999 QUEEN STREET WEST:
PATIENT LIFE AT THE TORONTO HOSPITAL FOR THE INSANE,
1870 - 1940

by

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A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy,
Graduate Department of History,
University of Toronto.

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ABSTRACT

999 QUEEN STREET WEST: PATIENT LIFE AT THE
TORONTO HOSPITAL FOR THE INSANE, 1870-1940

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This study examines the individual experiences of
people who were admitted to the Toronto Hospital for the
Insane between 1870-1940 within the context of institutional
practices and relationships. The purpose is to
contribute to our understanding of psychiatric history
by placing patients' perspectives and experiences at the
forefront of historical inquiry instead of having them come
second to the administrators who ran the hospitals.
Clinical files are the main primary source used for this
work. Letters written by patients during and after
confinement form an essential part of this thesis.
Observations left by third party observers such as family,
friends and hospital staff also illustrate patient culture.

This thesis is structured around themes that highlight
the various stages of the lives of the men and women who
populated 999 Queen Street West: diagnosis and admission;
daily routine and daily relationships; patients' leisure and
personal space; patients' labour; family and community
responses to mental hospital patients; discharge and death.
Above all else, the people whose voices and experiences make up this study show later generations that psychiatric patients have a great deal to teach us about what it was like to be confined in a mental institution and to live with the psychological troubles that brought them to 999 Queen Street West.
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A fellow patient at St. Thomas Psychiatric Hospital in 1979, whom it would only be appropriate to identify as Barbara, provided the original vision for this entire thesis. Barbara’s friendship and humane concern for other patients who lived at St. Thomas Psychiatric Hospital is a cherished memory for me which resonates throughout the following pages. The quote from Ralph M., cited at the very front of this thesis on page xiv, eloquently speaks to later generations about the hopes, dreams and sorrow that people who have been in mental hospitals can have. His words, and the lives of many other psychiatric patients, like Barbara and Shirani, offer the greatest inspiration for this work. It is my hope that this study will have contributed in a small way to remembering their lives and the lives of so many other people who been patients in mental health facilities, past and present.
Finally, I would like to express appreciation to my closest relatives including my two brothers and four sisters, Ron Reaume, Anne Dupuis, Carole Delisle, Dan Reaume, Brenda Verkoeyen and Laura Reaume, as well as their entire families for all of their support. I would like to remember my maternal grandfather, Francis Udall, who died in 1974. He was a veteran of the First World War who suffered shell shock and was a psychiatric patient at various times during his life. I also wish to remember my maternal grandmother, Anne Udall, who died in 1976. She supported her husband, inside and outside of hospitals, whenever he experienced mental health problems during their forty-seven year marriage. Their example lives on in my mother, Josephine Reaume, and my father, Nelson Reaume. They know what is like to see a loved one, both a parent and a child, experience mental illness and become a patient in a psychiatric facility. For always being there, this thesis is dedicated to them with love and gratitude for being the wonderful parents that I am so privileged to have.
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Josephine Reaume and Nelson Reaume,
with
Love and Gratitude
"Oh that I had wings I would fly like a dove and be at rest I would fly out of this asylum... There is nothing impossible with our Heavenly Father all powerful He could give me wings as easy as He"

Ralph M.
1841-1911
Husband, Father, Farmer

A patient at 999 Queen Street West from 1898 until his death in 1911.
Chapter 1. Introduction: The Historiographical, Physical and Therapeutic Setting

The Historiographical Setting

The people who inhabited the Toronto Hospital for the Insane, 999 Queen Street West, between 1870-1940, lived and died during a period of colossal change in the local community and in the world of mental health care. Similarly, there have been colossal changes in the approach to the study of the history of psychiatry during recent decades. In order to provide background information about each of these areas, a discussion of the historiographical setting will place this thesis within the context of scholarly studies on this topic, after which a survey of the physical setting and therapeutic setting will round out this introduction.

The confinement and treatment of individuals in institutions for the insane has aroused considerable interest among academics since the 1960s. A number of approaches have been advanced to understand the asylum, its inhabitants and their caretakers over the last thirty years which examine social control, gender, and more recently, patients' perspectives. Prior to this, Whiggish interpretations dominated accounts about the great men and heroic advances of what is now called psychiatry, a term which has been widely used among practitioners only since the early twentieth century, though it has been applied to the distant past as well.(1)
This began to change when the work of French philosopher Michel Foucault challenged the linear view of historical progress. In his 1961 doctoral thesis, published in an abridged English version in 1965, Foucault argued that the insane asylum, as it had developed by the early nineteenth century reflected the values of a rising middle class and capitalist economy. The insane, he argued, were made to feel guilty for their affliction by the bourgeoisie who would not tolerate behaviour that was seen as both irrational and unproductive in a world where rational thought and a utilitarian existence were increasingly seen as barometers of public morality. (2)

American historians such as David Rothman, Christopher Lasch and sociologist Andrew Scull have also contributed to the social control school of thought. They argue that the asylum was used to deal with people who were non-conformist and who therefore threatened the dominant ideological underpinnings of middle-class morality in which predictable behaviour and hard work were stressed. (3) Critics of the social control approach, such as Eric Midelfort and Klaus Dorner, have questioned Foucault's seriously flawed empirical research and generalizations about the insane. Regional variations between France, Britain and Germany were not taken into account by Foucault and he only concentrated on state-run institutions. (4)

The critique of the Marxist approach, as Mark Poster has noted, centres around the de-emphasis of economic
determinants as the primary force for historical change. While capitalism may provide the basis for the rise of certain institutions, it does not provide an understanding of the nature and dynamics of the power-knowledge relationship according to followers of Foucault. (5) Gerald N. Grob and Marlene A. Arieno have also criticized the social control model for not taking into account the changing functions of the asylum in the nineteenth and twentieth centuries when certain groups such as the senile and aged were committed because there was no other source of support for them. Thus the nature of the asylum population, who were frequently committed by their families, was a more important feature of its changing role in the community than any broad ideological construct. (6)

Feminist studies have pointed out the importance of gender in understanding the different forms of treatment accorded male and female patients. Elaine Showalter, Phyllis Chesler, Yannick Ripa and Jane Ussher have argued that perceptions of madness in Western Europe and the United States during the last two hundred years have been characterised by viewing insanity as a predominantly feminine trait in contrast to the "rational" male. (7) Wendy Mitchinson has also discussed how the nature of women's bodies in nineteenth century Canada led to treatments such as gynaecological surgery which was influential in keeping women under control, though she also noted that this surgery was opposed by some asylum
superintendents. (8) Efforts to understand how insanity has been defined for both men and women, based on notions of masculinity and femininity, have been studied by John S. Hughes, Janet Oppenheim and Joan Busfield. (9) The nature of cultural and genetic influences on mental health has been studied by Edward Shorter in an effort to uncover the causes of psychosomatic disorders. (10)

Case studies have also been very important in bringing to light the intricate details of the operation of the asylum. Nancy Tomes’ work on the mid-19th century Pennsylvania Hospital for the Insane has shown that families of patients were very influential in sending people to asylums. Physicians merely confirmed the necessity for admission, rather than orchestrated it as social control theorists have argued. (11) The study of the London, Ontario Asylum by S.E.D. Shortt and Ellen Dwyer’s work on the Willard and Utica Insane Asylums in New York state during the nineteenth century, have shown how daily routines, doctor-patient relationships, and family intervention can be illuminated by a critical examination of hospital records in an effort to understand the internal dynamics of an institution’s operation. (12) Cheryl Krasnick Warsh’s study of the Homewood Retreat in Guelph, Ontario, and Charlotte MacKenzie’s work on the Ticehurst Private Asylum in Britain, have shown that private institutions differed significantly in certain respects from their public counterparts in that the former were not so completely alienating from the
outside world as the latter, though this was due more to problems of administration and finance than due to altruism. (13)

The influence of the community on the treatment and care of mentally ill people is the subject of a study by Denise Jodelet on the French town of Ainay-le-Chateau. (14) Elizabeth Lunbeck examines how early twentieth century psychiatrists at the Boston Psychopathic Hospital went beyond the confines of the institution and extended their professional territory by analyzing the daily troubles of a growing community. (15) Peter McCandless has provided the most expansive case study by looking at the treatments accorded the insane in South Carolina between 1670-1920, though he primarily concentrates on the women and men who were confined at the state’s mental hospital after it was built during the 1820s. (16) His work about an understudied region follows upon Steven Noll’s book which examines facilities for the mentally retarded in the southern United States during the early twentieth century. (17) This book was published shortly after James L. Trent’s ground-breaking history of mental retardation in the United States, an area of medical history which has only recently begun to attract widespread scholarly attention, unlike the much more developed field of studies about people who were considered insane. (18)

Articles on the London, Ontario Asylum by Cheryl L. Krasnick during the late 19th century and by Mary-Ellen Kelm
on the admission and daily routine of women at the British Columbia Provincial Hospital for the Insane between 1905-15, have provided additional contributions to Canadian psychiatric history along with the earlier cited studies on women and doctors in Victorian Canada and the Homewood Retreat.(19) Other Canadian studies in this field include Andre Paradis’ article on the obstacles encountered in setting up Quebec’s Beauport Asylum in 1845, Barry Edginton’s thesis on the rise of asylum policies in early nineteenth century Upper Canada, and Edgar-Andre Montigny’s article on family care for aged people in 19th century Ontario.(20) Studies on mental retardation and the history of mental health policy in Ontario have also been published by Harvey Simmons, John P. Radford and Deborah Carter Park.(21) Jennifer Stephen has examined how working class women were classified as “feeble-minded” at the Toronto Psychiatric Clinic between 1918-1923.(22)

The one institution in Canada which has received greater attention than any other facility for the insane is the one which is the focus of this thesis. Thomas Brown wrote an administrative history up to 1911, Wendy Mitchinson has used case files to study gender relations and therapeutic treatments and, most recently, James E. Moran has published an analysis of the lives of female and male attendants at 999 Queen Street West between 1875-1905.(23) Given that Canadian medical history is a relatively young field, it can be stated that the Toronto Hospital for the
Insane has been comparatively fortunate to have received so much interest. However much it has been studied, this institution shares one common feature with much of the rest of psychiatric history in Canada and elsewhere, up to the last few years: an absence of patients' voices. An attempt to remedy this historiographical gap is the purpose of this entire thesis and is why it is a different approach from what has been done thus far. Lykke de la Cour is presently working on her doctoral thesis in the Department of History, University of Toronto on the experiences of women patients at the Ontario Hospital, Cobourg from the 1920s to 1970s. Irit Shimrat, an independent researcher based in Vancouver, is also presently writing a book on the history of groups run for and by psychiatric patients in Canada. These studies will be among the first in Canadian psychiatric history to examine the period beyond the mid-twentieth century. Before getting into the history of the Toronto institution, it is essential to round out this historiographical survey with a discussion of how patients' perspectives have developed in recent years.

Looking at the history of medicine from the point of view of patients' experiences is an area which has only recently been given serious attention. One of the first scholarly studies in this regard is Sheila Rothman's book Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History. In this study Rothman uses the accounts of patients to understand
what they thought about their medical condition and relations with doctors. More generally, using medical records to reconstruct historical experiences has generated increasing interest in recent years with a number of articles on methodology. Guenter B. Risse and John Harley Warner have noted that much more work needs to be done in researching hospital records for what patients thought about illness and treatment. (26) At the same time, historians such as Michael MacDonald have noted the methodological constraints when using primary sources which were written from the point of view of observers rather than from the perspective of people believed to be of unsound mind. (27) This cautionary point, however, should not prevent more extensive research into the patient's perspectives by uncovering the recorded behaviour and comments of people who were mentally ill. A number of examples of writing from the patient’s perspective will be mentioned to demonstrate how this point has been approached thus far.

When a researcher is fortunate enough to have access to the writings of particular patients the result can be an impressive account of what it was like to experience confinement. Barbara Sapinsley's biography of Elizabeth Packard, an asylum critic and advocate on behalf of patients who was confined for three years in the 1860s, and John S. Hughes' edited collection of letters written by a "Victorian Madwoman," Andrew M. Sheffield, incarcerated for the last thirty years of her life, are two recent examples of
American patients who left enough documentation to go far beyond the medical recorder's views, into the world of the patient or former patient. (28) Similarly, primary sources left by John Willis Mason have been used by Michael Barfoot and Allan W. Beveridge to discuss his life as a patient in an Edinburgh asylum during the second half of the nineteenth century. (29)

Anthologies of writings by people who were in institutions, edited by Dale Peterson and by Jeffrey Geller and Maxine Harris, have provided valuable first-person accounts, almost all of them critical of their treatment. (30) I.D. Smith and A. Swann use the writings of J.R. Adam and James Frame to present a more positive perspective of the asylum by inmates from 19th century Glasgow, while Steven Noll discusses the views of inmates at the Caswell Training School in early twentieth century North Carolina. (31) Examination of how race and ethnicity have influenced diagnosis, and the related study of psychiatric history outside of Europe and North America, has also been developed in recent years. This includes work by Roland Littlewood, Maurice Lipsedge and Suman Fernando, as well as Jonathan Sadowsky's article on the views of Isaac O., a man who was confined in Nigeria at different times between the 1930s to 1960s. (32) Roy Porter is the most prolific English-language researcher uncovering the individual lives of people looked upon as insane since the seventeenth century. His work is either in the form of social history
or collection of writings. In these cases patients can speak for themselves because of the writings they left behind, an option which many illiterate and semi-literate people did not have.

The question, then, is how to move beyond only first-person accounts of insanity to allow hospital documents to be used to reveal the views of psychiatric patients. In his introduction to the anthology, The Faber Book of Madness, Porter observes that the "writings of these outcasts...cannot simply be written off as delusional. They contain astonishing insights into their own disturbances and into the wider questions of normality and abnormality." Yet in his earlier work, A Social History of Madness, Porter implies that it is not even possible for an historian to move beyond first-person accounts of madness when trying to retrieve "lost voices." Their insights, unless written of their own accord, will have to go undetected by historians, even though medical records, very plainly in many cases, often record the perspective of a patient on any number of matters. Thus for Porter the issue is one of methodology, in which he wishes to "simply and quite literally...see what they had to say" rather than "reading between the lines" or "explaining away what they said." The sources which Porter examined consist primarily of first-person accounts written by literate, relatively privileged members of society in the form of diaries, letters, or memoirs and therefore represent a very narrow
segment of people who were classified as insane. The records examined for this thesis attempt to fill in this gap in understanding the patient experience by bringing to light the lives of ordinary men and women, many of whom kept no first-person accounts, along with references to privileged patients. This evidence from clinical records allows researchers to begin to move beyond the limitations of examining accounts written only by upper class or middle class patients.

The experiences of people who were institutionalized have also been recorded by oral historians and community literacy workers. The work of the Oral History Group at Kingston Literacy in Kingston, Ontario, has provided a permanent record of the views of five people who were incarcerated as children at the Rideau Regional Centre in Smiths Falls, Ontario during the 1950s and 1960s. There is also a publication from this same group about the lives of these five individuals as adults, as well as about the experience of confinement as seen through the eyes of the parents of one former inmate of this facility.

This approach to uncovering the voices of people who have lived in long-term health care facilities, developed by community activists working independent of conventional historians, provides an invaluable example of the importance and fruitfulness of hearing the patient's views.

Since the nineteenth century, people who have been in mental institutions have published accounts of their
experiences, and some like Clifford Beers, have gone on to have a significant impact on mental health policy. (38) In recent decades, as access to information has expanded, people who have been in psychiatric institutions have published more memoirs than ever before. (39) This has provided a rich and constantly growing collection of writing on patients' perspectives and includes magazines and newsletters written by current and former psychiatric patients. (40) These accounts range from anti-psychiatry views to writers who advocate working within the mental health system, to individuals who express both critical and supportive perspectives on psychiatric treatments. (41) The diversity of views among current and former patients about their experiences and approaches to mental health, indicates the fallacy of trying to categorize recipients of psychiatric treatment as belonging to a homogeneous group.

Given these historiographical and contemporary developments, the need for more histories from the perspectives of people who have been confined in mental institutions is clear. Such work can serve as an addition to the already well developed field of examining psychiatric history from the perspectives of administrators and practitioners. This does not mean writing the doctors out of asylum history, an approach that would be historically inaccurate and would in itself ignore an important part of this type of history: staff-patient relations. Nor is this approach meant to portray all physicians and hospital staff
as in perpetual conflict with their patients, for employees were as varied in their views and practices as were inmates. Indeed, intense disputes between physicians over therapeutic approaches preclude generalities about alienists (or psychiatrists), a point which will be noted elsewhere in this thesis. Rather, the primary purpose of this thesis is to write history where patients’ views and experiences are at the forefront of historical inquiry instead of coming second to the administrators who ran the institutions. In so doing, this work is an attempt to make a contribution to the on-going historiographical dialogue on what it was like to be in a hospital for those patients who were diagnosed with a mental illness.

Chapters are divided into the general themes which illustrate the lives of mental patients, from the admission and diagnosis of a person as mentally disturbed, to their daily relationships and leisure and labour activities which they engaged in, either at their own behest or at the direction of hospital officials. Family relationships will be discussed throughout, with a chapter devoted to the families’ perspectives on the institutional experience, followed by a discussion about the last part of an inmate’s life, discharge and death. Throughout these varied themes, patients’ views and experiences form the core of each chapter, save in the one on family and community perspectives, though here too patients’ perspectives will be included.
The main sources used for this thesis are the material contained in the clinical files of four hundred patients who were admitted to the Toronto Hospital for the Insane between 1870-1907, most of whom had died or had been discharged by 1940, hence the termination date for this study. All records are stored at the Archives of Ontario, Toronto, RG 10, Series 20-8-2, Queen Street Mental Health Centre Records, Box Q1 to Box Q11. Every patient record in these boxes was methodically examined and those that were selected were chosen on the basis of what their files reveal about patients' experiences. Therefore, this was not a random selection. If one document in a file had a statement, or more than a statement such as a transcript of an interview, which expressed the point of view of a patient through a third party, this file was chosen. All files which contained writing[s], or in a few instances, drawings, from a patient were selected without exception. The methodology used for this thesis was based entirely on uncovering every and anything about the experiences of psychiatric patients as was available in each person's records and was not based on a numerical quota. When a file was selected, material that provided an overall understanding about an individual's life was included. As much information as possible was selected on a patient's life that existed in a file, beyond the document[s] that shed light on a given patient's perspective. This approach led to the selection of predominantly chronic patients, people who stayed for at least
several years, if not decades, in contrast to individuals who resided at 999 for several months. Long-term patients were more likely to have a larger accumulation of documents than did short-term patients, though this was not always the case. These documents include administrative correspondence between hospital officials and families and friends of inmates, as well as letters to and from government inspectors. There are also clinical records and charts in files, primarily dating from after 1907, providing information on the mental and physical state of patients, as well as about relationships within the institution. Without any doubt, the most treasured resources uncovered for this thesis are writings from the patients themselves, either written while still confined, or after they were released. These invaluable documents provide the most important insights into life in a mental hospital from the patients' perspectives that a researcher could possibly hope to find. In order to adhere to the Freedom of Information and Protection of Privacy Act of the province of Ontario, all patient files have been re-coded. Patients who were admitted less than one hundred years ago, that is after January, 1897, have had their names and the names of their relatives anonymized, using their actual first and last initials. It should also be noted that there are some patients who were admitted prior to 1897 who have had their names anonymized as well, though this is not standard in every case for people admitted prior to 1897.
In and of themselves, these case files, and thousands more from this institution, contain a rich mine of material that has already been delved into by historians in the recent past, and can contribute to many more projects in the future. However, two cautionary points need to be addressed. The first point is that there is a wide variation in material in these records, with some files containing hundreds of documents which accumulated over decades of a patient's life, while other files have very little material. This lack of material in some files includes long-term patients who were among the most isolated inmates who had no outsiders inquiring about them. In order to provide as wide a variation as possible on patients' experiences, including from among isolated inmates, information from files has been used on the basis of themes set out in this study. This has included material from the slimmest to the largest folders. A small amount of material in a file does not mean lack of value, just as a large number of documents does not mean an automatic treasure trove about patients' views. For example, there are files which have only a few documents but which include invaluable insights into a particular patient's perspective, while other files have an enormous amount of material but contain little or nothing about an inmate's views. This is why the selection process was one in which each and every item in all files were examined from the least obvious, such as receipts, to the most obvious, such as clinical records, in
an effort to uncover primary sources that could shed light on the lives and views of psychiatric patients.

The second point is to emphasize that this thesis does not claim to be representative of a majority of patients who were admitted to this particular facility. During the seventy years covered by this thesis, 18,643 women, men, and in some cases, children were admitted or re-admitted to 999 Queen Street West. Given such massive numbers of people, no study could dissect each and every file, not least because not all files have survived. Where statistics have been used, these have been gleaned from the Annual Reports of the Inspectors and Superintendents rather than from clinical records. While statistics can provide details on certain general trends, such as deaths or numbers of patients who worked during certain years, this material cannot provide the information that is essential to understand what patients thought about what was happening to them, as is contained either in their own writings or in third-party observations. A qualitative approach may only provide a "snapshot" of an inmate’s views or experiences at a given moment in time. Nevertheless, a "snapshot" can provide a far more concrete indication of a patient’s views than can be provided by statistics where an individual is subsumed under a mass of aggregate data. Weaving various "snapshots" together under specific themes, as is done here, can provide a far more complete picture of patients’ experiences, than a quantitative approach could ever
possibly begin to do. Just as a picture can be worth a thousand words, so too a "snapshot" of a patient’s life can be worth a thousand statistics. It is this desire to understand the individual experiences of the people who make up this thesis, within the overall context of institutional practices and relationships, that is the over-riding purpose of this study. In order to provide part of the picture of this overall context, it is essential to provide a brief historical survey of the physical and therapeutic setting between 1870-1940 at the Toronto Hospital for the Insane.

The Physical Setting

The first Provincial Lunatic Asylum opened with seventeen patients in 1841, and was originally situated in the county gaol on Toronto Street. There was not enough space however, so branch facilities were set up in a house at the corner of Front and Bathurst Streets and in the east wing of the Parliament Buildings. In January, 1850, a new insane asylum located three miles west of downtown Toronto, at 999 Queen Street West, received its first patients. This new facility was only several hundred yards north of the shores of Lake Ontario and was placed on unoccupied farm land, away from the bustling core of the nearby city. However, this rural tranquillity was not to last. By the late 1880s, the institution’s grounds had been reduced from over a hundred acres to 26 acres, and by 1940 the total land mass for 999 was only twenty acres. The asylum’s designers had wanted to move away from the city, in
the tradition of William Tuke's famous retreat where the insane could recuperate in peace and quiet, in the clean air of the country. However, the urbanization of Toronto and the birth of the local community of Parkdale in the 1870s, just west of the institution, led to the re-absorption of this mental hospital back into the city. In a forty year period after 1851, Toronto's population had grown by five times from 30,000, to 150,000, and by the mid-twentieth century, the core city alone was teeming with 675,000 people, while the suburbs had another 360,000 inhabitants. Though there was talk of closing down this location entirely, especially during the first two decades of the twentieth century, this never happened so that to this day there remains a mental health facility on the grounds that were opened in 1850.

During the period studied here, the name of this facility changed four times: Provincial Lunatic Asylum, 1841-71; Asylum for the Insane, Toronto, 1871-1907; Hospital for the Insane, Toronto, 1907-19; Ontario Hospital, Toronto, 1919-66. In order to provide consistency, the standard full reference for this thesis will be Toronto Hospital for the Insane, while the terms asylum and hospital will be used in short forms, as both these words were used by patients even after name changes. The chronic care background of the patient population at the Toronto facility was reflected in annual reports throughout this period. In 1876 it was estimated that seven-eighths of the asylum population were
chronic and by the turn of the century it was estimated 81.5% of all admissions to 999 were in this category. (50)

By 1940, over 85% of patients at the Toronto Hospital for the Insane were not considered fit for discharge, indicating how chronic care was the primary feature of the patient population over the seventy years considered here. (51)

What kind of a building did these patients live in?

By the time that this study begins in 1870, the central administrative building and the attached east and west wings had been built, structures which remained until their demolition in the mid-1970s. (52) This structure was 584 feet in length, ranging from four to five stories high, each story averaging eleven and half feet in height. The front of the building was 120 feet long and 90 feet in depth, with the extreme height of the dome tower being 120 feet from the ground and forty feet in diameter. During the early years of its existence, the asylum dome tower was the tallest structure in Toronto, a modest precursor of the CN tower, and as famous in its day to the local inhabitants.

The two oldest wings which patients lived in during this entire period faced north and were 210 feet in length each, excluding verandahs which were 50 feet in diameter, 30 feet by 20 feet. These wings were 60 feet wide and 45 feet in height. Two more wings for patients were opened in the early 1870s and remained in place for a century. These wings were attached to the main building and faced south. They were 215 feet in length, 60 feet wide, four storeys in
height like the older wings, and also had the same types of verandahs.\(53\)

The basement was four feet below the surface and included stores, workshops, and dormitories for some working patients. Corridors throughout the above-ground buildings were fourteen feet wide at the end of which were the semi-circular verandahs on each ward, noted above.\(54\) Non-resistant patients could be domiciled in so-called cottages, which were massive three storey houses on the grounds.

There were three such facilities at 999, two for over one hundred females and one for about fifty males, which were used from the 1880s onward.\(55\) From 1906 to 1917, when it was condemned as unsanitary, the nearby "King Street branch," or Mercer Reformatory, was used to house approximately 125 female patients from the free wards to relieve chronic overcrowding.\(56\) When it was closed, additions were made to one of the cottages and an industrial building to house patients. This overcrowding, which C.K. Clarke publicly referred to as "embarrassing" in 1909, frequently led to administrative offices being turned into dormitories and other structural adjustments, as some patients even had to sleep on sofas in corridors.\(57\) Staff residences also changed from being in separate housing on the grounds to nurses being domiciled on wards with patients by the 1920s and sleeping in the upper floor of the main building during the 1930s.\(58\) The physical awkwardness of certain aspects of these facilities was commented upon by
Superintendent Daniel Clark in 1904, a year before he retired, in an illuminating critique of the original architectural style:

The church, so called, was in a dingy garret, under the dome. The pulpit was built ten feet in height and a stair was made so that entrance was procured by it from the outside corridor. The preacher was supposed to be in danger when addressing the patients so in order to secure his safety he could not be reached from the pit in which they were gathered below. Small windows were put in near the ceiling to be beyond the patient’s reach. This shows the erroneous opinion architects and boards had in respect to lunatics. (59)

As will be discussed in Chapter 5, a more accessible and less foreboding chapel was built with patient labour during the early 1890s. In total, there were sixteen wards, eight for males, eight for females. Six wards out of the total were for paying patients who were charged from two to six dollars per week, with the largest number of beds being on public wards which had up to eighteen people sleeping in each dormitory, while the most privileged patients could purchase their own private rooms. (60) Each ward had dining and sitting rooms, toilets and washing amenities, dust and clothes shafts. Not surprisingly, there was more attention to providing comfortable furnishings on the most expensive paying wards, than on the free wards. (61)

There were also two infirmaries separated from the main structure, one for each gender, 60 feet by 35 feet, a central kitchen building which was opened in 1890, a laundry building 122 feet by 52 feet, cow-sheds (which were closed in 1912), a mortuary and a farm which had dwindled to only
several acres by the late 1880s. There was also a small garden, trees and a large fountain facing Queen Street to the north, and two smaller fountains in the back of the grounds.(62)

While the buildings were completely refurbished in the 1920s, and a new laundry was built at that time, the physical dimensions remained essentially the same throughout this period as the old structures remained in place.(63) There was not too much room to manoeuvre for patients or staff, a point which officials complained about over the years as neighbourhoods and nearby industries, notably the railroad yards to the south, overtook the once quiet countryside.(64) Out of all this, all that remains of these various structures in the late 1990s are the brick walls on the east, west and south sides of the present-day Queen Street Mental Health Centre. The old brick wall facing north, which completed the physical circumvention of the grounds, has been torn down. As will be discussed in Chapter 5, these walls were built primarily by patients in the late 1880s and averaged 16 feet in height.

The Therapeutic Setting

So what happened within the walls of this massive institution? Before getting into the core chapters which answer this question, a general outline of therapeutic developments between 1870-1940 is necessary to provide a medical context for the lives of the people who make up this study. Table I provides an overview of the different
approaches to medical therapeutics that were in place at 999 Queen Street West between 1870-1940, and reflect very much on broader developments within the international field of mental health care. As will be discussed in the chapters on leisure and labour, during the second half of the 19th century Canadian officials who were responsible for insane asylum inmates implemented moral treatment as a form of institutional therapy. While the therapeutic emphasis would shift over the seven decades studied here, if there was one continuity it was that elements of moral treatment remained in place during the entire period under consideration. As with their British and American counterparts who had earlier used the ideas of William Tuke to try to move away from physical coercion, Joseph Workman, Superintendent from 1853-75, and Daniel Clark, Superintendent from 1875-1905, both saw this approach as more humane.

Part of this non-coercive policy was to declare the end of using physical restraints at 999 Queen Street West in 1883, an approach which reflected the then on-going debate among authorities at Anglo-American institutions about the efficacy of this approach. What this meant theoretically in regards to the day-to-day existence for patients was that they were no longer threatened with being confined in crib-beds, restraining muff, waist-coats and chairs. It also meant that most able-bodied patients were expected to engage in some work and entertainment as
part of their therapy, though this was not uniformly practiced, partly due to matters that were beyond the control of physicians, as will be noted later in this thesis. While John S. Hughes argues that moral treatment was more "feminine" than later "heroic" approaches, the large volume of work undertaken by both male and female patients indicates that this therapy did not produce a "soft" or easy life, as will be shown in Chapter 5.(69)

Both Workman and Clark advocated what can best be described as a "non-interventionist" approach to treatment, hence the categorisation of the 1870-1905 period in this thesis, as is outlined in Table I. While somatic intervention was practiced for physical ailments, neither physician believed in the large-scale use of medication to treat mental disorders. Drugs such as chloral hydrate, opium and bromides were used as sedatives, but Workman suggested that their use had been "overdone" outside the asylum, while Clark insisted that "fresh air, generous diet, and cleanliness," were better than drugs in treatments for insanity.(70) Clark advocated the use of alcohol as a way to make "excited" patients more manageable, which he said was safer than medications. However, he did this over the opposition of other Superintendents and Inspector Langmuir, as well the opposition of provincial politicians who, influenced by the temperance movement, reduced expenditures for this provision in 1878.(71) Thus the hospital's daily routine consisted of a small amount of alcohol consumption,
usually whiskey, among disturbed inmates. Patients who refused to eat could also be force-fed with a stomach tube, as occurred to an unnamed woman in the late 1870s to whom this was done 558 times, twice a day with food being mixed at times with whiskey and cod-liver oil. (72)

Clark’s publicly stated conservatism in treatment most certainly saved some of his patients from further anguish in one important respect: his opposition to operating on the sexual organs of inmates, primarily females, to "cure" their mental distress, as will be mentioned in the chapter on admission and diagnosis. (73) Yet this conservatism did not stop him from initiating an important advance in medical therapeutics at 999. In 1898, Clark began employing a dentist for paying patients, though he also asked that money be set aside for the treatment of free inmates. Clark pointed out that proper dental care would lead to better mastication habits and an improved diet which would have a positive physiological impact on a person’s physical and mental health. (74) Within a few years, money had been set aside to treat a minority of free patients and by 1931, this programme of dental hygiene was adopted across the province when dentists were employed part-time in mental hospitals to examine all patients. (75) It is interesting to note that Josephine Wells, one of Canada’s first female dentists, was employed by Clark during the early years after this treatment began at 999. (76)
In 1898, Daniel Clark wrote that, where mental disorders were concerned, "correct classification is impossible." (77) This view is striking when contrasted with the therapeutic approach that followed his retirement and the appointment of Charles Kirk Clarke as Superintendent in 1905. Daniel Clark's views were similar to that of other asylum administrators during the late nineteenth century, who believed that the insane were to be managed within the walls of an institution where an active medical cure was unlikely for a condition believed to be degenerative. (78) However, by the turn of the century, with increased disputation between therapeutically conservative asylum superintendents and more interventionist-oriented neurologists, there was a greater emphasis among mental hospital administrators to demonstrate the relevance of their work in the relief and interpretation of mental illness. (79) In an effort to do this, North American alienists began to look to German and Swiss doctors like Emil Kraepelin and Eugen Bleuler who developed more scientific standards in the study of mental illness. (80)

The acceptance of the German school of classification for psychiatric patients by doctors at Toronto is reflected in their published writings and in clinical records beginning in 1906-07. This time period is significant, for it marks the early years of C.K. Clarke's superintendency, a post he held from 1905-11 when he was succeeded by J.M. Forster who was in charge until 1920, and who was in turn
succeeded by Harvey Clare as Superintendent from 1920-25. Forster, Clare and Superintendents who came after them, such as F.S. Vrooman and W.C. Herriman, were all trained in this classification system which became the accepted diagnostic approach at Ontario mental hospitals well into the 1930s and 1940s, though as will be noted, this later period became much more interventionist. (81)

As Thomas E. Brown has written of the early years of the 20th century, "psychiatrists insisted that the first priority was the proper classification of the insane." (82) This desire to come up with a more definitive and standard code of diagnoses was seen as important in very large part because of the desire amongst psychiatrists to be taken more seriously by other members of the medical profession. One of the 999's physicians, Dr. Ezra H. Stafford, chided his colleagues in 1897 for the "consummate awkwardness" of their terminology, observing: "This intolerable evil of many names makes psychiatry the ridicule of the outside profession." (83) Nearly a decade later, Dr. C.K. Clarke told a meeting of the British Medical Association in August, 1906 that Kraepelin's practice of conducting systematic clinical investigations of patients over a number of years would put the psychiatric profession "on a more solid basis than has yet been the case." (84) Like Kraepelin, Clarke believed that there was an organic basis for mental disorders such as dementia praecox. (85) After visiting Europe, and meeting Emil Kraepelin and Eugen Bleuler,
medical conferences were instituted three times a week in 1907 at the Toronto facility to discuss diagnoses and to develop "true standards" about which psychiatrists could agree. (86)

Thus, the adoption of Kraepelin's methods of systematic investigation and classification by Dr. Clarke and other prominent Ontario officials was done in part because of a desire to bring some order to the chaotic world of early twentieth century psychiatric diagnosis. This approach was also accepted in the hope that systematizing would improve the reputation and prestige of a profession which practitioner's felt was badly in need of greater legitimacy. By 1908, Clarke noted that 55% of all patients at the Toronto facility had dementia praecox. (87) This desire for more professionalization was also reflected in the introduction of a training school for nurses at the Toronto mental hospital in 1906, the first such school in all of Canada. (88) By the time he left 999 Queen Street West in 1911, Clarke's model of nursing schools had spread to other parts of Ontario. (89)

Closely connected to these professional pressures and changes was the modernization of hospital bureaucracy. As Barbara Craig has shown in her work on hospital records and record-keeping in Ontario and London, England between 1850 - 1950, the expansion of the medical bureaucracy after 1890, and especially the use of typewriters by the early twentieth century, had a significant impact on the scope and extent of
records kept on individual patients. (90) Again, the influence of the new classification scheme can be discerned in these developments. Clarke believed, along with Kraepelin, that tracing the heredity of a person was crucial in determining the outcome and thus the diagnosis of mental patients. (91) In order to do this a more extensive mode of record-keeping was introduced, and a large portion of this thesis uses the records which were established during these years. Classifying patients included not only new arrivals, but also long-term patients who had been admitted prior to 1906. More than two hundred patients admitted between 1861 to 1906 have an official medical conference report from November, 1911 with Assistant Superintendent Harvey Clare's initials. One-hundred and eighty of these patients were given the most prevalent diagnosis, one of three forms of dementia praecox, or what came to be categorized in provincial reports as schizophrenia by the early 1930s. (92)

In an article published in 1916, Harvey Clare noted that the largest percentage of patients in provincial hospitals were those with dementia praecox, making up 25% of all people admitted. (93) The remaining patients were diagnosed with manic depression at 15%, followed by 10% each for people with diagnosis of senility, involutional melancholia, general paresis, and exhaustion and 5% each for epilepsy, "imbeciles," alcoholism, and other drug and toxic problems. (94) The view that dementia praecox was "the most frequent form of mental disease" was widely accepted among
asylum doctors within a few years of this classification system being introduced to Ontario, as is made clear by Dr. J.P. Harrison in an article published in 1910. (95) Harrison wrote about the numerous psychoses which were grouped under this term and stated: "There is consequently little to be gained by efforts to differentiate too sharply between the various subdivisions, for many symptoms are common to all." (96)

While mental hospital doctors placed most of their emphasis on proper classification, it would be inaccurate to portray the 1905-24 period as being without some form of active therapies. For example, in 1906 hydrotherapy was introduced at 999. (97) This treatment was continued well into the 1930s when more continuous baths were added. (98) Water therapy was intended to calm the nerves of excited patients and soothe depressed people. (99) Emphasis on individual treatment was also encouraged during the classification period, and included a new outpatient service for low-income patients which was opened in 1909. Ernest Jones was placed in charge of this clinic, though none of these latter patients were admitted to the asylum. (100) However, by the mid-1920s, efforts to clearly categorize mental patients and their disorders were increasingly influenced by a desire to be more active than ever before in finding relief for mental illness. This led to the era of "heroic" treatments.
While there was a continuation of classifying patients along the lines first established in the years after 1905, the later period covered by this study is characterized by the rise of interventionist treatments, which continued past the period looked at in this thesis which ends in 1940. As with the other therapeutic developments outlined above, these treatments for mental illness occurred within the context of approaches first developed in Europe and the United States. At the Toronto institution, the first signs of this more active approach occurred in 1924, when sulfoxyl salvarsan began being administered through intramuscular injections to syphilitic patients. (101) These treatments continued for at least seven years. By 1931, seventeen hundred injections of manganese chloride were given annually to over one hundred patients to treat syphilis, and patients with this disorder were also given malaria during the early 1930s in an effort to relieve their illness through an induced fever. (102) Salvarsan was considered relatively effective in the treatment of infections found in advanced cases of syphilis, but it was ineffective in relieving firmly embedded brain damage caused by the disease. This was a widely promoted treatment by the Austrian psychiatrist, Julius Wagner von Jauregg, who developed the method of inducing fever in patients. (103) Doctors at Toronto, like elsewhere, concentrated most of their interventionist treatments on syphilitic patients up until the mid-1930s. The organic nature of this condition
was viewed as the basis for mental illness, and to conclusively arrest this disorder would be considered an essential breakthrough.\(^{(104)}\) However, towards the end of the period studied here, there was greater interest in expanding "heroic" treatments beyond patients with syphilis, as a "therapeutic and theoretical vacuum," had developed within psychiatry, as Elliot S. Valenstein has observed.\(^{(105)}\) This led to somatic treatments being directed at larger numbers of patients who were diagnosed with chronic mental illness.

By the end of this decade, interventionist treatment had increased significantly. The first insulin shock treatments in Ontario occurred in May, 1937 at the mental hospital in New Toronto (or Mimico), four years after this first of the three shock treatments was reported in Europe.\(^{(106)}\) Due to its relative "simplicity" to administer, metrazol shock therapy, instead of insulin shock, was introduced at Toronto, Whitby, Hamilton, London, Kingston, and Brockville mental hospitals in 1938-39. Out of 443 patients treated during this first period, 74% were men and women diagnosed with schizophrenia, 21% were diagnosed with manic depression and 5% had involutional melancholia. It was found that insulin shock gave better remission rates with schizophrenia, and metrazol shock worked better with people in the other two categories. It was also noted that "More severe complications follow metrazol therapy," which most likely referred to fractures.\(^{(107)}\)
By the end of the period studied here, Superintendent J.R. Howitt recorded the introduction of an artificial fever therapy unit at 999. Established to treat patients with syphilis, these "fever cabinets" were said by Howitt to have been "very satisfactory" for this purpose. (108) Shock treatments and fever cabinets continued to be used into the 1940s, as the interventionist period which had begun in the mid-1920s reached a crescendo throughout the province, especially between 1945-55 when lobotomies were performed. (109) It was well after the period studied here that "heroic" treatments were largely superseded by the introduction of neuroleptic drugs, such as chlorpromazine in the mid-1950s, a development which ushered in another new era in the history of psychiatric treatments. (110)

With these broad historiographical, physical and therapeutic contours outlined, the stage is set for a more detailed consideration of patient life at the Toronto Hospital for the Insane between 1870-1940.
Notes:

All patient file numbers for this thesis have been re-coded, and patients admitted after 1897, and their relatives, have had their names anonymized using actual first and last initials, in accordance with the Freedom of Information and Protection of Privacy Act of the province of Ontario. Patient files are located at the Archives of Ontario, Toronto, RG 10, Series 20-B-2, Queen Street Mental Health Centre Records. Throughout the notes for this thesis, "AO" refers to the Archives of Ontario, and "AR" with the year, refers to Annual Reports of Inspectors of Insane Asylums (or Mental Hospitals as they were called in Ontario after 1907).


21) Harvey G. Simmons, *From Asylum to Welfare* (Downsview, Ontario: National Institute on Mental Retardation, 1982);


22) Jennifer Stephen, "The 'Incorrigible,' the 'Bad,' and the 'Immoral': Toronto's 'Factory Girls' and the Work of the Toronto Psychiatric Clinic," in *Law, Society and the State: Essays in Modern Legal History* Eds., Louis A. Knafla and Susan W.S. Binnie (Toronto: University of Toronto Press, 1995): 405-439. I would like to thank Lilith Finkler for bringing this article to my attention.


24) Among the historical studies that go beyond the 1940s in Canadian psychiatric history are: Anne Collins, *In the Sleep Room: The Story of the CIA Brainwashing Experiments in Canada* (Toronto: Lester & Orpen Dennys Publishers, 1988);


34) Ibid., p. xv.

35) The full quote is as follows: "I am not attempting to decode what mad people said, wrote and did in the light of some or other psychiatric theory, to reveal what disease or syndrome they really had or even to discover the "real" (that is, unconscious) meaning of their actions. S sensitively attempted, that can be a fruitful and illuminating enterprise. As a mere historian, I don't feel qualified, however, to undertake it. Neither is it my principal interest."
Rather I wish to examine not the unconscious of the mad but their consciousness. Instead of principally reading between the lines, searching out hidden meanings, reconstructing lost childhoods, baring unspoken desires, I wish to explore what mad people meant to say, what was on their minds. Their testimonies are eloquent to their hopes and fears, the injustices they suffered, above all of what it was like to be mad or to be thought to be mad. I wish simply and quite literally to see what they had to say. It is curious how little this has been done; we have been preoccupied with explaining away what they said." Porter, A Social History of Madness, pp. 1-2.


37) Kingston Literacy, I Live My Own Life Now (Kingston, Ontario: The Read-Write Centre, Kingston Literacy, undated); Kingston Literacy, If We Had Only Known (Kingston, Ontario: The Read-Write Centre, Kingston Literacy, undated, though written in 1992).


42) This figure was arrived at by adding all admissions between 1870-1940 noted in the annual reports. This can be done by subtracting 3,832 who were admitted up to 1869 from the 21,043 admitted up to 1937 and then add 1,432 who were admitted between 1938-40, to come up with 18,643.


44) AR, 1878, p. 263.

45) AR, 1885, p. 47; AR, 1888, p. 4; AR, 1940, p. 104.


48) For references to closing down the Toronto Hospital for the Insane see: AR, 1908, p. 3; AR, 1910, p. ix.
49) Since 1966, this institution, which was completely torn down and remodelled in the 1970s, has been called the Queen Street Mental Health Centre. The address has also been changed since 1979, when the modern building was opened, from 999 Queen Street West, to 1001 Queen Street West. This information, and the historical dates and names of the institution since 1841, can be found at the Archives of Ontario, Toronto, under catalogue "Inv. 10/2, Ontario Psychiatric Hospitals Branch, Series RG 10-20," on the first page entitled: "Queen Street Mental Health Centre Series, RG 10-20-B, Scope and Content."

50) AR, 1876, p. 207; AR, 1898, p. xv.

51) AR, 1940, p. 39.


54) Ibid.


57) AR, 1909, p. 3.

58) AR, 1923, p. 11, reports that fifteen nurses lived on wards, fifteen in one of the women's cottages. A year later over thirty nurses were reported living in the main building: AR, 1924, p. 8. Reference to nurses using the upper floor of the main building as a dormitory can be found in: AR, 1931, p. 21.

59) AR, 1904, p. 6.

60) AR, 1879, p. 28; AR, 1883, p. 48-49.

61) AR, 1882, p. 17.


63) AR, 1928, p. 6-7.
64) Daniel Clark complained that nearby trains "keep up a constant concert day and night," which upset patients, especially new arrivals. AR, 1876, p. 213.

65) Shortt, Victorian Lunacy, 128-29; Krasnick, "'In Charge of the Loons,'" p. 166-70.


68) AR, 1883, p. 62.

69) Hughes, "The Madness of Separate Spheres," p. 64.

70) AR, 1870-71, p. 131; AR, 1877, p. 245.


72) AR, 1877, 238.

73) References to Clark's stated medical conservatism can be found in: AR, 1896, p. 39; AR, 1898, p. 39.

74) AR, 1898, p. 40.

75) AR, 1900, p. 6; AR, 1931, p. 73.

76) See evidence of this in case files such as: Erin L., Patient File #3019. Receipt, August 28, 1901: 653 Spadina Avenue, Phone 3422, Re: Erin L. In Account with Dr. Josephine Wells, Dentist. Extracting and filling $2.00. Dental accounts were also arranged and settled by letter with family or friends of patients, or with the Public Trustee.

77) AR, 1898, p. 40.

78) Shortt, Victorian Lunacy, p. 124.


81) Superintendents at 999 Queen Street West during the period covered by this study were as follows: Joseph Workman, 1853-1875; Dr. Gowan, 1875; Dr. Metcalf, 1875; Daniel Clark, 1875-1905; C.K. Clarke, 1905-1911; J.M. Forster, 1911-1920; Harvey Clare, 1920-1925; F.S. Vrooman, 1925-1928; H.A. McKay, 1928-1930; W.K. Ross, 1930-1932; W.C. Herriman, 1932-1933; J.S. Stewart, 1933-1935; R.C. Montgomery, 1935-1937; J.R. Howitt, 1937-1941. Of these figures, Dr. Workman and Dr. C.K. Clarke, after whom Toronto's Clarke Institute of Psychiatry is named, have aroused the most historical interest. See for example: C.G. Stodgill, "Joseph Workman, M.D., 1805-1894: Alienist and Medical Teacher," The Canadian Medical Association Journal 95 (October, 29, 1966): p. 917-923; Cyril Greenland, Charles Kirk Clarke: A Pioneer of Canadian Psychiatry (Toronto: The Clarke Institute of Psychiatry, 1966); Ian Dowbiggin, "Keeping This Young Country Sane: C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1925," The Canadian Historical Review 76:4 (December, 1995): p. 589-627.


85) Ibid., p. 223.
86) C.K. Clarke, "The Psychiatric Clinics of Germany", The Bulletin of the Toronto Hospital for the Insane (This journal was renamed The Bulletin of the Ontario Hospitals for the Insane) 1:4 (January, 1908), pp. 18-20, re visit to Zurich Clinic and Bleuler; pp. 25-35 re visit to Munich; quote re "true standards" is on p. 30. See also, AR, 1907, p. 10.

87) AR, 1908, p. 4.


89) AR, 1911, p. 109.


92) Out of these 180 patients diagnosed with either hebephrenic, catatonic or paranoid dementia praecox in November, 1911, there were 87 women and 93 men who had been confined for between five to fifty years at the Queen Street facility. For an early reference to dementia praecox being referred to as schizophrenia in Ontario, see: AR, 1933, p. 75.


94) Ibid.


96) Ibid., p. 7.

97) AR, 1906, p. 7.

98) AR, 1932, p. 97.


100) AR, 1909, p. 3; AR, 1910, p. 101-02. For more detail on Ernest Jones during his years in Toronto from 1908-1913 see: R. Andrew Paskauskas, "Ernest Jones: A Critical Study


103) I would like to thank Professor Pauline Mazumdar for her comments on this point. See also: Valenstein, Great and Desperate Cures, p. 29-31.

104) Ibid., p. 32.

105) Ibid., p. 34.

106) AR, 1938, p. 5; Valenstein, Great and Desperate Cures, p. 47.

107) AR, 1939, p. 5-6; Valenstein, Great and Desperate Cures, p. 53.

108) AR, 1940, p. 21.


Chapter 2. Diagnosis and Admission

Introduction: The Admission Process

There were as many circumstances and responses which led to confinement as there were patients. These contrasting images ranged from the asylum being viewed with genuine fear and loathing to a place which was considered to be a last refuge for those who felt they had no where else to turn. These images appear again and again throughout this thesis, as patients, families and acquaintances tried to cope with a variety of personal crises that brought so many people to 999 Queen Street West, Toronto.

This diversity of views as expressed by people about to be committed is evident in the following two cases. Elizabeth W. was about to be sent to the asylum for the second time when an examining physician found her to be "very nervous and much distressed at the thought of returning to the Asylum," about which she had threatened to commit suicide.(1) Confined in 1893 at the age of 42, Elizabeth remained locked up until her death in 1920. Seventeen year old Henry N., on the other hand, told the committing physician that he "Wants to go to a Lunatic Asylum for a rest."(2) Confined in 1906, he was discharged six months later. While most admission papers do not contain many specific responses to the prospect of confinement, these two examples highlight important points: previous experience and the need for shelter. Elizabeth already had been in the asylum and it is obvious from her
comments that this had not been a positive experience, or why else would she have threatened to end her life if returned? Henry had no such previous experience of being a patient in an asylum. However, his admission papers state his utter terror of returning home, thus illustrating that for someone experiencing domestic problems, being confined appeared one of the few options available to getting away from the place of torment, while also ensuring one's basic needs were met.

Before uncovering what brought about this process, it is essential to set out the general medico-legal context of the committal process. Patients admitted during the period covered by this study had to have their diagnosis of insanity certified by registered physicians who conducted examinations prior to recommending an individual be sent on to the asylum. Patients admitted up to the summer of 1882 were required to be examined by three physicians. However, this changed after the middle of 1882 with examinations being conducted by two doctors, a practice which was maintained for the remainder of the time period under consideration. These documents took the form of official printed sheets, called Form K, and after 1882 Form A, providing two sections on one side of a foolscap page: one space was for the doctor's observations and why he believed a patient was insane (there were no female doctors), and the second section listed details provided by others, such as relatives or neighbours. For inmates confined in prison who
were transferred to the asylum, physicians or legal authorities wrote or typed statements attesting to a prisoner's insanity, which could be supplemented with a deposition in support of the doctor's statements from a family member or acquaintance. Along with the official statements certifying a person's insanity, one of the admitting doctors was required to fill out a Form of History of a Patient explaining in more specific detail the personal circumstances, as well as physical and emotional state of an inmate. This document went from two pages for the earliest patients being examined in this study during the 1870s to four pages in 1907, when it was decided by the Ontario Ministry of Health that a more detailed form would help with the scientific study of insanity. (3)

It is important to note that these Form of History documents were filled out only for those patients who were admitted from the community, whether resident in a private home, public hospital or a charitable boarding house. For those patients admitted from prison, there was instead a document referred to as "Schedule 2," which was more concise, one to two pages, which asked similar questions about an inmate's personal life and family background, albeit with less space than the more expansive Form of History. Prisoners were also required to have a transfer warrant to allow the police to transport all warrant cases to the asylum, where they could only be released upon the express authority of the Lieutenant-Governor of Ontario, who
usually took the advice of the Inspector of Public Charities on such matters, the direct superior of asylum superintendents in the provincial bureaucracy. In other words, there were two types of documents that were required to be filled out before someone could be admitted to an asylum: statements from two physicians (or three physicians before mid-1882) explaining why someone was considered insane, and a more in-depth form which described the personal background and condition of a person believed to be of unsound mind. There was also a certain protocol to be observed among doctors when engaged in the committal process. Practitioners from outside would sometimes send patients without notifying medical superintendents that a new inmate was arriving, and would at times neglect to fill out the necessary papers. This could create problems, not the least of which was providing space for an unexpected arrival. In order to prevent such occurrences, physicians were urged to telegraph or correspond with the relevant institution in their district to have the proper documents sent to them for certification, and also to give prior notice to asylum authorities about the arrival of a new patient. (4)

It should be pointed out that the information contained in these documents varies greatly. In some cases, there are very detailed accounts given of a person’s emotional state at the time of committal while in other examples there are very limited comments, sometimes no more than a sentence or
two. However, when considered as a body of evidence about patients at the beginning of their confinement, and life prior to admission, this material provides a wealth of detail about the social world and point of view of both recorders and people who were the prime focus of attention - the soon to be asylum inmates - as the following sections on gender and sexuality, violence and social support networks illustrate.

Gender and Sexuality

The confinement of individuals for matters relating to gender and sexuality needs to be placed in the context of the social attitudes of the time. In her discussion of middle class "manly nerves" in Victorian Britain, Janet Oppenheim has written about how most medical officials in the late nineteenth century saw masturbation as contributing to emotional collapse among those who engaged in this self-centred, uncontrolled "vice": "it curtailed and eventually destroyed a man's productivity; it sapped his vitality and at length rendered him idiotic."(5) Cheryl Krasnick Warsh has found that masturbation was more often linked to male committals to the Homewood Retreat in Guelph, Ontario nearly five-fold, in the late nineteenth century, than among females.(6) Since contemporary moralizing strictures against "self pollution" emphasized how much this practice was a dangerous waste of emotional and physical energy, it is not surprising that the more masculine of the two sexes would become the prime focus of this diagnosis, since
according to the predominant perspective among both physicians and laypeople alike, society had most to lose if males could not control their sexual impulses. This emphasis on males as being particularly prone to a sexual practice that could lead to madness is evident in thirteen admission records of people who were confined at 999 between 1880 to 1900. These thirteen individuals were between the ages of 16 and 44 of whom ten are males. Like his colleagues elsewhere in the English-speaking world, Superintendent Daniel Clark shared the prevailing medical/moral interpretation of masturbation, writing to a former student that his brother's delusional insanity with melancholy was due to his sexual habits since: "Your brother [William P.] has been up to admission a masturbator." In one case, that of 24 year old Edward M., a physician operated upon the patient's penis, "splitting the prepuce under cocaine....in order if possible to aid in a cure of his masturbating practices." Within two weeks of this operation, Edward became increasingly violent and distressed and was admitted to the asylum where he remained until his death twenty-five years later. The relationship between female sexuality and admission to asylum is evident through what Wendy Mitchinson describes as the "three mysteries," - puberty, menstruation and menopause. In her study of Toronto Asylum records prior to 1900, Mitchinson notes that nearly one-quarter of women sent to this institution had their diagnosis linked to
"female-related causes: childbirth, lactation, miscarriage, menstrual disorders, uterine disorders" and other similar ailments for those patients whose predisposing cause of insanity was recorded. This connection made by physicians between a woman's emotional condition and her physical state was very much tied in with the somatic theories of the time. It was standard teaching by the end of the 1800s among American and English medical authorities to relate problems in the area of a female's pelvis to her brain which they claimed led to emotional disturbances. Thus, it was in such a context that patients like Frances C. found herself confined in 1880 at the age of thirty-one. Never before having experienced any previous attack of madness, Frances' mental collapse was directly related to her having recently given birth. Sixteen days before admission she had experienced "protracted and severe labor," after which she became violent towards herself and others, including threatening her newborn baby and believing others were attempting to poison her. Considered a case of "puerperal insanity," Frances would remain confined for the rest of her life until she died in 1931.

Stories like that of Frances C., indicate how uniquely feminine physiological experiences, in this case childbirth and post-partum depression, came to be diagnosed as part of "women's madness." The uterus was seen as the central locus of such instability, commonly referred to as "hysteria" with the "wandering womb," in the words of Jane
Ussher "acting as an enormous sponge which sucked the life-energy or intellect from vulnerable women."(15) For a woman like Frances to reject her responsibilities as a mother was especially shocking to people in late nineteenth century Victorian society, where it was expected that a female's central responsibility was to marry, reproduce and care for her children.(16) At the other end of the diagnostic spectrum were menopausal women whose reproductive years were over, but whose emotional state continued to be tied in with their feminine biological timetable – such as Sarah S., a 48 year old widow with four children when she was admitted to the asylum in 1894. She would remain in 999 until her death almost thirty years later. Terrified that certain unnamed people were going to take her children away and were abusing her, she had barricaded herself in a bedroom with all of her children inside.(17) Similarly, 52 year old Ellen M. was admitted in 1903 after having attacked her daughter, and became very upset about being examined for insanity. The cause of her madness was recorded as having been due to "menopause + grief + worry," though it was also noted that Ellen was reported to have been emotionally distressed, with "lucid intervals," for thirteen years, prior to the onset of menopause.(18) She would remain confined until her death in 1928. The emotional turmoil these women were experiencing is obvious to anyone who reads their files, as is the influence of gender and biology in
helping to arrive at a diagnosis which, in cases like these, was ascribed to "change of life."

In some cases, surgical intervention was tried in an effort to alleviate an individual's emotional difficulties. Cynthia H. was a 49 year old childless widow at the time of her admission in 1904. Prior to her admission to the Toronto facility she was a patient at the Homewood Sanitarium in Guelph, Ontario for four years, where she was reported to have been restless, terrified of being deserted by everybody and "in constant dread" about not being provided food.(19) Cynthia was originally from Montreal, and it was while she was living there shortly before being admitted to Homewood, that a local physician, Dr. Gardner, surgically removed Cynthia's womb, fallopian tubes and one ovary.(20) This hysterectomy was undertaken on Cynthia because she was at the menopausal stage, or the "climacteric condition," as Dr. Hobbs wrote.(21) For his part, Medical Superintendent Clark denounced an operation "which did no good to the patient as far as her mental condition is concerned," though he agreed with the admitting physicians that menopause was the correct diagnosis "largely because of lower vitality than in the earlier stages of life."(22) Clark thought a better approach to finding a remedy to Cynthia's distress was to "see what nature can do."(23) As it turned out, she would be an inmate at 999 Queen Street West until her death in 1909.
This particular patient's experiences prior to admission to the Toronto institution highlights the increasing attention, and controversy, which was created by the practice of gynaecological surgery on insane patients in the late nineteenth century. Superintendents like Daniel Clark of Toronto and James Russell of Hamilton were vocal opponents of such operations, practiced by, among others, Dr. Richard Bucke of the London, Ontario Asylum.(24) Clark's opposition also tells us something about his diagnostic outlook and attempts to treat patients. While he had no control over what happened to people before they arrived at the asylum, he made sure that one gender-based intervention was not attempted on female patients after their admission. In 1897 Clark wrote to the admitting doctor of Lizzie C., who had enquired about the possibility of removing her ovaries "to restore her mental faculties":

I may say that I have made several examinations of Lizzie C and find nothing wrong with the organs to which you refer. My experience here is that these matters are very much magnified as the cause of insanity and I have a number here who have been operated upon and unsexed by practitioners with the result that matters were worse instead of better afterwards. If any disease is found it is of course necessary to ameliorate that condition as far as possible but as a cause of insanity it is much overrated. An epidemic of utero mania has broken out among some members of the profession which has done more harm than good in many ways; morally as well as physically. The unsexing of a large number of them has been done of late years in the hope of improving their mental condition and has not been a success either among the public or in Institutions.(25)

Thus, even in the context of the period in which this operation was undertaken, the potential damage such a
procedure could do to the well-being of a patient was observed and debated among leading figures of the medical profession. Clark’s opposition was in itself, at least partly gender-based, as he viewed gynaecological surgery as an attack on a "woman’s innate sense of modesty." (26) His comments also indicate that he did not believe there was any notable progress for a patient after such procedures. Unfortunately, the feelings of patients who experienced this operation, such as Cynthia, will have to go undetected as the records are silent on this point.

Gender and sexuality also helped to influence admission and diagnosis to an insane asylum in another respect, in this instance the observance of promiscuous behaviour among females belonging to the lowest classes of society. When considering this aspect of the committal process, it is essential to place such confinements in the context of the emerging eugenics movement at the turn of the century. Harvey Simmons, Angus McLaren, Pauline Mazumdar and James W. Trent have all written about the desire among middle class social reformers in Canada, the United States and Britain to "cleanse" society of those who were deemed "feeble minded." (27) This term was meant to encompass those individuals who were considered in terms that are now seen as offensive: "half-wits," "idiots," people believed to be of below-average intelligence for their age, and thus devalued as members of society. This category also included people with epilepsy and "wayward females."
brought all of these institutionalized groups together, as far as medical and legal authorities were concerned, was the assumption that "chronic insanity was highly related to membership in the lower classes."(28) This in turn led to the myth of the menace of the feeble minded, which prompted proposals in Canada by such activists as Dr. Helen MacMurchy and the National Council of Women, to segregate those who were seen as contributing to social problems. As Angus McLaren has noted: "For the middle class, of course, it was a comforting notion to think that poverty and criminality were best attributed to individual weaknesses rather than to the structural flaws of the economy."(29) An integral part of this campaign to confine people who came under this all-encompassing social sweep, was the emphasis placed on preventing the proliferation of feeble minded citizens from "overwhelming" society. Thus by locking up such people, the reasoning went, social order and a healthy "race" would be preserved from "contamination" by an unhealthy gene pool.(30) It was in such an environment that women like 38 year old Madge M., a domestic servant, was incarcerated. She had been imprisoned for a year in the York County Gaol, before transferral to the Toronto Asylum in 1904. Madge was a single mother of two children, both by different men and was said to want "to have another Roman Catholic after her parents refused to let her marry the father of her first child."(31) It was noted that she could no longer see one of her children, a son, as he had been adopted. Madge had
no control over this matter either, as she was informed of this decision by the Superintendent of the charity in which she was residing. (32) What became of her other child is not revealed. One of the committing physicians stated it was necessary for Madge to be locked up so as to prevent her from giving birth "to more unfortunates of her own kind to be a burden to themselves and the State." (33) Her parents had long since left town, so Madge had "for many years" lived in charitable institutions for destitute women, the House of Providence and, prior to her imprisonment, the Haven. (34) It was also recorded that Madge was epileptic, and it was this condition which was listed as the cause of death when she died in 1916. She was described as "feeble-minded" by one of her two admitting physicians, and this raises the only mystery surrounding her confinement: why was she sent to the Toronto facility, which was explicitly not for those labelled "feeble minded"? The answer may be related to her dual diagnosis of also having epilepsy, which may have been the reason why she was not sent to the institution at Orillia, where many who were given the "feeble minded" designation were locked up at this time. (35) This story also illustrates how 999 Queen Street West was prepared to receive those who were not supposed to have been sent there.

The confinement of lower class females who engaged in sexual relations outside of marriage could begin as soon as the local authorities became aware of such behaviour. It is
possible to trace the history of one women confined repeatedly over a thirty year period for her sexual lifestyle. Marcia F. was a 45 year old single women at the time of her arrest in Cobourg, Ontario in July, 1906, where she had been for less than a week.(36) The admission papers state, and an exchange of letters two decades later documents, how Marcia was repeatedly confined since the age of fifteen for the sole "reason" that she frequently engaged in sexual relations with males. From her first incarceration in 1876, until her final discharge in 1907, she spent more than twelve years in the Toronto Hospital for the Insane, and an unspecified number in the Hamilton Asylum, with one reference stating she had been confined for a total of nineteen years, indicating seven years were spent in this latter institution.(37) Marcia spoke "freely" about her sex life, "does not detect her error," "Is lacking in the usual womanly modesty and sense of shame," "is not repentant" and since a child "was always crazy after men."(38) When referring to her previous admissions it was stated by her father that this was "Always for full illegitimate intercourse with men."(39) Other than Marcia, only men were interviewed about her life history, one of whom stated "her acts are of the most immoral kind."(40) On the margins of society, Marcia's occupation was listed as a domestic servant, though, she had no money or property at the time of confinement. It was also noted her memory was good, she could read and write, did not drink or smoke and
was not viewed as dangerous to herself or anyone else. Her primary delusion was that she believed certain men wanted to marry her. (41) In effect, she was seen as insane because of her sexual promiscuity and nothing else. No violence or any other secondary factor was recorded. The fact that she was living in poverty would also have counted against her, as she had no financial resources or influential social network to look to for support. Marcia eventually made her way back to Cobourg after discharge from Toronto in 1907, and died in the Cobourg House of Refuge in 1918. (42)

The records of the Toronto Hospital for the Insane also show that sexual promiscuity, combined with homosexual behaviour could lead to incarceration. Mathilda M. was a single woman, "about 29" when she was confined in 1903, after spending two months in the Toronto Gaol. This was her third confinement and she would be discharged in 1907 as "Manic Depressive Recovered." (43) The medical certificates attesting to her insanity, state that she was in love with another woman, with whom she had engaged in sexual activity, and had "continually impure desires towards her." (44) Mathilda also talked "unblushingly" about her sexual relations with males, as well as with other females.

