KAMIKA TANEJA

WARTIME ASYLUMS

A HISTORICAL PERSPECTIVE (VOLUME 2)

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Need for Food, Farm and Fuel in Civilian Lunatic Asylum

Introduction

Within days of war breaking out the country faced a torrent of problems including "extraordinary chaos in the Food Market". At Napsbury Asylum, the grain and flour supplier backed out of his contract because imports failed to arrive, and Nestlé stopped deliveries because the government required its stocks. The standard of bread fell because much yeast was imported and consequently unobtainable. Fish was suddenly unavailable because "as the Steamers return they are being laid up pending events."[1] Foods such as meat, and other items considered healthy by early twentieth century nutritional scientists, were prioritised for the soldiers.[2] The large contracts for food required by the asylums became particularly vulnerable. There were many challenges in addition to obtaining supplies, including coping with a capped budget, concerns about cooking to avoid exhausting limited fuel supplies, and resident staff voicing discontent about the food provided for them. Limited understanding of nutrition, and patterns of inequitable food distribution within the asylums according to rank rather than health need, also contributed to an unsatisfactory diet for patients.

In order to contextualise and explain the situation in the asylums, this chapter begins by outlining the national position with regard to food, then, in the context of nutritional understanding, explores asylum supply and demand issues, patients' communal meals, and food distribution.

Some of the challenges faced by asylum farms, and the use of fuel, another precious commodity, are also discussed.

The National Food Context

Until the war, Britain imported about 60 per cent of its food. As in the lyrics of *Rule, Britannia!*, "Britannia rule the waves",[3] it could not conceive of any way in which its sea routes could be disrupted, neither had it envisaged the possibility of a prolonged conflict nor interruption of trade by submarines.[4] The country produced one fifth of its wheat, two fifths of its butter and cheese, three-fifths of its meat and bacon, and none of its sugar. Only in respect of fish, milk and potatoes was it self-sufficient.

A few days after war was declared, the government passed the Defence of the Realm Act (DORA) which gave it authority to control many aspects of civilian life, including food supplies. This system of national government-led welfare was new: earlier, providing and controlling resources would have been in the hands of voluntary bodies.[5] It was a change with potential to influence future welfare policy. At the same time, Walter Runciman was appointed president of the Board of Trade. Consistent with Runciman's free-trade principles and the Liberal government's general philosophy, his lack of intervention inhibited the development of a coherent food policy.[6] Nevertheless, behind the scenes, the government amassed emergency supplies of essential food stuffs such as wheat,[7] and took control of the sugar supply, two-thirds of which was usually imported from Austria-Hungary.[8] Inclement weather and the reduced availability of ammonia, which was used to produce both fertilisers and explosives, affected home-grown crops.[9] Despite threats to the food supply, in the view of William Beveridge (later, draftsman of the welfare state), until late 1916 "there was no general food problem in Britain".[10]

Administrative errors caused local shortages, such as sugar supplies to retailers being based on pre-war sales patterns, due to failing to take into account large scale civilian population movement for munitions and other work.[11] War inflation, higher costs of freight, and panic buying, all contributed to higher food prices and caused public discontent, but according to an analysis by Gerd Hardach, most food stuffs remained within reach of poorer people.[12] An independent committee, appointed by the government, which investigated wartime life for working class people found that dietary energy levels for community dwellers were

generally maintained, although intakes of some key nutrients deteriorated.[13] For some households, with a father in the forces and a mother with young children relying on the meagre "separation allowance", life was a struggle.[14] Some oral histories recalled experiences of persistent hunger among working class children, and families who attributed deaths of younger siblings to malnutrition.[15] Two years into the war, food prices had almost doubled.[16] For many in the community, high rates of employment and some increase in salary partly compensated for the steep price rises.[17] An asylum, of course, was an employer, so was responsible for paying the "war bonus" increases to its non-resident staff to cover their higher daily living costs. Within a framework of a budget capped by the Lunacy Act 1890 which stipulated a maximum outlay of 14s (shillings, 70p) per patient per week to cover all asylum running expenses, including staff salaries,[18] the outcome was less money to spend on food for patients and staff who were resident in the asylum.

