than a mere chaotic and haphazard explosion of cerebral matter. The neurons would appear to be associated during an epileptic fit as in the normal state. This, in my opinion, is the most distinguishing feature of a true epilepsy as compared with Jacksonian attacks, whose progression of symptoms is merely anatomical. In the former there remains the indissoluble union between the motor, sensory and mental functioning of the brain, making an epileptic a risky if not a dangerous member of society.

The Boarding-out System in Scotland.[1] By GEORGE GIBSON, *D.S.O.*, M.D., F.R.C.P.Edin., Deputy Commissioner, General Board of Control, Scotland.

ANY paper on the " boarding-out system " in Scotland would be entirely incomplete without a reference to the recent death of its distinguished advocate and supporter, Dr. John Fraser. For seventeen years as a Deputy Commissioner Dr. Fraser visited patients throughout the length and breadth of Scotland, and his interest and enthusiasm in the method lasted to the end of a long life. His devotion to duty and the high standard he always set are fully appreciated by one who, as a Deputy Commissioner, is privileged to come after him, and finds a daily difficulty in adequately following in his footsteps. It is matter of real regret that he is not with us here to-day.

The expression " boarding-out " strictly refers to the arrangement obtaining in Scotland under which mental patients are domiciled in specially licensed houses, under the care of strangers. In the fuller application of the term, it has come to refer to any parish patient living under private care either with relatives or strangers.

The term is hardly felicitous; it is apt to give a wrong impression, and convey the idea that all these patients are boarded out from asylums. This is far from being the case, for it is a feature of the system that it is entirely divorced from the asylum treatment of the insane—so much so that many patients treated under this system never have, and probably never will, see the inside of an asylum. Furthermore, the local authorities concerned in providing for the care of patients in private dwellings are not the same as the bodies who control the asylums. Parish councils are responsible for the provision and selection of the specially licensed houses, while

[1] A paper read at the Quarterly General Meeting held at Edinburgh, February 19, 1925.

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the management of institutions is in the hands of District Boards of Control.

The aim and object of the system is to ensure that all mental patients in receipt of parochial relief, while under private care, shall only receive such relief on the understanding that he or she lives and is treated under conditions which are prescribed by the State, through the Board of Control. Further, such a patient is to be inspected from time to time, to see that those conditions are being fulfilled.

The superintendents of asylums are concerned only in so far as they may decide from time to time that certain patients would be the better for being boarded-out. Once these patients have been transferred from the asylum to private dwellings the superintendents' responsibility ceases. It is not their duty to visit them. Indeed, they may never see them again, unless from some cause, either mental or physical, it becomes necessary to return the patient to the asylum.

As the administration is entirely in the hands of the parish councils, and of their officials, the inspectors of poor and parish medical officers, certain regulations were laid down by the Board of Lunacy, for their guidance, and to insure a uniformity in the working of the system. These regulations are practically the same whether the patient be certified under the Lunacy Acts or under the Mental Deficiency Act.

The parish councils select the guardians and houses, paying attention to the comfort, the feeding and the clothing of the patients, and taking such steps as are necessary to see that the guardians are trustworthy, efficient, and that they are properly remunerated.

The patients must be visited by a medical man appointed by the local authority at least once every three months, and by an inspector of poor once every six months. These visits are recorded in a visiting book, kept for the purpose in the house where the patient resides. In this book the medical officer enters any suggestions for improving the patient's condition which may appear necessary. In addition each patient certified under the Lunacy Acts is visited at least once a year by a medical deputy commissioner of the Board of Control. In the case of certified mental defectives the deputy commissioner visits twice a year. These visits are of the nature of surprise visits, and may be paid at any time of the day or night.

Various directions for the guidance of guardians are laid down. These are concerned with the employment and recreation of the patients. The procedures to be followed in the event of the patient escaping, meeting with an accident, being taken ill or becoming

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unsuitable for private guardianship are also detailed. In addition certain conditions must be observed in the accommodation provided. The quarters must be free from damp, well ventilated, and the bed must be comfortable and have sufficient coverings. The patients must have a complete change of clothing, and their personal cleanliness must be carefully attended to.

