imbecility*, p. 158. This low figure stands in contrast with popular discussions of Mental Deficiency Colonies, which often focus upon the unmarried mother who was institutionalised for life as a punishment. My study of Meanwood Park shows that though this could and did happen, such cases were comparatively rare.

¹⁰⁸ A. F. Tredgold, *Mental Deficiency ‘Amentia’* (London, Baillière, Tindall and Cox, 1922).

¹⁰⁹ *Report of the Royal Commission on the Care and Control of the Feeble-Minded*, Vol. 8, p. 3.

¹¹⁰ *Ibid.*

¹¹¹ R. Langdon Down, ‘Nomenclature and Classification’, *National Conference on the Prevention of Destitution: Report of the Proceedings of the National Conference on the Prevention of Destitution* (London, Orchard House, 1911), pp. 555-591, p. 557.

adults who were considered to be unmanageable and also undesirable to the cheaper Poor Law accommodation. Thus effectively, not only did this practice leave these individuals and their families susceptible to the ‘stigma of pauperism’ but also left them in what was often considered to be inferior accommodation for their (educational) treatment and long-term care.¹¹² In many ways this mirrors the dilemma in general medicine where the cure imperative (in this case an individual’s ability to be trained) drove patient selection in voluntary and specialist hospitals, leaving the Poor Law to sweep up the rest.

This ability to select and reject patients based upon various criteria was not the case for an institution like Stanley Hall, which, like a regular lunatic asylum, had little choice but to admit the cases that Poor Law Guardians brought to its door. This did not stop the superintendent from appealing for a better class of cases however. A report published in *The British Medical Journal* as early as 1908 reported the views of Dr Bevan-Lewis with regard to the “undesirable admissions” sent to Stanley Hall. The report evidently highlights that his expectations and desires for the home had considerably changed since his comment in the Asylum’s Annual Reports in 1900 (noted above) that Stanley Hall “should not aim at too much in the way of attempts at education... but should be mainly a receptacle for un-improvable idiots...”¹¹³ In complete contrast to this mentality, in the report published by *The British Medical Journal* Bevan-Lewis emphasised:

The undesirability of allowing the home to degenerate into a centre for the most degraded class of idiot and imbecile, but rather that it should be reserved for the children who, though certifiable, are educable and capable of being elevated to a higher level. In the second place, Dr. Bevan-Lewis urges the

¹¹² WYAS, C85/1/15/7, Annual Reports of the Board of Control (1920), p. 64.

¹¹³ WYAS, C85/1/12/10, Annual Reports (1891-1899), Report of Medical Superintendent, 1900, p. 11.

importance of setting an age limit, so that children of infantile years, whose convulsions, paralytic or other physical disabilities make them a burden to their parents, shall be refused admission.¹¹⁴

These pleas were clearly not taken heed of however, as several years later, and crucially following the Mental Deficiency Act, in their Annual Report of 1914, the Board of Control again commented upon how many of the idiot and imbecile boys at Stanley Hall “are of the more helpless and degraded class.”¹¹⁵ Again, it would appear that the boys’ status – i.e. being considered to be of the ‘degraded’ class – meant that Stanley Hall was considered to be the best place for them. The same report continued to explain that the inspectors of the Board were:

Very happy with the treatment of the idiot and imbecile boys at Stanley Hall; many of them are of a more helpless and degraded class, but for such of them who are capable of improvement, suitable instruction is given by properly qualified instructors.¹¹⁶

Five years later than this however, and crucially, following the end of the financial stringency imposed by the war effort, the Board of Control began to suggest that Stanley Hall might not be the best or most suitable place of care and treatment for certain patients admitted therein.¹¹⁷ The Board of Control’s desire that certain patients (notably those

¹¹⁴ Anon., ‘Hospitals and Asylums’, *British Medical Journal*, 26 September 1908, 955.

¹¹⁵ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 338.

¹¹⁶ *Ibid.*

¹¹⁷ WYAS, C85/1/15/6, Annual Reports of the Board of Control (1919), p. 208.

under sixteen) should be removed from Stanley Hall to properly certified Mental Deficiency institutions became a consistent feature in their annual reports. Again in 1930 they identically observed:

Today we have seen the occupants of... Stanley Hall and Hatfield Hall.¹¹⁸ At the two later places there are fifteen of each sex under the age of sixteen, several of whom we thought would be better accommodated at mental deficiency institutions if they were available.¹¹⁹

These fluctuating desires of the Board of Control highlight that the continued shortage of institutional certified space meant that accommodation would necessarily be limited to *certain* types of patients. The in-depth analysis of patients admitted to Meanwood Park and Stanley Hall below identifies interesting differences with regard to the patients admitted within the different types of institution.

The Patients: Evidence from the Casebooks

A close inspection of the admission registers, casebooks and reception orders can identify many differences and some similarities between the patients admitted to Stanley Hall and Meanwood Park Colony after Meanwood Park was opened in 1919. For the most part these sources correspond with the idea that the boys of Stanley Hall were in some ways

¹¹⁸ Hatfield Hall was an institution run along very similar lines to Stanley Hall. Its job however, in contrast to Stanley Hall, was to provide institutional residential accommodation and cater for mentally deficient girls. Rather confusingly in 1927-1928 the males and females were removed from their respective buildings and placed within the other building. Therefore in this report the males were residing in Hatfield Hall, and the females in Stanley Hall. Despite this however, in order to create continuity and to avoid confusion with this chapter I will refer to the male institution as 'Stanley Hall' throughout.

¹¹⁹ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1930), p. 103.

more difficult, i.e. considered to be either untrainable or unmanageable and thus for the most part more 'undesirable' than the patients admitted to Meanwood Park Colony.

At first indication, the reasons for certification and admission into Stanley Hall are invariably similar to the reasons indicated by David Wright in his study of Earlswood Asylum,¹²⁰ and, as will be shown in the following paragraphs, of the few cases of idiocy admitted to Meanwood Park Colony. A child's lack of speech or propensity to make inarticulate noises often led to certification. Such cases include six year old Jack S who "cannot talk at all,"¹²¹ six year old Joseph H who was "unable to talk and makes no motion when spoken to,"¹²² and Charles C from Wakefield who was described as being able to "use a few simple words, but frequently he just grunts and makes inarticulate noises."¹²³

Similarly to Wright's study, there are also many cases where a lack of emotion in the child and certainly lack of any kind of "self-help skills"¹²⁴ was often linked to the institutionalization of a child. Cases of patients being unable to feed, dress or attend to the calls of nature are prevalent throughout the casebooks and include boys such as Harry N, who was described as being "dirty and destructive of [his] clothing"¹²⁵ and John William T, who although four years old was "unable to do anything for himself."¹²⁶ These cases seem to correspond to Wright's thesis that these individual's illnesses were to an extent sympathized with and that there was a real as well as perceived need for care. Often a child's lack of self-help skills was blamed for many parents' lack of control over their children. This phrase – lack of control – and the notion that the patient "has to be con-

¹²⁰ Wright, 'Childlike in his Innocence', p. 130.

¹²¹ WYAS, C85/3/6/186, Male case book reports, Stanley Hall (1908-1924), patient record no. 381.

¹²² Ibid., patient record no. 369.

¹²³ Ibid., patient record no. 337.

¹²⁴ Wright, 'Childlike in his Innocence,' p. 123.

¹²⁵ WYAS, C85/3/6/186, Male case book reports, Stanley Hall (1908-1924), patient record no. 513.

¹²⁶ Ibid., patient record no. 501.

stantly watched”¹²⁷ or was becoming “unmanageable”¹²⁸ were the key phrases used by most parents and relatives when seeking external help. This is certainly the case of seven year old Edward P, who was described as being “incapable of ordinary control,”¹²⁹ and considered by the certifying doctor to be “in constant danger of dangerous circumstances, having no conception whatsoever of danger. He climbs buildings, runs under vehicles, plays with fire and is a constant source of terror to his parents.”¹³⁰

The few idiots who were admitted to Meanwood Park Colony were described in very similar terms, which almost identically mirror the cases described above. Cases include twelve-year-old Ben R, who was an idiot of the ‘ineducable’ type. His case notes declare that “although he is twelve years of age, he is incapable of articulate conversation. He is unable to dress and undress himself without assistance.”¹³¹ Other cases include eight year old John W, whose notes read: “dribbles, cannot feed, dress, or undress himself... cannot protect himself from danger, pays no attention to questions, continuously making incoherent noises [and is] childish in [his] behaviour;”¹³² Betty W who “cannot speak although nearly seven years old, utters, cries and makes unintelligible noises;”¹³³ and four year old Dorothy B, who “cannot walk or talk,” she is described in the casebook as being “dirty in [her] habits [and] stupid in appearance.”¹³⁴

For the most part however, as Table 2.2 above identifies, the majority of the inmates at Meanwood Park Colony were not idiots, but those who were regarded as ‘high-grade’ defectives, for the most part, ‘improvable’ imbeciles and the feeble-minded. Reading through the casebooks there is a clear sense that the institution focused upon educa-

¹²⁷ Ibid., patient record no. 389.

¹²⁸ Ibid., patient record no. 325.

¹²⁹ Ibid., patient record no. 445.

¹³⁰ Ibid., patient record no. 445.

¹³¹ WYAS, C904 (16), Case book reports, Meanwood Park (1924-1932).

¹³² Ibid.

¹³³ Ibid.

¹³⁴ Ibid.

bility and improvability, and thus, admission records focus predominantly upon the educational abilities of the individual. The few extra notes in the case-files concern the bodily condition of the inmate; whether or not epileptic; whether or not dirty in their habits; and acknowledge any institution or special school, if any, that the inmate had previously attended.

This method of reporting predominantly upon a patient's educational abilities in their case notes, mean that often the majority of the case notes for specific defects are comparatively similar. The following extracts are representative of the case notes that referred to patients who were considered to be 'feeble-minded.' On admittance to Meanwood Park, Claire K was reported in the casebooks as "very simple and childish. Very talkative. General knowledge very limited. Can read, but cannot spell words like 'remember,' etc."¹³⁵ Similarly thirty-five year old Alice M, was described as "very simple and childish, very easily influenced and has no initiative."¹³⁶ Further, for twenty year old Dorothy P, it is also noted that "her general knowledge is very limited. Can read fairly well. [But] was only capable of simple work under supervision;"¹³⁷ and seventeen year old Dorris B was described as, "able to read a bit, but does not understand what she reads. When asked to write her name, she is unable to do so."¹³⁸

This predominance of focusing upon the educational abilities of individuals is correspondingly extended to the imbeciles that were accommodated within the institution. In a similar manner to the feeble-minded, they too were given a series of tests on admittance, which were formally written up into the patient's case notes. Patients defined as 'imbeciles' and admitted to Meanwood Park Colony in the years 1924- 1927 included twenty-eight year old Doris C who "does not know her age, date of birth, the present

¹³⁵ Ibid.

¹³⁶ Ibid.

¹³⁷ Ibid.

¹³⁸ Ibid.

month or number of months in the year. Fails to copy the shape of a diamond and cannot name the present Prime Minister. Her mental age is six years;”¹³⁹ Francis B, who “although ten years of age, he cannot read, write or spell his own name. He cannot add... He answers questions with hesitation, but most of his answers are guesses;”¹⁴⁰ and ten year old Dorothy C, who was “unable to count on her fingers or recognise letters of the alphabet. Babyish, chatters at random [and] cannot dress or undress.”¹⁴¹ Similarly, the casebooks explain that “although twenty years of age,” May C was unable to “recognise the letters of the alphabet. She cannot do simple calculations – she says that $2 + 5 = 17$. She has no initiative and does not take any notice of her surroundings. She is dull and stupid in appearance and manner and answers questions in a childish way. She cannot manage herself or her affairs.”¹⁴²

It is these descriptions of the imbeciles, and the previous descriptions of the idiots admitted to Meanwood Park Colony, that are the most fascinating with regard to the present study. Indeed, the overall descriptions of the majority of the imbeciles and idiots in Meanwood Park Colony provide a stark contrast with the overall picture at Stanley Hall. Certainly, within the reports of Stanley Hall, a token concession is made to assessing a child’s educational ability. With regard to eleven year old Harry N, an epileptic patient from Bramley, it is noted that “he is of limited intelligence and little knowledge. He makes poor progress at school.”¹⁴³ Similarly, in the casebooks fifteen year old David H’s mental condition was described. The case notes identified that “his intelligence is very limited. He cannot read or write. Is unable to spell anything correctly saying “cat” is “cad,” “dog” is “cod” etc...”¹⁴⁴ Despite similar assessments of a patient’s educational

¹³⁹ Ibid.

¹⁴⁰ Ibid.

¹⁴¹ Ibid.

¹⁴² Ibid.

¹⁴³ WYAS, C85/3/6/186, Male case book reports, Stanley Hall (1908-1924), patient record no. 513.

¹⁴⁴ Ibid., patient record no. 295.

ability being present in many of the case-records however, this is not the message that comes across as the most immediate or important with regard to these children institutionalised within the Poor Law accommodation of Stanley Hall. Instead the most notable, and indeed arguably frequent feature within the casebooks of Stanley Hall are the observations that were made upon particular individuals' violent, aggressive and destructive behaviour.

Despite the few cases noted above of idiocy at Stanley Hall, which seemed to correspond both to David Wright's analysis of Earlswood Asylum and the cases of idiocy within Meanwood Park, for the most, a very different picture can be inferred. In his study Wright identifies how idiot children were often sympathised with, and institutionalisation was frequently linked to "concerns of [an individual's] self-sufficiency."¹⁴⁵ In contrast however with regard to a considerable number of cases institutionalised within Stanley Hall it can be deemed problematic to observe the parental phrases "out of my control" and "needs to be constantly watched" merely in a way which simply connotes 'for the care and sympathy of the individual.' Undoubtedly, in contrast to Wright's findings at Earlswood Asylum, the casebooks at Stanley Hall could easily be said to give a new context to much of Andrew Scull's thesis that asylums (and in this case all types of Poor Law accommodation utilised instead of certified mental deficiency institutions) can be understood to have been places for the "impossible, the inconvenient and the inept."¹⁴⁶ Very often within the casebooks, a patient's behaviour can be seen to be 'out of control' for reasons to do with violence and aggression, sometimes to the point where the patient's behaviour verges upon criminality. Under this banner, Stanley Hall can be identified as a place not merely for the weak and helpless but also the misbehaved, the volatile, the aggressive, and the problematic.

¹⁴⁵ Ibid., patient record no. 124.

¹⁴⁶ Scull, *The Most Solitary of Afflictions*, p. 370.

Certainly, violent, aggressive and destructive children, along with children who breached conventional 'childhood' behaviour sexually, are frequently to be found in the casebooks of Stanley Hall after 1913. Examples of this deviant behaviour spill out of the pages of the casebooks, and include boys who are described by their relatives as "difficult to manage,"¹⁴⁷ and dangerous to other children or other members of society. This behaviour ranged from the unpleasant to the extremely violent, and includes children such as thirteen year old John William P who "frequently becomes violent, shows a strong dislike to his sister... and strikes his mother,"¹⁴⁸ and nine year old Frank N who was also described as "very violent [he] scratches and bites at anyone about him."¹⁴⁹ Similarly, another patient, four year old John Henry W, was "constantly getting into mischief or danger... has burnt a brother of his [and has a propensity to] strike other children."¹⁵⁰ Perhaps even more bizarrely than the rest, David H found himself admitted at the age of fifteen after reportedly having "once got into a butcher's shop and stabbed a sheep."¹⁵¹ Furthermore twelve year old Michael B was admitted to Stanley Hall after trying to "attack his mother with a knife [and] had to be forcibly restrained" in order to stop him doing mischief.¹⁵² On his admittance to the institution his mother noted that her son was very "violent and will attack with anything handy, particularly knives. He is destructive and quite beyond control."¹⁵³ Michael's propensity towards criminal behaviour continued during his stay at the institution, wherein after a few months it was noted that he "steals from other patients."¹⁵⁴

What the examples above suggest is that a considerable number of the cases of id-

¹⁴⁷ WYAS, C85/3/6/186, Male case book reports, Stanley Hall (1908-1924), patient record no. 329.

¹⁴⁸ *Ibid.*, patient record no. 433.

¹⁴⁹ *Ibid.*, patient record no. 385.

¹⁵⁰ *Ibid.*, patient record no. 296.

¹⁵¹ *Ibid.*, patient record no. 295.

¹⁵² *Ibid.*, patient record no. 321.

¹⁵³ *Ibid.*, patient record no. 321.

¹⁵⁴ *Ibid.*, patient record no. 321.

idiotcy and imbecility institutionalised within the Poor Law accommodation of Stanley Hall Home were in many ways different and often much more violent, aggressive and difficult to manage than the cases institutionalised within the certified institution of Meanwood Park, and those identified by David Wright in his study.¹⁵⁵ To take this observation further, in his study Wright refers to idiotcy as a disability that “evoked strong allusions to the permanency of childlike dependency.”¹⁵⁶ He explains further that within his study sexual “references are very rare indeed and the prevalence of sex and sexuality as an indicator of mental handicap shows little of the predominance that they acquire amongst the Edwardian intelligentsia outlined”¹⁵⁷ in many of the studies about the mentally defective.

A similar observation can be made of Meanwood Park, where references to sex and sexuality are again particularly infrequent. Most references are bound up with other issues and interpretations: Alice M, for instance, was described as having “had one illegitimate child to her step-father,”¹⁵⁸ suggesting perhaps deviancy in her sexual behaviour, or perhaps other Edwardian concerns linked to incest and heredity. Another reference ambiguously states that Claire M “cannot protect herself from moral danger.”¹⁵⁹ Despite these two vague references however, much like in David Wright’s study sexual references are, for the most part, “very rare indeed.”¹⁶⁰

These findings are however less true of the boys admitted to Stanley Hall, who appear to be more troublesome than cases admitted to Meanwood Park. Cases where a child’s behaviour is noted to be problematic, or subverting conventional childhood norms with sexually deviant behaviour, seem to be more apparent within Stanley Hall. They in-

¹⁵⁵ Wright, ‘Childlike in his Innocence’.

¹⁵⁶ *Ibid.*, p. 124.

¹⁵⁷ *Ibid.*, p. 126.

¹⁵⁸ WYAS, C904 (16), Case book reports, Meanwood Park (1924-1932).

¹⁵⁹ *Ibid.*

¹⁶⁰ Wright, ‘Childlike in his Innocence’, p. 126.

clude cases such as six year old George S whose mother commented he is “uncontrollable [he] deliberately exposes himself and uses very filthy language,”¹⁶¹ Christopher D who “runs around the grounds naked... and undresses in the street,”¹⁶² and Ralph Y, who was described as persistently “interfering with the other patients ... He is continually masturbating.”¹⁶³ These cases identify that little had changed with regard to the behaviour of the boys admitted to Stanley Hall despite the introduction of the 1913 Act and the opening of Meanwood Park Colony, as patients with ‘undesirable’ behavioural characteristics continued to be admitted therein. Patients who were incarcerated before the 1913 Act who displayed behaviour which was considered to be sexually deviant included boys such as ten year old Walter K, of whom it was noted that he “masturbates, uses obscene language and frequently speaks of performing dirty acts.”¹⁶⁴ Similarly, fifteen year old Albert G was removed from the workhouse in Goole, for amongst other things, “constantly exposing his person and behaving in an indecent manner”,¹⁶⁵ and Herbert K, who was also noted to have “a perverted moral sense – handles the genitals of other boys and girls and masturbates into the fireplace.”¹⁶⁶

At this point it is necessary to explain that although there is a noticeable dividing line between different individuals’ behaviour characteristics at each institution, there was also a level of fluidity with regard to some of the cases. Just as a few of the idiot and imbecile children at Stanley Hall did not seem to be as innately aggressive or troublesome as their fellow inmates, occasionally the casebooks of Meanwood Park Colony also refer to a troublesome patient. Suffering from “congenital idiocy”, for instance, seven year old Betty W was described in the casebooks as being “difficult to control... she is destructive

¹⁶¹ WYAS, C85/3/6/186, Male case book reports, Stanley Hall (1908-1924), patient record no. 325.

¹⁶² Ibid., patient record no. 333.

¹⁶³ Ibid., patient record no. 361.

¹⁶⁴ WYAS, C85/3/6/167, Male case book reports, Stanley Hall (1888-1912), patient record no. 293.

¹⁶⁵ Ibid., patient record no. 41.

¹⁶⁶ Ibid., patient record no. 407.

with toys, clothing and bedding.”¹⁶⁷ The casebooks further note that it was “impossible to leave her alone.”¹⁶⁸ At the other end of the deficiency spectrum, nineteen year old Olive S was one of the few moral imbeciles admitted to Meanwood Park. Her case notes describe her as being a “high-grade moral defective. A good worker... Very dangerous and mischievous in her statements and conversation.”¹⁶⁹ Her case notes further identify that “her conduct with other girls requires the closest supervision.”¹⁷⁰ Despite the existence of these and a few comparable cases however, the extraordinary infrequency of similar statements regarding the behavioural problems of patients in Meanwood Park in comparison to that at Stanley Hall speaks volumes about the type of inmate who was incarcerated within this particular certified institution for mental defectives. Furthermore, the two cases discussed above were arguably much less problematic in their behaviour than the array of violent, aggressive, destructive, criminal and sexually deviant behaviour of the patients who were reported within the casebooks of Stanley Hall.

The evidence in the casebooks of Meanwood Park Colony and Stanley Hall strongly suggests that a patient’s behavioural characteristics were as important, if not more important, than the notion of trainability when selecting which defectives were sent to Poor Law accommodation and which cases were sent to the new certified institutions. Though it is clear that the voluntary idiot asylums, such as Earlswood Asylum, which was financially “based on the election of patients by subscribers”¹⁷¹ would be selective with the types of patient it admitted, it is surprising that some certified institutions run by the Local Mental Deficiency Committee, and paid for by the rates, could run along similar policies. The predominance of violent, aggressive, destructive, deviant, troublesome and difficult cases institutionalised within Stanley Hall, in comparison with the fractional

¹⁶⁷ WYAS, C904 (16), Case book reports, Meanwood Park (1924-1932).

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

¹⁷¹ Wright, *Mental Disability in Victorian England*, p. 194.

amount of corresponding cases incarcerated within Meanwood Park Colony, seems to hint that Leeds Local Committee for the Care of the Mentally Defective tried to stream their candidates along similar lines to the voluntary institutions. However, perhaps as a new service set up with a view to providing training, it is not surprising that municipal colonies tended to act the same way as voluntary institutions.

In many ways this tendency of separating patients along the lines of trainability and behaviour characteristics can be seen as a triumph of classification; one that not only separated the trainable from the un-trainable but also in many ways the 'deserving' from the 'undeserving.' Though this 'triumph of classification' can be seen to have had a 'positive' effect for those institutionalised within Meanwood Park, the same cannot be said for those who languished within the walls of the Poor Law accommodation. The fact that the only way to implement the new legislation was to provide a two-tier approach to care highlights that the original ideology of the Mental Deficiency Act was flawed from the outset. Established with a view to providing care for *all* people considered to be mentally defective, it is clear that the variety of conditions under the umbrella of 'mental deficiency' could never be treated as one homogenous category. Within the West Riding of Yorkshire, it appears that the fate of each individual was to be decided, not by the strict letter of the law or recommendations of the Board of Control, but by the limited availability of space at certified institutions and the behavioural characteristics and classification of deficiency of particular individuals. This was a practice that effectively left the troublesome and violent to workhouse and asylum accommodation, and inevitably, the stigma of pauperism that existed side-by-side with the Poor Law.

Conclusions

This chapter has consistently found that Stanley Hall was less innovative than Hoole's research suggests. Although it was an early attempt to separate mentally deficient children from adults within the asylum system, this approach was not necessarily unique, nor was it solely Bevan Lewis' idea. Moreover, the legislation of 1913 rendered the institution outdated by attempting to create a mental deficiency service separate from the Poor Law Authorities.

This development in legislation teamed with gradual changes in thinking meant that slowly Thomson's idea that the "less eligibility principle of the workhouse and the stigma of pauperism were wholly inappropriate and inhumane," was beginning to take root.¹⁷² However, this was a process of gradual change, hampered by stringent financial restrictions that meant that a process of negotiation and compromise had to be instituted both on a national and local level. The financial stringency imposed upon Local Authorities during the Great War and the subsequent depression led to an inevitable lack of certified institutional accommodation. This explains the Board's vacillating views, using Poor Law accommodation to make up for the crisis of space available in certified mental deficiency institutions during these years. Moreover the Act was hampered at the very outset by its competing responsibilities for the mentally deficient with the Education Authorities and the Poor Law Authorities who remained in charge of idiots and imbeciles certified under the various Lunacy Acts.

Although the Board of Control accepted that many would remain in Poor Law accommodation for life, they were clear about which residential space was preferred. Within their reports they repeatedly expressed the desire that "the extended use of Poor

¹⁷² Thomson, *The Problem of Mental Deficiency*, p. 11.

Law accommodation may only be a temporary necessity,”¹⁷³ and that they thought that many cases of mental deficiency “would be better accommodated at mental deficiency institutions,”¹⁷⁴ rather than Poor Law accommodation. The very lettering of the Act was set out to encourage the local Poor Law authorities to “transfer many of their cases [of mental deficiency] to the Local Committee for the Care of the Mentally Defective,” which were correspondingly established in 1913.¹⁷⁵ Clearly, despite the Board’s early claims, it would seem that their hopes that “all defective children without exception, will, in future be reported to the Local Committee for the Care of Defectives, whose statutory duty it has now become to provide for them,”¹⁷⁶ were unachievable during the years studied.

The case books of the inmates admitted to the certified institutional accommodation of Meanwood Park Colony and Stanley Hall Home highlight some key differences in the patients admitted to each institution. The evidence suggests that whilst the cases of mental deficiency sent to Meanwood Park Colony were predominantly trainable, educable and not particularly difficult to manage, the cases admitted to Stanley Hall, for the most part, reflect the opposite picture. The distinction between the cases admitted to both institutions identifies that perhaps certified mental deficiency accommodation was not wholly dependent upon trainability (although the majority of defectives within Meanwood Park *were* considered trainable) rather, admittance to a particular institution seems in many cases (although again not all) to be linked to an individual’s behavioural characteristics. This suggests perhaps that where the local community could raise only limited funds, new expensive residential accommodation would only be available to those not only with prospects of trainability, but also who, in their eyes, were ‘deserving’ of such

¹⁷³ WYAS, C85/1/15/7, Annual Reports of the Board of Control (1920), p. 64.

¹⁷⁴ WYAS, C85/1/15/6, Annual Reports of the Board of Control (1919), p. 280.

¹⁷⁵ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 46.

¹⁷⁶ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 50.

an opportunity.

Therefore due to consistent underfunding as a result of a more urgent demand for cash elsewhere and thus a subsequent lack of space in certified institutions for mentally defective persons, the attempt to take mental deficiency services out of the remit of the Poor Law Authorities was doomed to fail; *especially* whilst the 1890 Lunacy Act still rendered the Poor Law Authorities responsible for idiots and imbeciles under their care certified under the Act. Overall, what this chapter has identified is that in the twentieth century, the Poor Law was increasingly being observed as a last resort, to be utilised only as a final option, when problems with the cash flow made other alternatives problematic. In this respect attempts to take mental deficiency services outside the boundaries of Poor Law provision – although inherently flawed from the beginning – were just one strand of an increasing mid-twentieth century trend towards removing from all sub-divisions of mental health care services from the Poor Law and thus its stigmatising connotations. The following chapter will observe how this attempt to remove certain ‘deserving’ individuals from the stigma of pauperism was extended to mentally distressed service patients who had fought for their country during the First World War.

Chapter Three

War and Peace: The Stigma of Pauperism and the Ministry of Pensions Hospital

“All soldiers and sailors who have become insane during the war, shall be classed as private patients, and shall have no relation to the Poor Law authorities.”¹

Over the years the subject matter of the First World War has continued to captivate many historians, and the centenary has opened the way for a proliferation of museum exhibitions, film and television adaptations and many revisionist historical investigations. Historically works have ranged from studies of high-profile military men, commonly dubbed ‘great-men’ history, to more literary-focused studies wherein scholars have directed their attention to the war poets and the literature of warfare.² More recently academics have focused their attention on trying to understand in meticulous detail the ‘everyday lives’ of recruits, volunteers and conscripts during the war.³ Within this vast literature, shell shock has become “part of the wider mythology of war.”⁴

In their studies of shell shock and war neurosis, historians have identified and analysed many aspects of trauma and mental breakdown in trench warfare, and consequently have begun to understand some of the social, cultural and medical meanings and interpretations which were attached to the illness both by the sufferer and wider society in the

¹ WYAS, C488/1/5, West Riding Asylum, Minute Book (1914-1920), p. 249. My emphasis.

² P. Fussell, *The Great War and Modern Memory* (London, Oxford University Press, 1975); S. Hynes, *A War Imagined: The First World War and English Culture* (London, Bodley Head, 1990). More recently David Taylor has questioned the legitimacy of the accepted canonical writers of the First World War, and has instead tried to explore alternative soldier narratives in his work. See D. Taylor, ‘From Fighting to Writing the War: From Glory to Guilt?’, *Contemporary British History*, vol. 23, no. 3, 2009, 293-313.

³ R. Duffett, ‘A Taste of Army Life: Food, Identity and the Rankers of the First World War’, *Cultural and Social History*, vol. 9, no. 2, 2012, 251-267; C. Makepeace, ‘Male Heterosexuality and Prostitution During the Great War’, *Cultural and Social History*, vol. 9, no. 1, 2012, 65-83.

⁴ P. Leese, *Shell Shock, Traumatic Neurosis and the British Soldiers of the First World War* (London, Palgrave, 2002), p. 6.

early twentieth century. Two key texts are frequently noted to be the stimuli of further interest in this topic. The first is Paul Fussell's work *The Great War and Modern Memory*, which began to attempt to understand how individual soldiers experienced the war.⁵ Secondly, Eric Leed's *No Man's Land* discusses the different treatment regimes utilised in British War Hospitals to treat shell-shocked soldiers. He argued that there were two different ways of treating these men – the disciplinary way, focusing upon Dr Yealland's approach and the use of faradism, and the analytic approach represented by Dr Rivers at Craiglockheart.⁶

In response to Leed, Peter Leese questioned just how representative doctors such as Yealland were in practicing faradism at Queen Square Hospital, noting amongst other things that Queen Square only treated two-hundred patients, a relatively small number in comparison with other hospitals which were either set up, or adapted to provide a similar service during the war years.⁷ Leese's work focuses primarily upon a comparison between the different experiences of officer ranks and ordinary rank soldiers who were suffering from shell shock during the First World War. In his work Leese investigates the differences in both the social standing and treatment regimes allocated to differently ranked men. Importantly, this work has offered many insights into the issue of rank and class during the war, which has been pivotal to my understanding and analysis of the men admitted to the Ministry of Pensions Hospital in Kirkburton in the interwar period.

Other writers have noted that the concept of class was interconnected with the ideas of gender during the First World War. In her work Busfield analyses both shell shock and psychopathic disorder in order to examine “the ways in which class and gen-

⁵ Fussell, *The Great War and Modern Memory*.

⁶ E. Leed, *No Man's Land: Combat and Identity in World War I* (New York, Cambridge University Press, 1979).

⁷ Leese, *Shell Shock, Traumatic Neurosis*, p. 75.

der are embedded in psychiatric work.”⁸ Much scholarly emphasis has been attached to the concept of gender, particularly as the issue of shell shock seemingly undermined the ‘traditional’ concept of masculinity. Hysterical complaints during the war were quick to be characterised as weakness and were simultaneously gendered in language. As early as 1917, Thomas Salmon, Chief Consultant in Psychiatry to the American Expeditionary Force,⁹ described shell- shocked men as being “childish and infantile, [and who] needed to regain their manhood.”¹⁰ Arguably the subsequent academic scholarship on gender, masculinity and shell shock was popularised by Elaine Showalter who argued that mental illness in the late nineteenth and early twentieth century was frequently observed as being a distinctly *Female Malady*, and as such breakdowns and mental disorder within the army became “a crisis in masculinity and a trial of the Victorian masculine ideal.”¹¹ George Mosse reiterates the interpretation that this condition became a metaphor for ‘unmanly’ actions. He argues that many writers at the time provided many “stereotypes [which] could easily be used to explain so called abnormal behaviour.”¹² Joanna Bourke too analyses the notion of masculinity and war in her works, *Dismembering the Male*¹³ and also ‘Effeminacy, Ethnicity and the End of Trauma.’¹⁴

More recently, historical ideas of masculinity and the First World War have developed further. Michael Roper’s work offers a psychoanalytic approach to analysing

⁸ J. Busfield, ‘Class and Gender in Twentieth Century British Psychiatry: Shell Shock and Psychopathic Disorder’, in J. Andrews and A. Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Class and Culture in the History of British and Irish Psychiatry* (Amsterdam, Rodopi, 2004), pp. 295-322, p. 295.

⁹ For more on Salmon and his career see G. Grob, *Mental Illness and American Society, 1875-1940* (Princeton, NJ, Princeton University Press, 1983), pp. 162-163; E. Bond, *Thomas W. Salmon, Psychiatrist* (New York, Arnos Press, 1980), pp. 18-19.

¹⁰ T. W. Salmon, *The Care and Treatment of Mental Diseases and War Neurosis (Shell Shock) in the British Army* (New York, War Work Committee, 1917), p. 525.

¹¹ E. Showalter, *The Female Malady: Women, Madness and the English Culture, 1830-1980* (London, Virago Press, 1996), p. 171.

¹² G. Mosse, ‘Shell Shock as a Social Disease’, *Journal of Contemporary History*, vol. 5, no. 1, 2000, 101-108, 101.

¹³ J. Bourke, *Dismembering the Male: Men’s Bodies, Britain and the Great War* (London, Reaktion Books, 1996).

¹⁴ J. Bourke, ‘Effeminacy, Ethnicity and the End of Trauma: The Sufferings of ‘Shell-Shocked’ Men in Great Britain and Ireland, 1914-39’, *Journal of Contemporary History*, vol. 35, no. 1, 2000, 57-69.

men's experiences during the war.¹⁵ Further, Jessica Meyer's work utilises the same type of sources – diaries, letters and memoirs – in her attempt to re-construct how those who fought “used their experience to define themselves as men, both in relation to other men and to women.”¹⁶ By focusing upon two ‘dominant’ masculine ideals – the domestic and the heroic – Meyer's analysis seeks to understand how different men attempted to construct their identities in line with these ideals. This focus upon (re)constructing identities of masculinity inevitably brings up the concepts of trauma, mental handicap and mental illness.¹⁷

Aside from class and gender, historians have also attempted to reassess shell shock and contextualise it within a wider historical framework, rather than merely perceiving it as a peculiar episode that occurred within the British psyche during the First World War. This approach is true of Showalter's analysis, where she creates a historical overview of hysteria.¹⁸ Similarly Mark Micale's *Hysterical Men* offers a chronological approach to analysing the changing scientific, medical and cultural discourse of hysteria over time.¹⁹ In their work Edgar Jones and Simon Wessely try to embed shell shock within the wider historical framework by taking a “thematic and chronological approach.” Their analysis is centred upon tracing the links and similarities between the “distinct post-war combat disorders” which occurred between 1900 and the Gulf War, before concluding that “important foundations were made for military psychiatry before

¹⁵ M. Roper, *The Secret Battle: Emotional Survival in the Great War* (Manchester, Manchester University Press, 2010).

¹⁶ J. Meyer, *Men of War: Masculinity and the First World War in Britain* (Basingstoke, Palgrave Macmillan, 2009).

¹⁷ See T. Loughran, ‘A Crisis of Masculinity? Re-writing the History of Shell-Shock and Gender in First World War Britain’, *History Compass*, vol. 11, no. 9, 2011, 727-738. Also see her forthcoming monograph: T Loughran, *Shell-Shock and Medical Culture in First World War Britain* (Cambridge, Cambridge University Press, Forthcoming).

¹⁸ Showalter, *The Female Malady*.

¹⁹ M. Micale, *Hysterical Men: the Hidden History of Male Nervous Illness* (Cambridge, MA, Harvard University Press, 2008).

World War One.”²⁰ In *A War of Nerves*, Ben Shephard explores the ‘dialogue’ that took place in military psychology, by providing a comparative analysis between Britain and America throughout the various conflicts of the twentieth century.²¹ Within her work Joanna Bourke uses equivalent techniques to historically re-align the practice of malingering and the feigning of illness in war with those malingering in industry back in Britain.²² Furthermore, the edited volume *War, Medicine and Modernity* offers a collection of works, which seek to create a broader theoretical analysis of “the place of medicine in the larger history of the relationship between war and modernity.”²³ All of these studies have helped to encourage other historians to rethink the old definitions of shell shock, and as such observe it as an illness that originated long before the twentieth century, and one whose effects would be felt long after the armistice in 1918.

Within the past few years there has been a dramatic and noticeable shift in how historians have responded to, researched and thus represented the problem of shell shock and war neurosis. As Fiona Reid explains, although many “scholars have written extensively about war time shell shock, the life of the mentally wounded man after the armistice has been strangely neglected.”²⁴ The obvious exception to this rule is Peter Barham’s meticulous coverage of the treatment of mentally disabled war veterans in asylums who were at the mercy of the Ministry of Pensions officials following the end of the war.²⁵ In comparison to Barham however, Reid’s work discusses instead how shell shocked veterans were able to “rebuild their lives afterwards.”²⁶ Both of these recent

²⁰ E. Jones and S. Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Sussex, Psychology Press, 2005), p. 18.

²¹ B. Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (London, Pimlico, 2002).

²² Bourke, *Dismembering the Male*, p. 107.

²³ R. Cooter and S. Sturdy, ‘Of War, Medicine and Modernity’, in R. Cooter, M. Harrison and S. Sturdy (eds), *War, Medicine and Modernity* (Gloucestershire, Sutton, 1999), pp. 1-21.

²⁴ F. Reid, *Broken Men: Shell Shock, Treatment and Recovery in Britain, 1914-1930* (London, Continuum, 2011), p. 4.

²⁵ P. Barham, *Forgotten Lunatics of the Great War* (London, Yale University Press, 2007).

²⁶ Reid, *Broken Men*, p. 4.

studies suggest a new direction in the historiography of mental health care of mentally distressed war servicemen in Britain during the interwar period.

The work by Barham and Reid signals the beginnings of a new trend within the history of war trauma. However, these new findings simultaneously raise new questions, and highlight large gaps within our present historical knowledge. As historians begin to analyse the experiences of shell-shocked soldiers *after* the war, one begins to question how different the soldiers' experiences of asylum life were to those of pauper lunatic patients in general. Interestingly, within the historiography many of the studies undertaken by the so-called 'lunacy historians'²⁷ finish their analysis of various pauper lunatic asylums and their patients at the outbreak of war.²⁸ The problem with having to address an entirely different set of works for the mentally ill serviceman is that it leads to a lack of continuity within the historiography of mental illness in general, and thus provides no clear comparative analysis of the two groups of mentally disturbed servicemen and non-service lay persons both during and after the war.

To date it would appear that historians of shell shock have merely taken it for granted that the mentally disabled casualties of war *were* treated differently to regular asylum inmates. Both Joanna Bourke and Fiona Reid have similarly argued, "The war left these servicemen stranded in no-man's land, isolated both from the sane and the insane;"²⁹ and "The afflicted were not lunatics, they were soldiers."³⁰ Barham has also identified that "the welfare of the humblest citizen soldier commanded genuine attention

²⁷ J. Melling, 'Accommodating Madness: New Research in the Social History of Insanity', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society: A Social History of Madness in Comparative Perspective* (London, Routledge, 1999), p. 6.

²⁸ J. Melling and B. Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London, Routledge, 2006). To see the full extent of this phenomenon see the bibliography of this thesis.

²⁹ Bourke, *Dismembering the Male*, p. 109.

³⁰ Reid, *Broken Men*, p. 22.

in the public imagination”³¹ whereas “when it came to the ravaged minds [of the ordinary civilian lunatic] there was no semblance of equality, neither in professional attitudes nor in treatment regimes.”³² These works however fail to adequately address just what the difference was between the pauper patient and the service patient when they were behind the closed doors of the asylum.³³

This chapter fits into this gap within the historiography by showing the differences and similarities between institutionalised veterans and lunatics. Firstly, my work will provide an examination of how the war affected the ordinary lay patient both nationally and also locally inside the West Riding Pauper Lunatic Asylums from 1914-1918. The second part of this chapter offers an analysis of two interlinked developments which were set up to relieve the mentally afflicted ex-serviceman from the double disgrace of both pauperism and lunacy. It analyses both the intentions behind, and the realities of, the 1917 Service Patient Scheme, and offers a detailed overview of the patients admitted to the Ministry of Pensions Hospital in Kirkburton, which was opened from the years 1924-1931.

Curiously, the patient case records from this particular hospital have preserved a number of letters, poems, notes, and appeals written by the patients to the Superintendent; the “Docktor”³⁴ [sic]; countless Ministry of Pensions and ex-army offices; the patients’ family and, in many instances, the notes merely voice grievances or delusions of the patients, which were addressed to nobody in-particular. This unexpected insight into the patient’s institutional lives has notably added to the subjective understanding of this particular chapter. Where appropriate to the commentary of this chapter, the patient’s let-

³¹ Barham, *Forgotten Lunatics of the Great War*, p.4.

³² *Ibid.*, p.3.

³³ For an attempt to bridge this gap, see A. Brumby, “‘A Painful and Disagreeable Position’: Rediscovering Patient Narratives and Evaluating the Difference between Policy and Experience for Institutionalised Veterans with Mental Disabilities, 1924-1931”, *First World War Studies*, vol. 6, no. 1, 2015, 37-55.

³⁴ WYAS, C416/5/158, Male Casebook Records of Private Service Patients (1924-1925), patient record no. 215.

ters and voices have been utilised in order to colour our understandings of institutionalisation in this particular hospital during the 1920s.³⁵

By comparing the treatment and experiences of ordinary pauper lunatics in asylums during the war with the experiences of the mentally disabled war veteran after the war, my work will provide an insight into the lives of institutionalised servicemen throughout the 1920s. This chapter seeks to provide a comparative analysis of the different treatment regimes that were set up for mentally afflicted servicemen. Although in 1915 the Government assured the public that they “had no intention of treating these unfortunate men as ordinary lunatics”³⁶ this chapter will investigate whether this *intention* became a *reality* for mentally afflicted ex-servicemen institutionalised within the Ministry of Pensions Hospital throughout the 1920s. This chapter will seek to understand whether the changes that were brought in to ‘protect’ mentally ill servicemen from the double stigmas of insanity and pauperism made a difference to individuals and families at both a national and local level.