The government aimed to avoid compulsory rationing and invited the public to participate in voluntary dietary restrictions, much as it initially encouraged voluntary military recruitment rather than introduce conscription.[19] However, from 1916, German "U-boat" submarines specifically targeted merchant ships with great loss of life and cargo, and food supplies were again in crisis. The government feared that if families sent letters to soldiers describing their daily problems, or if soldiers experienced the difficulties when home on leave, this would undermine military morale.[20] To deal with this, to "maintain war production and prevent unrest at home" the government established a Ministry of Food.[21] It was headed by a "Food Controller", rather than a Minister, and was empowered to regulate supply and consumption and to take steps to encourage food production.[22] Beveridge was appointed Permanent Secretary to the Ministry.[23]

The first Food Controller, Lord Devonport, a grocery stores magnate, continued to promote voluntary dietary adaptations, aiming to reduce the consumption of foods in short supply and to avoid waste when cooking. Some commentators have proposed that his *laissez faire* approach was founded on a financial conflict of interest.[24] The Ministry of Food proposed dietary guidelines in February 1917 (Table 5.1) which applied to domestic environments where each household member was assumed to have different nutritional requirements: food needs of a labourer and young child in the same household would probably balance out so that neither went hungry. Some households could supplement diets with

Table 5.1 Weekly food allowances under various rationing schemes

Recommended intake, general population, Feb. 1917	*Compulsory rationing, general population, Nov. 1917*	*LCC asylum patients, Nov. 1917*	*Compulsory rationing, general population, early 1918*
Sugar 12 oz	Sugar 8 oz Fats 10 oz	Sugar 7¼ oz Fats 7¼ oz	Sugar (adult or child) 8 oz Fats (adult or child) 8 oz
Bread 4 lb	Bread (age/gender/occupation) 3½ lb ("sedentary/unoccupied woman")–8 lb	Bread (average) 4¾ lb	Bread (age/gender/occupation) 3–7 lb
Meat 2½ lb	Meat 2 lb	Meat 1¾ lb	Meat 2 lb Use carefully: Cheese, milk, oatmeal, rice, tea, jam Unrestricted: Potatoes, fruit, vegetables, eggs, fish

Sources LCC LCC/MIN/00582 Meeting, 27 February 1917, 434 LMA; LCC LCC/MIN/00583, 27 November 1917, 175–76 LMA; BBC, "World War One: What Shops Were on the High Street? Rationing," http://www.bbc.co.uk/schools/0/ww1/25235371

home-grown produce, and a cook "in an ordinary household" could make many "small economies". Regarding institutions, those which solely housed adults lost the benefits of juggling supplies on the basis of individual nutritional requirements across the lifespan, and a handful of cooks feeding 2000 resident patients and staff seven days a week were unlikely to be able to replicate economies made in a household kitchen.

The second Food Controller, Lord Rhondda, an industrialist and politician, introduced compulsory rationing at the end of 1917, beginning with butter, margarine and sugar (Table 5.1).[25] Food queues in London, which had reached one and a half million people a week, diminished with compulsory rationing.[26] Rationing was intended to provide a state determined allocation of food to all, with flexibility for age, health, religious and other needs.[27] The entire country, including King George and Queen Mary had ration books, with their allowances calculated on the same ration scale as their subjects.[28] Everyone had their rations derived from a scale roughly tailored to their needs, but this would only be achieved if those rations were distributed equitably. In asylums, the

hierarchical culture, difficulties in economising in ways which might be possible in a household setting, together with escalating food prices and other higher expenses within a limited budget, contributed to a precarious food situation.

Asylum Diets: Supply and Demand

The asylums contended with unpredictable food supplies pre-war,[29] in contrast to the relatively stable situation for the rest of the country. They procured enormous quantities, had little access to refrigeration, and kept only minimal stocks. Suppliers knew this, and its implications, that asylums had to accept deliveries even if substandard.[30] Food might be "stale and unfit for consumption" at the time of delivery,[31] and even when fit, it was often best cooked the same day to prevent deterioration, serving it the following day.[32] Some asylums spent as little as 4s (20p) per patient per week on food, a sum independent of the amount of food provided by the asylum farm.[33]

Benjamin Seebohm Rowntree's study of poverty in *fin de siècle* York provides useful dietary comparators for the asylums in 1914. These comparisons are possible because there was almost no inflation or change in eating habits during this period. Rowntree found weekly food expenditure to be approximately 3s6d (18½p) per adult male in households of the lowest wage earners and 3s9½d (19p) in the workhouse. He incorporated into his analysis the most up-to-date estimates of the nutritional value of these people's diets. Analyses were generally limited to calorie and protein content, standardised to the bodily needs of a person at rest in a warm room.[34] Not only was the situation of being at rest in a warm room likely to be unusual for the poorest of the working classes in York, but even when based on these calculations, their diet was deficient in calories and protein by around 25 per cent.[35] Similar deficiencies were likely for patients living in asylums with poor quality clothes and inadequate heating and with high levels of bodily energy usage due to restlessness, co-existing physical illness, much manual work and having long distances to walk such as to the lavatories and dining hall.