Licence is granted to certified patients to reside in private dwellings under four separate provisions of the Lunacy Act:

1. Patients who have never been in an asylum—that is, patients whom the local authorities or their advisers consider harmless and quite suitable for this form of treatment. Two medical certificates are necessary. This type of certificate does not require a sheriff's signature; the Board of Control grant the sanction. The number of these sanctions is yearly becoming less. These patients, who are for the most part congenital cases, are now more usually dealt with under the Mental Deficiency Act.

2. Patients removed from asylums, either at the instance of the superintendent or by minute of the parish council, and whose names are still retained on the parish roll. Board of Control sanction is necessary, and if it later becomes necessary to return any patient to an asylum, a sheriff's warrant must be applied for.

3. As this method was considered cumbersome, a modification was introduced in 1913. Under this a patient can be transferred from an asylum to a private dwelling on certificate by the superintendent, and with the sanction of the Board of Control. Similarly, he can be returned to an asylum without the necessity of a Sheriff's warrant, sanction by the Board of Control being sufficient authority for his re-transfer to the asylum.

4. Patients may be liberated on probation from asylums for any period up to a year. If at the end of that interval they prove to be suitable cases, they may be discharged "unrecovered" to the guardianship of a private home, after sanction has been obtained from the General Board of Control.

The type of patient found in private dwellings may be classified into the following groups: (1) Idiots; (2) imbeciles; (3) acquired insanity.

Before the passing of the Mental Deficiency Act, the majority of patients of the idiot and imbecile class found in private dwellings had never been inside an institution. Now, however, we find quite a number of patients who have been transferred from one or other of the institutions for mental defectives.

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The patients suffering from acquired insanity are mostly transfers from asylums.

In either case, whether the patient is certified in the first instance for residence in a private dwelling or transferred from an asylum, he must be seen and reported on by some medical man: in the former case by two medical men, acting on behalf of the parish council, while in the latter, the medical superintendent gives the necessary certificate that the patient is suitable for a private abode.

It will at once be obvious that we are dealing with a picked class. From a psychiatric standpoint they may not present many interesting features. The types of mental derangement most to be met with are mild and chronic manias, patients with harmless delusions, dements, and patients showing the signs of congenital insanity from slight degrees of mental deficiency to idiocy. Suicidal and homicidal patients are naturally as entirely unsuitable for this method of disposal as are noisy, violent, restless and wandering cases. Epileptic patients must also be regarded with a suspicious eye, and though patients suffering from epilepsy may be permitted to remain at home with their relatives, they cannot be regarded as suitable patients to be boarded out with strangers. It is not fair to guardians to send them patients with unpleasant habits, or who, from physical infirmities, are unable to look after themselves.

When in 1855 a Royal Commission was appointed to inquire into the "State of Lunatics and Asylums in Scotland," it found among other things a serious shortage of accommodation for the reception of the mentally afflicted.

There was at that time 7 chartered or Royal asylums, 1 public asylum, and 12 poorhouses with separate wards for the insane. In addition 23 private establishments or licensed houses accommodated patients in varying numbers from 1 to 86.

The remainder of the patients were living with the ordinary inmates in poorhouses or in private houses with relatives or strangers.

The numbers were approximately—

	Private.	Parish.	Total.
In public institutions . . .	659	2,180	2,839
In private establishments . .	231	426	657
In private houses	—	—	1,363

Some doubt seems to have existed as to whether this last figure was correct. The number 1,363 was that returned by the Board of Supervision of the Relief of Poor. The returns of the Constabulary Force assessed the number of these patients at 1,998.