The Impact of War on Pauper Lunatics

In 1919 a damaging article written and published by *The Times* questioned: “Have we been sending our lunatics into the army and starving the others?”³⁷ Merely two years lat-

³⁵ There have been a few studies offering an analysis of letters to various asylums recently. See, for instance, Louise Wannell’s study of the York Retreat, which focuses upon letters written by patients’ families to the asylum in the year 1890. See L. Wannell, ‘Patient’s Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910’, *Social History of Medicine*, vol. 20, no. 2, 2007, 297-313.

³⁶ Anon., ‘Parliamentary Intelligence, House of Lords, Mon 26th July, Treatment of Nerve Shaken Soldiers’, *Lancet*, vol. 186, no. 4796, 31 July 1915, 261-263.

³⁷ Anon., Editorial, *The Times*, 6 September 1919, p. 11.

er, Montagu Lomax's *Experiences of an Asylum Doctor* was published.³⁸ His work was highly critical of the asylum system, and was a major source of embarrassment for the Board of Control. His publication subsequently led to the Report of the Committee on the Administration of Public Mental Hospitals.³⁹ Despite the seemingly sensational aspects of Lomax's book and *The Times* report however, the evidence seems to suggest that these reports were not merely exaggerated media hyperbole, designed simply with the intention of infuriating the general public. An investigation set up by the Ministry of Health identified that although Lomax's "book is sensational, it cannot be dismissed as mere journalism."⁴⁰ The reports of the newly established Board of Control throughout the War period seem to suggest that the words of these reports were, at the very least, grounded in an element of truth. It would seem that in the world's first total war, even the lunatic in the asylum had his own part to play, either by finding his way into the army, or else by being subjected to rationing and decreased standards in the asylums.

Unsurprisingly the Great War did have a dramatic short-term effect on the lives of ordinary pauper lunatics throughout the years 1914 to 1918, and the Board of Control made no attempt to hide this fact from its reports. As early as 1914, the Board noted how "the war has affected the asylums [and thus the lives of ordinary pauper lunatics] to a serious extent."⁴¹ The need for public buildings to be used for military purposes led to the shortage of institutional beds across the country and led to the "unavoidable limitation of admissions to cases most urgently needing treatment."⁴²

Arguably however, it was a reduction in the level of staff, teamed with overcrowding as seventeen public lunatic asylums removed the majority of their charges to

³⁸ M. Lomax, *The Experiences of an Asylum Doctor with Suggestions for Asylum and Lunacy Reform* (London, George Allen & Unwin, 1921).

³⁹ NA, MH 58/222.

⁴⁰ *Ibid.*

⁴¹ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 14.

⁴² WYAS, C85/1/15/4, Annual Reports of the Board of Control (1915), p. 9.

the remaining eighty that led to the declining standards within the asylums. As soon as the war broke out, the West Riding Asylum Minute Books document requests from members of staff desirous of leaving their situation temporarily in order to volunteer their services to the war effort.⁴³ It would appear that the patriotic desires of a few, teamed with the fact that the army was a reasonably well-paid, respectable job⁴⁴ in comparison to what some historians have described as the undesirability of asylum work, may have been some of the reasons why so many asylum employees left their normal duties in order to join the war effort.⁴⁵ The Board described the problems that they were facing with regard to staffing deficiencies:

The difficulty that existed before in keeping up the medical staff through the shortage of qualified practitioners willing to enter this branch of their profession, has, it is needless to say been increased by the war and many asylums are working with less than their proper strength.⁴⁶

As early as 1914, the Board were explaining that “the medical and nursing staff and other employees of the asylums have not been behind in responding to the country’s call for those qualified for military service. A considerable number of medical officers have vol-

⁴³ For examples see the Annual Reports of the West Riding Asylums Board; WYAS, C416/1/52, Minute Books of the West Riding of Yorkshire Asylums Board (1915).

⁴⁴ D. Silbey, *The British Working Class and Enthusiasm for War, 1914-1916* (London, Routledge, 2004), p. 2.

⁴⁵ See D. Gittins, *Madness in Its Place: Narratives of Severalls Hospital, 1913-1997* (London, Routledge, 1998); D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford, Oxford University Press, 2001); and P. Nolan, *A History of Mental Health Nursing* (London, Chapman and Hall, 1993).

⁴⁶ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), pp. 15-16.

unteered for medical service with the army, including three superintendents.”⁴⁷ The Board seemed to be filled with mixed emotions regarding the patriotism of asylum workers. Although they regretted that it led to a reduced (and inevitably inferior) workforce, they were clearly proud of the volunteer spirit of asylum workers and were highly supportive of the war effort more generally:

Every encouragement has been given by the asylum authorities to those desiring to join the military forces. The general practice has been to keep their places open (temporary substitutes, not of military age being engaged) and to take steps for ensuring that their patriotism shall not involve them in pecuniary loss.⁴⁸

The West Riding of Yorkshire echoed a similar response to that of the national picture. In November 1914 the Finance Committee of the West Riding Asylums Board reported that:

The officials and servants of the permanent staff of the Asylums Board who, with the consent of the respective medical superintendents volunteer for service in the Naval or Military forces in connection with the present war be given leave of absence, that they are reinstated on their return with no loss of position consequent on their enforced absence, and that

⁴⁷ *Ibid.*, p. 15.

⁴⁸ *Ibid.*, p. 15.

they be paid such an amount... as will equal their present salaries.⁴⁹

Such encouragement to serve in the war was not solely given to the male employees however. In the same month the Finance Committee responded to the request of a female nurse at Wakefield Asylum who had been accepted for service in the Red Cross. It was reported that:

Nurse Couldwell (Wakefield Asylum) be provided with a uniform and outfit as a Red Cross Nurse at an estimated cost of £5. [Further] if any nurse in the asylum service is accepted for service in the field as a Red Cross Nurse [a] similar uniform and outfit should be provided.⁵⁰

Given such encouragement to join the war effort it is perhaps unsurprising that although in the early years full staffing levels were maintained reasonably successfully, some positions soon became difficult to fill. The Annual Reports of 1914 identify that at Storthes Hall “the staff of attendants and nurses continues to be maintained at adequate strength and the record of duration of service is quite satisfactory.”⁵¹ Despite this however, it was also noted that the Superintendent, Dr Edgerley, was only working with three medical colleagues, and the Board highlighted how the attempts to fill a vacancy for an Assisting

⁴⁹ WYAS, C488/1/5, Minute Books of the West Riding Asylums Board (1914-1920), p. 425.

⁵⁰ *Ibid.*, p. 426.

⁵¹ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 331.

Medical Officer were proving very difficult.⁵² By the end of the war the Minute Books from the West Riding Asylums Board highlight how the war had affected the West Riding Asylums with regard to staffing levels. Tables 3.1 and 3.2 offer statistical information regarding staffing levels at the four West Riding Asylums in the year 1918. Table 3.1 identifies how many staff were actively involved in military service in 1918, whilst Table 3.2 highlights the small number of staff of military age who remained working within the asylums in July 1918.

Table 3.1: Numbers of staff engaged in service with naval and military forces on the 29 November 1918.⁵³

	Numbers of staff engaged in service with naval and military forces on the 29 November 1918.
Wakefield Asylum	185
Wadsley Asylum (Now Warncliffe War Hospital)	31
Menston Asylum	49 (plus a further 5 in munitions work)
Storthes Hall Asylum	45

Source: C416/1/55 Minute Books West Riding of Yorkshire Asylums Board, (1918)

⁵² Ibid.

⁵³ WYAS, C416/1/55, Minute Books of the West Riding of Yorkshire Asylums Board (1918), p. 26.

Table 3.2: Numbers of *remaining* employees (permanent and temporary) of military age who were available for service on the 17 July 1918.⁵⁴

	Numbers of remaining employees (permanent and temporary) of military age who were available for service on the 17 July 1918.
Wakefield Asylum	77
Wadsley Asylum (Now Warncliffe War Hospital)	-
Menston Asylum	38
Storthes Hall Asylum	53

Source: C416/1/55 Minute Books of the West Riding of Yorkshire Asylums Board (1918)

The fact that there were so few male employees of military age remaining in the West Riding Asylums in 1918 shows the extent of the effect that ‘total war’ and the role of conscription had on these institutions. It was noted that in the year 1918 alone that “thirty-two members of asylums staff [of the West Riding Asylums] had been killed whilst on active service and one had been reported missing.”⁵⁵ The Board of Control’s policy of encouraging either women, or else men who were not of military age, to stand in for their serving counterparts leads to the inevitable conclusion that fewer staff of perhaps reduced physical capacity and with less training were forced to look after an increasing number of patients during the war years.⁵⁶ This general shortage of practitioners and asylum workers across the country led the Board to take fairly drastic action early in the war years in 1915. In their annual reports they commented that they were:

⁵⁴ Ibid., p. 27.

⁵⁵ Ibid., p. 27.

⁵⁶ For more on the general shortage of asylum workers and the effects and arguments for and against employing women in the male wards of Wakefield Asylum in particular, see C. Chatterton, ‘An Unsuitable Job for a Woman? Gender and Mental Health Nursing’, *The Bulletin of the UK Association for the History of Nursing*, vol. 2, no. 1, 2013, 44-49.

Aware of the fact that many of the duties hitherto properly required of a medical staff are not essential to merely the efficient conduct of an asylum in respect to the medical care and routine treatment of its inmates have decided to suspend the operation of some of the statutory duties as to enable the primary objects of the institution to be carried on by a diminished staff.⁵⁷

Although the Board “made these suggestions, which [were] in direct variance with the policy they ha[d] always so steadily advanced with *deep regret*,”⁵⁸ they were clear about the status of the average pauper lunatic in comparison to that of the men on the front line. They commented:

It is not fair to the paramount necessities of the Army Medical Service that asylum medical men should be asked to spend time over such matters at present, and that as regards aetiological factors, in general, attempts to educe and record them at the moment must be in many asylums of very dubious value.⁵⁹

The suspension of duties that they proposed included reducing the number of entries made in the casebooks for chronic cases, and clinical notes in the casebooks being limited to facts of particular importance.⁶⁰ The medical register could be wholly suspended as could most post-mortems, and the case-notes on deaths and discharges of patients

⁵⁷ WYAS, C85/1/15/4, Annual Reports of the Board of Control (1915), p. 34.

⁵⁸ *Ibid.*, p. 36. My emphasis.

⁵⁹ *Ibid.*, p. 36.

⁶⁰ *Ibid.*, p. 34.

were reduced to only the most important information, omitting “all entries under the heading ‘duration of present attack’ and ‘form of mental disorder.’”⁶¹

By 1918 however, the Board of Control were forced to admit that there were very large decreases in asylum patients during the years 1917 and 1918, and these decreases were “mainly due to the abnormal number of deaths occurring amongst the patients in institutions for the insane and probably among the insane in other Poor Law Institutions and those on outdoor relief also.”⁶² Table 3.3 below identifies the alarming increase in the death rate in institutions in England and Wales by the final two years of the war.

Table 3.3: Average annual number of deaths in institutions for the insane (In England and Wales)⁶³

Year	Average annual number of deaths in institutions for the insane (In England and Wales)
1905-1914	10,085
1917	17,948
1918	19,515

Source: WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918)

Table 3.3 clearly identifies a dramatic increase in the death rate of pauper lunatic patients in institutions in England and Wales throughout the war years. In addition to providing the table (which has been replicated above) in their Annual Reports, the Board of Control also calculated how these figures translated into percentage death rates. The results highlighted an alarming increase:

⁶¹ Ibid., p. 35.

⁶² WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), p. 6.

⁶³ Ibid.

For half a century prior to 1915 the death rate had shown a slight but steady fall; the average death rate for the 10 years 1869-78 was 10.8% of the daily average resident, and that for 6 years 1909-1914 was 9.7%. In 1915 however, it rose to 12.11%, a figure not reached since 1860, in 1916 to 12.6% in 1917 to 17.6% and 1918 to 20.2%.⁶⁴

Once again the local figures provide a similar picture to the death rates at a national level. Although the death rate for Wakefield Asylum was reportedly lower in 1918 than it was in 1917, and lower than the national average for 1918, at 17.7 percent of the daily average number resident, the death rate was still considerably higher than the national pre-war figures.⁶⁵

In 1918 the Board of Control carried out an enquiry in an attempt to explain these huge increases in the death rate of pauper lunatics in asylums. The overall findings of the report were *highly critical* of the reduced standard of care and attention throughout the war years. In their findings, the Board of Control concluded that some factors were induced by the war and were therefore 'unavoidable,' such as the "*unavoidable* reduction in quantity and deterioration of the quality of the food supplied to the patients."⁶⁶ Furthermore they blamed the increased death rate upon the "impairment of staff efficiency incident upon decreased numbers, [and the] untrained character of substitutes,"⁶⁷ in addi-

⁶⁴ Ibid., pp. 22-23.

⁶⁵ WYAS, C416/1/55, West Riding Asylums Board Minute Books (1918), p. 6.

⁶⁶ WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), p. 24. Emphasis mine.

⁶⁷ Ibid., p. 25.

tion to increased “overcrowding, especially when combined with bad ventilation.”⁶⁸ Apart from these ‘unavoidable’ factors however, they were forced to admit that other factors had helped to cause the problem that were *not* related to war. These linked to perfectly avoidable hygiene issues, which helped to explain the serious increase of infection in hospitals. The enquiry damagingly referred to the “imperfect segregation of the sick and infectious patients”⁶⁹ and a “lack of personal cleanliness including lack of care in preventing patients from eating or handling food with dirty hands, [and] wrong methods of dealing with foul linen”⁷⁰

Once again parallels can be drawn between the national picture and that of the West Riding of Yorkshire, which could similarly link the rise in infection on the wards to an increased death rate. The Annual Reports of the Board of Control in 1918 reported upon the “severe epidemic of influenza amongst the patients and staff” at Menston Asylum, which led to “many deaths [which] unfortunately occurred amongst the patients on both the male and female sides of the institution.”⁷¹ Although infection in asylums was not new, the sheer scale of overcrowding, in addition to the severity of the infection (Spanish Influenza), teamed with the untrained nature and reduced staff levels, led to the unparalleled death rates within public lunatic asylums. A similar picture can be observed at both Wakefield and Storthes Hall.⁷²

All of this suggests that conditions in asylums *were* critical for patients institutionalised within asylums during the war years. It also highlights that *some* of Lomax’s experiences whilst working in Prestwich Asylum in the years 1917-1919 may well have

⁶⁸ Ibid., p. 25.

⁶⁹ Ibid., p. 26.

⁷⁰ Ibid., p. 26.

⁷¹ WYAS, C416/1/55, West Riding Asylums Board Minute Books (1918), p. 51.

⁷² Ibid., p. 51.

mirrored conditions within other asylums throughout this period.⁷³ Importantly here, it must be stressed that these conditions were exceptional and due, for the most part, to the war. Indeed, if the war conditions were the norm then the Board of Control would not have been able to report upon the shocking mortality rates in asylums during this period. By 1919 conditions were already beginning to again reflect the pre-war experiences with the recovery rate of patients again increasing. In 1919 the Board's Annual Reports highlight that the national "recovery rate, calculated upon total admissions was 31.83%, [which] showed a *marked improvement* from the low figure of 27.14 percent to which it had fallen in 1918."⁷⁴

Despite this recovery in the figures after 1918, the conditions in asylums during the war, the phenomenal increase in mortality rates, confessional works based upon the horrific conditions in asylums and newspaper reports claiming that asylums were 'starving' their inmates would have all provided much sensational propaganda, which would have inevitably inflamed the already widespread public mistrust of pauper lunatic asylums. For the most part then, these institutions were certainly not the types of place the public wanted to associate with their mentally afflicted war-serving veterans. The rest of this chapter will observe the experiences of mentally ill ex-servicemen who were incarcerated in asylums and hospitals in the West Riding of Yorkshire. It will identify the strengths and weaknesses of two different schemes, which were both intended to remove the stigma of pauperism and to some degree lunacy from these institutionalised men.

⁷³ Lomax, *The Experiences of an Asylum Doctor*.

⁷⁴ WYAS, C85/1/15/6, Reports of the Board of Control (1919), p. 11.

Shell-Shocked Veterans *not* Pauper Lunatics? The Service Patient Scheme, 1917:
Another attempt to abolish the Poor Law?

The deteriorating treatment of non-soldier lunatics in asylums during the First World War and the stigma attached to insane pauper patients more generally both added to the widely held public assumption that asylums were no place for men who had served during the war. In her work Reid argues that:

Throughout the war, lay commentators paid little heed to the distinction between psychosis and neurosis, and increasingly distinguished between shell-shocked soldiers, who did not deserve to be incarcerated by dint of their war service, and civilian or ‘ordinary’ lunatics who required a level of detention.⁷⁵

In 1917 the Government made an effort to respond to public opinion by attempting to remove the issue of pauperism from men who had served in the war, but who were now incarcerated within public lunatic asylums. In her work on the Ex-Services’ Welfare Society (ESWS), Reid notes the importance of the issue of pauperism. Her examination of the letters of the society suggests that there was a “particular exception to the term ‘pauper’ being used in reference to ex-servicemen in asylums.”⁷⁶ Furthermore within his work, Barham argues that the stigma of pauperism was an overbearing shame for any

⁷⁵ F. Reid, ‘Distinguishing between Shell-shocked Veterans and Pauper Lunatics: The Ex-Services’ Welfare Society and Mentally Wounded Veterans after the Great War’, *War in History*, vol. 14, no. 3, 2007, 347-371, 348.

⁷⁶ *Ibid.*, p. 364.

serviceman who was sent home from duty to an asylum. Barham even indicates that during the war this disgrace was even more humiliating than the stigma of mental illness. He argues that popular feeling maintained that “if the Board of Control could not keep insane servicemen out of the asylum altogether, they could at least endeavour to keep them out of the asylum in its embodiment as a Poor Law institution.”⁷⁷ This section attempts to identify how successful the attempt to remove the stigma of pauperism from ex-servicemen was during these years.

In an attempt to relieve some of the pressures of the stigma of pauperism from mentally afflicted ex-servicemen, a new set of rules was established. The Service Patient Scheme, which came into effect in 1917, can be observed as another initiative with regard to the abolition of pauperism for certain ‘deserving’ members of the mentally afflicted community. The scheme can be observed as yet another attempt to undermine traditional lunacy legislation by taking yet another of its services outside of the remit of the Poor Law authorities, as the Liberal Government had previously done for many patients described as ‘mentally deficient’ in the legislation of 1913. Instructions that were sent by the Board of Control on the 27th June 1917 to every asylum Superintendent in the country related to the new rules concerning “the classification and treatment of soldiers and sailors as “service patients.”⁷⁸

These new rules of 1917 identify that the authorities knew the reality of the stigma of pauperism, and felt that to identify war ‘heroes’ with the Poor Law was a step too far in the popular public imagination. The proposed ‘solution’ to this pressing problem was to keep these patients under the title of ‘service patients,’ according to the 1917 rules. However, when observed critically it would appear that there were many ambigu-

⁷⁷ Barham, *Forgotten Lunatics of the Great War*, p. 105.

⁷⁸ WYAS, C416/1/443, Instructions relating to the classification and treatment of soldiers and sailors as “service patients” (1917).

ties, conflicts and drawbacks to these rules, meaning that not only did patients have to bear the stigma of institutionalisation but some of their promised comforts never materialised.

On the first of January 1920, less than three years after the scheme was proposed, there were already 3,739 patients classed as service patients in institutions in England and Wales, and many more were added to the register in subsequent years.⁷⁹ Ten years later on the 1st January 1930 there were 4,618 service patients in institutions in England and Wales, showing a steady increase rather than decrease over the course of the decade.⁸⁰ By the first of January 1924 there were as many as 349 officially recognised service patients institutionalised in the four West Riding Hospitals alone.⁸¹ Collectively this group of Service patients formed a large minority within many asylum walls. The fact that the Service Patient Scheme made no promises of providing provision for these men outside of Poor Law institutions highlights perhaps the most fundamentally flawed aspect of removing the stigma of pauperism from these men.

As service patients, these mentally afflicted veterans in asylums were entitled to be kept and treated like private patients; their stay in the asylum being paid by the Ministry of Pensions through the War Pensioners scheme and *not* under *any* circumstance through Poor Law relief. It was noted in the West Riding Asylum's minute books on the 21st March 1917 that:

*All soldiers and sailors who have become insane during
the war, shall be classed as private patients, and shall*

⁷⁹ WYAS, C85/1/15/6, Annual Reports of the Board of Control (1919), pp. 7-8.

⁸⁰ WYAS, C85/1/15/3, Annual Reports of the Board of Control (1929).

⁸¹ WYAS, C416/1/61, Minute Books of the West Riding of Yorkshire Hospital Board (1924).

have *no relation to the Poor Law Authorities*.⁸²

It was further proposed that:

All soldiers and sailors who during the present war need institutional treatment for certifiable mental disorders are to be sent to County and Borough asylums and there classed and treated as private patients under the name of service patients... The amounts paid for the maintenance of a 'Service Patient' will not affect the pension payable to his wife and children. It is intended to treat the wife as though she was a widow, and children as if they were orphans.⁸³

Another privilege benefiting the service patient consisted of the benefit of a weekly allowance of 2/6d. Despite this however, the rules were somewhat vague and unclear in the case notes as to how this money was actually spent. Under the 1917 scheme each patient was theoretically entitled to a "special grant of up to 2/6d. per week *for extra comforts*."⁸⁴ Under Section 16 of the scheme however, it was ambiguously stated that the judgement as to which patients could actually receive this money would be left to the individual Visiting Committee, acting upon the advice of the Medical Superintendent. Thus

⁸² WYAS, C488/1/5, West Riding Asylum, Minute Book (1914-1920), p. 249. My emphasis. Similar information relating to the service patient scheme is available in another collection of the West Riding Asylum Minute Books. See WYAS, C416/1/54, Minute Books of the West Riding of Yorkshire Asylums Board (1917).

⁸³ WYAS, C488/1/5, West Riding Asylum, Minute Book (1914-1920), p. 45.

⁸⁴ WYAS, C416/1/443, Instructions relating to the classification and treatment of soldiers and sailors as "service patients" (1917). My emphasis.

it was the decision of the Visiting Committee as to:

Which patients are capable of appreciating and benefiting by the special grant up to 2/6d.; upon what additional comforts the money should be spent; and whether the patient may properly be entrusted with spending the money himself.⁸⁵

The case notes of the Ministry of Pensions Hospital seem to suggest that the money was utilised in different ways for different patients. In a few instances it seems clear that this money was actually given to the patients to spend, seemingly as they 'wished' in the asylum. In the case notes of the Ministry of Pensions Hospital it is occasionally mentioned that a patient had bought cigarettes or other such small luxuries, potentially out of this money. In other cases it seems that the money was only made available when and if the patient was released from the asylum. Not infrequently within the casebooks are copies of letters from the War Office stating that they had a sum of money available for a certain patient and asking about their condition to receive it.⁸⁶ Certainly it would appear that the benefits of this special grant of money were very often withheld until a patient was deemed responsible enough for such a privilege; this clause with respect to entitlement clearly left many patients without this additional benefit.

However it was not only the potential entitlement to a bit of pocket money that was supposed to set these men apart from 'ordinary lunatics' in asylums. In addition to the above differences under the rules of 1917, a 'Service Patient' was to be distinguish-

⁸⁵ Ibid.

⁸⁶ WYAS, C416/5/159, Reception Orders and Transfer Details of Private Service Patients (1924), patient record nos. 10, 14 and 15.

ble from pauper patients in asylums with regard to their physical appearance. Having analysed the options, it was decided that the service patient was to “wear a *distinctive* uniform, costing 3s 9d.”⁸⁷ The ‘other options’ which were debated consisted of the following, (1) to wear the same clothing as pauper lunatics which it was considered “would probably cause dissatisfaction,” or (2) the option of private clothes being worn, supplied by the patient’s friends and family. However, this was deemed worse still as it provided a high “risk that the supply will, in many instances be casual and result in the patients presenting a slovenly and uncared for appearance.”⁸⁸ It would seem that the debate over what uniform a service patient should wear proved highly provocative as this would create the image which would establish in the minds of the public the differences between the pauper lunatic and the service patient; as the first Minister for Health, Dr Addison, explained this was essential as it was “vital that this class of men should escape the *stigma* and disabilities of being classed as lunatics.”⁸⁹

Despite this, again the rules are somewhat ambiguous as to what exactly this uniform should be, merely proclaiming “the Visiting Committee will supply their ‘Service Patients’ with suitable private clothing.” Once again however, there was a catch to this rule:

Ordinarily, the jackets, waistcoats, trousers and overcoats intended for pauper patients must not be worn by “Service Patients,” but it will be left entirely to the Medical Superintendent to determine what clothing should be worn by (a) a patient when employed on the farm or gardens, or in any other work, (b) by a

⁸⁷ WYAS, C488/1/5, West Riding Asylum Minute Book (1914-1920), p. 45. My emphasis.

⁸⁸ *Ibid.*

⁸⁹ C. Addison, ‘Parliamentary News’, *Journal of Mental Science*, vol. 136, no. 67, 1921, 136.

sick patient; and (c) by a patient whose habits are faulty and destructive.⁹⁰

Again this rule left much scope for interpretation by individual Visiting Committees and Medical Superintendents. Although clearly the rule was intended to diminish the stigmas of pauperism by providing a different uniform to the other insane paupers institutionalised within the same institutions, there is little to suggest that patients either received these uniforms, or, if they did, where the differences were. Further the fact that many of the men admitted to the Ministry of Pensions Hospital were put to work in some capacity (as will be shown later in this chapter) may potentially have excluded them from the use of the uniform.

Although in her work, Fiona Reid argues that “it is difficult to make a generalisation about something as complex as social stigma,”⁹¹ it is clear that some of the patients admitted to the Ministry of Pensions Hospital felt that this scheme did little to alleviate the stigmas of either pauperism or insanity. Indeed, although the newly prescribed uniform was supposed to be different to the uniform of a pauper patient, there is evidence to suggest that a uniform of any kind would have led to natural connotations and generalisations about the wearer. A letter written by thirty-six year old George S, a patient admitted to the Ministry of Pensions Hospital, acutely identifies the problem: “People outside look at you with scorn and ridicule because of your garb, which causes the greatest disgrace imaginable.”⁹² It is unclear from this letter whether the ‘greatest disgrace imaginable’ is linked to pauperism or insanity, but it seems clear that the patient’s ‘garb’ or uniform clearly labelled him as an insane soldier. In her article ‘Appearance and Dress at Staf-

⁹⁰ WYAS, C416/1/443, Instructions relating to the classification and treatment of soldiers and sailors as “service patients” (1917).

⁹¹ Reid, *Broken Men*, p. 24.

⁹² WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 12.

fordshire,' Rebecca Wynter explains, "how important clothes were to personal esteem,"⁹³ identifying that within a space of confinement, to many patients "appearance was essential..."⁹⁴ She argues that with regard to Stafford Asylum, "The dress of the mad rich distinguished them within the asylum, but enabled their participation in wider society."⁹⁵ Arguably the uniform given to the service patients was supposed to distinguish them within the asylum; despite this however, some service patients clearly felt that their attire contributed to the negative connotations linked to insanity in the world outside of the institution.

The final 'privilege' provided by the Service Patient Scheme existed in death. Should the veteran be unlucky enough to die within a Poor Law institution then they would be spared the indignity of finding themselves buried in a pauper's grave or the asylum's cemetery, two massive social stigmas which often became a reality for friendless paupers who died within a Poor Law institution.⁹⁶ Although this clearly was a conciliatory move by the Ministry to offer peace-of-mind to deceased patients' friends and family, and the concerned general public, arguably, it was a concession that came too late for the patient himself.

Overall then, it would appear that removing the dependency on Poor Law finance by putting in place Ministry of Pensions finance and changing the language used to describe service patients and the uniform used to denote service patients from other pauper patients did not always mean removing the *association* with pauperism in either the private or public perception, especially as throughout the interwar years many service pa-

⁹³ R. Wynter, 'Good in all respects': Appearance and Dress at Staffordshire County Lunatic Asylum, 1818-54', *History of Psychiatry*, vol. 22, no. 1, 2011, 40-57, 47.

⁹⁴ *Ibid.*, p. 44.

⁹⁵ *Ibid.*, p. 47.

⁹⁶ WYAS, C416/1/443, Instructions relating to the classification and treatment of soldiers and sailors as "service patients" (1917).

tients were still institutionalised and treated within local pauper lunatic asylums.⁹⁷ In spite of intentions to rid servicemen of the stigma of pauperism the subsequent restrictions and limitations of the 1917 Service Patient Scheme created problems. Despite certain benefits, it would appear that for the most part the attempt to separate service patients from pauper patients in various guises failed. Indeed, it would appear that perhaps the biggest failure of the Service Patient Scheme was that it enabled no separate provision or accommodation for servicemen with the exception of a specific ward in a lunatic asylum. The rest of this chapter focuses upon a case study of a local hospital that *was intended* to be a separate hospital specifically for the purposes of service patients. By analysing these two national initiatives and how they operated at a local level together, this chapter will assess the impact of these schemes in the minds of patients and their families whose lives were affected by the Ministry of Pensions, the Service Patient Scheme and above all the Ministry of Pensions Hospital in Kirkburton during the 1920s.

Shell-Shocked Veterans *not* Pauper Lunatics? The Ministry of Pensions Hospital, Kirkburton: The Ideal and the Reality

Despite the introduction of the Service Patient Scheme, the official policy of placing ex-servicemen in pauper asylums remained an issue of serious contention throughout the interwar years.⁹⁸ Perhaps as an effort to cater to public opinion a new hospital was opened specifically for mentally ill ex-servicemen in the West Riding of Yorkshire. The Ministry of Pensions finalised their arrangements to set up The Ministry of Pensions Hospital in Kirkburton in 1923. The hospital was set up and run by the Ministry of Pen-

⁹⁷ There were 349 Service Patients institutionalised in the four West Riding Hospitals alone on the 1st January 1924. Ref: WYAS, C416/1/61, Minute Books of the West Riding of Yorkshire Hospital Board (1924).

⁹⁸ Reid, 'Distinguishing between Shell-shocked Veterans and Pauper Lunatics', 364.

sions, the Governmental body created in 1916, in charge of administering pensions and (institutional) care to ex-servicemen who had served during the First World War. It was created entirely for the benefit of mentally afflicted ex-servicemen of the First World War, and was one of only two such institutions – the other being at Old Manor near Salisbury, Wiltshire. Old Manor served the south of England; Kirkburton the north. Though this was several years after the war had officially ended, the Ministry of Pensions argued that the Hospital was opened in “pursuance of the Ministry’s plan to organise institutions locally for the treatment of mental cases among ex-servicemen.”⁹⁹ The hospital was described as an “experiment [to] separate arrangements for the treatment of selected certifiable cases of a hopeful type.”¹⁰⁰ As part of their plans, it was agreed that the Ministry would take over “part of the asylum accommodation” at Storthes Hall Pauper Lunatic Asylum, which allowed the Ministry to take over the responsibility and control of the acute hospital and two convalescent villas on the site.¹⁰¹ As such this annexation was similar to the appropriation of Stanley Hall, which was discussed in Chapter Two. The hospital was an attempt for the Ministry of Pensions to finally react to popular public opinion and to create small-scale residential institutions for mentally afflicted ex-servicemen to live in, away from the connotations of receiving aid from the Poor Law and the stigmatisation of life within a pauper institution. Within his work, Barham describes the Ministry’s plan as “an attempt to recreate the therapeutic enthusiasm of the war years in the mental health sphere.”¹⁰² In a report of 1925 *The Manchester Guardian* referred to this as “the Ministry’s other task... one in the performance of which has the whole sympathy of the nation.”¹⁰³

⁹⁹ Anon., ‘Mental Cases Among Ex-Servicemen: Storthes Hall Scheme’, *The Manchester Guardian*, 12 September 1925, p. 12.

¹⁰⁰ Parl Deb, 20 Feb 1923, as quoted from Barham, *Forgotten Lunatics of the Great War*, p. 411, n.35.

¹⁰¹ WYAS, C416/1/61, Minute Books of the West Riding of Yorkshire Hospital Board (1924), p. 8.

¹⁰² Barham, *Forgotten Lunatics of the Great War*, p. 278.

¹⁰³ Anon., ‘Mental Cases Among Ex-Servicemen’, p. 12.

The hospital boasted 350 available beds, and 290 cases were admitted in the first year of opening.¹⁰⁴ Though the institution was remarkable at the time for not being overcrowded, it hardly seemed to cater to public demands for a ‘small-scale,’ home that focused upon individualised treatment and care. Further, as the hospital was merely an annexe of Storthes Hall Pauper Lunatic Asylum, and therefore set on the grounds of an existing pauper lunatic asylum, it would not necessarily have removed the connotations of lunacy and pauperism from the patients who were institutionalised therein.

Nevertheless the Ministry of Pensions, in collaboration with the West Riding Mental Hospitals Board, were adamant that the new hospital should be seen in a progressive light. *The Manchester Guardian*, which was renowned for taking an enlightened perspective with regard to issues surrounding mental health reported on the opening of the new hospital in its characteristically progressive way. In an article they part-quoted the Chairman of the West Riding Mental Hospital Board explaining that:

Many people were under the impression that the men in the mental hospitals were ‘peculiar’ constantly. As a matter of fact, three-quarters of them, three-quarters of the time were as sane as anybody else. – A large number of ex-servicemen in the hospital who were present heartily cheered this statement.¹⁰⁵

This article shows that there was a mood of sympathy and understanding towards mentally ill ex-servicemen in certain factions of the media and public opinion at the time. Alt-

¹⁰⁴ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924) and WYAS, C416/5/158, Male Casebook Records of Private Service Patients (1924-1925).

¹⁰⁵ Anon., ‘Mental Cases Among Ex-Servicemen’, p. 12.

though the Hospital got some positive media attention however, it is also clear that official opinion was becoming much more conservative with regard to mentally ill or shell-shocked servicemen during these years. It is this difference between public sympathy and official conservatism that led to the enormous disparity between the public image of the new hospital, and the reality within. Despite the fact that many members of the public were often sympathetic with the plight of the 'shell-shocked' soldier, after the war the official picture with regard to shell shock was more complex, and much more conservative in outlook. The findings of Lord Southborough's *Report of the War Office Committee of Enquiry into 'Shell-Shock'* were published in 1922, two years before the hospital at Kirkburton was opened. The report stressed how inappropriate the term 'shell shock' actually was, and identified that long before 1922 it had ceased to be a medical term, despite the fact that it still held a prominent place in "the public imagination, and thenceforth there was no escape from its use."¹⁰⁶ It is important here to note that after the Lord Southborough Report of 1922, the term 'shell shock' was effectively "eliminated from official nomenclature."¹⁰⁷ This explains the persistent use of phrases and diagnoses such as 'war neurosis,' 'strain of war,' and 'war stress' within the patient casebooks at the Ministry of Pensions Hospital; quite simply the term 'shell shock' no longer existed in medical discourse.¹⁰⁸

The report explained how "it became abundantly plain to the medical profession" that war could produce "a condition of mind and body properly falling under the term "war neurosis," practically indistinguishable from the forms of neurosis known to every doctor under ordinary conditions of life."¹⁰⁹ Moreover, the essence of the Report was to completely dispel the notion that the war was in any way the main factor of an individu-

¹⁰⁶ Lord Southborough, *Report of the War Office Committee of Enquiry into 'Shell-Shock'* (London, His Majesty's Stationary Office, 1922), p. 5.

¹⁰⁷ *Ibid.*, p. 190.

¹⁰⁸ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924).

¹⁰⁹ Southborough, *Report of the War Office Committee of Enquiry into 'Shell-Shock'*, p. 5.

al's breakdown. This was important as it had an enormous impact on the level of pension attributable to a mentally incapacitated soldier. The Report explained:

Most witnesses were of the opinion that the stress of war rarely produced insanity in the stable man, but that it acted, as is commonly observed with other forms of stress, as a factor upon those who by pre-disposition were liable to breakdown.¹¹⁰

Thus the Report helped to re-ingrain popular nineteenth century illusions to the hereditary factor of mental illness, by suggesting that the vast majority of the men who were now suffering from 'war neurosis' would have eventually succumbed to mental illness anyway, as they were weak or else tainted hereditarily.¹¹¹

This official picture can help to explain the medical distinctions of the men who were incarcerated within the Ministry of Pensions Hospital. The inmates who were admitted to the Ministry of Pensions Hospital fit into this stereotype of the weak soldier who was pre-disposed to hereditary insanity, and as such was not suffering from 'shell-shock' but other forms of mental illness. These illnesses, it was argued, had merely been 'accelerated' by the conditions of war. Amongst the cases admitted were many whose insanity was precipitated *not* by "war stress," or "strain of war" alone, (although this was always noted to be a contributory – *aggravated* – aetiological factor¹¹²) but was noted to be hereditary. There is no denying that the inmates who were admitted do not appear to

¹¹⁰ Ibid., p. 144.

¹¹¹ For a fuller analysis of the report, see T. Bogacz, 'War Neurosis and Cultural Change in England, 1914-22: The Work of the War Office Committee of Enquiry into 'Shell-Shock'', *Journal of Contemporary History*, vol. 24, no. 2, 1989, 227-256.

¹¹² In 1918 distinctions were to be made as to whether shell shock was wholly a by-product of service (attributed) or whether service had simply worsened an existing disorder (aggravated) see Jones and Wessely, *Shell Shock to PTSD*, p. 144.

live up to the Ministry's description of the more hopeful type. Examples of patients who did not fit this category include twenty-three year old Percy H, an epileptic, whose father was an alcoholic,¹¹³ twenty-seven year old James G whose sister was across the road in the main building of Storthes Hall;¹¹⁴ and James Henry L, whose father was "known to have been an inmate at the South Yorkshire Asylum for many years."¹¹⁵ Other cases include twenty-four year old Samuel H, who was noted to be "wrong mentally," which was partly attributed to the fact that his "brother was feeble-minded and in the Western Counties Asylum for eight years."¹¹⁶

Perhaps the most obvious evidence which suggests that patients were sent to the Ministry of Pensions Hospital when they had little opportunity of improving can be observed in the large proportion of patients admitted who were diagnosed as being feeble-minded or mentally deficient. The discourse of the day explained that these patients, by definition, were extremely unlikely to ever recover without proper training within a designated colony or home.¹¹⁷ Patients fitting this category include thirty-five year old Edward W, who was described on entry as being "very feeble-minded. He shows very little intelligence and is dull and simple;"¹¹⁸ thirty year old John W, whose mother observed "ever since he left school he has done very little work and goes about giving his clothes and money away;"¹¹⁹ and Jack F who had been passed around the imbecile wards of the county before being placed in Storthes Hall and finally the Ministry of Pensions hospital in 1924.¹²⁰ All of this highlights again the "reasoned opinion" of *The Times* that

¹¹³ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 3.

¹¹⁴ Ibid., patient record no. 37.

¹¹⁵ WYAS, C416/5/159, Reception Orders and Transfer Details of Private Service Patients (1924), patient record no. 18.

¹¹⁶ Ibid., patient record no. 17.

¹¹⁷ See Chapter 2 for more on this. Also see A. F. Tredgold, *Mental Deficiency 'Amentia'* (London, Baillière, Tindall and Cox, 1922).

¹¹⁸ WYAS, C416/5/159, Reception Orders and Transfer Details of Private Service Patients (1924), patient record no. 22.

¹¹⁹ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 18.

¹²⁰ Ibid., patient record no. 35.

sufficiently large numbers of men “were passed for service in the army when they were more fitted to be certified for asylums”¹²¹ and other mental deficiency institutions. In his work for the US army, Thomas Salmon identified:

About eighteen per cent of the patients admitted to the military hospitals for mental diseases are mentally defective... The low grade of many cases received in the special hospitals is very striking and shows an amazing indifference on the part of recruiting officers to this type of disability. It is said that the worst types got in during the first rush of recruits under the voluntary system and that, since then, more pains have been taken to exclude them... Most of these soldiers were defectives of the restless, criminalistic type, many of whom had been civil offenders before entering the army.¹²²

It seems apparent that the proportion of mentally deficient at the Ministry of Pensions Hospital only mirrored a wider trend within the British Army itself.¹²³

Though the majority of patients were suffering from some form of delusional insanity precipitated by the strain of war, little else seems to link the cases together to explain why these were the chosen group for the ‘experiment.’ Age seemed to be of little importance, with men institutionalised from their early twenties to their late fifties. Similarly, although for most patients this was their first attack of insanity, like that of William

¹²¹ Anon., ‘Lunacy During the War’, *The Times*, 6 September 1919, p. 11.

¹²² T. W. Salmon, *The Care and Treatment of Mental Diseases and War Neurosis (Shell Shock) in the British Army* (New York, War Work Committee, 1917), p. 19.

¹²³ For more on the status of the mentally deficient during the war see M. Thomson, ‘Status, Manpower and Mental Fitness: Mental Deficiency in the First World War’, in R. Cooter, M. Harrison and S. Sturdy (eds), *War, Medicine and Modernity* (Gloucestershire, Sutton, 1999), pp. 149-166.

L, which had been brought about by reasons such as “shock from a bomb dropping near Boulogne;”¹²⁴ for others it was their fifth or sixth attack, such as forty-three year old William F, who had been having problems since the age of twenty-one and was now on his sixth attack of insanity.¹²⁵ Furthermore, the previous occupations of the men that arrived represents nothing more than the diversity of men who joined up, and subsequently found themselves mentally affected by their war service and in need of institutional help. Occupations include, amongst many, assistant grocers, warehousemen, a Deacon in Holy Orders, railway workers, a tailor’s dresser, clerks, miners, labourers, farmers, a commercial traveller, and a foreign correspondent.¹²⁶

All of this suggests that the Ministry’s grand plan to house “selected certifiable cases of a hopeful type”¹²⁷ within a specialist institution away from the stigmatisation of mental illness and asylums was a far cry from the reality. Instead the reality consisted of housing a collection of chronic sufferers of insanity and mental deficiency inside an artificially separate ‘hospital,’ which was merely located within the temporarily borrowed accommodation of an existing pauper lunatic asylum. In this case, it would appear that the language used and the reality just did not add up. However, this was not the only way that the language and reality did not add up; when one observes the journeys that these men made to the hospital it is easy to identify clear holes in the 1917 Service Patient Scheme. It would appear that despite the rhetoric of avoiding the complete stigmatisation of the Poor Law for mentally afflicted sufferers of the war, this was simply not the case.

¹²⁴ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 5.

¹²⁵ Ibid., patient record no. 6.

¹²⁶ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924).

¹²⁷ Parl Deb, 20 Feb 1923, as quoted from Barham, *Forgotten Lunatics of the Great War*, p. 411.