In contrast to Rowntree's analysis, Diane Carpenter, in her study of two Hampshire asylums pre-war, concluded that asylum food was better than in workhouses and often better balanced than that available to most poor people.[36] Her conclusions suggest variation between asylums, but

for those functioning at Rowntree's level, diet would have been insufficient to promote health and wellbeing, or to help the recovery of patients who required more calories due to their mental and physical disorders. Keeping to the Lunacy Act's budget of 14s per week per patient, was a constant challenge for the asylums. Barely feasible in the low inflation period pre-1914, the London County Council (LCC) found it unachievable during the war.[37] The financial target contributed to a culture of minimising expenditure, accompanied by the temptation to divert savings made by cutting food costs to benefit other, more outwardly visible, asylum needs. The 14s compared unrealistically with the average weekly general hospital cost of 28s per patient, or 45s in one Red Cross Hospital, even allowing for the different disorders being treated.[38] With wartime inflation, expenditure on asylum food did not increase: there were other priorities, including paying the staff to keep the asylums functioning. Psychiatrist William Stoddart cautioned in 1916: "It is false economy on the part of the authorities of many county asylums to keep down the maintenance rate by economising food."[39] His message fell on deaf ears.

In contrast to the situation for the general public, wartime food rationing began early for people in the asylums. We hear little from patients about the food, although one patient later alleged: "My wife brought in food. Else I should have been starved",[40] and another volunteered for kitchen work, and "got better food because I really stole it".[41] We hear more from the resident staff who were also subject to early rationing. With compulsory deductions from their already low wages for board and lodging, they had little option but to eat the food provided. They resented the dietary restrictions and food monotony which those outside did not have to endure.[42] At Hanwell, one nurse left, alleging that she was being starved. Others complained about rancid margarine, poor quality bacon, only one potato at dinner, small meat allowances and bread inferior to what was on sale outside.[43] The LCC attempted to improve staff food,[44] occasional seeking expert external advice to try to make it more palatable.[45] It justified allocating more and better quality food to staff to keep them well enough to care for the patients, to alleviate employee discontent, and to prevent them taking the patients' food.[46] However, since food supplies within the asylum were pooled,[47] a strategy of providing more for staff, automatically diminished quantities available for patients. One asylum management "visiting" committee (VC), pleased with its ingenuity in issuing bread directly to wards, reported that it reduced expenditure and waste and "every patient or member of the

staff has what he requires". Other evidence throws this open to dispute, because only staff held keys to the store cupboards, and when they were hungry, they took the patients' bread.[48] Visiting committee members lived in the un-rationed community outside the asylum, and sometimes appeared to lack a detailed appreciation of asylum life.[49]

The asylum economy and the external supply chain were major considerations throughout the war for the VCs and the national asylums' Board of Control ("the Board"). Regarding the main dietary staple of bread, shortage of wheat flour necessitated substitutions of un-rationed ingredients such as barley, oatmeal, rice, sago, tapioca, maize or potatoes.[50] Twenty pounds (20 lb, 9 kg) of potatoes could be mixed with 1 sack (280 lb, 127 kg) of flour.[51] Kitchen staff disliked the additional labour it required without a potato mashing machine.[52] Bread made with potatoes also tasted different and was unpopular with consumers.[53] Bran or wheatgerm could be added, a financially sound alternative,[54] but not always acceptable in a culinary culture which considered white bread best and wholemeal inferior.[55] The Board welcomed the news of a glut of cheap pickled and smoked herring on the market. It distributed to the asylums the Ministry of Food's recipe guide: herrings could be boiled, steamed, fried, grilled, baked, poached, stuffed, soused or curried, served with lemon sauce, in a pie or salad, or potted in vinegar.[56] The recipes were generally for household quantities, and whether they would translate effectively into mass-catering was uncertain.