In their report the Commissioners stated their opinion that poorhouses were ill-adapted for the accommodation of lunatics. The

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reasons given for adopting this point of view were connected with the unsuitability of the accommodation, the lack of suitable employment, the absence of amusement, the want of cheerfulness in confined rooms looking into small airing-courts. The whole of these conclusions are summed up in the sentence: "We have no hesitation in saying that, in providing accommodation for insane paupers, the parochial authorities have more consulted the interest of the ratepayers than the well-being of the patients."(2)

At the same time inspection of the private establishments or licensed houses revealed in many instances a deplorable state of affairs, as was also found when the conditions of lunatics living in private houses either with relatives or friends was inquired into.

In those early days none of the district asylums had been built, and the accommodation in the seven chartered and one public asylum was not adequate to accommodate even such patients as they were requested to do. As an example, in 1859, out of 1,234 applications for the admission of patients into the eight existing asylums, 316 were refused.

It will be seen that there was a decided shortage of accommodation, which was the more serious, as many of the existing institutions were found to be inefficient and badly conducted.

The Commissioners were prompt in their action of urging the district boards to erect asylums in the local areas, under their administration. But asylums cannot be built in a night, and some boards were slow in making up their minds, and already in the report of 1860 we see that efforts to solve the accommodation problem were being made in another direction, by advocating the opening of specially licensed houses, accommodating a maximum of four patients each.

That the Commissioners did not regard this new "boarding-out system" merely as a temporary expedient is obvious from their report, which reads as follows:

> "That all cases of insanity should be placed in an asylum is a proposition we cannot entertain; the welfare of the patients would not thereby be promoted, while the expense to the country would undoubtedly be greatly increased. . . . All great aggregations of permanently diseased minds are evils which should, as much as possible, be avoided, as their tendency is undoubtedly to lower and degrade each constituent member of the mass. Viewed in a certain light, then, asylums may be regarded as necessary evils; . . . we would gladly see it enacted, that any number of patients, not exceeding four, might be received into a private house. . . . Under some such provision we feel satisfied a system of cottage accommodation would gradually spring up, which would not only furnish more fitting accommodation for chronic patients than the lunatic wards of poor-houses, but would also be calculated to prove a valuable adjunct to asylums. . . . The practical advantages of such a system would be, the greater amount of liberty accorded to the patients; their more domestic treatment; and their more thoroughly recognized individuality."(3)

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When this was written the numbers of patients in private dwellings was estimated at 1,363. From that date the total gradually increased until the year 1913, when the "boarding out" reached its high-water mark of 2,909. The war caused a set-back to the system, from which it has not yet recovered.

The number of patients in private dwellings certified under the Lunacy Act is now 1,789, showing a decline of 1,120 from the total in 1913. At first glance one would think that this sudden shrinkage of about a hundred a year means that the system is galloping to its end in a rapid decline. It is hardly so serious as this, for we must not forget the 874 mental defectives living in private homes. Before the passing of the Mental Deficiency Act many of these patients would have been certified under the Lunacy Act for residence in private dwellings—some, but not all, for the Mental Deficiency Act is unearthing patients that the older Acts failed to discover. But even counting in these defectives, there is a diminution in numbers of 246.

In 1858, when the General Board first commenced its activities, the bulk of the patients in private dwellings were congenital cases who never had required asylum treatment. For twenty years (1860–79) after the General Board had been established the additions were mainly of that class. During the next twenty years (1880–99) the total was greatly swelled by the numbers of patients removed from asylums. During the early years of this century this condition of affairs persisted, and patients suffering from acquired insanity were boarded out in increasing numbers.

Now we have more or less reverted to the situation which existed from 1860 to 1879—that is to say, the total is rather kept up by those certified and left at home, while the annual number of those transferred from asylums is appreciably less.

Several reasons have been advanced to account for this. The housing question has undoubtedly had its influence, as the scarcity of houses in rural Scotland has resulted in the available space being required for the ordinary inhabitants. Another important factor was that many of the older guardians died during the last few years. Changes in the economic conditions and the greater distribution of wealth in the years immediately following the war have made it difficult to replace these guardians.