Prison doctor James Richardson wrote: "She has evidently no control over her sexual desires." (45) Other than the brief observation that she laughs, "talks silly," sings and will not work, all of the comments emphasize Mathilda's sex life when framing the reasons for her committal as a
She described her unnamed female lover as an "angel from heaven" who could not possibly enter the jail. These latter two cases in particular point to what Elizabeth Lunbeck refers to as "woman as hypersexual," in which "the sexually assertive woman, the woman endowed with passion equal to that of a man, was by her own account real, and psychiatrists...were alone in recognizing her passion as dangerous." However, this point has to be tempered with the realization that physicians were not the only ones engaged in casting a wary eye on sexual promiscuity. For as Cheryl Krasnick Warsh has written, both laymen and medical men shared this desire to control sexual promiscuity among women, something which these admission papers reflect. Indeed, as the case of Marcia F. proves, it was the disproving gaze of non-medical males in her personal life that brought her sexual conduct to the attention of physicians. Thus, the emerging eugenics agenda, along with notions about uncontrolled forms of sexuality, whether masturbation practiced by males or promiscuity engaged in by females, contributed to the admission and diagnosis of women to the Toronto Hospital for the Insane.

**Violence**

Implied or actual violent behaviour towards oneself or others for both men and women could lead to confinement, though this conduct in itself was not the only reason for incarceration as it was usually also expressed in
conjunction with conduct which indicated mental disorder, such as delusions. As well, domestic violence in the home was also a factor which brought about emotional collapse for women in particular. Whether patient-initiated or inflicted on the patient, violence was a very important aspect of the committal process, as the following examples illustrate.

Eve S. was 25 years old when she was imprisoned in the York County Gaol in 1903, thereafter placed in the Hamilton Asylum, and then transferred to Toronto in 1906 where she remained until her death in 1910.\(^{(50)}\) Her confinement provides evidence of how sexuality, combined with violent behaviour towards others could lead to confinement. Eve had epilepsy, was reported to have no known relatives and had been jailed as a vagrant after living at the Haven. Prior to taking up residence at the Haven, Eve was reported to have lived with a man who told her that if she lived with him and they had a child together she would be cured of her epileptic seizures.\(^{(51)}\) How this relationship ended is not stated, but it is clear that she did not like men as she was reported to have hidden with a club and threatened to kill two male servants while employed as a domestic worker at a doctor’s house.\(^{(52)}\) Eve was also reported to have been suicidal, as well as violent in her relations with other inmates while confined in jail and at the Haven.\(^{(53)}\) Ellen G. was a 40 year old mother of seven children when she was confined in 1878, for what would be the remainder of her
life, until she died in 1918.\textsuperscript{(54)} Her admission papers state she feared being poisoned, was violent around the house and that "her husband is the source of all her sickness."\textsuperscript{(55)} This example raises the issue of domestic problems in the committal process. That women were driven to emotional breakdown by abuse in the home is made clear in second hand observations of relatives.

Anne D. was a 42 year old mother of seven when she was admitted in 1906. She had been abandoned by her husband and was unsure about how many of her children were alive, though two of her daughters were reported living at the Alexandra Industrial School.\textsuperscript{(56)} Anne was arrested and placed in prison before transferral to the asylum, on the basis of a complaint by a citizen that she was dangerous to be at large.\textsuperscript{(57)} Prior to this she had been living at the Salvation Army and Bellamy homes in Toronto. Her admission papers state she was not considered a threat to herself or anyone else and emphasize her utterly despondent condition. Anne was reported to sit for hours with a "vacant expression," had an impaired memory, was hesitant in her answers, while in other instances she stared blankly without responding to queries, and at one point was physically startled "as if she had been frightened."\textsuperscript{(58)} Her withdrawal indicates someone in the midst of a severe depression, while Anne's physical reaction shows how fearful she was.
A letter written by her sister, May, several years after Anne was confined provides valuable second hand evidence that adds to an understanding about what caused her to become so distraught. Fed up with her irresponsible brother-in-law who had abandoned Anne, moved to Calgary, re-married, and apparently lied about providing her with financial support May wrote, "She was driven insane by the brutality of her husband and his dis-loyalty to her...." (59) 

The years of work to which May and other family members had to resort to get support for their sister from this man, as is made evident by the often tumultuous correspondence in this file, clearly backs up the above assertions of spousal maliciousness. (Chapter 6 will have more on Anne D. and her relatives). The effects of this cruelty lasted for the rest of her life, as Anne remained confined until her death in 1944.

Men who were confined for reasons relating to violence had usually so isolated themselves from the community to which they belonged that their restraint was seen as an urgent necessity for the benefit of everyone involved. John H. was a twenty-three year old single man whose occupation was listed as a student and a school teacher when he was confined in 1883. (60) Considering the nature of his behaviour it is obvious why efforts were made to restrain him. John H. was reported to have exposed "his body indecently," was violent towards children which included threatening to burn a child with hot coals, was going "to
"[w]ring its head off" and was also said to have "strung the child up by the neck." (61) Since he worked with children as a teacher, John's brutality would have been especially alarming to the wider community since he was in regular contact with youngsters and was in an obvious position of power over them on a daily basis. He remained in the asylum until his discharge in 1909. When confined in 1884, Jed R. was a 48 year old single farmer who was observed to have been suicidal, experienced "religious mania," threatened to kill other members of his family, and had been "caught chasing little girls."(62) He remained at the asylum until his death in 1919. While there were other factors contributing to his being sent to the asylum beside sexual harassment, there is a clear realization that this man was a threat to girls. Thus, the confinement of both of these men were seen as protecting the most vulnerable members of society from further potential abuse.

Walter G. was an unemployed 23 year old when he was arrested in 1898 and transferred from prison to the asylum where he was admitted for the second time in as many years. (63) In this case, his sexual advances towards his mother and younger sisters led to his incarceration. One of the two recording doctors, William Oldright, noted "He seemed to have no sense of the (illegible) of such vile and unbrotherly conduct." (64) Oldright went on to note his association with both parents and believed this man would be a threat to both the wider community and at home and so
should be confined. Walter remained institutionalized until he was sent to a boarding residence in 1950. (65) Thus the home environment in this example was one in which there were others who sought to offer protection from harassment, and so the violator was able to be isolated and removed as a threat.

Wilfred S. was 28 when he was brought to Toronto from Reach, Ontario in 1897, where he would remain until being transferred to the Orillia Hospital for the Feeble Minded in 1911. (66) Wandering about the farm with a lantern at night, he was reported to be "the terror of his family + of the neighborhood + they had to handcuff him to bring him to the Asylum." (67) At the time of his admission in 1901, Christopher B. was a 45 year old farmer and father of four children who had beaten his wife after blaming her for casting a spell on himself and the farm animals. He also went out with a gun at night and had threatened to shoot some neighbours. (68) Christopher remained locked up until his death in 1912.

By far the most extensive documentation of an abusive male to be certified insane that has been found in the admission papers up to 1907, pertains to Harold T. Originally arrested and then sent by court order to the Hamilton Asylum in 1903 at the age of 53, he was transferred to 999 three years later where he died in 1909. (69) A farmer who lived in Haliburton County, Henry was married and a father of nine children between the ages of 8 and 29 in
His brutality is detailed not only in regular admission documents, but also in nine legal affidavits from physicians, friends of the family and family members themselves, all of which accompanied the usual papers. Worried that members of his family were plotting with an English Colonization Company to steal his farm, and with neighbours who were destroying the property, Harold committed numerous physical assaults on his wife, Sandra, and their children. His daughter Agatha testified that he:

frequently abuses my mother by throwing her down, kicking her and otherwise maltreating her, and frequently illuses the children.... On one occasion he went so far as to threaten to shoot the whole family.... because my deaf brother, Anthony, did not hear him he picked up the axe to slay him but was prevented by my oldest brother taking the axe from him.... he threatened to shoot my brother John.... he ran for my youngest brother, Samuel, (a boy about 11 years of age) with a pitch fork and if he had caught him, I believe, he would have thrust him through with it, but when he could not catch him, he threw stones at him putting the whole family in a terrible panic....(71)

Similar conduct was recorded by others, including throwing an axe at one of his daughters who was seriously wounded in the leg, throwing crockery at one of his sons, refusing to let his wife leave the farm or allow his children to get an education, allowing the farm land and house to collapse into ruin, which his children tried to help their mother with even though Harold forbad building repairs, thrashing of crops or clipped sheep wool to be used, in spite of the fact that all of this was needed for the survival of the family.(72) Harold had also piled up
mounds of stones around the 74 acre farm from which he
watched for his enemies.(73) When a family friend told him
to move if his neighbours were bothering him so much Harold
replied "What is the use, they are ever (sic) where and
where ever I go they would be troubling me."(74)

Harold’s abuses had been going on for a long time
before decisive action was finally taken, with two local
doctors noting they had visited the farm in December, 1902
and January, 1903 out of concern for the inhabitants, ten
months before his arrest, while his daughter stated her
father’s physical abuse had been taking place for three or
four years.(75) Since Harold refused to do any work and the
farm was almost in ruins, his arrest became not only a
social necessity but also an economic one. Thus as these
cases document, the incarceration of physically abusive men
was very much a community "event" in which people from the
immediate family, as well as from nearby households or farms
took action to protect others whom they felt were in danger
if nothing was done to confine the disturbed offender.

Uttering threats, when combined with delusions, also
led to being placed in asylum. Stephen E. was a married 44
year old farmer with four children when he was sent to the
asylum for the third time in 1894, where he would remain
until discharge in 1907.(76) He had threatened to injure
acquaintances, while denouncing Queen Victoria as "the
mother of the abomination of the earth" and declaring
himself King of Scotland and of the whole world.(77)
One man threatened violence against Governor General Aberdeen, which led to his arrest in late 1897 and subsequent transferral to the asylum in early 1898. Frank I. was a 28 year old, single, unemployed man who believed himself to be descended from royalty and that Queen Victoria was about to ennable him and other family members but was prevented from doing so by the Governor General. When Lord Aberdeen and his wife visited Toronto (which included a tour of the asylum), Frank was convinced the Queen's representative was aware of his presence and should have "recognized his Royal status by an Invitation" to one of the balls and dinners being held. Frank had even "walked up and down in front of Government House here in the hopes that you might call him in." When this did not happen he wrote Aberdeen a threatening letter. Arrested by the police and then transferred to the asylum, Frank remained confined until his death in 1907, where he was considered harmless and repented his conduct towards the Governor-General.

Violent behaviour or threats were not sufficient on their own to warrant confinement since, after all, this sort of conduct could just as easily be viewed as criminal behaviour for the courts to decide. That these cases were ultimately left up to medical officials to certify as cases of insanity indicates the importance of extenuating circumstances in which the patient found him or herself, usually relating to the expression of delusional comments,
indicating madness. When such comments were accompanied by the worrisome possibility of continued or potential violence, laypeople acted in conjunction with medical figures to restrain the recalcitrant person. The only significant exception to this was for women who were victims of domestic abuse who had been so traumatized by their experiences that they had an emotional breakdown. This last point raises the importance of social support networks in the committal process. For as the following section will show, the extent of one's friendship or kinship contacts could dramatically influence the timing and even location of confinement.

Social Support Networks

People who were socially isolated from supports could be at a severe disadvantage both in terms of when they were admitted and where they were initially sent from the community. Depending on one's class and personal relations, or lack thereof, it was possible to speed up, delay or change the place of confinement as the following cases indicate. As was mentioned in the introduction, patients could be admitted from jail by warrant, or transferred from the community through regular medical channels. The ability to influence this process depended upon access to a personal advocate and friends outside the asylum. For some family members, the thought of sending their relation to prison to await confinement was unbearable, as with the husband of Mern O. In 1900, Jason
O. refused to let doctors send his 47 year old wife to the county gaol even though "it is practically impossible for him to keep her at home."(82) His insistence led to Mern being spared the ordeal of jail, as she was admitted as a regular patient six days later, where she would remain until her death in 1913. The reputation of the prison in such a case was enough to force such action, and indicates the vast difference in reception accorded to someone with a personal advocate, such as Mern had, in contrast to a much less fortunate person like Jim C., an elderly tailor who had been living in a charitable house before becoming violent after drinking too much. After certification, he languished forgotten behind bars for almost four years in the county prison as insane before he was finally transferred to the asylum in 1902, where he would remain until his death five years later. This problem was recognized at the time by contemporary physicians who lamented that patients from the most poverty stricken backgrounds were often consigned for years in jail, awaiting an asylum opening.(83) The unhealthy state of this facility is indicated by that fact that when 74 year old Jim C. was finally admitted from jail, it was noted that he had vermin in his hair.(84)

It is also important to note that even these most isolated of inmates could receive some outside support, if the horrible conditions in which they existed attracted the attention of a concerned citizen, as occurred to two teenage females who had been locked up in the county jail since late
Three months after the arrest of Evelyn F., a woman who regularly visited the jail and who is referred to in documents as Mrs. Trornan, initiated contact with authorities about conditions in the prison. This prompted the following letter, forwarded to Dr. Clark, from the Jail Governor to the city Sheriff:

I beg leave to draw your attention to the crowded State of the Rooms in this Gaol Set apart for the accommodation of the Insane, there are at the present time 20 fully certified female lunatics confined here in two small rooms. I would especially draw your attention to the urgent need of the speedy removal to an asylum of two very young girls committed as lunatics.... Evelyn F____ aged 17 years....and Madge C____ aged 15 years.... (T)he two named are the most urgent.(85)

Within three days Evelyn was transferred to the asylum, where she died six years later, though there is no indication about what happened to Madge. Expediting the transfer of a patient from jail to the asylum could also be based on class "shame", as was expressed by Henry A., the husband of Mary A. Three days after his wife was sent to prison in early 1894, to await transfer to the asylum after exhibiting "such violent symptoms" of madness that it was no longer possible to keep her at home, Henry wrote a letter to Superintendent Clark making his distress clear: "She has been a well educated women + my children and myself feel keenly the fact of her being where she is when we would willingly pay for her."(86) Three weeks later Mary was transferred to the asylum where she remained until her discharge seventeen years later. Thus some patients
avoided going to jail only because of the action taken by a supportive spouse, or else were transferred more quickly to the asylum than may have otherwise occurred because of outside intervention, while the "lowest" class of neglected pauper insane had no such luck, only having to wait their turn.

Elderly men and women were also sent to the asylum, but as Edgar-Andre Montigny has argued, their confinement in Ontario institutions had less to do with uncaring relatives, than with an exhaustion of resources to care for them. Indeed, Montigny shows that the often stated claim by provincial authorities that the elderly were being "dumped" in institutions was exaggerated, and had more to do with the inability of officials to realize the financial difficulties faced by low and middle income families in caring for their relatives at home, as well as the desire of politicians to cut back on social expenditures. (87) The care of the elderly in nineteenth century Ontario remained stable during this period, though it is instructive to look at one such case where family supports broke down, leading to the confinement of an elderly woman. Gloria D. was a 69 year old widow with two children. She believed herself to be very wealthy, talked to people who were not present, charged others with trying to swindle her, and threatened her daughter-in-law. (88) Her son initiated the admission process, the circumstances of which aroused the ire of
Medical Superintendent Daniel Clark in a letter to the Inspector of Asylums:

....the statement of Dr. Machell’s is not that she is excited and unmanageable but that she is quiet and harmless and has been left alone for days and days. This is another illustration of the attempt to make this a place for incurables to save the friends the trouble of looking after them.... It always seems to me a great pity that an elderly person should be sent to the asylum for insane to die, especially when such are quiet and manageable as this woman seems to be. This woman....never attempted to injure herself nor others.... (T)he only delusion she has is that she has an immense amount of money at her disposal. Even if we had room for a patient of this kind I would resist the admission of a person who seems to be only in the dotage of old age....(89)

In spite of Dr. Clark’s opposition, Gloria was admitted to the asylum in 1899 where she remained until her death in 1907 at the age of 74. The man who sent his mother to the asylum was a salesman who travelled frequently which may explain why Gloria was “left alone for days and days.” While the precise motives for her confinement by her son are not spelled out, it may have been a way to see that his mother was consistently cared for while he was out of town.

People were admitted to the asylum in some cases as a result of their poverty stricken circumstances. When combined with no one to care for them, or their becoming unmanageable among destitute acquaintances, confinement appeared to be a necessary alternative. James D. was a 56 year old, single Irish immigrant who had no property and no known relatives in Canada at the time of his admission from the York County Gaol in 1896. He was recorded as having
been "a poor uneducated laboring man." (90) James was well known to the prison staff as he had been a "regular frequenter" of the jail for seven years on charges of theft and vagrancy and had twice before been admitted to 999 Queen Street West after his arrest. (91) He gradually changed to being argumentative and difficult to manage by shouting, singing and jumping, with a confused memory. (92) His principal thoughts were centred on the prison bookkeeper: "He says that I am his God and follows me around wanting to embrace me." (93) Transferred to the asylum, James remained confined until his death in 1914. The widowed mother of Carl G. testified about the violence of her 28 year old bachelor son upon his arrest in 1897. A brick maker from a working class family, he was no longer at home and slept in a vacant house "without bedclothes or fire, going over to his house to get food" during the week prior to his incarceration. (94) Like James, Carl's memory and observation was said to be impaired, not knowing the occupation of the person who took him from the vacant house "although he says the man had a blue suit and helmet." (95) He was transferred to the asylum where he died in 1925.

Audrey B. was a 39 year old mother of three children, whose husband had died four years before her arrest in 1905, after which she was transferred to the asylum. Though she had been left $2,000. at the time of her husband's death, it was not known what had happened to this inheritance. (96) Some time before her incarceration, she abused and rejected
her children who had been turned out of the house, after which they were split up and sent to other residences. (97) Previously committed two years earlier, Audrey was released "to run the streets ever since with no person to care for or treat her." (98) Unlike her previous demeanour, she began to drink moderately, would not work and was reported to turn up at the dwellings of acquaintances and refused to leave. (99) Audrey said all of her problems were due to losing her job as a caretaker at the Masonic Hall. (100) When she realized she was coming to the asylum Audrey "guessed this to be a place where they put things right, yet did not know what was wrong - nothing wrong with her." (101) She remained at 999 Queen Street West until her death in 1946. Carl and Audrey had both isolated themselves from people with whom they had lived through abusive conduct. Yet there was also a significant difference in their respective committals. After being released for the first time, Audrey was known to have lived on the streets for two years before being permanently institutionalized, whereas Carl had left home, or been made to leave home after becoming violent, only a week before his arrest. Since Audrey had a network of acquaintances from whom she tried to obtain support, unlike James, it is possible this lifeline kept her away from immediate re-incarceration, though ultimately this was not sustainable.

Family and friends of the individuals who initiated the committal processes could be in as desperate straits as the
patient. The statement of Carl’s illiterate, widowed mother, Mabel G., signed with a "X" is evidence enough of how, for others concerned, locking up a relative could be the only way to remedy a traumatic situation:

I am a widow. I have four children now in Canada. These children keep me. I am unable to support or contribute to my son’s support in an asylum. I know of no one who will support him.(102)

Thus working class and homeless patients and their families had few options to pursue when it came to looking for support during a domestic crisis. Carl’s incarceration was as much an act of desperation as anything else by his mother, while Audrey’s confinement was the response of neighbours who did not know what to do any more when she came knocking for shelter. As Gerald N. Grob has argued in regards to the United States, in an age when any sort of social support for unemployed working-class and homeless citizens was virtually unknown beyond charity, the asylum could be a source of refuge in an otherwise hostile world.(103)

Patients who came in and out of asylums would have had to deal with the need for support during the re-adjustment process back in the community. However, if this was not able to be maintained, especially when recurring bouts of emotional collapse made it difficult for family members to know what to do, social support could be re-directed to having a relative returned to the asylum. This is what occurred to Jerold M., a 47 year old married lawyer and
father of four children when he was admitted to the Toronto Asylum in 1904.\(^{(104)}\) He had a breakdown at the age of 22 but recovered without being hospitalized, and set up an "extensive law practice" in Barrie, Ontario when he was 25.\(^{(105)}\) After being injured falling off a horse, and then losing an election campaign in 1894, Jerold had another breakdown but again recovered after a few months rest. However, more emotional distress occurred in 1899, and he spent several months in Homewood Sanatorium in 1900, and six months in McLean Hospital in Waverly, Massachusetts in 1900–01.\(^{(106)}\) Papers from both Toronto and Waverly institutions show how Jerold became even more withdrawn, worrying to the point of crying about his finances and future prospects, and then became excited and "self-laudatory" just before committal in 1904.\(^{(107)}\) One of the two committing physicians from Barrie noted how Jerold's insanity was "generally known and talked of" in the community in which he had lived and worked for twenty years.\(^{(108)}\) His despair is indicated from a number of quotes recorded at Waverly such as when he lamented, "I am off the track and cannot get back. There is no ray of hope."\(^{(109)}\) His attempt to re-start his law practice in Barrie after leaving McLean Hospital in 1901 was unsuccessful according to Jerold because: "I carried the asylum thought with me always."\(^{(110)}\) His wife, Isabel, whom the file clearly shows loved and cared for her husband, could no longer handle the emotional trauma of their married life. She noted that Jerold was on
the verge of an "explosion" and she feared for herself and others as well as for her husband if he was not confined, as he had changed drastically during the previous four years, particularly during the few weeks before being confined to the Toronto Hospital for the Insane. Referring to the angry opposition of Jerold’s brothers and sister-in-law to his incarceration, Isabel wrote: "anyone who knows what my husband was to me in the days of his sanity, will acquit me of any desire to deny him any thing, that by any chance I could think was for his good...." Thus, this formerly well respected lawyer found himself fighting recurring bouts of emotional breakdown, up to 1904, which ruined his law practice and nearly destroyed his marriage. Jerold would remain confined, in a private room, in the asylum’s most comfortable ward for men until his death in 1912.

People who were less fortunate than Jerold not only from a class position but also due to language barriers were particularly vulnerable to social isolation, as they were unable to communicate their thoughts to physicians, or to those around them without the aid of an interpreter, when one was available. Lee F. was a Chinese labourer who had arrived in Toronto from Vancouver, only a few weeks before his arrest and subsequent transferral to the asylum in 1905. His age was not recorded though it is obvious that he lived in poverty. However, Lee did receive some assistance from others who spoke his language, though he was eventually deported to China in 1907.
total lack of personal family supports, combined with the obvious language barrier would have made a distraught person's emotional confusion all that more difficult to bear, being unable to talk with those to whom they were most familiar.

An example of the link between poverty, disability and the lack of social supports leading to confinement can be found in the file of forty-four year old Richard W., a blind man whose occupation was listed as a brushmaker when he was arrested in 1899. Since he was also recorded as having been able to read and write, it is obvious that his disability had occurred sometime during adulthood, though no history of this is indicated. Variuos reasons are given for his confinement, including testimony from his sister that he exposed himself and would chase and sometimes assault women. It was also noted that he had deteriorated mentally since the death of his mother, who was described as an "an inebriate," whom Richard had taken care of in her final days. He also talked to people who were not present whom he accused of trying to beat him. This man was said to have been insane "from infancy" and was "now serving a term for vagrancy at his own request [...] he has no home[."

How much his disability affected his class position is not indicated as the reference to Richard's blindness is fleeting and is not emphasized to any extent. However, it is very likely that lack of sight would have prevented him from gaining employment other than as a brushmaker, a trade
frequently taught to people with visual impairment. Thus, his job prospects were extremely limited. A letter five years after his incarceration is the only other reference to this condition. Dr. Clark mentions Richard's failing eyesight, in which "He can scarcely distinguish anything clearly now." (118) This evidence indicates that his visual impairment was gradual and was not total at the time of admission. Being a physical danger to women also indicates that this disability was in the developing stages upon confinement. Richard's verbal and physical harassment of females could still have taken place with limited sight, such as when he became aware of the presence of women, even if he could not clearly see them. His request to be jailed as a vagrant is especially telling, and is clear evidence that, for this poverty stricken, increasingly disabled man who had no supports, being locked up was a source of shelter where food and clothing was available. Whether he felt this way about the asylum where he remained until his death in 1913 will have to remain unknown. However, these records do indicate, that for an abusive man, who was becoming increasingly disabled and impoverished, confinement was considered a valid option in a world where blind working-class people had virtually no choices or assistance.

Connections between disability, confinement and the social welfare of new immigrants, are also important. Such was the case with Vincent J., a single, 20 year old labourer who said his relatives were well-to-do citizens
back in Britain, with his late father having been a jeweller.(119) Dazed and confused, he was arrested in 1904 as a vagrant and told one of the examining physicians that he had lost all of his clothes.(120) In a lengthy deposition from the Toronto Jail, Vincent wrote about his predicament:

I have lost my papers and money, also my trunk and overcoat so I don’t know what to do. I have come out to a strange country without no friends and am stranded, so help me God. I have an affliction in my speech so therefor (sic) have been unable to get on in the world.... I believe I came out here on the 2nd of February from Liverpool, having come from London: arrived on the 14th of February.... I have done nothing wrong but having been sent away to a strange country I have been disheartened and the consequence is I’m stranded and lost everything. I hope God will be good and restore me to my sisters and brothers once more in England.(121)

He was eventually sent back to England in 1907. The speech impediment Vincent refers to is the reason he ascribes to his desperate state, along with no resources, and reflects the barriers that existed for a person unable to communicate in a verbal manner that the majority could understand, even when belonging to the same language group. Whether his being sent out to Canada had anything to do with his disability is not stated. However, it is clear that Vincent’s impoverishment and isolation could only have been made worse by not being able to talk with people, at least in a clear manner, which probably also led to his being laughed at and scorned by others. Fortunately for him, he was an eloquent writer and so was able explain his
situation. Together these varied cases of people who experienced widely different levels of personal support, from genuine concern to complete isolation prior to confinement, and in some cases immediately after imprisonment before transferral from jail, illustrate the central role that was played in the committal process of social relations for people going through a period of emotional collapse.

Conclusion

The diagnosis and admission of people to the Toronto Hospital for the Insane during the late nineteenth and early twentieth centuries was seldom based on any one single symptom. As the above cases illustrate, a diagnosis of insanity usually occurred after an individual was brought to the attention of medical authorities by family or un-related acquaintances, and then usually after distraught behaviour was evident, from violent conduct or threats, to emotional collapse or behaving in a manner that was viewed as socially unacceptable, such as promiscuous sexual activity. In many cases, observations also included comments that the subjects were delusional or expressing feelings indicating a severely depressed state of mind, all of which would have convinced contemporary observers that individuals were in need of restraint or care, depending on the way they expressed themselves. Thus the primary cause of confinement was related to an inability of laypeople to know what else to do when someone they knew was experiencing a bout of madness.
whether it was of an outward form that threatened those around them or of a more introverted type that saw a friend or acquaintance withdraw from others, into a fog of emotional turmoil. Sending someone to 999 Queen Street West was, under such circumstances, a desperate attempt to try to remedy a difficult situation and find help for people who appeared to have lost their ability to cope with the world around them.
Notes:


3) Dr. Edward Ryan, et. al., "Rockwood Hospital Number" The Bulletin of the Toronto Hospital for the Insane (This journal was renamed The Bulletin of the Ontario Hospitals for the Insane) I:3 (October, 1907), p. 3.

4) "Admission of Patients to Hospitals for the Insane," The Bulletin of the Toronto Hospital for the Insane (This journal was renamed The Bulletin of the Ontario Hospitals for the Insane) I:3 (October, 1907), p. 13-14.


9) William P., Patient File #4004. Letter to Dr. P., St. Paul Minnesota, from Dr. Clark, April 28, 1890.

10) Edward M., Patient File #6036. Form A, Certificate of Insanity, April 30, 1900, signed Dr. John Stenhouse, Toronto.

12) Ibid., p. 301.


14) Frances C., Patient File #2031. Form of History of a Patient, March 6, 1880, signed Walter B(illegible), Toronto; Form K, March 4, 1880, signed Walter B(illegible), Toronto; Form K, March 6, 1880, signed J. F., Toronto; Form K, March 6, 1880, signed David O., Toronto.


17) Sarah S., Patient File #5001. Form A, Certificate of Insanity, January 18, 1894, signed Dr. T. McKenzie, Toronto.


20) Patient File #8010. Letter to Daniel Clark from C. Lane, Montreal, August 19, 1904.

21) Patient File #8010. Letter to Dr. D. Clark from Dr. A.T. Hobbs, Guelph, Ontario, June 20, 1904.

22) Patient File #8010. Letter to Dr. A.T. Hobbs, Guelph, Ontario, from Medical Superintendent Daniel Clark, June 21, 1904.

23) Ibid.

24) Shortt, Victorian Lunacy, pp. 143-155.

25) Lizzie C., Patient File #5017. To W.D. Clement, Woodstock, Ontario, from Daniel Clark, November 27, 1897. It should be noted that this correspondence took place two years after Lizzie C. was sent to the asylum.
26) Shortt, *Victorian Lunacy*, pp. 152.


31) Madge M., Patient File #8027. Copy of Medical Certificates in the Case of Madge M., signed Wm. Oldright, Toronto, September 23, 1903.


34) Patient File #8027. Schedule No. 2, signed B. Sanderson, G. Denison, Toronto, September 21, 1903; Copy of Medical Certificates in the Case of Madge M____, signed James H. Richardson, Toronto, September 23, 1903.

35) Opened in 1876, the Orillia Asylum had chronic problems with overcrowding which also may have influenced decisions about sending people there: Simmons, *From Asylum to Welfare*, p. 29-32. See also the discussion of this institution in: John P. Radford, Deborah Carter Park, "'A Convenient Means of Riddance': Institutionalization of People Diagnosed as 'Mentally Deficient' in Ontario, 1876-1934" *Health and Canadian Society* 1:2 (1993): p. 369-392.


37) Patient File #10005. Information to be Elicited Upon Inquiry, signed H.F. Holland, Police Magistrate for Cobourg, July 25, 1906; Letter to K.W. Wright, Public Trustee, Osgoode Hall, from Medical Superintendent Harvey Clare, March 1, 1924.

38) Patient File #10005. Form A, Certificate of Insanity, signed Dr. Thos. Clark Lapp(?), Cobourg, Ontario, July 25,
1906; Form A, Certificate of Insanity, Dr. James Henderson, Cobourg, Ontario, July 25, 1906.


42) Patient File #10005. Letter to Bursar, 999 Queen Street, from K.W. Wright, Public Trustee, Osgoode Hall, Toronto, February 26, 1924.

43) Mathilda M., Patient File #7053. Schedule No. 2, (signatures illegible), August 21, 1903. Her discharge status is recorded on the front of the case folder.

44) Patient File #7053. Copy of Medical Certificates in the Case of Mathilda M____, signed Wm. Oldright, Toronto, September 4, 1903.

45) Patient File #7053. Copy of Medical Certificates in the Case of Mathilda M____, signed James H. Richardson, Toronto, September 5, 1903.

46) Ibid.


49) Warsh, Moments of Unreason, p. 68.

51) Patient File #9045. Copy of Medical Certificates in the Case of Lizzie S__, signed Wm. Oldright, Toronto, April 16, 1904.

52) Patient File #9045. Copy of Medical Certificates in the Case of Lizzie S__, signed James H. Richardson, Toronto, April 15, 1904.

53) Patient File #9045. Schedule No. 2, signed G.A. Chapman, G. Denison, Toronto, April 15, 1904; Copy of Medical Certificates in the Case of Lizzie S__, signed James H. Richardson, Toronto, April 15, 1904.


56) Anne D., Patient File #10009. Schedule No. 2, signed (R?) Chapman, Police Headquarters, Toronto.

57) Patient File #10009. The Information and Complaint of: David Archibald, August 27, 1906, attached to Form D (Section 21) Certificate of Justice, signed by G.W. Denison attesting to Anne's insanity.

58) Patient File #10009. Form A, Certificate of Insanity, signed Dr. W.J. Harris, Toronto, August 17, 1906; Form A, Certificate of Insanity, signed Dr. James H. Richardson, Toronto, August 13, 1906.

59) Patient File #10009. Letter to "The Superintendent," from May K., Washington D.C. (undated, and no response to this specific letter is in file, though based on contents and sequence in relation to other letters in file, it is probably from the Summer of 1913).

60) John H., Patient File #3012. Form of History of a Patient, signed C. Brereton (no location), May (9?), 1883.

61) Patient File #3012. Form A ("K" crossed out), Certificate of Insanity, signed Dr. C.H. Brereton, Bethany, Ontario, May 10, 1883; Form A ("K" crossed out), Certificate of Insanity, signed Dr. Thomas Brereton, Bethany, Ontario, May 9, 1883.

62) Jed R., Patient File #3016. Form of History of a Patient, signed (J.?) H. Widdifield, Newmarket, Ontario,
January 18, 1884; Form A, Certificate of Insanity, signed (J.)H. Widdifield, Newmarket, Ontario, January 29, 1884; Form A, Certificate of Insanity, signed David L. Rogers, January 28, 1884.


64) Patient File #6013. Certification statements of James H. Richardson, Toronto, June 18, 1895 and Wm. Oldright, Toronto, June 17, 1898.

65) Patient File #6013. Information about William's discharge can be found in the Clinical Record entry of February 10, 1950.

66) Wilfred S., Patient File #5036. History Form, Ontario Hospital for the Feeble Minded, Orillia, Ontario, signed Wm. Armstrong, (no address), December 24, 1897.

67) Patient File #5036. Copy of Physician's Certificate of Insanity, signed Dr. Wm. Armstrong, Toronto, December 24, 1897.

68) Christopher B., Patient File #7005. Schedule No. 2, signed John Richardson, J.P., East Toronto, January 26, 1901; Copy of certification statements by Dr. Thos. Wylie, Toronto, January 31, 1901, Dr. James H. Richardson, Toronto, January 31, 1901.

69) Harold T., Patient File #9040. Admission dates can be found on front of folder and committal forms.

70) Patient File #9040. Form of History of a Patient, signed Sandra T. by her solicitors Biggs & Petrie, Confederation Life Building Toronto, October 14, 1903.


72) Patient File #9040. Form of History of a Patient, signed Sandra T. by her solicitors Biggs & Petrie, Confederation Life Building, Toronto, October 14, 1903; Form A, Certificate of Insanity, signed W.P. Chamberlain, Toronto, October 23, 1903; Form A, Certificate of Insanity, signed T.J. Page, Toronto, October 23, 1903; Affidavit of Henry Leverney T., signed H.L.J. T., and A.G. Russel Snow, Toronto, October 24, 1902, pp. 2-4.

73) Patient File #9040. Affidavit of Edwin H., unsigned though sworn and filed on behalf of the petitioner, Toronto, October (no date), 1903, p. 3.

74) Ibid.
75) Patient File #9040. Affidavit of Dr. William Giles, signed W. Giles, W. Priest, Haliburton, Ontario, February 5, 1903; Affidavit of Dr. Earnest Argyle White, Haliburton, Ontario, (signature page missing); Affidavit of Agatha T., signed A.E.T. and C.B. Nasmith, Toronto, October 29, 1902, p 3.

76) Stephen E., Patient File #5008. Form of History of a Patient, signed H.A. McCall, Milton, Ontario, May 12, 1894.

77) Patient File #5008. Form A, Certificate of Insanity, signed Dr. Joseph (Baseim?), Toronto, July 20, 1894; Form A, Certificate of Insanity, signed Dr. H.A. McCall, Milton, Ontario, July 20, 1894.


79) Patient File #6002. Letter to Governor General Aberdeen, Ottawa, from Daniel Clark, Medical Superintendent, January 31, 1898.

80) Ibid.

81) Ibid.

82) Mern O., Patient File #6037. Letter to Dr. Daniel Clark from Dr. Joachim Guinane, Toronto, May 15, 1900.


84) Jim C., Patient File #7025. His physical condition upon arrival is noted on an onion skin dated August 12, 1902, signed John J. Ryan, Provincial Bailiff, Toronto. The two copies of statements certifying his insanity while a prisoner are dated November 3, 1898, signed James H. Richardson, Toronto; and November 20, 1898, Toronto, unsigned statement.


86) Mary A., Patient File #5002. Letter to Daniel Clark from Henry A.A., Toronto, February 1, 1894. She was
transferred from prison to the asylum on February 21, 1894. A more extensive discussion of Mary A. appears in my article "Keep Your Labels Off My Mind! or 'Now I am Going to Pretend I am Craze But Don't Be a Bit Alarmed': Psychiatric History from the Patients' Perspectives," Canadian Bulletin of Medical History 11:2 (1994): pp 397-424. On page 414, there is a quote from Mary in which she states "...I was made a prisoner in 1893..." I then wrote: "Her memory of confinement was accurate as it dates back to being placed in prison several months before transferral to the asylum the following year." This sentence is not correct. The letter quoted above in this chapter, dated February 1, 1894 was overlooked. In this letter her husband, Henry, clearly states that she was placed in prison at the end of January, 1894. Thus she spent just under a month in prison, not several months, and was not in prison before 1894. Schedule No. 2, no date, signed Henry A., states: "Duration of present attack: Three months second attack." From this statement the mistake originated, thus leading to the incorrect conclusion that she had been placed in prison in 1893. Instead of the above sentence which I wrote in the article, the following should have appeared: "Mary's memory of when her confinement began was off by a year as she had been placed in prison in late January, 1894, where she remained for almost a month before being transferred to the asylum."


88) Gloria D., Patient File #6027. Form of History of a Patient, signed H.J. Machell, Toronto, August 23, 1899; Form A, Certificate of Insanity, signed Dr. (Edward W. Spragge?), no address, October 28, 1899; Form A, Certificate of Insanity, signed Dr. Henry J. Machell, Toronto, October 28, 1899.

89) Patient File #6027. Letter to R. Christie, Inspector of Asylums, Toronto, from Medical Superintendent Daniel Clark, October 19, 1899.


Certification statement of Dr. James H. Richardson, Toronto, September 21, 1896; Certification statement of Wm. Oldright, Toronto, September 21, 1896.


94) Carl G., Patient File #5031. Schedule No. 2, signed "X" by Mabel G., G. Denison, Toronto, April 20, 1897; Certification statement of James H. Richardson, Toronto, April 24, 1897.


96) Audrey B., Patient File #8042. Schedule No. 2, signed Mary B., Elizabeth C., (one other signature illegible), Toronto, May 19, 1905.

97) Ibid.

98) Ibid.

99) Ibid.

100) Patient File #8042. Copy of Medical Certificates in the Case of Audrey B___. Signed Chas. Sneath, Toronto, May 25, 1905.

101) Patient File #8042. Copy of Medical Certificates in the Case of Audrey B___. Signed Wm. Oldright, Toronto, May 26, 1905.

102) Carl G., Patient File #5031. Mabel G. swore two statements about her son. The one quoted in this chapter is the first statement recorded on a full scap sheet, along with other statements. Statement of Mabel G., signed with an "X" and with "her mark" noted above and below, April 20, 1897.


104) Jerold M., Patient File #8009. There is no form of History in this case, but instead there is a detailed personal history in the file from the McLean Hospital in Waverly Massachusetts sent in 1907. It notes Jerold was 44 at the time of his hospitalization in 1900-01, and so his age in 1904 has been calculated accordingly, though no specific age is listed in the admission documents for the Toronto facility. See McLean Hospital Report, page 1; Form A, Certificate of Insanity, signed Dr. John M., Barrie, Ontario, April 26, 1904; Form A, Certificate of Insanity, signed Dr. H.T. Small, Barrie, Ontario, April 27, 1904.


107) Patient File #8009. McLean Hospital Report, pp. 1-2; Form A, Certificate of Insanity, signed Dr. H.T. Small, Barrie, Ontario, April 27, 1904.

108) Patient File #8009. Form A, Certificate of Insanity, signed Dr. H.T. Small, Barrie, Ontario, April 27, 1904.

109) Patient File #8009. McLean Hospital Report, p. 3.


111) Patient File #8009. Letter to Dr. Clark, from Isabel M., Barrie, Ontario, May 29, 1904, pp. 3-4.

112) Patient File #8009. Letter to Dr. Clark, from Isabel M., Barrie, Ontario, May 29, 1904, p. 5.

113) Lee F., Patient File #9014. Schedule No. 2, sworn by Constable David McKinney, signed G. Denison, Toronto, November 27, 1905. This consists of a statement by the constable of not being able to find out practically any information about Lee, so none of the questions on the form are answered.

114) Patient File #9014. Copy of Medical Certificates in the Case of Lee F., statements of Dr. Wm. Oldright, Toronto, November 28, 1905, and Dr. James Richardson, Toronto, November 28, 1905. The deportation of Lee to China is noted...
as May 4, 1907 on the front of his case file, and in a brief typewritten form dated April 27, 1907.

115) Richard W., Patient File #6021. Schedule No. 2, signed Kate C., R.E. Kingsford, Toronto, April 5, 1899.

116) Patient File #6021. Copy of certification statements of Dr. James H. Richardson, Toronto, April 12, 1899, Em. (sic) Oldright, Toronto, April 11, 1899.

117) Patient File #6021. Schedule No. 2, signed Kate C., R.E. Kingsford, Toronto, April 5, 1899.


120) Patient File #8021. Letter to Mrs. N. J., Kensal Rise W., England, from Medical Superintendent, January 3, 1905; Copy of Medical Certificates in the Case of Vincent J____, signed James H. Richardson, Toronto, April 12, 1904.

Chapter 3. Daily Routine and Daily Relationships

Introduction: Daily Routine

The daily routine of the asylum was set down in the late 1870s, and over the next sixty years, clinical records indicate that the basic schedule remained the same. Employees who resided in the building, as well as working patients, rose at the sound of the morning bell at 4:30 A.M. from May to August, at 5:00 A.M. in March to April and September to October and at 6:00 A.M. from November to February. Patients who were ill or otherwise incapacitated, either on their ward or in male and female infirmaries, were allowed to stay in bed. All able-bodied inmates, whether employed or not, were expected to be up by the time breakfast was served. This first meal of the day was at 6:30 A.M. in the Summer, at 7:00 A.M. in the Spring and Fall and at 7:30 A.M. during the Winter. Dinner (or lunch as it is now called), the most substantial meal of the day, was served at 12 Noon year round, and tea was at 6 P.M. all year long.(1) As Table III shows, tea became supper by 1917. In comparison with other asylums during this period, such as the Pennsylvania Hospital for the Insane, there was nothing unusual about this daily regimen, though British Columbia's Provincial Hospital for the Insane had a slightly shorter day than at Toronto, lasting from approximately 7:00 A.M. to 7:00 P.M. during the early 20th century.(2)

Inmates who were employed did their work between these daily meals, though the hours of work were not uniform and
depended on the task and time of year, as will be discussed in the chapter on labour. As well, those patients who were fortunate enough to go to administrative-organized entertainments, did so after tea (or supper), with everyone expected back in their ward or cottage by 9:00 P.M. when the building was locked and lights were turned out year round. (3) The administration of medication, and in the late 19th century, alcohol, was given to able-bodied inmates on wards during the day as warranted, though it was most often provided during, or right after, meals since supplementing medicine with food and drink was part of the routine. Ward staff performed this function and had specific instructions to provide exact quantities in a measured glass. (4) Daily hygiene included the washing of hands and face of each patient every morning and during the day when necessary, either on their own or with the help of staff or other patients. All patients were to have a bath, or after its limited introduction in 1898, a shower, at least twice a week, which was not untypical practice during the late 19th and early 20th centuries. (5) Male and female patients and nursing staff were strictly segregated on their own wards, although female staff began being introduced to male wards in 1912. (6) Contact between the sexes could occur under supervised conditions, such as at social events, or among patients who had parole of the grounds.
Since the day was structured around mealtimes, more details about this routine are important. Dining facilities after the late 1870s were in small dormitories attached to each ward, and each dining room had a separate table for suicidal patients who were not given knives or forks but were fed by attendants. (7) Patients on the one male and one female refractory ward initially had to eat with their fingers or a spoon, but this changed after 1887 when dull knifes and tin forks were introduced without incident. (8) There was an average of eight people at meal tables in the Toronto mental hospital, which was lower than Hamilton with ten, or Kingston and London with twelve at a table. (9) Complaints during the late 19th century from officials about the uncomfortably cold temperature of wards during the winter, were extended towards dining rooms which were not properly heated until 1903. (10) The types of food eaten by patients are set out in Tables II and III from 1878 and 1917. The contrast between public and private patients in the 1878 table indicates how much better food was on the latter wards. Inspector Langmuir noted in 1881 that some patients received small cuts of meat, while others received only fat on public wards. He also mentioned that water needed to be supplied on tables at mealtimes though, by contrast, he reported that the superior wards had very good meal service. (11) Officers also received more abundant meals than did free patients, though Table II indicates that attendant's
food was on a closer par with their least privileged charges in the late 19th century. Left-over food from officers' tables was returned to the kitchen and then re-served to patients on wards until at least 1892.(12) However, since a good diet was seen as a crucial part of treatment Commissioner James Noxon suggested that henceforth all asylum populations, including officers and patients, should eat the same types of food, for reasons of economy.(13) The 1917 dietary guidelines in Table III indicates that both patients and staff had the same type of breakfast, though there was more variety of food available at staff suppers. By this time, the therapeutic purpose of a balanced diet was stressed to such an extent that Inspector Rogers had written in 1906 that food was second in importance only to medicine in treatment.(14)

The clinical records show that some patients had their own routine to suit their own culinary tastes, while still others found the food unpalatable. Willard C. was said to have been very fastidious about his personal health, was noted for his attention to hygiene, washed his dishes before eating, refused to let anyone else serve him and was a strict vegetarian who would not touch eggs. It was reported that this 73 year old man, during his thirty-fourth year of confinement in 1911, had "not eaten meat for twenty years and has never been sick; eats vegetables."(15) Within a year of this observation, Willard was discharged into the care of his sister who took him home to die of tuberculosis.
A fellow patient of Willard, Gene P., became "very sick" and vomited after the ward supervisor reported Gene had consumed "too many tomatoes." (16) He recovered, but five months later died at the age of 47 of a gastric haemorrhage a day after becoming seriously ill "immediately after taking a little milk." (17) Ralph M., who lived as a free patient at the same time as both Willard and Gene, wrote a letter to his wife about the impact of food on patients:

It has been proved lately that the food we get here is not fit for man at all, we have the proof here before us we cannot help but see if we open our eyes. the people who are obliged to eat it sick of getting sick and they all say it is that miserable food. They all have to eat of it three times a day or get stuffed [...] it not plasent. It is not so easy many thanks when we know it is making our fellows sick and a lot of them die. (18) [Original writing].

Ralph M., confined in 1898, died at the age of 70 in 1911 at 999 Queen Street of cystitis, inflammation of the urinary bladder. (19) It should be noted that this sentiment was not restricted to the free wards. Reginald F., one of the wealthiest patients in the asylum during his confinement from 1906-1914 complained to his wife, Alicia, that he "cannot eat" what was given to him, even though he was on the most privileged male ward. (20) While some inmates clearly did not enjoy hospital food, others were able to supplement their daily fare. Receipts in patient files for "dainties" indicate that patients could get treats from family and friends for consumption outside of institutional items. A wealthy patient, Elaine K., was sent a roast chicken by a relative, though this was unusual, as more
often food such as oranges, chocolates and chestnuts was sent for patients who were fortunate enough to have outside support.\(^{(21)}\) Thus, there could be more to an inmate’s daily diet than is found in the official meal lists. These contrasting perspectives about patients’ experiences of daily life in the hospital provide the basis for the rest of this chapter. In approaching this topic from the direction of what went on in the daily lives of inmates at the Toronto Hospital for the Insane, the purpose is to show how troubled people coped with one another and with themselves in their efforts to find friends, or deal with traumatic relationships among patients and staff in a mental institution.

**Daily Relationships Among Patients and Staff**

Just as it would be inaccurate to portray all inmates as contented with their lot, so too would it be a misrepresentation to claim that inmates and staff were constantly in conflict. There most certainly were patients and staff who formed close bonds, with this being most likely among nurses, attendants and their charges. Peter Nolan has recounted how an attendant at a British institution in the mid-twentieth century formed close friendships with inmates, and there is evidence from both sides that this also occurred in Toronto.\(^{(22)}\) This is especially important to note among those inmates who had no external source of support beyond the asylum. May F. had been confined for over forty years when it was noted: "This
patient has no relatives alive. Her only friends are the staff of this hospital." (23) Another inmate who strongly resented the fact of her seventeen years’ confinement, nevertheless had kind thoughts about those she left behind. After her discharge in 1911, Mary A. wrote to Dr. Clare: “I do miss you all so very much that I want to see you again [. ] remember me kindly to every one that I knew.” (24) Anna N. was confined in 1898 until her death in 1915. Several years before she died Anna wrote a letter to Doctor C.K. Clarke, expressing her gratitude:

I am thankful for the care I receieve from the Staff of Officers with the Nurses in Training… The attention I receive is excedently good under God it is all right[. ] I wish I could return some payment. But that is out of my power[. ] (25) [Original writing].

Since most of the entries and official correspondence were written by physicians, there is not as much about relations between patients and nurses and attendants. Most references to relationships between ward employees and their charges are inferred rather than explicit. For example, Albert L. spent more than the last three decades of his life in the asylum. A few years before his death, it was observed that he "gets along well on the ward and is easily managed by those who understand him." (26) "[T]hose who understand him" most likely refers to ward attendants. An implication of this passage was that those employees who knew him well and who were familiar with and accepting of Albert’s reclusive habits had a good relationship with this man. The constant presence of these ward employees was
much more significant in the daily routine of inmates than were the occasional visits by hospital doctors, as Ellen Dwyer and John S. Hughes have observed in regards to American asylums during the late nineteenth century, and as James Moran has shown for the Toronto facility between 1875-1905. (27) As will be seen below, this constant presence could also lead to a greater potential for friction, as well as friendship.

Minnie B. was 43 years old when she was sent to the infirmary in 1928. Her comments reveal how a patient viewed relationships between medical staff while in the infirmary, and the varied perspectives one could have towards treatment. Minnie offered a number of sharp observations about labour relations from a patient's vantage point:

January 23, 1928 - Drs. are no good only sit in an easy chair and draw a big salary + make the nurses do all the dirty work + get nothing....
January 31, 1928 - I will get hold of my chart + destroy it. Dr. Morphy sits at the table at night + plans all devilment + makes the nurses do all the dirty work. I know he does. (28)

These comments were recorded by a nurse who may have shared such sentiments with her patient about how they viewed male doctors' relations with women workers in the hospital. The fact that these very critical words were recorded suggests a degree of sympathy by the recorder who wrote into the record a positive view of her own role in contrast to that of her boss. However much these two people did or did not agree on labour relations, it is clear there was a divergence of views about one medical treatment
in particular. For over a week, Minnie was given hydrotherapy, also known as a "continuous bath," in which patients were confined in a tub with regulated temperatures as a way of trying to calm their nerves. Immersed in these tubs for anywhere from four hours to six hours, Minnie's comments indicate how therapeutic she felt this treatment was. An hour after being placed in the bath the first time she proclaimed "This is great treatment."(29) However, shortly after this she asked to be removed from the bath, and the following day, after more than two hours of hydrotherapy Minnie "says she cannot bear it any longer" and called for other patients to take her out of the tub.(30) An hour and a half after making these comments, Minnie was removed from the bath after four hours. Though Minnie was also reported to have been quiet and even slept in the tub, her feelings of hostility to this treatment illustrates how this medical therapy was considered less than beneficial for a patient on the receiving end.

Strained relations with the staff are revealed in another instance, when they interfered with socializing between the sexes. Ettie M. was confined from 1900 until she died at the age of 84 in 1918. Known for her sarcastic wit, it was recorded in 1912 that Ettie "has appropriated the privilege of mixing with the men patients on the grounds and when interfered with becomes very irate and stirs up a great deal of trouble."(31) Thus the gender segregation
rules were not accepted by all patients who wanted to make friends with one another, as Ettie tried to do.

Relationships between inmates of an insane asylum could run the whole spectrum of possibilities, just as in the outside world. Some of these relationships help to reveal the internal dynamics and volatility of social life within the asylum, and prove the emotional richness of patients' lives. Audrey B. was confined for the last forty-one years of her life at 999, until her death in 1946 at the age of eighty. After nearly two decades' confinement, Audrey was described as "fairly well flattened," which suggests a rather dull, almost catatonic existence among her peers.(32) However, it is also obvious that Audrey led an active life in which she showed a particular desire to be friends with specific inmates. It was noted that "her interest in other patients is quite marked, especially toward Ada T__."(33) Several years later, Dr. Winston noted that Audrey's "interest is confined usually to just one patient. At the present time it is Mrs. L. H____ and she is constantly brining (sic) her extra food and assisting her in many ways."(34) While her aloofness from other patients was observed, it was also clear that Audrey reached out to those around her, as she was said to have been "kind to the other patients and will comb their hair for them and straighten their beds."(35)

However, Audrey's attention was not always so welcome, such as when she upset other women who were trying to sleep
by repeatedly lifting up their bed sheets "to find out who they were."(36) During the last few years before she died, Audrey said many times that she saw her late husband wandering about the hospital grounds, at times coming up to a window and taunting her, prompting her to pull down the blinds, and even "thinks that other patients are her husband."(37) Isolated and never visited by her three children, something which she "cannot understand," Audrey found an important source of support among those patients she reached out to during her years of incarceration.(38) While Audrey apparently only had a few friends, the intensity of at least two of these relationships suggests the importance that companionship had for an inmate who was severely mentally ill and regarded as emotionally "flat."

The death of an inmate could provide an opportunity for reflection on the part of administrators, when informing their relatives. Such comments can help to give an insight into the status of relationships within the asylum that would otherwise remain lost to posterity. Annette F. spent the last thirty-nine years of her life in the Queen Street Asylum. During this time her relatives maintained a regular correspondence with hospital authorities. When Annette died in 1918 at the age of 83, Medical Superintendent Forster wrote that "she had special friends among some of the other patients who looked after her very kindly and took a deep interest in her welfare. She was one of the old landmarks about our Hospital, which are gradually passing
away. She has been missed greatly from the dances this year." (39)

The physical appearance of some inmates could affect their relationships with others in the institution, both inmates and staff. For example, Winslow H. was written up in the clinical record as "without doubt the silliest looking man on the ward.... He says he is six years old and as far as his mentality is concerned I believe he is about right." (40) This characterization was based on the fact that he was untidy in his dress, and in particular his tendency to exhibit "a very foolish grin," which is mentioned several times. (41) Referred to as a "happy imbecile" it was recorded that "his diagnosis is readily available in his face at any time." (42) On account of Winslow's "manneristic performances" he occasionally got into fights with other patients. (43) In spite of the negative impression his appearance made to hospital doctors, this man was also said to enjoy the patients' weekly dances. (44) So it is apparent that he was able to make friends among other inmates who accepted Winslow as he was, or else these social events would not have been so eagerly anticipated. The physical appearance of another man so challenged gender conventions around "proper" masculine attire that he became the object of harassment from both inmates and staff. Warren S. was a cross-dresser who "wears a woman's switch on the back of his head, and wears women's skirts." (45) Two separate entries note that he would
complain about someone, "nearly every day" and said that attendants and other patients, including those he worked with in the laundry, "try to do him harm."(46) Perhaps because of this distressing taunting by other men who made fun out of his dress, Warren eventually changed from wearing women's skirts "although he still wears a truss outside of his clothing entirely for ornament."(47)

This sort of taunting affected relations between inmates in other areas of social discourse. Jerold M., a wealthy lawyer, was recorded as making fun of other patients. Shortly after his admission in 1904, it was stated that Jerold "keeps the whole ward in turmoil by teasing the other patients" about which he was warned to stop lest he be assaulted.(48) Five years later he was still up to mischief when he was observed to be "Poking fun at V__ at times about his delusions," and was also noticed to be cross examining this same man on his "telegraphy powers" which Jerold found "wanting."(49) As will be shown below, some patients did not always turn a deaf ear to Jerold's comments.

A wealthy stock broker took the advice of his rich fellow inmate as to when to escape. Reginald F. out-ran a walking party on the hospital grounds and made it all the way to Hamilton before being returned. Reginald's wife Alicia wrote to Dr. C.K. Clarke "you can blame a man by the name of M__ for his going, as Mr. F. has often told me of his telling him to make a dash for liberty, + urging him to
do so."(50) This comment was corroborated by Dr. Clarke who wrote that Jerold M. "keeps influencing the other patients" to elope.(51) Both of these privileged middle-aged inmates would be dead within a few years; Jerold due to heart problems, Reginald, after his release, by committing suicide. Yet while they were incarcerated together, their relationship was hinted at and suggests how one inmate could plot with another one to plan an escape.

This mixture of taunting and prodding by a patient could be based on mental instability as well as insecurities about life in the asylum. Patients sometimes expressed anger based on the fear that their belongings were in danger of being stolen. The extent of theft is not clear but the incidence of patients missing articles suggests that it was not unknown, especially in the large public wards where there was very little privacy.(52) Such fears would have had an obvious impact on relationships. When this was combined with memories brought into the asylum from pre-admission experiences, or delusions, the mixture could be quite tumultuous within the institution. Avis S. spent the last fourteen years of her life at 999, from the age of seventy-one. During this period her relations with both patients and staff were repeatedly influenced by her thoughts based, at least in part, on her past life as a worker on a farm, being a widow and a mother of seven children. Her temperance and religious background also comes to the fore in her admonishments to those around
her. (53) Known for her "splendid" sewing work Avis liked to bring items from the sewing room back to her room. If anyone went into her room to retrieve these items she would get upset and tell them these were her things, and would accuse others of stealing her money and clothes as well as killing her cows. (54)

Fed up with the immorality that she felt was rampant on the ward, Avis claimed that the nurses had men around at night, and denounced both staff and patients when stating "if people in here would drink less brandy and pray more it would be much better." (55) An avid bible reader, she became angry when anyone interrupted her study, frequently scolded others for drunkenness, and constantly mentioned horrific images of murder and violence. No one, inmate or staff, escaped the wrath of this "striking character" as the following clinical entry makes clear about the comments made to a hospital physician by eighty-two year old Avis:

During the ward rounds she always wants to be noticed, shakes hands every morning and asks if your conscience is clear. She frequently tells me that I should be ashamed of myself for being the ring-leader of a certain murder that took place last night that there will be no place for me in Heaven. It is impossible to convince this patient of the fallacy of her sayings. Recently she accused me of murdering her daughter. She was very angry and did a great deal of swearing. The next morning her daughter called to see her, and she apologized to me every day for a week for accusing me of such a thing. She has peculiar ideas about wrong doing and many sexual ideas. (56)

The difficulty which both patients and staff would have had in forming a relationship with Avis can be imagined as she was usually recorded as making unpleasant remarks about
those around her, as the above references indicate. These quotes also suggest that this poor old woman did not mean any harm, but was becoming rather senile trying to ward off all the terrible thoughts that occurred to her by admonishing everyone. These distressing thoughts would have been most upsetting for her since she was unable to escape such ideas. Thus, relationships could be prevented or ruined by an inmate who was unable to find peace of mind, due to mental instability. Even as she lay dying at the age of eighty-five, Avis S. claimed that her final illness was "due to the Black Art," rather than having been brought on by falling and injuring her leg. (57)

The comments by Avis lead into the central reason why so many of the men and women who populate this thesis ended up at 999: mental illness. Daily lives of inmates were very often taken up with the most tumultuous thoughts which limited their relationships, and in some cases, ended any desire to continue living. Adam C., confined from 1897 until 1935, was tormented for much of his incarceration with the most cataclysmic ideas about persecution and plots. He offered a poetic rendering of his troubles in a letter not addressed to anyone, though it was likely intended for Superintendent Clarke considering its content:

Stop the Talking-Machine hurting my head
by electricity during the night time.
Stop, causing deafness in my ears or hearing,
Stop, paining my eyes and weakening my eyesight.
Stop, hurting and disturbing the waters in the physical body.
Stop, making soreness and aching in the
hips during the night time.
Stop, causing toothaches.
Stop, causing cramps in the feet and limbs.
And stop all electrical violence to my
    physical system and mental sphere.
These are some of the violences practised on me for
many years, and I tabulate them for clearness of
comprehension, in order that you shall command the
talking-machine woman to stop hurting and injuring me
by electricity. (58)

Another patient, Abbie G., spent her last nineteen
years in the mental hospital until she died in 1921 at the
age of 43. Her severely disturbed state was repeatedly
noted in her clinical file, particularly Abbie's frequent
biting of her hands and arms "until they are a mass of
sores." (59) She did this for years and covered herself
with scars in what is now called self-inflicted violence,
the intentional harming of oneself that is not suicidal.

Totally withdrawn from other inmates, Adam and Abbie
highlight the utter despair which some patients experienced
day in and day out. For such unhappy souls, the routine of
daily existence could be lost in a shroud of mental misery
that institutional life could do little or nothing to
alleviate. For still others, emotional despair was turned
to desperate resistance.

Resistance

Cheryl Krasnick Warsh has noted how turnover in staff,
and thus lack of supervision, could lead to situations which
made it easier for a person to escape from the Homewood
Sanitarium in Guelph, Ontario in the late nineteenth and
early twentieth centuries. (60) This sort of unstable
employee population also occurred at Toronto and enabled
more inmates to exercise various forms of resistance. (61) By the early 1900s it was estimated that an average of five patients "eloped" every year. (62) Staff members had a particular incentive to be careful not to let an inmate escape on their watch, for if it was found that they were responsible, an employee could be forced to pay the cost to the asylum of retrieving a run-away patient.

One of the best documented cases of persistent escape attempts is that of Arlene S. Confined in 1903 at the age of thirty, this woman was "kept under strict watch" as she was "continually and always watching for means of escape." (63) The desperation of her efforts is revealed in Arlene's frantic activities that were regularly entered into her Clinical Record from 1909 to 1918. She would break windows "praying and beseeching" unseen friends to take her out, and would even make her way to the reception room of her locked ward "where the visitors are admitted and speak to them under the door to take an interest in her and try to help." (64) Arlene also would not wear any brightly coloured clothes for fear that should she escape "these clothes would look remarkable on the street and cause her arrest." (65) Her plan of escape included tearing sheets and pillow cases to be re-fashioned into ropes to lower her from a window. She also took springs out of her mattress to pick the locks of ward doors. On one occasion, Arlene was caught picking the lock at three in the morning. Undeterred by
this failure, she was found a month later with her bed clothes made into a rope to get outside. (66)

On at least three occasions she did temporarily succeed in her escape plans. The earliest evidence is from 1906, but it simply consists of a receipt for two dollars paid by the hospital to a person who lived nearby for "recapture of escaped patient" with no further explanation. (67) In the other two known instances there is more detail. Around nine o'clock one evening, Arlene secreted herself in a group of patients who went from her ward to the church building, then slipped away out the front stair case of the facility. Upon reaching Queen Street, she "put on a hat made of a handkerchief and a pair of nurses cuffs" and boarded a street car going east. (68) Her description and name were even placed in a newspaper, supposedly to 'alert' readers in the vicinity, which noted her conservative dress of a "light waste and blue skirt" just as Arlene said would be the case, so as not to draw unwanted attention. (69) She was returned after a phone call from an informer, who wished to be anonymous (though this person was nevertheless identified). Authorities found Arlene a day after her "elopement" at her aunt's house. (70) Undaunted, she tried to escape from a walking party on the asylum grounds just two days after being recaptured. (71)

A little over a year later, Arlene made her way out once more, this time under cover of doing work around the ward, while the supervisor was eating breakfast. After
opening a door with a key, she made her way east again. That evening she was found by a former nurse about four miles east of 999 who turned her over to the police. However, Arlene was released by police for unexplained reasons. She set off yet again, and eluded her asylum pursuers who "followed her all day," until she was re-captured by a policeman in a downtown railway yard.(72) Several years later, Arlene was still noted to be "always" trying to escape, who "runs at every chance, can pick a lock with a piece of wire and open the door."(73) Arlene said she had no idea about where she would go if she escaped. In 1918, a year after making this comment, Arlene committed suicide at the age of 45. During this last period of her life, she was recorded as being less talkative about escaping. Rather than this reserve counting in her favour from the staff's point of view, it was instead cause to be even more wary as it was observed "for that reason [she] is very deceptive and requires a great deal of watching."(74) Even though it was mentioned that Arlene was very industrious about writing for help, even using torn pillow cases and aprons for writing material, none of these documents survive.(75) Nor is there any evidence that this single seamstress ever had any visitors, as her file contains no references to outside support, though her remains were removed to a funeral parlour with the permission of Arlene's mother. The only direct quote attributed to her speaks volumes about the tormented
thoughts of this resistant inmate. Arlene was recorded as having stated after years of being locked up that, she is "pretty near out of her mind and ready for the asylum."(76)

Reports indicate that escapes also occurred with those patients who were among the most trusted. After five years' confinement, Leonard G. was allowed out of his ward unsupervised to sweep the stairs of an outside corridor and ran off, never to be heard from again.(77) Another inmate, Henry S., escaped from the barn yard in the north-west corner of the hospital grounds, but was recaptured by the police in Barrie and returned several days later. Two years later, in 1910, Henry ran away while working with the "milking gang" at the same farm. After the standard thirty day period had elapsed and no trace of him was found, Henry was written-off as escaped. His clinical record noted, "It is doubtful whether he has enough intelligence to provide for his own wants."(78) Walter B. also made good on his trusted position by escaping from the horse stables where he worked, and was never apprehended.(79)

These escapes were made easier with outmoded security equipment. Joseph G. was able to leave unnoticed shortly before breakfast, thanks to a key he made to open and close the ward door. It was noted that "locks can be opened by almost any key."(80) Though he was arrested in Niagara Falls, New York, Joseph was let go and disappeared from the records, presumably making his way into the United States. Patients who were not trusted and were under closer watch,
nevertheless had opportunities to run away, such as when inmates bolted from the walking party. Nancy D., thirty-two years old, escaped in this manner in 1883, made her way to the nearby railway tracks, hopped a train and "was carried to Guelph." (81) She was arrested there and returned to 999 where she remained until her death fifty years later. Her escape is notable in that she and Arlene were among the minority of women who were reported to have escaped, as most references are to men. The fact that males had far greater access to the grounds, as will be discussed in the chapters on leisure and labour, indicates that women had fewer options to run away since they found themselves locked inside much more than men. Also, the long heavy dresses that women wore would have made it more difficult for them to run through fields and scale fences or walls. (82)

The motives for escape appear obvious in the implication that these inmates wished to be free. In one case where the pre-escape circumstances of a long-term inmate who was re-captured are noted, there is a suggestion that there could be more behind these motives than a clear-cut desire for freedom. Daniel K. had been an inmate for forty-five years when he walked away from the hospital late one stormy night in February, 1924. It was observed that he was never known to have done this before, and there was concern that he may be "lying helpless some where [sic] in the cold." (83) For years this man had worked faithfully with the "dairy maid Miss Denty" carrying the milk cans back
and forth between buildings after supper. (84) However, it was thought that Daniel may have become upset when Miss Denty left a year earlier, as well as after his duties were altered, and his living quarters were changed from a private basement room to a large ward. The day after he was reported missing, Daniel was found to have returned to his old home in Markham, Ontario. He told hospital authorities, "that he is entitled to a visit home," where he once taught school, and "seemed to think we should not have returned him to the hospital." (85) Several years later, Daniel was sent to an old person's home in Newmarket, after nearly fifty years in the asylum. (86) The observations contained in his file suggest that the emotional and physical disruption that occurred in the life of this quiet old man during the months preceding his escape may have prompted him to leave a world that was no longer as stable or "safe" as it had once been. Thus, to run away from the asylum and return to the world of his youth, could have been a way for Daniel to recapture some of the security that had disappeared when his trusted work mate departed and his familiar living and working patterns in the asylum had changed after so many years of reassuring routine. Superintendent Clark had noted that some patients who escaped, sometimes hundreds of miles from Toronto, returned on their own to live out their life at the institution they decided was their home after decades of knowing no other environment. (87)
Most of the acts of resistance that were recorded were by individuals acting on their own. Of course, resistance took forms other than escapes. The most frequently documented examples were inmates talking back to staff or refusing to cooperate in ward routine. However, one should be careful not to read into all such examples as a deliberate effort to subvert authority. Refusing to work could, for example, just as easily have been the actions of a tired, or lethargic individual. This option may have been chosen on the spur of the moment rather than deliberately strategized to upset the prevailing status quo. On the other hand, the comments or actions of some patients leave little room for doubt that flouting authority was intended by the individual(s) involved. Elaine M., a married mother of three, spent the last quarter-century of her life in the asylum, being admitted in 1903 at the age of fifty-two. During her final years, it was observed that this elderly woman would not tolerate intrusions into her privacy. When an asylum physician tried to interview her she "would give no information...told me to put my nose in the corner and leave her alone. She also expressed the desire that I should go to hell."(88) She continued in this manner by refusing to talk to medical personnel and "resisted all attention and treatment" right to the end.(89)

In one case, resistance was collectively organized to challenge the authorities by a patient whom the staff considered to be quite notorious. Arnold S., a bachelor
farmer, spent the last twenty years of his life in the asylum until his death in 1910 at the age of fifty-seven. This man was moved about once every year to a new ward as he was considered a manipulator and abuser of other inmates, with physical assaults being observed. In spite of this reputation, or perhaps because of it, a hospital physician wrote:

[Arnold] was the leading spirit of a mutiny, some years ago, against the attendants on his ward, and had it not been that one of the attendants, who was supposed to have left the ward had not done so, it probably would have resulted very seriously.