Asylum Diets and Nutritional Understanding

The VCs' track record of prioritising lowest possible expenditure, plus little grasp of emerging nutritional science,[57] was a potentially disastrous combination. Although the Board made recommendations in line with nutritional knowledge, for example suggesting high protein substitutes such as cheese, beans, lentils or peas when meat was in short supply, VCs, with one eye on the books, proposed puddings, fruit pies and rice, cheaper but hardly equivalent nutritionally.[58] Tenna Jensen's study of nutritional science and early twentieth-century institutional diets (in Denmark) indicated that, in spite of societal awareness of nutrition, incorporating that knowledge into institutional diets was far from universal. Instead, institutional diets focussed more on the need for food to be filling.[59] Knowledge could have a time lag of several years before filtering

through to institutional implementation, with the result that war time asylum diets tended to follow obsolete guidelines.

Regarding vitamins, discovered around 1912, their mode of action was still "immature views and guesses"[60] and their presence in food unquantifiable,[61] but the medical profession acknowledged their "astonishing properties" which could "profoundly affect" physical and mental health.[62] Regarding vitamin C just before the war, patients at Colney Hatch received "½lb fruit weekly per head in the summer" (0.25 kg).[63] When combined with plenty of potatoes and other root vegetables, vitamin C intake was probably adequate: none of the medical records examined in the course of researching this book referred to scurvy. Although more fruit may not have been considered essential to the diet, sugar, because of its calorie content was regarded as a vital nutrient. Pre-war, the nine LCC lunatic asylums consumed 10 tons of sugar between them each week, about 1 lb (0.5 kg) per person.[64] It was standard asylum practice to sweeten hot drinks. Typically, a gallon size pot contained 1 oz (28 g) tea, 4 oz sugar and 12 oz milk, with similar proportions for a gallon of coffee or cocoa.[65] In 1916, the LCC asked medical superintendents to suggest "dietary substitutes…to take the place of necessary food for patients caused by the great reduction of sugar allowance".[66] It also asked the Royal Commission on the Sugar Supply for more sugar for asylums "having regard to the fact that the issues of sugar at the asylums have already been reduced to the lowest limit which is believed to be compatible with good health". Nevertheless, the LCC oversaw inequitable distribution of sugar: ½ lb per patient and 1 lb per resident member of staff per week in 1916,[67] pointing to the nutrition of staff being prioritised over that of patients.

Nutritional understanding by VCs also contributed to how they interpreted government dietary recommendations which were often formulated in terms of maximum amounts which were not to be exceeded.[68] The general understanding was that if individuals did not need the maximum, it was fine if they ate less of their own volition.[69] Maximum quantities, however, in the asylums, were interpreted on behalf of the patients who had little individual choice or agency. Claybury's VC wanted to provide patients with "less than the maximum scale" of bread, cake, potatoes, meat, pudding, fish, coffee, tea, sugar, margarine, flour, dripping, jam and cheese.[70] Two weeks later, at the VC's next meeting, medical superintendent Robert Armstrong-Jones argued against their proposal: "The standards in use are the result of many years of thought

and experience and a lowering of standard does not necessarily lead to a saving", echoing Stoddart's message.[71] If any reductions were made, Armstrong-Jones continued, they should be on the basis of careful study of the entire food contract, not just chosen arbitrarily or to make financial savings.[72] Armstrong-Jones was aware of his VC's tendency to make decisions based on finance rather than on patients' wellbeing. Claybury did not introduce this across-the-board food reduction, but less dramatic dietary reductions followed. By contrast, interventions to increase patients' food intake were miniscule and half-hearted: when a medical officer at Hanwell suggested that each patient should receive an extra pound of potatoes a week, the VC reduced it to half-a-pound.[73] Asylums neglected to provide food according to the patient's needs. The simple and recommended act of weighing asylum patients regularly to detect malnutrition or disease was implemented inconsistently, suggesting a lack of concern or interest.[74] Patient Mary Riggall reported in her memoir of asylum life that her weight declined from 9 to 6 stones (57–38 kg) during her 18-month admission,[75] supporting the notion that balancing diet with energy expenditure, whether due to illness or occupation, was ignored.

The emphasis on balancing-the-books rather than patients' wellbeing fitted with the practice of allocating additional food to "working" patients, that is, to those whose work the asylum considered economically useful.[76] In contrast, a patient undertaking physical activities for their therapeutic benefit alone did not receive extra, regardless of energy expenditure. This valued a patients' economic contribution above stated ideals of considering activities as intrinsically therapeutic and important to wellbeing and self-esteem, regardless of whether they benefited the institution financially. When one considers the meagre lunch provided to female patients employed on Hanwell's farm—3 oz (90 g) bread with either ½ oz cheese or ½ oz treacle depending on availability—probably under 300 calories,[77] it is hard to identify what might have been considered "additional".