There are signs, however, that the shortage of houses is not nearly so acute as it was a year or two ago, while at the same time there is evidence that new guardians are coming forward, from the increased frequency of inquiries about patients, and the fact that several new houses have recently been licensed.

I do not think that the shortage of guardians and houses is

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entirely to blame. For some reason the system does not seem to enjoy the same popularity as formerly. This feeling is not among the general public, which seems, on the whole, to be sympathetically inclined; it is to be found elsewhere.

A great deal of the success of the boarding-out system in the past was due to the enterprise of certain inspectors of poor. It was greatly to the credit of some of those gentlemen that they recognized in this method a useful adjunct to the asylum treatment of the insane. For those others, who had the interest of the ratepayers most deeply at heart, there was the added inducement that it was possible to keep these patients for a comparatively low cost. For in those days the aliments paid for patients in private houses were low, and it was much cheaper to keep them under those circumstances than to pay the rates charged in the various asylums.

In 1897 Dr. J. F. Sutherland compiled some interesting figures, which show that the boarding-out of patients was an economic proposition. Taking Edinburgh Parish Council with 327 boarded-out patients as an example, he calculated that to provide institutional accommodation for this number would have entailed a building cost of £120,000 and an annual expenditure of £3,200.

Since Dr. Sutherland wrote conditions have changed, but the change is only in degree. Now the saving to the ratepayers is not so great, because while the cost of providing for patients in private dwellings and the aliments paid have all increased, the Government grant remains the same.

In another direction the situation is not so dissimilar. In Dr. Sutherland's time, in spite of the fact that several large district asylums were newly opened or on the point of opening, practically every bed was already bespoken. Again we are faced with similar circumstances, and in certain districts there is a shortage of asylum accommodation.

In spite of the circumstances being similar, the economic reasons for boarding patients out have certainly become less vital, and as they have become so there seems to be a tendency to adopt the easier method, and to allow patients to remain in asylums, for it is the easier way—about that there can be no doubt.

Before a patient is boarded out satisfactory guardians must be found; arrangements for medical visitation must be made and the patient must be transported to the new home. There, after all this trouble, he or she may prove to be an entirely unsuitable case, and have to be removed somewhere else after a few days. Then, if the patient be successfully domiciled, he or she must be visited twice a year by inspectors—rather a cumbersome procedure in

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each individual case. How much easier to avoid all this by allowing the patient to remain quietly in the asylum!

In 1904 we see Dr. Charles Macpherson calling attention to the fact that the great bulk of the boarding-out was from five or six institutions. This is merely another aspect of the economic side of the question, in that the large parishes, by boarding-out in bulk, effect very obvious economies which are apparent in the rates, while in small parishes, with only one or two patients, the saving to the ratepayers would be so small as to be hardly appreciable.

This may possibly be the cause of that apathy which Dr. Charles Macpherson describes when he states that inspectors of poor could scarcely be induced to look for homes for unrecovered patients. I am inclined to think that inspectors are not wholly to blame, and that in many cases the statement made twenty years ago "that asylum authorities do not press for the removal of their unrecovered inmates, who no longer require asylum care unless the institution is overcrowded," holds true to-day.

Remember there are 875 parishes in Scotland, running from Glasgow with over half a million parishioners, to Lyne, with 78. A host of the smaller parishes have either very few patients or none at all. To them the occurrence or certification of a case is a rare happening. As they have little practice in the working of the lunacy laws, it seems only natural to expect that they are possibly not fully aware of the merits of the "boarding-out system." Were their attention directed towards it, and its many advantages explained to them, it is possible that more patients from the smaller parishes might come under this system.

And there is another factor which possibly is not without its influence on the situation, with shorter hours of work and increased wages, the cost of providing male and female staffs for asylums has gone up very greatly. As a result the good working patient has acquired an enhanced value, especially as a farm-worker. The asylum authorities are less likely to be anxious to discharge these good patients, who frequently do nearly as much as an ordinary paid field worker.