Organizing such a revolt is an intriguing example of the extent to which some patients would go when resisting institutional pressure. Arnold’s conduct towards others in the asylum also highlights the abuse that occurred behind asylum walls, as is detailed in the next section.

Abuse and Censorship of Patients’ Letters

The extent to which inmates were physically and verbally abused by one another or by staff is an area which can only be sporadically recounted. Writings from former inmates during the nineteenth and early twentieth centuries in the United States and Europe confirm that abuse did take place. The compilation of accounts by Dale Peterson, Jeffrey Geller and Maxine Harris, provide a clear record of how some inmates experienced terrible trauma while confined. In his critique of the social control view of nineteenth century American asylums, Gerald N. Grob argues that the abusive nature of institutions has been
over-emphasized to the neglect of pointing out the way in which such places acted as a refuge for indigent members of society. (93) While this is an important point, it is also essential to point out that there can never be a quantitative assessment of the abuse hypothesis either way. No contemporaries systematically compiled statistics on the number of altercations or types of abuse between inmates and staff, or between particular patients during the nineteenth and early twentieth centuries, though Ellen Dwyer was able to uncover some data on this topic from ward injury books for the Utica and Willard Asylums in New York state during the 1880s. (94) However, not all types of abuse would have shown up on such registers, such as verbal and sexual misconduct. This lack of statistical data is hardly surprising as formal hospital bureaucracies were only in their most immature stages at this time, with such a category as "Types and Frequency of Abuse" not being established as an area in which to compile statistics. (95) All that researchers have to go on when this issue arises is the occasional report in clinical files, letters from family members and, when especially fortunate, writings from the inmates themselves. Taken together these documents show that abuse did occur at the Queen Street facility, though it is also clear that these reports were extremely contentious. (96)

In 1883 Katerina D., the sister of patient Nancy D., wrote a letter about the treatment this thirty-two year old
woman was reported to have received at the hands of staff.

As the following excerpt shows, her information was conveyed by another patient who said she was trying to help:

...during my last visit to the Asylum on Wednesday when in the ward with my Sister one of the patients, Miss D___, told me that she felt pained sometimes when the nurses were "punishing" my Sister. I then said what do they do + she replied "pull her hair and thump her." Miss D___ must have remonstrated with them as she said that they told her it was to make my Sister "better" + that they would do the same to her if she needed it.(97)

Doctor Daniel Clark responded by declaring that the charges made by this patient had "no foundation" as she was endeavouring to turn people against the staff.(98) This conflict between the point of view of a patient and that of hospital staff around the issue of abuse is also documented in another episode. Jim W. was a blind sixty-six year old inmate at Toronto who claimed to be regularly humiliated by both patients and staff. The abuse he recounted highlights the vulnerability experienced by people with disabilities at the hands of able-bodied individuals. He said attendants "were always pulling his nose and throwing water on his head."(99) In one incident, after he was told to get out of the way of the floor polisher, he stated that the attendants had "thrown him down on the floor."(100) With a black and blue bruise observed on his hip, his pain was obvious to both the doctor and Jim's sister who made inquiries about the incident. The attendants denied all knowledge of the origin of Jim's injury, views which were accepted without
doubt by the physician. Instead, other patients were blamed for this injury. It is clear from his clinical record that this man was repeatedly harassed by other inmates from whom he had to be separated at the dinner table. Yet it is also clear from his comments that, unlike staff, Jim had no doubt about who had caused this particular injury — hospital attendants and not other patients.

These two episodes illustrate the difficulty of retrieving the patient point of view around such contentious issues as abusive relationships. On the one hand, there are two documented references about the physical abuse of inmates, while on the other hand there are comments from the staff which refute these claims, at least insofar as the blame falling on the shoulders of hospital employees. In both instances, it is important to note, the recorded observations were prompted by relatives, the inquiries being made by the sisters of Nancy and Jim. There are other references to abusive conduct in the asylum from patients themselves which suggest the everyday tension that existed in the lives of inmates. Ralph M. was confined in the Queen Street facility at the age of 57 in 1898, where he remained until his death thirteen years later. In an undated letter, written to "My Dear Wife," Ralph wrote:

I have been called a son of a bitch I believe one hundred thousand times since I came to this place, If I had heard any one call my mother a bitch when I was young I would have knocked him down with a club and thought I was doing Gods service like Saul I would have been kicking against the pricks...(101) [Original writing].
A contemporary inmate of Ralph, Elsa P., wrote a letter about what she stated she had witnessed on her ward. She was admitted in 1903 at the age of fifty and was discharged in 1915. This twelve page letter, which does not have the year recorded but is addressed "To The Superintendent," is worth quoting at considerable length. It was written while Elsa was out on probation at her daughter’s residence on Centre Island in Toronto Harbour.

Sir for several years I have been tempted to write to the Superintendent... I do firmly believe it is the right thing to do... I certainly should never have done it while there because there are so many watching to get each other in some trouble that seems to be the nature of insanity. I have too much sympathy for my fellow sufferers to resent that... Sir I am very sorry to say that could you know and see what I have in the Toronto Asylum you would at least pity those poor unfortunates especially those who are without kith or kin. It's a deep grief to me to do this and I don't wish to mention any names or cause any woman to lose her position but some of those women ought to blush to take the money they are supposed to work hard for... if they only went about things differently it would be a blessing to us who are afflicted[.]

I must mention a few things in confidence no one even knows that I am doing this altho many times I resolved the next time I came to my daughters I would do so - I have suffered at their hands and altho I forgive them I feel sure it will be measured back to them some day... I want if possible to help those who are at their mercy[.]

I don't know how some of them dare to put on the beautifull uniform also partake of your goodness and treat those poor creatures in the manner they do sometimes[.]

I have watched until I could have thrashed some of the nurses myself... is the milk sent up to the wards to be skimmed for the nurses benefit also the best of everything kept back in their cupboard for their extra meals[.]

We were allowed perhaps ten minutes from the time we went in the dining room X until we returned [illegible] out called sometimes before our meal was half eaten, then the poor verandah patients pulled & knocked about like dogs, dogs sir[.]

I would not treat a cur so, then the poor things scarcely ever got a kind look, I have been so crushed there no wonder at what I had either said or
done, I say the nurses have a splendid time and the poor insane patients are at the mercy of a lot of inhuman giddy girls[.] I am very sorry indeed to speak like this[.] I shall say nothing of what I had to endure at their hands[.] God help us all but it seems so different when they are expecting the doctors or Matron that I feel sure you do not know and we are ordered about by the worst patients and they to[o] get privileges, are allowed to deceive and steal our food for the Nurses. I know it so because I made it my business to help in the dining room to see for myself – & the food that those who are sick and need it is given to the favourites. Yes, when my appetite was entirely gone they would give me things to eat but when I might have had a relish for something they would just be mean, I did not mind at all because when I am well I can eat dry bread for that matter[.] excuse me being so plain but I am just relieving my mind, this will do me good. I do not wish to be any detriment to a living soul, but I [illegible] believe in some way they are bribed to be kind to a few, God help the others… my sympathy is with them all, and I do assure you sir I could write a volume of the treatment I myself have seen there, but at present this is sufficient – trusting you will forgive my intrusion and that you will in some measure be led to see these things, I remain Yours sincerely...(102) [Original writing].

There is no response to this letter in Elsa’s file.

Her comments about patients abusing other patients, adds a further dimension to this topic, and suggests how some inmates had power over weaker patients. Physical abuse is frequently cited in records, and when this occurred the intervention of staff members would most likely have been welcomed by an inmate who was being assaulted by another inmate. Patient-on-patient verbal abuse is also sporadically mentioned in hospital files with class, ethnic, racial and religious prejudices directed at patients from another inmate. Bigotry came from all segments of the asylum population, including the most well educated and
privileged people. In these instances there are seldom doubts raised about who was engaged in abusive conduct.

In 1917, there was a formal investigation of allegations of the physical abuse of two male patients by two male attendants after complaints by the wife of one patient, Wesley W., who died of syphilis prior to the inquiry. The accused staff were exonerated during this hearing. The complainant, Hazel W., was blamed for being "vindictive" and listening to the charges of an insane patient, a man who was confined on the same ward as her husband. The methodological problem of getting at just what was going on in each of these episodes needs to always take into account the colossal power imbalances between patients and staff, as Dick Sobsey has shown in his study on abusive conduct towards people who have been institutionalized. While there was agency within the asylum, as is reiterated throughout this thesis, it is essential to remember that this was not based "on a level playing field," as Thomas Brown notes, for the vast majority of patients. This is most evident when considering reports of sexual abuse within institutions, a topic which has gained increased attention from researchers in recent years.

Thomas Brown has uncovered a sexual assault which occurred at 999 in 1886 when a former male employee was charged with rape after he had sexual intercourse with a female patient. However, the victim was blamed when it was
charged that she suffered from "erotomania," thus leading to the acquittal of the defendant.(107) The comments of two other female patients provide further glimpses of this topic. Agatha H. spent the last forty-four years of her life in the asylum, being admitted in 1903 at the age of thirty-one. During the 1930s, two clinical entries four years apart allude to her sexual fears, with one observation noting her refusal to sleep on a mattress.(108) The other reference is more detailed and relates the significance of this practice: "She is unapproachable and runs away. She sleeps on the floor all night, because she has many sexual ideas and believes she is abused during the night."(109) While later generations do not know what happened to Agatha to make her so fearful, her expression of such thoughts points to the unseen, traumatic side of institutionalization in which some inmates could feel themselves vulnerable to sexual abuse, or experience flashbacks of previous sexual assaults prior to confinement.

By far the most voluminous comments uncovered about allegations of sexual abuse at 999 are from the writings of Elaine O. Confined in 1905 at the age of "about" 35, this single domestic worker wrote almost three dozen letters and post cards to asylum officials after her release in 1910.(110) In two letters written shortly after her release, Elaine's anger at asylum authorities is evident:

the idea of having men like Carson and others to play with a woman as they have with me and you laugh[.] I have a good memory of what it ment to me to be locked

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up in that Prison house of Satan for 5 years for nothing.... you had no Business to take me into that Prison or touch my head or Body to do dispite to me.... what you have done and allowed done to me....(111)

You all aught to be ashamed of your selves such obscene practice... I was no man's wife nor was I running after men or keeping company with any man[.] to be Kept in that filthy Prison as tho I was a Polygamy or Bigamy conuBine the indecent assault a lot of men up there wrongly imployed the wicked ungodly Villains. I was not your servant the cheek of you or them... You would not dare to do and be so free to any other Toronto woman.(112) [Original writing].

Medical Superintendent Clarke received this letter around the same time:

that Brutal crowd of men you call cooks. You needn't think every one insane that gets into that cruel inhospital uncharitable Asylum get such a claw and paw on me. What right or licence have they. I cant see why you allow what you do.... I never did any-thing so insane or as bad in all my life as the Asylum attendants did any way....(113)

Elaine's hostility towards men is made perfectly plain in an undated, unaddressed note: "I am no admirer of men and I am very particular what Kind of Girls I associate with go out with..."(114) In these letters, Elaine referred to men who "play with women," or who "touch my head or body," or who commit "indecent assault," or who "get such a claw and paw on me." There is no response in Elaine’s file from hospital officials to her about any of her writings.

The issue of verification arises for an historian who comes across this material. Since there are no comments by a third party observer in Elaine’s file which allege any sexual misconduct while confined, does this mean that these documents, and those which allege physical and verbal abuse
cited earlier, should not be taken seriously? Mary Elene Wood has written about how patients "who reported abuses to authorities after their release were seen as vengeful, bitter trouble-makers who probably had not fully recovered from their illnesses."(115) Carolyn Strange has shown for Toronto during this period that a working-class woman like Elaine O. had very little chance of being taken seriously by officials when it came to charges of sexual misconduct, and indeed men were seldom prosecuted, let alone convicted, of rape in Canada during this period.(116) This context of the obstacles faced by disadvantaged groups, especially female patients as well as people with physical disabilities, and individuals who belonged to a racial, religious or ethnic minority, needs to be kept in mind when considering this evidence. Nancy Tomes has written about the difficulty of determining the accuracy of a patient’s complaints due to lack of corroboration, but she also notes that a superintendent’s dismissiveness towards such complaints was not reliable because of his self-interest.(117) This point serves as a reminder that the Superintendents at 999 Queen Street West had a similar position when they dismissed patient complaints. If patients’ perspectives were questioned in this regard, so too must questions be asked about the denials of administrators, especially when considering that they were not present when alleged incidents occurred. So who is to be believed?
At the Toronto institution, Daniel Clark made it clear during his long tenure (1875-1905), that any staff member found guilty of abusing an inmate would be immediately dismissed, a point which was also mentioned by his successor, C.K. Clarke. (118) However, as James Moran has written, "there appeared to be a fine line between clearly unacceptable, outright physical abuse (which, when discovered, resulted in dismissal) and a kind of 'rough handling' of patients which was tolerated by Clark." (119)

How an abusive employees' guilt was established is unclear. The burden of proof would have been difficult for an inmate to demonstrate, not only because they were in a subordinate position within the institution, but also because it was an inmate's word against that of a staff member who could dismiss the charge as part of a complainant's mental illness, if it was not corroborated by another non-patient. Fear of punishment, which Elsa has already raised, is another factor when making such charges, as Elaine and Elsa's letters were only written after they had left the institution.

There were additional influences that weighed against patients' complaints. Peter McCandless has highlighted an administrative rationale for not wanting to dismiss an abusive employee, which was divulged by an official investigation into conditions at the South Carolina State Hospital in 1909: very few replacements were available. (120) Toronto's Superintendents complained about lack of staff
repeatedly, particularly during and just after the First World War, and indeed Dr. Forster raised this point during the 1917 Investigation.\(^{[121]}\) Internal efforts by ward staff to hide abuse from their superiors, about which Elsa P. wrote, are another important part of the equation. This particular point has gained greater recognition among investigations into abuse at long-term care facilities, which have been conducted by health-care professionals in recent years.\(^{[122]}\)

At both the Willard Insane Asylum during the late 19th century and at the Boston Psychopathic Hospital during the early decades of the 20th century, physicians believed accusations that attendants had committed abusive acts against patients, unless the accused could prove otherwise, though Elizabeth Lunbeck shows that this was very much due to class prejudices towards employees.\(^{[123]}\) Steven Noll has shown how male staff were warned about any consorting with female patients at the Florida Farm Colony in the early twentieth century.\(^{[124]}\) At the Homewood Retreat in nearby Guelph, Ontario, Cheryl Krasnick Warsh found that an employee had to be caught in the act of ill-treatment by a doctor to face the consequences.\(^{[125]}\) Yet Warsh also notes that because of their distance from constant supervision by administrators, attendants had a great deal of independence from their superiors.

This is especially important when considering the ratio of inmates to ward staff. In the late 19th century,
it was sixteen inmates for every attendant at Toronto. (126) But this was so variable over time and on different wards, that on one of the female back wards at Toronto in 1918, there was one nurse for every 41 inmates. (127) With such widely diverse population ratios, it is conceivable that some staff-initiated abuse would be difficult to spot by other employees who were on the ward at the same time, as they may have been busily occupied elsewhere with other patients. Depending on the time and place, doctors could have had fewer employees to ask to corroborate an inmate’s accusations when such incidents were reported. (128) While various institutions had anti-abuse policies in place, their effectiveness could have been diminished due to the daily problems of overseeing so many people. Thus it is essential to be cautious when considering staff denials about abuse and to avoid re-pathologizing patients who left writing behind that sheds light on this topic. Researchers must always be aware of how the internal dynamics of daily ward life could lead to the under-reporting of this topic at an under-staffed facility like the Toronto Hospital for the Insane, and appreciate the vulnerability of people in institutions to having their complaints dismissed due to biases against them because of their status as mental patients.

One further aspect of abuse needs to be considered, and that is the censorship of patients’ letters by hospital authorities. In this instance there is no difficulty in
corroborating that this occurrence did take place. Almost all of the letters in this thesis which are not specifically addressed to physicians were intercepted by officials and placed in files. Letter to spouses, children, parents, siblings, friends and others were routinely confiscated by superintendents during the late 19th and early 20th centuries. While patients' rights activists, such as Elizabeth Packard, actively fought against this intrusion of personal privacy in the United States, asylum doctors in North America were quite open about their rationale for this practice. (129) In 1875, members of the Association of Medical Superintendents of American Institutions for the Insane passed a resolution which stated that "valuable information" about the thoughts of inmates can be obtained from patients' letters, and that letters from women patients in particular needed to be confiscated 'for their own good,' to prevent them from getting upset about their contents upon recovery. This resolution stated that it was "an outrage on common decency and common humanity" to be legally forced to send the letters of asylum inmates. (130) A few years later, Daniel Clark stated that no patients' letters were to be mailed by attendants. (131) In 1902, when referring to a patient's letter that 'escaped' the asylum, Clark wrote to a correspondent: "I do not know how the letter got away as all patient's letters are supposed to pass through my hands. The patients, however, are very cunning and sometimes overreach us in that matter." (132)
Patients knew what was happening and complained. Adam C. complained in two different letters about the censorship of his letters to friends who never received these communications because they were confiscated. (133) Elsa W., confined for seventeen years until her discharge in 1915, complained to Provincial Secretary Hanna in 1909 about this practice: "[S]urely a wife can write her honest thoughts to her own husband + sons without being censured by those who regarded it their duty to criticize my letters..." (134) As will be seen in the chapter on leisure, one patient responded quite strongly to this intrusion. This policy was also known to family members, and at least one relative, Alicia F., specifically asked that upsetting letters written by her husband, Reginald F., be confiscated. (135) Hospital authorities complied with this request, though Reginald was still able to get some letters out. Anna C., the wife of another inmate, Wendell C., had quite a different response to her husband’s letter, as she wrote to Dr. Clark, "thank you very much for letting it be mailed to us." (136) May K., the sister of inmate Anne D., expressed her anger at this policy in a 1913 letter to Superintendent Forster:

Will you kindly let me know why my Sister Mrs J.W.D__’s letters to her brother and myself are always destroyed and not mailed to us... I have no other means of hearing of her except through her letters. My brother addressed and stamped envelopes and gave [them] to her and told her to write him... he did not hear from her and went to the asylum to see her[.] she told him she had written three letters and had also written me [and]
that the letters had to be given to her nurse unsealed and had been destroyed[.] I was not aware that a hospital was a prison and its inmates had to be cut off entirely from all help and friends...(137)

Though May had asked for a reply allowing Anne to send letters unimpeded, there is no response to this request on file. Instead, Superintendent Forster wrote to her brother Paul, who lived in Toronto, that he did not understand why Anne’s letters went missing.(138) While Forster appeared surprised, he was engaged in the active censorship of inmate mail as had been his predecessors. This practice was openly acknowledged by his colleague, Assistant Physician John Webster of the nearby Hamilton mental hospital. In 1916, Webster wrote about a long-term male patient who wrote hundreds of immaculate documents of a legal nature, "carefully written with a special ink made by himself... beautifully bound and enclosed in an envelope of his own manufacture."(139) One of these documents composed by "T.L." was published in the Bulletin of the Ontario Hospitals for the Insane. This man was diagnosed as having "Litigious or Querulous Paranoia."

What is perhaps most striking about the letters found in case files is their lack of compliance, quite in contrast to many of the letters sent to Superintendent Kirkbride of the Pennsylvania Hospital for the Insane in the mid-nineteenth century which Nancy Tomes discusses in her book A Generous Confidence.(140) While expressions of gratitude and deference were expressed by some inmates, the critical perspectives of many other patients contained in confiscated
mail suggests why so many letters did not get beyond the Superintendent's desk. Ironically, this may be one of the reasons why more positive patient perspectives are not preserved, since officials allowed them to be mailed and thus they were not placed in case files as often. While this type of abuse was not as immediately devastating as physical, verbal and sexual mis-conduct discussed earlier, the fact that inmates' mail was so openly censored indicates that there were other forms of personal violations that mental patients were subjected to in their daily existence at 999 Queen Street West.

Affection and Family Relations Within the Hospital

While relationships among patients were, at times, strained and abusive it is also important to note that there was genuine physical affection in relationships among some inmates. Rhonda D., forty-six, was observed to be "very kind to other patients, kissing and caressing them."(141) Whether such relationships ever developed into homosexual affairs is not recorded in the documents examined. Sexual relationships of any kind among patients, whether consensual or coercive, are seldom referred to in patient files. One of the few comments about this topic from a patient was recorded by thirty-six year old Jack P. He wrote a letter to his wife in which he alludes to what appears to be rebuffing the sexual advances of another inmate:

Another little incident occurred the previous evening and I regret very much I struck one of my poor fellow patients. He, poor soul, was quite inoffensive, only I
was not in the state of mind to allow myself to be the plaything of a fellow patient..."(142)

Even though he hit his ward-mate, Jack expressed a certain degree of affection for this person, suggesting the man's advance was not aggressive, quite unlike Jack's response. Heterosexual relationships between inmates would have been possible among those patients who had the freedom to leave locked wards and roam the grounds, and at isolated places of work such as the farm, well removed from the main buildings. Indeed, James Moran has uncovered one such episode that occurred in 1881, when an asylum fireman witnessed two inmates engaged "in an improper manner together" at the blacksmith shop: "Clifford admitted to [Medical Superintendent] Clark 'that he stood and watched them for a time and made no effort to separate them until it was evident that sexual connection would take place, and then he separated them.'"(143) What happened to these two inmates is not known, but fireman Clifford was fired for not promptly informing authorities about this incident.(144)

A number of points can be inferred from this reference. One is the omission of the gender of the two people having sex. Since Clark referred to "sexual connection" it was likely that this refers to heterosexual intercourse. It is impossible to know whether this was consensual or coercive sex. However, since a hospital employee lost his job for failing to report this episode right away, it is clear that staff were required to report sexual activity between
inmates. This in turn indicates the lack of privacy that existed for patients who wanted to engage in heterosexual or homosexual activity.

Pregnancy of female patients who had been confined for longer than nine months indicates sexual contact within the institution and was reported elsewhere, as Wendy Mitchinson has noted for the Gladesville Asylum in Australia.(145) At Toronto there was a report in 1918 of a patient, Alice M., who was "assisting in preparing for the arrival of an infant" by another female inmate.(146) While it is not clear whether this unnamed fellow patient had become pregnant inside or outside the hospital, Alice’s work helping her friend shows how affection between inmates did lead to practical day-to-day support.

Attraction to others in the asylum, when reported in an inmate’s file, is nearly always asexual, with only enough information to gain a general, usually quite vague impression about the intensity of such relationships. Fifty year old Mildred O. was considered to be "perfectly oriented regarding both time and place" by hospital officials and so was likely trusted enough to wander about on her own.(147) Doctor C.K. Clarke also reported a year earlier in 1907 that she had "a little habit of falling in love with nearly every man she meets," after three (of five) years at 999.(148) This outpouring of affection while in the asylum may have been in response to her marital problems. In the one surviving letter of Mildred’s that is contained in her file
and was written the same month as Clarke's observation, she wrote to an acquaintance, "My Husband doesn't want me, that is very evident."(149) This view is corroborated by a family doctor who wrote to Clarke about the husband deserting Mildred.(150) Thus, this abandoned wife may have hoped to find a new mate among the male asylum population to replace her negligent husband, though there is no evidence that Mildred O. ever succeeded in this quest for heterosexual companionship. Another inmate, fifty-one year old Evelyn T., had a decidedly maternalistic relationship with other inmates, all of whom she claimed were her children. However, five years later, she claimed that her offspring had all been "abolished" since the death of her husband.(151) This changed attitude may explain why Evelyn no longer talked with other inmates at this time, whereas previously she was noted to be very talkative.(152)

What is perhaps most striking in the comments about patient relationships is the dearth of references to male expressions of affection towards one another or towards females. If anything, the vast majority of relationships depicted in case files involving men are usually in a conflictual state, with physical assaults or verbal insults, such as swearing. While this friction is most definitely recorded for women inmates, there is also a much broader range of kindness and nurturing observed between females than between males. Whether this is due simply to fewer observations of bonding between men, or a masculine desire
to avoid such outward expressions of friendship, or the biases of the observers, will have to remain a question mark. One of the few references about a male patient taking care of other male inmates was in the context of work duties, rather than social relationships. Gregory F. was reported to be friendly and enjoyed his job helping out in the male infirmary where he assisted the attendants taking care of patients confined to bed. (153) That Gregory was known to like this work rather than just did it unenthusiastically as part of daily routine, indicates that a male inmate was also capable of being active in nurturing activities, even though this was seldom recorded in case files.

Relations between family members who were confined in the asylum at the same time provide a unique opportunity to glimpse the transferral of care from home to institution among close relatives. As the following discussion will show, these relationships can also illustrate the broader themes around daily interaction among inmates and staff that have been highlighted in this chapter. Beginning in 1906, a mother and daughter were confined at 999 Queen Street West until their transferral to Cobourg in 1914. They were returned to Toronto in 1917 upon the request of family members in the United States, following the wishes of their mother. (154) During this initial period in the same facility, Ellen S. and Sandra S. were on separate wards. Described as "thin...very filthy and neglected" upon their
admission in 1906, the mutual dependency of mother Ellen and her unmarried daughter Sandra is indicated in a number of letters from inside and outside the asylum. (155) The support each provided the other is suggested in correspondence between hospital officials and Margaret B., a married daughter and sister of these two inmates. Sandra had been confined first in 1904, but was reluctantly released on six months probation in August, 1905 after her mother "torments me to allow her daughter to go away with her," in the words of Doctor Daniel Clark. (156) In February, 1906, shortly after Sandra was re-admitted, Margaret B. wrote to Assistant Superintendent Ross that the mental condition of her mother "is almost as bad as that of my sister," so confinement at the Queen Street facility was viewed as urgent. Margaret continued, "I am sure she would be perfectly happy there, so long as she knows she is under the same roof with her daughter, and I think you would have no difficulty in getting her there, as she would willingly accompany Miss S___." (157)

They were housed in separate rooms, with the younger woman on the $4.00 a week ward while her mother was on the $3.00 ward, as was instructed by Margaret B. (158) How this separation affected them is not known, but it is evident that the mother continued to be supportive of her daughter. A letter from Assistant Superintendent Ross to Margaret B. made reference to an inmate outing to the Canadian National Exhibition over six months later. He observed that, though
provision had been made for her to go, Ellen S. refused to visit the CNE because her daughter was not allowed to go with her.(159) This relationship was so strong that Ellen said she would accept her married daughter’s offer in 1907 to come and live with her on Long Island only upon the condition that Margaret’s sister Sandra would be allowed to join them. As a result of this condition, Margaret B. wrote that she was "compelled to relinquish the idea as being altogether unwise."(160) The closeness of this incarcerated mother and daughter was such that Ellen "fully believes" the statements of her daughter that a group of conspirators were out to kill Sandra, though it is evident from the writings of Margaret B. that she did not share these views of her mother and sister.(161)

Some of the surviving letters by Sandra and Ellen provide valuable insights into institutional life and relationships that extend beyond parent and child. A year before the admission of her mother, Sandra wrote Ellen a detailed letter in which she confides her views about dealings with others in the hospital. This letter provides a rare glimpse of the daily social life in the Toronto Hospital for the Insane from an inmate’s perspective. The two of them exchanged letters on a regular basis, as Sandra acknowledged "your very welcome letter" when writing to her mother, and there are other references to mutual correspondence in the period prior to their joint confinement.(162) Sandra wrote about how she sang in the
church choir earlier that Sunday with "Mrs. H___ 'the musical attendant,'" who was an employee of the asylum. (163)

When this woman insisted that Sandra was to come up to her room that same afternoon, Sandra wrote to her mother what she felt about this idea, and what she did about it:

I had such a terrible repugnance come over me that I could not say I would so she said she would call for me anyway so I said if some of the other patients went up perhaps I would. But I had made up my mind that I would tell Dr. Ross to tell her I couldn't go. So I saw Dr. Ross this morning after church and I told him to tell Mrs. H___ I had a letter to write this afternoon and that I must post it in the morning and I could not go up to her room at 3 O'clock. Dr Ross said he would tell her... I can get rid of Mrs. H___ without any trouble... (164)

Though she feared certain people were plotting to harm her, Sandra was equally sure that she had good friends among the other inmates of whom she wrote, "They are so fond of me that they would not let the wind blow on me if they could help it." (165) She went on to note that the nurses were trying to prevent her from speaking with Assistant Superintendent Ross, but she claimed other patients supported her efforts to get through to him:

I...speak to him as much as I like and I was very glad to talk to him about my cold and some of the patients came up and talked to him too + one of the ladies thinks so much of me that she has talked to him too + coaxed him very hard to give me some medicine + look after my cold for I had such a bad cough much to Dr. Ross's amusement + he was also very much pleased to have her take so much interest in me as she would not bother herself to do it for anyone else but me. I have been so successful in frustrating the nurses that they have had to stop all their efforts, much to the delight of the patients as they all think Dr. Ross should take notice of me + take care of me when I am sick. (166)
Sandra claimed she was not vindictive towards those nurses whom she said were against her: "I do not feel mad and I never allow any one to know what I think or feel about anything if I had I would not be alive today..." (167)

Furthermore, to spend energy on getting angry at the nurses, Sandra wrote to her mother, "would take my mind off the more important business of taking care of my life and yours." (168) Continuing on with a recounting of tensions with the nurses and friendship with inmates, Sandra wrote about another incident involving Doctor Ross, of whom she was obviously quite enamoured:

Wed Mar 15th Miss Strachan took her proper place as head nurse + Miss Weir kept after her + they both kept after the Dr. Ross + both kept the poor man so busy that he couldn't get a chance to speak to me... he held up his hand as a hint and so in spite of the nurses he took me by the arm + took me off to the Transit + said "course we will go together to this transit + I will look at your throat." So we went off together to the transit and one of the patients was there + she was awfully pleased to see him look at my throat... So the nurse (sic) were frustrated a second time + did not like it much. The patients have been trotting after the Dr. Ross too ever since + they are getting hold of him by the arm + helping me right loyally so the nurses are getting quite sick of their job + Dr. Ross is encouraging his admirers so that I can say good morning to him all I like + he can take as much notice of me as he pleases... I cannot lose Dr Ross for if I do I will lose all my protection here... XXXXXXXXXX Kisses for my dear Mother + please write soon. (169)

These observations by Sandra illustrate how competing for the attention of a doctor with nurses could lead to friction between inmates and staff. Regardless of whether or not the nurses were conspiring in the manner that Sandra
claimed, her charges that they were doing so would have been enough to increase tensions between this inmate and female staff. Interestingly, rather than worrying about competition from other women inmates for the attention of the Assistant Superintendent, Sandra seems delighted with their help which suggests the close bonds that could develop between similarly situated patients. Since the nurses were the only women who had clearly defined authority over her on the ward, Sandra saw them as competitors unlike other patients with whom she was on equal terms. It is also interesting to observe that her affection for Doctor Ross went so far as to see him as her protector, and in this sense, Sandra viewed institutional life as preferable to the world outside.

Superintendent Daniel Clark wrote that her delusions included the belief that she was "about to be married to Dr. Ross...and that she is safe here," but that she would be harmed by plotters on the outside if released. (170) It is also significant to note that of all the people she alludes to in this letter, Dr. Ross was the only non-patient whom she had positive feelings towards, unlike her views regarding the nurses and Mrs. H., the musical attendant, whom Sandra did not wish to be alone with for unwritten reasons, unless in the presence of other patients. There is no doubt that her hoped-for marriage with Ross did not occur and that her feelings for him were not reciprocated. Doctor Ross wrote to Ellen nine months prior to her own
confinement, that her daughter’s ideas about himself and the nurses were “a lot of foolish delusions.” (171) Yet Sandra’s feelings for this man, even though unrequited, show how an inmate could develop a strong emotional attachment to an authority figure in the asylum as a way of giving her hope that someone powerful was looking out for her interests.

Of course, what comes through so very clearly is how much Sandra trusted and loved her mother, both in the fact that she would confide so much in her, write about “taking care” of Ellen, and the manner in which she signed herself. A letter written in 1912 from Ellen to Chief Inspector Archibald of the Toronto police, provides a hint of how mother and daughter continued to look out for one another, six years after the elder woman’s admission. In this letter she wrote how a certain man, from outside 999 Queen Street, “and his agents” were using the nurses’ housecleaning duties to harass Ellen and her daughter Sandra:

Please kindly tell [Medical Superintendent] Doctor Forster to order Miss Hodgson head nurse in Ward 5 not to have my Bureau drawers meddled with and please tell Doctor Forster to order her not to have my daughter’s Bureau drawers meddled with. I wish to tell you that my daughter has thoroughly washed our Bureau drawers and washed the frames of the Bureaus both outside and inside most thoroughly and everything is tidy in the drawers. (172)

While nothing came of this complaint, which evidently was never mailed, Ellen’s letter illustrates how Sandra took care of her mother by doing such household chores as cleaning the furniture. Ellen would also have seen herself
as protecting her daughter, as well as herself, against the outside forces she believed were invading their privacy. Other letters contain similar concerns from Ellen about outside interferences, including a maternal effort to stop her daughter’s name being used on a "mock marriage agreement" which was to be so bizarre in nature as to convince "old Dr. Forster" that Sandra was insane. (173) This particular letter is an especially clear indication of the intensely close relationship between mother and daughter, as it was signed by both women, though the handwriting is very clearly that of Ellen. This rather sad letter from Ellen and her daughter also suggests the degree to which their mental torments were so pronounced at times. By this period, Sandra had already been declared insane for nearly a decade, and there was no intention by medical authorities to change this diagnosis. Yet, however improbable it was that such concerns were based on real threats by external conspirators, what is important to note about the relationship between Ellen and Sandra was how institutional life did not dampen their affection and caring for one another, with the mother in particular acting as an advocate and protector of her cherished daughter whom she had no intention of leaving on her own.

The confinement of a parent and child at the same time in the same institution was not unique to Ellen S. and Sandra S. As will be discussed in the chapter on leisure, Ellen K. and her single daughter Coreen K. were also
confined at the same time for twelve years in the Queen Street facility. There was also a father and son who were fellow patients in this institution. Gilbert D. had been an inmate in the Toronto Asylum since 1861, when his son Allen, a forty-eight year old farmer and widower, was admitted in 1903. Both men would be confined together for six years until Allen was discharged in 1909 and eventually returned to the family farm. (174) Gilbert remained confined until his death in 1914 at the age of eighty-eight, having spent the last fifty-three years of his life at 999. Unfortunately, there is virtually no information, unlike that of the previously mentioned parent-child inmates, to document how this father and son related to one another during their years together. The one scrap of information that does survive about the two of them together shows that even though Gilbert and Allen had been separated for over forty years by the time the younger man was confined, a caring relationship did exist between these two men. Shortly after his discharge, Doctor C.K. Clarke wrote that Allen, "while here received but few clothes and those he shared with his father, who is a patient here." (175) So for a few years at least, some of the needs of this elderly father were looked after by his younger son. The fact that such family relationships took place in the asylum suggests that the impersonal nature of a large mental institution was not a constant factor in the lives of people like Ellen and Sandra, Gilbert and Allen, when they were able to look out
for each other, or among non-related inmates who "adopted" other inmates as an informal family. At the same time, just as occurred elsewhere outside this facility, blood relationships did not always provide a natural bond to bring people closer together, as Ellen K. and her daughter Coreen were known to not get along and so were kept separated. (176)

Conclusion

The routine and relationships discussed in this chapter show later generations that the inmate population of this institution during the late nineteenth and early twentieth centuries was very active in trying to formulate ways of coping with their lives as mental patients. They were not simply being controlled from within the institution, plodding along according to the official schedule, incapable of responding to larger forces beyond their influence. For some inmates, securing close personal friendships among hospital staff and especially with fellow patients was an important way to build the support networks that people need to survive traumatic experiences, such as confinement and mental illness. At the same time, documents also show that incarceration could lead to more anguish, as abuse at the hands of staff or other patients only served to further distress some inmates who were already distraught enough to begin with. These conflicting perspectives and experiences reflect very much on the unstable patient culture that was constantly in flux as inmates and employees sought to understand and live with one another in the midst of so much
mental suffering. These experiences also lead into the next chapter on patient leisure where the therapeutic aims of administrators were taken further by inmates who created their own innovative ways of living in a mental hospital.
Notes:

1) AR, 1878, p. 269.


3) AR, 1878, p. 269.

4) AR, 1880, p. 292.

5) Ibid.


7) AR, 1877, p. 20; AR, 1883, p. 48.

8) AR, 1887, p. 45.

9) AR, 1892, p. 38.

10) AR, 1903, p. 3.

11) AR, 1881, p. 26; A table printed in 1888 shows that there was very little difference over a ten-year period with food served in 1878 on public wards. AR, 1888 p. 36-40.

12) AR, 1892, p. 41.

13) AR, 1892, p. 41-42.


16) Gene P., Patient File #3034. Clinical Record, April 24, 1912.


19) Patient File #6010. Clinical Record, July 18, 1911.

20) Reginald F., Patient File # 10015. Letter to Dr. C.K. Clark [sic], from A.E.F., East Orange, New Jersey, November 18, 1910.

21) Elaine K., Patient File #3037. Receipt: rec'd for Mrs. J.G. K____: 1 roast chicken from Mrs. M____, Port Arthur, Ontario, December 22, 1921. Much more common receipts for food received by patients with outside support can be found in the slips from the late 1920s and early 1930s, from Laura C., the wife of Adam C., Patient File #5030.


24) Mary A., Patient File #5002. Letter to Dr. Clare from Mrs. Henry A.A., June 6, 1911.

25) Anna N., Patient File #6012. Letter to Dr. Clark (sic) from Anna N, 999 Queen Street West, Toronto, March 1, 1911.


33) Patient File #8042. Clinical Record, April 20, 1933.


35) Patient File #8042. Clinical Record, November 11, 1941.


38) Patient File #8042. Clinical Record, October 10, 1940.


41) Patient File #8003. Clinical Record, July 26, 1920; August 23, 1921; June 29, 1927.

42) Patient File #8003. Clinical Record, September 8, 1923; June 20, 1924.

43) Patient File #8003. August 9, 1927.


52) Reports of theft are usually mentioned in the context of inmate delusions, though third party observers also made
such references, as did William S., the father of Gina B., though he later retracted this after meeting his daughter, Gina, and Dr. Clark. Gina B., Patient File #3002. Letter to Dr. Daniel Clark from William S., October 14, 1883; Letter to William S., from Dr. Daniel Clark, October 16, 1883; Letter to Dr. Daniel Clark from William S., October 26, 1883.

53) Avis S., Patient File #8019. Avis' background information can be found on her admission papers which includes the comment that she is "Strictly temperate": Form of History of a Patient, signed Dr. Gibson, Hillsburg, Ontario, August 26, 1904.

55) Patient File #8019. Clinical Record, July 16, 1909 (quote); May 4, 1910.
57) Patient File #8019. Clinical Record, October 7, 1918.
58) Adam C., Patient File #5030. Four undated pages, not addressed to anyone, circa 1907-08, when most of the letters which remain in his file were written.
60) Warsh, Moments of Unreason, p. 120.
61) References to staff departures include: Daniel Clark reported that there had been 44 changes to staff in 1902 and 39 changes in 1903 (out of 116 employees): AR, 1903, p. 4; C.K. Clarke reported many attendants had left due to poor pay: AR, 1908, p. 9; J.M. Forster reported "staff greatly reduced in numbers in practically every branch of the service." AR, 1916, p. 84.
62) AR, 1900, p. 3.
64) Patient File #7050. Clinical Record, January 25, 1909; February 1, 1909.
67) Patient File #7050. $2.00 Receipt for a nearby resident on Manning Ave. "for recapture of escaped patient," December 29, 1906. "Received with thanks" has been written on slip.

68) Patient File #7050. Clinical Record, date deleted in this note and in notes 69-72 to protect Arlene's confidentiality due to newspaper account, cited below.

69) Patient File #7050. Article pasted into Clinical Record, date deleted.

70) Patient File #7050. Clinical Record, date deleted.

71) Patient File #7050. Clinical Record, date deleted.

72) Patient File #7050. Clinical Record, date deleted.


74) Patient File #7050. Clinical Record, April 19, 1917.


76) Patient File #7050. Clinical Record, October 25, 1911.


81) Nancy D., Patient File #2040. Letter to Inspector R. Christie from Medical Superintendent Daniel Clark, June 15, 1883. The reference in this letter is to Nancy getting "on an immigrant at the sheds and was carried to Guelph." See also telegram from F.W. Randall, Chief of Police, Guelph, to "Doctor at Asylum," June 15, 1883 in which he states: "I have the Insane Woman that Escaped from your Asylum on [sic] yesterday in custody here. Send for her today answer."

82) Wendy Mitchinson also makes these points in regard to gender differences on the issue of escapes from asylums. She also notes that since females were socialized in the acceptance of authority more than males, women were less


84) Ibid.


87) AR, 1900, p. 4.


91) Patient File #4011. Letter to W.M. English, Medical Superintendent, Hamilton Asylum from Assistant Physician, Toronto, unsigned (probably Dr. Clare or Dr. Ross), April 28, 1909. This letter was prompted by an inquiry from Superintendent English who asked about Arnold S. because his nephew was confined at the Hamilton Asylum. This younger man had committed murders and was considered insane. In the file of Arnold S. there is pasted an article from a newspaper (date deleted for reasons of privacy) in which the murders of two people and wounding of several others are detailed. Written below this article in Arnold's file is "Patient...is an uncle of this man."


95) For contemporary studies of abuse of people at institutions in Ontario, see: Temi Firsten, "Violence In the Lives of Women on Psych Wards," Canadian Woman Studies/Les Cahiers de la Femme 11:4 (Summer, 1991), p. 45-48; Liz Stimpson, Colleen Weir, Georgia Maxwell, Margaret C. Best, Unlocking The Doors: Abuse Against Vulnerable People Within Ontario's Institutions (Toronto: Advocacy Resource Centre for the Handicapped; Ontario Ministry of Citizenship, Recreation and Tourism - Office of Disability Issues, 1996), 87 pages. I would like to thank Marianne Ueberschar for bringing this publication to my attention.

The expansion of a medical bureaucracy in Ontario after 1890 and especially the use of typewriters by the early twentieth century had a significant impact on the scope and extent of records kept on individual patients. In 1907, the first typed clinical records appeared at the Toronto Hospital for the Insane, though the typewriter had been in use for several years already by this time, for administrative correspondence. For a general discussion about provincial developments see: Barbara L. Craig, "Hospital Records and Record-Keeping, c. 1850 - c. 1950, Part I: The Development of Records in Hospitals," Archivaria 29 (Winter, 1989-90): pp. 63-64; Barbara L. Craig, "Hospital Records and Record-Keeping, c. 1850 - c. 1950, Part II: The Development of Record-Keeping in Hospitals," Archivaria 30 (Summer, 1990): pp. 22-25

96) For a discussion of the contentious nature of patients' accounts of abuse see: Grob, "Abuse in American Mental Hospitals," p. 298-301.

97) Nancy D., Patient File #2040. Letter to Dr. Clark from Kate Cecilia D., Toronto, May 11, 1883.


99) Jim W., Patient File #7051. Clinical Record, November 11, 1911. Abuse of people with disabilities is an area which some people in Canada continue to rationalize, as is most recently evident in the response to the 1993 murder of twelve year old Tracy Latimer by her father in Saskatchewan. For a discussion of how her murder has been "excused" by some mainline media outlets in Canada, and why this bigotry on the part of able-bodied Canadians puts people with disabilities in danger, see: Dick Sobsey, "The Media and Robert Latimer," ARCH TYPE 13:3 (August, 1995), p. 8-22 (newsletter of the Advocacy Resource Centre for the Handicapped, Toronto).

100) Ibid. Jim was discharged four years later in to the care of his sister.
101) Ralph M., Patient File #6010. Letter to "My Dear Wife," no year, with the date December 4 written on letter.

102) Elsa P., Patient File #7047. Letter To The Superintendent of the Toronto Asylum from Elsa P., Centre Island, September 7 (no year, though letter was found at back of her file with other documents from her last years in the asylum).

103) Inspector of Asylums Records, AO, RG 10, Sub-series C-3, Volume 767a, Investigation, Toronto Hospital for the Insane, 1917.

104) Sobsey describes how administrative structures work against complainants in institutions. This includes lack of enforcement of anti-abuse policies, and the way in which resentful ward employees, lacking power with their superiors, take out their frustration on residents in the facility who are the most vulnerable of anyone in an institutional setting. Dick Sobsey, Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance? (Baltimore: Paul H. Brookes Publishing Company, 1994), p. 90-91, 104-05.


110) Elaine O., Patient File #8016. Background information on Elaine can be found on Schedule No. 2, June 4, 1904, signed A.W. Roffe, Toronto. She was confined at the Toronto Asylum until 1910, when she was discharged in June of that year after six months probation. There is a discrepancy about how long she was in prior to 1905, with one document claiming this to have been ten years since 1894, while other forms make this less clear.

111) Patient File #8016. Letter to Mr. (---men?, illegible) from Miss O., Toronto, June 29, 1910.

112) Patient File #8016. Letter to Mr. Herriman (sic, Herriman) from Elaine O., undated, though found among early 1910 letters.

113) Patient File #8016. Letter to Dr. Clark (sic) from E. O., Toronto, September 14, 1910.


118) Daniel Clark stated that an employee "should never behave with harshness towards a patient" though he also cautioned that an employee was to be considered innocent of mis-conduct unless there was "absolute proof of wrong-doing." AR, 1880, p. 289, 286. In 1907 C.K. Clarke responded to Angela H., the wife of Jacob H., a patient who complained of abuse as follows:

I should like to know the source of your information because statements of this kind are heartlessly cruel and do a great injustice to the very much tried and conscientious Staff. It is my business to see that no cruelties are perpetrated here, and while it is true that there have been occasional mistakes made by attendants, such persons have been discharged instantly and will be discharged instantly as long as any reason for complaint is found.(23)

A month after this letter was written, the patient whom it concerned, Jacob H., made a successful escape and went home. Jacob H., Patient File #10011. Letter to Mrs. J.H. from Medical Superintendent, 27 February, 1907.

119) Moran, "Keepers of the Insane," p. 68. Moran mentions a case of an employee who was fired after a physician witnessed unacceptable behaviour. How the guilt of two other employees was arrived at, and who were discharged, is not explained. In still another incident, when a patient said abusive behaviour was witnessed by another employee, this workmate of the accused dismissed the charges as not serious, something which Clark only partially accepted as he cautioned the alleged offender believing "'there was something'" to this complaint. Ibid., p. 69.

120) McCandless, Moonlight, Magnolias, & Madness, p. 291.

121) In 1919 Superintendent Forster wrote about the "scarcity of nurses. Our expectation during the past year of having many applicants after the close of the war has not been realized." AR, 1919, p. 91. See also citations above in fn. #61 re staff departures at Toronto.


123) Dwyer notes that doctors at Utica Asylum did not believe abuse allegations as readily as did their colleagues at Willard: Dwyer, Homes for the Mad, p. 177-78; Lunbeck, The Psychiatric Persuasion, p. 171-72.

124) This rule stipulated that male workers were not to attempt "to notice, 'flirt' with, or talk to girl patients," or else they would be immediately fired. Steven Noll, Feeble-Minded in Our Midst: Institutions for the Mentally Retarded in the South, 1900-1940 (Chapel Hill: The University of North Carolina Press, 1995), p. 142.


126) The 16:1 patients to attendant ratio is cited twice by Superintendent Clark: AR, 1885, p. 42; AR, 1892, p. 6. Prior to this he had once cited a slightly higher ratio of 18:1 in AR, 1883, p. 62. At the London, Ontario Asylum, the ratio during this period was thirteen patients for every attendant. Shortt, Victorian Lunacy, p. 43. The average around 1900 in mental institutions in the United States was twelve patients for every attendant though in the Southern states it was fifteen to one, and on wards with black patients it was thirty-six inmates for every attendant, with one ward having 111 black patients and only two staff, indicating the wild fluidity of such figures. McCandless, Moonlight, Magnolias, & Madness, p. 288.

127) Arlene S., Patient File #7050. Letter to Inspector W.W. Dunlop from Medical Superintendent Forster, 29 April, 1918. This letter notes there were two nurses on a ward of 82 female inmates, when Arlene S. committed suicide. As has been cited above (fn. #121), this was at a time of severe staff shortages.

128) However difficult it was to corroborate staff-initiated abuse, there was much less difficulty in reporting on patient-initiated abuse. Hospital officials reported in-depth the case of an extremely abusive male patient who was observed sexually assaulting patients and killing animals, over many years. C.K. Clarke and J. Webster, "Notes of a Clinical Case: The Case of Wm. B. — Moral Imbecility," Bulletin of the Ontario Hospitals for the Insane 7:4 (July, 1914), pp. 207-231. Admitted to Kingston Asylum in 1870 William B. was sent to the Penitentiary Criminal Asylum in 1877, then was released briefly in 1878. He was reincarcerated after attacking a thirteen year old girl. He remained confined in Kingston Asylum until 1886 when William B. was transferred to the insane asylum in Hamilton where he remained in 1914 at the age of 76 in poor health.

130) *Propositions and Resolutions of the Association of Medical Superintendents of American Institutions for the Insane*, Compiled by Dr. Kirkbride of Pennsylvania, Dr. Callender of Tennessee and Dr. Nichols of D.C. (Philadelphia: Collins Printer, 1876), p. 31. Resolutions were passed at the AMSAI meeting held at Auburn, May, 1875.

131) *AR, 1880*, p. 287.


133) Adam C., Patient File #5030. He was confined from 1897-1935. In an undated letter addressed to Mr. William McGuire, which he also asks Dr. Clarke to read, Adam writes: "Do you send my letters, my correspondence, through the Toronto Post-office? If you post my letters in the post-office letter boxes, the post office letters-carriers would surely deliver them at the proper addresses. I wrote two letters to Mr. E.S. Caswell, Richmond St. West, prior to Christmas-time, and, when visiting me here, Mr. Caswell told me he did not get any of my letters. My letters would have prepared his mind to instant friendship."

In a letter to another correspondent noting he had received no answer to three letters to this person, Adam wrote: "...I was very Expectant of your responses to my requests; but there has been prolonged silence, not having received an answer. I concluded that you had not received my letters, and probably my conclusions are correct."

Patient File #5030. Letter to Mr. Arthur Macoomb, from A.B. C., April 6, 1908.

134) Elsa W., Patient File #6015. Letter to the Hon. W.J. Hanna, Provincial Secretary, Queens Park, Toronto, Mrs. E.F.W., Provincial Institution, Toronto, November 19, 1909.


136) Wendell C., Patient File #8689. Letter to Dr. Clark from E.A.C., Port Huron, Michigan, January 5, 1904.

137) Anne D., Patient File #10009. Letter "To the Superintendent," from May L.K., Washington, D.C., undated though found among letters from 1912-13. Since the subject matter of censored letters is referred to in Forster's
letter, cited below, to Paul K., it is very likely that this particular letter by her is from the Spring of 1913.


140) Tomes, A Generous Confidence, p. 223-226.

141) Rhonda D., Patient File #8033. Clinical Records, June 1, 1911.

142) Jack P., Patient File #11001. This letter to "Dear Bell," has been typed up in his Clinical Record, undated, during Jack's four month confinement in 1907.


144) Ibid.


147) Mildred O., Patient File #8004. Quote is from an unsigned statement certifying Mildred's mental state, October 14, 1908.

148) Patient File #8004. Letter to Dr. H.S. Griffin, Hamilton, Ontario from Medical Superintendent Clarke, November 26, 1907.

149) Patient File #8004. Letter to "Dear Dr. Griffin," from Mildred O., November 11, (no year but based on Dr. Griffin's letter to Dr. Clarke, cited below in note #150, in which he encloses Mildred's letter, her writing is definitely from 1907).

150) Patient File #8004. Letter to Dr. Clarke from Dr. H.S. Griffin, Hamilton, Ontario, November 25, 1907. He states "...her husband and friends do not seem to want her... I suppose if her husband cared to be bothered with her, she might be looked after outside..."


154) Sandra S., Patient File #8012. Ellen S., Patient File #9018. Regarding Ellen's desire to be transferred back to the Toronto facility from Cobourg, see Patient File #8012, Letter to Dr. Forster, from D.R., Denver, Colorado, January 20, 1915. See also Patient File #9018, Telex to Dr. Forster from D.R., Montclair, New Jersey, January 27, 1917; C.P.R. Telex to D.R., New Jersey, from J.M. Forster, January 29, 1917.


158) Ibid.

159) Patient File #8012. Letter to Mrs. Stephen B., Long Island, N.Y., from Assistant Superintendent Ross, September 14, 1906. This letter was prompted by an inquiry from Ellen's daughter who wanted to send money for her mother to go to the CNE: Letter to Dr. W.K. Ross from Margaret B., Woodhaven L.I., September 5, 1906.

160) Patient File #9018. Letter to Dr. Clark (sic) from Margaret B., Woodhaven, L.I., N.Y., November 19, 1907.


162) There are a number of letters from 1904-1905, in Sandra's file, to Dr. Clark from Ellen S. about her daughter prior to her own confinement. These letters were written from New York, where she was living. Margaret wrote to Dr. Clark, as early as February, 1905 informing him of Ellen's departure and plan to liberate Sandra. Quote is from: Patient File #8012. Letter to "My Dear Mother," signed B____ (short-hand for Sandra's second name), Toronto, March 19, 1905.


164) Ibid.
165) Ibid.
166) Ibid.
167) Ibid.
168) Ibid.
169) Ibid.


172) Patient File #8012. Letter to Chief Inspector Archibald, Police Department, City Hall, from Mrs. E.A.S., 999 Queen Street West, Toronto, March 22, 1912.

173) Patient File #9018. Letter to Assist. Dept. Chief Archibald, Police Department, City Hall, from Mrs. E.A.S., co-signed, (Miss) S.B.S., September 16, 1913. This letter, which was written by Ellen S., reverts back and forth between "We" and "I."


Chapter 4. Patients' Leisure and Personal Space

Introduction: Leisure as Therapy and Entertainment

What did asylum inmates do with their time when not working, if they were so occupied at all? It is curious that in the literature on patient lives, so little has been written about leisure and personal space, and where it has been mentioned it is usually only in passing and in the context of moral therapy. (1) Discussions on this topic have therefore concentrated on entertainments organized by the administration, without any serious attention having been devoted to what patients did to amuse themselves. The purpose of this chapter is to offer a wider and more comprehensive picture of leisure by including both recreational activities sponsored by medical officials as well as looking at entertainments initiated by inmates for themselves.

Ellen Dwyer, in Homes for the Mad, offers the most organized analysis of various forms of entertainment for both patients and staff. (2) Her research on Willard Asylum in New York State uncovered images which reveal more about the pathetic hopelessness in which many patients existed where enjoying amusements was exceptional for people locked away for years on end. (3) Peter McCandless has been among the few historians to highlight how patients engaged in creating their own amusements, such as by creating checker sets and initiating a short-lived baseball team for white male patients at the South Carolina
State Hospital. (4) This chapter discusses this topic not as a peripheral part of the overall picture, but as a central aspect of the daily existence of asylum inmates. For the ability of patients to enjoy diversions from the daily monotony of ward routine could be crucial to their emotional survival in a large institution where years of confinement produced emotional flattening and lethargy among bored inmates.

The way in which asylum inmates entertained themselves, or were entertained by others, helps to reveal a good deal about social interaction among patients, staff, and in some cases with outsiders, notably relatives or friends. Understanding the casual side of their daily lives by studying what patients did with their free time can also illustrate some of the inner workings of the asylum, its social structure and a wider variety of leisure-time activities. As will be revealed, patients who had greater access to financial resources and external support were more likely to be able to pursue a wider variety of leisurely activities, though lack of opportunities certainly did not stop less fortunate inmates from enjoying various forms of relaxation. In approaching this topic, the discussion will proceed from the general to the specific. The former will provide an overall view of what types of leisure there were at the Toronto Hospital for the Insane and who enjoyed them, while the latter will give detailed accounts of how some patients went about creating this world which was both
private and public, depending on the needs, circumstances and personalities of particular inmates.

The concept of leisure is given the widest scope here, ranging from large-scale organized events to private ways of coping with institutionalization. As such, the efforts of people to create a "personal space" for themselves is an important part of this theme of understanding patient culture, since carving out "safe" areas could be crucial to instilling a sense of ease and relaxation in a place where privacy was difficult to maintain. Thus, "creating a culture" of leisure takes on an added dimension that goes beyond pleasant diversions, but which also show how some people tried to come to terms with their environment by making it more bearable and easier to cope with as the years went by.

The overall medical perspective on this topic is essential to contextualize how administrators viewed the recreational activities of inmates. In the late 1890s Daniel Clark offered a clear, if cautious, link between leisure and the treatment of mental disorders:

It is difficult to estimate the benefit accruing to patients from moral treatment such as entertainments of all kinds. The lifting of the mind for even a couple of hours at a time from out of a pit of despondency and often despair may be the means of tilting the mental balance towards health or recovery... [Entertainments] are factors to produce health in many minds, but the extent of their efficiency is an unknown quantity.(5)

[A]musements are often of more value to tilt the mind into healthful channels than even our most valued medicines are.(6)
In order to provide as much of this "medicine" as possible, staff-organized activities were promoted among the patient population. Beginning in the late 1870s, volunteers from community and church groups were invited to come to the asylum, primarily between November and April to give concerts, readings and "dramatic performances" on Monday evenings. This was done so as to relieve the monotony on the wards during months when cold weather restricted outdoor recreation. A patients' dance was also held on Friday evenings, usually from 7:30 to 9:30 P.M. for inmates who were allowed off the ward. (7) Staff members and patients were also involved in these formal activities, such as by giving a "magic lantern exhibition," and by presenting their own concerts and readings. (8) Clark wrote that not only were a number of patients good musicians (piano players, cornet players, violinists) but also talented actors, reciters, readers and caricaturists. (9) According to Clark, patients looked upon these occasions as "the event of the week" with between twenty to thirty concerts being listed each year in Annual Reports up to 1905. (10)

Concerts and dances were continued well into the 1930s and 1940s and were supervised by the Occupational Therapy (OT) Department, continuing the therapeutic approach begun more than a half a century earlier. (11) However, these activities were reported far less frequently in Annual Reports. It was noted in 1936 that during the preceding
year, there had been six concerts with an average attendance of 185 patients, nearly evenly divided between both genders, and twenty dances with an average attendance of 150 patients, slightly more women than men.(12) The decline in the number of concerts, in contrast to earlier decades is notable. Perhaps as a substitute for fewer concerts, a new form of entertainment had begun by the 1920s, with the showing of "moving picture shows."(13) However, Superintendent Herriman noted in 1932 that movies were shown from an ancient "pathescope lantern" and most films were of little interest to patients.(14) This may account for the fact that only two showings are recorded several years later, though the attendance of 200 was not insignificant out of a population of 1100.(15)

During the late 19th and early 20th centuries winter leisure activities included sleigh rides and inside bowling for men, as well as year round ward leisure: billiards, bagatelle, cards, checkers, chess, book and newspaper reading.(16) During the summer throughout the entire period studied here, there were occasional picnics with music and dancing on the grass.(17) In 1895 over 400 patients attended, more than half of the average asylum patient population of nearly 700.(18) By the 1930s this activity, like other administratively sponsored leisure, was planned by OT staff.(19) Gender differences in outdoor warm-weather activities were noted with croquet being played by women and cricket by men in the late 1800s.(20) Cricket was
eventually replaced by baseball, an exclusively male
preserve which was first mentioned in 1900 and again in
1934. (21) It becomes increasingly clear from Annual Reports
that male patients had many more outlets for official
leisure activities during most of the period studied here.
Bowling, baseball and cricket were for men patients at 999
in the early 1900s, and in 1937 only males were recorded as
having been involved on the softball team. (22) When
physical training classes were instituted for otherwise
unoccupied patients in 1933, this activity was also
restricted to men. (23) While the number of patients who
took part was small, an average of 15, they were given the
opportunity at regular intervals, 70 times in one year. (24)
The one activity where women clearly outnumbered men was
also the one entertainment that took up the least time for
staff, being a sedentary pursuit that could take place on
the ward: card parties. Statistics indicate females
participated in this category of "other forms" of leisure
more than three times as much as men did in 1936. (25)

These officially-organized entertainments were clearly
not artificial examples of patronizing a few patients, or
presenting a pleasing image to outsiders, as there are a
number of references to how much some inmates enjoyed
themselves. One inmate, Jane F., referred approvingly to
"a grand picnic" held in June, 1911. (26) There are also
numerous references in the clinical records of other
patients about their attending and enjoying entertainments
held indoors during the cold months.(27) For many people whose social life was severely limited, large-scale social functions were something to look forward to with great anticipation. Confined for thirty-six years until his death at the age of 58 in 1914, Geoffrey T. was noted during his last years to be very fond of attending officially organized entertainments so much so that "if going to a dance or concert [he] will wash several times during the day."(28)

A leisure activity that was considered among the most uplifting by officials was religious services conducted for the patient population. During the early decades of the asylum's existence two Protestant services were held on Sundays. However, this was changed with a schedule that remained in place from 1880 to 1906. Church services were held three times on Sunday, Anglican service at 9:30 A.M., other Protestant denominations took alternate turns beginning between 2:30 and 3:00 P.M., and a Catholic service was held beginning between 4:00 and 4:30 P.M.(29) Prior to 1880, Catholic religious visited when they were requested by individual patients, a practice which continued.(30) Clark noted that ministers' sermons were well received by patients, as they tended to be cheerful, while they also avoided talking down to inmates with "'baby talk' as some of our patient hearers call it"(Clark's emphasis).(31) Though Daniel Clark claimed that 300-400 patients usually attended Sunday services, C.K. Clarke changed this routine, claiming it was an inefficient way to spend staff's time, while
attendance was low and half-hearted. From 1906, "there will be but one Protestant service each Sunday," with the Anglican church being asked to end their 9:30 A.M. service after fifty years, which Clarke's wording suggests caused some consternation. Though this form of leisure is less frequently commented upon in later reports, both Catholic and Protestant services were held well into the 1940s at provincial institutions. Whether the spiritual needs of non-Christians were respected at 999, such as among Jewish patients, is not indicated in the records.