In 1917, the medical superintendents discussed weight loss and high asylum death rates side by side and drew the Board's attention to the effects of food restrictions.[78] At Hanwell acting medical superintendent Alfred Daniel informed the VC that the rising death rate was "partly due to shortage of food", noting the introduction of dry bread for supper instead of bread and dripping,[79] and that "pudding" had only one-fifth

the calories of the same item produced earlier in the war. Food preparation advice to asylums included to boil food rather than roasting or frying it, to conform with government demands to economise on gas consumption,[80] but this reduced both calorie and nutritional content. In July 1918, with rising death rates at Hanwell—26 people in one month—Daniel sought advice from the local authority medical officer of health.[81] The same month, the Board reiterated that all patients should be weighed every 3 months "If not already done as a matter of routine" to monitor dietary adequacy, and that patients and resident staff should be allocated food to provide 2600 calories a day.[82] However, Hanwell did not even provide that amount to its shell-shocked patients, those deemed worthy of the best care. They received 2200 calories daily; the VC minutes did not state what was provided for the civilian patients. Diets at Hanwell for the shell shocked patients compared unfavourably to the 3350 calories daily provided at the Maudsley Military Hospital, dedicated entirely to soldier's mental health.[83] Rations in asylums were also inequitable when compared to those provided in the war hospitals which were created by vacating asylums. When Napsbury became a war hospital, about eighty male asylum patients and some asylum staff remained on site to tend the farm and gardens. The Board's circulated guidance on maximum dietary allowances only applied to these patients and staff. It was "not intended to apply to Military patients or any of the staff" looking after them.[84] Many of the soldier-patients recovering from injuries would have needed more calories than physically healthy individuals, but farm work was no less strenuous and demanding of an adequate diet than nursing the soldier-patients. The Board's action was nonsensical based on recognised nutritional criteria. Apart from desiring to minimise financial expenditure, or wanting to comply with Whitehall's directives, it is hard to see the rationale or humanity of making this distinction.

When the distinguished psychiatrist and researcher Frederick Mott, probably the most knowledgeable authority about the health of asylum patients in England, communicated his concerns about food restrictions directly to the Board, it minuted its intention to enquire from asylums to what extent there were grounds for his anxiety.[85] No answers appear in subsequent minutes. The asylum leadership sometimes tried to avoid discussing awkward issues, including about diet, and evaded questions when asked directly. The Cobb Inquiry about asylum standards demonstrated this: when the panel asked the chairman of one VC: "You must have been badly off during the war for potatoes?" he replied: "We gave

them an excellent quality of margarine".[86] It was hardly an adequate response.

The Board's preoccupation with doing as the Ministry of Food asked and maintaining its reputation as a compliant authority, may have contributed to its lack of action to ensure adequate food for patients. Throughout the war, its rigid advice to asylums contrasted with the government's strategy of encouraging voluntary initiative before compulsion. The Board emphasised compliance with dietary restrictions, even when uncertain whether the rules were applicable to institutions entirely for adults.[87] In contrast to the Board's inactivity, the prison authorities interpreted the Ministry's recommendations less stringently. They negotiated with the Ministry, so that in their institutions with all adult prisoners, bread was provided at the standard rate plus 2 lb (1 kg), giving each person an extra 2000 calories a week. Although directly comparing asylum and prison dietary regimes is complex, because different categories of prisoner received different diets, overall, calorie intake of prisoners exceeded that of patients in asylums.[88] Notably, prisoners did not suffer the high rate of infectious diseases, such as tuberculosis, compared to asylum patients. In addition, unlike most prisoners who had a release date, asylum patients could be detained indefinitely, so for many of them, poor nutrition could be of prolonged and indeterminate duration. The Board's minutes available at the National Archives provide no evidence that it knew about, asked about, or acted on, the prison diet experience.

Communal Eating for Patients and Staff

"The healthfulness of a variety of food is allowed by the best authorities; but beyond its healthfulness, its desirability is beyond doubt" wrote Charles Mercier in his book on asylum management.[89] Not only nutrition, but also palatability and presentation of food were important in Mercier's eyes. For patients, the food which arrived on their plates could be unappetising. Mott regarded oatmeal porridge with treacle four days a week for tea at Hanwell as particularly uninviting.[90] Too often food was poor quality and could be "abominably cooked".[91]