The Journey to the Ministry of Pensions Hospital

In 1924 recruits for the Ministry of Pensions Hospital arrived in large groups from pauper lunatic asylums across the country, but predominantly from asylums in the northern counties. Thus, not only did candidates appear *en masse* from the West Riding County asylums of Menston, Storthes Hall, Wadsley and Wakefield, but they also came in from all corners of England, including Sunderland Asylum, Carlisle Asylum, Middlesbrough, Claybury, Prestwich Asylum (near Manchester), Glamorgan and Kent. All of the patients that were drafted in to become the new hospital recruits came directly from pauper lunatic asylums where they had already been categorised as Service Patients under the Board of Control's instructions of 1917.¹²⁸

Patients were admitted to these initial asylums in two ways. Firstly, a patient could be transferred to a lunatic asylum directly from the War Hospital where they were already receiving treatment. Examples of this include the cases of David S, who was transferred directly from Long Grove Asylum to Huddersfield Ministry of Pensions Hospital in 1924¹²⁹ and Herbert D whose institutional journey took him from the Lord Derby War Hospital to Warwick Asylum before being brought to the Ministry of Pensions Hospital in Kirkburton where he eventually died in 1927.¹³⁰ More frequently however, the familiar process took place, whereby the distressed family of a mentally afflicted ex-serviceman were forced to apply for help from the Poor Law Relieving Officer, who would carry out the routine checks and a Poor Law Medical Officer would then fill in the required certificates including a Reception Order for a pauper lunatic as he would for any other pauper patient under the terms of the 1890 Lunacy Act.

¹²⁸ WYAS, C416/1/443, Instructions relating to the classification and treatment of soldiers and sailors as "service patients" (1917).

¹²⁹ WYAS, C416/5/158, Male Casebook Records of Private Service Patients (1924-1925), patient record no. 213.

¹³⁰ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 15.

Under these terms, it was the patient's family who decided when enough was enough and their charge was becoming too difficult to control. These findings are consistent with Barham's work, wherein he too noted that a patient's family were as likely to send their relative away from home and to an asylum as the military authorities.¹³¹ In this instance, First World War service patients mirror the cases of regular pauper lunatics in almost every way. On admission to a pauper lunatic asylum after the war, men who had served for their country during the First World War were in no way an 'isolated' or separate category as Bourke suggests, rather they were treated the same as any other pauper lunatic.¹³² The Reception Orders and transfer notes of the Ministry of Pensions Hospital identify that families often 'disposed' of their mentally ill, war-serving relatives for very similar reasons as they disposed of their non-serving family members.¹³³ The reasons families cited when applying for asylum admission for their loved ones were frequently linked to violent, uncontrollable behaviour, refusing to work, generally acting strangely or else in an eccentric or alarming manner. Examples include the father of twenty-three year old Edwin F, who claimed that his son "will not work and threatens to do harm to his family."¹³⁴ The mother of twenty-seven year old James G expressed concern when he started to take "a rifle to bed with him and sometimes [even] a poker,"¹³⁵ and the sister of nineteen year old James M explained that he had become "very strange and violent in manner" since his return from the war, and had subsequently "threatened her with a hammer."¹³⁶ Further, Edith Alice C told the Relieving Officer that her husband, forty-nine year old Christopher C tells her to:

¹³¹ Barham, *Forgotten Lunatics of the Great War*, p. 171.

¹³² Bourke, *Dismembering the Male*, p. 109.

¹³³ J.K. Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-1870', in W.F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II, Institutions and Society* (London, Tavistock, 1985), pp. 132-146.

¹³⁴ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 34.

¹³⁵ *Ibid.*, patient record no. 37.

¹³⁶ *Ibid.*, patient record no. 42.

Be very careful as the neighbours have installed a listening post in the basement... he is afraid to leave the house because people make remarks about him. [He] thinks that the neighbours say that he is a common murderer.¹³⁷

These examples identify that men who became service patients did so because of their contribution to the war effort, even though many of their illnesses and symptoms or ‘causes’ of illness did not necessarily clearly link to their time serving for their country. Though this fact can be seen in a positive light, other aspects of their journeys do not. All of the examples above demonstrate that the system meant that these distressed family members who could not afford private care would have been forced to apply initially to the Poor Law Relieving Officer even though their relative would eventually become accepted as a Service Patient.

According to the rules of 1917, only “as soon as information has been received from the Ministry of Pensions, Pensions Issue Office, that a man is to be so treated, [*then*] the Medical Superintendent should at once classify him as a Service Patient.”¹³⁸ All of this identifies that despite the rhetoric of the new Service Patient Scheme, ex-servicemen were obliged (at the outset at least) to endure exactly the same stigmas that applied initially to the pauper patient. Some servicemen were even held in the local workhouse until room at a nearby asylum could be found. This proved to be the case for sixty year old Robert H and thirty-three year old Joseph L who were both from Sheffield and similarly both detained in Sheffield Union Workhouse until sufficient space could be

¹³⁷ Ibid., patient record no. 32.

¹³⁸ WYAS, C416/1/443, Instructions relating to the classification and treatment of soldiers and sailors as “service patients” (1917).

found for their dispatch to a local asylum. Again this mirrors the practice of institutionalisation for many pauper patients. In this case, both servicemen eventually found their way to Wakefield Asylum, before finally being transferred to the Ministry of Pensions Hospital in Kirkburton in 1924.¹³⁹

A letter attached within the Reception Order and removal forms of one of the patients can shed more light on how long a patient was to be considered to be a ‘pauper’ before the official paperwork could be sent from the Ministry of Pensions War Office that the man was to be treated instead as a ‘Service Patient.’ A letter from Mr Jefferson, a clerk at the South Yorkshire Asylum (Wadsley), where Harry M had previously been under treatment, responded to the enquiries sent forth from the Ministry of Pensions Hospital, stating: “Harry M was received into this institution [Wadsley] on the 28 August 1917. On the 19 December 1917 he was transferred to the service class, and on the 21 May 1920 he was discharged recovered.”¹⁴⁰ This correspondence tells us that despite the rhetoric of the Service Patient Scheme, its implementation was far from immediate and thus ineffective if its sole purpose was to remove the patient from the stigma of pauperism. Such was the case for Harry M who had been classified as a pauper for four months before being ‘correctly’ re-classified as a service patient. Similarly, Francis B was admitted to Warwick County Lunatic Asylum on the 24th January 1920, and was also only classified as a ‘Service Patient’ several months later on the 23rd October 1920.¹⁴¹ These cases, and others like them highlight the length of time it could take to re-classify patients when they were in the asylums.

Once again, by analysing patients’ journeys to the Ministry of Pensions Hospital,

¹³⁹ WYAS, C416/5/159, Reception Orders and Transfer Details of Private Service Patients (1924), patient record no. 26 and WYAS, C416/5/160, Reception Orders and Transfer Details of Private Service Patients (1924-1925), patient record no. 51.

¹⁴⁰ WYAS, C416/5/160, Reception Orders and Transfer Details of Private Service Patients (1924-1925), patient record no. 55.

¹⁴¹ WYAS, C416/5/159, Reception Orders and Transfer Details of Private Service Patients (1924), patient record no. 1.

it would seem that there was a severe disparity between the ideological function of the 1917 Service Patient Scheme, to avoid the stigmas of the Poor Law, and the reality of the scheme's implementation, which could not be emplaced until the Poor Law certification and the procedure of the patient's removal to an asylum had already taken place. Although all of these patients were finally allocated Service Patient status, their journey to their initial asylums did nothing to protect them from the initial stigma of both insanity and relying upon Poor Law relief, which sometimes even included the indignity of being housed within the workhouse to await both examination and certification before being removed to the local lunatic asylum.

Life Inside the Hospital: Power Hierarchies and the Game of Institutionalisation

Similar to other mental health institutions, once certified and admitted to the Ministry of Pensions Hospital, a patient had little chance of leaving the institution until the medical authorities and Visiting Committee of the institution deemed them ready to do so. Again, similar to other institutions, this involved a hierarchy of power, which often left patients feeling entrapped within the institutional 'game.' In his work, Goffman explains that 'total institutions' are on many levels characterised by:

A basic split between a large managed group, conveniently called inmates and a small supervisory staff... Each group tends to conceive of the other in terms of narrow, hostile stereotypes, staff often seeing inmates as bitter, secretive, and untrustworthy, while inmates often see staff as condescend-

ing, highhanded and mean.¹⁴²

An analysis of some of the surviving letters written by institutionalised service patients within the hospital can help us to understand how some of the patients processed, understood and experienced the power hierarchies and their relationship within the hospital. Many of the letters clearly identify that many of the patients often felt as though they were being (unjustly) held against their will and many wrote to try to alleviate their feelings of entrapment.

Forty-one year old Lucas C for instance was constantly writing notes on any scrap of paper that he could get his hands on about the injustices done to him. In 1926 he wrote to the Bristol War Office proclaiming; “This is to certify that I do hereby resign from the Bristol Army. You must not take everyman to be a bloody fool.”¹⁴³ Following the lack of response from this however, in 1928 he tried again, this time more forcefully by employing the Royal We into his cause.

This is to certify that I do heavily demand high damages off the war office for this nuciance [sic] going on around me. I am King of this Empire and I am not having this. We will have this case got into as soon as I get away from here. Hoping that to be soon.¹⁴⁴

However, with still no change of his circumstances in 1930, this King of the Empire was clearly losing the game and increasingly more and more of his wits, again writing;

¹⁴² E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (London, Penguin, 1991), pp. 18-19.

¹⁴³ WYAS, C416/5/158, Male Casebook Records of Private Service Patients (1924-1925), patient record no. 215.

¹⁴⁴ Ibid.

This is to certify that it is time you put a stop to this Game which is going on. All of you have done very foolishly, [and] now you are the laughing stock of the world, so I think you should put a stop to it.¹⁴⁵

Despite his letters and objections however, for this particular Private the game did not end, it merely changed setting as he was transferred to the Old Manor, Salisbury in 1931 to continue playing it.

For others the ‘institutional game’ appears to have been linked to the process of getting better and saying the ‘correct’ thing to the doctors at the hospital. The poem ‘Talk Health’ written by William C, in 1930 identifies his anger towards the medical staff at the hospital, and the artificial dichotomy between ‘illness’ and ‘wellness.’ The poem mockingly identifies the professional medical ‘help’ and ‘advice’ that William felt he was receiving from the Medical Inspectors at the Hospital:

You cannot charm, or interest or please,
By harping on the minor [illegible]-disease.
...
Say that you are well, or all is well with you,
And God shall hear your words, and make them true.
Thinking one’s ill makes one ill you see,
Thinking one’s well, makes one well, b’lieve me.¹⁴⁶

¹⁴⁵ Ibid.

¹⁴⁶ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 47.

The tone of the poem is scathing towards the medical staff at the hospital, and seems to identify that William C believed that the medical staff were uninterested in his illness and afflictions. The poem suggests that William felt that he was being accused of malingering, as it is heavily implied that he felt the medical staff believed he could get better if only he thought that he could get better.

Other letters which were written by the patients are often less clear in identifying their relationship with the hospital and appear to be the by-products of confused minds suffering from paranoia and delusions. Many letters express feelings of grandeur, which, in some cases, appear to stem from the patient's removal from an asylum to the Ministry of Pensions Hospital. One such instance was fifty-year-old Walter S from Liverpool who was described in the casebooks as "very deluded, exalted and full of absurd beliefs. His delusions as to his position in the Ministry of Pensions and as to the nature of the place continues as before."¹⁴⁷ These delusions become clear in the corresponding notes and letters attached to the file. Significantly, these delusions had somehow managed to pass into the hands of the Director General of Medical Services, in Westminster, who had kindly typed up a letter he had received from Walter S and sent it back to the hospital with a note claiming: "The attached copy of a letter is passed to you for information" – although it is unclear what information the letter gives us, or quite what the Director wanted the hospital to do with it. The letter proclaims:

Gentlemen,

You surprise me to think that you would all be so backward and slack. This Dep. as [sic] been opened for housing in their little homes pensioners that had lost all from the

¹⁴⁷ Ibid., patient record no. 7.

1914 trouble... I opened this place for the housing of pensioners that wanted homes two years and a half ago and not one pensioner to my nolage [sic] has been housed yet...¹⁴⁸

Clearly to Walter S, the title ‘Ministry of Pensions Hospital’ was significant, and led him to the delusional belief that he himself was an employee of the Ministry. This case is not unusual however, as many ex-servicemen developed pseudonyms and grandiose titles and positions during their stay at the hospital, such as Lucas C, who has already been noted as “King of the Empire.”¹⁴⁹ Other similar cases include Lee H who, in the Doctor’s words, “thinks he is a much more important man... [than he is. Thinks he has] a controlling influence over the war in France;”¹⁵⁰ and forty year old Ernest B, who was adamant that “he [was] a member of the Board of Control and that no one has any right to detain him.”¹⁵¹ Further too James G similarly informed the Medical Superintendent and his staff at the Hospital that he “had been posted as an Advisory Medical Officer to the general commanding Northern area and has permission to close all asylums.”¹⁵² Although these feelings of grandeur could suggest that being transferred from a Pauper Asylum to the Ministry of Pensions Hospital may have given the patients a new lease of hope and belief in themselves, as is not altogether implausible for Walter S; what is perhaps more likely, especially for the others, is that they assumed these fictitious identities in order to assert their importance, trapped as they were within the institution.

All of these reactions to institutional life again identify that there was little differ-

¹⁴⁸ Ibid., patient record no. 7.

¹⁴⁹ WYAS, C416/5/158, Male Casebook Records of Private Service Patients (1924-1925), patient record no. 215.

¹⁵⁰ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 19.

¹⁵¹ Ibid., patient record no. 32.

¹⁵² WYAS, C416/5/160, Reception Orders and Transfer Details of Private Service Patients (1924-1925), patient record no. 58.

ence between the responses of these men and the reactions of pauper lunatics institutionalised in similar asylums across the country. Clearly many patients' subjective experiences of incarceration within the Ministry of Pensions Hospital were in many ways very similar to other institutional experiences.

Occupation and Entertainment

An analysis of patients' day-to-day lives inside the Ministry of Pensions Hospital again identifies that despite the changes in semantics, (potentially) different uniform and separation from pauper lunatics, the patients' 'improved' status as 'Service Patients' made very little difference to their day-to-day lives of institutionalisation. The Chief Nurse's Report Books identify some key information about everyday institutional life. These books refer to the numbers of patients who were in bed; numbers taking exercise, both in the airing courts and beyond the hospital estate; numbers employed, and in what occupations; numbers involved in outings, weekly entertainments and sports; and the numbers who attended religious services on a Sunday. Records have been kept for three years, 1925 to 1927, of the day-to-day experiences of the private service patients residing in the hospital. Despite the fact that the books only exist for three of the seven years, the regularity and similarity of the reports on a weekly basis seems to indicate that it is not unreasonable to infer that such patterns continued throughout the years of the running of the hospital. By comparing these sources to our knowledge of other asylums throughout this period, we can again identify the similarity of institutional life for these men in comparison to life at other asylums. Table 3.4 highlights the numbers of patients occupied in various ways on the first week in July for the years 1925, 1926 and 1927.

Table 3.4: Numbers of patients working in various occupations on the first week in July for the years 1925, 1926 and 1927.¹⁵³

	1925	1926	1927
Shoemaker's shop	15	15	10
Tailor's shop	4	4	12
Upholsters Shop	17	5	18
Stores	4	-	-
Kitchen	11	4	4
Wards	90	116	115
Garden	30	27	28
Clerical	3	2	2
Clock repairing	1	-	-
Other	1	1	1
Total number working	176	174	190

Sources: WYAS, C416/5/389, Chief Nurse's Report Book (1925); WYAS, C416/5/390, Chief Nurse's Report Book (1926); WYAS, C416/5/391, Chief Nurse's Report Book (1926-1927); WYAS, C416/5/392, Chief Nurse's Report Book (1927).

Table 3.4 identifies that actually, despite the Service Patient Scheme and despite being institutionalised within a 'separate' hospital to their fellow pauper lunatics, everyday life remained virtually identical, in most respects, to that of the fellow pauper lunatics residing next door in Storthes Hall and across the country. Almost two thirds of patients were made to work in some occupation, with the majority of patients engaged in domestic duties on the wards, as they would in other asylums. In 1923 The Board of Control had commented on the propensity of ward work in asylums nationally. They dismissed the organisation of work in asylums as being, "not altogether satisfactory," complaining that

¹⁵³ WYAS, C416/5/389, Chief Nurse's Report Book (1925); WYAS, C416/5/390, Chief Nurse's Report Book (1926); WYAS, C416/5/391, Chief Nurse's Report Book (1926-1927); WYAS, C416/5/392, Chief Nurse's Report Book (1927).

too many patients had no occupation other than ‘ward work.’¹⁵⁴ Certainly figures relating to patients working at Wakefield Asylum were very similar to these in 1924. The minute books of the West Riding Asylums Hospital Board identified that in the same year 1924, 625 patients (or 70 percent of patients residing in the asylum) were employed, with 456 of these patients being employed in domestic duties in the wards, corridors and halls.¹⁵⁵ So at Wakefield 73 percent of all patients working, were working in the wards in comparison to 51 percent, 66 percent and 61 percent of all patients working in the wards at the Pensions Hospital in the years 1925, 1926 and 1927 respectively. It would appear from this brief analysis that the institutional lives of service patients were actually very similar to that of their pauper patient counterparts, and again, despite the ideology of difference, the reality was one of continuity and similarity.

It would appear that for many patients admitted to the hospital, the monotonous routine of everyday employment seemed to do little to ease their minds, or to make them feel less trapped within it. Although The Board of Control argued that occupation was a “curative agent and a means of promoting the contentment and well-being of patients,”¹⁵⁶ many of the narratives enclosed within the casebooks reveal examples of marginalized individuals, who were critical of the hospital and their ‘imprisonment’ within it. It was noted of Thomas K, for instance, that “he thinks this place is a first class prison and that he is confined here for being a conscientious objector,”¹⁵⁷ whilst James G reported that “he is suffering here and that this is not a hospital.”¹⁵⁸ Similarly Joseph B wrote to the popular periodical, *John Bull*, in 1927 to inform them of his “desperate situation,”¹⁵⁹ and William H was described as “reserved, his attitude toward the medical staff is rather hos-

¹⁵⁴ WYAS, C85/1/15/9, Annual Reports of the Board of Control (1923), p. 10.

¹⁵⁵ WYAS, C416/1/62, West Riding of Yorkshire Mental Hospitals Board (1924), p. 24.

¹⁵⁶ WYAS, C85/1/15/9, Annual Reports of the Board of Control (1923), p. 10.

¹⁵⁷ WYAS, C416/5/159, Reception Orders and Transfer Details of Private Service Patients (1924), patient record no. 39.

¹⁵⁸ *Ibid.*, patient record no. 37.

¹⁵⁹ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 80.

tile since he regards them as partly responsible for his detention.”¹⁶⁰

Table 3.5 also identifies a similar picture to that of Table 3.4 with regard to the similarities between this institution and other pauper lunatic asylums. Although there was some form of entertainment provided in the hospital on most weekends, these too do not appear to be too different to the entertainments offered to pauper patients at other institutions.

Table 3.5: Numbers of patients occupied in various ways on the first weekend in July for the years 1925, 1926 and 1927.¹⁶¹

	1925	1926	1927
Attending Religious Services	149	134	107
Attending weekly entertainment	53	114	-
• Concert	20	252	137
• Cinema	-	21	-
• Cricket			
Taking exercise beyond hospital estate (daily)	180	176	161
Taking exercise in hospital airing courts (daily)	76	127	133

Sources: WYAS, C416/5/389, Chief Nurse’s Report Book (1925); WYAS, C416/5/390, Chief Nurse’s Report Book (1926); WYAS, C416/5/391, Chief Nurse’s Report Book (1926-1927); WYAS, C416/5/392, Chief Nurse’s Report Book (1927).

Table 3.5 identifies how, just as in other asylums, entertainments usually consisted of attending religious services, cinema screenings, concerts, cricket, football matches, annual sports days, and the occasional garden party. In her work Dolly Mackinnon argues that entertainments could cover a vast range of activities... all for the purposes of recrea-

¹⁶⁰ Ibid., patient record no. 47.

¹⁶¹ WYAS, C416/5/389, Chief Nurse’s Report Book (1925); WYAS, C416/5/390, Chief Nurse’s Report Book (1926); WYAS, C416/5/391, Chief Nurse’s Report Book (1926-1927); WYAS, C416/5/392, Chief Nurse’s Report Book (1927).

tion.”¹⁶² Similarly to other asylums however, it is questionable how much these token displays of entertainment actually did to relieve the boredom and enlighten the monotonous life of institutionalisation for the service patients admitted therein. This question can be seen as being particularly pertinent, especially as the figures highlight a severe rupture between the number of patients in the asylum, and the number of patients reported to be engaged in entertainments and activities. Despite the ‘provision’ in place for the patients, such as occupations and entertainments, it would appear from the extracts from both letters and the patient casebooks that many patients clearly still felt apathetic at best towards their incarceration and institutionalisation. It is clear from both the casebooks and patient’s letters that many patients felt that they were ‘imprisoned’ within the institution and yearned to leave its constraints.

Escape and Transfer

As identified above, many activities at the Ministry of Pensions Hospital entitled some patients to spend some time away from the hospital grounds, either by attending the local church service on a Sunday, which took place some distance from the site of the institution,¹⁶³ or else by being granted parole beyond the hospital estate. The sheer numbers of

¹⁶² D. MacKinnon, ‘Amusements are Provided: Asylum Entertainment and Recreation in Australia and New Zealand c.1860-c.1945’, in G. Mooney and J. Reinartz (eds), *Permeable Walls: Historical Perspective on Hospital and Asylum Visiting* (New York, Rodopi, 2009), pp. 267-268.

¹⁶³ Unlike the majority of Victorian and Edwardian institutions, Storthes Hall, Menston Asylum and Scalebor Park Asylum (a private institution also run by the West Riding Asylums Board) controversially never had chapels built on site. Instead, Storthes Hall and Menston usually utilised the main hall for the purposes of religious services. This was a major source of controversy between the Lunacy Commissioners, later the Board of Control and the West Riding Asylums Board as to what exactly was ‘a proper place of worship.’ See: WYAS, C85/1/15/3, Annual Reports of the Board of Control (1914), p. 13, p. 331 and p. 333. In 1912, this issue was brought before the Home Secretary, before it was finally dropped, in favour of the West Riding Asylums Board. As the MOPH was set up as an Annexe to Storthes Hall, effectively taking over the acute hospital and two convalescent villas, they did not have the use of the main hall, which is perhaps why religious services took place in a local church away from the hospital site. For the debate which took place in the House of Lords, see HL Deb 25 April 1912 vol. 11 cc825 37825, Asylum Chapels: <http://hansard.millbanksystems.com/lords/1912/apr/25/asylum-chapels> (Accessed 23/04/12) For evidence that the West Yorkshire Asylums Board won the debate, see WYAS, C488/1/5, Minute Books of the West

patients granted parole, and those allowed to take exercise beyond the hospital estate on a daily basis, identifies just how permeable the walls of the Ministry of Pensions Hospital could be.¹⁶⁴ In his work on Epsom Asylum, Rob Ellis has identified how wandering lunatics were described at the time as a “constant irritation to the townspeople.”¹⁶⁵ Although there is no surviving evidence as to what the public in Kirkburton thought, being granted permission to leave the hospital estate offered ample opportunity for a scheming patient to escape the confines of the institution.

Certainly for some patients finding a chance to escape was rather easy, and a few patients managed this on numerous occasions. Despite this however, as the following examples show, evading re-capture often proved much more of a challenge. Escape attempts were numerous and examples include James G, who according to his report of transfer in 1931 had “made several attempts to escape;”¹⁶⁶ and Thomas L, who similarly, no matter how hard he tried, could not break free of the constraints of the hospital. In 1925, the forty-five year old managed to escape by forging a letter from the Ministry of Pensions asking for his release. Though the letter was obviously fake – it was written by hand in pencil on a scrap of paper – Thomas clearly had an escape route planned and managed to flee the institution. His freedom was short-lived however as he was found at home by police the next day, and subsequently brought back by attendants.¹⁶⁷ Clearly upset by this debacle, it is noted in his case-notes that he “smashed the door in the side-room with his bedstead” and thus was removed to the padded room. Evidently still unhappy in his captivity, Thomas made another bid for freedom just a few months later in

Riding Asylums Board (1914-1920), p. 314. For a broader overview, see C416/1/5, Minutes of Conference on the Proposed Provision of Chapels at Storthes, Menston and Scalebor Park (1912)

¹⁶⁴ G. Mooney and J. Reinartz, *Permeable Walls: Historical Perspective on Hospital and Asylum Visiting* (New York, Rodopi, 2009).

¹⁶⁵ R. Ellis, ‘A constant irritation to the townspeople’? Local, Regional and National Politics and London’s County Asylums at Epsom’, *Social History of Medicine*, vol. 26, no. 4, 2013, 653-671.

¹⁶⁶ WYAS, C416/5/159, Reception Orders and Transfer Details of Private Service Patients (1924), patient record no. 37.

¹⁶⁷ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 23.

November 1925, attempting to abscond “on a return journey to hospital after a church service in Kirkburton.”¹⁶⁸ After this misadventure he became quiet and industrious in the wards again until 1928, when he tried again, this time by “absenting himself whilst on parole.” Interestingly, after he was again returned to the hospital, when questioned he reported that he had tried to run away because he was “depressed at his long detention.”¹⁶⁹

Another more legitimate attempt at departing the institution came in the form of transfer to another asylum. Analysis of the casebook reports identifies that seven percent of patients (from a survey of the first one hundred patients admitted to the asylum) managed to leave the institution in this way prior to the hospital’s closure in 1931. Transfer occurred in two main ways. The vast majority of patients who were transferred found themselves reassigned to another institution at the instruction of the Visiting Committee or Asylum Board. However, it was possible for a patient to put in a request for a transfer to another institution for himself. In 1917 the Service Patient Scheme gave specific instructions with regard to transfer. It stated:

The Minister hopes that too much insistence will not be laid upon permanently retaining a “Service Patient” in the Asylum which he would have gone if he were a pauper, and which may be in quite a different part of the country to that in which his wife, family or friends are living. The main object of the scheme is to secure the happiness and contentment of the patient and to consult the convenience of his friends.¹⁷⁰

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ WYAS, C416/1/443, Instructions relating to the classification and treatment of soldiers and sailors as “service patients” (1917).

Despite this however, it would appear that the ‘contentment of the patient’ was not necessarily always the outcome for patients who wished to be transferred. Perhaps the most moving collection of letters to be found in the casebooks relate to the case of 24-year-old Francis G. Although the 1917 Service Patient Scheme had specific guidelines surrounding the transfer of patients, the case of Francis G identifies how the patient’s wishes could sometimes be callously disregarded, to potentially tragic consequences. Evidently unhappy about the location of the hospital he managed to successfully get in touch with the Board of Control asking to be removed to an asylum in Derbyshire to be “nearer to his relatives.”¹⁷¹ The Board’s response however was simply to pass the case over to the Ministry of Pensions, proclaiming that they were “unable to take steps in connection with [Francis’] removal to Derby County Borough Mental Hospital.” In July 1924, the Ministry of Pensions finally sent a perhaps surprising and certainly seemingly vindictive response identifying that “no useful purpose would be served by transferring the above named man to an institution in Derbyshire.”¹⁷² After receiving this news in August of the same year he too tried to escape the confines of the hospital, but his attempt was also foiled. Finding escape attempts to be to no avail, he evidently felt that the only resort was to try to end his life, trying the first time to cut his throat, and the second time to strangle himself. In a letter attached to his case file, a letter to his mother reveals the deep-seated pain and emotion caused not only by the “stress of war,” but also the pain of institutionalisation, specifically the pain of being kept purposefully away from friends and family.

¹⁷¹ WYAS, C416/5/158, Male Casebook Records of Private Service Patients (1924-1925), patient record no. 203.

¹⁷² Ibid.

Dear Mother,

I am sorry if I have to end my life like this, but I cannot stand the pain any longer, only God and myself know what I have suffered... I do not wish to impose on you or any of my sisters or relatives or companions. They have all been very good to me. I am going to do this for the best and I do not want you to think that I am out of my mind... You will find me coming as a corpse to your house someday and my only desire is that you shall not morn [sic] me, as I am the one who suffered the most in the family... Goodnight and God bless you, I remain, your heartbroken son.¹⁷³

In addition to the raw emotion revealed in the letter, the P.S. endnote of the letter is more revealing still about Francis' frame of mind and what he thought about his treatment in the hospital. The letter contains a frank confession:

One of the Ordileys [sic] here has called me such names that I think it better for me that I should depart from this world, so as I can get peace, which I haven't had for years.¹⁷⁴

The case of Francis G can tell us much about institutional life at the Ministry of Pensions Hospital Kirkburton. Although this extremely sad letter is a by-product of a disturbed,

¹⁷³ Ibid.

¹⁷⁴ Ibid.

delusional and evidently deeply depressed man, the raw feelings uncovered within it are real and should be treated as such. The earlier letters from both the Board of Control and Ministry of Pensions Office show a callous indifference to the suffering of ordinary, individual soldiers admitted to their Pensions Hospital. Further, the fact that it was reported that “no useful purpose would be served” by removing Francis closer to his relatives, tells that the Ministry clearly thought that the men inside the hospital would not need to be near to their families. Indeed, it seems fairly clear that even at this early stage, the Ministry understood that most of the men in the hospital would never permanently return home. Further too, the final P.S. of the letter identifies a distressing allegation that bullying in the hospital was so severe that this patient at least was driven to the desire to take his own life.¹⁷⁵ Although there is no way of uncovering the truth behind this claim, at the very least it should be acknowledged that Francis G was just one of many patients who were deeply unhappy and frustrated at their incarceration within the hospital.

The Prospects of Departure and Recovery

As with regular lunatics in pauper asylums, exit from the hospital took place in a number of forms and the unsuccessful attempts at escape and transfer noted above were only two potential options in a series of exit strategies. As hinted at above, ways of departing the hospital were numerous and included death, escape and transfer to another institution, be it a pauper asylum or a Ministry of Pensions Hospital. Other methods of departure included to be discharged recovered or relieved. Patients could even be discharged ‘not improved’ to the responsibility of friends or relatives if they applied to the asylum and

¹⁷⁵ For more on the cases of suicide and suicidal patients in asylums, see S. York, ‘Alienists, Attendants and the Containment of Suicide in Public Lunatic Asylums, 1845-1890’, *Social History of Medicine*, vol. 25, no. 2, 2012, 324-342.

accepted full responsibility for the maintenance and care of the patient, under Section 72 of the 1890 Lunacy Act. Again, all of these methods of departure reflect the processes of departure for ordinary pauper lunatics. There was however one exception peculiar to the Service Patient. The rules of 1917 clearly stated that if a relative took action to remove their loved one from institutional care, contrary to the advice of the medical staff, then the family member would no longer be accepted back into institutional care as a service patient, should the need for re-admittance arise.

The first most striking and most apparent reality however, when studying how patients departed from the Ministry of Pensions Hospital at Kirkburton is simply how few of the patients actually managed to permanently leave in *any* of the ways mentioned above until the closure of the Hospital in 1931. Certainly the inconsistencies between the ideal of the Ministry's plan as a home for the 'hopeful type' of curable cases and the reality of a hospital for chronic cases of delusional insanity can be observed nowhere more clearly than in the recovery rates of the patients admitted therein. Table 3.6 provides an indication of what percentage of the hospital patients departed from the hospital and in what ways they left. The sample used is a case study of the first one hundred patients admitted into the hospital, using the patient's case notes.

Table 3.6: Case study of how the first 100 cases admitted to the Ministry of Pensions Hospital, Kirkburton, left the institution¹⁷⁶

Types of departure from the Hospital	How many patients left?
Removed in 1931 because of the hospital's closure, to another asylum or Ministry of Pensions Hospital, 'not improved.'	69
Removed to another asylum pre-1931, 'not improved'	7
Discharged under Section 72 to friends, contrary to medical advice	1
Discharged before 1931 either 'relieved' or 'recovered'	15
Discharged to another Ministry of Pensions (Hardening) Hospital, pre 1931, 'relieved.'	4
Died	4

Source: WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924)

Table 3.6 indisputably identifies that contrary to the Ministry of Pension's initial ideal, the hospital was in no way a home for pensioners of a 'hopeful type.' The fact that only nineteen percent of patients recovered enough to be discharged back to their homes and families or another Ministry of Pensions Hospital highlights that the majority of the patients incarcerated were chronic, unrecoverable cases, who did not respond well to life and treatment at Kirkburton.

The best way to illustrate this point is by comparing the recovery rate for this institution with the national recovery rate as calculated by the Board of Control in their Annual Report for the same year, 1924. The Board's records show that the national recovery rate for England and Wales, which stood at 34.86 percent, was nearly twice as high as the results being obtained at the Ministry of Pensions Hospital.¹⁷⁷ Similarly too, although in 1924 the West Riding Hospitals consistently had a lower recovery rate than the national average, they too were considerably higher than the Ministry of Pensions Hospital, being 25.5 percent for Wakefield, 32.73 percent for Wadsley, and 32.26 percent for

¹⁷⁶ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924).

¹⁷⁷ WYAS, C85/1/15/10, Annual Reports of the Board of Control (1924), p. 7.

Menston.¹⁷⁸

It should be noted at this point that despite the appalling recovery rates, the death rates at the Ministry of Pensions hospital at the very small figure of four percent was a fraction of the local figure at the West Riding Hospitals which was calculated at between nine and ten percent in the year 1924. Surprisingly too, it was even smaller than the national figure, which stood at 7.62%.¹⁷⁹ The reasons for this however seem reasonably self-explanatory. Firstly, the hospital, which catered for men who had served during the war, would have contained younger and much less frail patients than other pauper asylums, as all of the men would have had to have been of a certain physical standard at least to have qualified for war service. Secondly, as the hospital was only open for a period of seven years from 1924-1931 there would not have been sufficient time for the men who remained uncured to languish in the hospital walls until their inevitable deaths as occurred in so many other asylums across the country.

Despite this however, prospects of departing the hospital remained bleak throughout the 1920s. Indeed, any initial hope which the Ministry of Pensions and Board of Control may have had for the hospital soon deteriorated as these facts became ever clearer. Interestingly, as early as 1924, only a few months after the hospital had opened, this view was already becoming apparent. During the first inspection of the hospital by the Board of Control in their annual visits to individual institutions the author of the Report commented on the patients he had seen that day:

I had conversations with a number of the patients, none of whom were fit to be discharged. Indeed, taking them as a

¹⁷⁸ WYAS, C416/1/61, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1924), p. 88. – No figures are available for Storthes Hall Mental Hospital in this year.

¹⁷⁹ WYAS, C85/1/15/10, Annual Reports of the Board of Control (1924), p. 7.

whole, it would appear that there were few, if any, with good prospects of recovery.¹⁸⁰

Despite the low levels of recovery and discharge however, the letters found at the hospital highlight that for the minority of the patients who did recover, the process of securing discharge could be enhanced through a process of negotiation between the patient and the hospital authorities. Such evidence re-locates patients back into the analysis of their own recovery. Previous historical analyses have sought to re-define the way we see families in the process of a patient's discharge.¹⁸¹ The evidence in the casebooks of this hospital is a reminder that many patients were able to instigate the process of discharge for themselves.

One such instance of the process of successful negotiation between a patient and the hospital authorities was written by thirty-seven-year-old William Arthur E. William E was transferred to the Ministry of Pensions Hospital from Prestwich Asylum in 1924, where he had been an in-patient for over three years without much improvement. On admission to the hospital he was noted to be "dull and depressed. [Has] delusions that he has syphilis, that he is rotten and that his skin is peeled up off. [Also] says he is responsible for the misfortunes of other people."¹⁸² Only one month after admission however he semi-coherently appealed to Dr Graham, and began the process of negotiation to secure his own discharge. He enquired:

Dear Sir, I would like to ask you a question with a view to securing my discharge. I take it that I am only being held on account of

¹⁸⁰ WYAS, C416/1/61, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1924), p. 73.

¹⁸¹ Walton, 'Casting Out and Bringing Back', pp. 135-46.

¹⁸² WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 10.

my being so unconvincable. [sic] I should have been less so...
There was no one that fought harder with oneself as I did try and
master the ideas and notions of which I did have and I must say
that I have had much more satisfaction while I have been here... if
that is the only obstacle in my way, I see no other alternative but
to be convinced and have a bid for home. I hope that you will ac-
cept these few lines and take a satisfactory view of them.¹⁸³

This letter is important as it shows the process of negotiation within the doctor/patient power relationship. In his letter, William suggests that he understands the institutional hierarchies; his letter states that he has “no other alternative but to be convinced” by the opinion of his doctors, and humbly “hope[d]” that the authorities in charge would “accept [his] few lines and take a satisfactory view of them.”¹⁸⁴ It would seem that knowing one’s place within the power hierarchy of doctor/patient relationship was a successful way to proceed as after a month of successful parole, William was eventually discharged relieved in July 1924, less than seven months after his admittance to the hospital.¹⁸⁵ In this particular case, only after the patient’s release is there any (known) correspondence from the patient’s family who informed the Superintendent that “Mr E is keeping well up to the present time with care and attention.”¹⁸⁶ Although it is clear that the willingness of Mr E’s family to receive him back to the hearth of the family home was important, in this case, the process of negotiation for release appears to have been instigated by the patient, rather than his family.

Another seemingly satisfied patient at the hospital was fifty-year-old James F

¹⁸³ Ibid.

¹⁸⁴ Ibid.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

from Doncaster, who was also admitted to the Ministry of Pensions Hospital in January 1924, suffering his second attack of insanity, this particular attack being exacerbated by war stress. His wife had previously had him admitted to Wakefield Asylum in October 1919, complaining that he had done nothing but “lay on the sofa for a week without taking his clothes off... [he] won’t wash himself, sometimes refuses food and says “why am I not like other men? Devils are dragging me down.”¹⁸⁷ However, despite showing little sign of improvement to mark his five year incarceration at Wakefield Asylum, his stay at the Ministry of Pensions Hospital clearly did him the world of good, for in less than four months it was proclaimed that he “remain[ed] well, and is fit for discharge home.”¹⁸⁸ Certainly James himself seemed to be entirely satisfied with his treatment in the hospital, writing the next day:

Dear Dr Graham,

Just a few lines to let you know we got safely home... so all is well that ends well. Thanking you for all your kindness shown to us. I will conclude, Dear Sir, with best respects to yourself and all the staff,

Yours Respectfully,

James F.¹⁸⁹

James F’s conduct on his release from the hospital won him further respect from the medical officer who responded sharply to the Ministry of Pensions after he was informed of the meagre war pension proposed for the patient. In a letter to the Ministry of Pensions

¹⁸⁷ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), patient record no. 25.

¹⁸⁸ Ibid.

¹⁸⁹ Ibid.

Department, Dr Graham wrote:

Even though there are no psychotic symptoms present, it is thought that if the pensioner is subject to financial worries...the possibility of relapse would be greatly increased and to guard against this eventuality, it is advised that a pension be granted at a much higher rate than the above picture suggests.¹⁹⁰

This collection of letters appear to suggest that in some cases (notably the cases of patients who recovered and returned home) patients were relatively satisfied with their treatment and *temporary* institutionalisation at the Hospital. Despite these particular cases however, complete recovery and discharge back to a patient's friends and family was a remarkably rare occurrence at this hospital. In comparison to the national recovery rate, and even in comparison to the local regional asylums at Wakefield, Menston and Sheffield, it would appear that a patient's prospects of recovery at the Ministry of Pensions Hospital was exceptionally bleak during the years 1924-1931.

Taken together then, when analysing the journey to the hospital, life inside the hospital and departing the hospital, it becomes very clear that initial ideas regarding the 1917 Service Patient Scheme and the Ministry of Pensions Hospital were ineffective in bringing about the changes that they proposed. In practice, the schemes became little more than empty promises to bring about reform in the experiences of lunacy and psychiatry for veterans who fought in the war and who experienced mental problems as a *direct* result of, or aggravated existing mental conditions as a result of, their wartime ex-

¹⁹⁰ Ibid.

periences.

Conclusions

Both the 1917 Service Patient Scheme and the Ministry of Pensions Hospital were introduced as attempts to separate, in both physical space and the public imagination, the mentally afflicted war-serving veteran from the non-serving pauper lunatic. In this respect, both of the schemes can be observed as attempts to protect the mentally ill ex-serviceman from the double disgrace of both pauperism and lunacy and to prove to a sceptical public that the Government and its associated ministries and agencies “had no intention of treating these unfortunate men as ordinary lunatics.”¹⁹¹ Despite these intentions however, this chapter has highlighted that these two schemes actually made very little difference to the experiences of the mentally ill ex-serviceman and their families throughout the 1920s.

Despite the introduction of the Service Patient Scheme it is clear that many mentally ill service patients were initially subjected to exactly the same certification process and stigmatisation as their non-serving counterparts. The fact that the Service Patient Scheme made no attempt to remove the patient from the local pauper lunatic asylum would certainly not have done very much to reduce the stigmas and remove the associations of pauperism and lunacy from the minds of the ex-serviceman, their families and the wider public in general. No matter how different their financial arrangements and uniforms, the very fact that these ex-servicemen were incarcerated within regular pauper lunatic asylums would have tainted them as insane paupers merely from the association with the institution.

¹⁹¹ Anon., ‘Parliamentary Intelligence, House of Lords, Mon 26th July, Treatment of Nerve Shaken Soldiers’, *Lancet*, vol. 186, no. 4796, 31 July 1915, 261-263.

This is why the Ministry's plan to create a separate hospital purely for the purposes of ex-servicemen became such an important ideological concept. The concept of separating mentally ill soldiers from regular pauper lunatics was one that met with popular public approval. However, there were significant disparities between the Ministry's ideal of setting up a home for the hopeful type of ex-serviceman and the reality of what the hospital became. These disparities stem largely from the cases that were originally admitted to the hospital. Instead of hopeful cases, the hospital received many who, from the outset, appeared to have little chance of full recovery.

As a direct consequence of the low-grade chronic and unrecoverable patients that were recruited to Kirkburton in 1924, the recovery rate and discharge rate of the patients was also at direct variance from the initial hopes and ideologies of the hospital. An analysis of the patients' lives inside the hospital identifies very little difference to the lives of the pauper patients from whom their new hospital had separated them. It is clear that the available activities in the form of work and entertainment varied little from the activities of pauper patients and there is little to suggest that any 'special privileges' of any kind were offered to these men, except for those granted under the terms of the 1917 Service Patient Scheme. When analysing some of the words and letters that have been preserved of some of these men, there were few, if any, who seemed to comprehend that this was a special hospital which was set up specifically for their needs, and many clearly could not see the difference between this hospital and the pauper asylum that they had been transferred from.