Leisure, Personal Space and Support Networks

Whether or not a patient had external support helped to determine the extent of leisure one could enjoy. Access to outside financial aid was crucial to purchasing amenities, such as fruit and chocolates, as well as providing some patients the chance to go on outings and receive items like reading and sewing material. As will be seen, access to monetary assistance could also help secure private quarters which could become a haven from an often noisy and stressful ward environment.

An annual effort to provide a source of enjoyment for asylum inmates of all classes, including those with no money, occurred during the Christmas season, albeit in a rather haphazard fashion. Beginning in 1893 and continuing into the 1920s Superintendents requested relatives or friends of paying patients to send a gift to
place under the Christmas tree which was set up in every ward. These circulars also mention how important it was to send something extra for those lonely patients who had no one to support them whatsoever. In 1895, over 700 Christmas gifts were sent for both classes of inmates.(35) In one case a Christmas circular was sent to the Department of Indian Affairs in regards to Charles M., a Native Canadian who received financial support under the Indian Act since he was confined in 1893.(36) Noting that this was the first such request that the Department had ever received for any patient, even though Charles had by this time been confined for twenty-seven years, the official asked for a list of all Native people in the asylum after the receipt of which they "will then give consideration to the request."(37) Unfortunately, the response to this letter does not exist, nor is there any evidence of a gift being sent for Charles. But this communication does reveal that these Christmas gift requests were by no means applied on a systematic basis to every patient who had access to external financial support. Thus, it is not difficult to surmise that many patients who marked Christmas as a special holiday in their lives, went without gifts either because of the irregularity of circulars soliciting donations, or more simply due to their complete isolation from any outside support networks.

Regardless of their level of outside support many patients spent a good deal of leisure time going for walks
around the asylum, particularly in the warmer weather. The hospital grounds included gravel and plank walks, a garden, trees, one large and two small fountains. This most common type of leisure took two distinct forms when it came to access outside of the ward. One form was a walking party organized by asylum staff in order to accompany groups of patients who were not allowed off the ward on their own. This included about 75% to 80% of the inmate population during the late nineteenth and early twentieth centuries, for whom going out was considered an essential way to get exercise, as with patients like 48 year old Cyril M. who walked "up and down the lawn talking and laughing." How many patients on locked wards were able to get out for exercise with walking parties is very difficult to determine. However, Inspector O'Reilly provided a glimpse during a visit in July, 1883. Forty-two out of 64 inmates on the male refractory ward were outside with a walking party, though he also noted during this same visit that all of the occupants on the female refractory ward were inside. Several years earlier, he noted that while many male patients could be seen walking about the grounds there were only a few female inmates doing so. Over half a century later, this gender bias continued, though less severely. Statistics clearly show more males on locked wards were taken out on walking parties, the most frequently reported leisure activity, 150 times in one year with an average of 120 males to 75 females, even though men and
women were nearly equal in terms of the overall patient population. (42) Inmates included in these groups were considered threats either to themselves or others and so were not trusted to wander about freely, while some patients also had a reputation for escaping when they were unsupervised, though this type of scrutiny did not always prevent people from bolting and getting away from their overseers. (43)

What two patients thought of these supervised walks suggests that these were not the sort of pleasant strolls most people associate with such activities. Connie D. spent her last nine years in the asylum, beginning in 1905. In August, 1910, this 41 year old woman wrote to her parents, "after walking round the flower bed so many [times] I was afraid of getting dizzy for you must know we are not allowed to go off of that square, it gets very tiresome." (44) Another long-term patient, 57 year old Timothy F., wrote that same year to Dr. Clarke that "when Mr. W. McCreary [Chief Attendant, Ward 4] was putting me out with the 'Walking Party,' to sit in the cold, being lame, when the others were walking in line around the fields, you arranged for me stay within doors." (45) Both of these letter-writers give an indication of the discipline on a walking party which was organized and confined to specific physical spaces on the grounds.

The second form of access to the space beyond the ward was for non-resistant patients whom the staff trusted. (46)
This group had complete parole of the grounds to wander about as they pleased during the day-time. In 1882 among 701 patients, 200 were allowed parole of the grounds on the "open door" system which was reserved for patients in the three cottages and four basement wards (which housed working patients), in contrast to the locked wards on upper floors. (47) By 1895 this figure had declined to 154 paroled patients out of a population of 695 and by 1900 had fallen further to 140 patients out of 710. (48) As the above figures indicate, this privileged group comprised between twenty per cent to twenty-five per cent of the inmates housed at a given period, and was closely tied to being trusted as an inmate labourer as will be discussed in Chapter 5. One patient, Jim P., who was an inmate for over forty-two years until his death in 1941, was trusted so much that there is a picture pasted into his clinical record from 1927 showing him walking three dogs on the grounds, though it does not state who was their owner, or if this form of exercise for man and animals was a regular occurrence. (49)

Some patients took their strolls very seriously and did not look too kindly on being interfered with while out. May F. spent the last fifty-four years of her life at 999 Queen Street West, dying on Christmas Day, 1952 at the age of 81. (50) She worked as a housemaid for the Medical Superintendent and Nurses during the 1920s, and was therefore able to enjoy complete freedom to wander at will. As May lived in one of the cottages, access to
the grounds was easier for her than for patients in the more restrictive main buildings. Not content to stay indoors at night, as was the rule, she was observed to have "rambled about" the grounds as early as four in the morning. (51) On one occasion May "engaged in wordy combat" with the Night-Watchman whom she proceeded to strike in the face, presumably when he admonished her for walking outside at such an early hour. (52) Though the guard was not hurt, May temporarily lost her privileges and was confined to a ward for a month after which she was returned to the cottage to resume her position as before. (53) Enjoying leisure also had clearly defined boundaries that applied to even the most favoured inmates.

The majority of patients who were not so favoured, were expected to make do with spaces created for their daily leisure on the ward. Enclosed verandahs were attached to each ward, quadrangular in shape, measuring 30 feet by 20 feet. (54) After windows and screens replaced the iron bars in 1890, verandahs were used year-round, and eventually were re-fitted by the 1920s as sun-rooms for twelve patients confined to their beds. (55) These airing courts were particularly important for "invalid" patients, though Inspector Langmuir cautioned that such places were no replacement for outdoor exercise. (56) However, Daniel Clark noted that "maniacal" patients were, as a rule, kept inside and so were the ones who benefited the most from using verandahs. Re-constructing these airing courts to
allow for more privacy and year-round comfort also had the added benefit of giving exuberant patients a place to release their "pent-up emotions," where they would no longer attract public curiosity "by their fervid eloquence and melodious oratorios." (57) Thus patients who enjoyed singing and making speeches could do so without hindrance, at least as far as public interference was concerned. Patients who were confined to the ward were reported in clinical records to frequent the verandah on a regular basis such as 73 year old Arturo C. in 1911. (58) This change of venue from their regular living quarters would have provided some relief for patients with more outdoor lighting and a panoramic view of different parts of the grounds than was possible to obtain in the more constricted space on the rest of the ward.

Patient files from the late nineteenth and early twentieth centuries also provide numerous examples of one particular type of entertainment which was administratively encouraged on an annual basis. Passes were given by the Directors of the Canadian National Exhibition for patients to attend free of charge with the participation rate climbing from over 100 inmates in 1879 to over 200 by 1897. (59) It was noted that patients never eloped during these day trips and that they enjoyed criticizing how judges classified and awarded paintings and agricultural, floral and industrial displays at the fair. (60) However, this free admission policy was eliminated by the early 1900s so hospital officials solicited financial support from
families to send relatives to the Canadian National Exhibition. Thus, these eagerly anticipated outings were more frequently available to those who were fortunate enough to have access to financial aid beyond the asylum. Inmates who lived in the most comfortable wards not only had a greater amount of personal space than those who resided as public charges on more overcrowded wards, but were also offered greater variety when it came to entertainment by the very fact that such privileges could be purchased by some and not others. Whether this created any resentment among different classes of inmates is not revealed by the sources, but it does help to show how the internal class structure of the asylum permeated all aspects of patient’s lives, including access to leisure activities.

Being confined all the time would obviously have been quite boring and conducive to instilling lethargy in people who had no where to go. So it is not surprising that laziness developed as a form of everyday leisure for some patients, such as Sophia S. who “[l]ounges all day on the couch and when asked to move becomes violent.” Shortly thereafter she took to her bed for months where “she seems to like it...” A year later Sophia died of tuberculosis at the age 50 after twenty-six years of confinement, during the latter part of which she expressed no interest in anything, other than resting. Such an example of someone whose life was extremely constricted by being locked on a ward illustrates the obvious limits of
leisure in an insane asylum. Some patients had so little chance to pursue any form of external entertainment that their condition deteriorated into one of virtual hopelessness, as occurred with a seriously physically ill patient like Sophia. Mavis M., confined at the age of 19 in 1878, died thirty-eight years later, in a similarly lethargic condition, being variously described as "filthy," "impossible to understand" and sitting on the floor with her skirt over her head.(65) However, she too was able to find some solace for her hours of leisure on the ward where Mavis was reported to be fond of music and enjoyed drinking large amounts of tea.(66) That such amenities were available raises the point that some forms of relaxation were provided to these most isolated patients by staff or outsiders, within the especially depressed world of a locked ward. Indeed in 1896, a musical attendant was employed to help with religious services as well as to visit the wards to encourage patients to engage in musical activities as a form of therapy, something at which several women on private wards were reported to be especially talented.(67)

While lack of resources did prevent some inmates from having much choice when it came to diversions, there emerges from underneath this poverty an ability to use whatever was available to create personal comforts. The leisure-time pursuits of two women asylum inmates illustrate how gender differences in social and economic roles could be used to their advantage. Mabel I. died at the age of 72 in 1918
after forty-eight years of institutionalization. A worker in the laundry, she was recorded as carrying around a bag full of clothes "altered by herself, her own style and design... most elaborate, fit for a museum." Ellen G., who died in 1918 at the age of 80 after forty years in the asylum, was also reported as having been what is now referred to as a 'bag lady' during the last few years of her life. It was noted that she was seen going about the grounds in a straw hat and apron, at times carrying a tin wash-basin in which she would put rags and other things that she had picked up, and would later re-make into her own clothes. It was during one of these outings that Ellen fell and injured herself which brought about her death two days later.

The resourcefulness of both of these women in creating their own clothing was directly tied in with their having parole of the grounds, and being able to find "raw material" for their sewing projects. Thus a combination of leisure, labour and gender biased roles in which females were taught to sew, illustrates how these two women were able to sustain a small degree of a self-reliance, if only in the clothing they created and wore. Since appearances are a significant part of self-esteem, it is important to consider these fashion-conscious efforts as part of the wider picture of creating a personal space within the context of leisure. Considering the amount of work which would have been required to make these personal items, it is also important
to note the linkages between labour and leisure, as such
time-consuming efforts would most likely have been a source
of enjoyment for their creators who otherwise had so few
pleasurable pursuits to occupy their time.

Reading was another source of recreation with over
1,400 volumes in the patients’ library by the end of the
century.(73) Located in the general administrative office,
the chief attendant of each ward was responsible for keeping
track of loaned books among their charges.(74) Clark
reported that light literature was most widely read though
history, travel, and biography were also frequently checked
out among the 3,800 times that books were borrowed in
1879.(75) Though this number had climbed slightly to 4,000
borrowed times by 1897, it also oscillated up and down for
as Clark remarked, the number of library patrons among the
overall patient population was not large.(76) It should be
noted that patients were not free to read any available book
which may have discouraged library use. Staff prevented
patients from reading "as far as possible, erotic literature
from the prurient; religious books from those afflicted with
religious melancholy; murders and suicides from those of
homicidal impulses, lest these accounts be suggestive."(77)

Clark made it clear that this particular free-time
activity was not just for "killing time" but was encouraged
so that "select reading" could aid patients in their
recovery by giving readers a chance to escape from their
troubles, a goal he wrote "cannot be overestimated."(78)
Men were said to read more than women; women patients were occupied with domestic chores and so had less free time.\(^7\) There are no references to this gender division for later periods, so no clear picture of male and female reading patterns emerges beyond the late 19th century.

However, the therapeutic influence of reading was stressed well into the 1930s and 1940s as hundreds of new books were purchased, circulating "branch" libraries were established on each ward, presumably for patients who could not get out, and in 1938 a reading room was opened in the library itself for patients who, prior to this, had to take books back to the ward to peruse.\(^8\) This was done at a time when "bibliotherapy" was advocated as a form of treatment within the provincial hospitals to try to interest inmates in reading and thus remove themselves from mental distress.\(^9\)

Weekly newspapers from throughout southwestern Ontario were sent free to the asylum throughout the late 19th century, some having been donated since the early 1850's.\(^8\) Beginning in 1879, the Toronto Evening Telegram sent copies of their daily publication to the asylum and later the Toronto Globe sent twice weekly exchanges. All of these papers were distributed to the wards.\(^8\) According to Clark, newspapers were avidly read since patients, "like sane people, hunger for news."\(^4\) Inmates were often observed reading to one another and checked wall maps on their ward to locate a newsworthy place.\(^5\) By the 1930s newspapers and periodicals were donated by public libraries,
after they had finished with them, either at the end of a week or end of a month. (86) It was also possible for people to get books and newspapers from family and friends. (87) But this most common of leisurely pursuits could be ended by a patient's lack of resources. It was reported in 1916 that sixty-five year old Elaine M. was "a great reader, but since breaking her spectacles cannot read" so she carried with her a "bundle" of papers which she was no longer able to see clearly. (88) Elaine died twelve years later without any reference to her being able to read again.

Reading material was not the only source for an imaginative, "folklorish" escape from everyday hospital routine. Story-telling was another source of leisure for some patients as with 74 year old Wallace M. who enjoyed spinning tales ranging from "catching whales with hook & line to travelling in far off countries gathering gold chains from trees." (89) Whether he had much of an audience is not stated, but that he engaged in recounting such fanciful tales as a source of fun illustrates how oral traditions of myth-making could be used as a way to pass the time and cope with boredom.

Patients also wrote letters, poems and drew art work. Walter T., considered a reclusive man by physicians, left seven small drawings, some which show a manor house, others which are densely crowded with human and animal figures. Two sketches refer to a "Cockatoo" in the drawing as "The sport of kings..." (90) There is even a photograph of an
old cider mill torn out of a contemporary magazine, on which Walter, in 1910, has drawn faces peering out of the water and roof of the mill. As is noted in the chapter on daily routine and daily relationships, writing letters was not always intended by writers as a relaxing activity and could be curtailed by administrators. Another form of leisure activity was also curtailed, in this case for both inmates and staff. In 1887, smoking and chewing tobacco was banned from the asylum for hygienic and safety reasons, lessening the possibility of an accidental fire and eliminating much expectorating. (91) How long this ban was in effect is not clear, though by the late 1920s male patients were observed to be smoking without censure in the hospital. (92)

Visits by outsiders could be an occasion for great anticipation for patients eager for familiar contact from beyond the asylum walls, though these sojourns could also be a source of distress, igniting painful feelings of resentment and hurt. Because of such upset, Medical Superintendents would sometimes discourage visits. (93) Thus, the seemingly benign process of an outsider spending leisurely time with a patient encountered various responses, from mutual enjoyment, to intense hostility, to family interference for their own benefit rather than that of the patient.

Those patients who did not have the good fortune of helpful outside support could nevertheless find ways of enjoying themselves with a sort of self-directed "internal
outing" while still on the grounds of the hospital.

Cindy R., confined at the age of 40 in 1897, spent the last thirty-three years of her life at the asylum, during which time no visitors were recorded. On a summer day in 1918, she was reported to have appeared at one of the front gates all "dressed up" with her friend and fellow inmate Rochelle W. When asked what they were doing Cindy said "they were just going to have a look around" after which they returned quietly to their living quarters at one of the cottages.(94) It is easy to imagine these two women, one of whom it is certain had no outside support, deciding to treat themselves to a leisurely stroll around the grounds, dressed in their best clothes, as if going for a walk in a park. That they went to one of the gates on the edge of the grounds is especially intriguing, and it is worth speculating that the prospect of peering into the forbidden world beyond 999 Queen Street West was considered by these two patients as an added attraction to their outing. Such seemingly mundane pursuits would have made life more enjoyable for anyone while institutionalized, let alone for an isolated inmate for whom walking with a friend in their best clothing was something to look forward to while living such a constricted, lonely life.

Having sketched this general outline of the various types of amusements that were available to a cross-section of inmates, more in-depth examples follow to show just how rich patient culture was when it came to creating a world of
leisure and personal space. These case studies also reveal a great deal about relationships and the inner-workings of the asylum.

**Building a Patient’s Life of Recreation from Scratch**

One of the most innovative and creative inmates that is revealed in the files of the Toronto Hospital for the Insane was Winston O., who was incarcerated as a public charge for almost fifty-eight years by the time he died in December, 1934 at the age of 89. The close relationship between labour and entertainment is made obvious in this man’s energetic outpouring of physical activities during the last two decades of his life, the period for which there is the most evidence in his clinical file. The skills Winston learned as a cooper prior to his confinement were put to good use in his extraordinary carpentry endeavours. Well into his seventies and eighties, this patient was reported to be busy creating homemade inventions for his enjoyment and that of others around the institution.

Over the years the recreational pursuit he was reported to enjoy most often was his ability to make and play the violin, which in one case he had fashioned out of a box. Whether sitting in an alcove in the basement, or on the ward which he makes “brighter with his music,” Winston’s talents were appreciated by his fellow inmates for whom he performed “nearly every day.” One can only imagine the refreshing spirit such sounds brought to the lives of those patients who heard these performances, on otherwise dour and
depressing wards where entertainment like this was seldom seen or heard.

Violins were not the only items of leisure that Winston created. Because of his non-resistant nature, he was allowed complete freedom to walk around the grounds all year, a privilege which he took full advantage of when engaging in his many recreational pursuits. (98) Winston was reported to have built an automobile in 1912 at the age of 67, "as a joke." (99) It worked so well that he drove his car around the asylum grounds and had a picture taken of it which was sent to his sister, who wrote regularly enquiring about his welfare. (100) He was still building automobiles in 1916. Dr. Forster noted that though it was not "speedy" it was "a formidable affair" with "a horn, bells and other late contrivances to warn erring pedestrians." (101) At the same time, this patient also built a snow shovel which he put to good use around the asylum after winter storms. (102) Winston’s attentiveness to what was happening in the world beyond the asylum is made clear when the Medical Superintendent wrote:

He seems to watch closely all the latest ideas about these machines and attempts to incorporate these in his own way. (103)

In his early seventies, Winston kept busy building an "airship," which Dr. Forster did not think would run, though he is still reported to be working away on an "aeroplane" eighteen months later. (104) Wheelbarrows and "many other articles," were also part of his productive
output during this same period.\(^{(105)}\)

At the age of 77 he was reported to be able to "swing an axe with most of his juniors," something which he was able to put to use for his benefit and that of the asylum on any number of occasions.\(^{(106)}\) Whenever landscaping was undertaken at the hospital, such as cutting down trees or moving buildings, Superintendent Harvey Clare reported in 1924 that Winston "is always consulted and takes an active part in directing the operation..."\(^{(107)}\) During the warm weather, he would build himself couches in "shady nooks" as a place to rest and was also keen on growing things, while in the Winter he liked to skate and sail an ice-boat on the asylum rink.\(^{(108)}\)

One of the most notable features about all of this creativity by an elderly inmate was his enthusiasm for bringing into the asylum the very latest technological developments. His fascination with the world around him was remarked upon by hospital staff, who noted he was always "watching" what was taking place inside and outside the asylum, including a trip to the Canadian National Exhibition where he enjoyed observing "all the improvements of the modern age."\(^{(109)}\) It is interesting to observe that even though he was a public charge, Winston was allowed to go to the CNE, unlike most other such inmates who did not have someone to pay the cost, and is further evidence of the special favours that were granted him.

That Winston had the skills to make and play violins is
notable enough. That he was skilful enough to recreate, or attempt to recreate, so many modern inventions, regardless of his age, is a testament to his enormous talent. When his many creations are considered, what emerges is a picture of an asylum where there existed an active patient culture, in this case tolerated, even admired, by medical authorities who clearly had a great deal of affection for this colourful inmate. The Medical Superintendent wrote how this man who seemed "happy and contented" smoking his pipe, was on the best of terms with everyone, both patients and staff, all of whom he considered his old friends.(110) He had individual names for everyone, referring to an asylum doctor as "Jimmy," and once asked him "what I am doing down here, says he thought I was over at the corner grocery."(111) In the one instance where he was reported to have had a fight with another patient, 83 year old Winston insisted after being hit in the side of the head with a brick that "'Billy the Cooper' wanted to fight but that he is not hurt" though a one inch cut to his ear was noted.(112) His conversation was reported as "somewhat silly" and included a number of references to his earlier life, thinking that Abraham Lincoln, "great praise on him!," was still President of the United States, and a belief that the Superintendent of the Hospital was the same man for whom he worked on the Rideau Canal more than 50 years before.(113) Yet, he was not unaware of changes that occurred over the course of time as his inventions make clear, as well as the fact that he was
very interested in the First World War, having had a long conversation about this and "other public matters" with Dr. Forster in the latter's office, and even talked about enlisting after watching military parades, another source of pleasure for this old man.(114)

Perhaps what is most remarkable about Winston was his vitality at such an advanced age, after having spent so many decades in an institutional environment where being worn down as the years went by was a common occurrence, which even his medical observers remarked upon.(115) Indeed, a few weeks before his 89th birthday, and less than a year before his death due to broncho-pneumonia, Winston was reported busy constructing "tubs and buckets in the carpenter's shop."(116) However, his years in the asylum did affect him in other ways. His devoted sister Anna wrote how "strange" it was that he could write no better than a child when she remembered in her youth what a good writer he had once been.(117) It is also clear that his abilities made him something of a celebrity, a development which asylum officials apparently did not discourage. In order that her brother would not be viewed as some sort of exhibit, Anna wrote to the Medical Superintendent in 1916 and requested a stop to visits by those people who "call to see my brother only thru curiosity."(118)

That such an elderly inmate engaged in so many pursuits which the staff allowed because "no one has the heart to restrict his activities" indicates a number of important
The most obvious point is the ability of this patient to create a world of recreational entertainment that reinforced his freedom within the institution. Clearly, Winston could not have built so many things without the compliance of the staff. The tools he needed to make his automobiles, airship, wheelbarrows, snow shovel, violins and other creations would likely have come from the carpenter’s shop, where he was often reported working. Given his ingenuity, and the reference about his transforming a box into a violin, it is not hard to imagine Winston spending a good deal of his time hunting around the asylum for material for his latest project. Having assembled such things as were needed, he would have required a dependable spot in which to do his work, while being sure it would not be thrown out, as projects like cars would have taken quite a while to build, and somewhere to be housed when not in use. All of this would have to have been done with the knowledge of asylum officials, whom the records clearly show were willing to let Winston do as he pleased.

Beside the non-threatening nature of this inmate, there are other reasons for this official compliance. Winston’s activities benefited the internal economy of the asylum as he helped to do some of the physical labour around the grounds and devices such as his snow shovel saved others from doing such work, while the wheelbarrows, tubs and buckets he made could be used by any number of people. His more recreational creations, such as automobiles and
violins, on the other hand, while of no direct economic benefit to the asylum, would have livened the place up and made life more enjoyable for those who watched him try out his latest devices and heard him play his music. Thus to allow him to pursue these manifold activities was beneficial to the overall social and economic climate of the institution. Not only was Winston causing "no trouble whatever," as the Clinical Record states, he was, most importantly, contributing to the community of which he was a part by working and entertaining fellow inmates, as well as himself. (120) As such, the degree of agency which he displayed is manifested in these various activities. Having accepted his status as an asylum inmate, he used his carpentry skills and powers of observation to create his own distinct personal space within a massive institution where such independence was difficult to secure, especially for a patient with no external financial support. (121) This in turn leads into the close relationship between work and leisure. What for many people would have been activities requiring an excessive degree of physical exertion, particularly at an old age, such as cutting down a tree, instead were for Winston something he enjoyed. Indeed, the fact that the clinical record notes how reluctant the staff was to curtail Winston's activities, shows how much his physical labour was for him a form of leisure and entertainment.

His references to his earlier life, prior to
confinement, are intriguing and raise the possibility that this world of creativity may have been a way of keeping in touch with the world of Winston’s youth and prevented him from deteriorating into a lethargic condition as was wont to happen to someone confined for such an extremely long time. Above all else, the world which Winston created for himself, virtually from scratch, full of new inventions while also recalling a distant past, shows he made sure the links with the community beyond the asylum were maintained and replicated for his enjoyment and those around him.

Subsidizing Patient Culture with External Financial Support

Another thoroughly documented example of a patient created culture of leisure and entertainment, can be found in the file of Felicity A. T. or, as she styled herself “Angel Queen XIII.” Admitted in 1894 after months of domestic tension between herself and her husband and children, whom she said treated her badly, Felicity remained in the Toronto facility until her death at the age of 79 in 1924.(122) During this thirty year period she became “probably our best known and most prominent patient, and in the social sphere in which circumstances placed her she at no time lost her ascendancy or any of her force of character.”(123) This "force of character," combined with a regular supply of financial assistance from supportive family members, enabled Felicity to pursue a variety of free-time pursuits in a world which she believed was hers by divine right.
Angel Queen's most obvious form of recreation was her prodigious output of clothing created from her own hands with an enormous quantity of supplies provided over the years first by her husband, and then after his death in 1918, by their daughter, Veronica. To get an idea of the variety of material that she was provided with since at least 1895, the date of the earliest receipt in her file, the following items are from a typical list, dated October, 1910, which she received:

8 yds. dark green Sateen
5 yds. dark blue cloth
5 yds. blue Silesia
12 yds. white cotton
2 yds. white linen
2 boxes blue silcotton (dark)
1 box light silcotton (5)
1 box green silcotton (3)
1 box bronze green silcotton (12)

The clinical record notes that she spent most of her time in her private room making clothes as well as banners, not only for herself but for "Angel King," for whom she had prepared "a robe beautifully embroidered," though she would not tell anyone where this man lived or when she expected him to arrive. (125) Felicity, who answered to no name other than "Angel Queen," by which she was well known throughout the institution, always dressed herself with bracelets, chains, crosses and crowns, kept her royal robes tucked away in her room and marked all of her belongings with "Angel". (126) She was very demanding when placing her fabric orders and made her displeasure known if the material she received was not to her specifications. Dr. Clarke
wrote to her husband, Gene, that Felicity had complained that the material he sent was not the right colour and so another order was placed. As for the items already received: "I wanted Mrs T____ to return the cotton on hand but she says 'Oh no Angel Queen never returns anything.'"(127) Another time, frustrated that her orders were not being followed, she took matters into her own hands by writing up a long list of sewing material demanding the "Best Quality," and concluded:

When I Stipulate The Knitting Silk Those Embroidery Crochet Silk Wont Do(.). There Is Not Enough On The Spool(.). Angel Queen XIII (128)

Her critical eye for style extended beyond her personal wardrobe. Like other inmates, she enjoyed watching nearby parades as a form of entertainment, and one march in particular received her official opprobrium. In 1918, Angel Queen was reported to be "very much put out at the Orangemen's parade" declaring it the worst she had ever seen because they "had no banners and no regalia at all."(129) The world she created for herself was one in which she held court and issued "devastating prophecies" to those whom she felt had offended her.(130) Some of these "prophecies" are preserved in a large document resembling a scroll, with "+ The Angel Queen XIII +" written in big letters across the top, in which she predicts the end of the world.(131) In another, longer undated letter, much of which is written in the third person, she threatened to kill those whom Felicity believed wanted to starve her, and to "Strike Down" anyone
who tried to remove her from Ward 7. (132) She also asked that Dr. Clarke be informed that the skim milk being sent to the wards was being taken by a staff member to make butter. Upset that other "Poor Creatures" were getting nothing but porridge, Angel Queen insisted that unless this state of affairs "Is Immediately Stopped And The Milk New Sent Through The Wards I’ll Put The Cows In A Dairy Outside..." (133) This effort by Felicity to render assistance to other patients on the ward, while impractical on the one hand, also displays her ability to cross over from a world of self-created leisure, into the everyday problems of hospital routine of which she "always took a great interest." (134) There is no evidence that anything ever came of this, or any other complaints that Angel Queen issued.

Like Winston and his carpentry work, Felicity was able to use her sewing talents and celebrity status within the institution to garner special attention and admiration from the staff who allowed her a great deal of leeway in the way in which she lived her constricted life. Unlike Winston however, Felicity had access to external financial support which she used not only to purchase her sewing fabric, but also her food. She maintained her own set of dishes which she washed and kept in her room, and refused to eat meals cooked at the institution, probably because of a fear of being "poisoned" which was mentioned in regard to some tea that Felicity was served in the infirmary. (135) While she
may have considered herself a monarch sent by God, her appetite was anything but grand as she "only eats boiled eggs, hot milk, soup or perhaps a cake, but her chief diet is milk."(136) No doubt this would have made her all the more concerned about the supply of milk sent to the wards about which she had complained.

Having established her abilities as a superb dressmaker she was given free rein to order as much material as desired, so long as it was paid for by Felicity's family. Her sense of style, along with her dramatic pronouncements and insistence on being called "Angel Queen" all served to enhance this relative freedom which she pushed to the limit. From her private room on Ward 7, Felicity believed she ruled the asylum, that all discharges, staff appointments, local improvements and ordering of supplies was done at her whim, while at the same time she dispensed patronage by issuing "large checkes" for people to be drawn from a bank named after her, and telling the nurses that since she owned Eaton's and Simpson's stores they had Angel Queen's permission to order whatever they wished as "it will be allright."(137)

During the last years of her life Felicity was physically disabled, after falling and fracturing a limb at the end of 1915, so much so that she could only get around her bedroom by "dragging her affected leg after her."(138) Unlike other disabled patients in the asylum, Felicity was able to secure special help to relieve problems
dealing with access and mobility. Her reputation was such that Angel Queen in her last years had another patient, Jean V., act as her "body servant" who would wait on her and would frequently bring hot water for Felicity's toilet. (139) That she was able to secure so many privileges, most notably in regards to a personal maid who received no pay for her kindness, is a testament to the "force of character" mentioned upon her death. Indeed, as she lay dying of pneumonia, Angel Queen insisted that her illness was due to "the poison gas which is put in her room." (140) That she was admired by other patients is obvious by the fact that Jean V. would serve her in such a way, while the affection of the staff is also clear in the clinical record and letters to her daughter. (141)

For all of her highly regarded status it is clear that Felicity was not so content as may seem to have been the case. Even in her relatively private room, she would get upset at the noise emanating from down the hall and exclaim from her bed: "If I could only get around the other patients would not carry on the way they do, breaking up my furniture all the time. I soon won't have any." (142) Perhaps the most poignant reference is to Felicity believing she would be leaving soon, and was "just waiting the call" to vacate the premises. (143) Thus, her world of royal edicts and dire predictions created for herself a self-contained, "safe" world in which to live where she felt under control, thinking that she would only be incarcerated for a little
while more.

To a remarkable degree she did exert some influence over her world, by being able to express her ideas in physical form with the creation of so many gowns, robes and jewellery, "busy with her fancy work all the time." (144) The financial support Felicity received from her family was crucial to sustaining and promoting these various creations, which enhanced her reputation and hence her freedom to entertain with so many tangible examples of a vivid imagination for all to see. While any number of patients expressed ideas about being a monarch or a person of great wealth, none were able to realize such thoughts to the extent that Felicity did, complete with class deference. Angel Queen not only had an impressive wardrobe, but also went so far as to have what amounted to her own "lady in waiting." How this arrangement came about is not revealed by the sources, but that such a relationship existed at all says a great deal about the importance and closeness of patient relationships, from the perspectives of both people. Jean was reported to have waited on Felicity "almost constantly" during Angel Queen's final years with a "great deal of care and attention." (145) Thus, this was much more than a "master" and "servant" relationship, as the affection of these two women for one another must have been very strong to sustain such a friendship, especially given Felicity's demanding personality, and the physical and emotional strains Jean would have encountered while caring
for an ailing person. How much her reputation within the asylum influenced this friendship will have to remain unknown, but it is conceivable that Jean may have felt a degree of privilege and self-worth by being so close to such a well known figure as was Angel Queen in the world of 999 Queen Street West. Their relationship also illustrates the high degree of classism which permeated the lives of asylum inmates, with elitist practices of deference reinforcing such attitudes on asylum wards. Above all else, the story of Felicity’s ability to realize so much relative independence while incarcerated says a great deal about the importance of agency and external support in pursuing a lifestyle that was far less encumbered by institutional rules, than for those inmates who had fewer resources to tap into.

Henrietta B. expressed herself in her free-time in a way that can also reveal an undercurrent of traumatic memories and attempts by a patient to engage in a form of self-help to cope with such images. Confined at the age of 31 in 1894, Henrietta would remain in the Toronto facility until she was released in the care of her mother in 1918.(146) Reported to be cheerful and "artistically inclined in every detail" who was "never happier" than when giving painting lessons in which she "excels", Henrietta was locked up after escaping her mother's house where the doors had been bolted, and stating that "it was her duty to destroy any books of light literature."(147)
Though she was reported to enjoy practising the piano and sewing while institutionalized, just as she did before being incarcerated, her primary form of leisure was painting. During the nearly quarter of a century that she was confined, Henrietta, like Felicity, was supported by her relatives, in this case her mother, and was able to enjoy the privacy of her own room. This support enabled her to create a secure place in which to create what became, in effect, an artist's studio. Henrietta's enthusiasm for painting was noted a number of times during her last decade at the hospital, at one point declaring "art to be the grandest thing on earth." (148) She expressed her feelings by creating pictures on canvas, on her furniture and even on the letterhead of her correspondence, as one of her two surviving letters attests.

Both of these very long letters are immaculately written with clear, nearly flawless handwriting, with prose style rich in detail and imagery, often of a harrowing nature containing nightmare-like episodes of physical and sexual abuse from her home community of Hamilton and Burlington, pleading for "Legal Help" at the end of one letter to "Superintendent Clark Of The Toronto Jail." (149) These letters illustrate Henrietta's exhaustive ability to spend a great deal of time working through her thoughts on paper, though recounting so many upsetting memories could hardly be considered a form of entertainment. This writing also illustrates less distressing views, in particular the
importance of her art to providing a sense of solace. In a letter thanking a correspondent for sending her a lily, Henrietta wrote about her loneliness and how "all my valuable hand-work so much prized by me" made the "place that I am in now...very much improved to what it was," even though it was not the home for which she longed.(150) She went on to write about her latest creations:

A fancy folding lawn chair, I have gilded and painted seven large maple-leaves on, and also made a flag cushion to go with it, which is very particularly attractive. Then another large flag cushion I have made for my bed-room (viz) bou-doir...(151)

Wearing "loud colors" on her dress with a penchant for "keep[ing] herself decorated," as well as jovial in nature, Henrietta's behaviour, in spite of outward appearances, was much more introverted than was that of Felicity or Winston.(152) Even though she was reported to have regularly attended the various hospital entertainments, Henrietta, for the most part in her daily life, appears to have remained aloof from other inmates, talking to herself and carrying her own little chair when out with the walking party so she could sit alone.(153) If anyone intruded "unawares" into her private room where she retreated most of the time, or frightened her in any way, Henrietta was said to become "hysterical," screaming for up to an hour, but was otherwise quiet.(154) This observation, and the ideas expressed in her letters indicate that beneath her pleasant and bright personality there existed a deeply disturbed person, filled with memories of danger, humiliation and
violence, terrified of the unexpected and unwelcome. When put in the context of these debilitating insecurities, Henrietta's private world of artistic creation through sewing, writing, piano playing and especially painting, can be viewed as a release not only from the confining world of the asylum in which she found herself, but also from horrifying images of abuse and suffering which haunted her. These traumatic images may help to explain why she kept most people at a distance in the asylum. While there is no indication of what happened to her after she was released at the age of 55, the evidence that does exist about this gifted person, indicates that for Henrietta B. recreational pursuits were not only a way of relaxing but were also a way of developing a form of self-therapy in an effort to try to heal an immense amount of emotional pain.

Some patients who could pay not only were able to secure more material privileges, but could also go out with staff to do their own shopping at local department stores. Ellen K. spent the last thirty-six years of her life in the asylum, dying at the age of 77 in 1923, while her daughter Coreen K. spent twelve of these years as a fellow patient from 1905 to 1917. They were from a very wealthy family as their husband and father was a successful businessman and politician who provided regular financial support to both, which continued after his death in 1910. This money not only allowed them to have private quarters, but also ensured they were provided with...
various luxuries, from food to clothing and drives outside the asylum, estimated in 1911 to cost $150 a year.\(^{(157)}\)

They were also able to purchase reading material and, most interestingly, both mother and daughter were taken out by nurses to go shopping on a regular basis.\(^{(158)}\)

The degree of this privilege is revealed in voluminous writings left by Coreen in particular. Noting that she had an annual allowance of $1,000 provided by her father’s estate, she wrote to the hospital’s Bursar requesting money because “the heat is so great I need cooling fruit ice cream...”\(^{(159)}\)

In another instance, Coreen asked for $10 not only for her enjoyment, but for some staff whom she wished to reward for their friendship:

> I intend taking a couple of the nurses whom I have found fairly faithful in the discharge of their duty for a trip to Niagara on the Lake tomorrow.\(^{(160)}\)

Yet these privileges were not an unfettered source of entertainment for such well-positioned patients. The same freedom to exert one’s independence in the pursuit of personal leisure activities within the asylum could also produce serious disputes, as occurred with Coreen and hospital authorities. During the final year of her incarceration in 1917, Coreen contacted a correspondence agency in the United States which specialized in romantic matches. Her name was put on a list as seeking a partner in marriage, and she apparently informed the men who contacted her that she was a nurse at the asylum.\(^{(161)}\)

Coreen’s bulging file contains a number of letters from men
who proclaim their devotion for her, with one man in Chicago being particularly insistent, pledging to visit her in Toronto. Alarmed at the amount of mail she was receiving, which the hospital authorities claimed was more than all the other patients combined, they began confiscating letters addressed to her. Not to be outdone, Coreen contacted a lawyer and private detective agency while still confined, to investigate what was happening to her mail, and duly notified Medical Superintendent Forster:

> As to the reading and opening of my letters in the office here, I wrote to the Detective Agency in Toronto and asked them to attend to it. My letters were all from honorable friends and I resent any criticism of them.

This intrusion into her personal space led Coreen to withdraw her services in playing the piano at the "Moving Picture Show," as well as to no longer appearing at classes for student nurses which she resented on the basis of her class position in the asylum. In effect, she went on strike. Coreen went on to write that her lawyer had secured statements from six nurses attesting that "I am perfectly sane, and have never shown any Insanity at all..." By violating their ‘social contract’ to respect her freedom to pursue leisurely activities while confined, in this case trying to prevent Coreen from developing romantic liaisons with male pen pals, hospital officials compelled a privileged patient to use her financial resources to a most powerful effect in her own favour. The money that she and her mother had available to
enjoy so many comforts and to reward favourite nurses, was now turned on the administration in an assault on the very legitimacy of her confinement. That she was able to get some asylum nurses to side with her makes this "leisure-based" revolt all the more remarkable. Undoubtedly, staff support was helped by the friendships Coreen was able to develop through her privileged position, going shopping and driving around the countryside on various occasions. Two days after writing the above letter, she was sent out on probation to the much more prestigious Trinity Hospital, then to a private residence, and six months later was discharged from the asylum, clearly demonstrating the influence she was able to wield with a combination of her contacts, money and personality. (166)

On the day of her release, Coreen wrote an angry letter to Dr. Forster threatening a court case and wishing to "forever sever all connections" with 999 Queen Street West:

I am so glad to leave also, for I don't like to remain in any place where the manager is dishonorable enough to read the patients letters, when he is really only a physician after all, not a postmaster, as he evidently imagines himself. Also, on your assertion that "men must be kept away," not one "Gentleman," I would rather term my friends, has been allowed to call upon me here, therefore the assertion was rather flat. The idea of writing as you did to my sister about my correspondence I took only as an impertinence. A Doctor after all has his limitations, and one of these is opening a patient's letters, as the Toronto Detective office agreed with me on this point... (167)

While issues beside leisure were involved in this dispute, it was her enjoyment of these privileges and
efforts to create a world of personal entertainments free of institutional restrictions, that led Coreen to feel so angry at the obvious violation of her privacy. Having lost the security of being allowed to do as she pleased within the asylum, she forced her way out, resentful at this intrusion into her personal space. (168)

When Coreen left the asylum she left behind her mother, something which she noted with regret. (169) Ellen, who was "a great favorite with us all" continued to receive preferential treatment because of her social class within the asylum, which a steady stream of money maintained. (170) It was noted in 1920 that when it came to meals, Ellen received a "special tray" arranged by the head nurse "sent directly from the kitchen to her." (171) Thus, she was able to enjoy a significant degree of personal space with specially catered meals as well as respect from staff members, though there is no record that Coreen contacted her mother during the last five years of Ellen's life, after she left. (172)

Whatever unpleasant feelings existed over the dispute between Coreen and hospital officials, there is no evidence that Ellen received any fewer privileges than prior to this conflict. Unfortunately, there is also no reference to the emotional impact on this elderly woman of the departure of her daughter after being confined in the same building together for twelve years. The state of their relationship is difficult to determine, though one
letter from 1911 noted that they should not be on the same ward since they have an "injurioys (sic) effect on each other."(173) Though they both benefited from outings and treats, their respective files also indicate that Coreen was able to get out more than her mother while confined, probably due to her less volatile moods, which are mentioned much more frequently for Ellen.(174) There is also no specific mention of them engaging in any activity together. So it appears that mother and daughter did not share their leisure activities together while confined, with the elder Mrs. K. more frequently presenting an image of an introverted, depressed and lonely figure compared to her ebullient and extroverted daughter.

Conclusion

The contrast between people with and without external financial support clearly reveals an institution where access to leisure-time privileges was influenced by social class and money, as well as by behaviour. For while relatively wealthy patients like Ellen K. often found themselves locked up on wards because of emotional distress, or a perception of unreliability, just as did the poorest of inmates, this latter group were not able to experience the wide variety of treats and creature comforts that their social "betters" in the asylum were able to purchase. Indeed, a patient like Cindy R., for whom nary an ill reference is contained during her lengthy period of confinement, could never possibly dream of such luxuries as
paintings, catered food or the chance to go on an outing. The reason was simple – she had no friends outside of the asylum and thus no money to purchase what was beyond her reach. Yet there is also no doubt that financially underprivileged patients like Ellen G., Mabel I., and especially Winston O., were able to develop a range of imaginative alternatives to "subsidized" entertainment by making use of whatever was at hand. Themes around labour are also important to keep in mind since it was their survival skills as workers that enabled some people, like these three inmates, to turn sewing and carpentry into closely allied leisure pursuits. Evidence also shows that for some inmates, regardless of their social status, the chance to attend functions organized by the administration was a major source of entertainment and relaxation.

Perhaps what is most poignant about this discussion of leisure, is the exceptional opportunities and freedom that were available to people covered by the in-depth case studies, compared to more general examples. This comparison shows how money and parole of the grounds were crucial in determining the extent to which it was possible for inmates to "create a culture" of leisure and personal space. It is also clear, that the majority of patients were not able to be so fortunate to have such economic resources and personal freedom. The reasons for this range from the often-mentioned concern over trustworthiness and mental state, but favouritism also played a role with well-liked, less
resistant patients being allowed more freedom than inmates who presented a disagreeable personality to the staff. Thus the pursuit of leisure in the asylum served to reinforce class distinctions on one level, while also making it possible for some inmates to develop and sustain their own creative coping mechanisms in a world which could more easily produce stress and mind-numbing lethargy, than an enjoyable and relaxing environment in which to live.
Notes:


3) Ibid., p. 141-143.

4) McCandless, Moonlight, Magnolias, & Madness, p. 272.

5) AR, 1895, p. 6.

6) AR, 1898, p. 43.

7) AR, 1876, p. 209; AR, 1886, p. 5; AR, 1890, p. 40.

8) AR, 1880, p. 284; AR, 1897, p. 11.

9) AR, 1898, p. 43.

10) AR, 1878, p. 292-293.

11) AR, 1934, p. 16.

12) AR, 1936, p. 34-35.


14) AR, 1932, p. 28.

15) AR, 1936, p. 34-35.

16) AR, 1884, p. 100; AR, 1890, p. 40; AR, 1897, p. 11; AR, 1898, p. 42-43; AR, 1903, p. 3; AR, 1904, p. 6.

17) AR, 1890, p. 40.
22) AR, 1937, p. 16. It should be noted that in 1936 under "Other Forms of Organized Recreation" is listed "Bowling, Softball, etc." in which women are cited as having been involved, an average of 40 females compared to 25 males 80 times during the year. However, given the specific references in the written reports in which only males are ever recorded as having played these two sports, it is likely women were not involved, though they may have played similar games like lawn tennis, though this is not specified under "etc." See AR, 1936, p. 34-35.

23) AR, 1932, p. 28; AR, 1933, p. 31; AR, 1934, p. 16.

24) AR, 1936, p. 34-35.

25) Ibid.

26) Jane F., Patient File #5010. Letter to Mrs. David S. from Jane F., July 20, 1911. Confined in 1895, Jane died from "epileptic exhaustion," at the age of 67 on August 31, 1911, only five weeks after this letter was written.

27) For examples of people who are reported to have enjoyed various administratively organized entertainments see:


29) AR, 1880, p. 284; AR, 1894, p. 6.

30) AR, 1876, p. 215-216.

31) AR, 1877, p. 260; AR, 1895, p. 7.

32) AR, 1897, p. 38; AR, 1906, p. 12.
33) AR, 1906, p. 12.

34) AR, 1924, p. 13; AR, 1932, p. 43; AR, 1941, p. 47.

35) AR, 1895, p. 6.

36) Charles M., Patient File #4034. Charles was confined at the age of 27 in 1893 and remained at the hospital until his death in 1923. There are numerous letters in his file noting cheques sent by the Department of Indian Affairs for his maintenance and some for clothing, with his admission papers stating this support began upon Charles' confinement.

37) Patient File #4034, Letter to Medical Superintendent from J.D. McLean, Assistant Deputy and Secretary, Department of Indian Affairs, Ottawa, December 21, 1920.

38) For a detailed drawing of a fountain and their location see: RG 15, 13-2-41, AO, Department of Public Works Drawings. P.L. Asylum, Design for Fountain to be Erected (1859); RG 15 13-2-73, AO, Department of Public Works Drawings. Lunatic Asylum Toronto, Block Plan of Buildings Shewing Proposed Removal of Woodsheds (1869). The 1859 drawing is for a fountain to be placed at the north front end of the asylum grounds, running along Queen Street West, while the 1869 drawing shows the location of two fountains facing south in the direction of King Street West. See also: AR, 1879, p. 27; AR, 1904, p. 5.

39) E.H.S. (Ezra H. Stafford) "Toronto Insane Asylum," The Canadian Journal of Medicine and Surgery, 3:3 (March, 1898), p. 166. This article does not use this figure but instead refers to 160 patients who were not locked up out of 700 to 800 people. Thus the figure of seventy-five to eighty per cent was calculated on the basis of the 540 to 640 who remained confined. See also references below in note numbers 47 and 48. The quote can be found in: Cyril M., Patient File #4001, Clinical Record, September 14, 1911. Cyril was confined at the age of 26 in 1889 and remained in the asylum until his death in 1912.

40) AR, 1883, p. 47.

41) AR, 1880, p. 38.

42) AR, 1936, p. 20-21, 34-35.

43) For an example of an inmate who successfully, though only temporarily, escaped while out with the walking party see: Nancy D., Patient File #2040. Letter to R. Christie, Inspector of Prisons & Public Charities, Toronto, from Daniel Clark, June 15, 1883. She was recaptured within one day. Nancy was confined at the age of 30 in 1881 and
remained an inmate until her death fifty-two years later in 1933.


46) For examples of patients who had parole of the grounds because they were trusted see: Edward D., Patient File #2021, Clinical Record, March 6, 1928. Edward was locked away at the age of 19 and remained in the asylum until he died fifty-four years later in 1932. Violet N., Patient File #3052, Clinical Record, January 28, 1914, August 12, 1916. Violet was confined in 1889 at the age of 35 and died in the institution in 1922.

47) AR, 1882, p. 49.

48) AR, 1895, p. 5; AR, 1900, p. 4.

49) Jim P., Patient File #6017, Clinical Record, March 25, 1927. Jim was confined at the age of 31 in 1898, and died in 1941 at 999 Queen Street West.

50) May F., Patient File #6007, May was confined from 1898-1952, though several times during this period she was sent to boarding houses in the 1930s and 1940s, but was returned each time to the asylum where she eventually died.

51) Patient File #6007, Clinical Record, September 2, 1921.

52) Ibid.

53) Patient File #6007, Clinical Record, September 2, 1921, October 4, 1921.

54) AR, 1879, p. 27.

55) AR, 1923, p. 11; AR, 1932, p. 27.

56) AR, 1879, p. 31.

57) AR, 1887, p. 43.

58) Arturo C., Patient File #3013, Clinical Record, December 19, 1911. Arturo was confined in 1883 at the age of 45 and died in the asylum in 1917.

59) AR, 1897, p. 11.
60) AR, 1879, p. 312; AR, 1880, p. 284; AR, 1890, p. 40; AR, 1891, p. 5.

61) For an example of a patient's family being asked to send two dollars to "defray expenses" for a trip to the CNE, which they complied with, see: Sylvie B., Patient File #3003, Letter to Mrs. B., Barrie, Ontario from Assistant Superintendent, July 29, 1904. Sylvie was confined at the age of 57 in 1882 and died at the hospital in 1911.

62) Sophia S., Patient File #3022, Clinical Record, March 28, 1909. Sophia was confined at the age of 24 in 1884 and remained in the asylum until her death in 1910.


64) Patient File #3022. Letters in Sophia’s file dating from her early years of incarceration in the 1880s shows her to have been generally quiet and withdrawn, with a lack of interest becoming more pronounced as the years wore on.


67) AR, 1874, p. 154; AR, 1894, p. 5; AR, 1896, p. 41.

68) Mabel I., Patient File #2001. Mabel was confined at the age of 24 in 1870 and died in the asylum in 1918.


70) Ellen G., Patient File #2017. Ellen was confined from 1878 until her death in 1918.

71) Patient File #2017, Clinical Record, September 26 (no year though it is between entries from 1911 and 1913).

72) Patient File #2017, Clinical Record, November 2, 1918, November 4, 1918.

73) AR, 1876, p. 209; AR, 1882, p. 16; AR, 1898, p. 43.

74) AR, 1882, p. 16.

75) AR, 1879, p. 312.

76) AR, 1897, p. 11; AR, 1899, p. 38.

77) AR, 1883, p. 62.
78) Ibid.


80) AR, 1933, p. 31; AR, 1934, p. 16; AR, 1938, p. 16.

81) AR, 1937, p. 82-83.

82) AR, 1876, p. 216-217.

83) AR, 1891, p. 4; AR, 1897, p. 11; AR, 1899, p. 38.

84) AR, 1879, p. 312.

85) AR, 1899, p. 38.

86) AR, 1936, p. 81.

87) E.H.S., "Toronto Insane Asylum," p. 165. For an example of reading material being provided by relatives see: Enid C., Patient File #4002. Letter to Dr. Daniel Clark from John C., Durham, Ontario, July 2, 1890. Enid was confined in 1890 and was transferred to the institution in Penetanguishene, Ontario in 1907.


89) Wallace M., Patient File #4009. Clinical Record, September 4, 1920. Wallace was confined from 1890 until his death at the age of 75 in 1921.

90) Walter T., Patient File #7021. Most of these sketches are drawn in pencil and the largest is letter size while the others are a quarter or half the size of standard letter paper. Walter was admitted in 1902 and died in 1914.

91) AR, 1887, p. 45.

92) See below citation for Winston G., Patient File #2013, note # 110.

93) For examples of patients who were upset by the visits of relatives see: Ellen G., Patient File #2017. Letter to Dr. Clark from S. G., Oakville, Ontario, July 3, 1883. This correspondent, her husband, wrote: "I have not visited Mrs. G. for some time past as she always became much excited during my visits which of course was rather injurious than otherwise; and also because of the abusive language she would use toward me which would not run off me as easy as water off a duck's back. Some of her sisters have also refrained from visiting her for the very same reasons." See also letter to S. G., Oakville, Ontario from Dr. Daniel
Clark, July 5, 1883. This letter is in very bad shape with much of the print faded away on the carbon paper. However, among the legible lines are: "I think it would excite her for you to return.... The same is (illegible) in regards to her sisters." Sylvie B., Patient File #3003. Letter to Dr. Daniel Clark from Judge B., Barrie, Ontario, December 19, 1896. This correspondent wrote: "On the last two occasions that I saw her as I left she became greatly excited and desired me never to come again...."

94) Cindy R., Patient File #5029. Cindy was confined from 1897 until her death at the age of 73 in 1930. Quotes are from clinical record, July 17, 1918.

95) Winston O., Patient File #2013. Winston was confined at the age of 32 on January 9, 1877 and remained at 999 Queen Street West until his death on December 8, 1934.


97) Patient File #2013, Clinical Record, February 8, 1921; Letter to Mrs. W.D., Westboro, Ontario, February 23, 1921.

98) Patient File #2013, Letter to Annie O., Ottawa, from Medical Superintendent, September 3, 1912; Letter to Anna O., Ottawa, from Medical Superintendent, January 6, 1914.

99) Patient File #2013, Letter to Anna O., Ottawa, from Medical Superintendent, July 8, 1913.

100) Patient File #2013. Unfortunately, there is no photograph of Winston or his car in his case file.


102) Ibid.

103) Ibid.

104) Patient File #2013, Letter to Anna O., Ottawa, from Medical Superintendent, July 4, 1917; Letter to Miss Annie O., Ottawa, from Medical Superintendent, January 16, 1919.

105) Ibid.


107) Patient File #2013, Letter to Mrs. M.D., Westboro, Ontario, from Medical Superintendent, July 14, 1924. There are three other references which note his tree-removing abilities: Letter to Mrs. M.D., Westboro, Ontario, from
Medical Superintendent, January 25, 1922 which states: "The high wind of a few weeks ago, blew down a tree in our park, and Winston superintended that it be removed." Letter to Mrs. M.D., Westboro, Ontario, from Medical Superintendent, November 2, 1922 which states: "...only the day before yesterday he cut down a tree, which had died in the park." The clinical record, July 26, 1926 notes 81 year old Winston "can show any of the young men how to cut down a tree."

108) For quote see: Patient File #2013, Clinical Record, July 26, 1926. Skating and ice-boating references are in: Letter to Anna O., Ottawa, from Medical Superintendent, March 5, 1914 and (ice-boat reference only in) Letter to Mrs. M.D., Westboro, Ontario, January 25, 1922. Reference to "he is very interested in growing things" is in: Letter to Mrs. M. D., Westboro, Ontario, from Superintendent, May 31, 1928. This letter also refers to Winston having an "iron constitution," which was beginning to "bend under the burden of years."

109) Patient File #2013, Letter to Annie O., Ottawa, from Medical Superintendent, July 3, 1912; Letter to Annie O., Ottawa, from Medical Superintendent, August 27, 1913.


112) Patient File #2013, Clinical Record, June 12, 1928.

113) Patient File #2013, Clinical Record, "somewhat silly" observation is from December 10, 1931 entry while the other observations are from the entry for September 23, 1927.

114) Patient File #2013, Quote is in: letter to Anna O., Ottawa, from Medical Superintendent, September 26, 1916. This letter also notes: "He is one of our most highly esteemed patients..." Reference to enlisting is in: letter to Anna O., Ottawa, from Medical Superintendent, March 19, 1917.

115) Patient File #2013, Clinical Record, December 10, 1931: Winston was referred to as "...some what demented, but considering his long stay at this Institution he is in fairly good shape..." 


117) Patient File #2013, Letter to J.M. Forester (sic) from Anna O., Ottawa, August 26, 1913.


120) Patient File #2013, Clinical Record, November 14, 1928.

121) Patient File #2013, There are two references, twenty years apart, which refer to Winston's perception of confinement. It appears that, like other long-term inmates, he came to accept his life there because of a lack of any alternative being offered. See letter to Medical Superintendent Forester (sic) from Anna O., Ottawa, July 4, 1914 in which his sister writes: "Winston realizes he cannot leave there But (sic) he does not understand the reason." The Clinical Record entry for January 2, 1934 observes: "Is content to remain in hospital for the balance of his life."

122) Felicity T., Patient File #5005. Felicity was confined at the age of 49 on April 21, 1894 and died in the institution on May 29, 1924.

123) Patient File #5005, Clinical Record, May 31, 1924.

124) Patient File #5005, Receipt dated October 21, 1910 addressed as: Clothing list: To G. T____, signed M. Cooke. There are dozens of receipts in Felicity's file listing an astonishing variety of sewing material, as well as food.

125) Patient File #5005, Clinical Record, April 24, 1909, October 25, 1911, January 5, 1914.

126) Patient File #5005, Clinical Record, March 21, 1922, October 1, 1923.

127) Patient File #5005, Letter to Mr. Gene T., Toronto, from Medical Superintendent, June 19, 1910.

128) Patient File #5005, Undated receipt signed Angel Queen XIII. She also sent along an undated note which states: "Give The List To The Clerk At Either Simpsons Or Eatons(.) They Will Fill It Out And Go To The Bank Called Montreal And Get Their Pay For The Items And Trouble Of Collecting It(.) Angel Queen XIII"

129) Patient File #5005, Clinical Record, July 17, 1918.

130) Patient File #5005, Clinical Record, December 1, 1923.

131) Patient File #5005, This letter, or scroll, is undated but is signed: "Written By Command Of Almighty God / Warning / By Angel Queen XIII."
132) Patient File #5005. This undated letter by Angel Queen is eleven pages long. References to the consequences of starvation and Angel Queen's threat to "Strike Down" others are on pages 2 and 6.

133) Patient File #5005. Quote is from page 1 of her eleven page letter.

134) Patient File #5005. Letter to Miss Veronica T., Toronto, June 2, 1924. Unsigned letter but it was almost certainly from the Medical Superintendent.

135) Patient File #5005, Clinical Record, October 1, 1923 states: "She also washes her own dishes and keeps them in her room." Angel Queen's Clinical Chart from the infirmary, where she was recovering from a fracture, reads in part:

- January 24, 1916 - 8 A.M. Pt says there is morphia in her tea... 6 P.M. Pt taking nourishment well, but refuses to take any more tea...
- January 30, 1916 - 7 A.M.... Pt refuses to take tea as it is poison in it."

136) Patient File #5005, Clinical Record, October 1, 1923.

137) Patient File #5005, Clinical Record, April 24, 1909, February 23, 1915, October 1, 1923. It was noted that during her last years, Angel Queen "used to write numerous checks, but recently it is rather an event for her to get out a check." *Ibid.*, Clinical Record, March 21, 1922.

138) Reference to the accident and subsequent physical disabilities are in: Patient File #5005, Clinical Record, December 30, 1915, January 15, 1916, July 1, 1916. Quote is from: Clinical Record, March 21, 1922.

139) Patient File #5005, Clinical Record, October 1, 1923, December 1, 1923.

140) Patient File #5005, Clinical Record, May 29, 1924.

141) Patient File #5005, Clinical Record, May 31, 1924; Letter to Miss Veronica T., Toronto, June 2, 1924 which states: "Your mother was always a great favorite with the staff. In spite of her affliction she retained qualities of mind and heart which endeared her to us....we all join with you in mourning her loss." This letter is not signed but it is almost certainly from the Medical Superintendent. See also letter to Miss Veronica T., Toronto, from unsigned though initials at bottom of page, "FSV/LC," indicate the author was Dr. F.S. Vrooman, June 5, 1924: "...nearly every morning I visited and conversed with her, and always felt a personal interest in her, as indeed did nearly every one who came in contact with her."
142) Patient File #5005, Clinical Record, October 1, 1923.

143) Patient File #5005, Clinical Record, July 17, 1918.

144) Patient File #5005, Clinical Record, October 25, 1911.

145) Patient File #5005, Letter to Miss Veronica T., Toronto, from unsigned though initials at bottom of page, "FSV/LC" indicate the author was Dr. F.S. Vrooman, June 5, 1924.

146) Henrietta B., Patient File #5003. Henrietta was admitted on May 1, 1894 and discharged on July 30, 1919, though she had been released on probation from the hospital on July 23, 1918.

147) Patient File #5003. These comments and observations are recorded in Henrietta's admission papers. See: Form of History of a Patient, May 15, 1894, Signed by Dr. Wm. Richardson, Burlington, Ontario; Form A - Certificate of Insanity, April 30, 1894, Signed by Dr. Austin H. Speers, Burlington, Ontario; Form A - Certificate of Insanity, April 30, 1894, Signed by Dr. Wm. Richardson, Burlington, Ontario.

148) Patient File #5003, Clinical Record, August 10 (no year but entry is between observations from 1909 and 1913).

149) Patient File #5003. This letter by Henrietta to "Superintendent Clark of the Toronto Jail" is thirteen pages long and has been written on the top of the first page: "No Date. ......." The word "Murder" is also written seven times sideways across the top of the first page. This letter is extremely detailed and imaginative, giving descriptions of dream-like images, often of a nightmarish quality and includes sexual and racist overtones with references to "Savages." In handwriting that is definitely not Henrietta's someone has written "July 1, 1916" which makes this letter even more curious since both doctors with the name to whom it is addressed (frequently mis-spelled in the case of C.K. Clarke) had long since departed 999 Queen Street West by 1916. C.K. Clarke left in 1911 and Daniel Clark left in 1905 and died in 1912.

150) Patient File #5003, Letter to Mrs. N. (no address), from Henrietta Emily B., no date, though there are patriotic references to Canada and the maple leaf in it indicating it may have been written during the First World War. This letter is seven pages long and contains a highly stylized description of a horse carriage road accident in Hamilton in which Henrietta and her mother were involved with the latter being seriously injured. The quotes are on pages 5-6.
151) Patient File #5003. Quote is on page 7 of Henrietta's letter to Mrs. N., undated.

152) Patient File #5003, Clinical Record, January 9 (no year, between entries for 1913 and 1916).

153) Patient File #5003, Clinical Record, November 20, 1913.

154) Patient File #5003, Clinical Record, April 10, 1909, July 18, 1909.

155) Ellen K., Patient File #3037. Ellen was admitted for the third time at the age of 41 on October 21, 1887 and died in the hospital on September 8, 1923. Coreen K., Patient File #9001. Coreen was admitted for the fourth time on August 13, 1905 and discharged on May 27, 1918, though she was allowed out on probation on November 26, 1917.

156) For a biography of John K., the husband and father of Ellen and Coreen see newspaper obituary attached to page 1 of Clinical Record, entries for period between March 4, 1909 to December 1, 1910 in: Ellen K., Patient File #3037. There are dozens of receipts and letters from throughout the period of incarceration for both women concerning the supply of money for maintenance, clothing, sewing, reading materials and food. After John’s death, funds were disbursed by The Toronto General Trusts Corporation.


158) Patient File #3037, Letter to Miss Corley from Hollie M., "Sunday" (no address or date but found among letters from 1903, two years prior to the confinement of Coreen). The correspondent is Ellen’s daughter and she refers to Miss Corley, an Asylum Nurse, shopping with and purchasing amenities for "Mama." Regarding books purchased by Coreen see: Patient File #3037, Letter to J.M. Forster, Medical Supt. from W.D. Langmuir, General Manager, The Toronto General Trusts Corporation, August 27, 1917. Even though this letter concerns Coreen it was mis-filed in Ellen’s file. Other references to excursions and purchases are noted below.

159) Patient #3037, Letter to Mr. Edgar, Bursar, T.I.A. from Coreen K., Ward 13, 999 Queen Street West, Toronto, July 27 191(? - The last number is obscured by a hole punch but it appears to be either 1911 or 1917). Even though this letter is from Coreen it was mis-filed in Ellen’s file.


162) Patient File #9001, Clinical Record, Summer and Fall 1917.

163) Patient File #9001, Letter to Dr. Forster from C.K., Asylum, November 24, 1917, p. 2.

164) Patient File #9001, Letter to Dr. Forster from C.K., Asylum, November 24, 1917, p. 3.

165) Ibid.

166) Details surrounding her release can be found in her mother's file: Patient File #3037, Letter to Toronto General Trusts Corporation, December 6, 1917 from Bursar. Letter to Dr. Forester (sic), from J.H. Drinkwater, Toronto, March 5, 1918. This letter notes that Coreen was enjoying herself, playing the piano, as well as going to church and on outings. Her date of final discharge is noted in the Clinical Record in Coreen's file: Patient File #9001.

167) Patient File #9001, Letter to Dr. Forster from Coreen K., Asylum, (no month or date) 1917. Coreen began this letter with the lines: "As you have promised to allow me to leave here Today I do not wish to remain one moment longer than possible." This reference, as well as the location of this letter in her file with other letters concerning this dispute, clearly indicates that she wrote this letter on the day she was allowed out on probation, November 26, 1917.

168) Over twenty years after her release from 999 Queen Street West, Coreen was admitted to another psychiatric hospital, though the outcome is not recorded in her file. This information is recorded in her mother's file: Ellen K., Patient File #3037. Letter to C.B. Farrar, Director of Toronto Psychiatric Hospital from J.R. Howitt, Superintendent, Ontario Hospital, Toronto, April 29, 1939. This letter is in response to a letter dated April 25, 1939 from Mr. Jackson writing for C.B. Farrar to Dr. Howitt requesting information on Ellen and Coreen K. which was provided in the form of admission histories with it being noted that Coreen was probated on November 26, 1917 and discharged as "Improved" on May 27, 1918. The initiating letter of April 25, 1939 notes that Coreen K. was admitted to the Toronto Psychiatric Hospital on April 17, 1939. There is no information about Coreen beyond this date.