On the first day of a Board inspection at one asylum in November 1914, the stew was unpopular, but the following day there was "roast beef and mutton with bread and two vegetables, the enjoyment of which was obvious".[92] Two meats in one meal was rare on asylum menus. It is likely that, having made an unfavourable initial impression, the asylum then laid

on a culinary treat. Food often improved on Board inspection days or when the VC made its rounds. Staff at Claybury described "Committee-day soup", which was far better than the usual "flour with the water", and vegetables which were "stalks, dead leaves and slugs" and "When one man picks up a caterpillar with his fork the others are done."[93] In one asylum, the main meal of the day consisted of rhubarb pudding with bread and cheese: the Board reported that the "change from a meat diet on one day in the week is looked upon with favour by the patients".[94] This may have been the Board's genuine understanding, but at a time when meat or fish was an expected constituent of a main meal, patients may have expressed their appreciation as they felt obliged to do so. Unlike when the inspectors received criticism from patients, they warmly accepted their praise, without attributing it to mental disorder. If the inspectors observed patients and staff enjoying a good meal they were unlikely to take food-related complaints seriously. They appeared unaware that a display might be created for their benefit.

Inspectors also evaluated routines of communal eating. Meals were often rushed: "Toothless old men had sometimes to wrestle with chunks of fat or gristle; they swallowed their food somehow or other, but had no time to masticate it properly".[95] Stoddart criticised nurses who rushed patients with their food due to their own working demands. He used military metaphor: "just as the velocity of a fleet is that of its slowest vessel, the duration of a meal must be that of the slowest eater."[96] Some patients who ate with great haste were labelled as greedy, but some were probably extremely hungry or worried that other patients would snatch their food.[97] So-called greediness also occurred in some brain diseases, such as general paralysis of the insane (GPI, syphilis), which could predispose patients to disinhibited table manners and to bolt their food. GPI could also impair swallowing which could result in choking.[98] A soft diet eaten with a teaspoon could reduce that risk, but if the need was not recognised, a patient could choke to death. That happened to Louis L, a prisoner of war at Colney Hatch, a horrible ending of life for the patient, and very disturbing to those around.[99]

The Board noted other aspects of mealtimes, which they thought could help make them as pleasant as possible. It was keen on communal recitation or singing of grace when patients were all seated, as a prelude to an orderly meal.[100] Inspectors advised one asylum that chipped and broken mugs should be replaced "at once", but did not state whether this was for safety, hygiene, or aesthetics.[101] They praised another where "crockery

plates and glass tumblers are gradually being substituted for the enamelled iron plates and mugs".[102] Some patients must have been considered sufficiently trustworthy for the change, but it is unclear for how long others continued to use the enamelled implements, or whether inspection routines influenced the changeover. Every meal, whether on a ward, in the dining hall, or in the staff mess room, concluded with the routine of counting in the cutlery, for fear it could be used to injure self or others.[103]

Food Distribution in the Asylums

The bureaucratic web embedded in the asylum's hierarchical culture, determined food distribution, and the quality and quantity of food served. It often failed to produce an equitable share for all. The medical officers, matron and assistant matrons usually received the best, and patients the worst.[104] Inequalities were enshrined in official guidance, such as the LCC's instruction: "Instead of Officers' Fish at 7d. and patients' at 2½d., take a contract for mixed fish and pick out the best for the officers",[105] or their recommended Christmas spending of 6d for each patient and 2s3d for each resident member of staff.[106] Dietary plans for patients and lower tiers of staff included serving them preserved beef, when the same asylums aimed to provide senior staff with "joints of English killed mutton".[107] When charge nurses, from the middle ranks of Claybury's work force, complained that the kitchen staff reserved the best flour for bread for the most senior staff, the VC ended the practice with haste.[108] Neither the reason for the VC's rapid response nor the motivation behind the kitchen staff action were recorded, although obsequiousness to seniors was replayed throughout the asylum system in multiple ways. Montagu Lomax recalled that during the war at Prestwich Asylum, cream for medical officers was provided by skimming the patients' milk.[109] Also, according to Lomax (with his italics), the following contributed to impairing patients' vitality[110]:

> unjust and unequal distribution of the *sufficient and available food*, the combination of official lavishness and waste, the incompetent management, the careless and unscientific cooking,…the neglect of opportunities for increasing the supply of asylum-grown vegetables—in a word, all the evils of the administrative system.[111]