In addition, it is possible to question just how serious the Ministry's attempt at providing separate accommodation for hopeful cases really was. Firstly, in an era where the psychiatric paradigm stipulated that the sooner an individual received treatment, the more susceptible he would be to its effects, setting up a specialist hospital in 1924 after

most patients had already been institutionalised within an asylum for several years hardly made logical sense.¹⁹² Secondly, the very position of the Ministry of Pensions Hospital, located within the buildings of an already existing pauper lunatic asylum did little to inspire confidence that this truly was a separate hospital with separate and specialised treatment facilities for the ex-servicemen admitted therein.

The 1917 Service Patient Scheme demonstrates another initiative to remove the stigmas of relying upon Poor Law relief for yet another section of society. Furthermore the new hospital temporarily removed another set of patients from the remit of the Poor Law Authorities. However, despite the ideological function of these schemes, neither the Service Patient Scheme nor the Ministry of Pensions Hospital really succeeded in their initial ideological endeavours to protect the mentally ill ex-serviceman from the double disgrace of both pauperism and lunacy. Contrary to accepted historical interpretation, the treatment of pauper patients and service patients was actually very similar during the interwar period. There is little evidence that these men managed to “escape the stigma and disabilities of being classed as lunatics,” as the stigmas relating to certification and incarceration remained.¹⁹³ All of the men in the Ministry of Pensions Hospital were certified lunatics under the 1890 Lunacy Act, and as such, they were unable to leave the institution voluntarily without the consent of the medical staff.

The stigma of certification and desire for treatment on a voluntary basis were pressing issues for the psychiatric sphere during these years and increasing attempts were made to reform the mental health system in this way. During these years there were increasing attempts to relieve patients from the stigma of certification alongside efforts to try to implement forms of voluntary treatment in asylums and hospitals. The hope was

¹⁹² The idea of early treatment was paramount during the nineteenth and twentieth centuries, and was one of the reasons for the implementation of the 1930 Mental Treatment Act as will be discussed in Chapters Four and Five. However this idea was not new and was identified as early as the mid-1800s. For more on this see H. Maudsley, *The Physiology and Pathology of the Mind* (London, Macmillan, 1867).

¹⁹³ C. Addison, ‘Parliamentary News’, *Journal of Mental Science*, vol. 136, no. 67, 1921, 136.

that treatment might be provided so that patients who “were getting depressed and felt symptoms of another attack... might be able to return [to an asylum] voluntarily, without being certified.”¹⁹⁴ The next section of this thesis focuses upon two innovations linked to the administration of mental health care that were introduced in order to provide this new service for some patients. The chapters in this section focus upon the establishment of outpatient departments and the Mental Treatment Act of 1930. Both of these attempts at changing practice share the common theme of the need to eradicate certification from mental health care and both of these innovations also deal with aspects of voluntary treatment.

¹⁹⁴ Anon., ‘Asylums for Lunatics: West Riding Suggestions’, *The Manchester Guardian*, 11 Dec, 1906, p. 14.

Chapter Four

Outpatients Departments and the Eradication of Certification

“There are obvious advantages in conducting an outpatient clinic... Patients will more readily resort to a centre which is not definitely associated in their mind with mental disorder.”¹

Although influential articles and edited collections have lately pressed for broader approaches to studying the history of mental health provision, the role and function of the mental outpatient clinic is still relatively understudied by scholars. Despite this however, scholarship on outpatient clinics can be seen as part of this new trend in identifying different approaches to mental health care. Over the past two decades a number of monographs, articles and edited collections have attempted to look past the walls of institutional history of the insane, and look instead to the types of external care which were often available to sufferers of mental disorder(s) and their families searching for non-institutional succour for their afflictions. Historical interest in these studies has often focused on the role of the families and approaches surrounding boarding out and other types of community care.

Studies on the care of those classified as ‘idiots,’ ‘imbeciles’ and ‘lunatics’ in seventeenth and eighteenth century England have suggested that families and communities utilised different approaches in order to provide care for their mentally afflicted members.² Similarly, recent work on the nineteenth and twentieth centuries has suggest-

¹ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p.4.

² P. Rushton, ‘Lunatics and Idiots: Mental Disability, the Community and the Poor Law in North East England, 1600-1800’, *Medical History*, vol. 32, no. 1, 1988, 34-50; P. Rushton, ‘Idiocy, the Family and the Community in Early Modern North-East England’, in D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London, Routledge, 1996), pp. 44-64; A. Suzuki, ‘The Household and the Care of Lunatics in Eighteenth-Century London’, in P. Hor-

ed that patterns of informal and external care may have continued long after the period of the emergence of the asylum.³ As such, many of these works have sought to challenge contemporary conjecture about the declining importance of the family with regard to administering care. In short, they have offered another narrative to Scull's allegation that "the asylum inevitably operated to reduce family and community tolerance,"⁴ by acting as a "culturally legitimate alternative."⁵

Following on from these studies, the edited collection *Outside the Walls of the Asylum* called for "a reconsideration of the place of the asylum within the historiography of madness."⁶ Within their introduction Bartlett and Wright proclaim that the history of madness has disproportionately focused upon the history of asylums and institutions, suggesting that this approach has been facilitated by "archival factors," which have led to the inevitable "convenience" of these collected sources for researchers and doctoral students.⁷ This concept appears to be more of an observation than a criticism however, as both editors have themselves focused upon singular institutional history both in their doctoral theses and in subsequent monographs.⁸ Nevertheless their insistence on the need to research non-institutional care is important. Papers within the volume seek to assess the long history of community care from the eighteenth century through to the nineteenth

den and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions and the Provision of Welfare Since Antiquity* (London, Routledge, 1998), pp. 153-175.

³ D. Wright, 'Familial Care of "Idiot" Children in Victorian England', in *The Locus of Care*, pp. 176-197; M. Thomson, 'Community Care and the Control of Mental Defectives in Inter-War Britain', in *The Locus of Care*, pp. 198-218.

⁴ A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven and London, Yale University Press, 1993), p. 353.

⁵ *Ibid.*, p. 352.

⁶ P. Bartlett and D. Wright, 'Community Care and its Antecedents', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (London: The Athlone Press, 1999), pp. 1-18, p. 5.

⁷ *Ibid.*, p. 3.

⁸ See P. Bartlett, 'The Poor Law of Lunacy: the Administration of Pauper Lunatics in Mid-Nineteenth Century England with special reference to Leicestershire and Rutland', unpublished PhD thesis, University of London, 1993; P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London, Continuum, 1999); D. Wright, 'The National Asylum for Idiots, Earlswood, 1847-86', unpublished D.Phil. thesis, University of Oxford, 1993; D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford, Oxford University Press, 2001).

century and beyond, to the closing down of mental hospitals throughout Great Britain in the late twentieth century.⁹ Significantly, despite its emphasis on treatment from outside the experiences of the institutionalised in-patient, the collection offers no insight into the development and significance of outpatient clinics in Britain throughout these years.

Similarly, in their edited collection *Permeable Walls*, Mooney and Reinartz and their contributors reflect on the open space of asylums and hospitals, seeing these places as porous rather than the isolated walled fortress that they have come to connote.¹⁰ The collection focuses upon hospital and asylum visiting. They observe, “visiting involved the comings and goings not only of relatives and friends but also of administrators, managers, philanthropists, lay care-givers, priests and visitors, entertainers and tourists.”¹¹ Given the broad array of subjects featured within the collection, once again it seems strange that such a study should miss out the regular or irregular visiting of asylum or hospital (clinics) by patients who were accessing a new form of treatment. Surely outpatient departments situated either at asylums (later mental hospitals) or indeed general hospitals represent these institutions at their most permeable capacity.

Within the context of researching different contexts of care, the mental outpatient clinic has started to receive some attention from academics. However, to date the scholarship remains substantially incomplete. In a chapter of the volume *Psychiatric Cultures Compared*, Oosterhuis ambitiously traces “the main similarities and differences between the twentieth century history of extramural psychiatry and mental health care in the coun-

⁹ For the eighteenth century see R.A. Houston, “‘Not Simple Boarding’: Care of the mentally handicapped in Scotland during the Long Eighteenth Century”, in *Outside the Walls of the Asylum*, pp. 19-44. For the continued involvement of families and communities in nineteenth-century Britain, see D. Hirst and P. Michael, ‘Family, Community and the Lunatic in Mid-Nineteenth Century Wales’, in *Outside the Walls of the Asylum*, pp. 66-85; A. Suzuki, ‘Enclosing and Disclosing Lunatics within the Family Walls: Domestic Psychiatric Regime and the Public Sphere in Early Nineteenth Century England’, in *Outside the Walls of the Asylum*, pp. 115-131. For the late twentieth century, see S. Payne, ‘Outside the Walls of the Asylum? Psychiatric Treatment in the 1980s and 1990s’, in *Outside the Walls of the Asylum*, pp. 244-265.

¹⁰ G. Mooney and J. Reinartz, ‘Hospital and Asylum Visiting in Historical Perspective: Themes and Issues’, in G. Mooney and J. Reinartz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York, Rodopi, 2009), pp. 7-30

¹¹ *Ibid.*, p. 8.

tries... France, the Federal Republic of Germany, Italy, the Netherlands, the UK and the USA.”¹² Although this work offers fascinating new comparative insights, such an ambitious undertaking necessarily lacks any detailed analysis of the finer elements of policy making and developments in any of these particular countries, let alone at a more localised level.

In his work John Pickstone analyses the “development of psychiatric units in general hospitals.”¹³ He argues that this innovation was linked to a “general drift of inter-war policy for psychiatry, which urged more integration with general medical facilities.”¹⁴ As such he credits the establishment of outpatient clinics, amongst other factors, with “reducing the barriers between asylums and community services.”¹⁵ However, although his work mentions the importance of outpatient clinics as a key factor in an evolving system of mental health services, his work focuses on the development of psychiatric units in general hospitals, and not outpatient clinics. As such there is little we learn about outpatient clinics and their patients from this particular source. Similarly, Hugh Freeman reveals more mystery than insight into these clinics. He confesses: “My examination of government records from the 1930s about these new outpatient clinics has not revealed very much as to what went on in them.”¹⁶

Also writing about provision in the 1930s, in his work on St Andrews Hospital, Steve Cherry offers a very optimistic analysis of the outpatients department that was established at Norfolk and Norwich Hospital in the 1930s. He associates the Superinten-

¹² H. Oosterhuis, ‘Outpatient Psychiatry and Mental Health Care in the Twentieth Century: International Perspectives’, in M. Gijswijt-Hofstra et al. (eds), *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam, Amsterdam University Press, 2005), pp. 248-276, p. 248.

¹³ J. Pickstone, ‘Introduction’, in J. Pickstone (ed.), *Medical Innovations in Historical Perspective* (Hampshire, Palgrave, 1992), pp. 1-16, p. 8.

¹⁴ Ibid.

¹⁵ J. Pickstone, ‘Psychiatry in District General Hospitals: History, Contingency and Local Innovations in the Early Years of the National Health Service’, in *Medical Innovations in Historical Perspective*, pp. 185-199, p. 188.

¹⁶ H. Freeman, ‘Psychiatry and the State in Britain’, in *Psychiatric Cultures Compared*, pp. 116-140, p. 121.

dent of the Hospital, David Thomson, with the establishment of the clinic here. In his work he suggests that during the 1920s Thomson “anticipated the Board Inspectors (Board of Control’s) suggestion” and promptly asked to establish the clinic.¹⁷ Despite this claim, Cherry’s work offers little insight into what actually happened within the clinic, which type of patients received treatment therein or how successful this treatment was.¹⁸

Though these works discuss clinics in the 1920s and 1930s, other works have shown that the development of outpatient clinics took place much earlier. Certainly in light of the work by Westwood, it is quite clear that there was nothing unique or special about establishing an outpatients department in the 1930s.¹⁹ Rather the fact that a clinic was not established *until* the 1930s suggests that actually facilities at Norfolk were reasonably far behind the national trend.²⁰ Within her work, Westwood identified the approaches of Dr Helen Boyle, whom she considers to be a ‘pioneering’ figure in mental health care in the late nineteenth and early twentieth century.²¹ In her article Westwood praised Boyle, stating that:

Helen Boyle’s theory and practice was different from the male-dominated tradition.... Boyle firmly believed that insanity could be cured or relieved if the condition was caught early enough and she was critical of the English mental health legis-

¹⁷ S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St Andrew’s Hospital c.1810-1998* (Woodbridge, The Boydell Press, 2003), p. 183.

¹⁸ *Ibid.*

¹⁹ L. Westwood, ‘A Quiet Revolution in Brighton: Dr Helen Boyle’s Pioneering Approach to Mental Health Care, 1899-1939’, *Social History of Medicine*, vol. 14, no. 3, 2001, 439-457.

²⁰ Cherry, *Mental Health Care in Modern England*, p. 183.

²¹ Westwood, ‘A Quiet Revolution in Brighton’, p. 439.

lation because there was no provision for temporary care without certification.²²

Despite Westwood's suggestion that Boyle was somehow revolutionary in her ideas and practice, this chapter will identify that this approach was actually far less new or novel than Westwood attempts to suggest. In fact it is quite clear that the 'male-dominated tradition' had in fact been arguing for the need to bring in patients for treatment at an earlier stage of their illnesses long before Westwood credits Boyle for this insight.²³ Though outpatient treatment is briefly considered within the article as one of a number of Boyle's great advances, there is little we actually learn from the article about the approach itself, how it worked, and how successful it was. Instead the article mostly focuses upon Boyle's work within her hospital and the in-patients that she treated therein.²⁴

More helpfully, within her thesis, Dee Hoole offers an analysis of a clinic which was also opened in the late nineteenth century at Wakefield Asylum.²⁵ Her brief six-page overview continues the theme established by Cherry and Westwood, wherein they attribute the founding of the clinic to the 'pioneering' work of the medical superintendent. This analysis of the outpatient clinic is a small section within a larger chapter on innovation at Wakefield Asylum. This particular chapter of her thesis contributes to her argument that Bevan-Lewis should be observed as a respected physician "who advanced the biological alienist field."²⁶ Fitting into the framework that Bevan-Lewis acted as a modernizer and innovator, Hoole argues that the outpatient clinic "was an important innova-

²² Ibid., p. 442.

²³ See for example, H. Maudsley, *The Physiology and Pathology of the Mind* (London, Macmillan, 1867).

²⁴ Westwood, 'A Quiet Revolution in Brighton'.

²⁵ D. Hoole, 'Idiots, Imbeciles and the Asylum in the Early Twentieth Century: Bevan-Lewis and the Boys of Stanley Hall,' unpublished PhD thesis, University of Aberdeen, 2012, pp. 124-130.

²⁶ Ibid., p. 117.

tion in the history of the treatment of mental illness.”²⁷ As such her history of the clinic is integrated within her history of Bevan-Lewis and therefore does not extend beyond the year of his departure in 1910, although in reality her analysis only gives a cursory coverage after the first few years of the clinic’s opening.²⁸

Though collectively these works have begun to address a gap within the historiography, evidently much more work remains to be carried out before we have a clearer understanding of how these clinics worked. As Gijswijt-Hofstra and Oosterhuis have previously observed the “historical research of out-patient care *still* leaves much to be desired.”²⁹ This particular chapter seeks to expand upon these works and is different in several important ways. Firstly, my work will seek to create a more comprehensive understanding by offering a much more detailed examination of the workings of the clinic. Crucially with relation to Hoole, my work extends far beyond Bevan-Lewis’ exit from Wakefield Asylum and seeks to trace the changes at outpatient clinics into the 1930s. In creating an analysis which extends from 1890-1938, I hope to address the gap within the historiography of what happened *between* the establishment of the very first clinics in late nineteenth century, through to the move to general hospitals in the 1930s.

Although some of the data for this period is patchy, this chapter will first highlight some of the strengths and weaknesses of the available sources and show how they can be used to piece together a more rounded study of outpatient treatment than has hitherto been carried out. Following this summary, the chapter is split into two main parts. Part I analyses the outpatients clinic which was established at Wakefield Asylum in 1890. It traces the reasons for its development, splitting this into medical and financial-or-institutional reasons. By offering a more in-depth analysis of the outpatients register

²⁷ Ibid., p. 124.

²⁸ Ibid., pp. 124-130.

²⁹ Gijswijt-Hofstra and Oosterhuis, ‘Introduction’, in *Psychiatric Cultures Compared*, pp. 9-34, p. 24. My emphasis.

and case records of the patients attending the clinic, my work will challenge the perhaps over-optimistic analysis of Hoole. In many ways Part II mirrors the structure highlighted above for Part I; however, the analysis seeks to look beyond the clinic established at the asylum and instead seeks to analyse the clinic which was established at Clayton General Hospital in the 1930s. Again, it traces the reasons behind the desire to open a clinic at a general hospital, and then looks at what differences, if any, emerged between the two clinics at the two locations. By providing answers to these questions, the chapter seeks to establish how innovative outpatient clinics were in the late nineteenth and early twentieth centuries, and to what extent this new model of treatment succeeded in reducing the stigma associated with accessing treatment for mental health conditions.

A Note on the Primary Sources

It is possible that the gap in our knowledge of the workings of outpatient departments is largely related to a lack of primary source material available concerning the everyday functioning of these clinics. Throughout the years of this particular thesis, outpatient clinics were regional and local experiments. The Board of Control wrote that although “such clinics have for some time been in successful operation... the right of local authorities to incur the necessary expenditure has not been free from doubt.”³⁰ Even following the Mental Treatment Act of 1930 however, such clinics were not enshrined in law as compulsory.³¹ Merely the 1930 legislation “empowered” the Local Authorities, giving them the right to provide a clinic.³² This ambiguous legal status means that records relating to

³⁰ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 4.

³¹ An analysis of this legislation on both a local and national framework will appear in Chapter 5 of this thesis.

³² WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 4.

these clinics are patchy, as they remained outside of the official inspection of the Lunacy Commissioners and later the Board of Control.

At the four asylums in the West Riding many problems exist with relation to primary sources for this particular chapter. At both Menston and Storthes Hall either no material appears to have been documented, or else nothing has survived with regard to the outpatient clinics at these institutions. Similarly no patient records can be traced relating to the psychiatric outpatient clinics that were established at both the Royal Infirmary and the Royal Hospital in Sheffield in the year 1920.³³ The collection at Sheffield Archives includes a Register of Outpatients at the Middlewood (formerly Wadsley) Hospital, however only one year of this register survives; a year far outside the date restrictions of this thesis; 1957.³⁴

More helpfully however, some very interesting documents have survived for both of the clinics that were set up in Wakefield, at the asylum (which was moved to the new Acute Hospital soon after its opening) and also the clinic which was opened later at Clayton General Hospital, Wakefield's Public Subscription Hospital.³⁵ For the original clinic at Wakefield Asylum a Register of Outpatients exists and covers the dates from when it was established in 1890 to 1949.³⁶ This register is an essential body of evidence which documents the patients' name; date of admission; age; profession; address; who recommended the patient for treatment; the ailment; result and finally the date of dis-

³³ WYAS, C416/1/65, Minute Books of the West Riding of Yorkshire Hospital Board (1920), p. 64.

³⁴ SA, NHS3/6/7/1, Register of Outpatients (1957). Also available at Sheffield Archives relating to outpatient departments, but again far outside the time limits for this thesis, are outpatient notes relating to Middlewood Community Psychiatric Nursing [Outpatients] Department for the years 1979-1987. See SA, NHS3/5/1/66 - NHS3/5/1/68, Middlewood Community Psychiatric Nursing [Outpatients] Department (1979-1987).

³⁵ Thomas Clayton, the Mayor of Wakefield, founded Clayton Hospital in 1854. It was set up as a public subscription hospital and was run entirely through the generosity of its subscribers and supporters. For more on Clayton Hospital see Wakefield Local Studies Library, *Clayton Hospital Wakefield 1854-1954, Centenary Celebrations Friday 12 November 1954* (1954). See also *Clayton Hospital and Wakefield General Dispensary, 104th Report Adopted at the Annual Meeting Held 27th July 1921* (1921). The full archive relating to Clayton Hospital can be found at WYAS.

³⁶ WYAS, C85/838, Register of Outpatients (1890-1949).

charge for each patient receiving treatment from the clinic.³⁷ Unfortunately however, finding and understanding the corresponding qualitative data to these cases in the early years is more problematic. Patient case-files exist for both of the clinics at Wakefield Mental Hospital and Clayton General Hospital from the 1930s and 1940s. At the clinic at Wakefield Mental Hospital the decision to keep accurate records of the patients appears to have taken place in 1937, the date when all the records begin, despite the fact that the patient's 'date of admission' is often dated much earlier. In some cases the first note made in these patient case sheets merely reads, "same as before," or "no change since last visit," indicating that although the records seem to begin in 1937, they do not necessarily correspond with the patient's initial visit to the clinic.³⁸ Due to this, no detailed qualitative individual case material appears to have been recorded at Wakefield prior to 1937.³⁹ More information is however available in the case sheets from the clinic at Clayton, wherein detailed qualitative information appears to have been kept from the year of its opening in 1933.⁴⁰ Utilising these two sets of papers together offers valuable comparative insights between the functioning of the clinic at the mental hospital and its functioning at the general hospital.

In particular, existing sources offer important quantitative and qualitative information as to the patients in attendance and can illuminate their reasons for attending, how long they attended for and how their attendance at the clinic intersected their daily lives. This information will be supplemented from the Annual Reports of the Sub-Committee of the Asylums and the Medical Superintendent, Bevan-Lewis, allowing us to trace the origins of the clinic and assess the main reasons for its establishment. Furthermore, the Annual Reports written by the Board of Control are testimony to the growing desirability

³⁷ Ibid.

³⁸ WYAS, C85/839, Wakefield Out-Patient Clinic (1930-1940).

³⁹ Ibid.

⁴⁰ WYAS, C85/840 Case notes from the Clayton Out-Patient Clinic (1930-1940). See also WYAS, C235/1/48, Annual Reports of Clayton Hospital (1930-1934), p. 28.

of setting up outpatient clinics throughout the 1920s, over thirty years after its establishment at Wakefield Asylum. Importantly these reports suggest the reasons why it was considered that the establishment of an outpatient department at a general hospital was preferable to their establishment on the site of a mental hospital. Collectively the sources offer insights not only into the reasons behind the establishment of the system, but also into the many limitations of the outpatient clinic with regard to the battle to entice patients and their families for early treatment of their mental disorders. Overall then, although the records for the outpatient clinics are far from complete, it is possible to extrapolate a clear picture using the existing quantitative and qualitative materials.

PART 1: The Clinic at Wakefield Asylum

Though many historians have tended “to view the asylum in the later nineteenth century as a failure, full of incurable cases”⁴¹ wherein “medical superintendents accepted the reality of asylum management and resigned themselves to the task of custodial containment,”⁴² it is clear that many alienists at the time did not observe their professions in such stark and pessimistic terms.⁴³ As early as 1878 Crichton Brown, who had left Wakefield Asylum just one year previously, predicted the need for a new era of psychiatric treatment arguing that “the medical psychologist of the future cannot be confined to

⁴¹ P. Bartlett, ‘The Asylum and the Poor Law’, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London, Routledge, 1999), pp. 48-67, p. 48.

⁴² S. York, ‘Suicide, Lunacy and the Asylum in Nineteenth Century England’, unpublished PhD Thesis, The University of Birmingham, 2009, p. 35.

⁴³ F. Lyman-Hills, ‘Psychiatry: Ancient, Medieval and Modern’, *Popular Science Monthly*, vol. 60, no. 1, 1901, 31-48. See also F. Crompton, ‘Needs and Desires in the Care of Pauper Lunatics: Admissions to Worcester Asylum, 1852-72’, in P. Dale and J. Melling (eds), *Mental Illness and Learning Disability Since 1850* (Oxon, Routledge, 2006), pp. 46-64, p. 59.

his hospital wards. It must be his to walk abroad and anticipate disease.”⁴⁴ Though in 1894 the Chairman of Wakefield Asylum described in the Asylum’s Annual Reports how the population of Wakefield Asylum “include[d] a very large proportion of utterly hopeless chronic cases,”⁴⁵ this did not deter the Superintendent Bevan-Lewis and the Asylum’s Sub-Committee from attempting to create changes in their psychiatric practice to entice patients for treatment at an earlier stage of their illnesses. One such attempt to change the system and bring in a new era of treatment for mental health care came with the very early attempt to establish an outpatient clinic within the grounds of the asylum.⁴⁶

The outpatient clinic at Wakefield Asylum, which received its first patient in January 1890, was amongst the first of its kind to be opened in the country, though there is some ambiguity as to whether it was the first. In her thesis Dee Hoole claims that the clinic at Wakefield was the first of its kind to be opened.⁴⁷ There is evidence however that around a similar time, another outpatient department was opened at an asylum in London.⁴⁸ Furthermore in the year 1888 an anonymous letter to *The Times* signed by ‘a neurologist’ suggested a series of improvements that could be initiated at Bethlem Royal Hospital. Amongst the suggested improvements was that “an outpatient department, to which, any person threatened by insanity or suffering from it in its incipient stages and milder forms, when it may so often be arrested or cured... might resort for advice and treatment.”⁴⁹ Evidently, although the outpatient clinic at Wakefield was a very early example of its kind, and clearly one of the first in the country, the concept of attaching outpatient clinics to asylums was not without ideological precedent or practical implementation in the early 1890s. Regardless of which clinic was the first to be established, it is ev-

⁴⁴ J. Crichton Browne, ‘Presidential Address’, *Journal of Mental Science*, vol. 24, no. 1, 1876.

⁴⁵ WYAS, C85/1/12/10, Annual Reports of the Medical Superintendent (1891-1899), p. 4.

⁴⁶ WYAS, C85/1/12/9, Annual Reports (1881-1890), Report from the Medical Superintendent (1890), p. 10.

⁴⁷ Hoole, ‘Idiots, Imbeciles and the Asylum’, p. 124.

⁴⁸ Anon., ‘Notes and News’, *Journal of Mental Science*, April 1893, 308-312.

⁴⁹ Anon., ‘Bethlem Royal Hospital by a neurologist’, *The Times*, 7 September 1888, p. 4.

ident that these pioneering clinics were extremely important symbolically, especially since before the 1930 Mental Treatment Act, outpatient clinics represented the first way in which “the poorer class, who could not afford the employment of skilled alienists,” could receive medical advice and attention on a voluntary footing.⁵⁰ These clinics ‘side-stepped’ the compulsory need for certification and admission into the asylum wards, which many patients and their relatives felt so objectionable.⁵¹ In doing so, it was argued that these clinics provided a real opportunity for the treatment of patients in the “incipient stages and milder forms” of insanity and mental afflictions.⁵²

The decision to open an outpatient department at Wakefield Asylum for those suffering from nervous diseases was taken in 1889 by the Medical Superintendent, Bevan-Lewis, and the Asylum’s Sub-Committee.⁵³ In the Annual Reports of the year 1889 the Chairman announced that they had “formulated a scheme for the treatment of outdoor patients in connection with the asylum.”⁵⁴ The perceived benefits of the outpatient clinic are easy to identify and in his Annual Reports Bevan-Lewis frequently pointed them out.⁵⁵ Many of the perceived benefits echoed those which were stated in *The Times* report quoted earlier. Bevan-Lewis insisted that the benefits to patients were manifold, that advantages included helping to attract patients who would perhaps be put off by in-patient treatment, but who acknowledged that they needed extra support.⁵⁶ In addition the clinic constituted the only space wherein a poor patient could receive early treatment for incipient mental disease.⁵⁷ When the clinic at Wakefield Asylum was first established Bevan-Lewis explained in his Annual Reports that he hoped that the clinic would

⁵⁰ WYAS, C85/1/12/9, Annual Reports (1881-1890), Report from the Medical Superintendent (1890), p.10.

⁵¹ H. C. Burdett, *Hospitals and Asylums of the World*, vol. 2 (London, Churchill, 1891), p. iii.

⁵² Anon., ‘Bethlem Royal Hospital by a neurologist’, *The Times*, September 1888, p. 4.

⁵³ For a history of Bevan-Lewis and his role in the Wakefield Asylum see Hoole, ‘Idiots, Imbeciles and the Asylum’.

⁵⁴ WYAS, C85/1/12/9, Annual Reports (1889), p.5.

⁵⁵ WYAS, C85/1/12/9, Annual Reports (1889-1890), pp. 10-11.

⁵⁶ *Ibid.*

⁵⁷ WYAS, C85/1/12/9, Annual Reports (1881-1890), Medical Superintendent’s Report (1889), p. 5.

“meet... the difficulty at present existing and widely recognised in the early detention and treatment of mental disease and nervous afflictions.”⁵⁸ Therefore amongst other reasons, at its inception, the outpatient clinic was set up as an experiment, which Bevan-Lewis hoped would entice patients to come forward for treatment at an earlier stage of their illnesses by eradicating the need for certification and in-patient treatment, two stigmas which were frequently noted to be barriers to early treatment.⁵⁹ This is manifestly important as before the 1930 Mental Treatment Act, pauper patients, who relied upon help from the rates, would not have been eligible for any other treatment outside of the private sphere.⁶⁰ The clinic was supposed to act as a halfway house between institutional and familial care. It was intended to allow families and patients help, support and medications whilst they tried to battle with mental illness in the domestic setting. In her work Dee Hoole echoes the thoughts and ambitions of Bevan-Lewis by declaring that “the obvious benefit of preventing mental breakdown has to be the most persuasive reason for the establishment of an out-patients clinic.”⁶¹

Though Hoole is in no doubt correct in this argument, it seems clear that in addition to being of benefit to patients and their families, at its inception, the outpatient clinic was also designed to complement the asylum in a number of important and often financial ways. Its function appears to have been split between benefits for the patient and benefits for the institution and the rate-payers. The savings to the ratepayers are reasonably self-explanatory. The clinic helped to relieve overcrowding in already full institutions, and provided some relief from the unrelenting demand for asylum beds, as well as being a cost-effective way of providing patients with medication who did not require ex-

⁵⁸ Ibid.

⁵⁹ Ibid. These ideas continued and as late as January 1919, *The Times* argued that many insane people were purposefully kept out of the asylum “owing to the objection of their relatives to certification.” Ref: Anon., ‘The Lunacy Laws: Drastic Changes Urged’, *The Times*, 18 Jan 1919, p. 5.

⁶⁰ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 4.

⁶¹ Hoole, ‘Idiots, Imbeciles and the Asylum’, p. 130.

pensive in-patient treatment. In the early years of the clinic every patient who remained outside the walls of the asylum constituted a saving of 10s 6d, which was the weekly cost for inpatient treatment at the West Riding Asylums.⁶² Clearly, when one considers the accumulation of this weekly expenditure over the duration of a patient's stay, the clinic represented a huge saving to the rate-payers.

In the Annual Reports, the Chairman of Wakefield Asylum Sub-Committee explained that he hoped for "considerable advantages [which] may be derived by the opportunities thus afforded to the public, without causing expense to the rate-payers."⁶³ It is clear that in addition to being a cheap option one of these 'considerable advantages' would have been linked to institutional space. Pressure for institutional space was an ever-pervading concern across the country and this was no different in the West Riding of Yorkshire.⁶⁴ Throughout the late 1880s and into the 1890s Wakefield Asylum was constantly on or extremely near its maximum patient threshold, only being temporally relieved by the transfer of some of its patients to the newly opened Menston asylum.⁶⁵ Despite this temporary relief, by 1892, the Commissioners in Lunacy were once again proclaiming in their Annual Reports that:

The asylum is full on both sides. [And] some of the patients have to sleep on the floor... we are glad that the Committee are able to refuse admissions here for any fresh cases.⁶⁶

It seems clear that it was hoped that the outpatient clinic would relieve some pressure on institutional beds and provide a means of offering some treatment and relief to patients

⁶² WYAS, C85/747, Table of Expenditure (1901).

⁶³ WYAS, C85/1/12/9, Annual Reports (1881-1890), p. 6.

⁶⁴ WYAS, C85/1/12/10, Annual Reports (1891-1899), p. 32.

⁶⁵ WYAS, C85/1/12/9, Annual Reports (1881-1890), p.8.

⁶⁶ WYAS, C85/1/12/10, Annual Reports (1891-1899), p. 32.

who were refused in-patient treatment due to the space restrictions at the asylum. All of the above suggests that although the introduction of these clinics throughout the West Riding Asylums was in many ways an innovative experiment in the late 1800s, the establishment should be observed as being inextricably linked to an attempt to relieve institutional pressures such as cash and space.

Who Attended the Clinic?

The Register of Outpatients identifies that the staff who worked at the outpatient clinic frequently looked after patients who were suffering from brief illnesses or worries that did not necessarily require in-patient treatment.⁶⁷ Therefore the majority of patients attending the clinic were not considered to be suffering from certifiable mental disorder. The Register also notes the name of the doctor or person from whom each patient was referred. Patients were frequently seen at the outpatient department after their local Poor Law practitioner or family doctor had referred them there for treatment and advice.⁶⁸ In a few other cases referral to the clinic came from Poor Law Guardians and also the magistrates.⁶⁹ Many patients using the outpatient clinic in the first year of its opening were reported to have been suffering from a wide range of early or mild forms of disease. These included patients suffering from 'slight,' 'incipient' or 'acute' forms of melancholia, neurasthenia, insomnia and transient depression, enfeebled health and even alcoholism.⁷⁰ A decade later patients were seen at the outpatient clinic for very similar reasons; the most

⁶⁷ WYAS, C85/838, Register of Outpatients (1890-1949).

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ Ibid. All these cases can be found in the record for 1890.

frequent ailments included neurasthenia, melancholia and epilepsy, and this continued throughout the 1910s and 1920s.⁷¹

Frustratingly, as mentioned above there are no surviving (probably because they were never written) individual case files, which detail the care and treatment that patients received at the clinic in the early years. Despite this lack of evidence however the Register of Outpatients does identify that some patients were treated successfully and were subsequently discharged recovered, especially in the early years of the opening of the clinic. Early cases of success at the clinic included thirty-one year old James B, who was stated to be suffering from an attack of neurasthenia. James came to the clinic after seeking the advice and receiving a referral from his doctor in April 1890. The register notes that James B was discharged from treatment successfully recovered one year later in April 1891.⁷² Similarly, thirty-five year old Joseph T from Eastmoor was said to be suffering from ‘hypochondria with some depression’ when he first attended the clinic in May 1890. However, just a few months later he too was discharged from the clinic ‘much improved,’ in July of the same year.⁷³

Despite this initial success at the clinic however by the turn of the twentieth century and certainly from the 1910s and also throughout the 1920s and 1930s the numbers of patients being declared as successfully recovered and discharged from the register seriously declines.⁷⁴ Though examples of success still existed they became more infrequent. Mrs Elizabeth A was one of the patients who recovered from her brief illness. She began to attend the clinic in 1938 reporting the cause of her “trouble [to be] over the legal adoption of a child”⁷⁵ and was discharged recovered just over two months later when it

⁷¹ Ibid.

⁷² Ibid.

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ WYAS, C85/839, Case notes from the Wakefield Out-Patient Clinic (1930-1940), 3A. Adoption was finally legalised in 1926, so the process was still in its infancy. The 1939 Adoption of Children (Regula-

was noted that the “trouble over adoption [had been] settled, [and] financial help secured. Much better.”⁷⁶ Despite individual success stories however, most patients in the register after the first decade or so of the clinic’s operation are instead noted as having “ceased to attend” the clinic for treatment, or else they were admitted as an inpatient.⁷⁷ It is difficult to ascertain why this disparity between successful treatments at the clinic might be, but this disparity certainly accounts for the more optimistic interpretation of outpatient treatment identified by Hoole’s research, which only analyses the first few years of the clinic.⁷⁸

The Register also highlights that often patients who attended the clinic were not suffering from illnesses that staff at the outpatient clinic thought they could help. In the case of Sarah L for instance, who was referred to the clinic in the first month of its opening, a “change of air was recommended,” and she was discharged that day.⁷⁹ Further in the case of Henry S, who came for treatment in March 1890 the Register identifies that he was “not suitable for outpatient treatment”⁸⁰ and was also discharged that day. Furthermore, five year old Stanley B was brought to the clinic by his mother in 1900, however the Register identifies that he was diagnosed with ‘idiocy’ and therefore also unsuitable for outpatient treatment.⁸¹ Similarly in 1911, forty-four year old Walter L came to the clinic suffering from G.P.I and Mary B was identified as suffering from dementia: both were considered to be unsuitable patients for outpatient treatment.⁸² This practice continued, although less frequently into the 1920s whereby patients were still attending

tions) Act attempted to tighten up the process.

⁷⁶ Ibid., 3A.

⁷⁷ Ibid. For more on the category ‘ceased to attend’ see the next section of this chapter.

⁷⁸ Hoole, ‘Idiots, Imbeciles and the Asylum’, p. 130.

⁷⁹ WYAS, C85/838, Register of Outpatients (1890-1949).

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ibid.

the clinic with conditions which were considered to be ‘unfit for outpatient treatment.’⁸³ Cases included Paul H, who was said to be suffering from ‘delusional insanity’, and thirty-five year old Mary H, who was considered to be mentally defective.⁸⁴ These particular cases serve as a reminder that not all patients coming to the clinic at Wakefield for advice were suitable candidates for treatment, and therefore we must be wary of evidence which attempts to quantify the numbers of patients receiving treatment from the clinic.

For those who were accepted for treatment at the clinic, it was noted with pride in the Annual Reports in the early 1900s that cutting-edge treatments could be offered for some of these illnesses included “the modern application of electricity... in the form of static electricity, the high frequency current, electrical baths and the risen light.”⁸⁵ Other treatments mentioned seem to suggest that the clinics acted as a place where doctors would listen to their patients, offer advice, and prescribe medications, especially for people suffering from epilepsy.⁸⁶ Certainly one of the most frequent uses of the clinic appears to have been to be able to prescribe drugs and medicines to epileptics who were in no need of asylum in-patient treatment. The clinic appears to have been a space where epileptic patients could go for advice and support and receive medicines, usually barbitone and bromide treatment at cost price.⁸⁷ In 1890, twenty-four percent of the original forty-nine patients attending the clinic were said to be suffering from epilepsy. A decade later this figure had increased to forty-eight percent, and it remained at roughly fifty percent throughout the remaining years to the 1930s.⁸⁸ Though epileptic patients included a large number of cases who were discharged successfully from the clinic, there were still some problems which held back the success for some. Although Bevan-Lewis had cele-

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ WYAS, C85/1/12/11, Annual Reports (1901-1905), p. 5.

⁸⁶ WYAS, C85/838, Register of Outpatients (1890-1949).

⁸⁷ Ibid.

⁸⁸ Ibid.

brated the fact that patients could receive treatment and prescriptions at cost price, this could still be a barrier to treatment for impoverished patients. Examples include thirty-six year old Ben H, who was noted in the register to be “unfit for outpatient treatment- cannot pay,”⁸⁹ and also the unemployed Roy H, who was also described as having “no means of paying for medicine.”⁹⁰ Both of these patients were said to be suffering from epilepsy, and clearly the cost of treatment for this condition left these two patients with little hope of receiving appropriate treatment within their respective and restricted budgets.⁹¹

Despite the fact that referral to the outpatients department was common for patients suffering from epilepsy, in many cases patients who attended the clinic (suffering from epilepsy) had only been advised by their doctors to go to the clinic for outpatient treatment some years after they first started having fits. One such case was fifteen year old John B who had been having fits since the age of five. After suffering from his condition for ten years, it would appear that his family doctor sent him to the outpatient clinic at Wakefield in order to see if there was any other treatment for him. His case notes identify that the new medication that the medical officers at the outpatient clinic put him on appeared to have been working, and he was sent back to his doctor with a new prescription seven months later.⁹² This particular case suggests both the success and failure of the clinic. Although John B was finally prescribed the correct medication to alleviate his condition, it is not unreasonable to suggest that he could have received this medication much earlier, if it was not for his doctor’s late referral for him to attend the outpatient clinic.

⁸⁹ Ibid.

⁹⁰ Ibid.

⁹¹ Ibid.

⁹² WYAS, C85/839, Wakefield Out-Patient Clinic (1930-1940), 14A.

Unfortunately, for the late nineteenth century and early years of the twentieth century there is little way of knowing how long a patient was ill before coming under treatment, as this information was not recorded within the Register of Outpatients book that exists. Despite this however, we can infer from the records that many patients who came for outpatient treatment were not the intended patients suffering from early or incipient illness. The fact that not infrequently patients needed to be certified and brought into the institution (especially in the first decade of operation of the clinic) suggests that some patients had been suffering from severe or prolonged illnesses, often for quite some time before their first outpatient consultation.⁹³ In the report of the Medical Superintendent for the year 1890, Bevan-Lewis observed that in the first year of the clinic running, out of forty-nine applications for treatment, “six cases were of so urgent a nature as to require admission into the asylum.”⁹⁴ During the first ten years of the outpatient clinic the percentage who attended the clinic and who were subsequently certified and admitted as inpatients averaged between ten and twenty percent.⁹⁵ This figure was however reduced during the later years, arguably as space in the asylum was at an ever-increasing premium.⁹⁶ The fact that some patients attending the clinic continued to need to be certified throughout the late nineteenth and early twentieth century challenges Westwood’s viewpoint. Instead, it would appear that even after providing “provision for temporary care without certification” there could still be many problems with regard to treatment.⁹⁷

From the case files for the 1930s for the clinic at Wakefield, it is clear to observe that many patients attending outpatient clinics for the first time were not the ‘expected’

⁹³ WYAS, C85/838, Register of Outpatients (1890-1949).

⁹⁴ WYAS, C85/1/12/9, Annual Reports (1881-1890), Report of the Medical Superintendent (1890), p. 3.

⁹⁵ WYAS, C85/838, Register of Outpatients (1890-1949).

⁹⁶ WYAS, C412/1/64, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1927), p. 97.