169) Patient File #9001. Letter to Dr. Forster from C.K., Asylum, November 24, 1917, pp. 2-3. Coreen wrote: "I only wish I could have all Mother's money withdrawn from here and her also, for I see no advantage in this Hospital with the modern Hospitals of the day."
170) Ellen K., Patient File #3037. Letter to Assistant General Manager, Toronto General Trusts Corp. from Medical Superintendent Dr. Harvey Clare, May 8, 1920.

171) Ibid.

172) It is important to observe that the 1920 letter referred to in the two preceding notes above, mentions that Mrs. K. was worried about being taken away from her daughter, if she was ever transferred to Whitby Hospital from 999 Queen Street West, something which did not happen. Her admission papers state Ellen had five children, and as there is no reference to any sons during her long incarceration, it is assumed that all of her children were daughters, though this is not specified anywhere. The closest reference to the gender of her children is in a letter from Ellen’s sister which mentions a parcel from “one of her daughters...” Patient File #3037, Letter to Dr. Harvey Clare from Miss E.H., Port Hope, Ontario, January 2 (no year though based on Clare’s response it is from 1923). Since Coreen had been released two and one half years before Ellen’s comments in May, 1920, it is not clear which daughter is being referred to, though it does show at least one of her children lived close enough to the institution to have visited her regularly. In any case this and other letters are clear evidence that Ellen received visitors during her final years, including a sister, so she was by no means forgotten by outsiders.


174) Ellen’s Clinical Record notes her feelings which culminated in severe depression on a number of occasions, as for example is indicated in the following entry: Patient File #3037, Clinical Record, March 12, 1912:

Is as a rule a quiet, agreeable and pleasant woman, quite vivacious, and with very gradual deterioration. She has, however, frequent periods of varying lengths, during the early part of which she is more or less fault-finding and unpleasant. She finally lapses into a condition where she sits in her chair without speaking for days or weeks at a time. During the last fourteen years of her life there are two references to Ellen going on day-trips outside of the asylum, neither of which occurred during her final decade of incarceration, indicating she did not get outside of the hospital after 1912, unlike her daughter during this period, as is mentioned above. Re Ellen going out during the latter part of her confinement see: Patient File #3037 Clinical Record, July 8, 1909, August 17, 1912. This latter reference notes Ellen “went for a little trip to Niagara which she enjoyed very much.”
Chapter 5. Patients' Labour

Introduction: The Therapeutic and Economic Context of Patients' Labour

Moral treatment in which coercion was officially downgraded while suasion through work and leisure were emphasized as the best way to treat a troubled mind, came to be the primary medical justification for patient labour at 999 Queen Street West. As Charlotte MacKenzie has outlined, versions of this theoretically more gentle approach to dealing with insanity existed in Britain by the late 1700s, especially when contrasted with the common-place brutality that had made mad-houses notorious among the public. However, it was from 1813 onwards, with the publication of Samuel Tuke's *Description of the Retreat*, that moral reform began to make gradual inroads among officials who were responsible for the mentally disturbed.(1) Administrators were not the only people who promoted this policy. An anonymous former inmate of the Glasgow Royal Asylum in the mid-nineteenth century described how a stable mind was most likely to be achieved by "keeping the fingers employed at some light and useful labour."(2) But this former patient also warned that if an inmate-labourer was "placed under the charge of some harsh, unfeeling clown who would give them work above their strength or allow them to overwork themselves, as some nervous excitable patients would be very apt to do, the result would be the reverse of desirable."(3) Cheryl Krasnick Warsh writes that a contemporary term for this treatment is behaviour modification, though the term
industrial therapy has also been used in the second half of the twentieth century.(4)

During the long tenure of Joseph Workman as Superintendent of 999 Queen Street West, from 1853-1875, he advocated moral treatment by promoting "kindness in the treatment of the insane" and preferring to not use restraints.(5) Daniel Clark intensified this policy of moral reform during his tenure from 1875-1905 so that by the time of his retirement, the Toronto Asylum for the Insane had a firmly rooted practice of promoting work as therapy, something which the records show was carried forward well into the middle part of the 20th century. One of Clark's successors echoed this policy when, in 1918, Superintendent J.M. Forster wrote, referring to patient Alice M., that labour was important "for the taking of patients out of themselves."(6)

Having patients work around 999 was instituted from the earliest days of its existence. Only a few years after the Provincial Asylum opened on Queen Street West in 1850, Susanna Moodie wrote after a visit, that a group of male patients were to be seen working outside in the garden, while inside, women sewed on the ward.(7) This policy of mental hospital administrators in Ontario, including both Superintendents and provincial Inspectors, reveals the widespread adoption of Anglo-American therapeutic aims in the promotion of work as therapy. Inspector Langmuir noted in 1879 that one third of all asylum inmates in
Ontario were employed in labour, though some worked less regularly than others. He argued that labour along with recreation and amusement were the most effective factors in treating mental disorders, and he stated that more emphasis needed to be given to inmate work. The hours of work were never clearly stated, but would have varied according to jobs and ability of workers who were always supervised by staff employed at specific work stations. These hospital employees in effect became "occasional attendants" as James Moran has noted. Superintendent Isaac Ray of Butler Hospital in Rhode Island wrote in 1866 that the working day for patients "never exceeds eight hours." In France during this period, the work day could be longer, lasting from eight to twelve hours depending on the season.

As Table IV indicates, the cumulative rise in the percentage of days worked to collective stay at provincial hospitals clearly shows that Langmuir's goal of increasing the number of patients involved in labour was implemented from the early 1880s onward. This did not occur without questions being raised about the effectiveness of this plan. In 1885, as asylum labour was intensifying in every locale, Daniel Clark commented that classifying who was to work was a problem. He stated that it was good for a physically healthy patient with chronic mania to work when it proved to be a sedative. But for someone with acute mania who was made to work to exhaustion this would be "positively injurious":

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This new-fangled idea of endeavouring to extract as much work out of the insane as possible is mischievous, useless, subject to certain conditions and limitations... [I]t is evident that discrimination should be used in urging patients to perform manual labour. Many will work to whom it is a manifest injury. Such can be urged to it by coaxing, or by bribing with something of a trifling nature, such as an extra cup of tea or coffee, or a piece of tobacco to any old smoker... Some of them would work night and day...were they permitted to do so... The question is not how much work can be got out of patients, but how much work can be done by those to whom it is a healthy exercise and will be conducive to recovery?... [I]ndiscriminate labour has not the therapeutic effect its ardent advocates claim for it.(12)

Ironically, during the decade after these words were written, 999 experienced a period in which inmate labour was the most intensified of all the years covered by this thesis. It is not possible to trace the extent of work among groups with specific diagnoses, since statistics on labour do not provide this information. However, there are statistics reproduced in Tables IV, V and VI which show the extent of inmate labour from the early 1880s to early 1900s. Figures in Table V indicate that work among the overall Toronto asylum population reached a peak of 88.83% in 1895, but was thereafter gradually reduced to two-thirds and then just over half by 1905. Until 1892, Toronto's percentage of days worked never rose above those of the other provincial facilities. However, for the remainder of the last decade of the 19th century, 999 Queen Street West achieved a rough par, when it was not in advance of other hospitals, as it was in 1895. After 1900, and especially after Daniel Clark left in 1905 when rates for days worked declined to their
lowest since 1886, Toronto was consistently lower than its three oldest neighbours, with the exception of 1903 when Hamilton was the lowest.

Part of the reason for these generally lower figures at Toronto can be found in Clark's complaint that the relatives of paying patients often refused to let this private class engage in any employment. Yannick Ripa has found similar family resistance in 19th century France. (13) Efforts were made to get paying patients to work at 999, with the argument that it would be therapeutic by helping with their physical and mental health. In 1894 Clark noted that out of 225 paying inmates at least 50% were capable of some type of work. Relatives objected to this goal as they viewed it "as derogatory to the social status of the patients." (14) Yet it is clear from the statistics that some success was registered in getting paying patients to work. During the record year of 1895, paying patients made up 37% of Toronto's hospital population, a higher rate than any other provincial facility, the next closest being London where paying patients made up only 20% of the overall inmate population. (15) It had been noted by both Clark and Inspector Langmuir as early as 1883 that Toronto's non-working private patients were an impediment to increasing the work-rate there, in contrast to other facilities in Ontario where there were far fewer in this category. (16) Yet in spite of this family opposition, it is clear from the annual statistics that for most of the 1890s up to 1900,
some paying patients were included among the inmate working population.

Since Clark directed his criticism in particular at relatives of inmates who paid full rates, the highest class of inmates, this suggests that these individuals were exempted from work more generally than the majority of their peers who were not as wealthy. It is clear that patients who were not among the wealthiest $6.00 per-week inmates were expected to work as a way of contributing to their board and earning their keep. Patients whose relatives paid lower maintenance fees were not exempt from work, nor were men and women who were on so-called "free wards," that is, people who had no outside financial support. Wealthy non-working patients included a well-established lawyer, the wife and daughter of a rich businessman and a stock-broker with friends on Wall Street.(17) They were not singled out for their non-working status in clinical files, a point that is frequently mentioned in regards to less fortunate inmates who either refused to work or were seen as incapable of work. Working-class, or poor rural patients who did no work had this point specifically mentioned in their clinical records, as with William G., a farmer, who was described as "useless" as a worker in the asylum.(18) Irene B., a dressmaker, was also noted to have refused to do work, while Erin P. was referred to as the "laziest" patient on her ward.(19) As will become evident below, patients who were regular workers were complimented for their efforts. This
theme of patients who contributed to the internal economy of the asylum by working on a regular basis as being more worthy than inmates who did not work regularly, or who did no work at all, is repeated over and over in case files for those who were not rich, and has also been documented in late 19th century records of the London, Ontario Insane Asylum by Cheryl L. Krasnick.(20) Wendy Mitchinson has observed that while staff did not force patients to work at Toronto, pressure was exerted and included the sort of bribes that Clark referred to in his 1885 report.(21)

Favouritism towards working patients was also practiced at the nearby asylum in London, Ontario according to S.E.D. Shortt.(22) Thus, there was a general de-valuing of non-working inmates who were expected to engage in some form of labour, though the outright intolerance mentioned by Yannick Ripa towards "idleness" in French institutions was more implicit than explicit at the Toronto facility.(23)

Generally, it can be said that those patients with the most money did the least institutional work, while those with the least money or none at all, did or were expected to do most of the work among inmate-labourers. Part of this was simple demographics, as the Toronto Hospital for the Insane was made up primarily of non-paying patients. Those patients whose stay was well financed could literally buy more leisure time than people who had little or no financial resources. Furthermore, the prevalent middle class attitude of this period was intrinsic to moral therapy, part of which
was based on judging a person's character on their self control and hence reliability for work, as Andrew Scull has discussed. (24) When a well-to-do patient was noted to be engaged in work, such as Angel Queen XII with her numerous sewing projects (discussed in the chapter on leisure), this task was chosen by the inmate whose efforts were subsidized by their family and were usually, though not always, for themselves rather than for the wider hospital community. As such, this type of work was far different than the toil of those patients whose hospital-directed jobs had a direct impact on the internal economy of the asylum, by reducing expenditures for more paid staff and producing outputs, like new clothes or helping with building maintenance. While not in any way diminishing the labours of a more privileged patient like Angel Queen, she had a choice that many other inmates did not have for lack of money and social status behind asylum walls.

The large number of private patients at Toronto contributed to the workload of their less fortunate peers. Clark complained that the ironing of paying patients' clothes was a "heavy weekly task" which would not be so if the hospital had only free patients, which suggests these privileged patients had more clothes that were given greater attention than would have otherwise been the case. (25) This raises the point, how therapeutic was patient labour and how much was it exploitive? In 1900 Inspector Christie noted that 76% of provincial patients were employed at their
place of residence and that during the previous ten years 75% were so occupied, up from the 45% provincial average recorded in 1881. These figures clearly indicate that inmate labour had become a central part of institutional life throughout Ontario and was essential to the internal economy of the provincial mental hospital system. In this respect, Canadian administrators borrowed from the example of European and some American physicians. Nancy Tomes has observed that by the 1860s employment of patients was advocated as a way to reduce the need for restraints through a regular work regimen which would also ensure that inmate labour kept down maintenance costs.

While farming and gardening were considered among the best work agents for inmates, Inspector Langmuir also noted that out-door work and "products derived therefrom very materially reduce the cost of maintaining Asylums." Inspector Christie wrote in 1896 that the quantitative increase in the average number of working patients benefited asylums and their inhabitants.

[T]he present condition of the institutions...indicate their advanced and improved state... These have been done largely by institution labor, and the employment of patients... The benefit patients derive from this cannot be overestimated, and if outside labor were employed, it is obvious that the expenditure would be largely increased.

Even before the provincial-wide intensification of employing patients began in the late 1870s, local administrators had already begun this process. Joseph Workman reported in 1872 that "all clothing" for Queen
Street inmates was made in the institution by patients, with help from a tailor on the male side and a seamstress on the female side. As Tables V, VI, VII and VIII show, the vast amount of unpaid work done by inmates directly cut down on internal costs. All boots, shoes and slippers for patients were made at 999 work-stations occupied by inmates by the turn of the century. During just one year, 1898, this work included the creation of 175 tin vessels, 803 tin vessels were repaired, 69 chairs and 7 sofas were upholstered and 83 mattresses were remade. The total value of all of this was estimated by Clark to have been $1,343.96. In 1906, it was estimated that three million pieces of laundry went through this department in all provincial mental hospitals combined, most of which would have been work done by female inmates. This material was then sent on to the sewing room for mending when necessary after being washed. As Tables VII and VIII make clear, the amount of inside and outside work done by female and male patients was enormous. In her study of women asylum inmates in 19th century France, Yannick Ripa has written that physicians were aware of, but remained silent about, the material benefit to institutions of inmate labour, preferring to emphasize work as therapy. Yet documents cited above clearly show that Canadian physicians during this period did not hide their enthusiasm for the reputed mental and material benefit of inmate work.
Within the labour regime at the Toronto Hospital for the Insane, gender divisions are apparent in a number of areas. The most obvious bias in this regard is the choice of jobs available to male patients in contrast to female patients, set out in Tables V and VI. Out of 32 job-categories between 1880-1905 only two, or 6%, were allocated exclusively to women, whereas nineteen, or 60% of occupations, were reserved solely for men. Of the remaining eleven, or 34% of jobs, both men and women were involved. Evidence shows that women were never allowed to work outside, an exclusively male preserve, though both groups were employed inside. However, women worked inside far more than men with their highest rate recorded as work on wards and halls where females did 60% of the total labour under this category. Women’s work was focused primarily on traditional areas, notably sewing and repairing clothes, domestic servants for medical officials, as well as basket making, floor scrubbing, and dusting. Clinical records indicate that both genders did sweeping and polishing of floors on the wards in which they resided, and helped to care for other inmates who were sick in sex-segregated infirmaries.

While there was gender cross-over in areas like the laundry, women did the vast amount of work there, 86% by 1905. The area of closest parity was dining room work where both women and men equal out almost evenly at 50% of the total of six sample years. This figure is not surprising
given that patients were assigned work at their own eating facilities which were strictly segregated by gender. What is surprising is that men were recorded as working much more than women in the kitchen which became an exclusively male preserve by 1890 when a new central kitchen building was opened up, replacing the old system of six kitchens scattered about the basement. Nor are women patients ever recorded as working in the bakery, only briefly in the dairy, and never on the farm or in garden work, all areas which females worked in traditional household economies of this period. This occupational segregation into a few areas for female patients was similar to French asylums. (34)

Wendy Mitchinson has argued that gender divisions in patient labour and leisure at Toronto were based on the favouritism Clark showed male patients. In particular she notes how "even in the asylum, women's work was never done," as men had more time off during periods of inclement weather and at night, when outdoor work was not practical. (35) Statistics in Table VI which compare days worked percentage by gender and patient population by gender support this argument for the period 1895-1905, when women, who made up just over half of the inmate population, did an average of 61% of the work. During the period from 1880-1890 the days-worked figures show men did 55% of the work during a period when they were in a slight majority of the patient population. Men also worked inside doing year-round jobs, though far fewer than women, as categories like carpenter's
shop, tailor’s shop and storeroom show. Male patients were also employed in at least one outside occupation year-round, the wood yard and coal-shed, essential not only for cooking, but also for heating during winter months. They were also put to work on building projects around the institution, as Table VII shows, and Clark wrote in 1893 that “most of the rough and heavy [construction] work” was done by these men patients. (36)

Outdoor work could be extremely tedious such as when male inmates were put to work in the late 1870s to pick by hand thousands of potato bugs by the “bushel and barrelful,” and to apply Paris Green on the crop in order to stop the blight of this produce. (37) This reference to the use of a highly poisonous insecticide also indicates the hazards all patients, male and female, could face on the job. As early as 1853 patients were put to work in unsafe places, clearing up a three year old cess-pool released by unconnected pipes from water-closets underneath the asylum’s basement. (38) Laundry work which was done by hand until 1876 when it was mechanized, as well as sewing, mending and making clothing, as well as constructing buildings, could all be physically demanding jobs with hands and limbs getting strained under difficult conditions where there was no financial compensation. In 1903 Harriet T. asked that her brother, Daniel T., be paid for his work, so as to offset the $3.00 weekly charge that his family paid for his confinement. (39) Superintendent Clark responded, “We cannot possibly have a
patient work here and give him credit for his work, although it is always a great benefit to a patient to be employed in one way or another." (40) Clark made similar observations about other inmates, noting Jim P.'s reliability as a worker who "earns more than his keep in this way," while virtually identical comments were also made about Wilfred S. (41) Clark went on to state the rationale for Wilfred's work with the gardener, and by extension, other similarly situated patients. Noting that he "encouraged" such tasks, Clark wrote, "it is good for insane people to be employed." (42) This non-payment of inmate labour was in contrast to some inmates in France who were paid, albeit very unevenly, during the 1830s and 1840s. (43)

Not only were patients at Toronto never paid, as a matter of policy, but some of them also viewed their places of work as less than inviting. Women's work, sewing and knitting, was done in a cramped attic atop the main building, which was also used as a chapel and amusement hall, a place that Clark described as "gloomy and forbidding." (44) Some women refused to go to this room in a patient-initiated 'job action' in 1884 that altered institutional labour practices. Administrators implemented a new policy after this episode of having women sew on wards with the result that "many of those who could not be induced to work before" were thereafter employed. (45)

This change in work venue as buildings and work practices evolved over the decades was most noticeable on
the farm. By 1888, 999 Queen Street West had been reduced to 26 acres in total size, whereas only a few years before in 1880 it had been 105 acres. Clark noted that this land curtailment would cost $6,000 annually in lost crops. (46) This reduction of outdoor labour left eighty male workers without their usual employment, most of whom had been farm labourers back in their communities. A new building with industrial workshops opened in 1892 and was intended to remedy this unemployment. (47) Mimico, from 1888-1894 and later on Whitby, from 1912-1917, served briefly as replacement farms with inmate labourers sent from 999 Queen Street West. But after these facilities were separated from Toronto they no longer served as branch farms. (48) While the reduction of land was not so dramatic during the 1900s, it was slowly whittled down to twenty acres most of which was taken up by buildings, as only three acres are listed as being set aside for the cultivation of fruit and vegetables by 1940. (49)

For the first time, women patients were recorded as being allowed to do outdoor labour at Toronto when an acre of ground around the female infirmary was used as a vegetable garden in 1918. (50) These women would have been a tiny minority of the overall female patient population, quite privileged in this regard. Since males were allowed to work outside far more, it is obvious that this group of workers were among the most privileged in the asylum, being able to get fresh air on a regular basis and a better diet.
which was provincial policy for outside labourers by 1907. (51) By this time, 40% of all patient workers across Ontario toiled outside. (52) A decade later, Ontario Hospital dietary guidelines stipulated that employed patients were to get one extra egg for breakfast, though it is not clear if this included both men and women. (53)

Perhaps the most unorthodox reward given to working patients during the entire period studied here was the reference to some inmate labourers, most likely males, being given beer at Toronto in the late 1870s, though Inspector Langmuir had advised against this for financial reasons. (54)

Working inmates who were being prepared to be returned to the community were also granted certain privileges. Female patients employed as domestic servants at the residence of the Superintendent were allowed to receive dinner at his table, rather than with other patients. They were eventually to be released back to their families, and so were given domestic duties in this setting to make them more "tractable and contented," according to Commissioner Noxon. (55) After 1911 some male patients were allowed to return to work outside the asylum, though they continued to reside inside the hospital until it was decided that they could leave. (56)

Class status prior to confinement was reflected in the types of jobs patients had in the institution. It was not uncommon to link inmates to jobs with which they had had previous experience on the outside, a practice which improved efficiency and reduced the need to
train inmates. (57) Mabel I., considered a "good reliable patient" who was regular at her laundry job, had also been a domestic worker prior to confinement. (58) Edward D., a cabinet-maker, worked at the paint shop well into his seventies. (59) Stanley L., a shoemaker before admission, was employed on a daily basis in the shoe shop. (60) Wallace S. was listed as a general labourer at the time of his admission in 1888. In 1926 it was noted that this 66 year old man carried coal to various fireplaces, and had been doing his "routine work" in the same manner for nearly forty years at 999. (61)

This internal class system also manifested itself in another significant manner: the transferral between institutions of inmate-labourers. In 1909, following a request from Inspector Armstrong for two inmate-labourers, Dr. C.K. Clarke transferred two brothers, Daniel R. and Egbert R., to the recently opened facility in Penetanguishene, Ontario, both of whom he said were "good workers." (62) Later that same year Dr. Clarke sent "four good working patients" to this same facility, two men and two women. In the case of one of these inmates, Aline P., Dr. Clarke thought that since she spoke only French, she would be better employed in Penetanguishene where she would "be likely to get more companionship in that district than here as we have very few patients of this nationality." (63) A few years later Wilfred S. was presented at a medical conference to determine whether he was suitable to be sent
as a worker to a "bush farm" at the Orillia Hospital for the Feeble Minded. (64) He was transferred there in 1911 after fourteen years at 999. Another patient was sent to Orillia a few weeks later. The reasons given to the brother of Geoffrey P. indicate that this transfer was seen as therapeutic for the inmate. Dr. Clarke stated farm labour at this facility would do Geoffrey good as it would "show that he is capable of concentrating his mind on some work." (65) Patients who were considered reliable workers were clearly valued by administrators. Dr. Wilson of the Cobourg institution for women asked Dr. Clarke to send him such an inmate, as "we are over run with noisy non workers." (66) Clarke complied a few days later.

In one case, there was a dispute between two institutions about who should get a particular inmate. Francis F. was a 31 year old patient when he escaped from the asylum in 1908. Several months later he was locked up for vagrancy in the Central Prison, ironically, just several hundred yards south of the asylum. Upon learning of his former status as an asylum inmate, a series of letters went back and forth between Dr. Clarke, Warden Gilmour and Inspector Christie about whether prison was the proper place for Francis. In the midst of this dispute, Warden Gilmour provided a rare glimpse of how asylum work contrasted with that of labour in a prison. The Warden claimed this man was very industrious, a point which Clarke supported. (67) To bolster his argument to keep this man, Warden Gilmour used
what he said were Francis' own words comparing work at both institutions: "The regular work with the machines in the [prison] factory was much more interesting than making up beds and choring around the asylum." (68) Francis remained in prison. Whether or not Francis did in fact say this can never be confirmed, but it does illustrate the importance attached to retaining valued workers during this period.

In another related episode, lack of skilled labour outside the institution caused a former employer to ask for one of their workers back. James W., 43, had been confined for less than seven months when in 1900 the Booth Copper Company of Toronto wrote to the hospital for the second time asking if he was "sufficiently recovered" to be released and returned to his old job as "we are anxious to obtain his services, coppersmiths being very scarce." (69) Daniel Clark responded that he was not well enough, so James remained confined until his death in 1928, long since forgotten by his former employers, as he was friendless at the end. (70) James spent his institutional work-life with the tinsmith, and informed staff "he would much rather work than lie idle." (71)

Some patients tried to create their own internal economy for self support. Evelyn M. was a former domestic servant and free patient who worked regularly in the laundry. She would steal other people's clothing and re-make them into her own style, thus hoping to improve the drab institutional garb with which she was provided. (72)
This sort of patient-initiated effort around clothing was not too unusual. In 1916, Superintendent Forster noted that patients like Andrew H. took matters around provisions into their own hands, when noting it was sometimes difficult to get inmates to wear the clothes that they were given "as many of our patients will trade and exchange clothing without consulting us."(73) An even more direct example of this is Laura L. who was confined at the age of 40 in 1902 until her death in 1919. Described upon admission as a "spinster" this woman spent her time "at fancy work, can make very pretty collars and cuffs, table centres, handkerchiefs, etc. with honiton braid...shows it to the best advantage by placing colored paper at the back of it."(74) There was a reason for this careful display, beside pride in one's abilities. Laura had earlier tried to make some money by asking people in the hospital to buy her work.(75) The self-sufficiency of these patients shows how some inmates tried to provide for themselves rather than feel obligated to wait for others to provide for them through the expected process of working for one's board among lower class patients.

The therapeutic component of institutional work continued to be promoted by officials throughout the first half of the twentieth century, and so too did the economic benefits to the provincial hospital system. In 1928 labour was touted as being of "real healing value" as patients did much of the work in "various trades."(76) In 1934, it was
noted that inmate labour contributed "in a very practicable way to the upkeep and maintenance of hospital grounds, industries, wards, etc." and also contributed to the physical and mental health of patients. (77) Building projects were mentioned during the 1920s and 1930s, such as the reconstruction of the laundry in 1928 to allow for more light and air, though there is no reference to the involvement of patient labour. (78) Superintendent S.R. Montgomery reported in 1941 that patients worked in many of the same areas that had been established during the late nineteenth century. This included wards, kitchens, dining rooms, the laundry, shoe repair shop, carpenter shop, paint shop and garden, all of which he claimed were supposed to be therapeutic. (79)

Provincial statistics on labour are absent for two decades up until 1927, and when these figures re-appear it is only for a decade and with much less detail than the earlier period for which evidence exists. Nevertheless, these statistics, as reproduced in Table IX, do reveal that the decline in overall employed inmates at Toronto which began in the early 1900s was continued during the intervening years. With the exception of 1928, there was never more than half of the hospital patient population at work during the 1927-1937 period, a figure which dropped below one third by 1931, before picking up during the following six years. The eleven year average of employed
patients was 41%, a notable decline from the average of 55.33% for 1905, this latter figure recorded in Table V.

The most glaring feature of these later figures, is their consistency with the earlier set in one crucial area: gender bias in favour of men patients. The earlier figures do not afford a precise breakdown of how many women and men worked at every specific job, except where there was gender exclusivity, though they did show how many work-days were done by both in comparison to the general population. The statistics from the 1920s and 1930s, while less detailed in types of work, and offering no work days’ breakdown, do show exactly how many women and men worked overall. Without exception, women patients were consistently underemployed in hospital labour between 1927-1937, in contrast to men and their respective percentage within the overall patient population. The closest was an 8 1/2% difference in 1930, while this disparity soared to 52.8% two years earlier. The eleven year average reveals that while 41% of the entire inmate population were employed, a disproportionate number, 54.66% of all male inmates worked at one time or another, while only 29.5% of the total female population were occupied with hospital labour during this same period. As with previous decades, women were concentrated in inside work, with the industrial occupation category being laundry jobs, while men still had sole preserve of farm and garden labour, even though this was far reduced from the earlier
period. Thus the 1918 report of women working outside the infirmary does not appear to have been continued for long.

The question of why there was an overall decline of inmate labour may have been partially due to the general increase in patient population by the 1920s and 1930s, with fewer jobs available and most choice of work going to men. However, a clearer explanation is offered in Table X, listing attendance at vocational and occupational classes between 1931-37, and the unspecified "Special Occupation" category, the only area reserved again for men. These figures show that women made up over 79% of patients who were engaged in these categories. During the seven years for which statistics exist, there was an average of 82 women involved in these activities, as opposed to 21 men. This indicates that a significant number of women who would have been previously employed within the internal labour system were shifted to non-labour classroom work by the 1930s. Thus, institutional labour practices were supplanted in part by occupational therapy programmes primarily involving women during the last years of this study for which statistics are available.

Andrew Scull has written that the actual employment of patients in 19th century British institutions was far removed from the therapeutic aims of the architects of moral therapy. In reality, work allowed institutions "to run more smoothly and more cheaply."(80) Considering the fact that Toronto was primarily a chronic-care facility where employed
patients worked for years, even decades, the therapeutic achievement appears negligible in contrast to the financial achievement, a dual goal which was proclaimed from the earliest days by hospital officials in Ontario. The lack of official optimism in the belief that work was in fact therapeutic is palpable in the much more muted references to this point in annual reports during the period after the early 1900s. Peter McCandless has noted that by this time in the United States greater pessimism had developed towards work and leisure therapy, as moral treatment gradually declined while asylum populations grew. A greater emphasis was placed on the somatic basis of insanity among physicians who looked to Kraepelin rather than Tuke for their ideas, which explains in large degree why work therapy, though still proclaimed, was no longer emphasized as strongly by Toronto's Superintendents after 1905, when Daniel Clark retired. With an ever-increasing inmate population, work as therapy seemed less of a promise to cure insanity, than an effort to keep in place a decades old patient-labour system that reduced internal costs. What patients felt about this work and whether they viewed it as therapeutic forms the remainder of this chapter.

Labour and Compensation

Ellen Dwyer's study of patient life during the 19th century at two asylums in New York state highlights the need for more patients' perspectives on this subject. After describing the contemptuous views of one assistant physician
towards employed inmates, Dwyer wrote that "no one knows" what patients thought of work as therapy. (82) As the following pages will illustrate, inmates thought a great deal about the place of institutional work in their lives. While mental patients were not paid for their labour, it is important to recognize that some patients raised the issue of compensation with staff and family members. This happened during and after confinement and reveals how unpaid labour was not something which all patients accepted without question. The following examples will also show that money was not the only way in which some inmates tried to have their labour rewarded, though the most clear-cut examples of patients asking for some form of compensation are women and men who asked for a wage.

The manner in which the comments of one such inmate were recorded also helps to reveal something about official attitudes on this subject. Josie B. had been confined for just over seven years, during which time she had been employed in the laundry. In 1913 the file for this 33 year old woman records an observation that speaks volumes about the way in which some inmates advocated on their own behalf: "She is constantly demanding her wages and by her conduct and conversation shows that she does not realize her position as an Asylum patient. She seems to think she is employed here and is not receiving her pay." (83) These comments in the clinical record are aimed at driving home the point that Josie’s desire for compensation was a sign of
her insanity. The male recorder’s writing “that she does not realize her position as an Asylum patient” says as much about the official attitude towards unpaid patient labour as it does about an inmate’s advancement of her rights.

The emphasis in this quote is intended to convey an image of Josie being mentally unstable because she is making supposedly irrational demands that are completely out of place for her status as a patient. Yet, this observation can also be read as the unintended record of an inmate putting forward claims that many contemporary union organizers and advocates of women’s rights would have seen as entirely justified, had Josie been working outside the asylum. The fact that her "position as an Asylum patient" prevented her arguments from being taken seriously by medical officials illustrates how inmate labour was exploited and discriminated against, a point which was recognized and protested by some inmates who were occupied in unpaid labour at that time. For Josie there would be no compensation, as she would die two years after these comments were recorded. While she was still alive, her ability to stick up for her rights made quite an impression on at least one other inmate. In 1910, after her own release, Elaine O. had written a plaintive inquiry about this laundry worker: "What about Poor Josie B... to think you cant give any one like her what her mind and ability requires her to have with out fighting..."(84)
A male inmate made similar requests and eventually convinced himself that his demands were met. Jonathan T. was confined from 1890-1930 when he was discharged at the age of 78. During most of the last twenty years of his residence, this man was reported to have worked faithfully in the kitchen, but it was also noted on several occasions that Jonathan had definite ideas about getting something for this work. In 1927, he told physicians that he deserved "a large sum of money for his services."(85) A few months later, Jonathan was recorded as having a delusion that he had been given a total of $7,000. for work at 999, which in fact did not occur.(86) By deluding himself in this way, this elderly man was "rewarding" himself for work that no one had paid him to do. One inmate turned this question upside down, by believing she had to work to earn her keep, just as the administrators stated. Enid W., a school-teacher, was said to have a "mania to scrub floors" which she believed was required of her to pay for the institutional clothing she received.(87)

Even a patient who was recorded as not working on a regular basis, was known to ask for payment after taking on an occasional task. Constance B. spent the last twenty years of her life at 999 until she died in 1926. On one of the few occasions in which she is recorded as having done institutional work, this 76 year old woman had dried the dishes for several days after which "she asked the nurse how much she would get for it."(88) It was also noted that she
was "too deaf" to understand what was said to her, so while this elderly woman was able to communicate her feelings to staff, she was unable to hear any oral response to her compensation request. (89) After this reference, three years before her death, there is no mention that Constance did any other work during her last years. Another inmate appreciated this lack of monetary gain prior to doing any hospital labour and decided on a course of action beforehand that settled matters quite definitively. Marianne B. was a 57 year old woman who had refused to work at 999, since she said she "is not paid for working in an Asylum." (90)

The most well documented person to request financial compensation uncovered for this thesis was of a patient who had left 999 Queen Street West, only to write back to advance her cause. Mary A., was sixty years old upon her release in 1911. After leaving under the care of her husband, she wrote letters sporadically to asylum officials, notably in the months after returning home and in early 1922. Among other things, these letters reveal her memories of labour while confined beginning in 1894. During this time she had been employed in the laundry. In one of her first letters a few weeks into her probation, she wrote that she had been "hoping it will be alright and that after being a hard worker in the building for 17 years I could have an extended leaf (sic) of absence... I have had no holiday..." (91) A few days later she wrote, "if I could
do the work I used to I should not feel so bad because I
know full well that every body has to do a certain amount of
work for their living." (92)

At this early stage of her post-asylum life, Mary was
still unsure about whether she would be allowed to stay out
permanently, and was initially trying to justify her
release, which the doctors had reluctantly consented to, as
a reward for her labours. Her second letter also shows how
this work was something she felt obliged to do as part of a
wider community. Yet as the years proceeded and it became
clear that she and her husband, Henry, would be able to live
out their final years together as they had wanted, Mary
became bolder when addressing this issue. Why she decided
to take up the cause after so many years of apparent silence
is unclear, but the following excerpts say something about
how important obtaining a just settlement was for a former
patient-labourer at 999. In 1922 over a decade after being
discharged, Mary again wrote to her former doctor, who was
by this time Medical Superintendent Harvey Clare. In these
letters she requested compensation for her years of work at
the institution.

[W]ord was sent to me while I was in No. 7 ward that I
was to earn my own living[..] now why should a married
woman earn her own living... every body that earned
money received theirs but received none but was kept a
prisoner not aloud to go out any where[..] now in 1910
a Mrs. M____ an insane woman pushed me over after I came
from my work + I received a compound fracture of the
leg + hip that was when I had to quit my work which I
always did... now don’t you think that the money I
earned should have been sent to me when I came to live
at 16 ___ Street. I want it. Please will you send me word why I did not receive it.(93) [Original writing].

The references to the year in which an attack by a specific inmate took place are corroborated in the clinical record.(94) Mary was released a year after this assault thanks to her husband's persistent support. In response to this letter, Dr. Clare wrote that she should not worry about a job: "I think you have done your share of work in this world."(95) Undaunted, Mary again wrote to Dr. Clare about compensation a few days later.

When I asked for information from you I knew how much I had earned while working in the asylum[.] I earned a pretty good amount at 3 dollars a week that is for the 17 years imprisonment it was 1248 dollars[.] I really think a little should have been sent to me by the paying clerk when I left the asylum every month say about 25 dollars. Now Mr. A__ has...retired...so we require every cent we can get[.] you will not work for nothing you want yours and know where to apply for it which I don't...(96)

After no response was received she wrote again to Dr. Clare asking him to acknowledge her inquiry and requesting her letters be shown to the "new Mayor Mr. Maquire and the new Magistrate to see what they can do for me..."(97) Clare apologized for not responding sooner, noting that he had been ill, acknowledged her concerns, and concluded, "You must not worry about anything, just leave it in my hands, trust in me and I will do all I can to make the matter right."(98) In her final surviving letter, Mary wrote that she wanted this issue settled before her death as "if not done quickly I shall not need anything it will be too late."(99) There is no further correspondence in her file.
on this matter, and just over a year later Mary A. died in May, 1923, never receiving the compensation that she had requested.

There were other ways in which patients asked to receive some official reward for their work, beside wages. A contemporary laundry worker of Mary's had similar feelings about the practical worth of her labours. Jane F. had been a domestic servant prior to confinement in 1895. In 1909, it was noted that Jane believed she did "more work than any twelve people" at 999.(100) Two years later, she wrote to her sister: "I have worked in the Laundry for 13 years so I think I ought to be able to come home...I hope we will meet in heaven."(101) In effect, Jane was asking to be "retired" from her job by having her sister take her away from her work-place. Her wish was never granted, for just over a month after she wrote these words, this 67 year old woman was dead from epileptic exhaustion.

Another inmate who made a similar request was more fortunate, at least over the long-term. Elsa W. was admitted to the asylum in 1898 at the age of 44. She was reported to have worked about the ward doing house-cleaning tasks.(102) Like Jane, she felt that her work entitled her to be let out and made this clear in a letter to Dr. Clarke in 1909:

If it is required of me to give you a written resignation I wish to do so now. It seems to be the general impression that I have taken up a permanent position here, which I never intended to do... While here I have tried to do my true duty to God + my
neighbor to the best of my ability. I wish you to understand that I wish, from this time, my release from this institution and my self-imposed duties, which I tried to do in the true spirit, hopefully awaiting my release...(103)

Elsa would have to wait over five more years after writing these words to get the freedom she felt her work entitled her to. Significantly, her reference to "self-imposed" duties suggests a degree of choice in her work that other inmates did not record. But it is also clear that in the context of her letter, she felt that the work she did should improve her chances for discharge.

For most inmates for whom evidence on this subject exists, compensation requests meant what they do for most people: wages. But for a minority of others, years of work could also be used as a way to barter their way out of the asylum. None of the people mentioned above received what they had been asking for in the way of compensation for their work, other than Elsa, and in her case her barter suggestion made no apparent impact as she was released long after writing to Clarke, by his successor as Medical Superintendent, Dr. Forster. However, these requests show that patients tried to explain to themselves and to others the need for some form of tangible gain from their hospital work. In so doing, they were telling their contemporaries that their labour should not be taken for granted.

Perhaps the most poignant example of how an inmate used her labour to extract some form of compensation is from the story of Violet N. who was 68 years old at the time of her
death in 1922. Abandoned by her husband, she had been confined since 1889. Dr. Vrooman wrote the following testimonial to her years of labour after she died:

This poor old lady has been here 33 years, and to my certain knowledge for 12 years, and I do not know how much longer, she has worked willingly and faithfully and has done all the drudgery and unpleasant tasks about the admission ward. She was very jealous of her duties and was very displeased if anyone else was allowed to do any of her work; I may here state that as far as I know there was practically no rivalry for the position. The only thing that she ever asked was to have a little fruit, which she seemed to enjoy... She finally died from diabetes after a short illness... She was a strong, deep chested, thick woman, weighing about 200 lbs. She had always been robust and it was rather pathetic to hear her say that she couldn’t understand it, that when she wanted to get out of bed her legs would not hold her up. She was buried by the hospital. Although it is not likely that anyone will ever read this account, as she was friendless, I thought I would like to write a record of her faithful services.(104)

For someone as isolated as was Violet, her work was compensated for by what would seem like a small pleasure to most people on the outside: "a little fruit."

Labour and Self-Esteem

For many patients at 999, labour not only kept them occupied but it was also closely tied in with their feelings of self-worth as contributing members of the community of which they were a part. As the following accounts indicate, certain designated tasks were taken very seriously by men and women whose life often centred on their jobs.

Theodore F. was confined at the age of 19 in 1898 and remained at 999 until his discharge in 1940. For years this man worked in the laundry and basement, but there was one task of which he was particularly proud. This was his daily
trip to a store across from the Queen Street facility to collect newspapers for the staff, as well as mail and other errands. It was noted that "He looks upon this as a very important part of his days work."(105) In the fall of 1926, Theodore became ill and was replaced by another patient in the daily newspaper trip. After recuperating, another man with whom he worked at the laundry, forbade Theodore to resume his old paper route which, according to his sister, he missed very much as it was a "pleasure and a little diversion" for him.(106) His clinical record notes that by early 1927 he was given back this particular job, following requests, as it was "about the only interest" he had.(107) Theodore kept this job until December, 1933, after which date no further references to it are made, most likely due to pneumonia and bronchitis that incapacitated him for ten months beginning in January, 1934.(108) After recuperating from this severe illness, he was transferred out of the laundry department, due to a lung abscess, and was instead employed taking care of the rats and guinea pigs that the hospital kept for medical tests, from 1936-1939, right up until just before his release.(109)

Walter G. was confined from 1898 to 1950 when he was transferred at the age of 75 to an old person's home. From 1926 to 1950 officials wrote that he was employed in the bake shop.(110) At one point it was observed that he took a great interest in his work, but in little else.(111)

Mathilda K. spent her last forty years in the asylum until
her death at the age of 76 in 1938. Like Walter she was without financial support throughout her residence, and so was a prime candidate for working to earn her board, which she did by daily toil in the dining-room and laundry. Her self-esteem in regards to this work is evident in a number of observations recorded about her conduct and views towards institutional labour. This diminutive woman, whose weight was listed only as high as 90 pounds, stated she considered herself a paid employee at 999 and was very protective of her duties, chasing any other patient-labourer out of the dining-room where she worked, to keep them from assisting her. (112) During the last year of her life, Mathilda's job was cut back due to her age, "to which she objects and she has become more disagreeable." (113)

Sandra T., confined in 1903 at the age of 38 spent the last twenty-nine years of her life at the Toronto institution as a free patient. Six years after admission, this black woman made references to white people being her enemies and how she needed to protect herself from them by keeping a weapon under her mattress on the ward. (114) From 1909 until 1922, Sandra is recorded as having been a regular worker in the asylum laundry. (115) Yet while she was known to "curse" staff when they made their rounds during this period, it was also stated that, when employed at her daily occupation, Sandra "seems to be happier there than when she is in the ward." (116) Similar positive feelings that she clearly had towards her laundry job are mentioned when
Sandra was forced to stop work due to cataracts over each eye, which eventually led to blindness during the last decade of her life. When this happened in 1922, Dr. Vrooman recorded that Sandra "feels rather depressed about having to stay on the ward, but understands why she cannot go to the laundry."(117)

Feelings of self-esteem were expressed in concepts of ownership towards certain positions an inmate had been holding for years. A waitress before admission at the age of 30, Edna B. had been confined for thirteen years when it was recorded that she claimed to be a housekeeper at 999 Queen Street West.(118) Considering the tasks she was recorded as having done, this is an accurate self-description. Her "rough work" included scrubbing, washing dishes and making beds, assisting with the bathing of patients, and working at the nurses residence.(119) Edna was recorded as having been especially interested in this latter job. Her clinical chart shows that when she was sick in the infirmary for a week in 1921, Edna asked "if everyone is well at nurses home and says she would like to be back to work."(120)

For lonely inmates, work and the sense of purpose it gave, could help to pass the time and give a feeling of self-worth. Mary M. was an elderly free patient who was not known to have any visitors, except her daughters at Christmas.(121) Isolated from any regular outside support, she was said to be "not of much use" as a labourer, even
though she liked to go around doing "odd jobs." (122)
Considered a "quiet old lady, quite stupid and rather frail," she worked with a staff member and helped by doing dusting on the ward until her health began to decline. (123)
The impression obtained from these comments is of an elderly woman who wanted to do some household work as a way of feeling better. Perhaps such duties allowed a friendless patient like Mary to cope with her loneliness. Another patient believed his labour, while not essential, was nevertheless too onerous for others, so he needed to stay at his post. Warren S. stated that while the laundry could get along without him, "it would be a trial on the hospital staff if he left," as he claimed it took three men to do his job. (124)

Audrey B. is perhaps the most vivid personification, among the people discussed here, of how an inmate's self-esteem became so thoroughly wrapped up in institutional work that there seemed nothing more important than getting back on the job. Confined at the age of 39 in 1905, this former domestic servant remained at 999 Queen Street West until her death in 1946. During this four decade period, documents show that, with the exception of several years in the mid-1920s when she was working in the men's dining room, Audrey worked almost constantly in the asylum sewing room from at least 1910 until early 1943. (125) Her views towards labour and self-worth are brought to light in a number of comments, particularly during the latter years of her institutional
work-life. The earliest comments, in 1910, state that she was "very dissatisfied," and five years later Audrey was said to be "negativistic" to those around her. (126) By 1927, when it was noted that she "never misses a day" in the sewing room, she had changed from her previous mood to one in which she had become quiet, except for repeating comments about "my wonderful self," as well as about how much people wanted to be with "such a lovely lady." (127) Unlike her previous demeanour, 67 year old Audrey was not reported to be resistive and was even known for her wit as when a physician asked her age: "I guess I’m 300 or 400 years old." When asked if she wasn’t 600 years old, she said ‘Gracious what do you think I am, people just don’t live that long.’" (128)

Throughout this alteration in character, she worked daily in the sewing room. As she grew older, there are references to how this job seemed to affect her "where she is more content than when left on the ward." (129) After a brief illness, Audrey became upset at missing sewing room work where she felt she belonged "to see how things are getting along there." (130) At the age of 72, she still went every day to her old job, at which Dr. Howitt said she was extremely skilled. (131) The following year a clinical entry noted that Audrey literally worked to exhaustion, wearily leaning over her sewing machine, and so was put to bed, but she was back on the job within two weeks, "because she insists on going." (132) As her health became more fragile,
Audrey was frequently kept on the ward, about which she was very unhappy, standing by the door asking to go to work, as this 1940 observation mentions:

She works regularly in the sewing room making underwear. She is under some pressure of activity and if she is not allowed to go to the sewing room to work at what she has done for the last thirty years, she will pace up and down and will ask why Miss Bowden does not come for her.(133)

Audrey’s persistent campaign to be reinstated at her old job was successful, as she was allowed back for half a day in the sewing room in the Spring of 1941.(134) This 75 year old woman also worked in the kitchen after meals.(135) The last references to her sewing-room work are from early 1943, when Audrey would have been 77.(136) It is apparent from the evidence that the last few years of this labour were more sporadic than in the period up to 1940. It is also evident how much this work meant to this isolated woman who had no visitors. There are fifteen separate entries in clinical records and charts during these last few years, in which Audrey repeatedly asked to be allowed to go back to the sewing room, while in the infirmary or on the ward: "asks frequently - who is working in the sewing room + why can’t I go."(137) As Audrey became increasingly confused about her surroundings, this poor old woman spent her last three years away from the job to which she had become so devoted, as her health deteriorated leading to her death in 1946, after a lifetime of institutional work.(138)
A Tale of Two Accounts: Mabel M.'s Institutional Labour

Obtaining a clear idea about what asylum work was like for an inmate is made more difficult by lack of first-hand accounts or perspectives from people outside the asylum walls. While documentary evidence, such as for Audrey B., indicates overwhelming eagerness to work, just one letter from a non-medical observer can throw this whole picture into question. Perhaps this is best illustrated by the contradictory accounts provided in medical documents and in a letter from the daughter of Mabel M. This material also shows the vast amount of labour that an individual inmate could do while confined as a long-term patient.

Mabel M. lived for over four decades at 999 Queen Street West, beginning in 1904, until her release at the age of 83 in 1947. For over thirty of these years, beginning with the first reference to her labour in 1912 and continuing up until the last such work-related observation in 1943, it is possible to follow this abandoned wife and mother of two daughters, as she kept constantly occupied in the daily tasks of the hospital. For this patient, her work was something in which she seemed to take great pride. It was also evident that this work was not moderate or light.

Eight years after her admission, it was noted that Mabel worked every day "galloping over to the laundry like a child of eight," though a few weeks later it was also recorded that she dusted and swept around the ward. Her laundry work was observed repeatedly over the years,
noting in 1922 that Mabel "is one of our good machine workers," indicating her duties were to operate the washing machine, while others sorted and pressed material at this place of employment. (141) She continued in this job until she was 61 in 1925, twelve years after the first reference, and then this "garrulous old woman" was reported to keep busy by working on the ward. (142) By late 1927 she was toiling in the dining-room, and two years later was "always busily engaged" in the ward's diet kitchen. (143) By 1932, 68 year old Mabel was again complimented on her hard work, this time in the kitchen of which she had taken "complete charge" and kept everything "spick and span." (144)

Time and again, her colourful personality was remarked upon. This ranged from her "remarkable" knowledge of local gossip, which she was "only too ready to repeat," to her reputation as the "greatest talker" at 999, sounding "like a phonograph," while another time ordering the staff to Kingston Penitentiary, and giving the impression that she saw herself as "the most important member of our community." (145) At the age of 71 she still kept the kitchen in good shape and four years later she was again said to be "an excellent worker." (146) Mabel put her ward cleaning work to personal use where she slept, with characteristic flair. In 1941 she placed three mouse traps under her bed, which she said "were for the three blind mice." (147) But her age was telling on Mabel's energetic lifestyle. By late 1941 it was recorded that her
forgetfulness caused this now 77 year old woman to mix up
the laundry where she continued to do some work, and she
was also said to be "too old" to work in the kitchen, though
only the year before she was said to have been "domineering"
with both patient and staff co-workers. (148) Mabel still
"insists on helping about" in the ward kitchen in early
1942. (149) By the end of that year, "each morning" Mabel
went about scrubbing the floor of her dormitory where she
slept, though three months later she was said to be
"sloppy." (150) In June, 1943 Mabel M. was 79 years old and
observed to be very feeble, but still "insists" on working
about the ward. (151) This is the last recorded observation
of Mabel's hectic work life at 999. She gradually became
disabled, until she could no longer walk by 1945, though she
maintained a lively interest in what was happening around
her. (152) In 1947, after forty-three years in the asylum
Mabel's daughter, Ivey L., took her mother out to care for
her at home during her final days. (153)

If we look at these decades' long medical reports of
Mabel's work life, it appears that this woman was a willing
participant in the labour regime at 999 Queen Street West.
This seems so much so that towards the end of her working
life, from 1941-1943, the references about Mabel seem to
hint at a certain reticence among the staff in allowing her
to continue working into her late seventies. Yet the only
non-medical report about her working conditions gives a
somewhat different picture, at least in regard to her
earlier years of working in the laundry. Ivey L. undertook some rather lengthy and difficult negotiations with hospital officials to secure her mother's release in 1947. At one point, she wrote a heart-rending letter about her personal life, noting how, as a ten year old girl, she and her sister were placed in an orphanage after their mother was confined and their father abandoned them. Ivey wrote that her mother refused to accept any items she had left for her at the Queen Street facility as Mabel said "she was working for the hospital and that they should supply her needs." (154) Ivey also wrote a particularly revealing passage about why it was so painful to not take her mother out of 999 sooner:

It was not easy to have to leave her there, knowing how extremely hard she was working. I have no doubt but that in the resident doctors' opinion, my mother was better kept occupied, but it was not easy knowing the long hours she spent in the hospital laundry. I have been told by former nurses from the Ontario Hospital, that my mother had to work extremely hard as long as she was able. (155)

Thus what comes across as a somewhat benign labour system in the official medical records, appears much more demanding and exploitive, when seen through the eyes of Mabel's daughter, and in the comments of this patients' nurses, to whom Ivey paid "sincere tribute" for their "very human interest and understanding" of her mother. (156) The point of this contradictory evidence is to show that while it is possible to follow a patient throughout much of their career as unpaid hospital labourers, it is much more
difficult to reveal what individuals felt and experienced during years of toil while confined in a large institution.

**Conditions of Work**

Evidence on the description of the specific conditions under which inmates worked, from the point of view of patients or outside observers is scant. But what does exist reveals the often stressful environment of institutional labour, as well as the mundane nature of such tasks. In the early 1900s, Timothy P., a man in his fifties, wrote about both his work duties, and on-the-job injuries:

...while in that ward [12] I did with alacrity any work I was told to do and this while waiting for the breakfast bell to ring such as sweeping floors, making beds and cleaning the woodwork.(157)

More than ten years back I had my spine hurt, helping Johnny D____, who died a few weeks ago, to carry one four seated and another three seated form (sic) out of the chapel.(158)

Records show that in the two years leading up to his death in 1912, Timothy no longer worked, stating he was not well enough to do so.(159) Whether he stopped working permanently as a direct result of this injury is unclear, though the letter in which this reference is made suggests that he no longer did heavy jobs. In this particular case, the patient's own writing shows he maintained a willing attitude towards his work. However, his comments about on-the-job injuries bring to light the physical strains caused by institutional labour.

These strains would have been most obvious among the elderly and those in declining health. Age and frail
physical conditions did not prevent hospital officials from continuing to employ some patients as long as possible. Janet C. was 58 at the time of her death, to which Dr. Vrooman paid tribute for her years of work, noting that, "she was most faithful and efficient in the discharge of her duties in the officials’ dining-room, where she made toast, did any cooking there was to do and generally managed the place."(160) Noting that she had suffered for the last two years from auricular fibrillation, Vrooman wrote "it is a wonder she has been able to carry on as well as she has," until just a few weeks before her death in 1923.(161)

The issue of work place health standards is raised when considering the following example of an elderly patient who worked for years around paint fumes. Well into his early seventies, Edward D. was reported to have worked every day mixing paints at the paint shop, even after fifty years at 999. It was noted that this old man preferred to lie in bed, during the last years of his life, suggesting he was too tired for work at his age.(162) However, the record shows that he continued to work in the paint shop for over four more years after this observation, until he developed skin and chest problems in the months before he died.(163) Whether Edward’s health was adversely affected by so many years in the paint shop is not stated in the file. However, in 1925, seven years before he died, there begins a series of clinical reports about how this man complained of abdomen problems and sickness, which was put down as being due to
old age. He continued to work in the paint shop until September, 1931 when he was 72. (164) At this time Edward’s skin erupted over his chest, shoulder, and arm. His condition deteriorated and he died in January, 1932 of pneumonia and heart problems. (165) At the very least, this old man’s place of work would not have helped his physical condition, particularly as he began to decline in the mid-1920s, when his file indicates he wanted to rest much more than before.

Patients who were severely mentally deteriorated, but in good physical shape, worked so long as they could be directed about in their daily tasks. Each of the following people was considered “feeble-minded” and incurable. Theodore R., a farmer, was said to be one of those “harmless demented who make useful patients” by working around the facility. (166) Another such patient, an elderly man named Jimmy M. who had been a tailor and tinsmith, lived in the asylum for over fifty years, where he worked in the basement until his death in 1927. (167) Some of the official references to patient labour contain interesting editorial comments on the author’s view of this work in the wider scheme of things. Farmer Carl M. was 68 when it was noted that his work around the basement allowed him to “eke out an existence which, while devoid of most of the excitement and distractions of modern social life, on the other hand presents none of the difficulties of the present strenuous struggle for existence.” (168)
Yet it is apparent that the emotional toll work could take on mentally distraught patients shows inmate labour could be quite strenuous and was not a refuge from the outside world for some people. Elaine O., a forty year old woman at the time of her discharge in 1910, wrote dozens of angry letters to the asylum authorities about her treatment, one of which includes a labour-related reference: "the idea of working a person to death why dont you treat a person according to age and accountability." (169) While there is no indication in Elaine's letter about what type of job she was referring to, her comment, along with the following example, suggests work was not too therapeutic for some patients.

Advocacy efforts by May K., the sister of inmate Anne D., are discussed in the chapter on family and community responses, to get Walter D. of Calgary to pay support for the wife he had abandoned in 1906. May also left behind accounts of her experience with the asylum's labour regime while visiting her distraught sister. In the Summer of 1915 she wrote two letters to Dr. Forster on this subject:

I saw a little also of the loving care she gets while I was there. the nurse in charge of her came into the room while I was talking with her and told her she ought to be scrubbing the floor. She is not in the asylum to scrub floors but to be taken care of... (170) [Original writing].

I insist upon my sister having a comfortable room and proper care in the asylum and given simple tasks that are congenial to her. she used to be fond of sewing and it is perfectly all right for her to do things of that kind, but I will not have her scrubbing and doing all kinds of menial work and I will have Mr. Coatsworth...
take the matter up with the asylum authorities if it is not stopped and she given a chance for her life and sanity. it is inhuman brutal the way she has been treated there.(171) [Original writing].

Anne’s institutional work-life was very unstable, as she was reported at different times to have worked, though her tasks are not specified, and was also said to be "not fond" of asylum employment, while at other times she was too distressed to work.(172) Whether May’s letters had any effect on this issue is not documented, though in 1925 Anne was said to have washed dishes and polished the floor when she was not upset.(173)

Jack P., who was confined for four months in 1907, provided about the only picturesque glimpse of labour conditions uncovered for this thesis, in this case the daily walk of inmate-labourers from their residence to place of work. While his observations begin in a cheerful vein, this writer hints at the deeper sorrow beneath the surface.

The female patients who assist in the laundry have just gone over (a procession of many colored gowns, blue, red, even green and white aprons) some with their arms around the female attendants waist, so this is elegance of art where least expected, the slow easy walk -- no rush, excitement or competition. But of course all is not as it seems, and I daresay there are many poor broken spirits among them who have such memories of past happiness, and some who cannot quickly catch the passing sunlight, brief tho’ it may be.(174)

Third party observations about the physical appearance and clothing of female inmate-labourers provides additional information on conditions inside the laundry, which are less florid than that provided by Jack P. In 1904 a lawyer wrote on behalf of Mary S., the sister of Hazel G., a 52
year old woman who had been confined since 1892. W.J. Clark wrote to Inspector Robert Christie that the deceased mother of this patient had left enough money for Hazel to be clothed. In spite of this, Mary S. was "astonished to find that absolutely nothing had been expended for clothing for her sister, and that she was so destitute of clothing, she had not sufficient to allow her to come out of the wash room where she is kept working."(175) Medical Superintendent Daniel Clark responded to an inquiry from Christie that requests for clothing from friends of the patient had previously gone unanswered, but future supplies would be purchased and billed to the estate. He then offered the following glimpse of working conditions for women in the laundry:

The patient works in the laundry + when at work we furnish half worn clothing. Her work is to do ironing + it is dry and easy work + is good for her. Over twenty of our women patients are thus employed. None of them work where it [sic] is not new to that kind of work.(176)

The physically demanding nature of laundry work, especially when lifting heavy irons, raises questions about whether this was really so "easy" as Dr. Clark suggests. What these women workers felt is impossible to say, since they left no first-hand accounts. However, third party observations about the conditions in which laundry workers toiled, from Ivey L.'s letter about her mother Mabel M. having to work so long and hard, to the above quoted reference from Dr. Clark about "half worn clothing" provided for women employees in the drying department, suggests that
this was not "soft" work by any means. An observation by the sister of a male laundry worker provides further evidence that working conditions could wear one down. Wesley P. had been confined since 1895, when his sister, Laurie D. wrote in 1912 to the hospital that her 41 year old brother "looked so pale + thin the last time I saw him. I suppose doing laundry work, he does not get much fresh air..."(177) Dr. Forster responded Wesley was in good health and that he would see to it that he was well taken care of.(178) Two years later this man was discharged after returning to his farming community.

Medical observations support the contention of outsiders that patients worked very long hours, as noted in reference to 45 year old Rhonda D. In 1910 it was noted that from "morning till night she goes through all sorts of work" including washing, ironing, cooking, sewing, teaching music and singing.(179) By Tuke's definition moral therapy was to be light in nature for it to have a redeeming effect on an individual's mind.(180) However, it is apparent that this therapeutic approach was less emphasized among able bodied workers at 999 where a demanding regimen turned tasks into a job like any other outside the asylum. The significant difference, in comparison to work in the community, was that there was no pay.

Some lower-class patients could be rewarded after years of steady work. Usually, this was possible among the most privileged inmates, whose reliability at their jobs was
credited by giving them greater freedom to roam. This was most obvious for those patients who could go to and from places of work with relatively light supervision. Jake M., whose pre-admission occupation was listed as a "huckster," wrote an undated letter about his various duties while still a patient at the hospital, around 1915, though he was working outside 999: 

I did not get back on Tuesday night but I did good work on the lawn so Jm. Forester said[.]. I trimmed the undergrowth around the trees and I cut all the lawn filled in some of hallow spots in preparation for the seed[.]. I raked all the dead chips[.] the other man quit and I have not filled in the gate ways yet as there is no cart there and it would be rather slow work for one man man loading the wagon[.]. I am going to trim the bushes tomorrow and I am to stay with the contractor at night Jm. Blacklock so please don’t worry.... Every day I see a change on the inside of the House...(181) [Original writing].

The clinical record mentions that this patient was considered so trusted and reliable as a labourer that, beside working around the asylum grounds, he was also sent out into the community to work at various homes, including places owned by Superintendent Forster and another physician. As a result of these efforts, this 56 year old man was discharged as recovered after eighteen years' confinement in 1915.(182) Thus for Jake M., there was a considerable degree of freedom that was directly related to the type of work he did, and the relatively unsupervised conditions in which he was allowed to operate.

The records also show that this sort of privilege was unusual as most patients remained confined behind the walls
of 999 Queen Street West for the duration of their institutional work life. More common was what happened to Daniel K., a teacher, who was known as a "good milker" with the dairy cows. (183) Ellen Dwyer has mentioned that inmates at the Utica and Willard State Asylums in late nineteenth century New York only had ground privileges to go to and from work. (184) As is mentioned in the chapter on leisure, a minority of inmates, about one fifth, or 160 people out of the overall asylum population of 700 to 800, were accorded wide-ranging probation of the grounds in Toronto. (185) This would mean that in the late nineteenth century most of the 420 to 480 inmates who worked, 260 to 320 people, did not have unrestricted freedom, similar to Utica and Willard. This is a conservative figure, as records also show that some of those who had ground parole were elderly inmates who no longer worked. So there were probably even more patient-workers who had no general parole outside of work, than is suggested above. They were escorted to and from work, as the above quote from Jack P. suggests. Even those who did have relative freedom to wander to and from the job, were subject to loss of privileges should they transgress the rules. This is what happened to Daniel who ran away at the age of 63 while doing his job of carrying milk cans around the buildings, only to be returned a few days later. Thereafter, he was put to work in more closely supervised jobs, as a polisher and tinsmith, never getting back the job he had previously held
for years and to which he wished to return. Daniel was released to an old person's home three years later to live out the last days of his life.(186)

Conclusion

The evidence presented here shows that inmate labour played an essential role in the lives of patients and in the internal economy of the Toronto Hospital for the Insane. It is abundantly clear that unpaid labour, and the immense amount of work patients did, saved administrators a very significant, though generally untabulated, amount of money. It is also clear that while patients were housed and fed some inmates, like Mary A., did not feel that this was adequate compensation for years of work. The devotion to their jobs that people like Audrey B. exhibited, also showed how labour could provide a significant degree of self-esteem, especially for the most isolated of inmates. There are references among administrators about the therapeutic goals of labour into the 1940s. However, records also show that the constant demands of these labour-intensive jobs, with men and women toiling as long as possible, indicates that patient work was much more intense than any light type of duties that the architects of moral reform had envisioned. Thus, as the hospital's labour regime became more entrenched over the decades, the stated therapeutic aims of superintendents was replaced by a demanding system in which producing for the overall well-being of the
institution superseded work acting as a curative agent for unpaid inmate labourers.
Notes:


3) Ibid.

4) Warsh, *Moments of Unreason*, fn. 2, p. 197. For an account of occupational therapy in the early 1900s, see: C. Floyd Haviland, "Occupation for the Insane," *American Journal of Insanity* 69:3 (January, 1913): p. 483-495. During the 1970s and 1980s, occupational therapy was craft-oriented (pottery, drawing, woodwork), whereas industrial therapy was paid employment for specific tasks, either within a mental institution or at a sheltered workshop in the community, such as at Goodwill Industries. Well into the 1980s, Section 24 of the Ontario Employment Standards Act legalized compensation below the minimum wage for people who worked at sheltered workshops (other than management). This discriminatory practice, which was also in place in other provinces, was challenged in various locales across Canada during the late 1980s and early 1990s by people who worked in these facilities with the result that regular wages have only recently begun to be paid to some people with psychiatric disabilities. See: "Will the Charter Change Sheltered Workshops?" *Phoenix Rising: The Voice of the Psychiatrized* 5:2/3 (August, 1985), p. 31A-32A (written by the Advocacy Resource Centre for the Handicapped, Toronto). An example of employment agencies run for and by current and former psychiatric patients is the Consumer/Survivor Development Initiative in Ontario. Funded by the Ministry of Health since 1991, there are thirty-six CSDI sponsored work-places across the province in 1996. See: CSDI, *Consumer/Survivor Development Initiative Project Descriptions* (Toronto: Consumer/Survivor Development Initiative, March, 1996).


8) AR, 1879, p. 19.


11) Ripa, Women and Madness, p. 108.

12) AR, 1885, p. 45.

13) Ripa, Women and Madness, p. 106.

14) AR, 1894, p. 6.

15) AR, 1895, p. 35.

16) AR, 1883, p. 13-14, 66.

17) Jerold M., Patient File #8009; Elaine K., Patient File #3037; Coreen K., Patient File #9001; Reginald F., Patient File #10015.


22) Shortt, Victorian Lunacy, p. 132.