As well as externally sourced food, produce home-grown on the asylum farm was also distributed unevenly. At Claybury, when 400 lb of strawberries were harvested just over half was shared between the 2000 patients, and the rest between 200 staff.[112] When VC minutes mentioned that their farm provided staff with fruit for desert or lettuce with their tea, they failed to indicate any similar provision for patients.[113] In view of asylums' lack of attention to vitamins in food, distribution was probably based on a desire to add interest to the diet. There could be little justification, however, for the inequity demonstrated at Colney Hatch, where, in stark contrast to the low allowance of fresh fruit for patients, the most senior asylum personnel were permitted to purchase up to 7 lbs of fruit a week and unlimited quantities of milk and vegetables.[114] There were other inequitable purchases: in spring 1915, Armstrong-Jones purchased goods to the value of £25 from Claybury's stores, three times that of the next highest spender in the same period. The VC scrutinised the list of staff spending without further comment.[115] Armstrong-Jones might have had a legitimate reason for doing this, or he might have exploited his privilege of rank. Backdoor shopping by higher social classes occurred in the community where it caused fury among those less privileged.[116] When it occurred in the asylums, the patients would have suffered most as a result. Even if patients knew about it, if they complained, there is little evidence that their voices were heard.

Asylum Farms

Asylum farms were integral to the institutions. They produced milk, eggs, fruit and vegetables to supplement asylum diets, provided employment for many patients and generated income from sales to staff, to other asylums and on the open market.[117] Shortly before the war, some asylums produced large quantities of food. In one fortnight in 1913, Colney Hatch farm produced 2300 eggs and farrowed 28 pigs, and slaughtered 20 pigs and 2 cows for use in the asylum. Later that year it harvested 22,000 lb onions, most of which were used in asylum food.[118] Crop success stories are harder to find during the war. In autumn 1914, Hanwell's farm had poor vegetable and root crops due to drought. The following month blight destroyed all the Brussels sprouts. In discussion with the farm bailiff, in early 1915 the VC approved the proposal to grow wheat under the special circumstance of the war. This was controversial in an urban area where house sparrows were known to "exact a very heavy

toll" on grain crops. Inexplicably, it was "left to the medical superintendent to decide as to the acreage to be sown".[119] Whether he had the agricultural expertise to take this decision, or if it was delegated to him on the basis of his overall leadership of the asylum, was not stated.

The weather over successive war years was deleterious to farming. At Hanwell, drought affected the farm early in 1915, upsetting sewing and transplanting.[120] The protracted and harsh winter of 1915–1916 particularly affected early crops and poultry, with only 3000 eggs laid compared to 5000 in the same period the previous year.[121] Heavy rain and hail after sowing late wheat in 1917 battered down the soil which became "so hard that the young shoots could not break through".[122] In 1918, incessant rain followed the worst drought for 12 years.[123] Some senior farm staff, such as the bailiff, ploughman and head cowman, were exempt from military service,[124] but many others enlisted or moved into munitions work. Adverse weather conditions, reduced availability of synthetic fertilisers, bureaucratic asylum management, and less experienced farm staff,[125] probably all contributed to lower yield.

Land usually used for recreation in asylums (Fig. 5.1) was ploughed

Fig. 5.1 Cricket pitch at Claybury, before 1917 (Armstrong-Jones collection, Royal College of Psychiatrists' Archives)

and cultivated,[126] as elsewhere, such as in the nine LCC parks which together produced 3½ tons of tomatoes in 1917 and the vegetable patches which replaced flowerbeds at Buckingham Palace.[127] Occasionally farms undertook new projects, such as bee keeping at Colney Hatch. Shortages of materials and staff affected the farms. Hanwell's VC declined the chance to purchase a motorised tractor, which could have compensated for fewer farm staff, sped-up farm work and replaced the fittest horses which had been enlisted alongside the men.[128] The decision not to purchase the tractor may have been one of finance: in the farm bailiff's view, the asylum had the philosophy of doing everything atleast expense, which probably adversely affected "the returns from the stock and the present condition of all the herds".[129] Relentless economising and understaffing may also have been associated with lack of attention to the environment, probably linked to the death of one cow, found to have nails, wire, tin, stones and ashes in her stomach at post mortem.[130]

Fuel

Before the war, in most asylums, coal provided heating and was used to generate gas and electricity for domestic amenities and for light industry in the workshops. The Board was impressed with one asylum which generated its own electricity for lighting and recycled the steam to supply the entire asylum with hot water,[131] and another which reduced its coal consumption by lubricating the electricity-generating steam-engines with graphite rather than oil, which allowed vast quantities of water, previously wasted due to oil contamination, to be re-used in the boilers.[132] Praise for these innovations was aligned with achieving budgetary targets.[133]