⁹⁷ Westwood, ‘A Quiet Revolution in Brighton’, p. 442.

or ‘hoped for’ cases of patients suffering from incipient stages of their illnesses.⁹⁸ Instead many patients had been suffering from their illnesses for some years before either speaking to their local doctor, or else being referred or accepting the referral from their local doctor. Therefore in spite of the intentions of the clinic of bringing patients under observation at an earlier stage of their illnesses, this was not necessarily the case. During the 1930s the case notes that have been kept for the clinic at Wakefield Mental Hospital suggests that many patients still put off going to the clinics for treatment or had trouble being referred in the incipient stages of their illnesses. Cases include thirty-nine year old Ivy A, who was noted to have been “poorly since the birth of her first child sixteen years ago.”⁹⁹ Since that time it was explained that her illness had deteriorated within the last two years. During this period it was noted that she had been overcome by ‘weakness’ that she had “lost interest in her husband and children, [and] couldn’t do housework” also it was noted that she was also suffering from a “gradual loss of appetite.”¹⁰⁰ Furthermore, George B’s condition was said to have begun one year before he was advised to attend the clinic at Wakefield Mental Hospital for outpatient treatment. In this particular case, it is clear that George would have frequently been consulted by doctors and medical men as his illness was said to have begun after “being knocked down by a motor car” and subsequently suffering from facial injuries and anxiety.¹⁰¹ Despite this however, he too appears to have suffered from a long delay before he was referred to the outpatient department. Similarly too thirty-four year old Edith B was said to have been ill for over a year, suffering from feelings of depression and insomnia before she was referred to the clinic by her personal doctor. An accompanying letter written by her doctor to the clinic explained: “her husband says she is as though in a trance, and many of her actions are di-

⁹⁸ WYAS, C85/1/12/9, Annual Reports (1881-1890), Medical Superintendent’s Report (1889), p. 5.

⁹⁹ WYAS, C85/839, Wakefield Out-Patient Clinic (1930-1940), patient record no. 55.

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid.* patient record no. 37.

rected by voices. I shall be glad of your opinion of her.”¹⁰² These cases indicate that some patients were subjected to a prolonged delay, sometimes of many years, before being advised to undergo, or else coming forwards for outpatient treatment.

The evidence above suggests that many patients who attended the outpatient clinic often only submitted themselves for treatment at these clinics after suffering from various disorders for months or even years. In addition to the problem of patients coming too late for treatment at the outpatient clinic, the clinic also does not appear to have made much difference to the number of patients being brought into the mental hospital for inpatient treatment at an earlier stage of their illness. It would appear, contrary to the views of Westwood and Hoole, despite the establishment of the outpatient clinic in the late nineteenth century, by the mid-1920s and 30s little had changed in the attitudes of the public with regard to the delay in diagnosis and treatment of potential patients. In his Annual Report of 1926, Joseph Shaw Bolton, the Medical Superintendent of Wakefield Mental Hospital, spoke of the “disastrous delay” involved in the late committal of many patients on admission to the hospital.

Whether this disastrous delay in diagnosis and treatment can be prevented is largely a matter for the legislature to decide, but the gross inadequacy of the present method, whereby cases leave home only when they cannot be managed... must be obvious to all.¹⁰³

This statement appears to suggest that Shaw Bolton faced exactly the same problems in the 1920s as Bevan-Lewis faced in the late 1890s with regard to the late admittance of

¹⁰² Ibid., patient record no. 93.

¹⁰³ WYAS, C85/1/12/14, Annual Reports (1923-1927), p. 86.

patients for treatment. It would appear then that Bevan-Lewis' early expectation that the outpatient clinic would be the key to providing early treatment and diagnosis of a large proportion of people proved too ambitious.¹⁰⁴ It is clear that even by 1926, when Shaw Bolton was writing, the clinic had not managed to change the trend towards seeking external help when medical officers thought that it was too late. In other words, the outpatient clinic *could not* as Bevan-Lewis initially hoped "meet... the difficulty at present existing and widely recognised in the early detention and treatment of mental disease and nervous afflictions."¹⁰⁵ Clearly whilst the clinic did bring in some patients for early treatment, the patients attending the clinic at Wakefield Asylum were not always the desired patients that Bevan-Lewis was expecting, nor was the clinic the resounding success that Dee Hoole suggests.¹⁰⁶

More Problems with Outpatient Treatment

It could easily be argued that the biggest barrier to successful treatment that was inherent within the framework of the scheme was the very problem of voluntary treatment itself. It is important to remember that neither the people who recommended the patient for outpatient treatment, nor the asylum or hospital authorities who ran the clinic, had any authority to oblige patients to attend these sessions. As such, a patient's attendance could prove unpredictable and often the asylum staff were reliant upon the attitudes and physical and financial abilities of the patients and their families to get to the clinic, as to the patient's attendance or non-attendance at the clinic.¹⁰⁷

¹⁰⁴ WYAS, C85/1/12/9, Annual Reports (1881-1890), Medical Superintendent's Report (1889), p. 5.

¹⁰⁵ *Ibid.*

¹⁰⁶ Hoole, 'Idiots, Imbeciles and the Asylum', p. 130.

¹⁰⁷ J. Bullen, 'The Out-Patient System in Asylums', *Journal of Mental Science*, October 1893, p. 491.

An analysis of patients' journeys to the outpatient clinic can identify many problems with the initial conception of opening an outpatient clinic at Wakefield Asylum. As noted above, patients first had to seek the advice of the Boards of Guardians, or else their Poor Law physician or family doctor, before they could be referred to the outpatient clinic.¹⁰⁸ The very process of needing a referral in itself may have added an extra and perhaps unwanted level of bureaucracy and potential expense to the process of receiving treatment. Indeed, the level of expense encountered by patients receiving treatment is an important factor when analysing the limits of the outpatient clinics for providing treatment. Regular treatment at a clinic would have meant the cost of travel as well as potentially the need to take time off from work. This clearly indicates that the issues of distance and convenience were essential in successfully receiving outpatient treatment.

Since there was no obligation for individuals to come to the clinic for treatment, the responsibility lay in the hands of the asylum and later the mental hospital authorities to make the clinics as accessible to the general public as possible. The Register of Outpatients identifies that patients who came to the clinic in the first year of it being opened came from a variety of places including Bradford; Wakefield; Horbury; Sandal; Halifax; Batley; Barnsley; Castleford; Normanton and Leeds.¹⁰⁹ As a response to the distances that these patients had to overcome, a year after the clinic first opened at Wakefield Asylum, the Asylum Sub-Committee explained:

We are glad to report that the system of out-door treatment has been adopted at Wadsley and Menston, otherwise, had it been confined to the Wakefield Asylum only, the distance which

¹⁰⁸ WYAS, C85/838, Register of Outpatients (1890-1949).

¹⁰⁹ *Ibid.*

some of the patients would reside would have afforded serious obstacles to the operation of the scheme.¹¹⁰

This extract identifies the need for various clinics to be available, in order to offer a variety of locations for treatment for patients. It also identifies how the scheme was not solely linked to Bevan-Lewis as Hoole suggests, but was a joint initiative with the Asylum Sub-Committees of the various West Riding Asylums. As such it seems clear that the clinic at Wakefield Asylum could not successfully operate on its own.¹¹¹ Despite the opening of two more clinics at Wadsley and Menston Asylums however, many patients still often found themselves with an arduous journey to attend clinics that were often situated in the out-of-the-way and-difficult-to-get-to locations of nineteenth century lunatic asylums.¹¹² In March 1905 a 'one-off' census was carried out within the asylum, which identified the geographical radius of how far patients travelled in order to attend the clinic. Given that outpatient clinics were accessible at both Menston and Wadsley during this year, the results are perhaps surprising. However, they leave little wonder that often patients struggled to keep up their attendance at the clinic at Wakefield Asylum.

¹¹⁰ WYAS, C85/1/12/9, Annual Reports (1890), p. 4.

¹¹¹ Hoole, 'Idiots, Imbeciles and the Asylum', p. 130.

¹¹² Storthes Hall was of course not opened until 1904.

Table 4.1: Distance patients travelled for outpatient treatment in March 1905¹¹³

Distance travelled	Number of patients
From Wakefield City	43
Within 3 miles	21
Within 10 miles	60
Within 16 miles	5
Within 24 miles	1
Total	130*

Source: WYAS, C85/1/12/11, Report of Medical Superintendent, (1905)

Table 4.1 identifies that a large majority of patients had to travel between four to ten miles to attend the clinic at Wakefield, with some patients travelling even further. Given these distances, it is unsurprising that opening more clinics in strategic places would make attendance easier for some patients and encourage new attendees amongst potential patients who were either unprepared or else financially or physically unable to travel such long distances to the asylum clinic.

It was frequently noted that these three factors of distance, time and money could be and commonly were considerable disadvantages that limited the successfulness of the outpatient clinic at Wakefield Asylum throughout the late nineteenth and into the early twentieth century. As early as 1893, Dr Bullen, a pathologist at Wakefield Asylum was published in the *Journal of Mental Science* identifying some of the limitations of the new outpatient clinic at Wakefield Asylum. In his paper on “The Out-patient System in Asy-

¹¹³ WYAS, C85/1/12/11, Report of Medical Superintendent (1905), p. 13.

* This total is different from the number of new patients attending the clinic, as it represents both old and new cases attending the clinic within the one particular month.

lums” he observed one of the greatest challenges which was fundamentally inherent within the outpatient scheme:

Many patients were unable to follow out treatment by reason of their poverty and inability to attend on account of leaving their daily work. *A considerable portion ceased to attend for such stress of circumstances.*¹¹⁴

This identifies the most obvious limitations of the clinic. Whilst the key benefit of outpatient treatment was that theoretically a patient could receive medication and support for incipient mental disease whilst still in employment, often balancing attendance at the clinic with work and home life could prove immensely difficult. It would appear then that Bevan-Lewis’ overly optimistic attitude was not shared by all of his staff, at least after a few years of experience. By the year 1893 in which Dr Bullen was describing, it had already become obvious that a “considerable portion” of patients would suddenly stop coming to the clinic, often with little or no notice, and usually before the medical staff thought that they were ready to do so. In fact, patients who ‘ceased to attend’ before the medical staff thought that they were fit to do so was seen to be one of the biggest problems with regard to outpatient treatment.

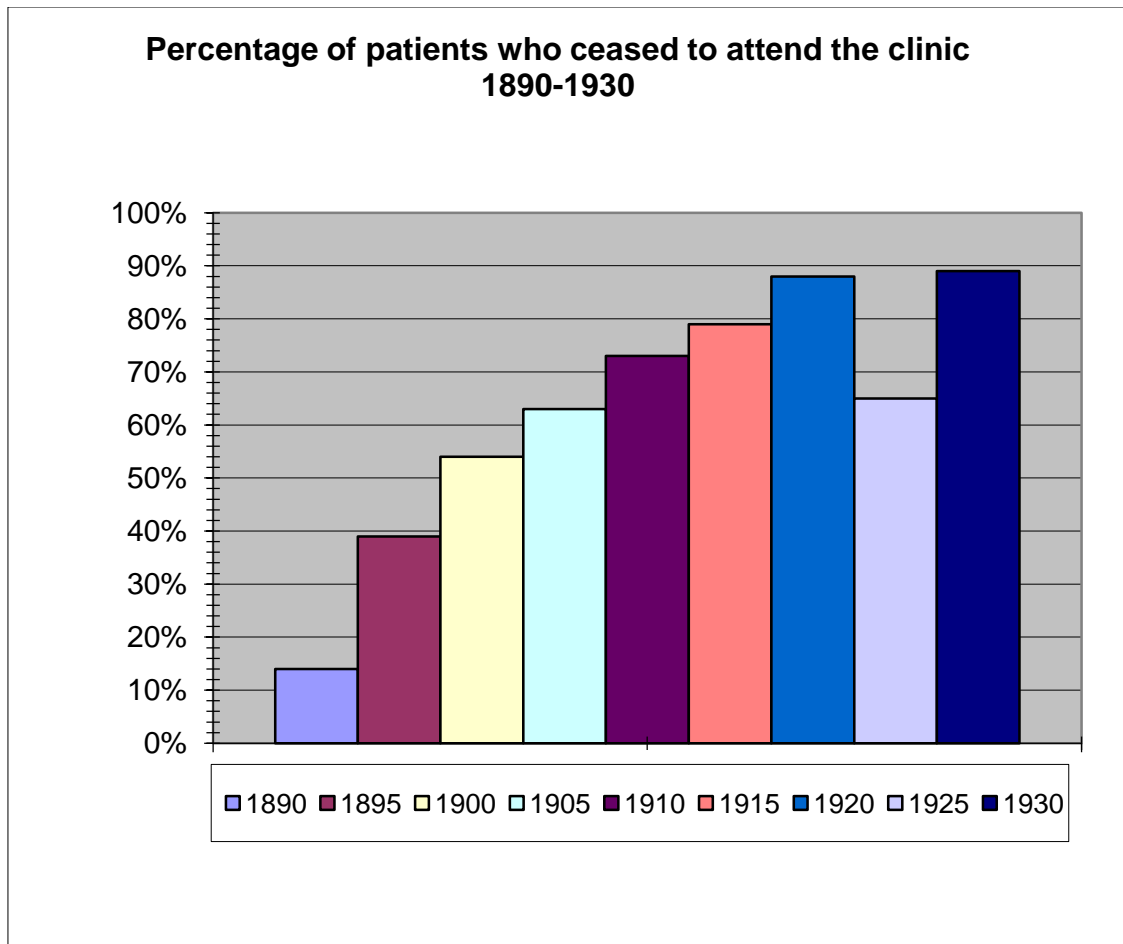
For the historian attempting to analyse the recovery rates of the clinic through the Register of Outpatients, the ‘ceased to attend’ comment proves as infuriating as it must have been for the doctors attempting to treat their patients. In fact, attempting to work out the recovery rate for the clinic is almost impossible. The Outpatients Register identifies the outcome of a patient’s treatment which usually came under one of the following am-

¹¹⁴ J. Bullen, ‘The Out-Patient System in Asylums’, p. 491. My emphasis.

biguous headings: 'discharged;' 'recovered;' 'improved;' 'relieved;' 'not recovered;' 'no change;' 'not known;' or else 'ceased to attend.'¹¹⁵ The ambiguity involved in many of these variations does not really allow for a confident analysis of the outcomes. The difference between the terms 'improved' and 'relieved' and also 'not improved' and 'no change' remains highly elusive. Similarly, the Register offers no details as to why some patients were 'discharged.' Hence it is impossible to know whether they were discharged improved or not. In addition we can only logically infer that the outcome of a patient was 'not known' simply because they 'ceased to attend' the clinic. This however offers little more insight as the category 'ceased to attend' is also filled with ambiguity. Table 4.2 identifies the number of patients whose 'Outcome' category either reads 'ceased to attend,' 'not known' or 'only attended once' and as such were never officially 'discharged' by the medical staff.

¹¹⁵ WYAS, C85/838, Register of Outpatients (1890-1949).

Table 4.2: Number of patients who are registered as having ‘ceased to attend’ 1890-1930¹¹⁶



Source: WYAS, C85/838, Register of Outpatients, (1890-1949).

Table 4.2 offers a snapshot on a five yearly basis of large numbers of patients who ceased to attend the clinic without their doctor’s consent. From the graph, we can glimpse the enormity of the problem. Though the numbers fluctuated throughout the fifty years studied, Table 4.2 does identify that trying to assess the outcomes of the patients attending the clinic is almost impossible, especially in the later years where the description ‘ceased to attend’ frequently reaches in excess of sixty-percent of the patients’ departures. This description is extremely problematic as there is little way of knowing why a patient ceased to attend the clinic. Patients may have stopped attending the clinic for any number

¹¹⁶ Ibid. All numbers are rounded to the nearest whole number.

of reasons, be it that they felt better, or worse, could no longer make the journey, or simply that they merely thought their attendance at the clinic was not helping their situation. Due to all of these ambiguities and difficulties in knowing what the outcome of treatment was, it is impossible to create any meaningful data or analysis as to the recovery rates and successfulness of this particular clinic with regards to concrete results. Despite this however, it does seem possible to infer from Table 4.2 that patients who ‘ceased to attend’ without the consent of their doctors were a major source of frustration. It seems reasonable to infer from this that perhaps the voluntary approach to treatment inherent within the scheme was one of the biggest limitations of the clinics. Put simply, the clinic set up at the mental hospital struggled to retain its patients under treatment until medical staff considered them to be fully cured of their ailments, suggesting perhaps that although the idea itself may well have been innovative, in practice, the method was extremely limited.¹¹⁷

It is difficult to assess the reasons why patients may have ceased to attend the clinic, and the evidence within the Outpatient Register can only be used for quantitative purposes, however within the case sheets from the 1930s, we can briefly glimpse into the lives of patients who attended once, or else a few times before ceasing to attend the clinic. Some examples of patients who ‘ceased to attend’ included thirty four year old Mary B. Her case notes explained that, “she is depressed, apprehensive and worried. She is frightened that she might ‘go off her head’ and states that on several occasions she has felt like ‘finishing things’ by jumping under a bus, but something has always stopped her from doing so. She has not slept and has no appetite.”¹¹⁸ At this point, no more information is given within Mary’s case file, presumably as she stopped attending the clinic for outpatient treatment. Others ceased to attend for other reasons such as twenty-six year

¹¹⁷ J. Bullen, ‘The Out-Patient System in Asylums’, p. 491.

¹¹⁸ WYAS, C85/839, Wakefield Out-Patient Clinic (1930-1940), patient record no. 7.

old William N from Sandal, who attended the clinic for three months, receiving treatment for epilepsy. William abruptly stopped coming to the clinic however, after he was advised to attend the LGI (Leeds General Infirmary) for a physical ailment. After this, his records come to an abrupt stop and we can learn no more about him.¹¹⁹ More tragically fifty-seven year old Robert B who first attended the clinic in April 1915 was immediately 'recommended to be certified,' However, on account of a delay, probably linked to a lack of space in the region's asylums, he was not immediately admitted to inpatient treatment and subsequently managed to commit suicide one month later, presumably without receiving the treatment he needed.¹²⁰ These particular cases, and many more besides, clearly identify the loopholes both of outpatient treatment and also of the surviving records that allow us only a glimpse at these people's stories.

Patients who ceased to attend the clinic merely represent one problem with outpatient treatment. As the last case above suggests, a second and equally problematic issue for staff who worked at the outpatient clinic was what to do with patients who needed more care and attention than could be given by outpatient treatment. In the case files of the patients who attended the clinic at Wakefield Mental Hospital we can trace the patients' process of admission into the hospital as in-patients. Since these particular records date after 1930, they follow the rules of the Mental Treatment Act, and a few of the patients who were considered to be in need of in-patient treatment appear to have been actively encouraged and occasionally cajoled into applying to an institution for voluntary treatment. One such case was Mrs E who was encouraged to apply for voluntary treatment at Storthes Hall Mental Hospital. A letter written by the clinic in advance of her application to the hospital proclaimed:

¹¹⁹ Ibid., patient record no. 36.

¹²⁰ WYAS, C85/838, Register of Outpatients (1890-1949).

Dear Dr Bruce,

Mrs E has been attending our out-patient clinic on and off for a considerable number of years. She improves at times, but quickly relapses under strain to an anxiety state... She came to me today after an interval of three months during which time she had been unable to leave her house or tackle her housework. She was anxious to have in-patient treatment and her husband was willing for her to go into hospital.

I advised them to apply to you for her admission as a voluntary patient and they agreed to do so.¹²¹

This type of letter usually accompanies the files of any patient who was advised to apply for in-patient treatment. Interestingly, the decision to finally admit a relative to in-patient care often occurred when the patient's family were unwilling or unable to maintain a consistent level of care and control within the domestic sphere. Mrs E's case above identifies a three-month gap in her attendance at the clinic, wherein her husband would have had to maintain a level of support and care without any help from the clinic or hospital authorities. Indeed, the very fact that a patient in need of treatment could stay away from the clinic for such a long period of time identifies various considerable problems and loopholes within the outpatient system. The reference in the letter to Mrs E's neglect of her household responsibilities may have led to her husband's eventual persuasion that she

¹²¹ WYAS, C85/839, Wakefield Out-Patient Clinic (1930-1940), patient record no. 43.

should be admitted for in-patient care.¹²² This perhaps suggests that relatives continued to be a major influence on what type of care a patient received.¹²³

A very similar letter was written with regard to twenty-two year old Sydney M. The doctor at the outpatient clinic wrote to Sydney's doctor explaining: "I consider that he is showing a rather acute anxiety state... I think that in his condition treatment as a voluntary patient would be advisable, at least for a time until his symptoms have abated. I have advised his mother that this course should be taken and they both agreed to consider it."¹²⁴ These letters and many similar ones seem to suggest that for some patients outpatient treatment was an unsuitable alternative to inpatient care. The unsuitability of various patients to undergo outpatient treatment does not necessarily represent a failure of the clinic in its task to keep patients outside the walls of the asylum or mental hospital, but it is instrumental in showing the limits of outpatient treatment. A letter regarding Mrs C, a housewife from Doncaster, explained:

In view of her long history, with the suicidal tendency of late becoming stronger, I think that she ought to consider going in to the mental hospital for treatment as a voluntary patient. She did not think that she could attend the clinic often very conveniently and I consider that she should really have more constant care than is possible at the clinic.¹²⁵

¹²² Ibid.

¹²³ For more on the role of the family with regard to committal and discharge see: J. K. Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in W. F. Bynum, R. Porter, and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol. 2 (London, Tavistock, 1985), pp. 132-146; D. Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, vol. 10, no. 1, 1997, 137-155; D. Wright, *Mental Disability in Victorian England*, p. 82.

¹²⁴ WYAS, C85/839, Wakefield Out-Patient Clinic (1930-1940), patient record no. 91.

¹²⁵ Ibid., patient record no. 42.

This letter identifies some of the limits of outpatient treatment. It is clear that for Mrs C successful treatment at an outpatient clinic was a highly unlikely, and probably also an unconsidered outcome. This is especially true as she was not only suffering from suicidal feelings - a condition which by itself usually warranted in-patient treatment - but also found it difficult to come to the clinic. The case also identifies that some patients who attended the clinic merely did so as a stepping-stone towards voluntary in-patient treatment. It would appear that for these particular patients the clinic was not about treatment at all; instead it acted as a filter for the mental hospital, offering a second opinion to that of the patient's family doctor who had referred them to the clinic.¹²⁶

This part of this chapter has identified some of the uses and problems of the outpatient clinic that was established at Wakefield Asylum, latterly Wakefield Mental Hospital, from its inception in 1890 through to the late 1930s. It has attempted to identify that whilst innovative in its establishment, it faced many problems in achieving its objective of treating patients in the incipient stages of their illnesses and removing the stigma from the process of treatment. Though there were a few outpatient departments established across the country, receiving treatment at an outpatient clinic was still relatively unusual before the 1930s. After the 1930 Mental Treatment Act however, the emphasis and prominence of outpatient care shifted from the older outpatient clinics that were originally established at asylums to setting up new clinics at general hospitals. The rest of this chapter will seek to understand the reasons for this relocation of outpatient care. It will highlight how the new clinics opening at general hospitals in the 1930s suggests that there were fundamental problems linked to how many patients accessed care in the clinics in the mental hospitals in the earlier years. Similarly to Part 1 of this chapter, the next part will identify various reasons for the desired change in location for outpatient clinics, as well

¹²⁶ For more on this see Chapter 5 on the Mental Treatment Act.

as observing the differences and similarities between the two clinics. An analysis of the patient case files for outpatient treatment at the clinic at Clayton Hospital will identify how many of the same problems highlighted above continued at the clinic at Clayton Hospital throughout the 1930s.

PART II: Clinics at General Hospitals

Though to date very little work has been carried out on outpatient departments at asylums in the late nineteenth century, much work has emphasised the growth of outpatient departments during the 1930s. Work often begins with the much celebrated opening of the Tavistock Clinic,¹²⁷ whereas others have highlighted the importance of the 1930 legislation with regard to the increase in outpatient clinics.¹²⁸ The new clinics which were being advocated in the 1930s were however, considered to be fundamentally different to the clinic analysed above at Wakefield Asylum. The 1930s discourse unanimously identified that outpatient clinics should operate at general hospitals rather than at mental hospitals.

The popular discourse of the 1930s suggested that the ever-pervading issue of the stigma associated with the asylum was a barrier to successful treatment and that many patients would be more easily persuaded to seek help and advice, at least initially at the more 'neutral' location of their local general hospital.¹²⁹ In 1929, Dr McCowan, the Medical Superintendent for Cardiff Mental Hospital, gave a paper at the 12th Annual Meeting of the Mental Hospitals Association. His paper on 'Mental Out-Patient Clinics'

¹²⁷ P. Allderidge, 'The Foundation of the Maudsley Hospital', in G. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London, Gaskell, 1991), pp. 79-88; P. Griffiths and V. Franks, 'Nursing Mental Health at the Tavistock', in S. Tiley (ed.), *Psychiatric and Mental Nursing: The Field of Knowledge* (Oxford, Blackwell, 2005), pp. 57-77.

¹²⁸ K. Jones, 'The Culture of the Mental Hospital', in *150 Years of British Psychiatry*, pp. 17-28.

¹²⁹ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 4.

summarises perfectly the argument that suggested that outpatient clinics should be located at general hospitals.

There is no doubt that the near future will see important developments in the treatment of mental health in the community and I feel that out-patient departments are to play a very important part of this development... Such a department may be of three kinds, namely, in connection with a general hospital, or in connection with a mental hospital or in connection with a special psychiatric hospital, such as the Tavistock Centre at the Maudsley hospital.¹³⁰ All have their relative advantages and disadvantages, but there is little doubt that the chief development will be and should be in connection with our big general hospitals. *The advantages of the latter is that the patients will more readily attend a general hospital.* [However] the medical officer in charge of such a clinic should undoubtedly be the medical superintendent of the corresponding mental hospital.¹³¹

In order to underline his objection to these clinics being set up at local mental hospitals further he continued:

If it is decided to run the out-patient department apart from a general hospital, then it would probably be advisable to obtain a room

¹³⁰ For more on the Tavistock clinic see, Griffiths and V. Franks, 'Nursing Mental Health at the Tavistock', pp. 57-77.

¹³¹ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Hospital Board (1929), p. 164. Emphasis mine.

outside the mental hospital, on the lines of an ordinary surgery, as there is no doubt that there would be much more difficulty to get patients to attend the mental hospital itself.¹³²

Such an analysis clearly assumes that outpatient clinics needed to do all they could to disengage with the stigma of mental illness and mental hospitals. In this view, it was not enough merely to rid a person of the stigma of necessary certification for in-patient treatment. Instead it was deemed necessary to remove a patient from the stigma of having *any association* with the mental hospital itself. Although it is difficult to validate the extent of the truth of this claim, the fact that some doctors and also the Board of Control advocated this belief identifies another implicit problem inherent with outpatient clinics which were established at public mental hospitals throughout the years that this thesis deals with. Indeed, after the Mental Treatment Act had been passed, the Board of Control explained how in their opinion, outpatient departments should be established in voluntary or general hospitals, rather than mental hospitals.

Another change of great importance is the statutory recognition of the outpatient clinic. Such clinics have for some time been in successful operation in certain areas, but the right of local authorities to incur the necessary expenditure has not been free from doubt. Authorities are now empowered to provide the clinic, or to arrange for its provision with the voluntary [general] hospital of the area. There are obvious advantages in conducting an outpatient clinic as part of a voluntary hospital. Patients will

¹³² Ibid.

more readily resort to a centre which is not definitely associated in their mind with mental disorder.¹³³

These examples clearly identify that many professionals working within the sector of psychiatry in the twentieth century thought that there were many problems connected to outpatient clinics that were set up at mental hospitals and that the foremost concern was that of stigma. In short, many medical men were worried that patients with very slight or acute illnesses would be put off by the stigma of being treated at an asylum or place ‘associated in their mind with mental disorder.’¹³⁴ This is important, as the issue of stigma related to asylums was not the foremost concern for Bevan-Lewis when he opened the clinic at Wakefield Asylum in 1890.¹³⁵ Instead in the 1890s Bevan-Lewis was concerned about trying to eradicate the need for certification before a patient was allowed to access treatment for mental health problems; an issue which had technically been eradicated by the Mental Treatment Act of 1930.¹³⁶ In some ways this factor helps to explain why the focus on the location of outpatient care changes during the late 1920s and 1930s. Having eradicated the ‘stigma of certification’ there was an attempt to rid the stigma of receiving treatment at a mental hospital, by blurring the distinction between general and mental hospitals by attempting to treat “mental disease the way that they treat physical disease.”¹³⁷

¹³³ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 4.

¹³⁴ Ibid.

¹³⁵ WYAS, C85/1/12/9, Annual Reports (1881-1890) Report from the Medical Superintendent (1890).

¹³⁶ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

¹³⁷ Anon., ‘Mental Treatment: Improvements under the New Act’, *The Manchester Guardian*, 11 October 1930, p. 8. See also: WYAS, C416/1/67, Minute Books of the West Riding Mental Hospitals Board (1930), p. 173; and J. Crammer, ‘Training and Education in British Psychiatry,’ in *150 Years of British Psychiatry*, Vol. II, pp. 209-242.

New Locations: Continuing Problems?

During the 1930s this process of opening outpatient departments at general hospitals was widely adopted in the West Riding of Yorkshire and the Annual Reports of the West Riding Mental Hospitals Board frequently made reference to this. In 1932 it was declared that an outpatient department would be opened at Clayton General Hospital every Wednesday afternoon from 3pm to 4pm under the supervision of Dr McGraph and Dr Wilson, two medical officers of Wakefield Mental Hospital.¹³⁸ Also in 1932 a clinic was established at Huddersfield Royal Infirmary in connection with Storthes Hall, and again would open its doors every Wednesday.¹³⁹ By 1933 a similar clinic was established at Bradford and yet another was established at Leeds General Infirmary and was held each Saturday at 3pm under the supervision of Professor Shaw Bolton.¹⁴⁰ In each of the cases above, medical officers at the local mental hospital would be in charge of the running of the clinic at the general hospital, as was suggested by Dr McCowan in his paper quoted earlier.¹⁴¹ Interestingly however, in the case of the West Riding of Yorkshire these new clinics at general hospitals were established to *supplement* rather than to *replace* the clinics at the mental hospitals. Seemingly unperturbed by the concern of stigma, in the West Riding of Yorkshire, these new clinics worked in tandem with and alongside the more established clinics at the Mental Hospitals. This is important as it suggests that despite the discourse, the issue of distance remained as much of a factor as that of stigma for many patients in the West Riding.

A letter attached to one particular patient's case files identifies how useful such a variety of options and locations of treatment could be to patients. It also identifies the power of successfully developing relationships based upon trust between staff and pa-

¹³⁸ WYAS, C85/1/8/9, Minutes of the West Riding Mental Hospitals Board (1932-1933), p. 90.

¹³⁹ *Ibid.*, p. 178.

¹⁴⁰ WYAS, C85/1/8/10, Minutes of the West Riding Mental Hospitals Board (1934-1935), p. 63.

¹⁴¹ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Hospital Board (1929), p. 164.

tients. Thelma B had been attending outpatient clinics on and off, always seeing Dr Wilson for a number of years. After a small absence from treatment she wrote to Dr Wilson asking for another 'interview'. Dr Wilson's reply identifies that by the mid-1930s patients were given a wide variety of options regarding the location of and also the people responsible for their treatment.

Dear Thelma,

I was sorry to hear from your letter that you are not feeling so well. I shall be pleased to see you and give you any help that I can. Unfortunately, I am not at present taking the clinic at Leeds Infirmary, but if you care to go there tomorrow afternoon, my colleague Dr Brut would see you and advise you. If however, you would prefer to come to Wakefield to see me, I am at Clayton Hospital every Wednesday between 4 and 4.30pm. The buses from Corn Exchange Leeds pass the gates of the hospital.

Alternatively, I could see you at 4pm tomorrow, Saturday at the Mental Hospital if you will ask for me at Lodge Gate.¹⁴²

Dr Wilson's reply identifies the array of options that by the mid-1930s were available to patients who felt that they needed help, advice or support at one of the clinics. It is clear from the letter that Dr Wilson was aware of the difficulties that her patients often faced in attending the clinic and her recommendation for Thelma to attend the clinic at Clayton is clearly down to the accessibility of the clinic on the main bus service from Thelma's

¹⁴² WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 1 A-G, patient record no. 623.

hometown in Leeds. The evidence does suggest however that although the clinics had now become more accessible to patients, there were still many barriers and restrictions. Dr Wilson's letter identifies that her attendance at Clayton Hospital was only for thirty minutes, a very short window in which to properly attend to her patients. This evidence is in contrast with the times stated in the Annual Reports quoted earlier, suggesting either an error, or else, perhaps more troublingly, a reduction in the length of time available to see patients at this particular clinic.¹⁴³

Further, despite the array of new locations that a patient could attend to receive outpatient treatment, the evidence suggests that this did not necessarily reduce the difficulty for patients attending, and much like cases at the clinic at Wakefield Mental Hospital, many patients also ceased to attend the clinic at Clayton General Hospital. The case of Harry K identifies that little had changed despite the opening of new clinics. The records identify that in 1937 after just a few attendances, the mother of ten-year-old Harry K, an epileptic from Normanton, stopped bringing her son to the clinic at Clayton Hospital. A letter written from the clinic back to the family's doctor in Normanton, who had initially referred the case over, explained that Harry's mother "finds it very difficult to bring the boy up to Wakefield."¹⁴⁴ Again this particular case identifies that the interconnected issues of distance, time and money that it took to attend outpatient clinics, whether at the mental hospital or general hospital, often remained crucial factors in a patient's attempt to receive outpatient treatment.

Similarly, forty-three year old Sam A from Kirkhamgate started to attend the clinic at Clayton in the year 1936. His case notes identify that he was an unemployed colliery lamp-man who was diagnosed as suffering from 'neurasthenia' and complaining of a

¹⁴³ WYAS, C85/1/8/9, Minutes of the West Riding Mental Hospitals Board (1932-1933), p. 90.

¹⁴⁴ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 2, H-M, patient record no. 201.

“pain in the back of his head.”¹⁴⁵ After attending the clinic once a month for a few months for medication Sam also disappeared from the clinic without trace. The case notes indicate no sign of recovery, but the records stop a few months later.¹⁴⁶ We are left to speculate whether he recovered, ran out of money to pay for his medication, found employment and could no longer attend the clinic, or whether some other factor stopped his attendance. Either way, it is clear that similarly to the clinic at Wakefield Mental Hospital, patients who ‘ceased to attend’ also continued to be a problem at the clinic at Clayton General Hospital.

The need for a patient to have a family who was willing and also able to have their kin treated at the outpatient clinics continued to be imperative in order for the medical staff to carry out their work in assessing their patients. This point is especially true for the plight of children, as parents were under no obligation to bring their children to attend the sessions at the clinics. In 1938, five-year-old Leonard C was referred to the outpatient clinic at Clayton due to his ‘behavioural difficulties.’ Leonard’s “disruptive behaviour and bad language” were later attributed “to circumstances in the home and an abusive father.”¹⁴⁷ These factors however meant that Leonard’s mother was either unwilling or felt unable to bring Leonard back to the clinic a second time. A letter attached to Leonard’s file, written by a doctor at the clinic identifies that since the boy’s first visit, “I have twice written to Mrs C to ask her to come and bring Leonard up to see me at Clayton. She has not attended however.”¹⁴⁸ The letter concludes by explaining: “Successful treatment at a psychiatric clinic would depend on a sympathetic attitude from the parents.”¹⁴⁹ Clearly in this particular case, this ‘sympathetic attitude’ of the parents was not forth-

¹⁴⁵ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 1, A-G, patient record no. 158.

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*, patient record no. 411.

¹⁴⁸ *Ibid.*, patient record no. 411.

¹⁴⁹ *Ibid.*, patient record no. 411.

coming, and the boy was not brought back to the clinic for treatment.

The Wrong Type of Patient for Treatment?

Another notable problem for staff at the clinic with regard to treating patients, was that many patients referred for treatment were simply not considered to be in any fit state to receive treatment from an outpatient clinic. There is much evidence which supports the view that the clinic at Clayton General Hospital made little difference to the type of patient attending the clinic and patients attending both clinics often needed to be admitted for in-patient care. A letter attached to the case notes of Thelma B identifies the strain that dual patient care between the hospital and the domestic sphere could have upon the relatives of patients. The mother of thirty-year-old Thelma B wrote to Dr Wilson after her daughter was advised to apply for voluntary in-patient treatment. The letter tells of a mother's emotional plea for help after acknowledging the breakdown of domestic care:

Dear Dr Wilson,

It has been my intention to write to you and thank you for all you have been doing for Thelma. Thank you with all of my heart.

You are the only one who has an influence on Thelma. She does believe in you and takes your advice only.

...What to do for the best for Thelma I leave to your wise judgement.

...I wish I could help her like you can.¹⁵⁰

This letter from Thelma's mother highlights that at this particular stage, domestic care had broken down and Thelma's mother no longer felt able to provide adequate support and care for her daughter. In the letter she acknowledges that the dual-care of outpatient treatment was no longer working and that the care of her daughter should be left to the 'wise judgement' of Dr Wilson, even if that meant temporally succumbing to institutional in-patient care.

A large percentage of the letters written by the medical officers at the clinics also suggest that if a patient or their families were unwilling to submit themselves or a relative for institutional in-patient treatment then the medical staff were often forced to look after patients who they felt needed more care than that which they were able to provide within the constraints of the clinic. Following the 1930 Mental Treatment Act, there was little that the authorities could do to intervene if the patient or his family was unwilling to accept or undergo voluntary in-patient treatment. During the 1930s, a level of persuasion was often required and medical practitioners frequently resorted to family members to help in their persuasion. One such battle took place around thirty-five year old Sam H, who was described as "still very depressed and shows a suicidal tendency."¹⁵¹ A letter attached to the case-file identifies: "Both Mr H and his Mother are quite willing for him to go to Storthes Hall as a voluntary patient... his wife I understand may oppose this step, but his mother promises to put the dangers of him staying at home clearly before her."¹⁵²

¹⁵⁰ Ibid., patient record no. 623. Emphasis original.

¹⁵¹ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 2, H-M, patient record no. 555.

¹⁵² Ibid.

In addition to having to struggle with the desires of each patient's family, the patient case notes at the clinic at Clayton Hospital also suggest that the staff at the clinic had to battle with patients who refused to take their advice and accept in-patient treatment. One letter attached to the file of thirty-two-year-old Herbert K stated:

I saw your patient Mr Herbert K again at the Clayton clinic last Wednesday and had a talk with him about the advisability of going to Storthes Hall as a voluntary patient. His wife, who was with him, was quite willing for him to take this advice, but Mr K himself was unwilling to do so. I think the chief difficulty that exists is the fact that his father died in Storthes Hall some years ago.

...If he is still unwilling to be an in-patient, I do not know what we can do to help him, as he is certainly not a certifiable case.¹⁵³

This particular case identifies that in many instances the clinic could be powerless and could do little to help certain patients but offer 'advice.' It also identifies that patients attending the clinic at Clayton could be just as problematic as those attending the clinic at Wakefield Mental Hospital. The fact that Mr K was not certifiable, meant that the staff at the clinic did not know "what [to] do to help him," which suggests that their powers of treatment could be extremely limited.¹⁵⁴ This is powerful evidence too that the outpatient clinic *did not alter the stigma* attached to mental hospitals, or lessen their frightening

¹⁵³ Ibid., patient record no. 32.

¹⁵⁴ Ibid., patient record no. 32.

reputation for many patients. It also foretells the limits of the Mental Treatment Act, which will be analysed in Chapter 5 of this thesis.

Similarly, in the case of Arthur A attending the outpatient clinic at Clayton General Hospital appeared to be just a step towards institutional care. For his GP the referral appears to have been a formality, rather than there having been any real expectation of outpatient treatment.¹⁵⁵ Arthur had been a patient at Wakefield Asylum from the years 1905-1918, since when he had been in and out of the institution throughout the 1930s following the Mental Treatment Act.¹⁵⁶ In 1936 he was advised by his doctor to attend the clinic at Clayton, whereupon the medical attendant once again advised in-patient voluntary treatment, to which Arthur agreed.¹⁵⁷ In this particular case, and many more besides, the clinic, just like the clinic at Wakefield Mental Hospital, merely acted as a stepping stone to institutional treatment. It was merely a place for initial diagnosis, rather than a place of cure and treatment.

Equally a small minority of patients within the case files suggest yet another unexpected use of the clinics. The case files identify that a small number of patients were sent to the clinics (both at the mental hospital and at the general hospital) by various probation officers in order to ascertain the mental soundness of their charge. This was the case for seventeen year old William B,¹⁵⁸ nine year old Harry A¹⁵⁹ and also for twelve year old Clifford B¹⁶⁰ amongst others. All of these particular cases found themselves referred to the outpatient clinic by their probation officers during the 1930s. Many cases appear to have been sent in order to determine whether the patient's considerable behav-

¹⁵⁵ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 1, A-G, patient record no. 116.

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid.*

¹⁵⁸ WYAS, C85/839, Case notes from the Wakefield Out-Patient Clinic (1930-1940).

¹⁵⁹ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 1, A-G, patient record no. 690.

¹⁶⁰ *Ibid.*, patient record no. 318.

itorial problems could be attributed to mental deficiency and whether this condition might affect their particular punishments. A letter attached to the file of Clifford B written by his probation officer explains “I should like to say that this boy is an abnormal child, and I doubt whether he is altogether responsible for his actions...”¹⁶¹ The tone of the corresponding letter from the medical officer in charge appears to be quite blunt about the uselessness in sending the boy to the clinic for treatment.

I have no doubt that the boy suffers from a degree of mental deficiency and this is generally the basis for the behavioural disorders that these cases often show.

Since he has a degree of mental deficiency, (which is, of course, permanent) you will appreciate that it is unlikely that he will derive any benefit from attending a clinic such as this, where he would only be seen occasionally.

If he continues to misbehave then no doubt the authorities will place him in an institution where he will be under more control and discipline than he can get at home.

I thought that the mother was rather hostile and resentful and too ready to blame other children so it is not unlikely that he is being treated too indulgently at home... I have warned the mother that she will have to be more strict with the boy.¹⁶²

Despite the tone of letter and the medical officer’s view that outpatient treatment was not the correct place for treatment for this boy, it is unclear that treatment was ever the probation officer’s intention; rather it appears that in these instances, the clinic was merely used as a place of diagnosis. Similarly in the case of nine-year old Harry A, a letter was written by a member of Ossett Education Committee, who tentatively wrote:

¹⁶¹ Ibid., patient record no. 318.

¹⁶² Ibid., patient record no. 318.

I do not know whether I am doing the right thing in asking you to see him, but I would like a little advice as to whether you think we are justified in trying to get him into a school where he would be able to have individual attention, and which type of school, if any, he should be sent.¹⁶³

The cases above have identified the many limitations of the outpatient clinics. These particular cases, similarly to cases attending the clinic at Wakefield Mental Hospital, also serve as a distinct reminder that the numbers of patients attending the clinics on a weekly, monthly or yearly basis do not provide an indication of the number of patients undergoing treatment.