23) Ripa, Women and Madness, p. 106.


26) AR, 1881, p. 20; AR, 1900, p. xiv.
28) AR, 1879, p. 21.
29) AR, 1896, p. xxiv-xxv.
30) AR, 1871-72, p. 20.
31) AR, 1898, p. 41.
32) AR, 1906, p. xi.
33) Ripa, Women and Madness, p. 106.
34) Ibid., p. 109.
36) AR, 1893, p. 3-4.
37) AR, 1876, p. 215; AR, 1878, p. 259; AR, 1879, p. 311. Clark refers to Paris Green in each of these reports, though he ruled out using it in 1876 because it was poisonous. In 1878 he reported his "great timidity" in having it applied to the potato crop as he feared patients may eat it. In 1879 he wrote that it was used "with good effect," though he also noted that the "utmost care was taken to put it only in the hands of those who were careful in using it." Paris green was used as an insecticide and pigment. It consisted of acetate and arsenite of copper, a "highly poisonous bright-green powder," which was also known as "French green, emerald green, Schweinfurt green, Vienna green, and mitis green." Reference can be found under "green" in: Websters New Universal Unabridged Dictionary, Deluxe Second Edition (New York: Dorset and Baber, 1983) p. 799, column 2.
38) AR, 1878, p. 264.
41) Jim P., Patient File #6017. Letter to Inspector R. Christie from Medical Superintendent Clark, March 31, 1903; Wilfred S., Patient File #5036. Letter to Inspector R. Christie from Medical Superintendent Clark, November 27, 1902.
42) Patient File #5036. Letter to William S., Uxbridge, Ontario from Medical Superintendent Clark, September 19, 1900.

44) AR, 1878, p. 258.

45) AR, 1884, p. 45.

46) AR, 1885, p. 47; AR, 1888, p. 4.

47) AR, 1886, p. 6; AR, 1887, p. 44; AR, 1891, p. 5.

48) AR, 1888, p. 4-5; AR, 1904, p. 4; AR, 1912, p. 110; AR, 1917, p. 85.

49) AR, 1940, p. 104.

50) AR, 1918, p. 86.

51) AR, 1907, p. xx.

52) AR, 1906, p. xii.


55) AR, 1892, p. 39.

56) AR, 1911, p. 109.

57) Superintendent Ray of Butler Hospital, Rhode Island, also suggested the proper selection of inmates for specific tasks would enhance the "financial result": Ray, "The Labor Question," p. 450-51.


65) Geoffrey P., Patient File #7028. Letter to F. Nichols, Chicago, from Medical Superintendent Clarke, July 18, 1911.

66) Jill D., Patient File #10002. Letter to Dr. Clarke from Dr. W.T. Wilson, Hospital for the Insane, Cobourg, Ontario, October 2, 1909.

67) Francis F., Patient File #8038. Letter to Dr. Clarke from Warden J.T. Gilmour, December 29, 1908; Letter to Inspector Armstrong from Dr. Clarke, December 31, 1908.


69) James W., Patient File #6028. Letter to Dr. Daniel Clarke [sic] from Secretary A.G. Booth, The Booth Copper Co. of Toronto Limited, Coppersmiths, June 11, 1900.

70) Patient File #6028. Letter to A.G. Booth from Dr. Clark, June (18?), 1900; Clinical Record, May 10, 1928.


76) AR, 1928, p. 27.

77) AR, 1934, p. 32-33.

78) AR, 1928, p. 7; AR, 1932, p. 96; AR, 1933, p. 31, 111.

79) AR, 1941, p. 18.


84) Elaine O., Patient File #8016. Letter to Dr. Clarke, unsigned but clearly written by Elaine O., undated found among other letters which she sent and signed in the Summer of 1910.


86) Patient File #4003. Clinical Record, September 27, 1927.


89) Ibid.

90) Marianne B., Patient File #7017. Clinical Record, April 12, 1910.

91) Mary A., Patient File #5002. Letter to Dr. Clare from Mary A., July 29, 1911.

92) Patient File #5002. Letter to Dr. Clare from Mary A., August 4, 1911.

93) Patient File #5002. Letter to Dr. Clare from Mary A., February 28, 1922.


95) Patient File #5002. Letter to Mrs. H.A. from Medical Superintendent Clare, March 3, 1922.

96) Patient File #5002. Letter to Dr. Clair (sic) from Mrs. Mary A., March 28, 1922.

97) Patient File #5002. Letter to Dr. Clare from Mrs. Mary A., undated, though based on Clare's response it was likely written in early April, 1922.

98) Patient File #5002. Letter to Mrs. M.A. from Medical Superintendent Clare, April 12, 1922.

99) Patient File #5002. Letter to Dr. Clare from Mrs. Henry A.A., April 22, 1922.
100) Jane F., Patient File #5010. Clinical Record, August 30, 1909.


103) Patient File #6015. Letter to Dr. C. Clarke, Suptd. from (Mrs) E.F.W., August 31, 1909.


106) Patient File #6008. Letter to Dr. Fletcher from Mrs. L.O., Toronto, November 14, 1926.


110) Walter G., Patient File #6013. The first reference to Walter working in the bakery is in the Clinical Record, July 22, 1926, while the last reference is in a letter to Lambert Lodge, Toronto from Superintendent C.A. Cleland, February 9, 1950. In this letter, Cleland inaccurately states Walter had been working in the bakery for 15 years, when the clinical records show it was longer by nearly a decade.

111) Patient File #6013. Clinical Record, June 18, 1932.


114) Sandra T., Patient File #7041. Clinical Record, April 19, 1909.


120) Patient File #7049. Clinical Chart, September 11, 1921.

121) Mary M., Patient File #8018. Clinical Record, November 18, 1929.


125) Audrey B., Patient File #8042. See relevant entries in Clinical Record, (typed and handwritten) and Clinical Chart.


133) Patient File #8042. Clinical Record, October 10, 1940.

134) Patient File #8042. Clinical Record (handwritten), June 16, 1941.

135) Patient File #8042. Clinical Record, June 19, 1941.

136) Patient File #8042. Clinical Chart, February (no date), 1943.


139) Mabel M., Patient File #8015. Mabel was sent out on probation under the care of her daughter Ivey L. in July, 1947, and formally discharged on January 1, 1948.


141) Patient File #8015. Clinical Record, March 9, 1922.

142) Patient File #8015. Clinical Record, November 16, 1925.


148) Patient File #8015., Clinical Record, November 24, 1941; Clinical Record (handwritten), May (no date), 1940.

149) Patient File #8015. Clinical Record (handwritten), January (no date), 1942.

150) Patient File #8015. Clinical Record (handwritten), December 14, 1942; Clinical Record, March 12, 1943.


152) Patient File #8015. Clinical Record (handwritten), February 27, 1945.


155) Ibid.

156) Ibid.

157) Timothy P., Patient File #6023. Letter, written in the style of an affidavit, not addressed to anyone, signed T.P., undated. It should be noted that this man's last name is incorrectly spelled throughout his file with an "F" instead of a "P" which is clearly distinct in his own hand-writing.

159) Patient File #6023. Clinical Record, 1910-1912.


161) Ibid.


163) Patient File #2021. Clinical Record, October 11, 1928, July 29, 1930; Clinical Chart, September 1, 1931.


169) Elaine O., Patient File #8016. Letter to Dr. Clark (sic) from Elaine O., Toronto, November 4, 1910.

170) Anne D., Patient File #10009. Letter to Dr. Forrester (sic) from May K., Boston, Massachusetts, July 14, 1914.

171) Patient File #10009. Letter to Supt. Forrester (sic) from May K., Boston, Massachusetts, undated but clearly from July, 1915, based on Forster’s letter to her of that same month to which May is responding.


174) Jack P., Patient File #11001. Typed into Clinical Record: Copy of a letter addressed to Mr. E.H.P., "Winstanley" Kings Langley, England, from Jack P., Toronto Asylum, Good Friday-07 (i.e., 1907).


177) Wesley P., Patient File #5011. Letter to Dr. Clarke from Laurie D., January 4 (no year but based on Dr. Forster’s response, it is from 1912).

178) Patient File #5011. Letter to Laurie D. from Medical Superintendent Forster, January 9, 1912.


181) Jake M., Patient File #5033. Letter addressed "To Friend," from Jake M., undated but based on content and information in the Clinical Record, the letter is likely from around 1915.

182) Patient File #5033. Clinical Record, September 8 (no year), November 1, 1915.


184) Dwyer, Homes for the Mad, p. 16.


Chapter 6. Family and Community Responses to Mental Hospital Patients

Introduction: Public Perceptions of Mental Illness

Mental illness was genuinely feared and frequently scoffed at by the public. Janet Oppenheim has written that males who had a nervous breakdown were looked upon as weak and passive, something which brought men "perilously close to the feminine condition." (1) During the late nineteenth and early twentieth centuries, masculine perceptions were based on notions of self-reliance and self-control among the middle-class, upper-class, and higher stations of the working-class. Thus for a man to have a mental collapse was judged to be a moral failure and a disgrace, as he was no longer a productive member of society. (2) Women were seen as highly unstable because of their reproductive systems, and were therefore believed to be prone to nervous disorders more than men. (3) As Wendy Mitchinson has noted, associating madness and a female's body was widely accepted not only among medical practitioners, but also among women themselves who internalized these views. (4)

Though popular beliefs held that women were more likely to have an emotional collapse than men, this did not lessen the stigma of confinement which could be devastating for an individual's personal relationships, regardless of their gender or class. However, working class patients were especially vulnerable to additional biases. Angus McLaren has shown that during this period in Canada, hereditarian concerns about "mental defectives" were rooted in class
prejudices. Proponents of this view argued that this group represented a potential "criminal" element in society who had to be confined, and ultimately, prevented from reproducing through sterilization. (5) The target of the eugenists was, for the most part, a different population group from that found among most of the patients at Queen Street. However, the belief that people with mental afflictions inherited an illness which was passed on from generation to generation encompassed all variations of diagnostic pathologies. In 1879 Daniel Clark stated that at least 45% of all patients admitted to asylums were there due to hereditary cause, which "in the community [means] that it is incurable," though he cautioned this perception was not always true. (6) Nearly thirty years later, C.K. Clarke wrote that the linking of blood relations with insanity was much more difficult to determine than was often assumed by physicians. He also noted that arriving at scientific conclusions about this point was made more of a challenge by families who were reluctant to divulge "family secrets." (7) As will be seen, some families went to great lengths to ensure that other members of the community were unaware that their relative was confined in an insane asylum.

In their Annual Reports, Medical Superintendents expressed their anger at what Joseph Workman called "empty-headed" visitors who came to the wards only in order to "stare and laugh" at patients. (8) To curtail this, Daniel
Clark began to restrict ward visits in 1876 to family members and people who could prove a scientific rather than voyeuristic purpose.

None were more grateful for this check upon sight-seers than a majority of patients themselves. It is often pitiful to see them hiding in corners, closets, bedrooms, or any other available place when strangers are approaching, in order to avoid their gaze and questioning. (9)

Public display of the insane at places like Bedlam up to 1770 was well known, and it was likely that the historical memory of such cruelties encouraged Superintendents at Toronto to protect their charges from similar intrusiveness. (10) Robert Bogdan has also shown that this sort of "entertainment" was still publicly accepted throughout this period from the mid-19th to mid-20th centuries when a variety of so-called "human-oddities" were put on display in commercial ventures. (11) This association with viewing asylum inmates as objects to stare at is made clear when Clark wrote in 1878, and again in 1892, that during the week when the Canadian National Exhibition was on, a large number of people "raided" the institution after visiting the fair. They had hoped to see patients as an extension of their sight-seeing, but were refused entrance, a rule which he noted was unpopular only with those people who "have no friends on exhibition." (12) Yet, while the wards were off limits to all but those who had genuine cause to be there, the grounds of the facility were open for all to wander. Thus the intrusive gaze of
outsiders could still be felt among patients on the grounds, and towards inmates who were getting some fresh air on any of the twelve verandahs which were attached to wards. Originally built with iron bars on them, "like cages for wild animals," by 1890 these bars were replaced with windows and screens. (13) Beside allowing for the year-round use of verandahs, this architectural improvement had the added benefit of providing more privacy for patients who had formerly been leered at by visitors wandering about the grounds in expectation that inmates would perform "fantastic tricks," according to Clark. (14)

Beside physical changes, semantic changes were advocated as a way of fighting stereotypes. In 1906, Inspector S.A. Armstrong noted that the name "asylum" was being replaced with "hospital" since the former had such negative connotations, in contrast to the latter. (15) In 1907 the name of the Toronto facility was changed in accordance with this view. However, C.K. Clarke noted a year after this new name was adopted that public prejudices continued, as before, to look down on such facilities as an "asylum," a name he said was considered "repulsive" to family and friends. (16) Inspectors wrote optimistically in 1901 and 1921 about how public attitudes were changing for the better when it came to admitting people to mental hospitals, and the erosion of stigma attached to confinement. (17) These comments accord with similar promotional efforts on the part of 19th century American
superintendents which, as Nancy Tomes has written, were crucial to encouraging a more positive reputation for the profession.(18) However, administrators at Toronto, along with families and patients expressed a different reality when it came to interaction with outsiders. Prejudice continued from people who did not know or care about people housed in these facilities. C.K. Clarke wrote in 1910 that the public were "not only indifferent, but terror-stricken and very often heartless," when it came to relating with mental patients.(19) The "terror-stricken" aspect of this view related to what Daniel Clark had a few years earlier referred to as "Popular Delusions About The Insane," in which one of the most pervasive prejudices was the belief that to be an asylum inmate, one must therefore be a "maniac."(20) This view was common in spite of the fact that it was estimated that less than 5% of Toronto's patients were "suicidal or maniacal" in 1895.(21)

One of the few consistent positive interactions between the wider community and asylum inmates reported by authorities was the concerts and donations of reading material to the institution discussed in the chapter on leisure. Such occasions were also intended to brighten up the atmosphere and spread an uplifting moral message, as with the 98 visits between 1889-1891 of one devoted member of the Bible Flower Mission who distributed 5,323 bouquets with scriptural readings attached.(22) Merchants and druggists who had contracts with the asylum donated prizes
and other items for a picnic and games which over 400 patients participated in, during the Summer of 1895.(23) Yet these instances of community support for asylum inmates are striking by their contrast with the frequently cited everyday obstacles patients and their families encountered among people who showed little or no understanding of the experience of mental illness. The personal stories uncovered for this chapter from clinical records reveal the human face of family members and friends of patients at the Toronto Hospital for the Insane.

**Births After Confinement: Family and Community Responses**

Prejudice in the wider community towards anyone connected to an insane asylum could exacerbate a private tragedy. Such attitudes also reveal how the hereditarian taint that was associated with mental illness could negatively affect even the youngest and most vulnerable members of society. The most obvious agony that some family members had to face when confronting mental illness has to do with separation that confinement brings with it. Where there was a caring relationship, this can be especially traumatic. It is therefore appropriate to illustrate this point with the account of three families and the vastly different options that were available to them after the birth of a baby following the incarceration of one parent.

Mathilda M. was confined at Toronto for twenty-one years until her transferral to Penetanguishene in 1912. Several months after her admission in January, 1891 it was
observed that she "has been gradually growing larger in the abdomen" and was believed to be seven or eight months pregnant, though she claimed her swelling was due to "poisoned food." (24) Since this condition was not noticed at the time of her admission, hospital officials made it plain in May, 1891 that Mathilda’s husband Harold should take her home to their farm in L’Amaroux when she was about to give birth. As there was no response to this request, Dr. Clark wrote Harold a month later asking him to provide "the necessary articles" for mother and child and to remove the baby after birth. (25) Evidently, there was a meeting between Clark and Harold in early July at which the prospective father informed the Superintendent that he could not take care of this baby and so wanted it to be placed in a local institution. This is referred to in a letter from a county doctor who supported the contention that Harold was in an "impossible" financial and personal situation with "a large family of small small children the oldest too young to be entrusted with the care of an infant," all of whom subsisted on their father’s earnings as a farm labourer. (26)

After a baby boy was born to Mathilda on August 8, 1891, Clark wrote Harold that institutional rules stipulated that it was his responsibility to remove their newborn child. (27) Since Harold "paid no attention to this request" Clark stated that the rules forced him to have the child removed after ten days had elapsed from the time of birth. (28) Clark claimed that at their July meeting Harold
had promised to send clothing and remove the infant. When this did not transpire, the Medical Superintendent personally applied to have the baby accepted into The Infant’s Home, a foundling centre which received annual funding from the province. However, they "will have nothing to do with it" unless maintenance was paid in advance.(29) Clark next telephoned a local Catholic charity, The House of Providence, to accept this baby. He had originally looked elsewhere as the unnamed child was the son of Protestant parents. Clark wrote to Inspector Christie, "to their credit...the nuns at once took the child in charge, without any enquiry as to payment or parentage."(30) This poor "helpless and homeless child," as Clark wrote in his letter of thanks to the nuns, died by the beginning of September, 1891, less than a month after he was born, having been described only a few weeks earlier as a "very fine healthy boy and like its father in feature."(31)

How the separation of mother and child affected Mathilda is not recorded, other than a brief reference in a letter to her brother four months later that while officials hoped her mental health would improve after childbirth, they were "disappointed in this expectation."(32) During the ten days after his birth in the asylum, the baby was cared for by a nurse on the ward "in addition to her daily work," until being sent to the House of Providence.(33) Clark angrily wrote that the Board of Management, which was responsible for The Infant’s Home, "has not come up to its
"duty" in regard to the plight of Mathilda's son, as they had never before been approached by the asylum with such a request, "especially on behalf of an infant of an insane Protestant mother."(34) This episode of who would care for the nameless baby of Mathilda M., highlights a number of crucial themes that arise time and again in relation to community and family response to asylum inmates. In this case it has the added dimension of response to an inmate's offspring. The Infant's Home claimed money was the reason for turning down the asylum request in spite of their receiving public finances and the obligations that this would have entailed in such a unique situation. Municipal officials, all the way up to the Mayor, were asked to intervene on behalf of the baby "with no better results," according to Clark.(35) Prejudice towards the mentally disturbed mother of this baby and the place of his birth is strongly hinted at by Clark. Clark charged that Harold had abandoned his child and the evidence bears this out, though it is also clear that he was overloaded with family duties on the farm.(36) The care and removal of his son was left entirely in the hands of asylum staff, in spite of entreaties to take an interest in the child before and after his birth. Yet the predicament of the parents of this hapless child illustrates the horrible dilemma that families could face. A mentally disturbed mother who was destined to have her child taken from her since there was no possibility of raising a baby in the asylum, is contrasted
with her husband who had a large family to raise on his own in a financially strapped situation out in the county far away from one another. In such a situation the stress and despair for both parents would have been enormous. For a few years afterwards, letters were exchanged with Harold and asylum officials which make clear that Mathilda loved her children whom "She likes to hear from," believing they and her husband were somewhere in the institution. (37) For his part, Harold also expressed his and their children's affection and concern for Mathilda's well-being. (38) However, from the mid-1890s onwards there are no further letters from Harold, and so it is not possible to trace the extent of his support or that of their children for Mathilda during most of the two decades that she spent at 999 before she was transferred in 1912 and disappeared from the Queen Street records.

A similar episode took place four years later in 1895 when a single 22 year old woman, Cindy W., gave birth to a child two months after her admission. Fearing a repetition of the events of 1891, Clark asked Inspector Chamberlain to request admission of the baby to the Infant's Home. When Chamberlain received no response from the agency after waiting five days, the baby, whose gender is not mentioned, was sent to the home, at which time it was accepted. (39) There followed complaints back and forth that the women who were in charge of the Infant's Home were treated in a brusque manner by the Inspector. This dispute was primarily
over the issue of maintenance costs which they insisted upon and which the Inspector adamantly declined to pay, as well as about the appropriateness of transferring a child from the asylum to the Infant’s Home prior to a response being received. The provincial Secretary responded that there should be no charge as the Infant’s Home received public funding. (40) In a crucial departure from the earlier episode, documents reveal that this episode concluded on much better terms, at least in the short-term period for which evidence exists. Cindy W. was discharged as recovered four months after her child had been born, and went directly to the Infant’s Home where she took up residence with her baby which had not died, as Mathilda’s son had. (41) Yet, this episode also reveals the lingering resentment that the management of this charity continued to have at being asked to accept a baby from a mentally ill mother.

In another instance, the roles were reversed when an insane man’s wife gave birth to their daughter a month after his admission in 1882. Elaine Y. wrote to Doctor Clark asking him to inform her forty-nine year old husband, farmer John Y., that “he has another little girl who will be three weeks old on saturday (sic) I would like to have him send her a name...” (42) Clark responded to Elaine how “very glad” John was to hear from her and that he would write to his wife, presumably recommending a name as had been requested. (43) Unlike the story of Mathilda and Harold and their family, there was never any doubt about who would
raise Elaine and John's newborn baby. Furthermore, it is also possible to trace the long-term support of members of this family for their husband and father from both a wife and daughter's perspectives, as well as glimpse the immense stress which Elaine Y. endured raising their children on her own. During the nearly thirty year period of his confinement, family members regularly corresponded with hospital officials about the welfare of this man, and made clear their support for him. One particularly poignant letter from daughter Rochelle Y., written in May, 1911, was addressed to Doctor Clarke with lines at the bottom of the page which she asked to be read to her sick father. Addressed to "Dear papa," she wrote:

Mama told me or wrote that you had been ill. I am married I suppose she told you and we have a big boy fifteen months old. I may come up soon to see you with my husband[.] I wont come alone[.] goodbye[.] your loving daughter Rochelle (44)

A few weeks later John Y. died in the asylum at the age of seventy-eight. During the last days of his life, the clinical record noted that this dying man "talks a good deal to himself about his daughter." (45)

These three families reflect vastly different options available for people who experienced the birth of a baby after confinement. Harold chose to leave his son behind for hospital officials to deal with, unlike Elaine who had no such choice, having given birth under altogether "normal" circumstances, that is, at home and not in an asylum like
Mathilda. Cindy, on the other hand was able to leave the asylum after a relatively short period and continued her life with her child, unlike the other two parents whose mental state was too severely impaired to allow such an option. Thus for a husband who had to take care of children while his spouse was confined, there was a way to alleviate the economic pressure on a family in a manner that was accidentally available to a father and not to a mother. It is also clear that child abandonment which Harold chose, temporarily cast the Superintendent in the role of adult guardian of a baby without a home. Finally, it is important to note that both parents who were long-term inmates, expressed concern for their children after admission during the period for which there is evidence, suggesting the pain they must have experienced by this permanent separation. As will be seen in the next section, this pain was often shared by family members about the condition of their kin and matters that were beyond their influence.

**Impact of Visits and Physicians’ Letters on Families**

The extent to which people visited their relatives and friends is not tabulated in hospital records, though in 1923 Superintendent Harvey Clare claimed that 999 Queen Street West had more visitors than all other psychiatric facilities in the province combined.(46) An indication of how little privacy existed for outside visitors up until the early 1930s can be found in Superintendent W.C. Herriman’s comments that there had recently been installed partitions
so as to allow quiet conversations between medical officials and families. Previous to this, one room would be congested on visiting days "with the entire Medical Staff carrying on interviews with the friends of patients amidst a babel of voices." (47) Visits between patients and family members or friends took place on the ward, or in cases where patients had parole of the grounds, could also take place outside during warm weather. For people who lived outside Toronto, communication was more often through letters.

The way in which family members and friends of patients responded to visits and received news about particular inmates can reveal a great deal about people outside the asylum, and how they coped with mental illness. Some family members were so upset by the sight of a loved one that their reaction was not only emotional but physical. Daniel M. had been in the asylum for 27 years when his mother Loretta wrote to the asylum in 1929 about how Daniel's pregnant daughter Mavis felt after seeing him one day. Mavis was so upset about her father's "tattered + torn" appearance that this visit "made her sick on the street car," so she no longer went to the hospital. (48) Daniel died at Queen Street nine years later. Reginald F. was confined for eight years before being discharged in 1914. Four years later he committed suicide. During most of the period of his residence at 999, Reginald's wife lived in the United States and occasionally visited. She also wrote voluminously about him and provided financial support.
After one visit a few months after her husband's admission, Alicia F. wrote to Dr. Clarke that she felt "great shock" at his appearance, and stated that "I would not want to go to see him very often, it made me feel so dreadful." (49) Not all such trips were so traumatic for relatives. Walter S. was confined in 1900 and was regularly visited by family members who lived in Toronto. Though he was known to be depressed after his relatives went home, Walter's sister informed Dr. Forster that they had seen so much improvement over the years that they wondered if he could be let out on probation. (50) Eventually these visits led to his complete discharge in 1916.

Years of marital separation were also ended when a spouse found that visits helped to heal old wounds. Henry A. and his confined wife Mary A. were brought together again by his visits after sixteen years, following an attack by another patient which left Mary unable to walk. She was eventually discharged a year later in 1911 thanks to Henry's constant support for Mary and his respect for her decision to wait for her to decide when she was ready to leave. (51) This elderly couple lived together in Toronto until Mary died in 1923. A letter Henry wrote in June, 1911 after his final visit to 999, suggests how much their recently re-established relationship meant:

I got Mrs. A___ home safely on Saturday in her new Invalid Chair, she enjoyed the journey very much more than I did as I have two bad blisters on my hand. (52)
Considering the fact that their house was over five kilometres from the hospital, and that this man was at least in his late fifties, it was no small effort for Henry to push his wife all that way in her wheelchair.

The impact of letters from hospital officials to family members was an area of potential distress, since frequently the news was not good. Eve L. was 25 when she tried to commit suicide a month after her admission in 1884, the details of which Daniel Clark conveyed to her husband.(53) When Gregory L. wrote back in "sorrow" he mentioned how this news had "taken all of the pleasure out of my life," so much so that he cancelled a business trip to Europe.(54) After 1884, there were no further letters from Eve's husband. He wrote from New York City at one point that he had not expected her to be there "half as long as she has been," and so was worried about the continued expense.(55) Gregory eventually abandoned Eve, as she remained confined for the rest of her life. She died in 1914.

Administrative letters informing relatives of the mental state of a patient were usually quite routine with the majority of recipients not writing a distraught response about the wording used by officials. However, there were a couple of instances where the recipients noted their distress over the choice of words. In one case, the brother of an inmate was so concerned about the impact on his mother of a letter from the hospital, that he requested and received a more positive second letter. James L. was a
professor at a university in the southern United States in 1908 when he received a letter from C.K. Clarke about his sister Caroline L. who had been confined since 1906. Clarke had written in his initial letter that Caroline was in a very severe depression, and was regarded as "incurable" with further deterioration likely. (56) James responded that he had originally inquired about Caroline at the request of his mother who was staying with him for the winter, but that "I dare not show your reply" as she was ill and "living in hope of the ultimate recovery of her child." (57) James asked Clarke for another letter which could offer "a little hope + which I could show to my dear old mother." (58) Clarke obliged with another letter, this time noting Caroline's "excellent bodily health," alternately cheerful and depressed, her enjoyment of reading and concluded "I trust [Caroline] will improve" in better weather when she could get outside more often. (59) The following year, this patient was discharged in the care of her mother.

In another instance, the outcome was not resolved as satisfactorily. In 1891, Daniel Clark wrote the father of inmate Etta C. that she was "childish and silly" though easy to get along with. (60) Etta's mother, Henrietta, responded that these words "distressed me terribly and makes me tremble with fear of a total collapse," so perhaps "my poor girl" would do better at home. (61) Clark wrote back his "regret" that the outlook for Etta was so poor, but that a return home may not do much good. (62) This advice was
accepted by the family. Sixteen years later another administrative letter caused upset when it was announced that Etta had been sent to Penetanguishene in 1907. Writing from Durham, Ontario, her mother noted how "deeply painful" this news was to the family which had been hoping to take her out for a visit soon. Moreover, Etta’s brothers and sisters lived in Toronto, were able to visit her and supplied clothing. Her parents also found it convenient to see their mentally ill daughter when in town to visit their other children. Henrietta C. concluded how "exceedingly sorry" Etta’s family was that they were not informed of this move until after the fact.(63) There is no response to this letter in the file.

The distress of this latter communication from Henrietta C. illustrates how some families were completely left out of administrative decisions which drastically affected their ability to provide personal support for an inmate. Another woman had both her son and husband confined at Toronto. Margaret D. regularly wrote letters inquiring about her husband Gilbert and their son Allen, who were confined together from 1903-09, though the elder man had been confined since 1861.(64) This poor old woman who lived in Blackstock, Ontario had not yet received Clarke’s official letter informing her that Allen was transferred to the House of Refuge in Cobourg, Ontario. Instead, a neighbour told Margaret this news after seeing Allen D. while on a visit to Cobourg. Most of her letters are very
gentle in tone, begging pardon for her handwriting style made difficult by ill-health and rheumatism. But upon hearing this latest news, the usually quiet Margaret made her distress very plain to Dr. C.K. Clarke whom she always addressed as "Dear Kind Frend":

it Almost cyled me[..] it [w]ont be as Well for me for I see my husband and Alan I have to go sixteen miles to (illegible) to take the separ gran to Coburg at Toronto[..] I trust friends Would meet me at the Station and go up to the hospitile With me and see me on the Seepar to go home[..] So then I got your let[er] With ters I was ner ded my hart ner give out[..] it is terable hard on me... I am over Sevent yers of age[..] Well doctor I dont Want yous to send Alan a away it wold kill me...do plese write to me[..](65) [Original writing].

Clarke wrote Margaret D. his "regret" about causing her to worry about Allen’s transfer, but went on to state that he believed it was for the best that her son was sent to Cobourg.(66) Within six months, Allen D., who was considered harmless, was back with his mother who reported him "hapy and contented."(67) While this episode turned out better than originally feared, patients and their families, even when re-united, could face insurmountable obstacles within the community.

The Experience of Community Stigma Towards Mentally Ill Patients and Their Families

Stigma towards people with a history of being in a mental institution is a widely recognized problem in contemporary literature, just as it was noted by practitioners like Superintendents of the Toronto Hospital for the Insane.(68) Psychiatric patients, families and
friends of patients and mental health professionals frequently have to deal with the prejudice of people who have no first-hand experience of mental illness. As the following section will show, the level of antipathy towards a current or former patient could be traumatic for both the person with a diagnosis and those who were related to them.

Irene B. had been in the Hamilton Asylum for four years when she was released in 1890. A thirty-eight year old single woman employed as a dressmaker, Irene’s only support was her sister Agatha. In financial difficulties of her own as a servant, Agatha was unable to support her sister when Irene was re-admitted to an asylum, this time to the institution in Toronto in 1896. Irene remained confined until she died in 1921. Her extreme depression was observed by the committing physicians. This point was also supported by another lodger who noted how little Irene ate, sometimes having nothing more on a given day than a few crumbs from a loaf of bread. The reasons for her withdrawn, isolated condition are made clear in the medical observations: “She says that even (sic) since she came out of the Asylum persons have been taunting her with having been there.” It was noted that she remarked in a “sarcastic, hurt manner” that “of course a person who has been in the asylum is not fit to associate with some sane people...that persons for whom she was working had this feeling about her.” There are no observations in her admission papers which dispute these statements. The support of Irene’s sister was not
enough to overcome the immense obstacles placed in this former patient's path by the verbal harassment and prejudice she experienced by other members of the community, which in turn reinforced her despondency and regression back into a state of emotional misery. The circumstances leading to Irene's distraught state highlight the importance of community response to released inmates, and how the way in which this response was expressed could have a direct bearing on an individual's mental health and options for reintegration.

This hostility towards mental patients by outsiders was something which hospital officials reported when trying to get non-violent inmates released into community boarding homes. Daniel Clark wrote in 1897 that even though recovered patients were considered "industrious and harmless" by medical officials, the public was less than receptive to welcoming them back like any other citizen, especially when they were poor and without family. Instead, these friendless ex-inmates were "watched and gazed at... are often not trusted," and believed ready to break out in a violent attack. This could lead to another breakdown, like Irene B. experienced, that could have been prevented had they been "treated kindly and as rational human beings."(73)

Community resistance to accepting socially isolated patients back in the community was also noted by Inspector S.A. Armstrong. He wrote in 1908 that a census had been taken of the eight public provincial mental institutions to
see how many people were considered recovered to be released into Houses of Refuge. Out of nearly 5,500 inmates, almost evenly divided between males and females, it was ascertained that 400 friendless patients could be allowed back into the community. But though efforts had been made to transfer them, "with few exceptions" the local authorities would not cooperate, so most of these patients remained confined.(74)

Josiah M., a fifty-seven year old man in 1899, was said by Daniel Clark to be "quite harmless" and not in need of any further confinement after three years in the asylum. In spite of efforts by Clark and Inspector Armstrong to try to secure lodging for Josiah, Clark wrote, "we have failed on account of the diffidence people have in taking anybody who has been insane."(75) This man would remain at 999 until his death twelve years later in 1911. Persistent efforts to get an inmate released into the community could take years due to community bigotry. Like Josiah M., seventy-three year old Ettie F. was described as harmless and someone who should be released.(76) But like Josiah, she also had to face social intolerance. After fifteen years' confinement, an application was made on her behalf in late 1905 to the Home for Aged Women in Toronto. The Board wrote that they "cannot accept" her as a resident even though an acquaintance of Ettie's had offered to pay maintenance, and the hospital provided the Home with a probationary option of returning her to 999 within six months should things not work out.(77) Over two years later, Doctor C.K. Clarke
wrote in a vein similar to that of his predecessor when noting that various city boarding homes "refuse to take her since she has been in the asylum." (78)

Clarke wrote in an earlier letter to Inspector Armstrong that while the Catholic-run House of Providence usually accepted released asylum inmates, "some exception was taken on ground of religion," in previous instances. (79) Thus, even the Toronto charitable institution that was reported as being the least prejudiced towards mental patients as a group, indeed the one that accepted Mathilda's poor baby son, nevertheless manifested bigotry in other forms by at times turning away non-Catholics, like Ettie who was a Protestant. (80) Noting the overcrowding of the asylum and the fact that Ettie "shows not the slightest evidence of insanity" Clarke increased the pressure to have her accepted at a new Home for Aged Women, particularly if they received government funding. (81) This time administrative efforts were successful in securing her release to the Belmont Home, where seventy-six year old Ettie F. was sent in September, 1908 some three years after the initial efforts failed. (82) In instances like this, hospital authorities played an advocacy role in securing a patients' discharge, while the institution itself served as a shelter for those who were rejected by other social service agencies. What Josiah and Ettie thought of all this is unknown. Considering the obstacles they faced, one wonders what sort of reception
awaited inmates like Ettie F. who were released into a less than welcoming community.

One former asylum inmate wrote a number of letters about her fears of being considered insane after release, while inquiring about her brother Reginald C. who was confined at Toronto from 1891 until his death in 1918. Katerina G. had been in the Hamilton Asylum in 1894 after a miscarriage where she said she was "kindly treated by doctors, nurses and patients," as she recalled in 1917 at the age of fifty-seven.(83) After Katerina was refused admittance to see her brother because she was said to have been ill, which she claimed was "news to me," she wrote a series of letters to try prove that there was not "anything wrong mentally."(84) Though she was granted permission to visit her brother once a month, Katerina felt that she was being unfairly restricted on account of her past psychiatric history, asking Dr. Forster, "Who started the story that I was not in my right senses I cannot prove. All our side are Conservatives, a nephew is in partnership with R.B. Bennett of Calgary..."(85) In two letters written eight months apart in 1917 Katerina sets out in great detail her personal abilities, "to prove my sanity."(86) For his part, Dr. Forster advised Katerina to not worry so much, lest she make herself sick.(87) While Katerina's circumstances were more advantageous than that which far less privileged patients (or former patients) faced, like Josiah and Ettie, her concern with dispelling the notion that she was mentally ill
suggests how important it was for a former patient to be accepted in the community. Relatives of inmates who had never been confined also shared this distress. A woman who lived in the eastern United States visited her mother, Stella S. in 1915. After returning home, Edna S. was upset at what she perceived to be comments "of an infamous character" from people in Toronto about herself and her family related to mental illness. She recorded a number of incidents, including one which occurred after leaving the asylum on the Queen Street trolley car of whispering bystanders with one man telling another "she came over to see her mother." (88) Superintendent Forster wrote back that they had been "charmed" by Edna's visit and that no staff were upset with her, but hoped that she had "gotten a good grip on your nerves," and would not let daily slights cause upset in the future. (89) Edna's sensitivity suggests how even the perception of public comments about mental illness and one's family could be so upsetting to a visiting relative.

This fear of the stigma of insanity extending to family members was deeply rooted among parents, children and siblings of many inmates. Since much insanity was seen as hereditary there was a great deal of guilt and shame in the nineteenth and early twentieth centuries about confined relatives, as Charlotte MacKenzie observes in regard to families of patients at Ticehurst private asylum. (90) Nancy Tomes has also noted that there was concern in some families
that patients could "deceive" neighbours about their condition, which would raise suspicions among acquaintances about motives for confinement.(91) This community inquisitiveness happened to a man whom neighbours were convinced kept his wife confined when Ellen G. should be released. They even had a church elder demand her release in 1886. Clark told Stanley G. to ignore their "meddlesome interference," as his wife was insane, according to the Superintendent.(92) Ellen remained confined from 1878 until her death in 1918.

Records frequently show relatives trying to prevent this type of external interest in the welfare of an inmate. How, and even if, the public should learn about or come into contact with an afflicted relative was an area for great concern among some families. The mother of Martha B., who was confined at the age of twenty-five from 1891 until her death twenty-two years later, wrote Daniel Clark with a special request. Minnie B. was upset that an individual from Brantford saw her daughter and then came back to town and had "generally given" an opinion about her appearance and mental state. In order to stop this from recurring, Minnie asked Clark to "deny any except relatives" when visitors came to call.(93) A similar request came from Edward S., the brother of patient Grace B., who wrote from Port Hope in 1906: "I would like you to keep visitors from seeing her or knowing anything about her[..] This is a small Town and some people are after news to tell."(94)
The mother of Rhonda B. sent a special note with a visitor, addressed to Assistant Superintendent Ross, which gave permission for a non-family member to visit her daughter on the basis that this person was a friend. Ruth B. also mentioned in this note that she had heard of "quite a few" being refused visitation rights with Rhonda for which her mother was "thankful that you did not grant their request." (95) Cheryl Krasnick Warsh has written about the "uninvolved" family, who effectively abandoned their relatives, the "overinvolved" family who were constantly active in the patient's life at the asylum, and the "pseudo-involved" family, apparently concerned about their relative but in fact desiring a degree of distance. (96) Yet these categories need to also take into account the sort of community ostracism which these letters reveal, as external prejudices could be crucial to determining the closeness or distance of relatives and how they tried to influence a patient's life behind asylum walls.

Family intervention in preventing unrestricted visitors could extend to patients going on trips outside the asylum where they may be seen among the general public. Andrew H. came from a prosperous family in Cobourg, where he had been a law clerk. (97) In 1903, five years after his confinement began, his mother Ellen H., wrote an angry letter to the hospital in response to the yearly circular requesting money to send certain patients to the Canadian National Exhibition. Offended that the envelope was received open
and with the official stamp on it, Ellen insisted on being sent mail in a plain and closed envelope in the future. In regards to the proposed trip:

I wish to adamantly forbid the taking of my invalid son on any such excursion and to insist for the privacy that we are entitled to in this matter... Will you be kind enough to notify Dr. Clarke (sic) or all whom it may concern on no account have my son taken from out [of] the Institution.(98)

In response, Assistant Physician Dr. Mitchell wrote that the unglued envelope had likely occurred after mailing and so was an accident, and that "it was only out of kindness to our unfortunate people that we write these letters at all...to make their lives less monotonous."(99) He went on to assure Ellen H. that her 35 year old son Andrew would not go to the CNE or anywhere else, just as she had requested. Andrew would remain confined until his death fifteen years after these letters were written.

This fear of public knowledge about any connection to the asylum, which extended to official envelopes received in the mail, was mentioned by several others. Magdelaine C., the daughter of sixty-five year old Sandra C., asked Superintendent Daniel Clark to "Please omitt the official stamp."(100) John C., the father of Adam C., also asked that a "plain envelope" be used when hospital officials wrote to him about his son.(101) One family member, a wealthy father who lived in Bradford, England not only wanted to hide the origin of asylum mail from people outside the house, but also from some of the people who lived
inside. Harold C. wrote to Superintendent Clark in 1884 in reference to his 27 year old son, Francis:

I must be supplied with an address which has no reference to the Asylum, and all letters sent here, must be in plain envelopes, and securely gummed, so that my servants may see nothing that might cause remark, as I wish to spare the feelings of my family as much as possible...take care of my poor son...(102)

Like other family members who made similar requests, Harold C. was trying to minimize the personal impact of public prejudice against asylum inmates and their relatives back in the community. While such moves were understandable, these actions could also limit the number of social contacts and even chances to get out of the institution for some inmates. As a result, relatives like Edward S. and Ellen H., ended up isolating their siblings and children further from the community to lessen their own personal discomfort in their neighbourhood. In an era when serious public education about overcoming stereotypes regarding mental illness was all but unknown, it remained the patients who suffered most from community intolerance, even when they did not always receive it first-hand, but instead had to endure the distressing response from prejudice experienced or anticipated by their families.

Fear of A Patient’s Release By Abused Wives & Families

While most patients were not considered violent offenders by medical officials, there were some whose prospective release was feared for good reason by relatives. This is most obvious with victims of domestic abuse. Several
wives wrote letters imploring physicians to keep certain men locked up, lest they return home. Joseph S. had been confined in the Hamilton and London Asylums, was released from both and was eventually sent to the Toronto facility in 1891 at the age of 56. Two years later his wife, Sally, wrote to Daniel Clark after hearing from one of their six children that her husband was improving. She wrote that he had acted "cute" before and was able to secure discharge from the other asylums, but when he returned home "he has such a spite to me...I would be in terror of my life."(103) His wife recounted that Joseph S. once told her that he had to "pray to the Lord to keep from killing me in bed at night."(104) Sally asked the Medical Superintendent to "keep him there for I cannot live with him again. You will have my everlasting gratitude."(105) Three months later a local man wrote on behalf of Sally S., supporting her earlier request.(106) Joseph S. remained in the asylum until his death in 1913.

During the first nine months after her husband Jack H. was confined in 1902, his wife Alice wrote several letters making her fears very clear. Upset that Daniel Clark had spoken of releasing her husband, she wrote that she and her six children had their lives threatened by him.(107) In another letter she said Jack H. had told her during a visit to the asylum that even if his release "was ten years from now he would have revenge."(108) The constant dread that
Alice and her family had lived under is made poignantly clear in a third letter:

"I don't want him out any more for I have had the gun pointed at me many times[..] the children don't want him home either for they say they have been knocked around long enough by him[..] now for I can get enough to eat now and I could not even I had him with me[..] so I am better without him and if he does come out I won't live with him so keep him there and then we will all be safe..."(109)

Jack H. was never released and died in the asylum in 1908. There is no response in the files from hospital officials to any of these letters pertaining to these two men and their wives and children. In another case, hospital officials were warned from a public trustee that William D., a man in his late thirties, had told friends in 1908 that he was going to escape. If this was to ever occur "his first direct act will be to murder his wife and family," with whom the letter writer, a government trustee, happened to be related by marriage.(110) Clarke gave reassurances that there was not the "slightest possibility" of this man's release, given his violent reputation.(111) A year later similar fears were expressed and assuaged.(112) In May, 1910, four years after his original admission, and two years after the first escape warnings were issued from outside the asylum, William D. eloped. Since he was a warrant inmate who could only be released by permission of the Ontario government, the trustee was especially upset, writing C.K. Clarke, "the responsibility rests with you" should any harm come to William's wife Laura and their four children.(113)
After William D.'s early morning escape he went directly to the east end home of his wife, arriving at four A.M. and left two hours later with cash. (114) Clarke noted that Laura was most likely too frightened to call the asylum when her husband showed up so unexpectedly in the middle of the night. (115) A letter written by Laura soon after his escape, gives an indication of her predicament. Noting that William D. had fled to Oshawa where his carpentry tools were sent by his mother, she wrote:

I am the only one who knows where he is, so could you let the matter rest for a few days so that suspicion does not fall on me... Please don't let him suspect I have let you know as if he comes home again, there is no telling what might happen. (116)

While Laura mentioned in this same letter that her husband seemed better, the immense strain and fear she had to live with is obvious. This is especially so considering the responsibility she had in raising four children on her own, who would have been between five and fourteen years old at this time, and then had to worry about the return of her husband. There is no response in the file to Laura's letter. How this situation developed is unknown, as William D. was not recaptured and so was written off after a month. (117) Taken together these documents illustrate how for some women and children, the confinement of their husband and father was a relief to the point of being potentially life-saving, and certainly helped to prevent further domestic abuse by these confined men. At the same time, the fear that each of these woman expressed was
obviously a nightmare which could come true, as it did for Laura D., with the memory of a traumatic relationship reasserting itself whenever the release, or escape, of a brutal spouse seemed imminent.

Support and Neglect of Patients by Family Members

Some of the most compelling evidence about how family members were affected by the confinement of a relative can be found in the three case studies which conclude this chapter. In each we can see how efforts to support a loved one were undertaken under the most trying personal circumstances, with families torn apart and separated.

Long-distance support for an asylum inmate was not in itself that unusual. However, there is one patient whose source of support was quite unlike that of almost any other inmate. Alan L. was in his early thirties when he was admitted to the Queen Street facility where he would remain from 1887 until his death in 1918. During part of the last twenty years of Alan's life a unique phenomenon occurred, so far as patients studied for this thesis are concerned: he received support from a sibling who was an inmate in another insane asylum. Alan's sister, Sandra L., was confined in the Kingston, Ontario Hospital for the Insane about a decade after her brother was sent to Rockwood. The date of Sandra's admission to Rockwood is not clear, though her brother's file has four letters from the Rockwood Asylum written by her between 1898 to 1911. There is not much information on their background, but Alan's admission papers
mention he was a labourer. It is also important to note that Alan had been convicted of assaulting his sister in 1886 and had threatened to rape her at the time of his admission in 1887. (120) This information makes Sandra's years of support for Alan all the more remarkable.

Her first letter from Rockwood suggests a degree of hesitancy. For while she wants to know about her brother, she also asked that he not be informed about her inquiry. (121) In 1900 she was upset that a previous letter to Dr. Clark had not been answered so she wrote to Dr. Robinson. Sandra refers to a visit by Dr. Ezra Stafford from Toronto whom she considered asking about her brother, but declined to do so as she did not want people in Rockwood to wonder, "as I have never told them anything about our family afares of course you know what a set they are here." (122) Her fondness for Alan is plain as she refers to the "poor boy must be very lonely...when he was well he was a good boy and allways did what was right...I have so longed to hear from him." (123) Less than a year later another letter was written, this time to Daniel Clark, inquiring about money sent to Alan from their late brother's estate in 1890. (124) References in administrative correspondence about the volume of her writing along with comments by Dr. Forster about another letter from Sandra in 1918 (which has not survived), suggests that this woman at the Kingston mental hospital wrote letters on a fairly regular basis to Toronto where her brother was confined. (125) It is also
evident that she remained concerned about Alan right until his death, as the tone of Dr. Forster's letter make clear:

Sandra I have some bad news for you. Your brother Alan...suddenly passed away... Now Sandra I do not want you to worry about this for he was most kindly treated, and had what pleasures in life here that he could obtain in the Hospital. Mrs. Forster joins with me in remembrances, and sympathy. (126)

Abused wives could also be inmates of the hospital, forced to live with the emotional devastation wreaked by a violent mate who remained at liberty. This is what happened in the following case which brings to light how advocacy for better treatment and conditions for asylum inmates could be most persistently promoted by devoted siblings. One of the most well-documented and strongest examples of this form of support is found in the patient file of Anne D., a 42 year old mother of seven who had been abandoned by her husband prior to admission in 1906. (127) Anne's severe mental deterioration over the next four decades was regularly recorded in her case file, until her death in the asylum in 1944. Well into the early 1940s, there is a steady stream of letters from family members about Anne. The bulk of efforts to provide support revolved around Anne's siblings, especially her sister May K., who lived most of this time in the eastern United States, mainly in Boston, Washington and New York, before moving to Los Angeles, where she worked as a nurse. It is not clear what happened to the seven children, other than that most of them were initially abandoned by their father,
Walter D., though at least two of their daughters eventually moved to Calgary by the late 1910s.

At least one daughter, Edith, was able to offer some form of support to her mother on the spot, taking Anne out on probation for a month to her home in Toronto in 1909. Several years later, May noted that Edith was the only family member who was "at all kind" to Anne, but this daughter had died by 1913, so that May, and her brother Paul, who lived in Toronto, were "both trying to alleviate at least a little of her sorrow and loneliness." It is clear from the years of long-distance correspondence by May that she regularly exerted pressure on asylum authorities to take better care of her sister, even citing her own experiences with mental patients as a nurse, while also threatening the severest action against her brother-in-law if he did not own up to his responsibilities. Over the years, most attention was focused on clothing provisions for this inmate whom hospital staff said was always tearing up material.

In order to make sure regular supplies were issued, May wrote that she had taken her brother-in-law to court through a lawyer in Calgary, where Walter D. had re-married, in an effort to force him to pay support. She was doing this while living in Boston as "I cannot bear the thought of her being left in the way she has been." Forster wrote back that "we know nothing" about Walter D. as he never visited or wrote about his wife, though "two or three years"
earlier this man had agreed to send $75. a year for his wife’s support, through his father in Guelph, "but something seems to have stopped" this annual payment. (131)

Immediately after May wrote two strongly-worded letters in July, 1915, Forster wrote to Walter D. in Calgary, and to Walter’s father in Guelph asking for payment, which the elderly man tried to collect from his son, all of which apparently elicited some money. (132) May then wrote a letter expressing her rage:

If money is not forthcoming at once to care for my sister, I insist on knowing it and Mr. W.J. D___ will have the matter and a few others brought to his attention with a horse whip or a bullet pretty soon. One of our brothers lives at Handly, Sask. not very far from him and it will give Gerald much pleasure to handle it in that way. it should have been done long ago for the contemptable scoundrel is not fit to live and I insist upon my sister having a comfortable room and proper care in the asylum...(133) [Original writing].

This sibling advocacy and painful family feud continued for some time. Even the Attorney General of Alberta became involved which hospital administrators in Ontario supported, as Inspector Dunlop informed Superintendent Harvey Clare in 1920 that Mr. D. was "legally liable" for Anne’s support. (134) By 1921, May’s legal efforts and cross continent advocacy paid off for her sister as she noted that Walter D. "at last" had been providing financial support. (135) She noted in a letter a few years earlier, that the only reason he agreed to even consider this form of support was because Anne’s siblings "refrained from taking the matter up in court against him of Desertion and cruelty...
on his agreement that he would see that her every need was supplied (sic)."(136) How long this very reluctant support from Walter D. lasted is unclear. However, what is clear is that from the 1910s, after May began her strenuous efforts on her sister’s behalf, until the early 1930s, Anne’s file contains dozens of receipts for clothing and food from her sister, brother and children. By the mid-1930s, this material support had ceased, and indeed the only letter from Anne’s husband contained in the file is from 1933, in which he asked for and received an update on her condition. Walter D. wrote that there had not been any contact with the institution for "some years," which suggests he had not kept up his obligations.(137)

That same year May wrote another angry letter about clothing supplies which she could not afford to pay as she had no income. She went on to note that Anne’s husband was employed in Calgary and should be contacted along with other better situated family members.(138) Her brother Paul’s conflict with staff was mentioned, as it had been in 1915 and in 1921. Over a decade earlier, May had noted how she was only able to visit her sister just once in fourteen years, but her brother Paul who lived in Toronto was "treated so rudely" by staff that he was not sure whether to return.(139) At that time, Dr. Clare had apologized for any rudeness by employees and hoped that this would not happen again.(140) In 1933, May mentioned this problem again with a reference that Anne had been "always very fond"
of Paul and how much he had supported her over the years. (141) This is corroborated by his letters of concern for her and receipts for items with his name on them in Anne’s file. May continued to send letters to the hospital asking about her sister until shortly before Anne’s death. It is apparent that when this poor patient died at the age of eighty in 1944, it was her devoted siblings who looked after her funeral arrangements, as her remains were released to brother Paul. (142) The years of legal threats and prodding that her siblings, especially sister May, had engaged in to get her properly clothed and cared for, illustrate how essential were family members for advocating on behalf of inmates.

The cruelty of some relatives and integrity of others in the face of an excruciating conflict is revealed in another family feud that erupted over the bequest left to a chronic patient, known for her quiet, withdrawn disposition. Admitted at the age of 31 in 1880, Frances C. spent fifty-one years in the hospital until her death in 1931. She had originally been committed shortly after the birth of her fourth child, with the diagnosis of puerperal mania. In 1927-28 a dispute erupted when the daughter and son-in-law of Frances claimed that they had followed the provisions of a will, left by Frances’ mother, that $1,000. was to be used for clothing and goods for this patient. (143) This will was supposed to have been in effect for over a decade when it was discovered that Frances’ sister, Edwina O., had been
sending provisions to her sister four times a year out of her own pocket. Edwina could prove her support with receipts and hospital officials confirmed that they had only been dealing with her.(144) The dishonesty of the daughter and son-in-law was compounded when this man wrote that he had personally helped his wife send out material to the hospital, though he offered no documentation to prove it, which was in direct contrast to Edwina O.(145) Ironically, this man was a lawyer. Deputy Provincial Secretary Robbins wrote to Superintendent F.S. Vrooman that there was "no evidence" that the daughter had carried out the terms of the will left by her deceased grandmother on behalf of the younger woman's mother.(146) Though the Public Trustee was involved to try to force the daughter to live up to her legal and moral obligations, Doctor Vrooman recommended to Robbins that the "matter might as well be dropped" as nothing would come out of "any further controversy."(147) Evidence in the file indicates that Edwina continued to provide clothing after this.(148)

The cruelty of this daughter and son-in-law even extended to the grave. They did not tell their aunt that her sister had died, as she was left to find out on her own, more than two months after Frances C. succumbed to heart failure when Edwina made one of her regular calls to inquire about her sibling.(149) The appalling nature of this family tragedy is perhaps best summed up in the words of
Edwina O. In the midst of the dispute over the bequest several years before Frances died, she wrote the following:

This unpleasantness has been most painful to me but the institution which has done so much should benefit from my dear mother’s bequest. Not one who has neglected her own mother who sacrificed her reason in giving birth to a heartless daughter... Mrs. C was so clever, so beautiful, so admired and loved by all. It has indeed been a living death. Pardon my tiresome rambling, but other days come back when we were children together.(150)

Conclusion

Family and community response was closely intertwined with prejudice and misunderstanding about mental illness, which hospital officials recorded both in public documents and clinical records. The idea of a hereditary taint associated with madness was so overwhelming among the general public, that it was nearly impossible to reverse the negative and usually false stereotypes that were associated with hospitalization. Thus, some families expressed shame and fear of being "found out" that their relative was insane, lest they be derided and ostracized. Some patients were even less fortunate, being abandoned by relatives after confinement, so that they became friendless and without any level of outside support. As the response of charitable agencies illustrates, hostility to both young and old who came from the asylum makes plain the type of obstacles which community prejudices forced upon some of the most vulnerable people in society. Yet documents also reveal that stigma did not prevent concerned relatives from expressing support
over many years, often decades, for their confined relatives.
Notes:
2) Ibid., p. 146, 149, 151, 158.
3) Ibid., p. 187.
4) Mitchinson, *Nature of Their Bodies*, p. 301.
7) *AR*, 1908, p. 6.
9) *AR*, 1876, p. 209; see also *AR*, 1877, p. 258.
12) *AR*, 1878, p. 292, repeated again in *AR*, 1892, p. 4-5.
13) *AR*, 1890, p. 42.
14) Ibid.
15) *AR*, 1906, p. x.
16) *AR*, 1908, p. 5.
17) *AR*, 1901, p. xi; *AR*, 1921, p. ix.
20) *AR*, 1900, p. 6.
21) *AR*, 1875, p. 5.
22) *AR*, 1891, p. 3.
23) *AR*, 1895, p. 6.


26) Patient File #4012, Letter to Dr. D. Clark from J.C. Clark, Agincourt, Ontario, August 18, 1891.

27) Patient File #4012, Letter to Harold M., L’Amaroux, Ontario, from Dr. Clark, August 8, 1891.

28) Patient File #4012, Letter to Harold M., L’Amaroux, Ontario, from Dr. Clark, August 18, 1891.


30) *Ibid*.


34) *Ibid*.


36) *Ibid*.


39) RG 63, Sub-series A-1, Inspector of Asylums, AO: File #2092, Child Born in Asylum, Letter to Inspector Christie from Supt. Clark (handwritten across top of letter: "Referred to Dr. Chamberlain"), May 28, 1895; Letter to
Mrs. Ina Ridout, President, Infant’s Home, Toronto, from Inspector T.F. Chamberlain, June 1, 1895. See also Schedule B, signed Danl. Clark, September 19, 1895, re date when child was transferred to Infant’s Home from asylum.


41) RG 63, Sub-series A-1, File #2092, see Schedule B, signed Danl. Clark, September 19, 1895, re discharge of Cindy W. and her going to the Infant’s Home from asylum.


43) Patient File #3004, Letter to Mrs. E.L.Y., Dartford, Ontario, from Dr. Clark, October 6, 1882.

44) Patient File #3004, Letter to Dr. C.K. Clarke from Mrs. T.S., Lasswade, Ontario, undated, though based on Clarke’s response this letter is from May, 1911; Letter to Mrs. T. S., Lasswade, Ontario, from C.K. Clarke, May 22, 1911.

45) Patient File #3004, Clinical Record, May 15, 1911.

46) AR 1923, p. 10-11.

47) AR 1932, p. 27.


49) Reginald F., Patient File #10015. Letter to Dr. C.K. Clarke from Alicia F., Buffalo, New York, December 20, 1906.

50) Walter S., Patient File #6031. Six letters were exchanged between Agatha L.S., Toronto, and Medical Superintendent J.M. Forster on this topic from July 11, 1914 to January 25, 1916.

51) Mary A., Patient File #5002. There are a large number of letters about Mary’s possible move from the asylum between the Summer of 1910 and June, 1911. This is largely due to a severe family conflict in which her son and daughter-in-law were opposed to her discharge, whereas Henry was very supportive of this move, while Mary gradually
became more comfortable with the idea as she was not sure at first.

52) Patient File #5002, Letter to Dr. Clare from Henry A.A., Toronto, June 6, 1911.


54) Patient File #3019, Letter to Dr. Clark from G.A.L., New York, June 7, 1884.


57) Patient File #10007, Letter to Dr. Clarke from J.W.L., Columbia, Missouri, April 9, 1908.

58) Ibid.

59) Patient File #10007, Letter to J.W.L., Columbia, Missouri, from Medical Superintendent Clarke, April 13, 1908.

60) Etta C., Patient File #4002. Letter to Joseph C., Durham, Ontario, from D. Clark, January 8, 1891.

61) Patient File #4002, Letter to Dr. Clark, from H.C., Durham, Ontario, January 12, 1891.

62) Patient File #4002, Letter to Mrs. H.C., Durham, Ontario, from Dr. Clark, January 16, 1891.

63) Patient File #4002, Letter to Dr. W.K. Ross, from Mrs. J. Cameron, Durham, Ontario, August 22, 1907.

64) Gilbert D., Patient File #1010. Allen D., Patient File #7052.

65) Patient File #7052, Letter to Dr. Clark (sic), from Mrs. M.D., Blackstock, Ontario, March 22, 1909. Clarke had written to notify Margaret D. about her son's move two weeks earlier, though it obviously reached her after a neighbour had already informed her. Correspondence in the file clearly shows the decision to move Allen was made on or
around March 3, 1909, more than a week before his mother was sent notice. See the following letters: Letter to S.A. Armstrong, Inspector, from Medical Superintendent Clarke, March 3, 1909; Letter to Doctor Clarke from Abel D., Blackstock, Ontario, March 11, 1909; Letter to Mrs. G.D., Blackstock, Ontario, from Medical Superintendent Clarke, March 11, 1909.


67) Patient File #1010, Letter to Dr. C.K. Clark (sic), Toronto, from Mrs. M.D., Blackstock, Ontario, July 6, 1910. In this letter Margaret reported Allen had been home for nine months, which would date his return home to October, 1909, seven months after arriving in Cobourg.


70) Patient File #5022, Statement of Dr. Wm. Oldright, April 20, 1896.

71) Patient File #5022, Statement of Dr. James H. Richardson, April 18, 1896.

72) Patient File #5022, Statement of Dr. Wm. Oldright, April 20, 1896.

73) AR 1897, p. 6.

74) AR 1908, p. vii-viii.

76) Ettie F., Patient File #4006. Letter to S.A. Armstrong, Inspector, from Medical Superintendent Clarke, January 30, 1908.


78) Patient File #4006, Letter to S.A. Armstrong, Inspector, from Medical Superintendent Clarke, March 6, 1908.

79) Patient File #4006, Letter to S.A. Armstrong, Inspector, from Medical Superintendent Clarke, January 30, 1908.

80) Patient File #4006, Ettie F. was a Methodist, and a widow, according to her admission papers: Schedule No. 2, signed Geo. Graham, Brampton, undated, though from 1890.

81) Patient File #4006, Letter to S.A. Armstrong, Inspector, from Medical Superintendent Clarke, March 6, 1908.

82) Patient File #4006, Letter to Superintendent, Belmont (sic) Home for Aged, Toronto, from Medical Superintendent Clarke, September 23, 1908; Probation Certificate, signed by President of Belmont Home, Mary Gunther, September 24, 1908.

83) Reginald C., Patient File #4018. Letter to Dr. Forster from Katerina G., Whitby, Ontario, March 9, 1917; Letter to Dr. Forster from Katerina G., Whitby, Ontario, March 20, 1917.

84) Patient File #4018, Letter to Dr. Forster from Katerina G., Whitby, Ontario, March 9, 1917.

85) Patient File #4018, Letter to Dr. Forster from Katerina G., Whitby, Ontario, March 24, 1917.

86) Patient File #4018, Letter to Dr. Forster from Katerina G., Whitby, Ontario, April 14, 1917; Letter to Dr. Forster from Katerina G., Whitby, Ontario, December 28, 1917. The quote is from the December 28, 1917 letter in which mentions that the earlier letter "did not seem" to prove she was sane.

87) Patient File #4018, Letter to Mrs. Katerina G., Whitby, Ontario from Medical Superintendent Forster, April 18, 1917.

88) Stella S., Patient File #5001. Letter to Dr. Forster from Mrs. E.S., Cambridge, Massachusetts, April 18, 1915.


91) Tomes, A Generous Confidence, p. 119.


93) Martha B., Patient File #4016. Letter to Dr. Clark from Minnie B., Brantford, Ontario, undated.


95) Rhonda B., Patient File #8033. Letter to Dr. Ross from R.L.D., Queensville, Ontario, August 31, 1905. This is the only letter from a family member in Rhonda B.'s file which was open from 1905 until her death at 999 in 1918.


97) Andrew H., Patient File #6003. Form of History of a Patient, signed Dr. J.A. Ivey, Cobourg, Ontario, January (no date), 1898.

98) Patient File #6003, Letter to Dr. Mitchell from Mrs. Ellen P.H., Cobourg, Ontario, August 7, 1903.

99) Patient File #6003, Letter to Mrs. Ellen P.H., Cobourg, Ontario, Assistant Physician Mitchell, August 8, 1903.

100) Sandra C., Patient File #4020. Letter to Dr. Clark from Magdelaine C., Los Angeles, California, April 9, 1905.

101) Adam C., Patient File #7003. Letter to Dr. Clark from John C., Streetsville, Ontario, September 27, 1900.


103) Joseph S., Patient File #4023. References to Joseph's previous confinements at Hamilton and London Asylums can be found in: Schedule No. 2, signed David Jackson Jr., Committing Justice, Durham, Ontario, October 18, 1891; Letter to Dr. Clark from Mrs. J.S., Durham, Ontario, April 30, 1893. Quote is from: Letter to Dr. Clark from Mrs. Joseph S., Durham, Ontario, April 30, 1893.

104) Ibid.

105) Ibid.
106) Patient File #4023, Letter to Dr. Clark from James (Gunn?), Durham, Ontario, July 18, 1893.

107) Jack H., Patient File #7030. Letter to "Mr Clark," from Alice H., Langstaff, Ontario, October (?), 1902. This letter was written at the time of his admission on October 18, 1902.


109) Patient File #7030, Letter to "DC" from Mrs. H., July 2(?), 1903.


111) Patient File #9024, Letter to F.R.D., Toronto General Trust Co., from Medical Superintendent Clarke, February 8, 1908.


113) Patient File #9024, Letter to Dr. C.K. Clark (sic), from F.R.D., Toronto General Trusts Corporation, May 23, 1910.

114) Patient File #9024, Letter to Dr. Clarke, from F.R.D., Toronto General Trusts Corporation, May 19, 1910.


116) Patient File #9024, letter not addressed to anyone other than a reference to "Doctor," most certainly Clarke, from L.D., undated, though considering it's contents and other correspondence in the file on William D.'s escape it was most certainly written in May, 1910 by his wife Laura.

117) The only other reference to what happened after the thirty day period had elapsed is a letter which notes some of William D.'s clothes needed to be picked up by Laura's son. Patient File #9024, Letter to Mrs. W.D., Toronto, from Medical Superintendent Clarke, August 11, 1910.