But it is chiefly in the attitude of medical superintendents towards the system that one would like to be instructed to-day. The economic aspect of the situation should naturally appeal less strongly to them than to non-medical authorities and officials of asylums and parish councils. One naturally expects them to regard the patients under their control as sick people, or at least as abnormal persons, whose welfare is their first and most sacred duty. Here, then, is a situation which involves the liberty of our fellow-subjects, in which no question of expediency born of government grants

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or ratepayers' pockets should be allowed to interfere with the true merits of the case, which should be judged impartially upon medical rather than upon economic grounds.

Do all superintendents exert as much pressure as they might do upon inspectors to get them to remove such patients to suitable homes in the country as no longer require asylum treatment? And do they try to influence their boards against the retention of good working patients in institutions?

We do not know of any change in type of insanity requiring the retention of more patients in asylums than formerly which would account for the falling-off in the numbers of the "boarded-out." We are therefore forced to the conclusion that there must be some patients in asylums who could quite well be provided for in private dwellings.

There is no getting away from the fact that there is still a prejudice against asylums in the minds of many patients. Much as these institutions have improved in the past and are daily improving, the average person has no ambition to be confined in one of them. A nearer acquaintance may bring about a change of opinion, and many patients have no desire to live elsewhere, or if removed, request to be readmitted. In the country they miss the orderly routine and the mild excitements, the concerts and lectures of institution life. I remember one patient, bored by the quiet life of a Fife village, who demanded to be sent back to the asylum. I think, however, the majority of patients would prefer to live outside the walls of an institution rather than inside.

By limiting the numbers of patients in specially licensed houses to four the Commissioners did away with the institutional character of the scheme. As a result the mentally afflicted are allowed the inestimable benefit of associating with the sane of the community, and in their condition of increased domesticity patients spend their time pottering round gardens, working in farm-yards, knitting, sewing and reading. In many instances patients are able to make small wages by doing occasional work for neighbours. Very many guardians allow the patients to keep the money so earned; as a result there are patients who own bicycles, I know of one who has a camera, another who paints quite good landscapes, and a third who turns out the most ingenious mechanical windmills. These are a few examples of the directions their expenditure follows, and it must be admitted that considerable discrimination is shown in their disbursements and in the selection of their hobbies.

The possession of money, with its accompanying spending power, small though it is, means an added dignity and importance, with a resulting increase in happiness. And to this we must add the

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greatest benefit of all, the extended liberty. Anyone who has visited "boarded-out" patients will tell you of the numerous delays constantly occurring because this or that patient has to be looked for. The guardian generally has a fairly good notion that this patient went gathering sticks an hour ago in the wood, or that that patient went for milk half an hour ago. Armed with this information the patient will soon be found carrying out the allotted task, unworried and unhurried. It is this free existence, this absence of bother and restriction which appeals to me as being peculiarly adapted for these patients. Here, for them, would seem to be the best chance of happiness, and are these patients not entitled to any share of happiness which may be going? After all we cannot ignore the patients' opinion, and must give heed to any views they may hold.

For practical purposes patients might be regarded as belonging to two classes—those who are going to improve and those who will never get any better.

As long as there is any chance of recovery we should neglect no methods which may result in curing the patient. Let us be as scientific and as modern in our methods as is possible.

But when no improvement is possible, when the case is chronic and will be so until the patient dies, are not kindliness, gentleness and the maximum of freedom of greater value than all the psychoanalysis and bacteriology in the world? I would humbly submit that those are to be found in making the patients' surroundings as much like home as possible, and would venture to suggest that this more cheerful home-life is to be found rather in the private dwellings and specially licensed houses of Scotland than in the wards and day-rooms of our asylums.