Though all of the patients above indicate that often there were many problems and limitations to receiving and providing outpatient treatment, there were also many cases of successful treatment at the clinic at Clayton General Hospital. As usual the evidence suggests that patients who were referred to the clinic early on in their illnesses, or who were suffering from mild and incipient illnesses were usually treated and ‘discharged recovered’ relatively quickly. Cases include twenty-three year old Mrs J, who attended the clinic in 1938 and was diagnosed as suffering from a “mild form of hysteria.”¹⁶⁴ Mrs J attended the clinic regularly, once a month for several months, at which time it was noted in the case files that she “feels much better,” and her attendance correspondingly ceased.¹⁶⁵ Additionally, seventeen year old Vera A from Lupset was similarly suffering from ‘a mild form of hysteria.’¹⁶⁶ After her attendance at the clinic Dr Kelly

¹⁶³ Ibid., patient record no. 690.

¹⁶⁴ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 2, H-M, patient record no. 316.

¹⁶⁵ Ibid.

¹⁶⁶ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 1, A-G, patient record no. 379.

wrote to her GP stating “I feel satisfied that she will have little trouble in the future. I have tried to explain her condition to her and will see her again if she has another attack.”¹⁶⁷

Furthermore, twenty-five year old Mrs A was suffering from depression following the birth of her first child. On her first visit she was described as being in a “depressive state with anxiety symptoms.”¹⁶⁸ She was noted to be “run down and tired. [She] had been doing a lot of sewing for the baby, and working late until 2am... Not sleeping well, not taking food. Cries a good deal. Afraid she won’t be able to bring [her son] up.”¹⁶⁹ In her work on puerperal insanity, Hilary Marland explains the “arguments [which] were put forward by ...practitioners for treating such cases in the domestic setting rather than the asylum.”¹⁷⁰ For Mrs A, the outpatient clinic offered a halfway house between the two.¹⁷¹ The few cases stated here represent a few patients amongst many who were suffering from the early stages of their illnesses, and who were able to attend the clinic for a short period to receive extra support without having to submit themselves to in-patient treatment. These cases identify how the outpatient clinic at Clayton General Hospital could be useful to many patients who attended for treatment.

Once again however, the records make it clear that not all patients attending the clinic at Clayton General Hospital attended in the early stages of their illness. Certainly it is clear that late admittance to the outpatient clinic was not necessarily unique to the clin-

¹⁶⁷ Ibid.

¹⁶⁸ Ibid., patient record no. 690.

¹⁶⁹ Ibid., patient record no. 690.

¹⁷⁰ H. Marland, ‘At Home with Puerperal Mania: The Domestic Treatment of the Insanity of Childbirth in the Nineteenth Century’, in *Outside the Walls of the Asylum*, pp. 45-65, p. 45. For more on puerperal insanity, its sufferers and their care and treatment, see H. Marland, “‘Destined to a Perfect Recovery:’ The Confinement of Puerperal Insanity in the Nineteenth Century”, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914* (London, Routledge, 1999), pp. 137-56; H. Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills, Palgrave-Macmillan, 2004); and H. Marland, ‘Under the Shadow of Maternity: Birth, Death and Puerperal Insanity in Victorian Britain’, *History of Psychiatry*, vol. 23, no. 1, 2012, 78-90.

¹⁷¹ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 1, A-G, patient record no. 690.

ic at the mental hospital. Patients appeared at Clayton General Hospital years after the onset of their symptoms of mental strain and anxiety, though it is noteworthy to mention that examples of this type of case appear to be more infrequent at Clayton General Hospital than at the mental hospital. One such case included forty-nine year old Amy A from Lupset. The records identify that Amy A was eventually referred to the clinic at Clayton after “feeling unwell” for a period of eight years. It was noted that the sudden death of her husband eight years ago had been a “great shock.”¹⁷² Since then it was explained that she had begun “to worry about everything [and] spent a huge part of the days weeping.” In addition she declared that she “can hardly get on with her housework on account of feeling weakness.”¹⁷³ The fact that there appear to have been fewer cases admitted to Clayton Hospital which resemble Amy’s story is perhaps, as was noted above, suggestive that there was less stigma associated with coming forwards for treatment at a general hospital rather than a mental hospital. Nevertheless, the fact that many patients at both hospitals came to the respective clinics for treatment sometimes years after the onset of their symptoms of illness and mental strain is highly suggestive of the *failure* of the clinic to bring in many patients at an earlier stage of their illnesses. It would appear from the cases that the intention of removing the issue of stigma by removing the clinic to a general hospital was not as effective in bringing in patients as it was formerly hoped.¹⁷⁴ Instead, patients attending the clinic at the general hospital were in many ways very similar to patients who attended the clinic at the mental hospital.

¹⁷² Ibid., patient record no. 133.

¹⁷³ Ibid., patient record no. 133.

¹⁷⁴ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Hospital Board (1929), p. 164.

Conclusions

Despite the differences in location and stigma between the clinics established at general and mental hospitals, an analysis of the case files for both Wakefield Mental Hospital and the mental outpatient clinic at Clayton General Hospital identifies that for the most part, patients with very similar illnesses, stresses and strains appear to have attended both of the clinics for treatment. It is obvious that the opening of new outpatient departments would have offered more choice to patients of where to go for treatment, however, it seems clear that the new responsibilities of running different outpatient clinics would have put mental hospital staff under more pressure than before by substantially increasing their work loads. As such many of the clinics run at general hospitals were only available for a maximum of a couple of hours each week, with some clinics being open for only thirty minutes. As such it is unsurprising that attendance at the clinic was considered to be “overcrowded” by 1937.¹⁷⁵

Furthermore, it is clear that although some things improved slightly into the 1930s with the introduction of more outpatient clinics at general hospitals in terms of a slight increase of choice for patients, nonetheless, many of the problems that were inherent within the late nineteenth century continued into the twentieth. An analysis of these problems identifies that we need to be critical of historians such as Hoole and Westwood who take such an optimistic approach with regard to these developments. Although the clinic was established in order to eliminate the need for certification, it did not necessarily eliminate the stigma associated with attending a clinic for treatment regarding a mental condition. An analysis of the records suggests that although the stigma of attending a mental hospital may have stopped certain patients from attending the clinics, the very

¹⁷⁵ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 3, N-Z, patient record no. 205.

stigma of mental illness itself may well account for another major flaw of the outpatient clinics.¹⁷⁶ The issue of stigma, teamed up with the substantial distances that many patients had to travel to attend the clinic for treatment, often provided substantial or prohibitive barriers for patients who wished to access care.¹⁷⁷

On top of these factors there were also other issues that highlight the limitations of the clinics in both locations in providing a different form of treatment for patients. This can be observed in the numbers of patients for whom outpatient treatment was, for whatever reason, deemed insufficient and who were advised to come into the mental institution to receive in-patient care. Patients admitted to inpatient care usually found it difficult to attend the clinic, or else were suffering from more severe forms of mental illness, or were presenting suicidal tendencies. The need to admit patients for in-patient treatment does not necessarily imply a failure of the clinic; however, we must remain aware of the limitations of the clinic for certain patients requiring treatment. Additionally, it would appear that well into the 1920s and 1930s many doctors and probation officers who referred patients to the clinic did so merely on the understanding that the clinic could provide a diagnosis for their charge. In many cases it seems likely that those who wrote the referral did not expect the clinic to provide treatment. For some patients the clinic merely provided a stepping-stone to institutional treatment. For others the clinic was merely asked to offer a diagnosis as to the mental soundness of a delinquent youth. These examples identify that we need to be careful before suggesting that a large proportion of people attending the clinic is proof that the clinic was a success, as it is clear that many patients who attended were unsuitable for treatment in the first place.

Overall, although the establishment of outpatient clinics was clearly an innovative idea, especially in the 1890s, it should be seen as little more than another local initiative

¹⁷⁶ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Hospital Board (1929), p. 164.

¹⁷⁷ WYAS, C85/1/12/11, Report of Medical Superintendent (1905), p. 13.

established for a small section of the mentally ill community, those in the early stages of incipient mental disease. However, it is clear that despite the many problems and limitations that can be observed with regards to the establishment of the clinics at both mental hospitals and later general hospitals, outpatient departments nonetheless represented yet another change in policy and the choice of treatments available to sufferers of mental illness; highlighting yet another change in psychiatric practice and experience between the nineteenth century and the interwar years.

The analysis of both of these clinics during the 1930s have identified to a certain extent how outpatient treatment in the 1930s had become bound up with issues relating to the new legislation of 1930. Due to this, some of the themes of this chapter will be carried through into the next chapter which seeks to identify the positives and limitations of the 1930 Mental Treatment Act, which likewise attempted to eradicate the stigma of certification from mental health care.

Chapter Five

Legislation, Treatment and the Eradication of Certification?

1930-1938

“The purpose of the act is to enable incipient mental cases to receive treatment without incurring what has been called the ‘stigma’ of certification...”¹

Similarly to outpatient departments, the Mental Treatment Act of 1930 can be seen as yet another attempt to remove the stigma of certification from those who applied for treatment and care in the sector of mental health provision. In addition it has long been recognised that the 1930 legislation went hand-in-hand with the new 1929 Local Government Act. The legislation of 1929 had given local councils the right to take over the administration and governance of old Poor Law facilities, thus formally abolishing the notion of the Poor Law, and bringing the remit of psychiatric medicine firmly within the control of local authorities.² In 1930 the Board of Control explained that “the dissociation of mental health services from the Poor Law Administration begun by the Local Government Act of 1929 has been carried a step further by the... Mental Treatment Act.”³ When the Mental Treatment Act was passed in 1930 it was hailed by many MPs, not least many Labour Ministers, as “a great charter for the poor of this country.”⁴ Many proclaimed that “for the first time [the act] gives the poor as great a chance as the rich”⁵ with regard to access to mental health care provision. This comment was especially true as private fee-paying patients were allowed to reside in private institutions as ‘voluntary boarders’ prior

¹ WYAS, C416/1/67, Minute Books of the West Riding Mental Hospitals Board (1930), p. 173.

² Local Government Act 1929, [19 GEO. 5, Ch17].

³ WYAS, C85/1/15/14, Annual Reports of the Board of Control (1930), p. 2.

⁴ J. H. Morris-Jones, ‘A Message of Hope’, *British Journal of Nursing*, no. 78, June 1930, 141.

⁵ *Ibid.*

to the 1930 legislation.⁶ Despite the evident legal and theoretical importance of these combined Acts, their significance has not been fully analysed. Though frequently mentioned in chapters discussing the twentieth century, many works have tended to focus upon the provisions of the laws themselves, rather than on their actual implementation. As such, whether or not the 1930 Act actually changed psychiatric practice in any *meaningful* way for the majority of patients and their families remains underexplored.

Within her now dated work Kathleen Jones described the 1930 Mental Treatment Act as a breakthrough or a triumph of the medical practice, which stood in direct variance to the 1890 Lunacy Act. After famously describing the 1890 Lunacy Act as “the triumph of legalism,”⁷ she explained that those who campaigned for the reforms in 1930 made no attempt to abolish the 1890 lunacy legislation. Instead she claimed, “The intention of this Bill was to by-pass it [the 1890 Lunacy Act] – to provide a framework of treatment which would make it unnecessary to use the older Act, except in extreme cases.”⁸

Jones’ views are confirmed by Clive Unsworth in his work *The Politics of Mental Health Legislation*, wherein he suggested a similar approach to studying mental health care throughout the late nineteenth and early twentieth centuries. In his work, he considered the 1890 Lunacy Legislation and 1930 Mental Treatment Act to be diametrically opposed to each other. He argued that one favoured the legal system whilst the other favoured the medicalisation of mental health care, by prioritising the expertise and

⁶ Private voluntary *boarders* were actually allowed in private and registered hospitals a long time before the 1930 Act was passed predominantly for the aid of rate-aided patients. In fact, there were 325 voluntary boarders in registered private hospitals on 1st January 1924. The largest intakes were in Bethlem Royal Hospital, The York Retreat, the Manchester Royal Hospital, and the Maudsley, which officially opened in 1923. In addition, there were 238 voluntary boarders in licensed houses across the country. Ref: WYAS, C85/1/15/9, Annual Reports of the Board of Control (1923), p. 35.

⁷ K. Jones, *A History of Mental Health Services* (London and Boston, Routledge & Kegan Paul, 1972), p. 153.

⁸ K. Jones, *Mental Health and Social Policy* (London, Routledge and Kegan Paul, 1960), p. 117.

knowledge of doctors.⁹

Similarly, in what could be described as an equally Whiggish tone, Peter Nolan argued that the passing of the 1930 Act was fundamental to the beginning of what he proclaimed was “a new phase” within mental health care; one which “saw the demise of the term ‘asylum’ with a slight shift in public and mental thinking away from ostracizing asylum inmates and the advent of the mental hospital.”¹⁰ In his work he further described the 1930 Act as “a remarkably enlightened piece of legislation, which defined the aims of psychiatry as treatment followed by rehabilitation, and which tried to eradicate the stigma of mental illness by introducing the era of the ‘voluntary patient.’”¹¹

Almost a decade later, Busfield again offered a very similar analysis in her chapter ‘Class and Gender in Twentieth Century Psychiatry.’ The chapter splits the twentieth century into four key phases; her work began by describing the period 1890-1929 as ‘custodialism under attack’¹² and then describing the era 1930-1953 as ‘integration and medical innovation.’¹³ Within this optimistic framework Busfield described the 1930 Act as “a major move away from the last resort philosophy that had governed the nineteenth century public asylums.”¹⁴

Furthermore, in his work Crammer offered a similar understanding of the 1930 Act. He argued that:

The Mental Treatment Act opened the way to outpatient clinics
and even beds in municipal hospitals for psychiatric patients,

⁹ C. Unsworth, *The Politics of Mental Health Legislation* (Oxford, Oxford University Press, 1987), p. 115.

¹⁰ P. Nolan, *A History of Mental Health Nursing* (London, Chapman and Hall, 1993), p. 10.

¹¹ *Ibid.*

¹² J. Busfield, ‘Class and Gender in Twentieth Century British Psychiatry: Shell Shock and Psychopathic Disorder’, in J. Andrews and A. Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Class and Culture in the History of British and Irish Psychiatry* (Amsterdam and New York, Rodopi, 2004), pp. 295-322, p. 297.

¹³ *Ibid.*, p. 299.

¹⁴ *Ibid.*, p. 300.

still as a ‘free’ service, a forerunner of the National Health Service... the 1930 Act represented a break with the past... [and] created the basis for modern British psychiatry.¹⁵

All of these works offer an invariably similar argument, that the 1930 Act represented a significant *break*, a *new phase*, a *shift away*, or a *major move away* from the past. Within these works it is overwhelmingly clear, with relation to 1930, that each author strongly emphasizes the new. This approach however simplifies and to some degree ignores developments that had already occurred in psychiatry prior to the 1930 legislation. For instance, this thesis has identified in Chapter Four that outpatient departments had already been operating in various asylums and localities for decades prior to the 1930 legislation, thus immediately identifying the weakness to Crammer’s argument above.

In many ways then, many of these similar accounts appear to merely take at face value the optimistic message that was disseminated by many critics working in the mental health sector at the time in which the act was legislated. In October 1930, *The Manchester Guardian* reported on an address by Mr L. G. Brock, Chairman of the Board of Control. The report outlined the Chairman’s speech and recorded his optimism for the 1930 Mental Treatment Act. He referred to the new legislation as an “enabling act,”¹⁶ which should be observed as an “*enormous advance* toward the treatment of mental disease the way they treated physical disease.”¹⁷ The histories provided above simply help to reinforce this optimistic message, by offering a summary of the “imaginary and much needed reforms”¹⁸ and ‘progressive’ ideas, which were arguably enshrined within the

¹⁵ J. Crammer, ‘Training and Education in British Psychiatry’, in H. Freeman and G. E. Berrios (eds), *150 Years of British Psychiatry*, Vol. II (London, Athlone, 1996), pp. 209-242.

¹⁶ Anon., ‘Mental Treatment: Improvements under the New Act’, *The Manchester Guardian*, 11 October 1930, p. 8.

¹⁷ *Ibid.*

¹⁸ Nolan, *A History of Mental Health Nursing*, p. 96.

new law. This summary of the new legislation appears to be informed by an analysis of the debate in the Houses of Parliament and Lords and the establishment of the Act in law, as opposed to providing any attempt at a systematic analytical assessment of how the new law was administered and implemented within the boundaries of either a local or national geographical area. As such, it is probably fair to say that the existing historiography relating to the Mental Treatment Act of 1930 and its wider social and cultural implications is, at present, limited in its diversity and character. As one of the most recently published scholars in the field, David Pearce explained, as yet “the impact of the 1930 Mental Treatment Act on the care of patients has attracted relatively little scholarly attention.”¹⁹

In response to this gap within our knowledge David Pearce has adopted a new approach to the analysis of the 1930 Mental Treatment Act within his more recently published work. This ‘new approach’ has clearly been influenced by the current trend within the recent historiography in mental health studies to provide regional, small-scale investigations into particular factors affecting patients and institutions relating to private and pauper lunatics and mental patients. Pearce’s chapter within Melling and Pamela Dale’s collected volume *Mental Illness and Learning Disability since 1850* in his own words “seeks to address the question of the influence of gender, families and social class on the admission, treatment and discharge of patients admitted to the Devon Mental Hospital at Exminster during the years 1931-38.”²⁰ By creating an in-depth analysis of how a piece of national legislation affected a specific region Pearce manages to create a quantitative history of the effect that the 1930 Act had at a local level. This more detailed approach provides a more useful insight into the actual role that the act had on individual patients

¹⁹ D. Pearce, ‘Family, Gender and Class in Psychiatric Patient Care during the 1930s: The 1930 Mental Treatment Act and the Devon Mental Hospital’, in J. Melling and P. Dale (eds), *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (Oxon, Routledge, 2006), pp. 112-130, p. 113.

²⁰ Ibid.

and their families during this period, as opposed to merely summarising the effect that the legislation *was supposed to have had* on these patients, as has been discussed in previous analyses.

In many ways the work by Pearce reflects a more statistically detailed local review of the Mental Treatment Act than earlier works. Similarly to many of these earlier histories however Pearce also offers an optimistic analysis of the new Act. In his chapter he argues that the “legislation of 1930 marked an important change in the ways in which people were admitted to, and treated within Britain’s mental hospitals.”²¹ Once again this conclusion stands in contrast to Bartlett’s hypothesis that “the nineteenth century presented a *remarkably similar set of options* to the twentieth when confronted with an insane person.”²² The work of these two writers provides an interesting dichotomy within the historiography of mental health provision. In contrast to Bartlett’s analysis, Pearce suggests that the 1930 legislation represented a significant or ‘important’ *change* to the admission and discharges of patients within the newly termed ‘mental hospitals’ in England and Wales.

In light of this particular debate, this chapter will assess to what extent this “great landmark in the history of legislation dealing with the treatment of mental disorder”²³ was in fact a landmark which created any *meaningful* difference in the admission and hospitalisation of the mentally ill in the interwar years, or whether it merely called for a change in semantics. This chapter will seek to assess how and why the West Riding Asylums Board came to be re-branded the West Riding Mental Hospitals Board and what changes, if any, this created. Following this, an analysis will be made of how long it took for the 1930 Mental Treatment Act to be legislated and how effective the act was when it

²¹ *Ibid.*, p. 115.

²² P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London, Continuum, 1999), p. 5.

²³ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 1.

was implemented. In part this will be measured by assessing the extent to which patients were admitted as both voluntary and temporary patients on both a national and local picture. The following sections of this chapter will attempt to give some qualitative insights into this topic, a subject that as yet remains chronically under-researched for this particular period of history. Using the patient case files of Wakefield and Storthes Hall, this chapter will explore: the process of applying for voluntary treatment, who applied for treatment and how a patient's socio-economic status and age may have affected their status upon admission. Lastly an analysis will be made of patient discharges from mental hospitals throughout the 1930s, before reaching a conclusion about how successful the Mental Treatment Act was in eradicating the stigmas of certification and thus contributing to a new era of mental treatment.

What the Act Enabled

The fact that so many historians have written so optimistically about the 1930 Act is perhaps unsurprising when one looks at the detail of the Act, and how it was welcomed by medical professionals at the time. The opening page of the Report of the Board of Control for the year 1929 testified to the excitement and optimism that was felt amongst the majority of mental health care professionals at the passing of the new legislation. The report rejoiced:

The outstanding event of the year was the introduction in November 1929 of the Mental Treatment Bill, which received the Royal Assent on the 10th July 1930. The Act is based, in the main, on the recom-

mendations of the Royal Commission ... We believe that this measure will come to be regarded as a great landmark in the history of legislation dealing with the treatment of mental disorder... we feel that anything which emphasizes the differences, perhaps inevitable differences, between the treatment of physical and mental disorders is prejudicial to the recovery from mental illness, and from a medical point of view, the more closely the procedure in both cases can be assimilated, the better are the chances of a patient's recovery... The new act is an encouraging sign of the growing education of public opinion.²⁴

For the first time in the history of mental health care in England and Wales the new legislation enabled two new classifications of people to come under treatment at a public mental hospital without the need for certification.²⁵ These two new groups consisted of 'voluntary' and 'temporary' patients. Under the wording of the legislation, voluntary patients were patients who, upon making written application to the Superintendent of a mental hospital to be treated should be received and admitted for treatment therein.²⁶ Crucially their admittance did not require the need for a reception order. Patients who were admitted in this way, and who were classified as 'voluntary patients' were also able to leave the hospital at any given time, by giving just seventy-two hours' notice (again in writing) of their desire to depart from the institution. Thus, theoretically at least, for the first time the patient was given some responsibility and also flexibility with regard to his or her own treatment.²⁷ In many ways this links into the ideas surrounding outpatient

²⁴ Ibid.

²⁵ The term 'public mental hospital' is important here, as private patients had been able to admit themselves to private clinics without certification for some time before the introduction of the Mental Treatment Act.

²⁶ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

²⁷ Ibid.

treatment, which were discussed in Chapter Four, where it was predominantly the responsibility of the patient to decide if they wanted or needed to undergo treatment and for how long.

The legal foothold of those within the temporary patient category was however slightly more ambiguous. The Board of Control explained:

The class of patient to whom this section applies is the person who is suffering from mental illness and is likely to benefit by temporary treatment, but is for the time being incapable of expressing himself as willing or unwilling to receive such treatment. The reception and treatment of such cases does not involve any order by the magistrate. There must be an application in the presented form and made, if possible by a husband or wife, or by a relative of the person to whom it relates, or a request of the husband or wife or of a relative by a duly authorised officer of the Board within whose area the person is.²⁸

Although this category sounds very similar to those patients certified under the 1890 Lunacy Act, there were in fact fundamental differences, which the Board of Control hoped would come to be observed as “an epoch-making change.”²⁹ They explained that the advantage of the temporary patient category was the absence of the “intervention of any judicial authority.”³⁰ This meant that the former rules whereby a patient must be declared a fit person to receive treatment in a public asylum by a magistrate could be bypassed.

²⁸ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1930), p. 173.

²⁹ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 2.

³⁰ Ibid.

However the real advantage of both the voluntary and temporary categories came with the absence of the need for certification. With relation to this, the Board of Control explained: “It is of utmost importance that the non-volitional patients, whose prospects of recovery may be favourable should have the chance of escaping the supposed stigma of certification.”³¹ An application for temporary treatment had to be signed by two registered medical practitioners. Temporary patients were allowed to be detained under this framework, against their will for a period of six months, at which time the Superintendent could appeal to the Board of Control for two extra periods of a further three months duration each. Following this time a patient must either be released (if still unwilling to undergo further treatment as a voluntary patient) or else be certified.³²

The final category of patients residing in mental hospitals after 1930 was the certified patients. These were the patients whose legal status with regard to admission was *not* affected by the Mental Treatment Act. As such, these patients continued to be admitted and certified according to the rules and legislation of the 1845 and 1890 Lunacy Acts. Under the remit of the new law however, these three categories were considered to be to some extent fluid, rather than stationary groups. This means that although a patient was admitted as one particular status, the patient could potentially find himself or herself placed into a different group as their illnesses progressed, improved or stagnated under the care of the professionals of the institution that they found themselves in.

It is clear that in theory the new act represented a “major move away from the last resort philosophy that had governed the nineteenth century public asylums.”³³ In her work Kathleen Jones argues that the 1930 Act was supposed to ‘bypass’ the older act, only using it when it was absolutely necessary.³⁴ Despite this however, the fact that certi-

³¹ Ibid.

³² NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

³³ Busfield, ‘Class and Gender in Twentieth Century British Psychiatry’, p. 300.

³⁴ Jones, *Mental Health and Social Policy*, p. 117.

fied patients continued to be admitted under the legislation of the previous lunacy acts identifies an immediate loophole to the creativity and effectiveness of the new act. In many ways it was not dissimilar to the way that people described as ‘mentally deficient’ could still be institutionalised under the 1890 Lunacy Act, after the legislation of 1913, as discussed in Chapter Two.

In addition to creating new categories of patients who could come under the scope for care, the 1930 Act made the use of more ‘modern’ terminology standard in psychological practice. The Act was designed to implement “important alterations in terminology reflecting the more enlightened view now taken in regard to mental illness,” by forbidding the use of words such as ‘lunatic’ and ‘asylum.’³⁵ The Mental Treatment Act has to be observed in conjunction with the 1929 Local Government Act, which provided the administrative framework for the 1930 Act to be imposed. Thus the first real semantic shift occurred with the legislation of 1929. The 1929 legislation formally abolished the Boards of Guardians who were set up under the Poor Law, and instead moved their authority to the new Public Assistance Committees, who were formally part of the council, or county borough council. In doing so, the Act broke up the remaining aspects of the Poor Law. Instead of the words ‘pauper’ and ‘Poor Law’ the legal nomenclature of choice became ‘rate-aided’ and ‘Public Assistance.’³⁶ In their 1930 Report, the Board of Control explained how the two pieces of legislation were entirely interrelated:

The dissociation of mental health services from the Poor Law Administration begun by the Local Government Act of 1929 has been carried a step further by the declaration in section 18 of the Mental Treatment Act regarding the status

³⁵ NA, MH 51/266, Correspondence (1930).

³⁶ Local Government Act 1929, [19 GEO. 5, Ch17].

of a rate-aided mental patient.³⁷

Within her work Kathleen Jones corresponds with this analysis by arguing that after the Local Government Act of 1929, “the Poor Law had ceased to exist, and much of the stigma of pauperism had gone with it. In the Mental Treatment Act of the following year, Parliament tackled the stigma of certification.”³⁸

However, despite the fact that the 1930 Act made changes to nomenclature compulsory, these changes had long been taking place. As it was stated in a special report of a sub-committee of the West Riding of Yorkshire Mental Hospitals Board after analysing the Report of the Royal Commission on Lunacy and Mental Disorder in 1926, “we would draw attention to the fact that the proposed new nomenclature has in fact already been widely adopted.”³⁹ The change in terminology was widespread across England and Wales, in some instances many years prior to the implementation of the Act.⁴⁰ Notwithstanding this however, the Board of Control was desperate to identify that this re-branding exercise of the 1920s and 30s was more than merely a change of semantics. To the Board of Control this change in terminology was part of the incorporation of mental health care within the broader sphere of physical medical health care as a whole. In their Annual Reports they argued:

Hitherto, the mental health service has been kept as it were, in a watertight compartment. Now it is recognised as being part, and a very important part, of the whole public health service.⁴¹

³⁷ WYAS, C85/1/15/14 Annual Reports of the Board of Control (1930), p. 2.

³⁸ Jones, *Mental Health and Social Policy*, p. 115.

³⁹ WYAS, C416/1/64, Minutes of the West Riding Mental Hospitals Board (1927), p. 108.

⁴⁰ WYAS, C416/1/55, Annual Reports of the West Riding of Yorkshire Asylums Board (1918), pp. 5-6.

⁴¹ WYAS, C85/1/15/14, Annual Reports of the Board of Control (1930), p. 14.

The West Riding Asylums Board, which was created from the legislation of 1912, officially became the West Riding Mental Hospitals Board in 1924.⁴² However, a series of fascinating debates documented within the Annual Reports of the West Riding Asylums Board suggests that as early as 1918 there was much confusion and discussion as to whether the Board was legally able to change the name of their asylums, and whether this would in fact be desirable. The Dewsbury Board of Guardians was the first to make the suggestion, and the Asylums Board subsequently discussed this in their Quarterly Meetings. In July 1918 it was reported that:

They had considered the communication dated the 30th March 1918 from the Guardians of the Dewsbury Union, suggesting that the term 'Mental Hospital' should, as far as possible, displace the designation of 'Lunatic Asylum' and that the use of the term 'pauper' should be discontinued.⁴³

After much discussion and explanation it was eventually decided that:

Although some County and County Boroughs were now designated 'Mental Hospitals,' legally, such hospitals were asylums, and in all official documents such as Reception Orders and Transfer Orders, they must be referred to as 'asylums' until the present law is altered.... [Thus] whilst sympathising with the intention of those who desire to

⁴² WYAS, C416/1/1/1, West Riding Asylums Act (1912) and WYAS, C416/1/1/2, West Riding Asylums Act (1912).

⁴³ WYAS, C416/1/55, Annual Reports of the West Riding of Yorkshire Asylums Board (1918), p. 5.

adopt the use of the name ‘mental hospital’... the official designation... cannot be altered.⁴⁴

This discussion is fascinating when compared with a following entry in the Minute Books of 1924. Although in 1918 it was resolved that changing a name without changing the law would be a useless endeavour, in 1924 the Board consented to do just that. A letter from the Secretary of the Ministry of Health dated the 8th November 1923 enquired as to whether the West Riding Asylums Board would “Concur [with] the introduction of an amendment to the Mental Treatment Bill, to provide that in the future the Board will be known as the West Riding of Yorkshire Mental Hospitals Board.”⁴⁵ The Minute Books document that in 1924, it was resolved that they would do just that, and in all subsequent documentation written by the Board, they were referred to as the West Riding Mental Hospital Board, and the four regional asylums were similarly referred to therein as Mental Hospitals.

This re-branding of institutional mental health care from Pauper Lunatic Asylums to Mental Hospitals came six years ahead of the 1930 Legislation, which formally changed the title of these institutions in law. In the 1930 Act, the West Riding Asylums Board had its own sub-section, along with the Lancashire Asylums Board, pertaining to how their names had legally changed in the law.⁴⁶ However, the debate to change the title of the institutions of the West Riding of Yorkshire took place entirely within a national framework of change. It would seem at least to the West Riding Asylums Board that the name change was merely a practice of a change in semantics, rather than any visionary attempt to reduce the stigma of mental illness and its treatment for institutionalised suf-

⁴⁴ Ibid., pp. 5-6.

⁴⁵ WYAS, C416/1/61, Annual Reports of the West Riding of Yorkshire Mental Hospitals Board (1924), pp. 7-8.

⁴⁶ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

ferers. Though overwhelmingly optimistic about the change in terminology, The Board of Control made clear that they knew that there were potential problems with changing the terminology and the reforms which were to be implemented by the 1930 Act more broadly. In their report they explained:

The provision of facilities for early treatment is of little use by itself until public opinion is educated sufficiently to appreciate the need for it... It is essential that the public should be taught to regard mental hospitals not as places of detention, but as places where treatment is provided for diseases from which recovery is often possible if treatment is begun at an early stage... [if this is not done] the change will become a mere alteration of a label, a mere detail of nomenclature.⁴⁷

This clearly highlights that even the Board of Control knew that a change in legislation and terminology alone would not necessarily be enough to convince a sceptical public to undergo treatment at an earlier stage of their illnesses. This factor appears to be one that has been conveniently ignored by many historians of the 1930 Act. What remains fascinating about the change in semantics however is that it appears to have been a change that took place from the bottom-up. The fact that many Mental Hospitals had changed their name before the legislation demanded this alteration seems to suggest that the legislation followed the popular trend, rather than led the innovation. This theory is unpacked in greater detail in the following section.

⁴⁷ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), pp. 2-6.

The Slow Process of Legislation

Although institutions could find ways to change their names prior to the change in legislation, the other arguably more significant changes, with regard to classifications of patients admitted to institutions, were forced to wait for a change in the legislature. As the section above suggested, both the Board of Control and many working within the profession had long anticipated the Mental Treatment Act. Indeed, though the Mental Treatment Act was finally passed in 1930, the legislation had taken over fifteen years to be brought onto the statute book. Therefore it can easily be argued that the sheer length of time it took to implement such ‘urgent’ legislation represents significant legal failings in the attempt to eradicate both pauperism and the necessity of certification in mental health care in the twentieth century. The first public suggestion made by the West Riding authorities of the need to change the legislation appears to have been made by Alderman B Crowther, who was the Chairman of the West Riding Asylum Committee. As part of the evidence that he gave to the Royal Commission on the Care and Control of the Feeble-Minded in 1906 he “raised various objections to the present system of lunacy administration.”⁴⁸ Amongst these objections he argued that he was of the opinion that it was:

Very desirable that the county councils should have the power to accept voluntary patients as boarders or paying guests without certification, so that when persons were getting depressed and felt symptoms of another attack they might be able to re-

⁴⁸ Anon., ‘Asylums for Lunatics: West Riding Suggestions’, *The Manchester Guardian*, 11 December 1906, p. 14.

turn voluntarily, without being certified.⁴⁹

The first real attempt to change the legislation along the lines suggested by Crowther above, came with The Mental Treatment Bill, which was introduced with the support of the Board of Control in 1915.⁵⁰ Despite the support of the Board of Control however, this bill never came to fruition in England and Wales even though similar legislation for the ability to treat patients without the need for certification already existed in Scotland, and for private paying patients in England and Wales.⁵¹ Furthermore, a similar Act was passed in 1915 in Australia, which became the Temporary Mental Treatment Act and Lunacy Act of 1915, a specific Act for the treatment of soldiers and sailors suffering from “mental disorder of recent origin, arising from wounds, shock, disease, stress, exhaustion, or any other cause.”⁵² In 1918 the Board of Control argued that a similar Act was needed in England and Wales for the treatment of the general (non-fee paying) public:

We believe that no proposal affecting the public health is more urgently needed or more pressing of improvement in national efficiency. The question of improved treatment of cases of incipient mental disorder and the training of the medical staff of institutions for the insane are closely connected, as both are dependent upon increased opportunities being furnished for

⁴⁹ Ibid.

⁵⁰ WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), pp. 1-2.

⁵¹ G. M. Robinson, ‘Correspondence – Emergency Bill for Mental Treatment’, *The British Medical Journal*, 15 May 1915, 868-869.

⁵² The Mental Treatment Act 1915, [6 Geo. V].

http://www.autlii.edu.au/au/legis/vic/hist_act/mta1915187.pdf (accessed 03/11/12).

clinical work, teaching or study.⁵³

This view was supported by *The Times* newspaper in January 1919. An article entitled 'The Lunacy Laws: Drastic Changes Urged' dramatically stated, "The Lunacy Acts and the Mental Deficiency Act are effete, and a drastic amendment of them is of urgent national importance."⁵⁴ One of the first changes insisted upon by both *The Times* and the Board of Control was "that the words 'pauper,' 'lunatic,' 'lunacy' and 'asylum' should be deleted from the Lunacy Laws."⁵⁵ Despite the support of the press however, there was no attempt within Parliament to legislate. In 1919, the Board of Control noted:

The Board regret that it was not found possible during the year to give practical consideration to the suggestions which they have put forward for the amendment of the law with the object of facilitating the early treatment of cases of incipient and unconfirmed mental disorder and they venture to reiterate their opinion that such a measure is of urgent importance to the health and welfare of the people.⁵⁶

Further attempts to pass similar legislation were tried, noticeably in 1923-24, but also without success, although this attempt did result in the establishment of a Royal Commission on Lunacy and Mental Disorder. In 1927, after the Royal Commission had given its findings, the Board of Control bemoaned:

⁵³ WYAS, C85/1/15/5, Annual Reports of the Board of Control (1918), p. 4.

⁵⁴ Anon., 'The Lunacy Laws: Drastic Changes Urged', *The Times*, 18 January 1919, p. 5.

⁵⁵ Ibid.

⁵⁶ WYAS, C85/1/15/6, Annual Reports of the Board of Control (1919), p. 2.

In our report for 1926 we discussed the recommendations of the Royal Commission on Lunacy and Mental disorder and with regret, we have to record that it has not been practicable to introduce legislation to facilitate early treatment... The need for this legislation is urgent, but our disappointment at the delay is tempered by our belief that the postponement is merely temporary and due to the extreme pressure on parliamentary time.⁵⁷

The view of the Board of Control appears to have been backed by the majority of medical superintendents of various mental hospitals, and the dissatisfaction of waiting for legislation to be passed is evident. At the tenth annual meeting of the Mental Hospitals Association, of which the West Riding Mental Hospitals Board was part, a paper was given which clearly highlights the frustration felt by many who were working within the psychiatric field. As one medical superintendent stressed:

We are still waiting and waiting and waiting for the lunacy reform bill... For years we have asked for the power to save these people from their affliction. Our local authorities are able and willing to relieve this distress, if they had the power. Royal Commissions are appointed to make enquiries, but when they report that something must be done and that reform is overdue and should be given precedence in parliament over other matters, the appeal seems to be met with almost callous

⁵⁷ WYAS, C85/1/15/12, Annual Reports of the Board of Control (1927), p. 1.

toleration... Incipient mental disorder is still untreated, except to a very limited extent. Those who have to receive public aid keep knocking for entrance and help outside closed doors. The government seems either unable, or unwilling to open the door for legislative relief. Everybody seems ready and willing to assist those who are physically sick or infirm... but [nobody seems to care for] the acute neurasthenic and the lonely and fretful worker, so harassed and worried that he or she is in daily dread of slipping uncared for into acute depression, which is the border line of lunacy... Almost everything- every other class and interest, tested or otherwise seems to find political precedence over the claims of those suffering from mental disorder.⁵⁸

All of this identifies that medical superintendents, doctors, nurses, and officials all considered legislation for the treatment of early disease to be both necessary and important. After the legislation was finally passed, the 1930 Mental Treatment Act was hailed as a “big step forward,”⁵⁹ a “change in wisdom”⁶⁰ a “beneficial provision”⁶¹ and a “great charter”⁶² by many working within the field of mental treatment in the early 1930s. However, the fact that the Act took well over fifteen years to be passed is very important and there is no other way to observe the delay of legislation which was considered to be so ‘urgently’ required, than as part of the “legislative inertia” that Bartlett argues is char-

⁵⁸ WYAS, C416/1/65, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1928), pp. 87-88.

⁵⁹ Anon., ‘Mental Treatment: Improvements Under the New Act’, *The Manchester Guardian*, 11 October 1930, p. 8.

⁶⁰ *Ibid.*

⁶¹ T. M. Davie, ‘Correspondence’, *The British Medical Journal*, 6 December 1930, p. 978.

⁶² J. H. Morris-Jones, ‘A Message of Hope’, p. 141.

acteristic of mental health legislation in the nineteenth and early twentieth century.⁶³

Implementing the 1930 Legislation: The National and Local Picture

Perhaps the most significant and thus most important point to stress with regard to the Mental Treatment Act of 1930 is how long it took for certain clauses of the act to come into effect in individual mental hospitals across the country. Indeed after taking so long for the bill to be passed, it took even longer to implement this *urgent* piece of legislation. Most noticeable in this regard was the time it took for many local doctors and related professionals to understand their roles and responsibilities for utilising the new categories of voluntary and temporary status. This problem was envisaged the moment that the act was placed on the statute book. In 1930 the Board of Control advised:

Some time must necessarily elapse before the effect of these far reaching changes can be felt, and the co-operation of the public, the medical profession and the local authorities will be necessary, if the benefits of the act are to be brought fully within the reach of those whom they are intended.⁶⁴

Despite this anticipated slow beginning however, in her work, Kathleen Jones suggests that the number of voluntary patients increased progressively throughout the 1930s. She explains “in the subsequent years [after 1931] voluntary admissions rose steadily. In 1932, the overall figure was seven per cent of total admissions. By 1936 it was 26.9 per

⁶³ Bartlett, *The Poor Law of Lunacy*, p. 5.

⁶⁴ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), pp. 2-3.

cent and by 1938 it had risen to 35.2 per cent.”⁶⁵ This analysis however distorts a truer picture, which instead highlights a fragmented, regional and uneven uptake of facilities enabled within the new act. The Annual Reports written and published by the Board of Control for the year 1931 highlight a much less distorted and more accurate picture of reality, one that reveals the fragmented nature of the implementation of the act across the individual mental hospitals in England and Wales.

It is of interest to record the extent of the response made during the first year’s operation of the Mental Treatment Act to the opportunity therein given to receive patients without certification... Of those hospitals which made a commencement in receiving voluntary patients, twenty-seven did so to the extent of less than 5% of their direct admissions, twenty in proportions ranging from 5-9%, fifteen did so to the extent of 10-14%, which having regard to the circumstances was not a bad beginning. Seven (Devon, Gloucester, W. Sussex, Isle of White, Exeter, Plymouth and Sunderland) did still better namely in proportions varying from 15-19%; and at seven, the proportion of voluntary patients amongst the direct admissions varied from 20% at Wakefield and E. Sussex, to 22% at Leicester City to... no less than 33% at the North Riding.⁶⁶

These dramatic regional variations identify the problems with Jones’ promising picture of national uptake. Although the extract only shows the progress made over the first year of

⁶⁵ Jones, *Mental Health and Social Policy*, p. 126.

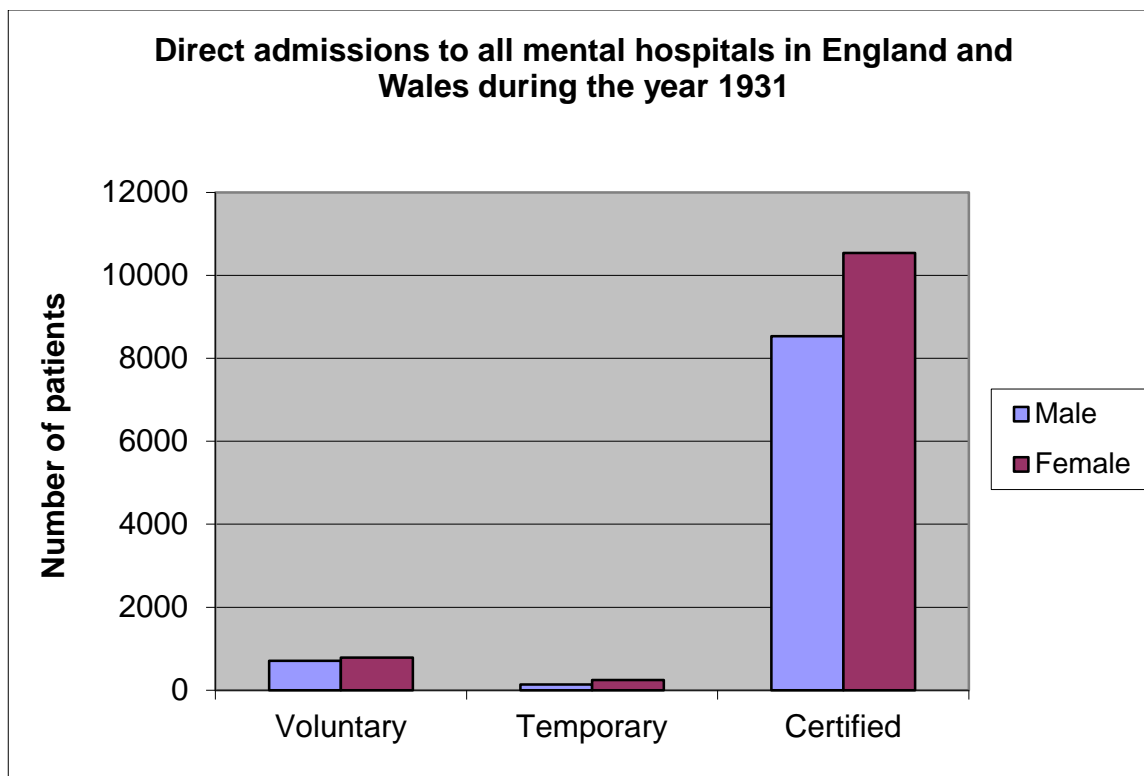
⁶⁶ WYAS, C85/1/15/15, Annual Reports of the Board of Control (1931), p. 28.

the operation of the new act, it does highlight the huge variations between regions and individual institutions. A major point of interest for this particular study is the specific institutions that are mentioned within the report. The report mentions by name both Wakefield Mental Hospital and Devon, highlighting them to be amongst the best institutions in the country for recruiting patients requiring, and subsequently applying for voluntary treatment.⁶⁷ This is interesting as Pearce neglects to mention in his work that this is the case at the Devon Mental Hospital, nor does he make any suggestion of the huge variations that occurred across the country.