118) Alan L., Patient File #3033. Schedule No. 2, signed Platt Hinman, J.P., Grafton, Ontario, undated, though obviously from 1887 when Alan was admitted.
119) There are two mystery letters in this file, the precise origin of which will have to remain unknown: Patient File #3033, Letter to "Sir," presumably Clark from A.J.L., East Hamlin, New Jersey, April 5, 1897; Letter to Miss A.J.L., East Hamlin, New York, from Medical Superintendent, April 7, 1897. The initials of the letter writer do not correspond with Sarah's first initial, but the handwriting style in this letter from New York state and that of Sarah in Kingston, or Rockwood Asylum as it was also known during the late nineteenth and early twentieth centuries, is almost precisely the same. There is also only a reference to one sister in Alan's admission papers. In any case, this correspondence occurred before Sarah was known to be in Rockwood, so it does not change the chronology of this story.

120) Patient File #3033, Schedule No. 2, signed Platt Hinman, J.P. Grafton, Ontario, undated, though obviously from 1887 when Alan was admitted; Handwritten statements of two physicians on paper: by Dr. J.R. Clark, dated 6/4/87, the second statement is extremely difficult to read, appears to be by Paris Green, 6/4/87.

121) Patient File #3033, Letter to Dr. Robeson (sic - Robinson) from Miss L., Rockwood Hospital, Kingston, June 11, 1898.

122) Patient File #3033, Letter to Dr. Robertsone (sic - Robinson) from Miss L., Rockwood Hospital, Kingston, March 7, 1900.

123) Ibid.

124) Patient File #3033, Letter to Dr. Clarck (sic) from Miss L., Rockwood Hospital, Kingston, January 24, 1901.

125) Patient File #3033, Letter to "Dear Miss L.," from Dr. Forster, Toronto, November 2, 1918. This letter, like an earlier one to Sandra from October, 1911, has no address nor official signature as Medical Superintendent, suggesting both personal familiarity and the probability that she was still confined at Rockwood at the time of Alan L.'s death. Dr. Forster's familiarity with Sandra was due to his having been her doctor at Kingston prior to moving to Toronto.

126) Ibid.


128) Patient File #10009, Letter to Dr. Clarke from E.D., Guelph, Ontario, July 2, 1908; Probation Bond for Anne B.D.,
released into custody of her daughter, Mrs. E.S., Toronto, July 24, 1909, for one month.


130) Patient File #10009, Letter to Dr. Forrester (sic), from M.L.K., Boston, July 8, 1915.


132) Patient File #10009, Letter to W.J.D., Calgary, from Medical Superintendent Forster, July 19, 1915; Letter to Mr. W.D., Guelph, Ontario from Medical Superintendent, July 19, 1915.

133) Patient File #10009, Letter to Superintendent Forrester (sic) from M.L.K., undated but clearly from July, 1915 based on Forster’s letter to her of that same month to which Walter D.’s father is alluded, a point which is briefly commented upon by May.


135) Patient File #10009, Letter to Dr. Claire (sic) from Miss M.L.K., New York, undated though based on Clare’s response it is from October/early November, 1921.

136) Patient File #10009, Letter to Dr. Forrester (sic), from M.L.K., Brookline, Massachusetts, "Mch. 19," no year though since it is addressed to Forster who remained as Superintendent until 1920, this letter is likely from 1918-20, as it was found among letters of this date.

137) Patient File #10009, Letter to Superintendent from W.J.D., Calgary, September 15, 1933; Letter to W.J.D., Calgary from Superintendent J.S. Stewart, September 21, 1933.

138) Patient File #10009, Letter to Dr. J.S. Stewart, Toronto Asylum, from M.L.K., Los Angeles, June 4, 1933. May was very angry at the hospital for asking her for clothing funds, and across the top of this letter is boldly written: "No reply."

139) Patient File #10009, Letter to Dr. Harvey Claire (sic), from Miss M.L.K., New York City, undated though based on Clare’s response, cited below, it is from October, 1921.
140) Patient File #10009, Letter to Miss M.L.K., New York City from Medical Superintendent Harvey Clare, October 18, 1921.

141) Patient File #10009, Letter to Dr. J.S. Stewart, Toronto Asylum, from M.L.K., Los Angeles, June 4, 1933.

142) Patient File #10009, see funeral home permission slip to remove Anne D.'s remains, on the authority of Paul K., February 18, 1944.

143) Frances C., Patient File #2031, Letter to Superintendent F.S. Vrooman from Deputy Provincial Secretary Robbins, December 12, 1927.

144) Patient File #2031, Letter to Deputy Provincial Secretary Robbins from Superintendent Robbins, December 16, 1927; Letter to H.M. Robbins, Deputy Provincial Secretary, from E.O., January 11, 1928.


146) Patient File #2031, Letter to Superintendent Vrooman from Deputy Provincial Secretary Robbins, February 6, 1928.

147) Patient File #2031, Letter to Deputy Provincial Secretary Robbins from Superintendent Vrooman, February 15, 1928.


149) Hospital officials said they had tried to contact Edwina about Frances' death but that they did not have her correct telephone number. She mentioned in response that it would not have been difficult to locate her, "no excuse for my not being notified." Patient File #2031, Letter to E.O. from Superintendent Ross, October 21, 1931; Letter to Superintendent W.K. Ross from E.O., Toronto, October 22, 1931; Letter to E.O. from Superintendent Ross, October 23, 1931.

150) Patient File #2031, Letter to H.M. Robbins, Deputy Provincial Secretary, from E.O., January 11, 1928.
Chapter 7. Discharge and Death

Introduction: Discharge Rates

The last chapter of this thesis examines the final part of an inmate's life at 999, and what happened after a person departed the institution, either to return to the community upon release, or after their death. Before getting into the actual experiences of the men and women who were discharged or who died at the Toronto Hospital for the Insane, some statistical figures are necessary, beginning with discharges, which will be followed by a section on death and disposal of an inmate's remains.

As Table XI B shows, during the first century of the existence of the Toronto facility, the discharge rate for males was slightly higher than that for females at 50.26%. Discharge rates varied over the period studied here from 5.25% of the entire asylum population in 1881 to 6.61% in 1910 (compared to the provincial mental hospital average of 5.69%) to 14.16% in 1940 (compared to the Ontario average of 12.25%).(1) From the 1870s to 1920s administrators also tabulated recovery rates based upon admissions. S.E.D Shortt has noted that physicians considered an annual cure rate of 40% as being low and 45% as being high when based upon annual admissions.(2) This inflation of figures was borrowed from the United States in an effort to present a more optimistic picture of the "curability" of asylums.(3) Annual reports indicate how unreliable these figures are during the 1890s and early 1900s when Superintendents
provided one set of figures for recovery rates based upon admissions at Toronto, and Inspectors offered another, usually lower, set of statistics in the very same report. The most glaring example of this discrepancy is in the 1906 report where there is a thirty per cent divide between their two statements.(4) It should be noted that recovery rates based upon admissions include patients with disorders which were classified as acute as well as patients who eventually became chronic patients. Therefore, the general discharge rate was lowered by the regular admission into the hospital of people who became long-term patients.(5) Nevertheless, there are consistent data on this topic in earlier and later reports. In 1870, Joseph Workman reported a recovery rate of 53% based upon admissions, a statistic which oscillated wildly over the decades.(6) This figure was reported as 42.74% in 1889 (compared to the provincial average of 35.40%), but had receded to 19.74% in 1910 (compared to the provincial average of 27.63%) and had fallen still further by 1925 when it was 15.85% at 999 (compared to 17.44% for all Ontario mental institutions).(7) Thus by the early twentieth century, the cure rate for both Toronto and the rest of the province was far below optimistic standards.

The volatility of these figures was not unique to Ontario. Charlotte MacKenzie has found that recoveries were 15% of admissions at Ticehurst Private Asylum between 1895 and 1905 and rose to 25% over the following decade.(8) The fact that the overall asylum population discharge rate at
Toronto had risen by almost nine per cent between 1870 and 1940 was influenced by the rise of therapeutic optimism during the later period when heroic treatments were introduced on a much larger scale than before, as was mentioned in the introduction of this thesis.

Not all patients were discharged as improved or recovered. Most unimproved patients were sent out only when families insisted on taking them out, usually over medical objections, and only when they were not certified under a Lieutenant Governors Warrant, in which case only the provincial authorities could authorize a release. Individuals who were deported were also let out as unimproved. All patients who escaped were discharged if they were not returned within thirty days. The question of just what it meant to be recovered or cured related to a change in symptoms, such as someone who was no longer reported to be hearing voices and who was no longer considered a threat to themselves or others. By the late nineteenth century, physicians believed that this sort of self-control and remission of previous symptoms, such as suicidal tendencies, were crucial to securing discharge.(9) However, as Ellen Dwyer has noted, mental hospital doctors were unable to develop "a valid, reliable definition of mental health, any more than they could agree on one of mental illness."(10) As will be discussed in case studies below, this vague understanding of what it meant to be
"recovered" could be greatly influenced by supportive relatives.

Perhaps because of this imprecision, there was a degree of flexibility in allowing for release of some non-violent patients. Superintendent Workman reported in 1871 that he chose to send a short-term male patient home after seven weeks as "unimproved" because he believed that to keep him confined longer would have "sunk" him. This man recovered "with amazing rapidity" once he was back home.(11) On the other hand, two male patients who were believed to have recovered and were capable of looking out for themselves back in the community, were discharged even though they had requested to remain in the institution "until they could get some work."(12) This report raises the point about how, in a pre-welfare state, mental institutions could serve as a shelter for those without anywhere to go, as Gerald Grob has noted, which in turn influenced lower discharge rates.(13) Inspector Christie mentioned a reason why so many people stayed in longer than was deemed necessary - because no one wanted them "and if put outside of the Asylum gates they would be left to die in the streets."(14) He estimated that up to one-third of mental hospital patients in Ontario could have been discharged had there been the proper community supports available.(15)

For most of the period covered by this study, mental patients had to have either family, friends, or a community refuge to go to prior to securing discharge, with this last
option being especially difficult for friendless patients, as was discussed in the preceding chapter. In an effort to provide an alternative to traditional options for a small minority of inmates to re-integrate into the community, provincial administrators set up their own approved and monitored boarding houses beginning in 1933. Patients who were sent to these houses were still on the books as part of the hospital population and continued to receive out-patient care by occupational therapy staff who organized social gatherings one afternoon a week, as well as by social workers who visited patients every week. By the mid-1930s, forty to fifty Queen Street patients were living at approved boarding homes in Toronto. Throughout Ontario, the figures for this group of mental hospital out-patients rose from 1.9% in 1934 to 3.6% in 1940. As has been evident throughout this thesis, statistics provide only a bare glimpse of the people who made up these numbers. To move beyond nameless statistics it is essential to look at specific examples of the conditions which allowed patients to leave the institution and their experiences after release.

The Process and Aftermath of Discharge

Discharged asylum inmates are among the most difficult patient experiences to trace since limited documentation exists in the best cases, while in most files for released individuals there is nothing at all after release. In some cases it is possible to infer that an individual had an
extremely difficult time back home. For example, Joseph Workman wrote about a woman who was re-admitted eleven times. He noted that the first time was after the birth of her tenth child, and she continued to be re-admitted after her fourteenth baby was born. Workman clearly placed the responsibility for her problems at the feet of the husband of this unnamed patient.(20)

The discharge of mental hospital patients has to be understood in the context of external support networks, and in light of whether or not their prospects for survival outside of the asylum would be helped or hindered by release. These were issues which doctors, friends, family members and the patients themselves were confronted with when this subject was raised. Wesley P. was released in 1913 on six months probation after eighteen years' confinement. This happened only after protracted negotiations between family members and hospital officials to secure his release over an eight year period. These efforts were initiated by Wesley who wrote to his sister in 1905:

Please send me back home when you can. I am just as well now as when I first came in cant Improve me any[.]. just as well at Home at work[.]. Its only nonsense putting me in here[.].(21)

This letter was returned to the asylum by his family when they made inquiries about releasing him. The main obstacle was finding someone to care for him back in the community, though farm labour was mentioned as a possibility
by Wesley's brother, who wrote in 1909 that "the poor boy seems heartily sick of being confined so long." (22) Doctor Clarke however, expressed concern that potential employers would not understand his mental illness. (23) Nevertheless, pressure from the patient on his family to get him released and their subsequent requests to the administration were kept up. In December, 1912, more than seven years after the family first requested his discharge, and then only after their confined brother initiated the process, the administration agreed. While agreeing to allow his departure was a significant change from before, Superintendent Forster was cautious about Wesley's condition and the energy needed to help him back in the community. (24) Curiously, the family did not offer to take him out for another year. (25) There is no indication in the file why there is such a gap between the hospital granting the request and the relatives acting upon it. Finding a responsible party among the brothers and sisters, which had been an issue earlier, may have been a delaying factor.

Yet all was by no means resolved by this apparently satisfactory outcome for the former patient. During the first few months after his probationary release in December, 1913, Wesley seemed to be working well at farms outside of Owen Sound. Eventually, he was fully discharged six months after his release. (26) However, even before his final discharge, problems began to surface. Wesley's brother
reported in April, 1914 that one of the two farmers who had employed the former asylum inmate was having difficulty hiring him out to other farmers in the area because "they all seemed afraid to take any chances."(27) Several months after his final discharge Wesley's brother wrote that six employers had let him go as "they all seem to be tired of him in a short time."(28) He then asked that Wesley be re-admitted into the hospital, as no one would employ him. There is no response to this letter in the file. Legally the hospital had relinquished all obligations upon final discharge. Wesley does not appear again in the patient records.

It is clear that his efforts to get released would not have succeeded had there not been a supportive family network helping his cause. His sedentary character was also crucial to securing his freedom, as a patient who exhibited violent or physically aggressive behaviour was considered too dangerous to be at large.(29) However, the reservations expressed by asylum officials over several years about the unlikelihood of his getting along in the outside world were proven accurate at least for the period during which we have evidence. This same evidence also records the sort of challenges discharged patients faced from prospective employers, as in the case of the farmers who were reluctant to hire him, which suggests the sort of community prejudice which was discussed in the preceding chapter. At the same time, the fact that he was hired at
six jobs in less than a year after release, also shows that some work was found for him, albeit of a temporary nature. How Wesley P. and his family coped over the long-term, however, will have to remain a question mark.

Ellen Dwyer has noted that patients "who kept in closest touch with their families had the best chance of being released."(30) Wesley's case certainly confirms this, but so too was it essential for family members to maintain contact with their confined relatives. When this did not occur, the potential for release could be delayed by years, if not completely evaporate. Patients and family members were not the only ones to ask for the discharge of an inmate. Hospital officials also made this request of families. Randall F., a single labourer from Peterborough, had been confined for eleven years when Assistant Physician, J.A. Mitchell wrote to his mother in 1904:

Your son asked me this morning to write you a letter for him. He wants to tell you that he is in very good health and feeling well and would like to have you write to him. He says he wants to send you his best respects and would like to know what day you would care to have him go home. My own opinion is that your son is so quiet and well behaved here that I think possibly you could get along with him very well and if you would like to take him out on probation for a month we will give you permission to do so and if you found him troublesome he could be returned to us.(31)

This letter was returned over a month later with several forwarding addresses on the envelope crossed out. There are no further documents of any sort in this file until a probation bond was issued seven years later. Signed
by one of Randall's sisters with an "X"; this form allowed him to be released into her custody to return to Peterborough for a month. He was fully discharged in October, 1911, after which there was no information.(32)

This example raises questions about the problem of finding support for a patient whom the administration wanted to see released but were constrained from doing so because of lack of outside support. It is clear that Randall, as well as his sister from Peterborough who signed the probation, were both illiterate, which would have made communication with relatives extremely difficult for hospital officials. In such instances, there was a limited amount that the hospital administration could do, particularly since there were obvious problems locating family members.

Locating support could pose obstacles for another group of discharged patients: women and men inmates who were deported. The deportation of people who were immigrants to Canada, and who ended up in mental hospitals, was an area of great interest among medical professionals and non-medical social activists who were motivated by a belief that this would reduce the number of so-called "unfit" citizens coming into Canada from overseas. By the early 1900s there was considerable debate about the federal government's responsibility in preventing the immigration of people considered mentally "degenerate."(33) As Ian Dowbiggin has detailed, one of the foremost campaigners for "keeping this
young country sane" was C.K. Clarke. Medical officials like Clarke enforced a restrictive policy by arranging with federal officials the return of mentally disturbed immigrants who came under their jurisdiction. This was not always easy to do, since employees were reluctant to accompany deported inmates on long trips. Deported patients were often sent to a mental hospital in their home country or returned to their relatives. Attendants were offered bonuses to accompany inmates from their provincial point of departure, to their country of destination, whereupon the deportee was to be handed over to family or local authorities.

While the general outline of this immigration policy is well known, it is very difficult to document what happened to people who were sent back to their land of birth. However, evidence from one such episode reveals things did not always work out according to plan. In December, 1906 two male patients were deported to Britain accompanied by an attendant, John Dyson, employed at nearby Mimico Asylum. Upon arrival in Liverpool, one former inmate was sent directly to a mental hospital. However, the other one from 999, Terence J., about whom Dyson wrote, "never showed anything to make me believe he was insane," had no one there to meet him. Since Terence was believed to be sane, the local Dominion agent suggested that the only option was to "send him to the poorhouse or turn him adrift in the streets of Liverpool." Attendant Dyson refused to do this.
Instead, he bought Terence J. a fourteen shilling ticket out of his own pocket so this former patient could take the boat back to his home community of Cork, Ireland. Dyson wrote "if that is the system of handling deports, dumping them in the streets of Liverpool without a cent in their pockets, it wants looking into."(38) Terence J. wrote to Dr. Clarke through an intermediary that he had arrived safely back in Cork. He wanted to reimburse the attendant for paying his passage on the final leg of his journey, and requested that money be sent to him that he was owed from military service in Canada.(39) This evidence shows how conscientious both the asylum employee and former patient were about helping one another. However, for most deported inmates it is impossible to know, even over the short-term, if they fared any better upon arrival. This is especially true for people like Lee F. who was sent back to China in 1907, sixteen months after his admission to 999.(40)

There are files which provide enough evidence to illustrate what happened to discharged inmates to the end of their life. The following two people show that not all patients wanted to be discharged right away, even when given the opportunity, and when they were released it was only after careful preparations had taken place. Mary A. had been confined for seventeen years when she was released in June, 1911 into the care of her husband Henry. While her distress at confinement is clearly stated in a number of her letters, there are no records of Mary making a specific
request to be discharged. Instead, her husband Henry initiated and kept up efforts to bring his wife home, in spite of the strenuous objections of some members of their family. Mary was, if anything, quite hesitant about leaving the hospital. This was due to her concerns about her physical disability of not being able to walk after being attacked by another patient, as well as due to the financial strain on her husband, a Toronto letter carrier. A letter from Henry to hospital officials mentioned that Mary was initially "pleased" at the prospect of leaving the hospital for a month, but then she expressed second thoughts, as "she has got into a certain routine which she is afraid she will forfeit by her absence." A letter from Henry to hospital officials mentioned that Mary was initially "pleased" at the prospect of leaving the hospital for a month, but then she expressed second thoughts, as "she has got into a certain routine which she is afraid she will forfeit by her absence."(42)

The fear of no longer having one's daily life situated in a structured environment after release was an impediment to discharge for a patient who depended on institutional care for her needs. Mary's concerns in this regard would have been intensified following her injury when medical attention was crucial to maintaining a sense of well-being. It is also clear that her husband was careful to reassure his wife that her wishes would be respected about if and when she was to be released. Protracted negotiations followed, not least complicated by the resistance of Mary's son and daughter-in-law to having her released. When she eventually left the asylum her release was granted because of Mary's "harmless" disposition and her husband's assurances he could care for her. Mary "insisted
on signing the probation bond herself," said she would make weekly reports to the hospital and "also made her will leaving her trunk and stuff which she had to other patients."(44) After arriving home she wrote to Dr. Clare:

I got to my destination all right. I went out on Monday not very far[,] it does seem so funny not to have so much noise around me now[,] it is quite a change[,] I do miss you all so very much.(45)

The most important influence in securing Mrs. A.'s release was the persistent efforts of Mr. A. By waiting until his wife felt comfortable enough to leave, and by meeting the hospital's condition of ensuring home support for Mary, this discharge was one where both the patient and asylum administration were persuaded by an outsider that it was time to depart. Mary's initial reluctance to leave a place she would refer to negatively in later writings, also raises the importance of the varied perspectives a given patient could have about the asylum experience. On the one hand being confined was traumatic, while on the other hand her fear of losing contact with a familiar place and friends among both patients and staff led to insecurity about what would happen to her afterwards. Though some relationships with patients were unpleasant as is obvious by the attack, her bequest upon departure also shows that she did have affection for other inmates. It is likely that the thought of leaving friends behind was difficult, especially since the ability to form new friendships in the outside would in itself have been a daunting prospect due to the stigma of
incarceration and her lack of mobility. When she did leave the difference was immediately apparent. The peacefulness of her new surroundings, which Mary remarked upon after arriving home, gives a strong impression of the stressful world she left behind. The fact that she started doing domestic work around the house so soon after her release, also indicates how this discharge was also seen as a practical benefit by her husband in the context of traditional gender roles, and supports the observation of Cheryl Krasnick Warsh that women who did domestic chores were prime "candidate[s] for premature discharge," at the behest of their family.(46)

Mary was finally discharged in December, 1911 six months after being released on probation with a diagnosis of "Dementia Praecox, Hebephraenic (sic) variety, improved."(47) What is notable about this is that her diagnosis was so positive from a condition that Dr. Clarke had several years earlier described as "evidently one of the most incurable of all mental diseases."(48) Mr. A.'s persuasiveness with the doctors was helped in large degree by his wife's quiet, dependable nature which was an important factor in ensuring her liberty. For the next twelve years, until her death in 1923, Mary and Henry lived together in Toronto. During her first three months of probation in 1911, and again during the year before she died, Mary wrote a series of letters to asylum doctors which
shed light on what she thought about her new life and about the place she left behind.

References to her physical pain and the feeling of being a burden to others are mentioned during the first months of freedom. Though her son who lived downstairs did visit her, this was not the case with other family members including Mary's daughter and grandchildren of whom she wrote, "does seem so hard to me having brought her up."(49) Henry took her out in the wheel-chair, including to church on Sundays where she "joined in the service very heartily."(50) Yet things did not go as smoothly as was first reported. Mary became increasingly upset during her second month of probation during which Henry reported the only way to soothe her was to play music on the gramophone.(51) Having had to take an additional leave of absence without pay at the post office, Henry asked Doctor Clare if she could be sent back to the hospital for a while as he feared it was not possible to look after her.(52) On the same day as this request was written, Mary also wrote to Clare asking for her own extended leave of absence, pointing out that she had been a "hard worker in the building for 17 years...but I don't want to be forced back[.] I will come quietly."(53) She was saying, in effect, her past work should entitle her to more time off.

This back and forth, to return or not to return, continued from late July to early September, 1911 and makes
for curious reading, not least because of the administration's response. On the same day as the Assistant Superintendent extended Mrs. A.'s probation for a month and wished her enjoyment during this period, the Superintendent wrote to Mr. A. asking him to return her as soon as possible. Knowing that she had requested to visit the asylum, it was suggested to Henry that he bring her there, and then tell her to stay.(54) The aim was obviously to surreptitiously return Mrs. A. with the least amount of resistance. Mary's stated position of returning if and when she wanted was softened a few weeks later with her own admission that she needed to get along with others at home by not quarrelling and trying "to hold my tongue."(55) This was at the same time that asylum doctors were trying to convince her to return to the asylum first by promising Mary "the best place we have in the house."(56) When this did not work, a punitive solution to problems with Mary's relatives was alluded to: "...we will always be glad to see you back here and possibly it would teach them a lesson if you just left them and came right back."(57)

A week later Henry informed the asylum that Mary was getting into a routine of dressmaking, was becoming more used to her surroundings and was troubled at the prospect of returning to confinement. His employment problems were worked out to their satisfaction and the earlier request to return her was withdrawn.(58) Mary's determination to stay at her new residence is made clear a few days later in a
letter to Doctors Forster and Clare:

....you ask me very kindly to come back to the institution (sic) really I have been in that building for 17 years and never been any were until I came here[...] that the change is what I wanted so when I get tired I will take your advice...(59)

There are no further letters in this file from the probationary period which ended in December, 1911. The difficulty of settling in to completely new living arrangements for both a released patient and relative is an important aspect of the discharge process which these letters highlight. This distress was intensified for a patient who had to experience bigotry from people who wanted nothing to do with her because of her status as a former asylum inmate. The efforts of both parties to try and consider the needs of the other person, Mary by curtailing her arguing, Henry by ensuring that she was kept occupied, were crucial to keeping this former patient at her new home. At the same time, Mary’s insistence that she wanted to stay out of the hospital, in spite of the initial efforts of her husband and the doctors to persuade her otherwise, demonstrates an ability to decisively influence her status, independent of the men around her. Whereas Henry was the most crucial agent in securing his wife’s release from hospital, it was Mary’s steadfastness that kept things moving along in a hopeful direction for the former inmate. Asylum officials were in a state of legal limbo during a probationary period such as this, and could only offer
advice from the sidelines. It was up to relatives or friends to return a released patient during a specific time period. (60) The final part of the discharge process after leaving the hospital was very much based on decisions made by laypersons rather than medical officials. This allowed a released inmate a much larger degree of influence about what would be their fate than when still confined.

Mary and Henry return to the files more than a decade after this tumultuous summer, in early 1922. Her friendly relations with the hospital staff, which comes through in much of their correspondence, even extended to writing a rather mischievous poem to her former doctor:

Oh my Dr Clare why do you stare
At the people whom you meet
It is so rude for you to glare
at them in the Street
and when you have done your staring
I am sure you must be tired
To have to do so much Glaring
at every little child (61)

After Mary's death in May, 1923, her husband informed Doctor Clare and noted: "She always thought very highly of you..." (62) As a fitting postscript, Henry also wrote that their son and daughter lived only a few minutes away "...so that the last you see we are all united again." (63)

The evidence clearly shows that this discharge was beneficial to the patient. Even though she did not explicitly request to be discharged, Mary was successful in maintaining her liberty because of the willingness of this patient and her husband to work at forging a supportive
relationship after her injury, in spite of the obstacles which they both encountered along the way. Their struggle for a life together again, beyond the barriers of the asylum walls, is a positive antidote to the often bleak assumptions about prospects for patients who were diagnosed with severe mental illness.

The release of a long-term patient to a neighbourhood boarding home provides evidence about the usefulness of community reintegration. Adam C. had pleaded for release for years after his confinement in 1897 through personal letters, though by the early 1910s this had stopped. In 1925 Adam and his wife, Laura, ended decades of estrangement. She began to visit him on a regular basis after he refused to see her for almost thirty years. (64) Her support for the man who had abused her prior to incarceration, and who then rebuffed her for so long is at least as impressive as that of Henry for Mary A., about whose relationship there is much more documentation. The evidence that does exist shows that during the last years of his life, Laura made dozens of visits to Adam and sent him regular supplies of clothing and food. (65) The importance of these visits to this elderly couple are obvious and may have helped give Adam enough peace of mind to unintentionally encourage his release. By December, 1933, entries in the clinical record note that 71 year old Adam C. was "able to carry on a good conversation [and] expresses no delusions or hallucinations." (66) Thus, this once withdrawn figure, fearing persecution and shunning
contact with many of those around him, had changed into a "quite pleasant and agreeable" patient by the time he was sent to a boarding-home on May 4, 1935. (67)

Yet, as with Mary A. over twenty years earlier, Adam had to be persuaded to leave the hospital. The similarity is striking in another respect: Laura, like Henry, was extremely cautious about not wanting to offend her spouse or do anything that Adam did not wish for fear of upsetting their re-established friendship. So while she was "more than willing" to take him home, Laura wanted to make sure this proposal came from the doctors and not herself. (68)

When the offer was made in the late summer of 1934 and again in March, 1935, Adam decided to stay in the hospital. (69) The only reason given for his stance was his wanting to "stay where he was for the winter." (70) For an elderly man used to nearly four decades of institutional life such a decision would have made particular sense. The prospect of coping with inclement weather was less intimidating in an environment he was familiar with, than in a neighbourhood about which he knew very little. Getting used to a new home in the spring was therefore physically safer.

For the first ten months after his release, Adam was placed in a boarding-home with other men where he was visited regularly by a social worker and his wife who went out walking with him. Since Laura was experiencing financial problems, the hospital agreed that "we had to look after our patients" and ordered new clothing for her
husband. (71) During this probationary period he was reported to be very quiet, "almost pathetic in his desire not to make trouble." (72) His withdrawn nature was believed due in part to deafness as well as a result of years of confinement in the asylum. (73) Thus the hospital report was making a link between the development of passivity and decades in an asylum environment. Certainly, this laconic disposition was in contrast to the years when he was writing letters demanding liberty. Yet, Adam was not without plans for the future. He "surprised" his wife by announcing he wanted to apply for an Old Age Pension so they could move into their own home. (74) His earlier attempt to secure a pension had been turned down in 1932 because he was a mental hospital patient. (75)

In late March, 1936 74 year old Adam C. was granted a pension and was given his final discharge from the hospital, less than a year after leaving the asylum and almost thirty-nine years to the day after his admission. (76) He was placed in another Toronto home, though there is no mention of moving in with his wife. A month later, Adam was admitted to St. Michael's Hospital where he died of carcinoma on May 4, 1936, barely six weeks after he had been discharged as Dementia Praecox, improved, and one year to the day after he walked away from confinement. (77) As with other cases, his prognosis and the extent of external support were important in influencing the prospects for release. Yet, what is most striking is that a person who
had spent so much energy trying to win his freedom, would
give up this quest so that it was left to hospital
officials to raise the suggestion. Ironically, his mellowing
with age was a major factor in ending both his campaign for
discharge and helping to secure his release. With the
steady support of his wife, Laura, Adam eventually developed
into a less troubled figure during the last years of his
life which more than anything else led to a favourable
prognosis. The change brought about by personal contact
with Laura, with whom Adam shared an obvious emotional bond,
made a great difference in his personality and in his
stability. The emotional levelling effect of confinement,
remarked upon after his release, also played a role in
altering his temperament and led to his release to a
boarding-home.

Though the case files of most discharged patients
examined for this thesis do not provide a great deal of
information on the post-hospital experiences of patients,
even those files with a "snapshot" provide some evidence to
glimpse how a former inmate was doing outside. Several
months after her release in 1928, Minnie B. wrote a letter
to Doctor Fletcher who had treated her.

I am writing this to thank you for the interest you
took in me + for all you did for me while I was in your
hospital. Am also sorry for the way I spoke to you the
day I was cross because I was not let go home.... I am
always "Doing those things I ought not to have done and
leaving undone those things I ought to have done."(78)
Though social relationships in the community are not discussed in this letter, Minnie's tone indicates that she was able to cope with life away from 999. In other instances, information in files on discharged patients points to the end of their journey. If a patient was fortunate to have relatives who were willing and supportive enough, their death could be eased by being released to go home to die. Nina B., 82 years old, gradually became weaker due to anemia in the Autumn of 1929. After almost a quarter century of confinement, her daughter took Nina home where this "elderly woman with white hair" passed away three weeks later. However, even when this was reported to have occurred, all was not so final. One 82 year old woman was taken home to die by relatives in 1875, but the change had such a "salutary effect" on her that she was returned "hale and hearty" though unimproved mentally. What happened to this unnamed patient after re-admission is not recorded. These latter two people provide a window onto the next section.

Death of Mental Hospital Patients

Yannick Ripa has written, "We have no idea of what madwomen thought about death... [T]here is simply no evidence at all." While this may be true about the nineteenth century asylums in France which Ripa studied, it is not so about the Toronto Hospital for the Insane. As will be shown below, there is evidence which provides a
small glimmer of light about women and men patients’ perspectives on, and experiences of, death and dying.

Figures in Table XI C show that the death rate at the Queen Street facility between 1846-1940 was highest for males at 55.25% of all inmate deaths, 44.75% for women patients. This figure is similar to the mortality rate of male and female inmates in France, though over a much shorter period, 1842-53. During the seventy year period covered by this study, death rates did not fluctuate as wildly as they did for admissions. In the early 1870s the death rate for patients in the Toronto asylum was 6% and in 1940 it was 6.53%. In between these years, figures dipped as low as 2% in 1884 to a provincial and institutional high of 16% in 1920 (compared with an Ontario mental hospital average of 8.50%). The average provincial asylum death rate between 1884-1904 was 5% to 7%, a rate which was reflected at Toronto. However, the death rate at 999 was higher than the provincial average in later years, with figures being separated by over 8% in 1920, 7% in 1925 (13.53% compared to 6.29%), and thereafter declining to a division of 3% in 1930 (8.65% compared to 5.79%) and a 2% divide in 1940 (6.53% compared to 4.74%).

These statistics show that mortality rates at Toronto were on a close par to the overall asylum discharge rate. However, the situation at Toronto in this respect was better than mid-nineteenth statistics for the Lancaster Asylum.
where J.K. Walton has found that "the death rate was almost always higher than the cures."(87) Why Toronto had more deaths among patients than the provincial mental hospital average is not clear, though it may have been due to the declining state of the facility as it became more dilapidated during the early part of the century, when there were plans to close down the building, plans which evaporated by 1920, after which the institution was refurbished.(88) Table XII shows that a majority of the causes of death (56.64%) were not tabulated between 1846–1920. Why there were so many unrecorded deaths probably related to a combination of unsystematic record-keeping during the nineteenth century, as well as what S.E.D. Shortt referred to as "vague and imprecise" diagnoses during this period.(89) Deaths that were recorded up to 1920 show that of the causes that were listed, mental diseases killed the largest number of patients, 27% of the total, out of which paresis made up 73% of this particular group, 90% being men. Old age was second at 18.4%, a figure that is not surprising in a large chronic institution. Infectious diseases made up the third largest cause of death at 15%, with tuberculosis being the leading killer here, comprising 73% of this category, a little more than half being women. Circulatory diseases were another prime cause of death at 13.3%, out of which two-thirds were due to heart disease, nearly evenly split between women and men.
When considering mortality figures for the last two years of this study, 1939-40, for all mental hospitals and the general population of Ontario found in Table XIII, heart disease is the only one that is closely approximated in statistics for non-mental hospital patient deaths. Respiratory diseases, pneumonia and bronchitis, were major causes of death among provincial mental patients, 29.8%, in contrast to only 6% for the rest of the province. This figure is striking in one other respect – the figures for Queen Street up to 1920 show that this category was only responsible for 8% of all known causes of death in earlier decades. Tuberculosis continued as a notable health threat, in contrast to the general population. However, it had declined from two decades earlier, likely due to the large-scale intervention programme undertaken beginning in 1933-34 at all provincial mental hospitals when regular TB check-ups were instituted every four months.\(^{90}\) Diseases of the arteries and cancer were the only two out of six causes of death listed in 1939-40 which were more widely felt outside provincial mental hospitals than inside.

During the entire period covered by this study, there were no major catastrophes, such as a fire, that impacted upon asylum patients' mortality. The closest disasters were reports of epidemics, or fear of an outbreak, such as in 1874 when four female patients contracted small-pox. Fortunately, this disease was contained and the patients recovered, but not before three-quarters of the staff fled.
in terror of being infected. (91) The most serious episode threatening the survival of a large number of patients at once was that which spread around much of the western world, and the Toronto Hospital for the Insane was no exception: the 1918 Spanish Influenza epidemic. It struck at the beginning of October, 1918 with nurses affected first, followed by twenty to thirty patients a day and lasted for a couple of weeks. Three hundred patients became ill, or 25% of the entire inmate population at that time, out of which thirteen patients died. All patients between 20 to 40 years of age were vaccinated and by the end of the month the epidemic was over. The hospital, which was closed during this episode, was then re-opened to visitors. (92)

All of these figures bring us back to the individuals who made up these statistics. Philippe Aries has written how, in the early twentieth century, death in the Western world was a very public affair, often with the whole community participating by observing an individual’s passing and burial. (93) For inmates of an insane asylum, how were death and the rites of mourning and burial experienced? What happened to an inmates’ belongings after they died? Were deaths of the insane "public" among those who knew them inside and outside the asylum? How did this most final of all human experiences affect those who remained behind in the asylum, if at all? In trying to answer these questions, the purpose of the rest of this chapter is to look at a topic that was an integral, and final part of the
patient's experience - death. The manner in which inmates died can help to explain a great deal about hospital conditions at the end of a patient's life, and the rituals and procedures which followed their death.

Tracing the last months and days of an inmate is possible through clinical records and clinical charts which provide details on the cause(s) of death and emotional state of an inmate during this final period. These often consist of references to a person's gradual decline after many years at 999 Queen Street West. Andrew J. had leg infections on and off for several years before being sent to the infirmary at the age of 83 to live out his last year in 1922-1923. It was reported that he was "becoming quite settled in the infirmary" where his condition was considered "rather good" for such an elderly person. Affectionately known as "The Captain," Andrew stated that the news was always bad and "will read away at his paper" while in the infirmary, right up until two days before his death which was attributed to old age after forty-one years of confinement.(94)

The gradual decline of a patient could be reported on with no reference to any treatment being delivered. Erin L. was 54 at the time of her death in 1914 after thirty years' confinement. Reputed to be violent and "extremely cruel" towards other inmates, she was obviously disliked. During the last two weeks of her life, three entries record how she was "in a comatose condition," was so restless that she was kept on a mattress, "breathing very heavily," and finally
died of apoplexy. (95) While the cause of death is usually stated, there are some files which provide only brief, rather vague references to the demise of an inmate, as is the case with 59 year old Jed M.:

Oct. 29, 1918. This man has gradually been becoming weaker for some time and now has to be spoon fed. I do not think he will live very long.
Oct. 30, 1918. Patient died today. (96)

In other files, information clearly shows that the impact of oppressive weather conditions, or a sudden injury could help to bring about the death of a frail, elderly patient. Seventy-eight year old John Y. spent the last four months of his life bed-ridden on the infirmary. Growing steadily weaker, it was noted in June 1911, that he "was much prostrated by the extreme heat yesterday and passed away quietly about six o'clock last night." (97) Eighty year old Ellen G. was known to enjoy wandering about the asylum grounds, and on one such occasion she fell and cut her head, requiring four stitches. Ellen went into shock and died two days later. (98)

There were also lingering deaths, in which patients painfully deteriorated over an extended period, as their ailment worsened. During her last two years at 999 Queen Street, Irene B. suffered from cancer of the right breast which gradually spread to the lymph glands, from which she died in 1933. (99) When patients such as Irene were on their deathbed, hospital staff tried to make their deaths less physically painful. Sixty year old Anna P. became steadily
weaker during her final month and was given strychnine and whiskey. She slipped into incoherence and her body became discoloured as she slowly died of "General Exhaustion." (100) At the same time, if a patient was unwilling to stay in bed, or receive medical assistance, the deathbed scene could be chaotic, even more painful for the inmate. Though she was dying of pneumonia, Nelly H., 58, was unwilling to stay in bed which "made it very hard to help her....and to keep her warm." (101) Evelyn T. was 63 when it was observed that her legs were "greatly swollen" with blisters, due to edema, or dropsy, of the "hard variety." (102) Her subsequent death, and refusal of medical assistance was recorded by Doctor Vrooman:

She would permit of no examination, and aimed two or three vigorous kicks at me when I approached her; these, however, did not reach their destination. She would not accept any attention from the nurses, but persisted in getting out of bed. Her condition was rapidly progressive, the edema spreading all over her body and swelling up her neck and face to a most extraordinary degree. She finally died from organic disease of the heart at 5.50 A.M. Feb. 8/23. (103)

The connection between physical and mental health was written about by one patient, and provides a rare glimpse of a distraught patient’s perspective about her final collapse. Fifty year old Annie E. had been confined for nineteen years in 1910 when she wrote to asylum doctors pleading with them to blow her up with dynamite because "Mine is the sadest case on earth." (104) A few weeks later, in July, 1910, she wrote that her body felt:
...unnatural... it unwound in the top of my head lick a clock + seemed to take all my nerve + natural life all down the back of my neck + head + a way down my back... if I lay down to sleep I cannot stay in bead I am up and down the Hole night[..] I feel very sorrow to half to explain all this to you but I have been like this longe enough and you Doctors don’t pay the slightest ationen to me were you should put the exrase on me and see what is wrong...(105) [Original writing].

Three months after she wrote this letter Annie died only a few hours following the discovery that she had a strangulated hernia.(106) Her immediate cause of death was recorded as "Exhaustion of Melancholia" lasting one week, while the primary cause was listed as "Manic Depressive Insanity" lasting twenty years.(107) During the last year and a half of her life, entries in her clinical record contain repeated references to her deeply distressed emotional state, which is reflected in the letter noted above. Her last months were spent without any expression of hope for herself, asking other patients and staff to kill her and predicting her imminent death on several occasions.(108) What these letters and observations indicate is the connection between an inmates feeling of hopelessness and her physical condition. Annie’s comments about the twisted state she felt her body to be in at the time of writing her last letter should be understood in the context of her deteriorating physical condition leading up to her death several months later. That she was asking for help is obvious in the desperation of her comments inviting death on the one hand and begging for more attention from asylum doctors on the other hand. Yet it is clear that the
impact of her severe physical problems on Annie’s overall health could only have exacerbated the emotional turmoil she was experiencing during her final traumatic months.

In the course of witnessing the death of an inmate, entries were sometimes made in their file which allows us to glimpse the last comments of psychiatric patients as they were about to die. Comments by two patients in particular expressed a haunting prediction about their pending demise. Forty year old Nancy K. spent her last weeks in the infirmary suffering from bladder problems and paralysis. When a urine sample was taken by catheter she wept and said "I can’t lie on my back or on my side, I don’t know what to do, they’re trying to murder me here."(109) A month later, writhing in pain, Nancy cried out “Oh if I only had a mother I could stand it better. I can see the minister standing there reading over me.”(110) She died the next day, only sixteen hours after this comment was made. Joseph S., an eighty-four year old man suffering from pneumonia, expressed impatience with his treatment. He not only refused food and liquids at times but was upset that, after having defecated in bed, he was not being attended to quickly enough: “Come on! Come on et change me! [sic].”(111) A few days later he said “I’m going soon” and died within a half hour.(112)

Other patients, while their last words were not recorded, nevertheless exhibited behaviour which provides a good indication of their state of mind as death approached. Only fifteen minutes before she died of complications
arising from a coronary thrombosis, Milicent M. was reported as "Talkative — seems to be scolding some one — very noisy."(113) Nelly H. was anything but calm during her last hours which she spent "greatly frightened and afraid of something."(114) Thoughts of one's earlier, pre-confinement life, could also recur during an inmate's last days. Albert C., 47, had been confined for twenty-two years at the time of his death in 1911. It was noted that shortly before his death "we heard him say something about Belleville and he also asked for his keys as he said he had to lock up."(115) Sixty-seven year old Elizabeth H. spent her last days in a state of complete despair, after her leg was fractured in an accident, crying and screaming that the plaster cast on her leg was hurting her, before she succumbed of "Exhaustion from dementia."(116)

While the deaths of some patients were recorded as sudden it is apparent that in some cases their deteriorating condition had not been caught before it was too late. In 1917, 63 year old William G. "suddenly took sick" only a few hours before his death. He complained of stomach pains, lost his pulse, turned blue and died of what was discovered to be duodenal cancer.(117) Some deaths occurred so quickly that medical help was impossible, as inmates died where they fell, among other patients. Cyril M. ate his breakfast, smoked his pipe and "was lying quietly on the sofa" talking to another patient, when he suddenly rolled onto the floor, "gave two short gasps" and died of heart failure.(118)
Similarly, in 1947 Michael F. ate his dinner, walked down the hall, and "slumped to the floor" dead from a coronary thrombosis, after forty years' confinement.\(^{(119)}\)

The two most shocking forms of death within the asylum were violent deaths, murder and suicide. There is no record of a staff member being found responsible for killing a patient, though it was reported in 1878 that an inmate died due to severe fracture of the ribs. After an investigation by Daniel Clark, it was concluded that none of the attendants was at fault with this death instead recorded as due to the patient being "exceedingly violent and unmanageable."\(^{(120)}\) How this led to death is not explained.

Three patients were recorded as being murdered by other patients between 1884-1890. These deaths, one male and two females, all took place in isolation cells on the refractory ward which were shared by two inmates.\(^{(121)}\) Clark ordered closer monitoring and an open door policy of these cramped rooms as a preventive measure after the last murder. Some two decades later, the death of a woman patient suggests how these cramped conditions brought about another inmate's violent death. Maude M. was confined at the nearby King Street branch of the Toronto facility in 1911 when she was attacked by an inmate who knocked her over and jumped on her with both feet in the room they shared. Two nurses who were present did not initially stop this assault as they feared that they would be injured as well. After she was rescued, Maude's pulse was noted to be weak and her limbs
were immobile. Doctor Clare suspected she might have had a fracture of the femur. He decided to "leave her alone until she might rally a little."(122) The next day, Maude died at which time Doctor Clare found that she did have a fracture of the left femur. He concluded his observation:

It was found that the patient died of a pneumonia of the right lung which had been caused by placing the patient in bed on her back... As we have no address of friends and as no one has visited patient for a long time and no correspondence she will be buried by the institution.(123)

As Table XII shows, up to 1920, suicide occurred among 1.3% of all known causes of death, with males making up the majority, 63.6%. For some inmates, despair, memories of the past and isolation were too much to handle. In one case, the motivations of a potential suicide were recorded in detail, as medical intervention postponed her death for a short period. The despondency which brought about a suicide attempt could be well planned and prompted by traumatic memories from the past, before confinement began. This occurred with Mabel I., a 72 year old woman who had been at the Toronto Hospital for the Insane for 48 years when she took cleaning disinfectant in 1918. She had hidden this poison for over a year in preparation for her attempt to kill herself which was triggered, at least in part, by memories of her own father's suicide half a century before, when he could not go through with selling the family farm. Her despondent feelings were recorded: "She said the pain was so bad that she had to pass into the other world. She
had been here a long time and they were calling her to the other world." (124) Her description of the day her father ended his life and the power this memory exerted on Mabel was recounted in detail in her clinical record with the conclusion:

It was a rather remarkable story from one who has been a patient here for almost 50 years and also shows that she had contemplated ending her own life, as it seems so imprinted on her mind. (125)

When the hospital staff washed out her stomach, Mabel became "quite excited" and begged the doctor to allow her to die. (126) Upset that medical treatment saved her life, she said her suicide attempt was "a poor way as it is not acting quickly enough" so she should have "tried some other way." (127) Mabel died two months later of pneumonia.

For other patients, a sense of hopelessness in their present situation could influence their decision to die. Francis B. was 64 years old when he took his life in his forty-first year of confinement in 1919. More than two decades earlier he had asked to be discharged in a letter to the Inspector of Asylums and in another communication to his brother-in-law. (128) Very little personal detail has survived about this man, but what does exist gives later generations a vivid picture of his last, despondent moments.

At 6:50 a.m. this morning Mr. Clark, supervisor of Cottage C was notified by patient W____ that Frank B____ was lying outside on the bench covered with blood.... I found the patient on the grass with a jagged wound in the right side of his neck about 3/4" long. The ground was covered with blood althoug (sic) the patient was not bleeding at the time. He was removed to ward 12 and appeared to be very weak from
loss of blood.... His pulse was very weak and rapid and he breathed with difficulty. He died at 8.15 a.m. Patient had inflicted this injury with a large jack knife which he owned. Before his death he talked in a very depressed manner. He said he wanted to die, that he was only dust and it was no use living any longer. (129)

When a suicide occurred, the coroner was called in and an official report was filed by the Superintendent with the provincial government. In one instance the Inspector was not satisfied with the information provided. Arlene S., 45, had been confined for fifteen years by 1918 during which time she constantly tried to escape, but was either unsuccessful, or was recaptured each time (as was discussed in Chapter 3). After breaking windows, she was placed in a pack, which was used to restrain patients, and was then confined in an isolation room, with tragic results.

Yesterday the nurse visited her about 2 o'clock when she was alright. About 4.30 o'clock they reported that she had made a noose and attached it to the grating of the door and strangled herself. When Dr. Clare saw her she was dead. (130)

After receiving a letter from Superintendent Forster about Arlene's death, Inspector Dunlop wrote back inquiring about the responsibility of the staff to prevent "such an accident." (131) Forster wrote back that, due to problems finding more personnel, there were only two nurses on duty. They were responsible for all 82 patients on the ward so that "while regretting the outcome in this patient's case, I cannot see how it could have been avoided." (132) There were no further inquiries about Arlene's death. This exchange between Dunlop and Forster highlights the
impersonal nature that death could take in such a large public facility. On a large ward such as this, with one member of staff for every 41 patients, it would not have been possible for the staff to give much personal attention to inmates, other than restraining measures which would only have intensified her distress. The common bond that makes the suicide of both Francis and Arlene so poignant is that both patients were recorded, at different times, as having unsuccessfully tried to secure their release, though by very different methods. This point provides an important clue about what may have motivated their last desperate act—despair at never being released.

However, one suicide provides another angle on motivation—distress at the thought of leaving 999 Queen Street West. An eighty year old man, John H., had been in the asylum for over thirty years when it was decided to transfer him to Hamilton with other patients in 1884. He cut his throat and died two days later in an act that Daniel Clark wrote seemed to have been brought about by "the idea of leaving this asylum, where he had resided so long."(133) This episode raises the point about how the prospect of removal, or actual removal from the institution, could have such a devastating impact on a patient, something which was revealed nearly fifty years later in the following non-violent death. Jonathan D. was 78 years old when he was sent to the House of Industry after twenty-five years at the Queen Street facility. It was noted that he was "very
quiet" so he was sent on probation to see if he could "adapt himself satisfactorily" to this new location. (134) Instead, this man who was originally from the United States and had no known family, was devastated at being removed from an environment he knew so well. The details of the events leading up to his death were reported in a newspaper:

It was about 4.15 [P.M.]... that D__ was brought to the House of Industry, stated Mrs. F Laughlen, superintendent of the establishment. "About 20 minutes later, according to my report, the old man approached the clerk and said that he was going home. This isn't a prison and we cannot exactly keep our inmates in by force. That was the last we saw of him...." Three hours later after having covered four weary miles of tramping, the aged man collapsed in front of R.H. Burrell, on Sunnyside Avenue. "I'm tired," is all he could say to Burrell. He was taken to St. Joseph's Hospital a few blocks from the home he had known for a quarter of a century and there he died four weeks later, while futile efforts were made to find his friends. (135)

Another report noted how Jonathan spent his last days in the hospital:

During his month at this institution the old man never uttered a connected sentence, the sisters said. He was never heard to say a word that even gave a clue about his former life. (136)

No cause of death is specifically stated anywhere in his file. The fact that he was in good physical health at the time of his release a month earlier, and considering the emotional distress he experienced, suggests that the trauma and disorientation of being sent away from the place he literally called home, may have been part of the reason for Jonathan's death. The tragic irony of this destitute old man's demise, is that the only reason we have such a
detailed account of what happened to him, is that at the
time of his death, press reports circulated that Jonathan
D., "the amnesia victim" according to the press, was in fact
Ambrose J. Small, a millionaire Toronto theatre owner who
disappeared in 1919.(137) Many of Small's former
acquaintances and a male relative came to look at Jonathan
as he lay in the morgue, and the Chief Coroner, Chief
Constable of Police and Assistant Chief of Detectives all
became involved in the investigation. It was not until
asylum Superintendent W.K. Ross saw the description of
Jonathan's clothes in the newspaper as belonging to his old
ward 8, that a positive identification was made.(138)

Jonathan D. spent his final days in, what must have
been for him, a bewildering world where he was unable to
communicate with those who were trying to find out his
identity. That he "fell through the cracks" is evident
since he left the House of Industry and "disappeared." The
employees there claimed to have told 999 Queen Street of his
departure, while the asylum claimed the call must have gone
out to the wrong institution, and no one at either facility
bothered to follow-up on how he was getting along.(139)
Forgotten by those who were supposed to watch out for him
while on probation, until the newspaper stories came out,
Jonathan's death serves as a tragic example of how taking
someone out of an institution was not an automatically good
thing for the patient involved, as clearly this had not been
the desire of this poor old man. It also illustrates the
class-based nature of his death, where he only became a person of widespread interest after he had died, and only then because of the mistaken belief that Jonathan was a missing millionaire. The publicity surrounding his death was certainly very unusual for an asylum inmate. Most people who were wards of the state, like Jonathan, more often died in the obscurity of the institution in which they resided, mourned in some cases by no one, or if they were fortunate, by family members, some employees and patients who had come to know them over the years.

There was considerable respect shown to dying inmates, both in the physical care they received and in attention to their spiritual needs. A few days before his death, due to chronic heart problems and senility at the age of 74 in 1926, Paul M. requested and was granted a visit from a priest who administered the last rites. (140) Similarly, Carl M., Winston O., and Mavis M., were visited by a priest from St. Michael’s College in the days before their death to administer this religious sacrament. (141) How deaths such as these affected others is not usually stated. In a few cases, however, evidence does exist which clearly shows the impact of an inmate’s passing on those around them, as is noted in the following observation about the reaction of May F., a long-term patient:

May works about the doctors’ flat usually, but at times she has spells, commencing with depression, for a week or ten days, usually brought on by being upset over somebody dying, whom she may just know. (142)
In the case of this patient, an orphan, and others like her, deaths of acquaintances among the patient population could have been especially upsetting. May belonged to that category of patients who were termed "friendless," individuals who had no known relatives or friends outside of the institution. Thus, the death of another patient with whom an inmate had had a friendship, possibly lasting many years, would have caused a great deal of grief for people without external support networks, as well as for anyone else who liked a particular resident. Staff were also affected by the deaths of those whom they had come to like, or felt sympathy for an especially unfortunate person.

Testimonials were occasionally recorded in case files, such as with Violet N., discussed in the chapter on labour. One man who died of phthisis in 1871 had been resident for twenty-three years. Joseph Workman noted, "He was the well known blind man, who rejoiced in the possession of all the highest titles of the British peerage; and he would have stood in the Hierarchy many degrees above St. Patrick, had he not declared himself that very personage. His absence has been felt not a little. Take him for all in all, this asylum will never hold his equal."(143) Fifty years later, another patient, Ellen K., had a lengthy tribute paid to her by Doctor Vrooman, two days after her death at the age of 77:

Sept. 10/23 (F.S.V.) Mrs. Ellen K__ has been a patient in this institution continuously for a period of thirty six years. During twelve years of that time I have had
her under my observation for considerable periods and, although very insane at times, her instincts have always guided her sufficiently that I have never known her to either do or say anything that was unseemly. In her lucid intervals she remained bright and companionable. She always read the daily papers and magazines and kept fairly well in touch with current events.... She is in age, as in length of residence, one of our oldest patients, and I wish to put it on our records that throughout her residence here she has commanded the respect of the other patients as well as those who have cared for her.(144)

Finally, there is the tragic story of Lizzie C. Her short life ended in 1912 at the age of only 27, the last eight years of which she spent confined at 999 with epilepsy. Lizzie, who spent her final years consoling herself by nursing and singing to a doll, had "severe frequent convulsions" which increased her weakened state.(145) After she died, Lizzie's autopsy noted that she weighed eighty pounds, and had "numerous adhesions" on her scalp, likely due to injuries sustained while having seizures.(146) The final entry in her clinical record poignantly illustrates the utter loneliness of life and death for some asylum inmates:

We have made every effort to locate friends but up to the present have been quite unable to do so. No one about the institution has ever known her to have a visitor. The name of the correspondent on our cards knows nothing about her, and she seems quite without friends or relatives.(147)

Disposal of the Remains of Patients

In 1887 Daniel Clark referred approvingly to American alienists' views that more autopsies were needed as too much "material" was allowed to "go to waste," without contributing to medical knowledge.(148) From the late
nineteenth century, autopsies were performed at the asylum mortuary, referred to by First Assistant Physician, Ezra Stafford as an "excellent" facility which was used for this purpose frequently. (149) The mortuary was located at the north-west corner of the grounds, attached to the complex of farm buildings. (150) Post-mortem exams were undertaken with the consent of families, according to Superintendent Forster, though for isolated inmates like Lizzie C., there is no evidence that consent was required by anyone. (151) However, after 1933, it was necessary to have the permission of both the next of kin and the District Crown Attorney at all provincial mental hospitals. (152)

Though autopsies were not conducted on all deceased inmates, there was a standard report filed on the physical condition of a patient at the time of death (or discharge) which began appearing in most patient files after 1909. This document, issued by the province, records the external physical appearance of a dead person as well as the items and disposal of a departed person's belongings. Most of the comments are very brief and are what one would expect to find on a form about someone who has just died. For example, "Very thin in a wasted condition," is noted about Henry K. after his death of pulmonary tuberculosis, while others are much less descriptive, such as that for Mathilda C. which contains one word comments of "Good," and "None" when referring to her physical condition and indication of bruises. (153) On the other hand, a description can provide
gruesome details of the hygienic conditions in which a patient died. The following entry was written about the corpse of Evelyn F., who died of tuberculosis on May 2, 1909 at the age of 23:

Body very thin: left hand and right elbow had been bitten by the rats the preceding night: slight discoloration there and above left eye.(154)

This form was signed the day after her death, but records the examination as having taken place less than two hours after Evelyn died, after six years' confinement. The reference to rats biting her "the preceding night" thus raises the spectre of this young, poverty-stricken woman spending her last night under especially distressing conditions.

The disposal of a dead patient's personal belongings, in cases where they had any, was taken care of quite simply, either by sending the material to relatives, or should they not want them, disposing of them within the institution. If clothing was sent to the morgue with the body, as occurred with Mary D. in 1932, then these items were most likely not fit to be re-circulated among other patients, and so were burned.(155) On the other hand, an individual's personal effects could be distributed among those inmates who had nothing. It is worth noting that among "friendless" patients, their only belongings were institutional clothing. The sister of Anna P. specifically requested that some of her items be given to this deceased patient's close friend:
...among the Patients, was a Mrs. W__, with whom my sister was very friendly, and who was kind to her, if she would like any little things, as a keepsake, would the supervisor be good enough to let her have them, there was a workbag, sent last Christmas. Any books or cards, in fact anything she would choose, and we would like you to thank her from us, for all her care + kindness...(156)

Dr. C.K. Clarke responded by noting this request, and an earlier reference to give "my poor sister's clothes" to other needy patients:

...we will dispose of the clothing, etc. belonging to Miss P__ as requested as we always have some patients who have no friends and who are very glad to get other than institution clothing...(157)

There were also families who were not so generous, as with the relatives of Ellen K. A very wealthy private patient, her belongings included a fur lined coat, two hats, three pairs of gloves, six handkerchiefs, bedroom slippers, books, pictures and a clock, among other luxuries, all of which was packed up and sent back to the family estate following her death in 1923.(158) In one case, a family member exhibited appalling cruelty by taking away a gold ring which belonged to her sister, Eunice M., as she lay dying of cancer of the breast, from which she succumbed two weeks later.(159) More common, however, was the respect shown to inmates like Sandra C. who was confined for over the last twenty years of her life. After her death at the age of 64, it was noted that Sandra's only personal belonging was her wedding ring, which the nurse wrote was "left on finger."

(160)
The disposal of an inmate’s body was a matter which was sometimes inquired about years in advance, to ensure that the wishes of a patient or their relatives were taken into account. Mary A. wrote on an undated card the following instructions to the Superintendent:

If I die it is my wish that my body shall be delivered over to Mr. Stone of Yonge St. to be forwarded to Mr. H A__, Miss A__ + Master A__[.] it must not be wash or dressed in here nothing done to it what ever but giving over just as death takes it[.] what ever are found on it giving up to Master E.F. A__ all of Toronto[.] Please if it happens pay attention to my wish[.] They know. Mrs. H.A. A__: (Original writing).

As it turned out Mary died at home in 1923, as is discussed earlier in this chapter. However, this small scrap of material helps to give some idea of how a patient made preparations for death with considerable self-worth and dignity, as well as the trust she placed in her family to look after her remains. One particularly devoted sister wrote to Superintendent Daniel Clark more than thirty years in advance of her brother’s death to make sure he was buried in the family plot in Merrickville, Ontario. Anna O. wrote in 1897 and then again in 1903, about “proper burial arrangements” for her brother, Winston O., a patient since 1877. Anna predeceased him by fourteen years. A niece of this brother and sister saw to it that Anna’s wish was respected as Winston’s body was returned to his home community after nearly fifty-eight years confinement, to rest in peace with his family.
Many other patients were not so fortunate as to have private burials with family members taking care of the arrangements. In some cases, families simply could not afford the expense, particularly during hard times like the Great Depression. This was the case with Irene B. whose funeral in 1933 was attended by eight relatives and friends. The costs were carried by the asylum where she had lived during the last 42 years of her life. (164) Inspector Christie wrote an observation in 1883 which was consistent for the entire period studied here. He noted that unless family or friends came to take them away, "indigent-chronics once in the Asylum remain there for life and are buried at the expense of the province." (165) Some of these indigent patients did not have any one on the outside who mourned their passing. When 62 year old Warren S. died in 1933 after twenty-eight years confinement, no relatives attended. Instead, a brief service was held, officiated by a Methodist Minister at Bates and Dodds Undertaking Parlour, a couple of blocks east of 999 Queen Street West. It was witnessed by a hospital supervisor. Warren was then interred at Prospect Cemetery. (166) By 1952, "friendless" patients like May F., an inmate since 1898, were buried at a larger and newer location, Park Lawn Cemetery. A service was conducted for May by Reverend Davies of Dovercourt Road Baptist Church, with one hospital employee being the only other recorded witness. (167)
Hospital employees were under strict instructions to treat the bodies of the dead respectfully, and were responsible for washing the body of deceased inmates as well as dressing them in a clean bedgown or shirt. Undertakers who were in any way disrespectful to "even a pauper patient's body" were to be dismissed at once. (168) Up until at least the mid-1890s the asylum mortuary doubled as a funeral parlour where family and friends could visit the deceased, and funeral services were also known to have been held there. (169) However by the early 1900s, the neighbourhood firm of Bates and Dodds became the official undertaking service under contract with the asylum well into the 1950s to provide the final journey for indigent asylum inmates. Formal reports were filed about some institutional burials with comments which state the proceedings were "reverently" carried out or were "satisfactory." (170) While the vast majority of people who died were Christians, people of other faiths also died in the asylum. Unfortunately, no indication is given of what happened to the remains of individuals such as Belinda R., a 44 year old Russian Jewish immigrant who died of meningitis in 1908, other than a report of her autopsy. (171) She had been confined for the last four years of her life.

Patients who had no known relatives were apparently buried in unmarked graves. This is evident in a reference to the burial of one particular person. Hospital administrators specifically requested that the remains of
Marcia B., who died of tuberculosis in 1914, be buried by Bates and Dodds in a marked grave, implying that had this request not been made her burial plot would have been anonymous. (172) Though she had relatives out of town, telegrams notifying them of her death had been returned. It is obvious that officials wanted to ensure that should relatives ever inquire about where she was buried, they would be able to locate her grave. Under such circumstances, these institutional burials underline how, at the end of their troubled lives, some "friendless" patients were given a degree of respect by hospital officials that the outside world had denied them in life.

Conclusion

The discharge and death of asylum inmates represent two diverging strands at the end of an inmate's life as a mental hospital patient. On the one hand an inmate's life within the walls was over, either to try and pursue a new life back in the community, or to go to a final resting spot after death. Evidence shows that even where there was care within the community, the challenges which a released patient faced were considerable under the best conditions. At the same time, patients such as Mary A. demonstrate how some individuals were able to live in the community with reliable support, even though her prospects were initially considered very poor. Her story and that of other former inmates is also a reminder about how being discharged did
not mean the end of emotional distress and the possibility of re-admission should things not go well.

Death provides a picture of the asylum as a place where the most disadvantaged inmates were cared for and then interred at the end of their life. The mental hospital could be for them a last refuge, the only community that looked out for their final needs. It is also evident that for some isolated inmates like Jonathan D., sent out into an unknown world beyond 999 Queen Street West, life as a mental hospital patient was especially precarious, being shunted about without being asked whether being released was what he wanted, which may have precipitated his demise. For many of the women and men who make up this chapter, whether they were discharged or died within the asylum, their lives had been irrevocably altered by their experiences as patients at the Toronto Hospital for the Insane.
Notes

1) AR, 1881, p. 16; AR, 1910, p. xxiv; AR, 1940, p. 39.
2) Shortt, Victorian Lunacy, p. 60-61.
3) Dwyer, Homes for the Mad, p. 150.
4) AR, 1906, p. x1, 3.
5) I would like to thank Professor Pauline Mazumdar for her comments on this point.
6) AR, 1869-70, p. 81.
7) AR, 1889, p. 28; AR, 1910, p. xxiv; AR, 1925, p. xviii.
9) H.F.H. Newington, "What are the tests of fitness for discharge from asylums?" Journal of Mental Science 32 (1887), p. 497.
10) Dwyer, Homes for the Mad, p. 149.
11) AR, 1870-71, p. 133.
12) AR, 1877, p. 22.
14) AR, 1883, p. 15.
15) Ibid.
17) AR, 1936, p. 15.
18) Ibid.
20) AR, 1870-71, p. 133.
22) Patient File #5011. Letter to Dr. Clark from J.E.P., Owen Sound, November 12, 1909.
23) Patient File #5011. Letter to J.E.P. from Dr. Clark, November 15, 1909.
24) Patient File #5011. Letter to Mrs L.B.D. from Medical Superintendent, December 17, 1912.