Some recent observations by Dr. Ferguson Watson are of great interest, and indicate other advantages which patients derive by being boarded out. His remarks are as follows:

"Patients are generally well fed. It is quite true the diet is not that of a hotel, and for that matter nor is it that of an institution. But is it any worse? My experience goes to show that it is much better than the latter. In my area the number of guardians who provide margarine instead of butter is but 5; in rate-paid institutions—at least those I have visited officially—all give margarine. In a private dwelling porridge is much better made; the scones and oatcakes are baked; there is plenty of sweet milk (I have often seen it brought fresh from the cow) without separation of cream, home-made cheese ("crowdy"), fresh meat, frequently fish, pork, and in the Lowlands an abundant supply of vegetables. The variation of dietary also is much in advance of an institution. In these conditions the patients put on flesh when removed from the large cities—and even when boarded out from an institution."(4)

These views advanced by Dr. Watson cannot be disregarded.

It is impossible to doubt that in another direction the "boarding-out system" has exerted an influence which might be described

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as educative upon public opinion. This has had a certain effect upon the attitude of the general public in Scotland towards the whole question of lunacy. The presence of patients in a country-side has had the natural result of showing the ordinary inhabitants that these harmless unfortunates are one of the best behaved and most orderly sections of the community. As a result the sane portion of the inhabitants regard this question with a broad-minded complaisance which is frequently the subject of comment by visitors from other countries. In some parts of the country I would go so far as to say the country people take a real pride and interest in these imported strangers. I would suggest that this spirit of tolerance exhibited outside has made itself felt inside the walls of our institutions, and is reflected in the humane and enlightened views which persist in our Scottish asylums. I suggest that our great superintendents, in introducing their historic reforms in the past, were largely assisted by the spirit of good-tempered interest existing outside the walls. Some of their early innovations, with open doors and absence of boundary walls, and the many escapes which resulted, excited a mild interest but little adverse comment in counties where boarded-out patients had long been familiar figures in the countryside. Strong men though they were, I doubt whether those great pioneers would have gone the lengths they did with an adverse public opinion, which they would have found in some countries where the idea prevails that mental patients can only be treated behind high walls and locked doors.

This extra-mural method of dealing with our problem is at once a corrective, an antidote and a safety-valve. It is the alternative, providing the opposition that prevents the asylum system from becoming a monopoly. Possibly it may appear anomalous to say that its future lies to a large extent in the hands of asylum superintendents; it is so none the less, and with good reason too; for allow the one to die out and the other will soon show signs of decay, for what system can exist in perfect health without the stimulating impetus of competition?

It is in the hope of re-awakening interest in this essentially Scottish system that I have ventured to address you to-day. We pride ourselves on the enlightenment of our national methods of dealing with a great problem; let us see to it that this well-tried, humane and practical scheme is not allowed to wither, to decay, by indifference and neglect.

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Certification as a "Moral Imbecile."(1) By JOHN MAURICE AHERN, M.B., B.Ch., Senior Medical Officer, H.M. Prison, Liverpool.

THE term "moral imbecile" used in the Mental Deficiency Act is generally recognized as an unhappy one. It is responsible for much difference of opinion as to the class of case which can be properly so described. There is a view widely held and often expressed that the number of such cases is very small; that to certify them is an unsafe procedure, and that consequently, their inclusion within the Act is of little or no practical value. Those who adopt this view seem to be guided by their own opinion of what constitutes a moral imbecile rather than by its statutory definition. The term, unfortunately, is suggestive of the existence of a moral sense as a mental entity, and the connation of an almost complete deprivation or imbecility with regard to it. Those who interpret it in this way and who believe in the existence of this hypothetical moral sense illustrate their point of view by the citation of comparatively rare cases, such as the person of good intelligence and education who foolishly and without any compunction or regard for the opinion of others persists in a life of crime—one who, in short, takes to crime not for material profit, but for the gratification it brings. Those who similarly interpret it, but are not of the same belief, consider it as nugatory as its supposed implication. There are

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