It was these variations and fluctuations across the country that this report highlighted so effectively. The report illustrated that over the course of the year 1931 some hospitals were yet to receive a single voluntary case. It also highlighted how low the uptake amongst voluntary and temporary status was at the majority of the asylums. The extent to which the admission of certified patients outnumbered the two new categories in the first years of the operation of the Act is powerfully demonstrated in Table 5.1, which compares the level of admissions for the three statuses, voluntary, temporary and certified admitted to mental hospitals across England and Wales during the year 1931.

⁶⁷ Ibid.

Table 5.1: Direct admissions to all mental hospitals in England and Wales during the year 1931⁶⁸



Source: C85/1/15/15, Annual Reports of the Board of Control (1931).

The figures for 1931 highlighted in Table 5.1 identifies that in its first year of implementation the Act barely had any effect at all. The figures provided by the Board of Control identify that out of 20,945 patients directly admitted to public mental hospitals in the year 1931, only 1,864, or just fewer than nine percent of these consisted of the two new classifications of patients. Of these patients, voluntary patients accounted for fewer than 1,500 patients and the temporary classification made up the tiny proportion of 379 patients. These figures mean that nationally over ninety-one percent of patients continued to be admitted as certified patients in the year 1931.⁶⁹ These results strongly suggest that during the first years in which the new legislation of 1930 had been enacted, admission

⁶⁸ Ibid., p. 29.

⁶⁹ Ibid.

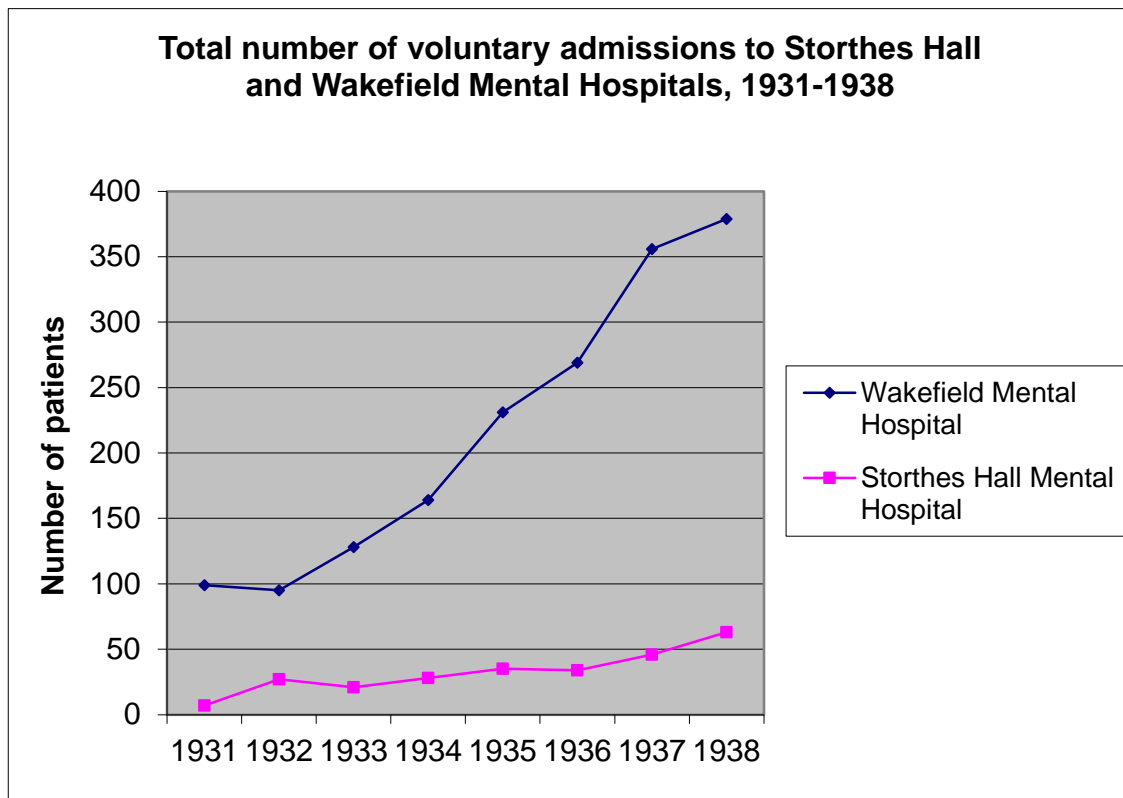
procedure in the early part of the twentieth century remained very similar to that of the nineteenth. Despite this however, the variation in uptake of the new act amongst different institutions, and the gradual, although uneven increase in the adoption of voluntary status amongst patients at all institutions over the following years, identifies that gradual changes *had* been taking place with regard to the admission of patients to mental hospitals throughout England and Wales.

Within his work David Pearce argues that the “legislation of 1930 marked *an important change* in the ways in which people were admitted to, and treated within Britain’s mental hospitals,”⁷⁰ and indeed, his own study of the Devon Mental Hospital seems to correspond with this viewpoint. As the extract from the Board of Control’s report highlighted above, this picture regarding the numbers of voluntary patients admitted to Wakefield Mental Hospital is similar to that recorded at Devon. As Table 5.2 identifies, at Wakefield, similarly to at Devon, the number of direct applications from persons requiring voluntary treatment rose steadily throughout the years 1931-1938, from just under 100 voluntary admissions in its first year, to a total of 379 voluntary admissions in the year 1938.⁷¹

⁷⁰ Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p. 115. My emphasis.

⁷¹ Both of these figures are substantially higher than those that Pearce found at Devon. For Pearce’s figures see the graph- Figure 6.1, *Admission of patients by legal status to Devon Mental Hospital, 1931-1938*, in Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p.116.

Table 5.2: Total number of voluntary admissions to Storthes Hall and Wakefield Mental Hospitals, 1931-1938⁷²



Sources: WYAS, C85/661- C85/667 Civil Register[s] of Voluntary Patients (1931-1938), and WYAS, C416/5/29- C416/5/30, Civil Register[s] of Voluntary Patients (1931-1941).

As Table 5.2 also identifies however, the proportion of voluntary admissions admitted to Storthes Hall Mental Hospital throughout these years is microscopic in comparison to that of Wakefield Mental Hospital. In contrast to the ninety-nine voluntary patients admitted in Wakefield in 1931, Storthes Hall attracted just seven voluntary applications. Furthermore, although this figure too increased throughout the years studied, by 1938, a year in which Wakefield received 379 direct voluntary applications, Storthes Hall re-

⁷² Figures for Wakefield - WYAS, C85/661 - WYAS, C85/667, Civil Register[s] of Voluntary Patients, (1931-1938). For the figures for Storthes Hall see WYAS, C416/5/29 - WYAS, C416/5/30, Civil Register[s] of Voluntary Patients (1931-1941).

ceived only sixty-three, a number far below that which Wakefield began with in the year 1931. In their Annual Report from the year 1931, the Board of Control suggested that:

The comparatively large numbers of both voluntary and temporary patients that have been received into [Wakefield] mental hospital under the Mental Treatment Act appear to be mainly due to the initiative of the Medical Superintendent [Dr Bolton].⁷³

What this initiative was remains un-explained by the Board of Control. However in the Medical Director's Journals it is very clear that Shaw Bolton was very aware and proud of the numbers of patients coming to his hospital for voluntary and temporary treatment. Although he offers no explanation as to why they came for treatment, for the final quarter of the year 1931 he reported, "one quarter of the admissions since the last report have belonged to the voluntary or temporary class."⁷⁴ Shaw Bolton's meticulous note keeping thereafter of the numbers and percentage of patients coming to his institution under the 1930 Act suggests an acute awareness and interest in these categories of patients.

In addition to the desires of the superintendent, another reason for the disparity between new admissions to the two mental hospitals may well have been linked to space. Throughout the 1930s all of the West Riding's Mental Hospitals were full, overcrowded, or at nearly full capacity. Of the four hospitals however, Wakefield was officially declared overcrowded. By 1930 Shaw Bolton explained in the Medical Director's Journal that:

⁷³ WYAS, C85/1/8/8, Minutes of the West Riding Mental Hospitals Board (1932-1933), p. 277.

⁷⁴ WYAS, C85/1/13/8, Medical Director's Journals (1926-1933), Nov 1931. Emphasis original.

As our numbers keep rising, it is becoming increasingly difficult, if not impossible to provide more official space in this institution without the provision of new buildings. I feel I cannot too urgently impress on the Committee the serious position in which we are faced.⁷⁵

In contrast to Wakefield however, throughout the early years of the 1930s, Storthes Hall was in a unique position of having spare beds.⁷⁶ In order to rectify this imbalance, in 1932 and again in 1933 many cases of chronic mental illness were transferred from Wakefield to Storthes Hall Mental Hospital in order to relieve the overcrowding at the former hospital: fifty patients were transferred to Storthes Hall from Wakefield in the year 1932 alone.⁷⁷ Ironically, by relieving itself of part of its chronic population, Wakefield may well have created space for more cases of acute insanity, leaving Storthes Hall filled with more incurable cases.

Overall the huge disparity between these sister institutions suggests the huge variations that were inherent within the individual and institutional implementation of the 1930 act. Perhaps in the cases of Devon and Wakefield, one could agree with Pearce's analysis that the 1930 Mental Treatment Act provided an important change in the way in which people were admitted to public mental hospitals. At Storthes Hall Mental Hospital

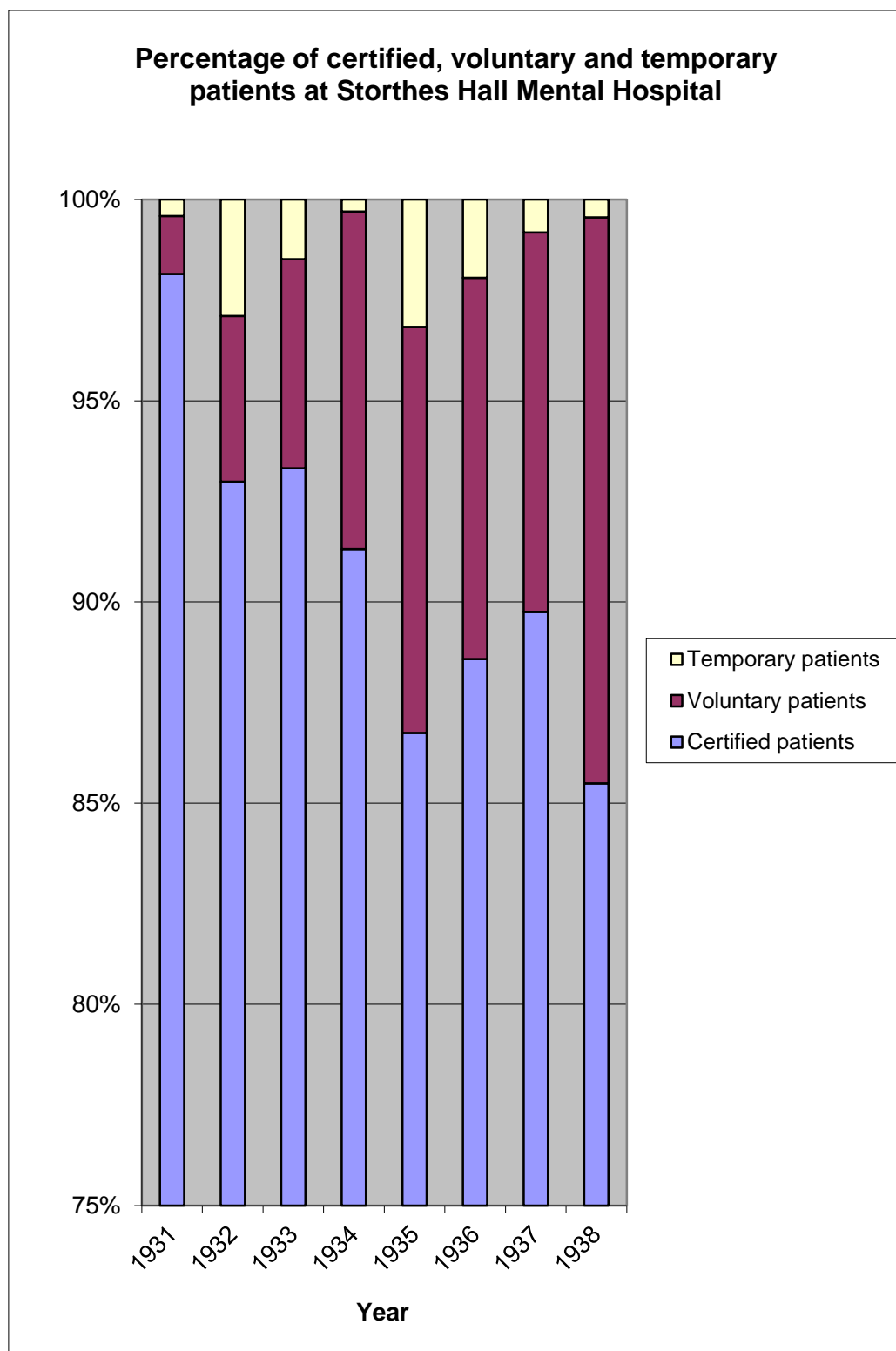
⁷⁵ WYAS, C85/1/13/8, Medical Director's Reports (1926-1933), Nov 1930.

⁷⁶ Spare beds were available at Storthes Hall Mental Hospital after the closure of the Ministry of Pensions Hospital in 1931. As Chapter 3 noted, many of the Service Patients who had been treated within the walls of the Ministry of Pensions Hospital were relocated to other Ministry and civilian mental hospitals. This process meant that the just over 300 beds became available again for the use of civilian cases of mental illness.

⁷⁷ WYAS, C85/1/8/10, Minute Books of the West Riding Asylums Board (1933-34), p. 75. For a quarterly review of the situation of overcrowding at Wakefield Mental Hospital, see WYAS, C85/1/13/8, Medical Director's Reports (1926-1933).

however, it would appear that actually little difference could be seen throughout these first eight years of the passing of the Mental Treatment Act, as for the most part, the vast majority of inmates were still being admitted as certified patients, under the legislation of the 1890 Lunacy Act. Table 5.3 below identifies the huge percentages of patients, both male and female who were certified and institutionalised in Storthes Hall during the years 1931 to 1938, in stark contrast to the percentages of those who came directly as either temporary or voluntary patients. Although it was theoretically possible that any number of these patients could still take advantage of the new act by having their status re-graded to either the voluntary or more rarely, temporary classification, as will be seen in a section on discharges, the actual admission of these patients would have had no bearing on the new 1930 Act.

Table 5.3: Percentage of certified, voluntary and temporary patients admitted to Storthes Hall Mental Hospital, 1931-1938⁷⁸



⁷⁸ WYAS, C416/5/29 - C416/5/30, Civil Register[s] of Voluntary Patients (1931-1941); WYAS, C416/5/18 - C416/5/23, Civil Register[s] of Certified Patients (1931-1939) and WYAS, C416/5/35, Civil Register of Temporary Patients (1931-1947).

Sources: WYAS, C416/5/29- C416/5/30, Civil Register[s] of Voluntary Patients (1931-1941); WYAS C416/5/18-C416/5/23, Civil Register[s] of Certified Patients (1931-1939) and WYAS, C416/5/35, Civil Register of Temporary Patients (1931-1947).

Table 5.3 suggests that even by the year 1938 the Mental Treatment Act was still in its infancy at Storthes Hall Mental Hospital. The graph shows the enormous percentage of patients being certified on admission, in comparison to the tiny minority of temporary and voluntary patients. These figures suggest that Kathleen Jones' analysis that the 1930 Act was supposed to 'by-pass' the 1890 Act, to "provide a framework of treatment which would make it unnecessary to use the older Act, except in extreme cases"⁷⁹ was simply not the case at Storthes Hall Mental Hospital. The graph highlights that the percentage of patients certified on direct admission to this particular hospital never fell below around eighty-five percent of the annual admissions during these eight years.

Thus, having observed the fundamental differences in the numbers of patients admitted to various institutions across the country, we now need to turn our attention to observe which types of patients applied to these hospitals for voluntary treatment, who was incarcerated under the temporary treatment category, and which type of patients continued to be admitted under the 1890 legislative framework. This section has highlighted the rationale for comparing the outcome of the act on two of the West Riding Mental Hospitals, which achieved two very different sets of results pertaining to the admission of the two new classifications of patients. The following sections will interrogate the possible differences in the admission procedure, treatment and the implementation of the act at a local level. Of course throughout this analysis it must not be forgotten that during the years that this chapter covers the numbers affected by the new legislation remain mini-

⁷⁹ Jones, *Mental Health and Social Policy*, p. 117.

mal, especially at Storthes Hall Mental Hospital. Despite this, it makes sense to analyse the available data to observe who was able to take advantage of this new legislation, who it catered for, and therefore what this can tell us about the act more generally.

The Process of Applying for Voluntary Treatment

As has been identified above the evidence clearly highlights that only a small minority of patients admitted to public mental hospitals after 1930 did so under the framework of the new legislation. This indicates that the idea that patients would happily submit themselves to voluntary treatment was a massive simplification. It would appear that many doctors had over-estimated just how many patients were “knocking for entrance and help outside closed doors” prior to the legislation of 1930.⁸⁰ Similarly, although it was noted by the West Riding Mental Hospitals Board in 1931 that “we have proof that there is no bigger factor today sending men and women mentally wrong than unemployment,”⁸¹ the Conservative Government’s worry that voluntary treatment in a public mental hospital would be a tempting source of three-square meals a day during the depression appears to be slightly misconceived. It appears that patients without any prior knowledge of the workings of a mental hospital were unlikely to have suddenly decided to admit themselves for treatment. Instead, many people suffering from various forms of incipient illnesses who subsequently became voluntary patients received some form of medical advice prior to applying to an institution for voluntary treatment.⁸²

In the West Riding of Yorkshire the evidence suggests that a large majority of pa-

⁸⁰ WYAS, C416/1/65, Minute Books of the West Riding of Yorkshire Mental Hospitals Board (1920), pp. 87-88.

⁸¹ WYAS, C85/1/16/10, Report of a Conference on Mental Hospital Accommodation (1931).

⁸² WYAS, C85/3/6/301, Medical Case Files (May-December 1935).

tients who eventually applied for voluntary treatment at one of the region's mental hospitals had initially sought advice from their local or family doctor.⁸³ From there, many patients were advised to seek more specialist advice and thus many were referred on to their local outpatient clinic. As was identified in Chapter Four, frequently it was the medical officer at the outpatient clinic who finally advised the patient (and often their families as well) as to their options surrounding voluntary inpatient treatment. It would appear from the evidence that there were many local doctors who used the services offered by outpatient clinics to provide a second opinion as to whether the patient was a suitable candidate for inpatient treatment. This was the case for forty-five year old Mrs C, a housewife from Doncaster, whose private doctor wrote a letter of referral after advising her to seek more expert advice at the outpatient clinic at Wakefield Mental Hospital. The letter explains "I feel it is a matter for psychological treatment and I will be much obliged if you could take the case in hand."⁸⁴ After Mrs C was seen at the clinic for the first time the attendants there agreed that her case was worthy of voluntary inpatient treatment. It was acknowledged that she had "a long history of repeated attacks of depression, with loss of the power of concentration, feelings of exhaustion and severe headaches" and she was advised to apply and subsequently accepted treatment at Sheffield Mental Hospital as a voluntary patient.⁸⁵ Another patient who applied for voluntary treatment after receiving guidance from the outpatient clinic at Wakefield Mental Hospital was Ethel B. The case notes identify that Ethel was a 43 year old epileptic with a seven month old baby who, in addition, was described as being very upset by the death of her father. Mentally she was described as being "in such a state of nervous exhaustion and depression that she is quite unfit to manage her home, and she promised to come up to Storthes Hall to ask for ad-

⁸³ Ibid.

⁸⁴ WYAS, C85/839, Case notes from the Wakefield Out-Patient Clinic (1930-1940), patient record no. 42.

⁸⁵ Ibid.

mission as a voluntary patient.”⁸⁶

Whether a patient had been seen at an outpatient clinic or not, nearly all of them had come to the mental hospital after receiving the advice of their family doctor.⁸⁷ However, the way in which this particular process was to be implemented varied frequently. A letter from the family doctor of one patient, Mrs S to the superintendent of Wakefield Mental Hospital explained, “Owing to a misunderstanding about voluntary patients, [Mrs S’s] husband did not come to me in the morning as arranged to get a letter for the hospital, but instead took his wife to hospital and then came and told me.”⁸⁸ The letter referred to in this particular case appears to be a brief hand written note explaining that the patient would like to come to the hospital for voluntary treatment, which was subsequently signed by the patient and acted as the formal evidence of proof of a patient’s application for voluntary treatment.⁸⁹

The journeys of these patients appear to be reasonably representative of how many of the patients found their way through the doors of a mental hospital as a voluntary patient. These journeys identify that many patients (and their families) sought medical advice prior to applying for voluntary treatment within a mental hospital. In some instances, this added layer of medical advice may well have added to the overall cost of the illness for the patient and these added pressures may potentially have acted as a barrier to patients from applying for voluntary inpatient care in the incipient stages of their illnesses. In addition, the fact that patients were often admitted to a different institution to the one which they visited for outpatient treatment (as has been shown above) again suggests that limited space in the region’s institutions may have meant that a patient was institutionalised further away from their families than would have been possible if there had

⁸⁶ Ibid., patient record no. 656.

⁸⁷ WYAS, C85/3/6/301, Medical Case Files (May-December 1935).

⁸⁸ WYAS, C85/3/6/330, Voluntary Medical Case Files (1937).

⁸⁹ WYAS, C85/3/6/301, Medical Case Files (May-December 1935).

been more available space.

Who Applied for Treatment?

The medical case files for voluntary and temporary patients admitted to Wakefield Mental Hospital in the early years of the implementation of the 1930 act offer interesting qualitative information about the patients who applied for treatment and what their reasons were for doing so. Although it must be remembered that these patients were only ever a small minority of hospital patients during these years, these records are important in helping us to understand how the 1930 Act worked in practice. As the new law dictated there were no reception orders for this particular group of patients; instead, on their admission to hospital patients received a similar document for the benefit of medical staff, a document referred to as a 'particulars of admission document.'⁹⁰ Much like a reception order however, this document recorded the patient's name; sex; religious persuasion; civil state; chargeability; occupation; date of application; whether first attack; whether previously treated in a mental hospital; age on first attack and the duration of the present attack and the supposed cause, if known. In addition to this, these documents helped the medical officers and nurses to keep track of whether a patient was considered to be epileptic, suicidal or dangerous.⁹¹

Patients applying for voluntary treatment came to the hospital suffering from a variety of mental conditions, from the most incipient worries and symptoms to often quite severe problems. The evidence does suggest that many patients were able to take up voluntary treatment who would not otherwise have been able to be admitted to a mental

⁹⁰ WYAS, C85/3/6/301, Voluntary Medical Case Files (1935).

⁹¹ Ibid.

hospital until their conditions had become much worse. Patients in this category might include thirty one year old Edith L who had been suffering from a 'state of depression' for two months,⁹² and Fred S who had been depressed for nine months after the death of his daughter.⁹³ Both of these patients recovered from their illnesses relatively quickly and subsequently left the institution cured. In addition to these patients the following patient- Daisy J- could easily be seen as the 'model patient' under the 1930 act. Her illness, state of mind, and recovery could well be seen as being exemplary of the new definitions of treatment under the new act. Daisy J was admitted to Wakefield Mental Hospital in August 1937 at the age of twenty-nine after suffering from 'anxiety neurosis' for a period of eight weeks before her admission. On admission to hospital she was noted to be "depressed and rather frightened by her illness." Despite this however it was also noted that:

She has insight into her condition, discusses the question of cause in a sensible and rational manner, and is anxious to be well again. She declares that the trouble started when she was fairly weak after her second baby was born, that she had attacks of 'feeling ill' at intervals for five weeks [afterwards], but then gradually passed off. Since then she has been 'poorly' at times, but has been in fairly good health until eight weeks ago.⁹⁴

Daisy's ability to discuss her illness in such detail clearly impressed the medical officer in charge. It is also very clear however, that a patient who was capable of communicating

⁹² Ibid.

⁹³ WYAS, C85/3/6/330, Voluntary Medical Case Files (1937).

⁹⁴ Ibid.

so rationally and openly about their difficulties would have found it extremely difficult, if not impossible to be certified under the older lunacy legislation. After a stay of just under one year as a voluntary patient in the hospital, Daisy was discharged recovered after requesting to go home. It is evident that Daisy's case represents a clear success story of the new act.⁹⁵

Despite the relatively frequent success stories of the new act however, the medical case files identify that many patients who admitted themselves to hospital under the new voluntary treatment category cannot be considered to be 'model patients' under the terms of the new act. Many of these cases include patients who did not come to hospital as early as wished following the onset of their illness. These patients included Amelia W, who had been suffering from 'melancholia' for two years before receiving treatment in Wakefield Mental Hospital in January 1938. On admission it was stated that, "she has been troubled with queer feelings going up her spine into her head... for the past two years."⁹⁶ In a letter to Amelia's husband two weeks after she was admitted to hospital the Superintendent explained, "Mrs W is suffering from a severe state of depressed nerves and it will probably be some considerable time before she makes a complete recovery."⁹⁷ More emphatically still, thirty-one year old Alice A was said to have been ill for five to six years, suffering from 'neurosis' before she applied for treatment. Her case notes suggest that her illness began after having a miscarriage, since which she had been in severe pain feeling "as though something would burst."⁹⁸ Moreover, thirty-seven year old Arthur H was noted to have been suffering from neurasthenia for six years and was finally persuaded to go to Wakefield for voluntary treatment after getting advice at the outpa-

⁹⁵ Ibid.

⁹⁶ WYAS, C85/3/6/301, Voluntary Medical Case Files (1938).

⁹⁷ Ibid.

⁹⁸ WYAS, C85/3/6/330, Voluntary Medical Case Files (1937).

tient clinic at Leeds General Infirmary.⁹⁹ His admission notes state that he was “full of complaints... He says that he has pains in the head... and is very annoyed because his neighbours were nasty because he was ‘being kept by the Guardians.’”¹⁰⁰ Arthur remained in Wakefield Mental Hospital from August 1936 to October 1937, when he discharged himself despite his doctor’s advice.¹⁰¹ All of these cases suggest that the Mental Treatment Act did not necessarily have the desired effect of bringing patients into public mental hospitals at an earlier and more incipient or treatable stage of their illnesses. This is problematic, as the key point of legislation was to bring patients into mental hospitals earlier. The Board of Control had adamantly asserted in 1929 that “from the point of view of both humanity and economy, treatment cannot begin too early.”¹⁰² Clearly however the desire to bring patients in sooner had little impact upon the patients noted above, and arguably their late admittance to hospital led to their continuing mental health problems.

In addition to the continued problem of patients coming to hospital for treatment too late, other patients who arrived at the mental hospital as voluntary patients did not necessarily fit the description of the type of patient that the Mental Treatment Act was seemingly designed for. Patients in this category include thirty four year old Charles B who was said to be suffering from ‘insanity with epilepsy.’¹⁰³ He was admitted on the 14th October 1937 after supposedly suffering from his condition for a period of three years. His admission notes explain that he was “quiet and amenable and gives quite a good account of himself. He is anxious that he should be seen in a fit, so that we may know his case better. Speaks readily, he is friendly and affable.”¹⁰⁴ One week later the

⁹⁹ Ibid.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

¹⁰² WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 1.

¹⁰³ WYAS, C85/3/6/330, Voluntary Medical Case Files (1937).

¹⁰⁴ Ibid.

case notes identify that he had had one fit since admission and two days after this insertion the notes explain that “he was discharged today, unimproved, at his own request.”¹⁰⁵ Similarly, thirty-eight year old Percy B was also admitted in October 1931 suffering the same condition, ‘insanity with epilepsy.’¹⁰⁶ His case notes identify that he had been suffering from this condition for a total of seventeen years before coming to the hospital. Again, identically to Charles B, it is also noted that he had never been in an institution for treatment before. Percy remained in the hospital for just two weeks, during which time he apparently had ten fits, before he was again discharged from hospital, unimproved at his own request.¹⁰⁷ For these two particular patients it would appear that there was little need or use for in-patient treatment, and potentially both patients could have received the necessary medication outside of the hospital walls. The fact that both patients discharged themselves unimproved after so short a period of time suggests problems with what certain patients expected from and also how they utilised public mental hospitals after the 1930 Act.

In addition to patients applying for treatment who were suffering from epilepsy however, other patients were admitted who were seemingly even less suitable for ‘voluntary treatment’ under the recommendations of the new act. Fourteen year old Frank B for instance somehow managed to be admitted as a voluntary patient by his mother in August 1937, even though his case notes clearly stated that he was suffering from ‘imbecility.’ His case notes identify many of the characteristics associated with mental deficiency. The Medical Officer explained, “he shows little evidence of intelligence, is foolish, childish, and grossly feeble-minded. He can only speak a few words...”¹⁰⁸ After one month of admission it was clear to the medical officer that this was not a suitable case for treat-

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid.

ment and his mother was subsequently asked to take him home “because of the difficulty” arising from his mental deficiency.¹⁰⁹ Cases such as this identify that sometimes the wrong type of patient could be admitted under the new legislation and the medical officers had to deal with the patient after their admittance. It is also more evidence to the effect that many patients suffering from mental deficiency continued to be left at home without any form of care or treatment, even if their families and relatives were struggling to look after them. Further it identifies that the actual implementation of the Mental Treatment Act may have been substantially less successful than even the quantitative figures suggest.

Social Class and Admissions to the West Riding Mental Hospitals after 1930

For many doctors, psychiatrists and politicians one of the main principles of the 1929 and 1930 acts were to provide the poor of the country with the same opportunities that fee paying patients had been able to take advantage of at private clinics for many years. When the 1930 Act was finally passed, the Labour Minister, Dr Morris-Jones who was the last speaker in the House of Commons on the debate, described the Mental Treatment Act as:

A great charter for the poor of this country... for the first time it gives the poor as great a chance as the rich. I think the Bill gets away from the spirit of detention to that of prevention and treatment.¹¹⁰

¹⁰⁹ Ibid.

¹¹⁰ Morris-Jones, ‘A Message of Hope’, p. 141.

Surprisingly the research that has been carried out on the implementation of the 1930 Act suggests that, in practice, those who benefited from voluntary admission to public mental hospitals were often people of a higher socio-economic stratum. Within his analysis, Pearce suggests that, “an important consequence of the new legislation was to encourage greater use of the public mental hospitals by more affluent groups, including lower middle-class salaried employees.”¹¹¹ Similarly in her work Joan Busfield argues that, “voluntary admission was accepted much more quickly for private than for pauper patients. In 1936, sixty per cent of private admissions to public asylums were voluntary compared with only thirty-two per cent of rate aided admissions.”¹¹² In this excerpt her figures are taken from the national figures of the Board of Control for the year 1936.¹¹³ Clearly then, this analysis suggests that a patient’s social class and occupation had a big impact upon which category they were likely to be admitted under. Again, as Pearce explains, “The evidence from the Devon case suggests that there were clear social class differences in the background of the different categories of patient and whereas ‘labourers’ were noticeably more likely to enter Exminster as certified patients, clerks and similar salaried employees were more evident amongst the voluntary intake.”¹¹⁴ The analysis put forward by both Busfield and Pearce seems to suggest that on some levels the Act may well have been counter-intuitive. Rather than merely providing a new opportunity for treatment for society’s poorest, in some places it would seem that the act gave a green light to the lower income middle classes to receive voluntary treatment at a much cheaper public institution.

¹¹¹ Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p. 115.

¹¹² Busfield, ‘Class and Gender in Twentieth Century British Psychiatry’, p. 301.

¹¹³ WYAS, C85/1/15/21, Annual Reports of the Board of Control (1937).

¹¹⁴ Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p. 118.

A similar picture to Devon Mental Hospital can be identified when we observe the occupations of the voluntary patients admitted to Storthes Hall. Akin to the certified patients, occupations such as domestic servant; housewife; builder; labourer; miner and mill worker predominate as the main occupations of the rate-aided patients receiving voluntary care.¹¹⁵ In addition to these occupations however, the voluntary category also included more people working in white-collar occupations. These occupations included clerks; a shop assistant; a typist; a library assistant and no less than four school teachers.¹¹⁶ This apparent tendency for white collar workers to admit themselves voluntarily to an institution for treatment may well suggest that there was less stigma involved in voluntarily admitting oneself for a short term of treatment, rather than being certified as insane. Arguably, as Melling explains within his work, this may have been more important to those who worked in more 'respectable' white-collar occupations.¹¹⁷

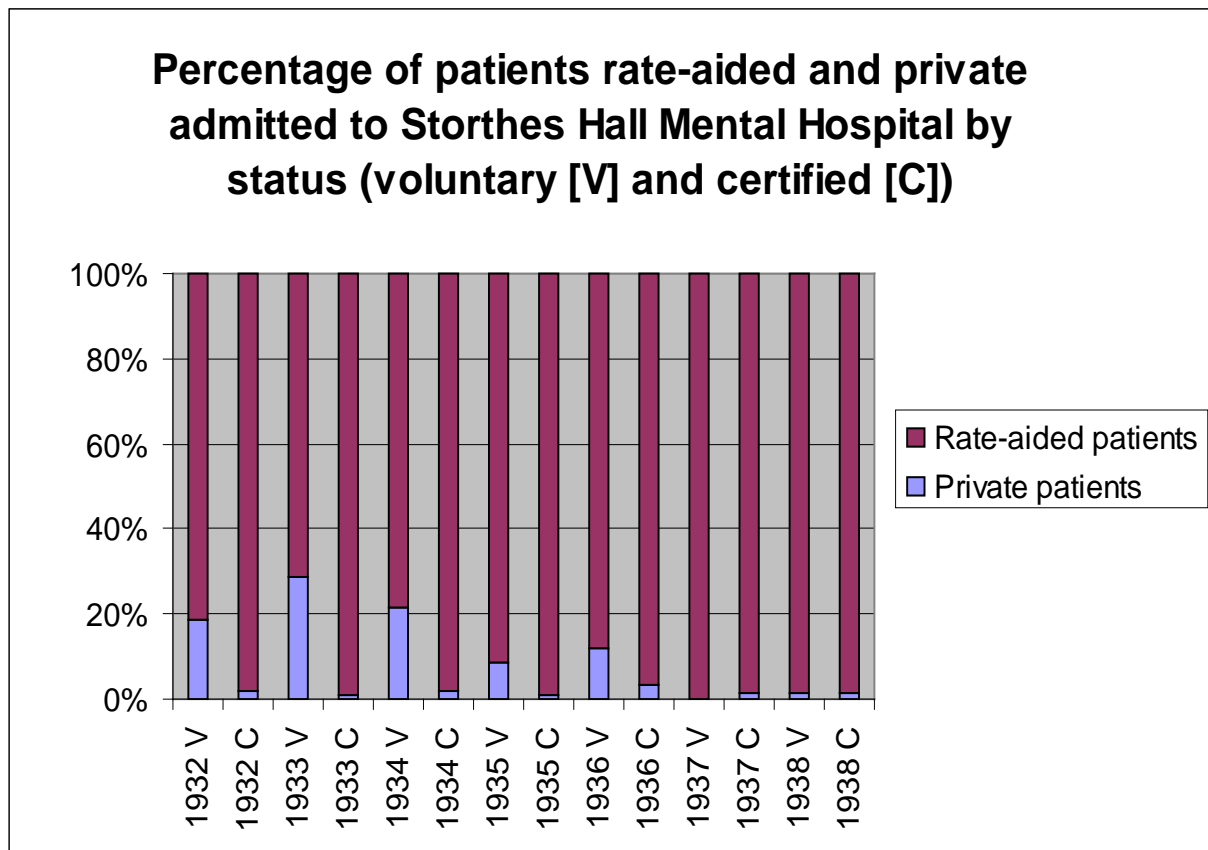
Table 5.4 below identifies the percentage of rate-aided and private patients admitted into both the voluntary (V) and certified (C) categories of Storthes Hall Mental Hospital during the early years of the implementation of the Act.

¹¹⁵ WYAS, C416/5/29 - C416/5/30, Civil Register[s] of Voluntary Patients (1931-1941).

¹¹⁶ *Ibid.*

¹¹⁷ See Melling's analysis of the stigma of certification and the Governess: J. Melling, 'Sex and Sensibility in Cultural History: The English Governess and the Lunatic Asylum, 1845-1914', in *Sex and Seclusion, Class and Custody*, pp. 177-222.

Table 5.4: Percentage of patients rate-aided and private admitted to Storthes Hall Mental Hospital by status (voluntary [V] and certified [C])¹¹⁸



Sources: WYAS, C416/5/29- C416/5/30, Civil Register[s] of Voluntary Patients, (1931-1941) and WYAS, C416/5/18- C416/5/23, Civil Register[s] of Certified Patients, (1931-1939)

The figures for Storthes Hall Mental Hospital appear to support the tendency found in Devon where Pearce claims that “voluntary patients were significantly more likely to be privately funded”¹¹⁹ than private patients entering the hospital who had been certified. Table 5.4 also suggests that although the majority of the patients in both the voluntary (V) and certified (C) categories were rate-aided as opposed to private patients, the tendency for private patients to be admitted to the institution as a voluntary patient rather

¹¹⁸ The year 1931 has been deliberately omitted from this graph, as there were only 7 patients admitted within this year: 3 private patients and 4 rate-aided patients. Such tiny figures distort rather than help reflect reality. Ref: Figures for Storthes Hall- WYAS, C416/5/29 - C416/5/30, Civil Register[s] of Voluntary Patients (1931-1941).

¹¹⁹ Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p. 119.

than being admitted after certification can easily be identified, especially in the earlier years of the implementation of the Act. This tendency for more affluent groups to take advantage of the new legislation seems to suggest that at this particular institution, private patients were able to take advantage of the new legislation by being able to reside in cheaper non-private accommodation, without the need for certification, or the stigma of staying inside a *pauper* institution after the 1929 Act.

A very similar picture to the voluntary intake can also be observed with regard to the temporary patient category both nationally and also locally at Storthes Hall Mental Hospital. On a national scale, the Board of Control were growing increasingly dissatisfied that the new law seemed to be disproportionately favouring those with more money, whose families arguably had more of an influence in the admission procedure of a relative. The concerns of the Board of Control were especially large with relation to the temporary patient category. With reference to the much smaller take-up of the temporary category and to the disparity of social class with regard to temporary patients, the Board of Control reported:

To some extent this is no doubt due to the fact that doctors in general hospitals have not yet become fully acquainted with the possibilities which the new act offers of treating those cases without certification. But the fact that the proportion of temporary patients is much higher in the case of private patients suggests that the considerations of cost also enter into the matter... if there is a second fee to be paid (with regard to getting a second medical recommendation needed for [temporary] admission), we fear that *in some areas rate-aided patients are de-*

*prived of the benefit which parliament meant to give them.*¹²⁰

It would appear that various imbalances in the admission procedure, namely the cost of having to secure the recommendation of two medical practitioners, meant that in reality the full effects of the temporary category were withheld to many poorer patients. This was an embarrassing early discovery for the Board of Control who had earlier announced that it was “of utmost importance that the non-volitional patients, whose prospects of recovery may be favourable, should have the chance of escaping the supposed stigma of certification.”¹²¹

This can tell us much about the scope of the legislation, and its primary failure in accomplishing what it set out to achieve. It is true that for the first time the Act put the poor on a (more) equal footing with private patients, as can be seen by the fact that the increase in voluntary classification throughout the years 1931-1938 was primarily made up of rate-aided patients. However, there is also evidence to suggest that the Act also catered for the more affluent groups who were unable or less able to pay for expensive private care in specialist clinics, but who could afford to contribute to their care and whose relatives arguably knew the advantages of escaping the stigma associated with certification. The reality of the cost-factor involved in becoming a temporary patient however may well have meant that many poorer patients were actually discriminated against, when it came to avoiding the stigma of certification.¹²² Again, this fact highlights a considerable problem with the histories that offer such an optimistic analysis of the new act.

¹²⁰ WYAS, C85/1/15/15, Annual Reports of the Board of Control (1931), pp. 3-4. My emphasis.

¹²¹ WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 2.

¹²² WYAS, C85/1/15/15, Annual Reports of the Board of Control (1931), pp. 3-4.

Hierarchies of Treatment and the Problems of ‘Voluntary’ Admission

Another factor which might have linked to the propensity for those of a higher socio-economic status to submit themselves for voluntary (and be submitted to temporary) treatment may well have been linked to the fact that the two new categories of voluntary and temporary patients appear to have received a very special status within the wards of public mental hospitals after the 1930 act. This special status that these particular patients were granted does not appear to have been shared by the patients who had been, and were continuing to be, certified in significant numbers under the older Lunacy Acts. A rare bundle of correspondence exists from a leading doctor working at Wakefield Mental Hospital, which identifies the differences between these two new classifications of patients and those who had been certified. The correspondence was between Dr Wilson, a senior doctor at Wakefield Mental Hospital and Mr Nutter, a Probation Officer for Leeds Crown Court, and it identifies fascinating anecdotal evidence as to how the Act was personally interpreted and implemented at Wakefield Mental Hospital.