25) Patient File #5011. Letters dealing with Wesley's release are: to Dr. Forester (sic) from J.E.P., December 10, 1913; to J.E.P. from Medical Superintendent, December 15, 1913.

26) Patient File #5011. References to Wesley's farm jobs are in: letter to Dr. Forester (sic) from J.E.P. January 11, 1913 [(sic), this should have been dated 1914, according to the contents of the letter referring to release discussed in the two previous communications of December, 1913]; letter to Dr. Forester (sic) from J.E.P., February 16, 1914.

27) Patient File #5011. Letter to Dr. Forester (sic) from J.E.P., April 9, 1914.

28) Patient File #5011. Letter to Dr. Forester (sic) from J.E.P., October 8, 1914.


30) Dwyer, Homes for the Mad, p. 114-115.


32) Patient File #4039. Probation Bond, dated September 2, 1911. Discharge Certificate, dated October 9, 1911, though Randall's discharge is also recorded as October 17, 1911 on his case file folder.

33) McLaren, Our Own Master Race, p. 48-50.

34) Ian Dowbiggin, "'Keeping this Young Country Sane': C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1925," The Canadian Historical Review 76:4 (December, 1995), p. 598-627. For C.K. Clarke's views on "Defective and Insane Immigration" while he was Superintendent at 999 Queen Street West, see AR, 1907, p. 3-10.


36) Undesirable Immigrant File. Letter to "Dear Sir" from [J.] Dyson, Hall Farm, Yorkshire, December 24, 1906.
37) Ibid.

38) Ibid.

39) Undesirable Immigrant File. Letter to Dr. Clarke from Terence J., per Daniel Driscoll, Cork, Ireland, January 8, 1907.

40) Lee F., Patient File #9014. April 27, 1907 immigration form.

41) Mary A., Patient File #5002. Letter to Dr. Clark (sic) from Henry A., November 4, 1910 (the date appears to be a month off based on Clarke's response which is December 8, 1910).


43) Patient File #5002. See entries in Clinical Record from June 11 to July 8, 1910 regarding Mary's pain due to leg injury.

44) Patient File #5002. Quotes are taken from: Clinical Record, June 3, 1911.

45) Patient File #5002. Letter to Dr. Clare from Mrs. Henry A. A., June 6, 1911. It is interesting to note that Mary and Henry often wrote to the hospital on the same day, though they preferred to keep their communications private. Mary noted: "Mr. H. A____ as informed me he as written to you on what subject I do not know as he writes to you without telling me..." Letter to Dr.'s Foster (sic) and Clare from Mrs. Henry A. A., September 4, 1911. Years later Henry would write about their arrangement in this regard: "I make it a point not to cross her more than I can help & so let her send the letter knowing your knowledge of her peculiar temperament would not cause you to take offence." Letter to Dr. Clare from Henry A. A., March 4, 1922.


47) Mary's diagnosis is contained in a conference report made five months after she was released and her improved status is noted on the front of her case file: Patient File #5002. Conference Report, November, 1911.

48) Dr. Clarke made these comments in a speech to a meeting of the British Medical Association, Toronto, in August, 1906. He argued it was "going too far" to "categorically assert" dementia praecox was incurable though he said "most of the so-called recoveries should be classed as cases of remission, or put under the heading 'improved,'" as was the case with Mary A. These quotes, and the one in the essay,

49) Patient File #5002. Quote is from letter to Dr. Clare from Mrs. Henry A. A., August 4, 1911. For references to Mary's physical pain and emotional distress see: Letter to Dr. Clare from Mrs. Henry Archibald A., June 12, 1911; Letter to Dr. Clare from Mrs. H.A. A., June 20, 1911. For reference to her being shunned by other family members, except her son, see: Letter to Dr. Clare from Mr. H.A. A., July 3, 1911.

50) Patient File #5002. Letter to Dr. Clare from H.A. A., July 18, 1911.

51) Ibid.

52) Patient File #5002. Letter to Dr. Clare from Mr. H.A. A., July 29, 1911.

53) Patient File #5002. Letter to Dr. Clare from Mrs. Henry A. A., July 29, 1911.

54) Patient File #5002. Letter to Mrs. H. A. from Assistant Medical Superintendent, July 31, 1911; Letter to Henry A. A. from Medical Superintendent, July 31, 1911.

55) Patient File #5002. Letter to Dr.'s Forster and Clare from Mrs. Henry A., August 22, 1911. After introducing this letter "To the Superintendents Dear Sirs", Mary wrote: "I don't know whether to say Ladies as well, because I am not their to see..."

56) Patient File #5002. Letter to Mrs. Henry A. from Acting Superintendent, August 8, 1911.


58) Patient File #5002. Letter to Dr. Clare from Henry A. A., August 31, 1911.

59) Patient File #5002. Letter to Dr.'s Foster (sic) and Clare from Mrs. Henry A. A., September 4, 1911.

60) Patient File #5002. Probation Bond, signed by Henry A. A. and Mrs. Henry A. A., June 5, 1911, witnessed by Dr. H. Clare. The probation bond makes it clear that during the specified probationary period, the person who is responsible for the released patient has to send monthly reports to the Medical Superintendent about their charge. Failure to do so within the required period would "forfeit the right for (her) re-admission to the said Hospital for the Insane." Thus the onus was on a friend or relative to decide whether
or not to return a released inmate while on probation. It was not the responsibility of the hospital to make such a decision after a patient had left their jurisdiction.

61) Patient File #5002. At the bottom of this undated poem, which is contained among Mary's letters from 1922, she wrote: "do you know when I wrote this to you(?)" Her last letter contained in the file, addressed to Dr. Clare asking him to visit her, is dated April 22, 1922.

62) Patient File #5002. Letter to Dr. Clare from Henry A. A., May 30, 1923. Though Henry does not mention the cause of death he does provide the following account of her last days: "I was in hopes this year she would be able to get out & sit in the Garden but six weeks ago she took a bad spell although able to get out of bed occasionally & two days before she died she could only keep on murmuring to herself. I was sitting by her bedside when she ceased talking & turned her face on the pillow as if dropping off to sleep so I left her for a few minutes to talk to my Son & Daughter who with the Grandchildren were in the front room. When I went back she looked very peaceful but I could not feel her heart beat so I sent for the Doctor who came at once & said her troubles were all over. I can see now it was all for the best, what would have become of her had I gone first..."

63) Ibid.

64) Adam C., Patient File #5030. Clinical Record, October 30, 1925, November 11, 1925, July 14, 1926. It should be noted that each of these entries gives a different length of time for their separation: The first reference says it was "for over 20 years", the second notes "a period of 18 years" and the third recording states: "Lately Mr. C___ has been reconciled to his wife from whom he has been estranged ever since he was admitted here 30 years ago..." This latter time-frame has been chosen as the most accurate because it is the only one recorded in two separate reports. Mrs C. is recorded as telling a social worker that she and her husband had experienced "trouble...which separated them for thirty years..." Ibid. Ontario Mental Health Clinic, Social Services Record, August 29, 1934.

65) Patient File #5030. Adam's case file contains numerous note papers acknowledging receipt of clothes, fruit, Christmas gifts and other goods, primarily from Laura C., especially during the 1930s. There is also a visiting sheet recording dozens of visits by her between June, 1933 and April, 1935.

66) Patient File #5030. Clinical Record, December 1, 1933.


69) Patient File #5030. Ontario Mental Health Clinic, Social Service Record, August 31, 1934, September 5, 1934; Clinical Record, March 16, 1935.

70) Patient File #5030. Ontario Mental Health Clinic, Social Service Record, August 31, 1934.

71) Patient File #5030. Ontario Mental Health Clinic, Social Service Record, August 17, 1935.

72) Ibid.

73) Patient File #5030. Ontario Mental Health Clinic, Social Service Record, January 15, 1936. This entry observes: "Mrs. Skene reports that he is no trouble whatever, in fact he is a little too quiet but this may be due to his deafness and of course to his long period of confinement in the hospital."


75) Patient File #5030. See letter to Adam C. from D. Jamieson, Chairman, Commission, Ontario - Old Age Pensions Act, April 13, 1932.

76) Patient File #5030. Ontario Mental Health Clinic, Social Services Record, March 24, 1936.

77) For information about his diagnosis upon final discharge see: Patient File #5030. Clinical Record, March 24, 1936. For information regarding the circumstances of Adam's death see: Ibid. Letter to Dr. Margaret McAlpine, Toronto from Dr. Gordon S. Foulds, St. Michael's Hospital, Toronto, May 20, 1936.

78) Minnie B., Patient File #5032. Letter to Dr. Fletcher from Minnie B., Mair, Saskatchewan, July 6, 1928.


80) AR, 1879, p. 209.

81) Ripa, Women and Madness, p. 156.

82) Ibid., p. 158.

83) AR, 1869-70, p. 83; AR, 1940, p. 39.

84) AR, 1884, p. 43; AR, 1920, p. XXX.
85) AR, 1904, p. xi.


88) For a discussion of whether to "Remodel or Remove," see, AR, 1906, p. 5-6.

89) Shortt, Victorian Lunacy, p. 61.


91) AR, 1874, p. 159.

92) AR, 1918, p. 86.


97) John Y., Patient File #3004. Clinical Record, June 3, 1911.


99) Irene B., Patient File #3047. Clinical Record, September 5, 1931, June 28, 1933, September 12 & 28, 1933.

100) Anna P., Patient File #2014. Undated handwritten Observation Note which records Anna's death on March 10, (no year, though 1911). Copy of Death Certificate, signed W. Frederick, F. Dey, March 10th, 1911.


103) Ibid.

104) Annie E., Patient File #4014. Undated letter from Annie S. E. to Dr. Clarke, though written on top of page is notation: "Mrs. E____ 17 June, 1910."

105) Patient File #4014. Undated letter from Annie S. E. to "Sir." Written overleaf is "Fyle Mrs. E____ 177 July 20/10."


107) Patient File #4014. Medical Certificate of Death, October 24, 1910, signed by Dr. W.C. Herriman.

108) Patient File #4014. See entries in Clinical Record from January 14, 1909 to October 24, 1910.


112) Patient File #1013. Clinical Chart, October 20, 1934.


115) Albert C., Patient File #3051. Letter to Mrs. A.C., Belleville, Ontario, from Medical Superintendent Forster, October 6, 1911.


Clark had repeatedly complained throughout the 1880s about the dangerous situation in the refractory ward for males and females. (One murder was on the male side, two murders were on the female side. One woman who committed a murder in 1884 died one day later, due to "congestion of the brain.") When no money was forthcoming to relieve overcrowding beginning in 1890, Clark had the doors of previously locked rooms kept open all night with frequent rounds made by staff to check on inmates.

122) Maude M., Patient File #8006. Clinical Record, April 12, 1911.

123) Patient File #8006. Clinical Record, April 13, 1911.


125) Ibid.

126) Ibid.


128) Francis B., Patient File #2020. Francis' September 18, 1896 letter to the Inspector is addressed to "your honor" and is marked with the Inspector's stamp, dated September 19, 1896. The request for release to his brother-in-law is noted in: Letter to Dr. Clark from W.B., Grandvalley, Ontario, September 28, 1898.


130) Arlene S., Patient File #7050. Clinical Record, April 24, 1918.


132) Patient File #7050. Letter to Inspector W.W. Dunlop from Medical Superintendent Forster, April 29, 1918.

133) AR, 1884, p. 4.

134) Jonathan D., Patient File #8035. Clinical Record, date deleted for reasons of privacy due to newspaper accounts, cited below.
135) Patient File #8035. This clipping is pasted into Jonathan's Clinical Record.

136) Patient File #8035. This clipping is pasted into Jonathan's Clinical Record.

137) Ibid.

138) Patient File #8035. This clipping is pasted into Jonathan's Clinical Record.

139) Ibid.


143) AR, 1871-72, p. 151.


145) Lizzie C., Patient File #8025. Clinical Record, March 12, 1910, November 5, 1910, March 18, 1911, October 1, 1912.

146) Patient File #8025. Post-Mortem Record, undated.

147) Patient File #8025. Clinical Record, October 1, 1912.

148) AR, 1887, p. 46-47.


151) AR, 1914, p. 106.

152) AR, 1933, p. 90.


158) Ellen K., Patient File #3037. Letter to Dr. Brooman (sic) from Mrs. H. M., Port Arthur, undated; Receipt for items packed signed "Received G. B.," November 8, 1923; Letter to Superintendent Harvey Clare from Estates Officer, Toronto General Trusts Corporation, November 10, 1923.

159) Eunice M., Patient File #7035. Clinical Record, April 4, 1911. The date of Eunice's death, April 18, 1911 is not listed in her clinical record, but it is written on the front of her file folder.

160) Sandra C., Patient File #7023. Report on Physical Condition on Discharge or Death, February 27, 1923, signed N. Franklin, K. Turney, Nurse(s).

161) Mary A., Patient File #5002. Undated card addressed: "To ever is Superdent" (sic).

162) Winston O., Patient File #2013. Letters to Dr. Daniel Clark from Anna O., April 15, 1897 and March 16, 1903.


165) AR, 1883, p. 15.


169) *AR, 1894*, p. 5.

170) These comments can be found in the reports on burials cited in notes 164, 166, 167.

171) Belinda R., Patient File #8026. Her post-mortem is typed in the Clinical Record, April 23, 1908, the same day that she died.

Chapter 8. Conclusion

The people whose experiences and voices make up this study have much to teach later generations about the world they inhabited at the Toronto Hospital for the Insane. While mental breakdown led to their confinement in a mental institution, the evidence presented in this thesis clearly demonstrates that this did not prevent patients from being active agents in their own lives and in the lives of those around them. These individuals were much more than a collection of diagnostic categories and symptoms whose entire existence can only be understood through the medical interpretations of their day. This medical context is, and will always remain, part of the picture, but it is only a limited part of the picture of any given patient’s life. Confinement in a mental health facility did not deprive the women and men discussed here from thinking about and influencing what was happening to them in ways that went beyond their diagnosis. Just as monolithic views about patients being perpetually controlled by administrators are proven inaccurate as more studies uncover the intricacies of asylum life, so too would it be inaccurate to assume that people who were diagnosed as mentally disturbed have little worth revealing to us because of their status as insane.

The themes that make up this thesis illustrate how patient life at 999 Queen Street West between 1870-1940 was part of a vibrant world where inmates sought to shape their environment in ways that made their existence more
tolerable. In this sense, mental patients were not too much different from people who had never been in an institution such as this. Individuals who have faced adversity, from a variety of backgrounds, have tried to find ways of living that reduced personal hardships and made life more bearable, such as working-class men and women who socialized to connect with their peers and build personal and political networks of support. Yet, this side of life in mental institutions has not been revealed to the extent it deserves, partly because so few studies have been done on psychiatric history from the patients' perspectives, as was discussed in the introduction. Where these studies have been done, accounts about inmates are usually presented separately from one another, more as personal memoirs or case studies with a broader picture of interpersonal relationships being left undeveloped. This thesis has been an attempt to remedy this situation by integrating the individual with the institutional, all the while keeping patients' voices and experiences front and centre.

The dreary and monotonous world which has previously shown the patient experience as being devoid of much variety is revealed here as being seriously lacking in development. While this sort of tediousness was part of inmate life, as has been noted particularly in regard to inmates on locked wards, there was much more to their lives than sullenly following ward routine and listening to staff directives. For some patients, this meant creating
friendships with both patients and staff to sustain them through their years at 999 Queen Street West, especially inmates who had no outside support. It also meant partaking, to an extent that at times went beyond the staff’s expectations, of both work and recreational activities such as was shown by Winston O. and Audrey B. In this sense, the therapeutic aims of administrators were overtaken by patients whose daily life was consumed by the need to keep active in ways that they found most enjoyable, regardless of official policy. Even for far less active patients, being able to interest themselves in daily life could be as ordinary as reading a newspaper, or telling stories on the ward, which indicates that there was more involvement than total withdrawal from the world than is often assumed as having occurred among mental patients.

For those patients who were withdrawn from the world, like Adam C. who wrote in poetic fashion about his troubles, understanding them also requires distinguishing withdrawal from inactivity. Even some of the most severely disturbed patients, like Lizzie C. who nursed a doll during her final, lonely years, engaged in activities that indicate that while such individuals had no social relationships with other patients or staff, they tried to cope with their mental illness in a way that they found therapeutic on their own. The degree of emotional relief these activities provided to such tormented souls is, of course, impossible to estimate. Yet their activities reveal them as being more active than
the dull, monotonous ward routine would otherwise suggest.

However varied were patients’ experiences, there was one crucial aspect of inmates’ daily lives that reveals a much more contentious nature of this subject, and that is the reports of abuse inflicted upon patients by staff. In this area more than any other, ward dynamics reveal that patients were at a distinct disadvantage when these episodes occurred, due to the massive power imbalance between inmates and staff. While social control arguments go too far in taking away agency from patients, it is also important that researchers acknowledge that there were real issues of conflict on the ward where abuse of patients reveal the limitations of agency in which patients’ accounts of abuse were secondary to staff views. Thus for some patients, life in the asylum could be traumatic and devastating due to being victims of violence. Class also reflected the limited choice that was available to patients both on and off the ward, as access to money allowed for greater luxuries and less hospital-directed labour for a minority of inmates. However, lack of money did not prevent those patients who were without financial resources from creating their own diversions.

The chronic care background of patients at 999, in which anywhere from 80% to 95% of all inmates were in the long-term category, was the most consistent feature of this institution. This was true regardless of the therapeutic changes that occurred during the seventy year period studied.
Thus, while therapeutic practices changed over the decades, this change did not significantly relieve the chronic care nature of the hospital. Life within this facility was influenced more by the people who resided there, sometimes for decades, than by the outside forces of change within psychiatry. Ultimately, patients made more of a daily impact than did medical practices. People who lived at 999 Queen Street West were not simply waiting to be "acted upon" either under the guise of social control or through evolving treatments. As has been shown throughout this thesis, mental patients were actively interested in their life and the environment in which they lived.

The chronic care function of the Toronto Hospital for the Insane also meant that there was a steady enough population in which to forge long-lasting and close relationships. Considering institutional relationships in this context is an antidote to the gloomier assessments of asylums as being utterly impersonal and primarily used for purposes of social control.(3) As has been revealed here, this aspect of patient culture is an area that deserves closer attention, more than portraying patients as being separated from one another, almost automatons who went about without much interaction. Weaving together the qualitative stories that make up this study under specific themes is one way of getting beyond an approach to patient's history in which accounts of people's lives are presented on
their own, rather than in conjunction with one another to illustrate a wider picture.(4)

An aspect of this topic that remained essentially unchanged throughout this study was the degree of public misunderstanding and prejudice towards people who were confined in mental institutions. Evidence shows that while there was a degree of support by social service agencies and religious groups which sponsored events at the asylum, this was outweighed by the antipathy shown to patients and relatives of patients who were at 999 Queen Street West. In this sense, hospital doctors shared the frustration of their patients and inmates' relatives. Efforts to combat negative stereotypes were not enough to wipe out the age-old image of people with mental illness as being either "violent maniacs" or as "stupid," "incompetent" people who are incapable of contributing anything useful to the community in which they live. This thesis has attempted to make a small contribution to challenging these prejudices and misconceptions, by showing that the women and men who lived at the Toronto Hospital for the Insane between 1870-1940 were much less of a monolithic group than has otherwise been understood. Above all else, the people whose voices and experiences make up this study show later generations that psychiatric patients have a great deal to teach us about what it was like to be confined in a mental institution and to live with the psychological troubles that brought them to 999 Queen Street West.
Notes:


2) For an example of a portrayal of these types of conditions, see: Mark Finnane, Insanity and the Insane in Post-Famine Ireland (London: Croom Helm, 1981), p. 185-189.


4) For examples of psychiatric history from the patients' perspectives through individual accounts, rather than thematically, see: Peterson, A Mad People's History of Madness; Porter, A Social History of Madness; Reaume, "Psychiatric History from the Patients' Perspectives," p. 397-424.
<table>
<thead>
<tr>
<th>Years</th>
<th>Therapeutic Approach</th>
<th>Method &amp; Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>1870-1905</td>
<td>Non-Interventionist Period</td>
<td>Moral therapy, begun under Joseph Workman (1853-75) with work and recreation, continued by Daniel Clark (1875-1905).</td>
</tr>
<tr>
<td>1877</td>
<td></td>
<td>Emphasis by Clark on natural healing. He prefers &quot;fresh air, generous diet, and cleanliness&quot; to drugs.</td>
</tr>
<tr>
<td>1878-1879</td>
<td></td>
<td>Clark defends use of alcohol as sedative for &quot;excited&quot; patients. He says it is safer than opium and chloral hydrate which is also used.</td>
</tr>
<tr>
<td>1883</td>
<td></td>
<td>Official end of the use of physical restraints.</td>
</tr>
<tr>
<td>1890s</td>
<td></td>
<td>Opposition by Clark to any sexual surgery on patients at 999. He denounces this practice by other doctors.</td>
</tr>
<tr>
<td>1898</td>
<td></td>
<td>Introduction of dental treatment which Clark links to patients' mental health: better teeth, easier to eat, improved physiological condition. Continued into the 1940s.</td>
</tr>
<tr>
<td>1898</td>
<td></td>
<td>&quot;Correct classification [of the insane] is impossible,&quot; says Clark.</td>
</tr>
<tr>
<td>1905-1924</td>
<td>Classification Period</td>
<td>C.K. Clarke (1905-11) stresses scientific methods, adopts Kraepelin's diagnostics. This work is continued by J.M. Forester (1911-20) &amp; Harvey Clare (1920-25).</td>
</tr>
<tr>
<td>1906</td>
<td></td>
<td>Hydrotherapy introduced.</td>
</tr>
<tr>
<td>1906</td>
<td></td>
<td>Training school for nurses is instituted.</td>
</tr>
<tr>
<td>1907</td>
<td></td>
<td>Medical Conferences three times a week are started.</td>
</tr>
<tr>
<td>1908</td>
<td></td>
<td>Standardized provincial classification system.</td>
</tr>
</tbody>
</table>
TABLE I
(continued)
THE COURSE OF MEDICAL THERAPEUTICS AT 999 QUEEN STREET WEST,
TORONTO, 1870-1940*

<table>
<thead>
<tr>
<th>Years</th>
<th>Therapeutic Approach</th>
<th>Method &amp; Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>1905-1924</td>
<td>Classification Period</td>
<td>(continued)</td>
</tr>
<tr>
<td>1909</td>
<td></td>
<td>Out-patient service begins.</td>
</tr>
<tr>
<td>1911</td>
<td></td>
<td>Diagnostic updating of files of chronic patients who had been at 999 from five to fifty years.</td>
</tr>
<tr>
<td>1924-1940</td>
<td>Interventionist Period</td>
<td>Rise of so-called &quot;heroic&quot; treatments for mental illness which reached its height in the period after 1940 with lobotomies (primarily 1945-1955).</td>
</tr>
<tr>
<td>1924-31</td>
<td></td>
<td>Intramuscular injections of salvarsan for syphilis.</td>
</tr>
<tr>
<td>1929</td>
<td></td>
<td>Province encourages more use of bio-chemistry in preventive treatments.</td>
</tr>
<tr>
<td>1931</td>
<td></td>
<td>Part-time dentists placed on staff at all provincial mental hospitals for reasons mentioned by Daniel Clark in 1898.</td>
</tr>
<tr>
<td>1931-1933</td>
<td></td>
<td>Malarial treatments and thousands of injections of manganese chloride for syphilis patients, as well as novarsam and trypar-samide treatments. Spinal drainages reported.</td>
</tr>
<tr>
<td>1937</td>
<td></td>
<td>First insulin-shock treatment in Ontario at New Toronto (Mimico).</td>
</tr>
<tr>
<td>1938-39</td>
<td></td>
<td>Introduction of metrazol shock treatment at Toronto and five other provincial mental hospitals. Used on patients with depression and schizophrenia.</td>
</tr>
<tr>
<td>1940</td>
<td></td>
<td>Use of &quot;fever cabinets&quot; to treat patients with syphilis.</td>
</tr>
</tbody>
</table>

* Sources: AR, 1870-1940; AO, RG 10, Series 20-B-2, Queen Street Mental Health Centre Records, Casefiles.
## TABLE II
PATIENTS & ATTENDANTS DIET ROLL,
TORONTO ASYLUM FOR THE INSANE, 1878*

### PATIENTS BREAKFAST

<table>
<thead>
<tr>
<th></th>
<th>Pay Wards</th>
<th>Free Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday:</strong></td>
<td>Tea, Coffee, Toast</td>
<td>Tea, Coffee, Bread,</td>
</tr>
<tr>
<td></td>
<td>Porridge, Cold Meat.</td>
<td>Butter, Porridge.</td>
</tr>
<tr>
<td><strong>Tuesday:</strong></td>
<td>Tea, Coffee, Bread, Butter,</td>
<td>Tea, Coffee, Bread,</td>
</tr>
<tr>
<td></td>
<td>Salt Herrings, Porridge.</td>
<td>Butter, Porridge.</td>
</tr>
<tr>
<td><strong>Wednesday:</strong></td>
<td>Tea, Coffee, Bread, Butter, Beef-steak,</td>
<td>Tea, Coffee, Bread,</td>
</tr>
<tr>
<td></td>
<td>Porridge.</td>
<td>Butter, Porridge.</td>
</tr>
<tr>
<td><strong>Thursday:</strong></td>
<td>Tea, Coffee, Bread, Butter,</td>
<td>Tea, Coffee, Bread,</td>
</tr>
<tr>
<td></td>
<td>Ham, Porridge.</td>
<td>Butter, Porridge.</td>
</tr>
<tr>
<td><strong>Friday:</strong></td>
<td>Tea, Coffee, Bread, Butter,</td>
<td>Tea, Coffee, Bread,</td>
</tr>
<tr>
<td></td>
<td>Fresh Fish, Porridge.</td>
<td>Butter, Porridge.</td>
</tr>
<tr>
<td><strong>Saturday:</strong></td>
<td>Tea, Coffee, Toast,</td>
<td>Tea, Coffee, Bread,</td>
</tr>
<tr>
<td></td>
<td>Porridge, Cold Meat.</td>
<td>Butter, Porridge.</td>
</tr>
<tr>
<td><strong>Sunday:</strong></td>
<td>Tea, Coffee, Bread, Butter, Beef-steak,</td>
<td>Tea, Coffee, Bread,</td>
</tr>
<tr>
<td></td>
<td>Porridge.</td>
<td>Butter, Porridge.</td>
</tr>
</tbody>
</table>

### PATIENTS DINNER

<table>
<thead>
<tr>
<th></th>
<th>Pay Wards</th>
<th>Free Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday:</strong></td>
<td>Corn Beef, Cabbage, Pickles, Rice Pudding,</td>
<td>Corn Beef, Cabbage,</td>
</tr>
<tr>
<td></td>
<td>Potatoes or Beans.</td>
<td>Boiled Rice, Potatoes or Beans.</td>
</tr>
<tr>
<td><strong>Tuesday:</strong></td>
<td>Roast Beef, Potatoes, Beets or Parsnips,</td>
<td>Boiled Meat, Soup,</td>
</tr>
<tr>
<td></td>
<td>Apple Pudding, Pickles or Sauce.</td>
<td>Potatoes, Boiled Rice.</td>
</tr>
<tr>
<td><strong>Wednesday:</strong></td>
<td>Irish Stew, Potatoes,</td>
<td>Irish Stew, Potatoes,</td>
</tr>
<tr>
<td></td>
<td>Sago Pudding, Pickles or Sauce.</td>
<td>Boiled Rice.</td>
</tr>
<tr>
<td><strong>Thursday:</strong></td>
<td>Meat Pie, Potatoes, Beets, Jam Pudding,</td>
<td>Boiled Meat, Soup,</td>
</tr>
<tr>
<td></td>
<td>Pickles or Sauce.</td>
<td>Potatoes, Boiled Rice.</td>
</tr>
<tr>
<td><strong>Friday:</strong></td>
<td>Fish, Meat, Soup, Potatoes,</td>
<td>Meat Pie, Fish, Potatoes, Boiled Rice.</td>
</tr>
<tr>
<td></td>
<td>Bread-pudding, Pickles or Sauce.</td>
<td>Potatoes, Beets, Boiled Rice.</td>
</tr>
<tr>
<td><strong>Saturday:</strong></td>
<td>Roast Meat, Potatoes,</td>
<td>Meat Soup, Potatoes,</td>
</tr>
<tr>
<td></td>
<td>Cabbage, Rice-pudding,</td>
<td>Boiled Rice.</td>
</tr>
<tr>
<td></td>
<td>Pickles or Sauce.</td>
<td></td>
</tr>
<tr>
<td><strong>Sunday:</strong></td>
<td>Roast Meat, Potatoes, Beets or Parsnips,</td>
<td>Boiled Meat, Soup,</td>
</tr>
<tr>
<td></td>
<td>Plum Pudding, Pickles or Sauce.</td>
<td>Potatoes, Boiled Rice.</td>
</tr>
</tbody>
</table>

* Source: AR, 1878, p. 273-274.
# TABLE II
(continued)

PATIENTS & ATTENDANTS DIET ROLL,
TORONTO ASYLUM FOR THE INSANE, 1878*

## PATIENTS TEA

<table>
<thead>
<tr>
<th>Day</th>
<th>Pay Wards</th>
<th>Free Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Tea, Coffee, Bread, Butter, Fruit or Pies</td>
<td>Tea, Coffee, Bread, Butter</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Tea, Coffee, Bread, Butter, Cakes</td>
<td>Tea, Coffee, Bread, Butter, Syrup</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Tea, Coffee, Bread, Butter, Fruit or Pies</td>
<td>Tea, Coffee, Bread, Butter</td>
</tr>
<tr>
<td>Thursday</td>
<td>Tea, Coffee, Bread, Butter, Fruit or Pies</td>
<td>Tea, Coffee, Bread, Butter</td>
</tr>
<tr>
<td>Friday</td>
<td>Tea, Coffee, Bread, Butter, Cakes</td>
<td>Tea, Coffee, Bread, Butter, Roast or Stewed Apples</td>
</tr>
<tr>
<td>Saturday</td>
<td>Tea, Coffee, Bread, Butter, Fruit or Pies</td>
<td>Tea, Coffee, Bread, Butter</td>
</tr>
<tr>
<td>Sunday</td>
<td>Tea, Coffee, Bread, Butter, Fruit or Pies</td>
<td>Tea, Coffee, Bread, Butter, Fruit, Cheese or Pies</td>
</tr>
</tbody>
</table>

## ATTENDANTS MEALS

<table>
<thead>
<tr>
<th>Day</th>
<th>Breakfast</th>
<th>Dinner</th>
<th>Tea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Coffee, Bread, Butter, Porridge</td>
<td>Boiled Meat, Soup, Potatoes, Rice, Bread</td>
<td>Tea, Bread, Butter, Syrup</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Coffee, Bread, Butter, Porridge</td>
<td>Roast Meat, Potatoes, Apple Pudding, Bread</td>
<td>Tea, Bread, Butter, Buns</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Coffee, Bread, Butter, Cold Meat, Porridge</td>
<td>Meat Pie, Potatoes, Beets, Bread</td>
<td>Tea, Bread, Butter, Cheese</td>
</tr>
<tr>
<td>Thursday</td>
<td>Coffee, Bread, Butter, Porridge</td>
<td>Roast Meat, Potatoes, Boiled Cabbage, Boiled Pudding, Bread</td>
<td>Tea, Bread, Butter, Apple Pies</td>
</tr>
<tr>
<td>Friday</td>
<td>Coffee, Bread, Butter, Cold Meat, Porridge</td>
<td>Fish, Meat, Potatoes, Sago Pudding, Bread</td>
<td>Tea, Bread, Butter, Syrup</td>
</tr>
<tr>
<td>Saturday</td>
<td>Coffee, Bread, Butter, Porridge</td>
<td>Roast Meat, Potatoes and other Vegetables, Bread</td>
<td>Tea, Bread, Butter, Fruit</td>
</tr>
<tr>
<td>Sunday</td>
<td>Coffee, Bread, Butter, Porridge</td>
<td>Meat Pie, Potatoes, Beets, Bread</td>
<td>Tea, Bread, Butter, Pies</td>
</tr>
</tbody>
</table>

* Source: AR, 1878, p. 273-274.
TABLE III
PATIENTS & EMPLOYEES DIET
STANDARD BASIC DIETARY RATION TABLE FOR USE AT PROVINCIAL HOSPITALS, 1917*

ONE MEAL BREAKFAST,
EMPLOYEES AND PATIENTS

<table>
<thead>
<tr>
<th>Cornmeal</th>
<th>Wheat Flakes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hominy</td>
<td>Farina</td>
</tr>
<tr>
<td>Rolled Oats</td>
<td>Rice</td>
</tr>
</tbody>
</table>

One Egg for Unemployed Patients
Two Eggs for Employed Patients

ONE MEAL DINNER,
PATIENTS ONLY

<table>
<thead>
<tr>
<th>Barley</th>
<th>Roast Beef</th>
<th>Mutton Stew</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>Roast Mutton</td>
<td>Frankfurters</td>
</tr>
<tr>
<td>Hominy (for Pudding)</td>
<td>Boiling Beef</td>
<td>Hamburger Roast</td>
</tr>
<tr>
<td>Crackers</td>
<td>Corned Beef</td>
<td>Sauerkraut</td>
</tr>
<tr>
<td>Green Peas</td>
<td>Salt Fish</td>
<td>Farina</td>
</tr>
<tr>
<td>Tapioca</td>
<td>Roast Pork</td>
<td>Beans</td>
</tr>
<tr>
<td>Split Peas</td>
<td>Salt Pork</td>
<td>Beans - Lima</td>
</tr>
<tr>
<td>Corn Starch</td>
<td>Fresh Fish</td>
<td>Potatoes</td>
</tr>
<tr>
<td>Fresh Vegetable</td>
<td>Beef Stew</td>
<td>Canned Vegetable</td>
</tr>
</tbody>
</table>

ONE MEAL SUPPER,
PATIENTS ONLY

<table>
<thead>
<tr>
<th>Cornmeal</th>
<th>Beans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honeyn</td>
<td>Cheese</td>
</tr>
<tr>
<td>Rice</td>
<td>Prunes</td>
</tr>
<tr>
<td>Crackers</td>
<td>Dates</td>
</tr>
<tr>
<td>Macaroni</td>
<td>Figs</td>
</tr>
<tr>
<td>Apricots</td>
<td>Peaches - dried</td>
</tr>
<tr>
<td></td>
<td>Apples - Evap.</td>
</tr>
<tr>
<td></td>
<td>Oysters or Clams</td>
</tr>
<tr>
<td></td>
<td>Salt Fish</td>
</tr>
</tbody>
</table>

ONE MEAL, WORKERS ONLY,
PATIENTS

<table>
<thead>
<tr>
<th>C.C. Beef</th>
<th>Salt Fish (Various)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pickled Meat</td>
<td>Corned Beef (Hash Meat)</td>
</tr>
<tr>
<td>Canned Salmon</td>
<td>Beef Stew (Meat)</td>
</tr>
<tr>
<td>Cold Meat</td>
<td>Fresh Beef Hash (Meat)</td>
</tr>
<tr>
<td>Salty Codfish</td>
<td>Frankfurters</td>
</tr>
</tbody>
</table>

* Source: AO, RG 63, Sub-series A-8, Inspector of Asylums; File: Standard Basic Dietary Ration for Use in Provincial Hospitals, 1917.
<table>
<thead>
<tr>
<th>Gelatine</th>
<th>Ham</th>
<th>Mutton Stew</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macaroni</td>
<td>Eggs</td>
<td>Salt Fish</td>
</tr>
<tr>
<td>Beans</td>
<td>Corned Beef</td>
<td>Liver</td>
</tr>
<tr>
<td>Cheese</td>
<td>Hash (Meat)</td>
<td>Cold Meat</td>
</tr>
<tr>
<td>Green Peas</td>
<td>Fresh Beef</td>
<td>Beef Steak</td>
</tr>
<tr>
<td>Split Peas</td>
<td>Hash (Meat)</td>
<td>Mutton Chops</td>
</tr>
<tr>
<td>Peaches - Evap.</td>
<td>Canned Salmon</td>
<td>Pork Chops</td>
</tr>
<tr>
<td>Prunes</td>
<td>Roast Beef</td>
<td>Ham</td>
</tr>
<tr>
<td>Eggs</td>
<td>Roast Mutton</td>
<td>Potatoes (Peeled)</td>
</tr>
<tr>
<td>Bacon</td>
<td>Fresh Fish</td>
<td>Rice</td>
</tr>
<tr>
<td>Eggs</td>
<td>(Dressed heads off)</td>
<td>Tapioca</td>
</tr>
<tr>
<td>Bacon</td>
<td>Hamburger Roast</td>
<td>Sago</td>
</tr>
<tr>
<td>Liver</td>
<td>Hamburger Steak (Meat)</td>
<td>Apples - Evap.</td>
</tr>
<tr>
<td>Frankfurters</td>
<td>Beef stew (Meat)</td>
<td>Pork Sausage</td>
</tr>
</tbody>
</table>

**BREAD AND BEVERAGES, PATIENTS AND EMPLOYEES ONLY**

- Coffee
- Sugar
- Tea
- Butter
- Bread

* Source: AO, RG 63, Sub-series A-8, Inspector of Asylums; File: Standard Basic Dietary Ration for Use in Provincial Hospitals, 1917.
TABLE IV
PERCENTAGE OF PATIENTS' DAYS WORKED TO COLLECTIVE STAY IN PROVINCIAL INSTITUTIONS, 1882-1907*

<table>
<thead>
<tr>
<th>Year</th>
<th>Toronto</th>
<th>London</th>
<th>Kingston</th>
<th>Hamilton</th>
</tr>
</thead>
<tbody>
<tr>
<td>1882</td>
<td>32.15</td>
<td>54.00</td>
<td>45.11</td>
<td>37.61</td>
</tr>
<tr>
<td>1883</td>
<td>30.44</td>
<td>69.89</td>
<td>50.33</td>
<td>62.38</td>
</tr>
<tr>
<td>1884</td>
<td>53.90</td>
<td>86.56</td>
<td>76.59</td>
<td>56.40</td>
</tr>
<tr>
<td>1885</td>
<td>38.40</td>
<td>79.58</td>
<td>61.13</td>
<td>48.82</td>
</tr>
<tr>
<td>1886</td>
<td>41.10</td>
<td>77.84</td>
<td>68.26</td>
<td>62.32</td>
</tr>
<tr>
<td>1887</td>
<td>56.37</td>
<td>77.84</td>
<td>68.26</td>
<td>61.49</td>
</tr>
<tr>
<td>1888</td>
<td>52.09</td>
<td>77.54</td>
<td>65.71</td>
<td>73.95</td>
</tr>
<tr>
<td>1889</td>
<td>51.39</td>
<td>77.30</td>
<td>70.56</td>
<td>57.32</td>
</tr>
<tr>
<td>1890</td>
<td>62.01</td>
<td>75.43</td>
<td>70.27</td>
<td>68.43</td>
</tr>
<tr>
<td>1891</td>
<td>67.04</td>
<td>74.40</td>
<td>87.24</td>
<td>77.27</td>
</tr>
<tr>
<td>1892</td>
<td>75.05</td>
<td>77.20</td>
<td>65.89</td>
<td>76.90</td>
</tr>
<tr>
<td>1893</td>
<td>73.44</td>
<td>78.71</td>
<td>73.22</td>
<td>77.20</td>
</tr>
<tr>
<td>1894</td>
<td>77.13</td>
<td>77.41</td>
<td>74.47</td>
<td>76.43</td>
</tr>
<tr>
<td>1895</td>
<td>91.64</td>
<td>76.11</td>
<td>68.60</td>
<td>76.74</td>
</tr>
<tr>
<td>1896</td>
<td>72.04</td>
<td>75.69</td>
<td>70.00</td>
<td>73.64</td>
</tr>
<tr>
<td>1897</td>
<td>64.99</td>
<td>78.01</td>
<td>69.39</td>
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</tr>
<tr>
<td>1898</td>
<td>66.70</td>
<td>71.16</td>
<td>60.00</td>
<td>76.14</td>
</tr>
<tr>
<td>1899</td>
<td>77.63</td>
<td>74.08</td>
<td>69.46</td>
<td>67.62</td>
</tr>
<tr>
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<td>72.67</td>
<td>67.58</td>
<td>76.38</td>
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<tr>
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<td>59.73</td>
<td>79.31</td>
<td>67.60</td>
<td>77.16</td>
</tr>
<tr>
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<td>69.38</td>
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</tr>
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<td>68.44</td>
<td>62.00</td>
<td>74.84</td>
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<tr>
<td>1905</td>
<td>49.</td>
<td>67.</td>
<td>60.</td>
<td>71.</td>
</tr>
<tr>
<td>1906</td>
<td>49.</td>
<td>60.</td>
<td>59.</td>
<td>72.</td>
</tr>
<tr>
<td>1907</td>
<td>48.</td>
<td>63.</td>
<td>59.</td>
<td>67.</td>
</tr>
</tbody>
</table>

* Source: AR, 1907, p. xlviii. Only the four oldest institutions are included in this sample, though figures are also available for Mimico (1892-1907), Brockville and Orillia (1895-1907), Cobourg (1902-07) and Penetanguishene (1905-07).
TABLE V
TYPES OF EMPLOYMENT AND ACTUAL NUMBER OF PATIENTS WHO WORKED
BY OCCUPATION,
TORONTO ASYLUM FOR THE INSANE, 1880-1905*

<table>
<thead>
<tr>
<th>Occupation</th>
<th>1880</th>
<th>1885</th>
<th>1890</th>
<th>1895</th>
<th>1900</th>
<th>1905</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpenter’s Shop</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Tailor’s Shop</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Engineer’s Shop</td>
<td>2</td>
<td>9</td>
<td>4</td>
<td>7</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Blacksmith’s Shop</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>--</td>
</tr>
<tr>
<td>Mason Work</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Roads Repaired</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Wood Yard</td>
<td>6</td>
<td>12</td>
<td>15</td>
<td>10</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>and Coal Shed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bakery</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Laundry</td>
<td>8</td>
<td>13</td>
<td>17</td>
<td>23</td>
<td>32</td>
<td>34</td>
</tr>
<tr>
<td>Dairy</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Painting</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Farm</td>
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<td>24</td>
<td>22</td>
<td>4</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Garden</td>
<td>5</td>
<td>34</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Grounds</td>
<td>4</td>
<td>--</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Stable</td>
<td>5</td>
<td>4</td>
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<td>6</td>
</tr>
<tr>
<td>Kitchen</td>
<td>8</td>
<td>17</td>
<td>16</td>
<td>10</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Dining Rooms</td>
<td>32</td>
<td>54</td>
<td>40</td>
<td>67</td>
<td>70</td>
<td>68</td>
</tr>
<tr>
<td>Officers’ Quarters</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Sewing Rooms</td>
<td>15</td>
<td>36</td>
<td>22</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Knitting</td>
<td>16</td>
<td>20</td>
<td>20</td>
<td>30</td>
<td>37</td>
<td>12</td>
</tr>
<tr>
<td>Spinning</td>
<td>2</td>
<td>1</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Mending</td>
<td>20</td>
<td>58</td>
<td>38</td>
<td>69</td>
<td>74</td>
<td>52</td>
</tr>
<tr>
<td>Wards &amp; Halls</td>
<td>48</td>
<td>130</td>
<td>204</td>
<td>362</td>
<td>192</td>
<td>117</td>
</tr>
<tr>
<td>Storeroom</td>
<td>1</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Shoe shop</td>
<td>--</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Butcher’s Shop</td>
<td>--</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Piggery</td>
<td>--</td>
<td>2</td>
<td>3</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Tinshop</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Book-binding</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1</td>
<td>--</td>
</tr>
<tr>
<td>Sewing in wards</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>61</td>
<td>21</td>
</tr>
<tr>
<td>Upholstering</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>6</td>
</tr>
<tr>
<td>General</td>
<td>5</td>
<td>18</td>
<td>30</td>
<td>130</td>
<td>28</td>
<td>89</td>
</tr>
</tbody>
</table>

OVERALL TOTAL: 225 469 504 772 580 503
Percent of Pt. Pop. 29.76 57.26 52.44 88.83 68.39 55.33

* Sources: AR, 1880-1905. Garden and Grounds were separate categories in the 1880 report, but they were combined in 1885, so the total figure has been placed under Garden for that year, but these categories are separated again in reports thereafter. Wards and Halls was another original category, though it was split in two in 1885 and 1890 reports but has been combined in this table. In the 1895, 1900 and 1905 reports Halls is no longer listed but Wards is, so the total reflects this category for these latter three years. Categories were dropped and added over the years which is reflected where no work is recorded.
### TABLE VI

**TYPES OF EMPLOYMENT AND CUMULATIVE DAYS WORKED BY PATIENTS BY OCCUPATION AND GENDER, TORONTO ASYLUM FOR THE INSANE, 1880-1905**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>1880</th>
<th>1885</th>
<th>1890</th>
<th>1895</th>
<th>1900</th>
<th>1905</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpenter’s Shop F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>626</td>
<td>534</td>
<td>1210</td>
<td>1248</td>
<td>1248</td>
<td>1340</td>
</tr>
<tr>
<td>Tailor’s Shop</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>1252</td>
<td>927</td>
<td>612</td>
<td>936</td>
<td>1012</td>
<td>1197</td>
</tr>
<tr>
<td>Engineer’s Shop</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>626</td>
<td>2170</td>
<td>1460</td>
<td>2184</td>
<td>2184</td>
<td>1460</td>
</tr>
<tr>
<td>Blacksmith’s &quot;</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>313</td>
<td>168</td>
<td>310</td>
<td>312</td>
<td>312</td>
<td>--</td>
</tr>
<tr>
<td>Mason Work</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>626</td>
<td>574</td>
<td>620</td>
<td>624</td>
<td>624</td>
<td>290</td>
</tr>
<tr>
<td>Road Repairs</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
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</tr>
<tr>
<td>M.</td>
<td>626</td>
<td>152</td>
<td>540</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Wood Yard and Coal Shed</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>1878</td>
<td>2650</td>
<td>4000</td>
<td>3120</td>
<td>1872</td>
<td>3119</td>
</tr>
<tr>
<td>Bakery</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>1000</td>
<td>750</td>
<td>930</td>
<td>624</td>
<td>936</td>
<td>936</td>
</tr>
<tr>
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<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>1300</td>
<td>1649</td>
<td>3130</td>
<td>5928</td>
<td>7614</td>
<td>8700</td>
</tr>
<tr>
<td>Dairy</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>365</td>
<td>500</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Painting</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>939</td>
<td>939</td>
<td>700</td>
<td>1560</td>
<td>1560</td>
<td>900</td>
</tr>
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<td>Farm</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>8138</td>
<td>7512</td>
<td>7756</td>
<td>1128</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Garden</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>1600</td>
<td>4136</td>
<td>2504</td>
<td>1872</td>
<td>2808</td>
<td>3700</td>
</tr>
<tr>
<td>Grounds</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>1350</td>
<td>--</td>
<td>3756</td>
<td>3120</td>
<td>2184</td>
<td>2640</td>
</tr>
<tr>
<td>Stable</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>1820</td>
<td>1460</td>
<td>2190</td>
<td>2520</td>
<td>2100</td>
<td>1410</td>
</tr>
<tr>
<td>Kitchen</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>2190</td>
<td>1800</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Dining Rooms</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>5840</td>
<td>5678</td>
<td>7300</td>
<td>10944</td>
<td>10390</td>
<td>13910</td>
</tr>
<tr>
<td>Officers’ Quarters</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
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<td>730</td>
<td>739</td>
<td>108</td>
<td>1407</td>
<td>1890</td>
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<td>Sewing Rooms</td>
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<td>--</td>
<td>--</td>
<td>--</td>
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<td>--</td>
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<td>936</td>
<td>246</td>
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<td>--</td>
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</tr>
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<td>M.</td>
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<td>6360</td>
<td>6000</td>
<td>9360</td>
<td>11410</td>
<td>2140</td>
</tr>
<tr>
<td>Spinning</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
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</tr>
<tr>
<td>M.</td>
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<td>261</td>
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</tr>
<tr>
<td>Mending</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
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</tr>
<tr>
<td>M.</td>
<td>5200</td>
<td>7580</td>
<td>9000</td>
<td>7200</td>
<td>12110</td>
<td>14110</td>
</tr>
<tr>
<td>Wards &amp; Halls</td>
<td>F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>9855</td>
<td>12976</td>
<td>28700</td>
<td>80600</td>
<td>42100</td>
<td>16036</td>
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<tr>
<td></td>
<td>M.</td>
<td>7665</td>
<td>13134</td>
<td>46220</td>
<td>27636</td>
<td>18700</td>
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TABLE VI  
(continued)

TYPES OF EMPLOYMENT AND CUMULATIVE DAYS WORKED BY PATIENTS  
BY OCCUPATION AND GENDER,  
TORONTO ASYLUM FOR THE INSANE, 1880-1905*  

<table>
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<tr>
<th>Occupation</th>
<th>1880</th>
<th>1885</th>
<th>1890</th>
<th>1895</th>
<th>1900</th>
<th>1905</th>
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<tr>
<td>Storeroom</td>
<td>F.</td>
<td>312</td>
<td>1460</td>
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<tr>
<td></td>
<td>M.</td>
<td>684</td>
<td>1460</td>
<td>312</td>
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<td>Shoe shop</td>
<td>F.</td>
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<td>--</td>
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<tr>
<td></td>
<td>M.</td>
<td>140</td>
<td>64</td>
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<td>1248</td>
<td>914</td>
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<td>Butcher’s Shop</td>
<td>F.</td>
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<td></td>
<td>M.</td>
<td>730</td>
<td>1050</td>
<td>365</td>
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<td>Piggery</td>
<td>F.</td>
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<td>--</td>
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<td></td>
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<td>730</td>
<td>1095</td>
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<td>Tinshop</td>
<td>F.</td>
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<td>Book-binding</td>
<td>F.</td>
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<tr>
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<td>M.</td>
<td>--</td>
<td>--</td>
<td>--</td>
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<td>Sewing in Wards</td>
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<td>--</td>
<td>--</td>
<td>14210</td>
<td>8410</td>
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<tr>
<td></td>
<td>M.</td>
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<td>--</td>
<td>--</td>
<td>4360</td>
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<tr>
<td>Upholstering</td>
<td>F.</td>
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<td>--</td>
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</tr>
<tr>
<td></td>
<td>M.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1204</td>
</tr>
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<td>General</td>
<td>F.</td>
<td>2608</td>
<td>5475</td>
<td>39960</td>
<td>4010</td>
<td>10180</td>
</tr>
<tr>
<td></td>
<td>M.</td>
<td>1565</td>
<td>2000</td>
<td>5475</td>
<td>6156</td>
<td>6099</td>
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<tr>
<td>Total by Gender</td>
<td>F.</td>
<td>34736</td>
<td>46453</td>
<td>65760</td>
<td>157856</td>
<td>103527</td>
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<tr>
<td></td>
<td>M.</td>
<td>38576</td>
<td>51688</td>
<td>106613</td>
<td>73623</td>
<td>72183</td>
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<tr>
<td>OVERALL TOTAL:</td>
<td></td>
<td>73312</td>
<td>98141</td>
<td>172373</td>
<td>231479</td>
<td>175710</td>
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<tr>
<td>Work Percentage</td>
<td>F.</td>
<td>47.4</td>
<td>47.3</td>
<td>38.14</td>
<td>68.2</td>
<td>58.9</td>
</tr>
<tr>
<td>by Gender</td>
<td>M.</td>
<td>52.6</td>
<td>52.7</td>
<td>61.86</td>
<td>31.8</td>
<td>41.1</td>
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<tr>
<td>Patient Pop. %</td>
<td>F.</td>
<td>48.28</td>
<td>48.96</td>
<td>50.88</td>
<td>51.09</td>
<td>51.42</td>
</tr>
<tr>
<td>by Gender</td>
<td>M.</td>
<td>51.72</td>
<td>51.04</td>
<td>49.12</td>
<td>48.91</td>
<td>48.58</td>
</tr>
</tbody>
</table>

* Sources: AR, 1880-1905. The final total figures for both female and male work-days for 1895 were incorrectly added in that year's report, but have been corrected above. Garden and Grounds were separate categories in the 1880 report, but they were combined in 1885, so the total figure has been placed under Garden for that year, but these categories are separated again in reports thereafter. Wards and Halls was another original category, though it was split in two in 1885 and 1890 reports but has been combined in this table. In the 1895, 1900 and 1905 reports Halls is no longer listed but Wards is, so the total reflects this category for the latter three years. Categories were dropped and added over the years which is reflected where no work is recorded for either gender under specific occupations.
### TABLE VII

**STRUCTURAL WORK COMPLETED WITH PATIENTS’ LABOUR AT THE TORONTO ASYLUM FOR THE INSANE, 1871-1904***

(Does not include work at Mimico Branch, 1888-94)

<table>
<thead>
<tr>
<th>Date</th>
<th>Project</th>
<th>Estimated $ Outlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1871</td>
<td>Ditch and drain digging</td>
<td>&quot;trifling expense&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Painting, Wood grained</td>
<td>(AR, 1871, p. 71)</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Front fence bronzed</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1877</td>
<td>Ditch digging, gathered stones</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1888</td>
<td>Boundary walls, 1,600-3,000 feet, &quot;tens of thousands&quot; of dollars saved</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1889</td>
<td>Two story brick work-shop, 100 feet x 30 feet</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1889</td>
<td>Brick coal shed, 140 feet x 40 feet</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1890</td>
<td>New central kitchen</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Brick connections between east wards and adjoining building, 45 feet of space, three stories in height</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>New stone and brick entrance</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1892-3</td>
<td>New brick Chapel and Recreation Hall, 45 feet x 85 feet, two stories tall</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1893</td>
<td>Brick male infirmary, three stories</td>
<td>$800.</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Brick addition to cow stable for seven more cows</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>New brick feed house for cows</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1894</td>
<td>Brick female infirmary, three stories &quot;reduced the cost very much&quot;</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Reconstruction of Steward’s house</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1895</td>
<td>Unspecified number of bedroom floors relaid</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Floor &amp; sitting-room in Ward 5 redone</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Repainting done in five wards, halls in central building and amusement room</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Addition to Conservatory built</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Concrete floors laid in cow stables</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Addition &amp; repairs to mortuary</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Replacement of dumb waiters</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Laundry room reconstructed</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>New heating boilers in laundry and Cottage C</td>
<td>&quot;&quot;</td>
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<tr>
<td>1896</td>
<td>Tramway built to outhouses and stables</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>New brick coal shed</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>&quot;&quot;</td>
<td>Small addition to east lodge</td>
<td>&quot;&quot;</td>
</tr>
<tr>
<td>1902-04</td>
<td>Brick bowling alley for men patients, 90 feet x 30 feet</td>
<td>&quot;&quot;</td>
</tr>
</tbody>
</table>

* All references can be found in Annual Reports for relevant years, though references to boundary walls provide different lengths in 1889 and 1895 reports which is why "1,600-3,000 feet" is cited. Quotes from Superintendent Workman and Superintendent Clark in "Estimated $ Outlay" column refer specifically to savings as a direct result of inmate labour.
### TABLE VIII
PATIENT'S INDUSTRIAL OPERATIONS,
TORONTO ASYLUM FOR THE INSANE, 1905*

<table>
<thead>
<tr>
<th>Department</th>
<th>Female Wards</th>
<th>Sewing Room (Female)</th>
<th>Tailor Shop (Male)</th>
<th>Shoe Shop (Male)</th>
<th>Tinware (Male)</th>
<th>Book Binding (Male)</th>
<th>Upholstering (Male)</th>
<th>Knitting (Female)</th>
<th>Laundry (86% Female)</th>
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</thead>
<tbody>
<tr>
<td>No. articles of clothing</td>
<td>5,233</td>
<td>6,685</td>
<td>331</td>
<td>20</td>
<td>31</td>
<td>20</td>
<td>275</td>
<td>282</td>
<td>409,868</td>
</tr>
<tr>
<td>and furnishings made</td>
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<tr>
<td>and furnishings repaired</td>
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<td>1,227</td>
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<td>779</td>
<td>125</td>
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<td>561</td>
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<td>275</td>
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<td>409,868</td>
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<tr>
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<td></td>
<td></td>
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<td>made</td>
<td>402</td>
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<td>402</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. pieces passing through</td>
<td>409,868</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>laundry</td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

* Source: AR, 1905, p. 15.
<table>
<thead>
<tr>
<th></th>
<th>1927</th>
<th>1928</th>
<th>1929</th>
<th>1930</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industrial Work</td>
<td>F. 30</td>
<td>30</td>
<td>45</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>M. 40</td>
<td>16</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Farm and Garden</td>
<td>F. --</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>M. 30</td>
<td>30</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>External Work</td>
<td>F. --</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>M. 60</td>
<td>150</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>Internal Work</td>
<td>F. 75</td>
<td>100</td>
<td>95</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>M. 70</td>
<td>100</td>
<td>90</td>
<td>140</td>
</tr>
<tr>
<td>Total Pts.</td>
<td>F. 105</td>
<td>130</td>
<td>140</td>
<td>220</td>
</tr>
<tr>
<td>Employed</td>
<td>M. 200</td>
<td>296</td>
<td>175</td>
<td>224</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>305</td>
<td>426</td>
<td>315</td>
</tr>
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</table>

Employed %

<table>
<thead>
<tr>
<th></th>
<th>1927</th>
<th>1928</th>
<th>1929</th>
<th>1930</th>
<th>1931</th>
<th>1932</th>
<th>1933</th>
<th>1934</th>
<th>1935</th>
<th>1936</th>
<th>1937</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industrial Work</td>
<td>F. 10</td>
<td>--</td>
<td>43</td>
<td>45</td>
<td>42</td>
<td>40</td>
<td>40</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M. 40</td>
<td>--</td>
<td>10</td>
<td>30</td>
<td>40</td>
<td>45</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farm and Garden</td>
<td>F. --</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>M. 30</td>
<td>45</td>
<td>45</td>
<td>35</td>
<td>30</td>
<td>36</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utility Staff</td>
<td>F. 25</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>M. 20</td>
<td>25</td>
<td>25</td>
<td>60</td>
<td>45</td>
<td>35</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housekeeping, Kitchen Ward</td>
<td>F. 12</td>
<td>10</td>
<td>10</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M. 30</td>
<td>39</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>40</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Pts.</td>
<td>F. 107</td>
<td>149</td>
<td>182</td>
<td>170</td>
<td>151</td>
<td>151</td>
<td>155</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>M. 180</td>
<td>209</td>
<td>298</td>
<td>278</td>
<td>273</td>
<td>356</td>
<td>240</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>287</td>
<td>358</td>
<td>480</td>
<td>448</td>
<td>424</td>
<td>507</td>
<td>395</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employed %

<table>
<thead>
<tr>
<th></th>
<th>1927</th>
<th>1928</th>
<th>1929</th>
<th>1930</th>
<th>1931</th>
<th>1932</th>
<th>1933</th>
<th>1934</th>
<th>1935</th>
<th>1936</th>
<th>1937</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industrial Work</td>
<td>F. 23.38</td>
<td>28.07</td>
<td>28.68</td>
<td>45.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M. 48.78</td>
<td>80.87</td>
<td>44.19</td>
<td>54.76</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population</td>
<td>T. 35.50</td>
<td>51.38</td>
<td>35.63</td>
<td>49.55</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual Pts.</td>
<td>859</td>
<td>829</td>
<td>884</td>
<td>896</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Source: AR, 1927-37. Categories listed as cited. Does not include occupational & vocational classes or "Special Occ."
TABLE X

VOCATIONAL AND OCCUPATIONAL CLASSES 
AND SPECIAL OCCUPATION, 
TORONTO HOSPITAL FOR THE INSANE, 1931-1937*

<table>
<thead>
<tr>
<th></th>
<th>1931</th>
<th>1932</th>
<th>1933</th>
<th>1934</th>
<th>1935</th>
<th>1936</th>
<th>1937</th>
</tr>
</thead>
<tbody>
<tr>
<td>V.C. F.</td>
<td>--</td>
<td>33</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>M.</td>
<td>--</td>
<td>10</td>
<td>10</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>O.C. F.</td>
<td>110</td>
<td>57</td>
<td>73</td>
<td>55</td>
<td>76</td>
<td>94</td>
<td>80</td>
</tr>
<tr>
<td>M.</td>
<td>11</td>
<td>30</td>
<td>25</td>
<td>10</td>
<td>10</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Spec. F.</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Occ. M.</td>
<td>--</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Total F.</td>
<td>578</td>
<td>79.29%</td>
<td>151</td>
<td>20.71%</td>
<td>729</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M.</td>
<td>151</td>
<td>20.71%</td>
<td>729</td>
<td>729</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Source: AR, 1931-1937. These statistical categories are not listed in earlier or later reports.
**TABLE XI**

GENERAL STATISTICAL TABLES, 999 QUEEN STREET WEST, 1846-1940

**TABLE XI A**

ADMISSIONS (1)

<table>
<thead>
<tr>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,849</td>
<td>11,626</td>
<td>22,475</td>
</tr>
<tr>
<td>(48.27%)</td>
<td>(51.73%)</td>
<td></td>
</tr>
</tbody>
</table>

1) Includes re-admissions and transferrals.

**TABLE XI B**

DISCHARGES (1)

<table>
<thead>
<tr>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,612</td>
<td>7,692</td>
<td>15,304</td>
</tr>
<tr>
<td>(49.74%)</td>
<td>(50.26%)</td>
<td></td>
</tr>
</tbody>
</table>

1) Includes deportations.

**TABLE XI C**

DEATHS

<table>
<thead>
<tr>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,559</td>
<td>3,159</td>
<td>5,718</td>
</tr>
<tr>
<td>(44.75%)</td>
<td>(55.25%)</td>
<td></td>
</tr>
</tbody>
</table>

TABLE XI
CAUSES OF DEATH AT 999 QUEEN STREET WEST BY GENDER, 1846-1920

<table>
<thead>
<tr>
<th>CAUSE OF DEATH</th>
<th>FEMALE</th>
<th>MALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious Diseases (1)</td>
<td>133</td>
<td>108</td>
<td>241</td>
</tr>
<tr>
<td>Constitutional Diseases</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Diseases of Digestive System</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Diseases of Intestines</td>
<td>27</td>
<td>19</td>
<td>46</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>69</td>
<td>62</td>
<td>131</td>
</tr>
<tr>
<td>Circulatory Diseases (2)</td>
<td>101</td>
<td>115</td>
<td>216</td>
</tr>
<tr>
<td>Blood and Glands Diseases</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Genito-Urinary Diseases</td>
<td>19</td>
<td>24</td>
<td>43</td>
</tr>
<tr>
<td>Nervous System Diseases</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Organic Brain Diseases</td>
<td>20</td>
<td>28</td>
<td>48</td>
</tr>
<tr>
<td>Functional Nerve Diseases (3)</td>
<td>35</td>
<td>40</td>
<td>75</td>
</tr>
<tr>
<td>Mental Diseases (4)</td>
<td>95</td>
<td>346</td>
<td>441</td>
</tr>
<tr>
<td>Debility of Old Age</td>
<td>159</td>
<td>139</td>
<td>298</td>
</tr>
<tr>
<td>Accident</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Suicide</td>
<td>8</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>Surgical Diseases</td>
<td>--</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gynaecological Diseases</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Malignant Growth or Cancer</td>
<td>17</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td><strong>Sub-totals</strong></td>
<td>697</td>
<td>923</td>
<td>1620</td>
</tr>
<tr>
<td><strong>Unascertained (56.64%)</strong></td>
<td>958</td>
<td>1159</td>
<td>2117</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>1655</td>
<td>2082</td>
<td>3737</td>
</tr>
</tbody>
</table>

1) 73% of infectious diseases were from tuberculosis with females comprising 54% of cases.
2) 67% of circulatory diseases were from heart disease, almost evenly divided between females and males.
3) 94.6% of functional nervous diseases were due to epilepsy, almost evenly divided between females and males.
4) 73% of mental diseases were due to general paresis, with males comprising 90% of the cases.

Source: AR, 1920, p. 111-112. It should be noted that there is an error of five extra in the original report, though this has been corrected above.
### TABLE XIII

**PRINCIPAL RECORDED CAUSES OF DEATH, ONTARIO MENTAL HOSPITALS - 1939-40 AND ONTARIO - 1939**

<table>
<thead>
<tr>
<th>CAUSE OF DEATH</th>
<th>MENTAL HOSPITALS</th>
<th>PROVINCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Rate(1)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>Pneumonia and Bronchitis</td>
<td>260</td>
<td>1490</td>
</tr>
<tr>
<td>Diseases of the Heart</td>
<td>197</td>
<td>1129</td>
</tr>
<tr>
<td>Tuberculosis (all forms)</td>
<td>61</td>
<td>350</td>
</tr>
<tr>
<td>Cerebral Haemorrhage</td>
<td>56</td>
<td>321</td>
</tr>
<tr>
<td>Diseases of the Arteries</td>
<td>60</td>
<td>344</td>
</tr>
<tr>
<td>Cancer (all forms)</td>
<td>39</td>
<td>224</td>
</tr>
<tr>
<td><strong>Sub-totals</strong></td>
<td>673</td>
<td>38.6</td>
</tr>
<tr>
<td><strong>All other Causes</strong></td>
<td>200</td>
<td>11.5</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>873</td>
<td>50.1</td>
</tr>
</tbody>
</table>

1) Per 100,000 under treatment (17,444), except totals which are per 1,000.
2) Per 100,000 population, except totals which are per 1,000.

Source: AR, 1940, p. 40.
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