The correspondence regarding seventeen year old William B began by Mr Nutter asking if a member of staff would be willing to examine this particular boy at the hospital's outpatient clinic. It was explained that the boy had had “a good education... and has been employed as an apprentice engineer.”¹²³ Despite this he was continuously in trouble with the magistrates for various offences including stealing and also firing a missile from a gun. Within the correspondence it seems clear that the boy's social class was linked to the Probation Officer's special interest in the case. Included within the letters is a report that was sent to Dr Wilson describing the boy's home surroundings. The report identified that the boy's home was ‘excellent,’ that there was “a sitting room and a dining room”

¹²³ WYAS, C85/839, Case notes from the Wakefield Out-Patient Clinic (1930-1940).

and that it was “clean and well furnished.”¹²⁴ In addition the doctors were informed that although the boy’s father was deceased, the mother was the proprietor of a nursing home. Moreover, it was made very clear that the boy had a “good education having been at college in Harrogate.”¹²⁵ After his elaborate description of the boy’s class and socio-economic position, the Probation Officer enquired whether Dr Wilson would be prepared to accept the boy as an inpatient to the hospital. Hinting that the reason may be class-based, he explained, “I am of the opinion that it would be fatal to the boy’s future if he was committed either to Borstal or to prison.” Leaving the issues of social class to one side for the moment however, Dr Wilson’s final response within this correspondence is fascinating for what it can tell us about the actual differences that existed between the three groups of patients, voluntary, temporary and certified. For this reason, the letter has been quoted at length:

Dear Mr Nutter,

If the authorities at Stamford Sessions decide that it is advisable for him to have treatment for his mental condition, we would be willing to admit him to this hospital.

If he is unwilling to come as a voluntary patient, and is mentally suitable for certification we could admit him as a certified patient.

We would of course, much prefer it if he would agree to the course that he make an application to be admitted to this hospital as a voluntary patient. Not only does this course relieve him from the stigma of certification but it makes the relationship between the doctor and the patient much more pleasant and engenders a feeling that we are making friendly efforts to help him adjust to normal life.

In actual practice, one very serious condition arises. Any voluntary patient can give us up to 72 hours’ notice of his intention to leave this hospital, and we have no legal hold over him whatsoever. We should therefore, appreciate the action of a judge in making some proviso such as this- that he is put on probation for say, one year, if he voluntarily submits to enter a mental hospi-

¹²⁴ Ibid.

¹²⁵ Ibid.

tal for treatment and promises not to discharge himself except with the approval of the medical superintendent that he has recovered from his disability.

In this case, any premature giving in of notice is reported to the authorities, and he remains liable to be dealt with as the judge directs...¹²⁶

This letter suggests that one of the outcomes of the 1930 Act was to create a ‘superior’ class or category of patient. The letter from Dr Wilson explains that the voluntary classification was preferable and explains that this was linked to the absence of the “stigma of certification” and a more friendly relationship between the patient and the staff, presumably as the patient was (theoretically) free to leave the institution with just 72 hours’ notice. Another perhaps more controversial analysis that could be applied generally about the voluntary class is that the voluntary patient might in many ways be preferable to asylum staff, as they were often less difficult to deal with than many more severely handicapped, chronically ill and certified patients with behavioural difficulties. The admission documents of patients admitted as voluntary patients suggest that many of these patients were much calmer than many of the certified patients, relatively few documents indicate that the patients were ‘suicidal’ and even less indicate that the patients were ‘dangerous.’¹²⁷

Another point of significant interest with regard to this correspondence is that of free will and what constitutes as volitional treatment. Undoubtedly in relation to the boy’s circumstances, under this context, it is difficult to observe how William B would have ‘voluntarily’ submitted himself to treatment if he had not otherwise been facing a jail sentence or he had not been coerced in some way. Although it is clear that this particular case was evidently an exceptional situation, this does raise interesting issues sur-

¹²⁶ Ibid.

¹²⁷ WYAS, C85/3/6/301, Medical Case Files, ‘Peculiarities of Admission’ files (1935).

rounding the concept of volition and accepting ‘voluntary’ treatment without coercion. Indeed, although far fewer patients were considered to be ‘dangerous’ or ‘suicidal’ in their admission notes, a handful of these particular patients did remain extremely difficult and troublesome, such as thirty-seven year old Arthur H, who was noted to be “hostile and aggressive” on admission.¹²⁸ This difficult behaviour may well have been connected to problems that existed around a patient’s *voluntary* residence in a public mental hospital.

Many surviving letters in the case notes identify that a patient’s family was instrumental in the decision process of admitting individuals to inpatient care, even when the individual was admitted as a voluntary patient. A letter written from Clayton outpatient clinic in 1938 to the private doctor of fifty-six-year-old Charles A explained the importance of not only medical advice, but more importantly, the co-operation and persuasive powers of family members to persuade their kin to opt for treatment:

I saw the above named yesterday at Clayton Clinic... He requires institutional treatment and I hope that you will be able to persuade his people to permit him becoming a voluntary patient... If it is insisted that he should stay at home then I am quite prepared to see him regularly at the above clinic, but I must repeat that hospital care is the only real kind of treatment for this type of patient.¹²⁹

This letter and many similar cases link into the work carried out by McGarry and Cho-

¹²⁸ WYAS, C85/3/6/330, Voluntary Medical Case Files (1937).

¹²⁹ WYAS, C85/840, Case notes from the Clayton Out-Patient Clinic (1930-1940), Box 1, A-G, patient record no. 319.

doff who argued that no patient would voluntarily submit himself for treatment without some degree of persuasion or coercion, usually from a close member of kin.¹³⁰ Certainly this level of persuasion and coercion is a factor that is evident in many of the voluntary patients' circumstances and raises questions about a patient's ability to make clear independent choices whilst suffering from mild nervous and mental complaints and disorders.

Age, Status and Familial Relationships with regard to Admission

Section 1, paragraph 2 of the Mental Treatment Act gave the right for any parent or guardian to admit a child who was under the age of sixteen to a public mental hospital for treatment under the 'voluntary patient' category if their application was accompanied by a medical recommendation.¹³¹ The fact that children under the age of sixteen had not, and legally *could not*, come to the hospital for treatment under their own volition highlights yet another significant loophole in the problem of assessing a patient's ability to apply for treatment voluntarily. An analysis of the admission records for the voluntary cases at Wakefield Mental Hospital identifies that a small minority of the patients admitted during the course of an average year consisted of patients under the age of sixteen years.¹³² In the cases of these children, who were clearly too young to apply voluntarily for treatment within the hospital, it was the responsibility of their closest parent or guardian to make the application on their behalf. An examination of these youngsters admitted into the voluntary category by written application from their parents at Wakefield Mental Hospital during the years 1931-1936 highlights that at this institution the mother and fa-

¹³⁰ L. McGarry and P. Chodoff, 'The Ethics of Involuntary Hospitalization,' in S. Bloch and P. Chodoff (eds), *Psychiatric Ethics* (Oxford, Oxford University Press, 1981), pp. 203-219, p. 210.

¹³¹ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

¹³² WYAS, C85/661-665, Civil Register[s] of Voluntary Patients (1931-1936).

ther appear to be equally involved in the process of the admission of their children, as almost fifty percent of the petitions came from either the mother or father respectively.¹³³

In comparison to the relatively large proportion of children admitted to Wakefield Mental Hospital under the voluntary category, usually none of the certified patients were between the ages of 0-9 and of the few in the category 10-19 years, only a very small fraction of these were under the age of fifteen.¹³⁴ These findings are also representative of the cases admitted to Storthes Hall Mental Hospital, although, in the case of the youngest certified patient admitted in 1931, a girl of twelve years old, the admission register recognised that she would be much better placed in a mental defective institution.¹³⁵

This pattern whereby younger patients were more likely to be admitted under the voluntary category than older patients is again repeated with those old enough to apply for treatment for themselves. The largest group of patients in the voluntary category for the year 1934 fell into the age group of twenty to twenty-nine years old.¹³⁶ Equally, as Table 5.5 below suggests, the certified patients represent a much older proportion of the hospital population than the voluntary cases, with patients far more likely to fall within the categories sixty to sixty-nine and seventy to seventy-nine than the voluntary patients. Further too, patients falling into the age group eighty to eighty-nine were made up solely of certified patients. Although as Pearce suggests, “attempting to understand the importance of family and kinship ties from such sources is not an easy task;”¹³⁷ the unwillingness of this older section of certified patients to admit themselves for voluntary treatment suggests that the role of the family remained strong in the 1930s in the decision to

¹³³ Ibid.

¹³⁴ WYAS, C85/650-655, Civil Register[s] of Certified Patients (1931-1936).

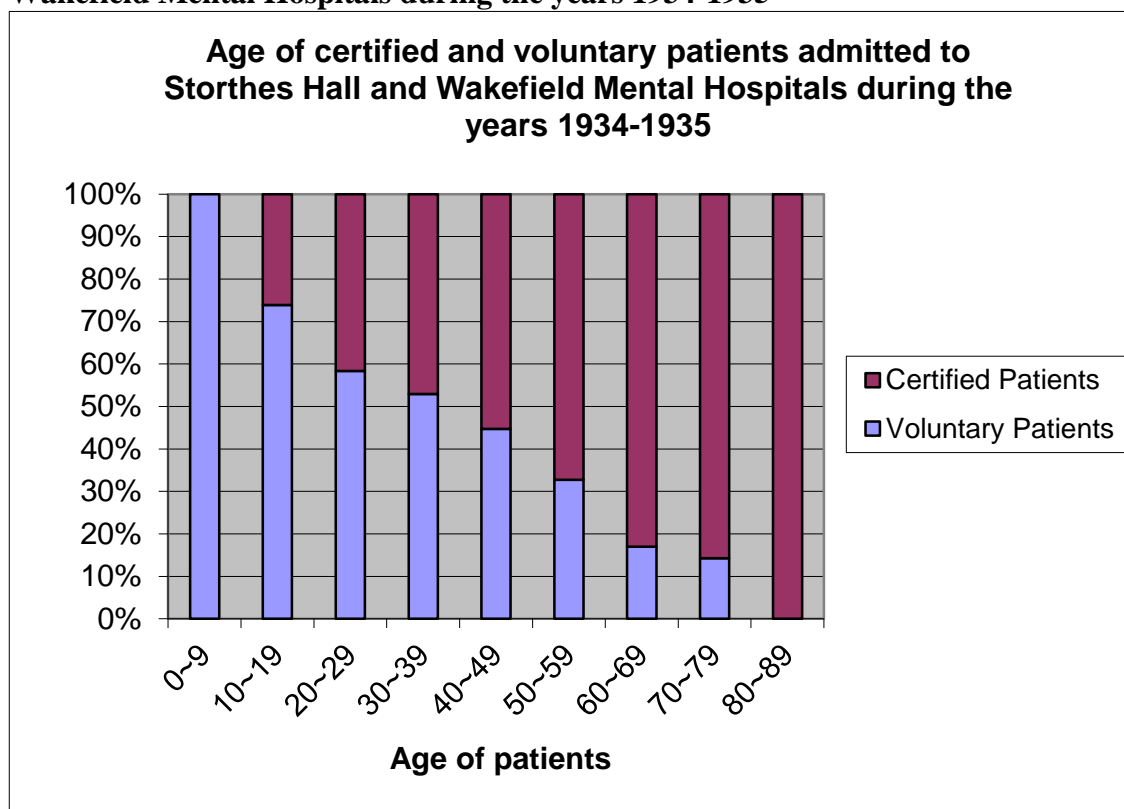
¹³⁵ WYAS, C416/5/19, Civil Register of Certified Female Patients (1931-1932). This is also more evidence for the argument in Chapter 2 that mentally deficient children continued to be admitted to asylums and mental hospitals long after the introduction of the Mental Deficiency Acts (1913 and 1927) and establishment of ‘more suitable’ places of care.

¹³⁶ WYAS, C85/663, Civil Register of Voluntary Patients (1934).

¹³⁷ Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p. 117.

commit their less productive members into institutional care.

Table 5.5: Age of certified and voluntary patients admitted to Storthes Hall and Wakefield Mental Hospitals during the years 1934-1935¹³⁸



Sources: WYAS, C416/5/21, Civil Register of Certified Patients (1933-1935) and WYAS, C416/5/29, Civil Register of Voluntary Patients (1931-1936).

Within the Admission Register for Certified Patients at Storthes Hall Mental Hospital a brief description was recorded, relating to the patient’s state of mind, behaviour and any particularly peculiar characteristics on admission to the hospital. These annotations however were only kept for about half way through the first year, 1931, at which point these types of observations stopped being kept within this particular book. Nonetheless these brief descriptions can give us an idea of some of the conditions of the certified patients

¹³⁸ WYAS, C416/5/21, Civil Register of Certified Patients (1933-1935) and WYAS, C416/5/29, Civil Register of Voluntary Patients (1931-1936).

on their arrival at the hospital.

Many of the older certified patients were noted to be suffering from ‘confusional insanity’ such as seventy-one year old George B, sixty-five year old Fred J and a slightly younger forty-four year old John S, amongst others. The descriptions of the characteristics of these patients’ symptoms are all very similar, being described as: “very disorientated temporally and spatially... [and] has many delusions of a persecuting nature [such as] every night people attempt to kill him.”¹³⁹ Similarly, John S was also noted to be “extremely confused, disorientated in time and space and quite unable to give any intelligible account of himself.”¹⁴⁰ These symptoms can again be witnessed in the cases of the older females who were also said to be suffering from the same affliction of ‘confusional insanity’. Seventy-three year old Sarah H for instance, was noted to be “confused and disorientated and incapable of giving any account of herself,”¹⁴¹ and seventy year old Mary B was described on admission as, “excited and restless, rambling and incoherent in her speech and unable to give any account of herself. She talks nonsense and does not know where she is.”¹⁴² Evidently for these patients, neither of the two new categories were particularly useful; none of the patients described above appear to have been in a fit mental state to apply for treatment voluntarily. Furthermore, it seems apparent that a preliminary six-months of treatment as a temporary patient would also probably not have cured them from their ailments. These cases highlight that perhaps even in the 1930s, for many patients’ relatives, the mental hospital still marked a “convenient dumping ground for confining the most troublesome”¹⁴³ or the elderly, who in their old age were increasingly becoming beyond the ability their relatives to care and control them in the domestic setting of the family home. As Dr Ewing, medical superintendent of Storthes Hall, pes-

¹³⁹ WYAS, C416/5/18, Civil Register of Certified Male Patients (1931-1932).

¹⁴⁰ Ibid.

¹⁴¹ WYAS, C416/5/19, Civil Register of Certified Female Patients (1931-1932).

¹⁴² Ibid.

¹⁴³ Andrew Scull, *The Most Solitary of Afflictions*, p. 135.

simistically remarked in 1931 the majority of patients over the age of 70 were “cases of irrecoverable forms of insanity.”¹⁴⁴

Other illnesses amongst the certified cases seemed to be those most likely to be thought of as the chronic illnesses and included patients suffering from mania, melancholia and senile melancholia, dementia and also cases of GPI which, as usual, were most likely to be suffered by male patients. There was little provision in the new 1930 Act that was catered specifically to benefit these types of patients; therefore for these patients, their experiences of mental health provision would not have been affected by the new legislation. For the younger and less chronically ill patients however, there was often the potential for either a full or else a partial recovery and thus theoretically the opportunity to be re-graded to either the temporary, or more likely the voluntary category. By having their statuses re-graded, such patients would have been able to benefit from what was arguably the most liberating feature of the new Act, the ability to discharge oneself with only seventy-two hours’ notice.

Discharges from the West Riding Mental Hospitals

For those of either the temporary or the certified class re-graded to the voluntary category, the majority used their new status to leave the institution within a very short space of time, usually within the space of two weeks and certainly not usually above one month.¹⁴⁵ Examples are numerous and include fifty-four year old Blanche W, a private patient, who after six months of being a temporary patient at Storthes Hall Mental Hospital was re-graded to voluntary status on the 8th March 1932 and left just over two weeks

¹⁴⁴ WYAS, C85/1/16/10, Report of a Conference on Mental Hospital Accommodation (1931), p. 6.

¹⁴⁵ WYAS, C416/5/29, Civil Register of Voluntary Patients (1931-1936).

later on the 26th March.¹⁴⁶ Similarly, after being detained as a temporary patient again at Storthes Hall for three months, Harry H, a rate-aided patient from Huddersfield, was re-graded to voluntary status, and departed the institution just four days later.¹⁴⁷ Such behaviour was extremely common and it is rare that patients stayed much longer than one month after having their status re-graded to a voluntary patient.

For those who applied and thus were admitted as voluntary patients a similar picture can be portrayed. On average, this class of patients usually stayed within the hospital as voluntary patients for longer than their re-graded counterparts, but also usually left within one year of their admission. Table 5.6 below shows the outcomes and discharges amongst voluntary patients of all types (re-graded and voluntary on admission) of persons receiving treatment as a voluntary patient at Wakefield Mental Hospital in the year 1931.

Table 5.6: Outcomes and discharges of voluntary patients admitted to Wakefield Mental Hospital in 1931¹⁴⁸

Discharged recovered	30
Discharged relieved	23
Discharged 'not improved'	23
Died	2
Changed status to temporary	2
Changed status to certified	2
Remained in the institution as a voluntary patient beyond one year	17
Total	99

Source: WYAS, C85/661, Civil Register of Voluntary Patients, (1931-1932)

Table 5.6 identifies that in the first year of the act over seventy-five percent of patients

¹⁴⁶ Ibid.

¹⁴⁷ Ibid.

¹⁴⁸ WYAS, C85/661, Civil Register of Voluntary Patients (1931-1932).

who were either admitted as voluntary patients or else had their status re-graded to voluntary status left the institution within twelve months of entering it. Of these seventy-six patients who left the institution however, twenty-three of them (almost a quarter of those who were admitted in 1931) were considered by their doctor to be 'not improved' on their discharge. This unimproved minority were likely to form the backbone of the patients of what became known as the revolving door policy of the mental health care system, whereby some individuals made the decision to pass in and out of the system as their illness lapsed and relapsed.

Ironically this group of people identify that one (re)occurring problem of voluntary treatment was the patients' ability to discharge themselves even though their doctors thought that their discharge was inadvisable. In essence therefore, the great success of the act could also be its greatest failure. This was the case for many patients who became regulars within the hospital walls after they left the institution without being treated successfully for their illnesses. This appears to be true of sixty-three year old Alice S, who was admitted to Wakefield Mental Hospital in 1935. Before 1935 she had frequently been in and out of hospital since her illness began when she was twenty-three. Despite her history of relapse however, within just a few months of treatment, she again gave her notice of discharge, prompting the Superintendent to write to Alice's husband, proclaiming:

Mrs S is still not recovered and is still depressed and miserable. However she insists upon giving her notice to leave the hospital and cannot be persuaded to reconsider her decision. As she is a voluntary patient it is of course within her

rights to do as she wishes.¹⁴⁹

Under the rules of the new Act, the Superintendent had no rights to hold a patient if they were not so ill as to be certified, and hence, Alice S was discharged once again not recovered from her illness.¹⁵⁰ Similarly, after being admitted in a “state of depression” on the 28th April 1938, thirty-one year old Edith B immediately asked to be sent home the next day; her case notes state that she “repeats ‘I want to go home, I am no better than I was yesterday.’”¹⁵¹ Although the medical staff “managed with difficulty to persuade her to stay,” her ability to be persuaded did not last long, and she was discharged just 12 days after she was admitted “at her own request, against medical advice,” unimproved.¹⁵² Although of course the ability to discharge oneself represents the great liberating feature of the act, for a large minority of people, this clause could also be seen to be an inherent failure of the system to provide ‘cures’ for people with acute illnesses.

This process of easy discharge set up in the 1930 legislation for the group of voluntary patients stood in stark contrast to the process of discharge for certified patients, which, in practice, continued as it had under the regulations of the 1890 Lunacy Act. The Reception Orders for these patients have been categorised and kept by date of death and discharge, and they reveal the process of a patient’s discharge within each corresponding year. The records highlight that many patients were discharged either relieved or improved after a petition of a friend or relative who had signed the ‘undertaking’ that the patient would be properly taken care of, prevented from injuring himself or others and importantly, would no longer be a burden upon the rates. Often this process was simple

¹⁴⁹ WYAS, C85/3/6/328, Voluntary Medical Case Files (1935).

¹⁵⁰ Ibid.

¹⁵¹ WYAS, C85/3/6/301, Voluntary Medical Case Files (1938).

¹⁵² Ibid.

and easy, especially when the patient had been showing good signs of recovery and the hospital were anxious to discharge the patient. A clear example of this can be observed in the case of fifty-seven year old Florence Annie H, a rate-aided patient from Wetherby. With regard to her discharge, the Medical Director wrote to her brother stating:

The Medical Director begs to inform Mr H that Miss F.A.H has now improved in her mental condition and is fit to live at home under certain conditions... she is especially anxious to return to her sister.¹⁵³

In this case her brother duly signed the undertaking and the patient was discharged relieved to the care of her relatives in February 1934, within one month of the initial Hospital correspondence.¹⁵⁴ This case illustrates that in the 1930s, for some patients little had changed with regard to the discharge procedure from institutional confinement. In Wright's study of Buckinghamshire in the mid nineteenth century he suggested that institutional decisions to discharge patients were usually dependent upon "the ability and willingness of the inmate's family to receive the person back into their household."¹⁵⁵ The evidence in the Reception Orders at Wakefield Mental Hospital suggests that for many patients certified and thus institutionalised within the 1930s, this dependency had remained unchanged.

In other cases however, especially those wherein the patient was likely and frequently prone to relapse, the process of discharge often took much longer and was, very

¹⁵³ WYAS, C85/3/1, Reception Orders (Dec 1933-April 1934).

¹⁵⁴ Ibid.

¹⁵⁵ D. Wright, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England: The Case of Buckinghamshire, 1853-1872', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society: A Social History of Madness in Comparative Perspective* (London, Routledge, 1999), pp. 93-112.

often, a painstaking process of negotiation between hospital authorities and a patient's family, who had become anxious to receive their loved one back into their care. The case of Dorothy M identifies this reality acutely. Tucked inside Dorothy's Reception Order is a series of correspondence between Dorothy's husband, his personal doctor and the Superintendent of Wakefield Mental Hospital. This correspondence is made up of no less than ten separate letters between these three bodies in a series of negotiations relating to whether in this particular case the hospital or the home was the correct locus of care, and if discharge could be secured, under what terms it should be. Eventually, after enlisting the help and advice of an 'impartial' personal doctor, Mr H managed to secure the release of his wife, but the correspondence is evidence that the procedure was neither straightforward, nor simple.¹⁵⁶

These stories highlight that the process of securing discharge regularly remained an onerous, often difficult and clearly sometimes daunting process of negotiation between a patient's relatives and the hospital authorities. This reality, teamed with the fact that certified patients remained the majority inmate population in mental hospitals, highlights that the idealism of the 1930 Mental Treatment Act expressed by writers such as Jones and Nolan remained a long way from the reality for many patients and their relatives during the 1930s. In addition to this, as mentioned earlier, different rules were also applied to 'voluntary' patients who were admitted under the age of sixteen. Similarly to those who were certified, these children too could only be discharged at the request of the family member or guardian who applied for the child to receive treatment.¹⁵⁷

Unquestionably the number of these petitions for discharge from patient's relatives concealed within the Reception Orders highlights that in reality few patients were

¹⁵⁶ WYAS, C85/3/1, Reception Orders (Dec 1933-April 1934).

¹⁵⁷ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

actually re-graded from certified to voluntary status. This meant that in actual fact, at these two particular institutions, the process of securing discharge remained in practice as closely assimilated with the 1890 Lunacy Legislation as was the patient's certification and order for removal to the hospital grounds in the first instance. What this can tell us is that despite the rhetoric that the 1930 Act could benefit more people than just those who consisted of the direct admissions to either voluntary or temporary status, this remained something of a rare reality. This shows a continuation of the anomaly highlighted by Scull, wherein he argued that in the nineteenth century the small number of curable patients "in contrast with the rest of the asylum only emphasized the more cruelly the bleak existence provided for the overwhelming majority of patients who were left to languish in the back wards."¹⁵⁸

Furthermore, the evidence identifies that for a large minority of voluntary patients the ability to discharge oneself without the advice and blessings of the medical officer in charge suggests that many patients may well have discharged themselves prematurely. Without doubt many patients like Mrs S departed the institution before it was considered that their illnesses were treated or even improved.¹⁵⁹ Arguably, a patient's premature discharge may well have had serious consequences for the patient's treatment regime, involving a further relapse at a later stage, and the need for even more costly inpatient care.

¹⁵⁸ Scull, *The Most Solitary of Afflictions*, p. 287.

¹⁵⁹ WYAS, C85/3/6/328, Voluntary Medical Case Files (1935).

Conclusions: The Ending of the Poor Law of Lunacy and Certification?

There is no doubt that when the 1930 Mental Treatment Act was finally passed, the majority of professionals working in the psychiatric sphere thought that the new legislation was a great step forward. This contemporary view appears to have been taken for granted by many historians who have written early histories of mental health care in the 1930s, without offering an analysis of primary qualitative and quantitative data. Their histories proclaim that the passing of the act represented a time of “great interest in the mentally ill” in the House of Parliament¹⁶⁰ and “a new phase”¹⁶¹ in mental health care as a whole, without evidence to back up this claim. Even David Pearce, who offers a more detailed critical account of the implementation of the act within a local area, argues that the act represented “an important change in the ways in which people were admitted to, and treated within Britain’s mental hospitals.”¹⁶² In contrast, my research has suggested that although the legislation of 1930 was an important legal and social step forward in the treatment of mental illness in its early and incipient stages, there were still *significant problems* with the Mental Treatment Act in the early years of its implementation. These problems appear to have been ‘conveniently’ ignored, overlooked or else forgotten by the earlier historians.¹⁶³

The fact that the 1930 Act took nearly fifteen years to come to fruition suggests that Bartlett’s concept of “legislative inertia” can be accurately applied to the legislation that governed the practice of mental health care throughout these years.¹⁶⁴ Moreover, the length of time that it took to implement certain aspects of the act further underscores this notion. An analysis of the first eight years of the implementation of the Act identifies that

¹⁶⁰ Jones, *Mental Health and Social Policy*, p. 118.

¹⁶¹ Nolan, *A History of Mental Health Nursing*, p. 10.

¹⁶² Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p. 115.

¹⁶³ Scull, *The Most Solitary of Afflictions*, p. 3, n. 3.

¹⁶⁴ Bartlett, *The Poor Law of Lunacy*, p. 5.

actually there were enormous fluctuations in the number of patients coming under the two new categories, voluntary and temporary. On a national level, the numbers were minimal and those coming under admission under the terms of the new act represented only a small minority of patients. A local breakdown of this picture identifies just how divergent uptake of the 1930 Act could be.¹⁶⁵ Whilst Wakefield Mental Hospital represented one of the best hospitals in the country with regard to people applying for voluntary treatment over the first years of the implementation of the act, the numbers at Storthe's Hall remained only a tiny fraction of the overall in-patient majority.¹⁶⁶

Clearly the fact that the majority of patients continued to be admitted to a public mental hospital as certified patients under the older lunacy legislation of the nineteenth century represents a failure in the new act to become the defining legislation of mental health care throughout these years. In addition, despite the wording of the new legislation, the majority of these certified patients, at least in the West Riding of Yorkshire, were never re-classified to either of the two new categories. Collectively, these two facts would have meant that the new legislation *never made any difference whatsoever* with regard to the ways in which many patients were admitted and discharged from a public mental hospital throughout the 1930s. Clearly this reveals that for the majority of patients the new act represented a failure in terms of legislative practice and practical implementation. Kathleen Jones' idea that the 1930 Act would "bypass" the older act clearly never came to fruition in the first eight years.¹⁶⁷

Despite this, however, for new patients coming to mental hospitals for treatment under the new legislation, many things had changed significantly. Though they only represent a small minority, the evidence suggests that this new group of patients may well

¹⁶⁵ WYAS, C85/661 - C85/667 Civil Register[s] of Voluntary Patients (1931-1938), and WYAS, C416/5/29 - C416/5/30, Civil Register[s] of Voluntary Patients (1931-1941).

¹⁶⁶ WYAS, C85/1/15/15, Annual Reports of the Board of Control (1931), p. 28.

¹⁶⁷ Jones, *Mental Health and Social Policy*, p. 117.

have benefited from the new act. Patients who submitted themselves for voluntary treatment came to the institution for short periods of time, and many of these were discharged 'recovered' or else 'improved' after getting treatment in a hospital without the need for the stigma of certification. However, even for patients who were admitted as voluntary or temporary cases, there were still several problems with the act. The issue of space at available mental hospitals meant that many patients seem to have been sent further away from their relatives than the nearest mental hospital, and this can be seen by the disparity between where patients received outpatient treatment and where they were ultimately admitted into hospital. Furthermore, with the voluntary category, as always questions arise when assessing a patient's ability to 'voluntarily' admit themselves for treatment. Many surviving letters seem to suggest that a patient's relatives were involved in some way in the patient's decision to accept in-patient treatment.

It would appear that a voluntary patient's ability to discharge themselves as and when they liked, without the permission of a medical officer meant that some patients left the institution against the advice of medical doctors when they were still in deep periods of depression or mental illness. Arguably this tendency may well have been detrimental to the patients and their families, as well as potentially being an added expense to the rate-payer as untreated patients frequently found their way back to a mental hospital to restart the process a few months or years later.

Overall, though the Mental Treatment Act was a national piece of legislation for the treatment of mental illness, the Act was only ever going to help a small minority of patients. Clearly over the years many innovations were attempted to try to limit the growing number of insane by segregating various types of patients into other institutions and by trying to reach patients at an earlier and arguably more curable stage of their illnesses. The Mental Treatment Act was part of these changes. It was designed to entice patients at

an earlier stage of their illnesses by attempting to eradicate the need for certification for patients in the incipient stages of their illnesses. However, like all the other chapters of this thesis which focus upon various social and legal experiments with regard to the segregation and admission procedures, the Mental Treatment Act only catered for a small minority of patients, leaving the majority of chronic, certifiably insane and seemingly incurable cases to stagnate inside the walls of the asylum.

Conclusion

During the late nineteenth and into the early twentieth century there was much for the psychiatric profession to be pessimistic about, with numbers of patients institutionalised within public mental hospitals rising at an alarming rate. Some psychiatrists optimistically argued that the increasing numbers in mental hospitals were linked to a falling death rate within these institutions. Though there is evidence to support this viewpoint, the records also identify that an increasingly large majority of patients were institutionalised for the rest of their lives as incurable chronic cases.¹ Furthermore, the early twentieth-century preoccupation with mental deficiency only added to the numbers ‘stored’ in mental hospitals and mental deficiency institutions for life. Those in charge of managing and also working within these institutions were, as the West Riding Mental Hospitals Board exclaimed, “up against the impossible.”² Though it was clear to all that mental institutions could “not be extended indefinitely”³ throughout the twentieth century numbers of the insane continued to increase at a startling rate.

In his work *The Poor Law of Lunacy*, Bartlett suggests that little changed from the late nineteenth to the early twentieth century with regards to the majority of peoples’ experiences of mental health care.⁴ Despite the innovations which have been analysed within this thesis, there is little reason to suggest that life changed very much at all for the large majority of people who were suffering from chronic mental illness, deemed ‘unrecoverable’, and institutionalised within asylums or workhouses. The Annual Reports

¹ WYAS, C85/1/8/16, Minutes of the West Riding Mental Hospitals Board (1939-1940).

² WYAS, C85/1/16/10, Report of a Conference on Mental Hospital Accommodation (1931), p. 18.

³ *Ibid.*, p. 6.

⁴ P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London, Continuum, 1999), p. 5.

show that life remained stagnant for the majority of these people throughout these years, and for this majority population everyday life remained unchanged despite the passing of numerous pieces of legislation. The ever-growing figures of the mentally ill are also particularly interesting, as they identify that despite the new innovations and legislation, psychiatric pessimism with regards to the chronic cases of insanity and suggestions as to the suitable place for their detention had not moved on since the late nineteenth century. The evidence suggests that many medical staff and Superintendents still considered the workhouse to be the best place for their incurable chronic population, especially when space in the public mental hospitals was at a premium.⁵

Despite the stagnation of chronic cases within mental hospital and workhouse walls, however, the four initiatives analysed in this thesis suggest that some things were changing for a small minority of sufferers of mental illness throughout these years. The identification of these developments as specific attempts at innovation within psychiatric practice corresponds with Westwood's notion that "interesting developments have been under researched, which has perpetuated the view that twentieth-century care, prior to the First World War, followed a nineteenth-century pattern."⁶ Though most of the innovations with regards to experimenting with the segregation of various types of illness and bringing patients in for early treatment began in the late nineteenth century, these experiments were intensified in the twentieth. The legislation of 1913 encouraged more separately organised mental deficiency institutions to be created, in order to provide specialist care for those labelled as idiots, imbeciles or feeble-minded. Similarly the Ministry of Pensions Hospital was opened at Storthes Hall, with the intention of segregating certain mentally ill servicemen who had fought in the First World War. Both of these initiatives

⁵ WYAS, C85/1/16/10, Report of a Conference on Mental Hospital Accommodation (1931).

⁶ L. Westwood, 'A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899-1939', *Social History of Medicine*, vol. 14, no. 3, 2001, p. 439.

appear to have been linked to an attempt to remove these groups of people from the stigma of pauperism. Furthermore, the experiments established for the service patients also appear to have ambitiously attempted to remove these patients from the stigma of insanity.

Throughout these years there was also a growing acceptance of and use of mental outpatient departments. Within the West Riding of Yorkshire, these departments were established in the late nineteenth century. As the twentieth century progressed however there were repeated calls to relocate these departments from the old asylums to general hospitals. Arguably this relocation was also a concerted attempt to remove the association with the stigma of insanity from the patients who attended these clinics.⁷ Moreover the new legislation of 1930 allowed rate-aided patients to be able to voluntarily submit themselves for treatment for the first time in England and Wales. This new legislation also gave these new voluntary patients the power to discharge themselves without the consent of their medical officers.⁸ Theoretically at least, together these new powers fundamentally altered the admission and discharge procedure of the mental health system for rate-aided patients. Collectively the relocation and opening of new outpatient departments alongside the 1930 Mental Treatment Act represented new and innovative ways of attempting to entice many patients to institutions for mental treatment at an earlier stage of their illnesses. Similarly these two innovations should be observed as a legitimate effort by the psychiatric profession to attempt to eradicate the need for and therefore the stigma of certification in the treatment of mental disease for poorer patients.

There is no doubt that each of these innovations in the administration of mental health care had some success. Generally, the patients who were admitted to Meanwood Park rather than Stanley Hall appear to have had more educational training at special

⁷ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Hospital Board (1929), p. 164.

⁸ NA, FD 1/1398, Copy of the Mental Treatment Act (1930).

schools, which identifies that for some patients the joint authority of the Mental Deficiency Act had some effect. Furthermore there is evidence in the casebooks and letters of the patients admitted to the Ministry of Pensions Hospital that a tiny fraction of patients recovered from their illnesses, and were extremely grateful to the hospital staff for their treatment therein.⁹ Moreover, there is considerable evidence that many patients who attended the outpatient clinics at both Wakefield Asylum, (later Mental Hospital), and Clayton General Hospital came to the institutions at an early stage of their illnesses and subsequently made a full recovery. Equally, similar stories of successful treatment can also be attributed to many patients who admitted themselves to Wakefield and Storthes Hall for voluntary treatment after the 1930 legislation.

Despite the few success stories, a closer observation of the evidence clearly suggests that there were more problems, with regards to these initiatives, than successes. As Marijke Gijswijt-Hofstra and Harry Oosterhuis explain in the introduction to their edited volume, *Psychiatric Cultures Compared*, “It appears to be crucial to distinguish between ideas and ideals, rhetoric, norms, intentions and plans with respect to mental health care on the one hand, and what was actually realised on the other.”¹⁰ With regards to the four developments analysed within this thesis it is clear that there was a very marked difference between the ideas behind the innovations and actual reality of the established scheme.

The ever-pervasive and interconnecting factors of a lack of finance teamed with a lack of institutional residential space can be identified as major reasons for the real failure of these new initiatives. These reasons are especially true with regards to establishing new services and institutions for people suffering from different types of mental defi-

⁹ WYAS, C416/5/157, Male Casebook Records of Private Service Patients (1924), 25.

¹⁰ M. Gijswijt-Hofstra and H. Oosterhuis, ‘Introduction: Comparing National Cultures of Psychiatry’, in M. Gijswijt-Hofstra et al. (eds), *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam, Amsterdam University Press, 2005), pp. 9-34, p. 25.

ciency. The two issues of finance and space led to what can only be described as a 'two-tier approach' to services for mental deficiency, whereby improvable and easily managed 'deserving' cases were admitted to new mental deficiency institutions and the 'undeserving' semi-criminal, problematic cases were left inside what was considered to be 'second rate' workhouse and mental hospital accommodation.

In addition to these two issues, with regards to the Service Patient Scheme and Ministry of Pensions Hospital, it would appear that a lack of foresight and implementation with regards to the rules were contributory aspects to the overall failure of the schemes. Collectively these factors meant that many patients never escaped the stigma of pauperism or were able to take advantage of the benefits offered to them. Equally the majority of men who were deemed 'unrecoverable,' and who were subsequently institutionalised in the hospital at Kirkburton identifies that perhaps the 'innovative' experiment was more of a façade to keep up appearances with the general public. Clearly how few of the patients recovered or improved enough to be returned home to live 'normal' lives suggests the real failure of these innovations (See Table 3.6). Overall, despite the attempts of improvement from both mental deficiency institutions and the Ministry of Pensions Hospital the majority of these patients subsequently became part of the incurable chronic residuum, and increasing mental hospital population.

Problems existed too with regards to the attempt to remove the need for certification and thus the associated stigma from different elements of mental health care. Though outpatient clinics were established in the West Riding Asylums in the late nineteenth century, the evidence has suggested that the problems of location of the asylum and associated stigma were a distinct barrier for many patients in need of treatment.¹¹ Even when these clinics were removed to General Hospitals, the stigma of mental illness remained,

¹¹ WYAS, C416/1/67, Minute Books of the West Riding of Yorkshire Hospital Board (1929), p. 164 and WYAS, C85/1/15/13, Annual Reports of the Board of Control (1929), p. 4.

and in both cases the added expense of being referred by a doctor may have stopped some patients from seeking treatment. Once more the expense of being referred by a doctor again constituted one of the main reasons for the minimal use of the Mental Treatment Act in the 1930s. The huge numbers of people who continued to be certified, teamed with the fact that many voluntary patients discharged themselves, despite the fact that their doctors regarded them to be unimproved identifies huge weaknesses to this particular piece of legislation.

Collectively there is considerable evidence that corroborates with Peter Bartlett's hypothesis of the twentieth century. This is especially true of his suggestion that the "nineteenth century administrative networks ha[d] much to say about the roots of the twentieth century statute."¹² Within this framework, the Mental Deficiency Act can easily be observed as a more detailed and compulsory attempt to redress the failures of the earlier 1888 Idiots Act. Both pieces of legislation were concerned with identifying and creating new places of cure and care for patients with varying types and degrees of mental deficiency. Equally, the powers granted to Local Authorities to establish outpatient clinics under the 1930 Act, was taken informally in the West Riding of Yorkshire, and other places as early as the late nineteenth century. Furthermore there is no other way to observe the length of time that the Mental Treatment Act took to be legislated, than as part of the 'legislative inertia' that Bartlett identifies as being fundamental to twentieth century mental health legislation.

Similarly there is plenty of comparable evidence to legitimise Bartlett's argument that "the history of mental health legislation demonstrates... a history of cut and paste law making."¹³ Again both the Mental Deficiency Act and the Mental Treatment Act provide evidence of this. The fact that the 1930 legislation never abolished the procedure

¹² Bartlett, *The Poor Law of Lunacy*, p. 5.

¹³ *Ibid.*

of certification established under the earlier Lunacy legislation meant that the procedure of certification continued to be the primary method of admission into a mental hospital well after the establishment of the 1930 Mental Treatment Act. In fact, in direct contrast to the view established by Kathleen Jones that the new act would ‘by-pass’ the 1890 Act, to “provide a framework of treatment which would make it unnecessary to use the older Act, except in extreme cases,”¹⁴ research into the West Riding of Yorkshire has shown that instead it would not be unfair to say that in implementation the new act *relied* upon the older legislation, as so few patients took up the new categories of voluntary or temporary treatment. It could also be argued that the Mental Deficiency Act of 1913 also identifies a ‘history of cut and paste law-making’ as in practice, it only added to confusion between the competing authorities of who was supposed to provide care. Certainly Shaw-Bolton’s assertion that after “the Mental Deficiency Act of 1913 [many patients suffering from mental deficiency] are... worse off than when we treated them here under the former Act” provides a damning indictment against the 1913 legislation.¹⁵

The four developments highlighted within this thesis identify important attempts to remove the stigmas of certification and pauperisation from certain groups of people suffering from different types of mental afflictions and learning disabilities. Within his work, Bartlett reaches the conclusion that during the mid to later part of the nineteenth century, “reform should be seen in terms of incrementalism, gradually increased physical standards and a more pervasive regimen, not in terms of theoretical changes.”¹⁶ In contrast, my research into the various innovations carried out in the West Riding has identified that fundamental changes between the late nineteenth and early twentieth century with regards to “the dissociation of mental health services from the Poor Law Admin-

¹⁴ K. Jones, *Mental Health and Social Policy* (London, Routledge and Kegan Paul, 1960), p. 117.

¹⁵ WYAS, C85/1/12/14, Annual Reports (1923-1927), Report of Medical Superintendent (1924), pp. 79-80.

¹⁶ Bartlett, *The Poor Law of Lunacy*, p. 228.

istration”¹⁷ and the removal of certification as barriers to early treatment should be seen in terms of the gradual experimentation with and implementation of larger theoretical changes.

In part these findings agree with the work of Westwood when she argues that “interesting developments [of the twentieth century] have been under researched.”¹⁸ Far from merely offering another purely progressive history of mental health care however, my work has identified that despite the implementation of these various theoretical changes, actually little changed for the majority, in terms of *actual patient experiences* of institutionalisation. Although it has been evidenced that these changes had a positive effect for a very small minority of sufferers, for the large majority of patients this thesis tells the tale of a narrative of failed experiments, which had only a very limited effect in changing the institutional administration of mental health care throughout the late nineteenth and early twentieth century.

¹⁷ WYAS, C85/1/15/14, Annual Reports of the Board of Control (1930), p. 2.

¹⁸ Westwood, ‘A Quiet Revolution in Brighton’, p. 439.

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