Coal shortages started at the beginning of the war, "with the Railways under the control of the Government, and the first necessity being the safety of the Nation",[134] leading to additional reasons for fuel economy, both for private households and public institutions.[135] One way in which the authorities tried to prevent "fuel fraud" and inequity, was to allow each household to register with only one coal merchant.[136] However, in asylums, as with food, the coal was pooled which facilitated inequitable distribution. One medical superintendent, for example, received a coal allowance for his "motor garage".[137] By contrast, the VC at Hanwell reprimanded a nurse for unnecessary use of gas when she was caught frying onions late at night over the gas in her bedroom. She justified her cooking as not wasting gas, because after dark she needed a light anyway

and the gas served both purposes simultaneously. The same asylum used gas to make tea for working women patients when they returned to the ward in the afternoon. The VC wanted to discontinue this practice, but the medical superintendent refused to allow them to do so, since "it would do away with perhaps the last pleasure and privilege" left to those patients, which could only be "justified in case of grave necessity".[138]

Fuel supplies became dangerously depleted, but not quite "grave". Six months into the war, in mid-winter, the LCC asylums at Banstead and Long Grove had only 4 days' coal in stock. Claybury had sufficient for one week, and the others had marginally more. Military demands for coal, plus reduced labour and flooding in the mines, hindered collieries from filling the LCC's coal order. Lack of equipment to unload coal from boats on the Thames, plus "congestion on the railways" delayed deliveries.[139] Hanwell had a slight advantage over the other asylums: its coal was delivered by barge as it had its own dock on the Grand Union Canal which ran along its southern perimeter. To monitor coal deliveries, each asylum had a weighbridge. Sometimes asylums received under-deliveries, and very occasionally, slight excess.[140] The variability might have been due to deliberate under-supply or genuine error, due to faulty weighbridges at collieries or trucks being filled with wet coal which then dried.[141] Large deficits in the region of 2 tons were harder to explain and asylums sought answers or refunds from their suppliers.[142] With rising fuel prices, careful tendering was needed for contracts on huge purchases for institutions, such as for an order of over 6000 tons of "house coal" to provide ward heating for six months in the LCC asylums.[143]

Late in 1915, the LCC advised its asylums that infirmary wards could be heated at night, but other wards should be heated only if temperatures fell below freezing,[144] hardly likely to promote a good night's sleep for patients or provide a healthy work environment for night staff. When the Board inspected Claybury in 1916, and patients complained about intense cold, it advised more heating,[145] but conflicting advice from higher authorities hardly helped VCs steer a safe course. The Household Coal Distribution Order 1917 prompted the LCC to state that:

> consumption of coal and coke at the London County Asylums has always been closely studied, and that the quantities consumed have been brought to what is believed to be the lowest level which is compatible with the efficiency of the administration of the asylums and the health of the inmates.[146]

It is unclear who, if anyone, defined "compatible…with health" or what it meant in practice. Using the outdated derogatory term "inmates", rather than the more respectful "patients" which was usually found in official asylum documents at this time, suggested negativity towards those in their care, which may have reflected on decisions regarding distribution of precious resources.

In autumn 1918, because of the cold, Claybury's VC predicted increasing death rates, which were already well above those in the community and in most other asylums. The LCC could envisage no way to prevent them.[147] By closing some wards for the winter to help economise on fuel,[148] other wards became unhealthily overcrowded, creating environments ripe for spreading infectious diseases. The authorities were under pressure to conform to fuel economy targets, and compared to the other LCC asylums, Claybury used more than its expected share, attributed to its damp location on London clay soil.[149] However, both the LCC and Claybury's VC were complacent about the risks of their austerity measures. As with food, the authorities tended to accept their allocations of fuel without demanding more, even when human tragedy was predicted.

Conclusions

John Walton wrote in his book on fish and chips that, in 1910, the eminent Scottish psychiatrist Sir James Crichton Brown praised the warming, sustaining and nourishing benefits of fish and chips, which might also be "a useful auxiliary in the fight against tuberculosis".[150] Walton commented that "Perceptions of living standards were as important as actual nutritional levels", and that the warmth, tastiness and timesaving qualities of fish and chips for the general population was an argument for eating it during the war.[151] Fish and chips would have had value against tuberculosis in the general sense of being nutritious, high in calories and protein, but no asylum menus have come to light which included it, despite the country being self-sufficient for fish and potatoes.

Aiming to feed the patients and resident staff and keep them warm was an enormous juggling act with moving goal posts to conform to restrictions and to ensure best use of erratic supplies with lowest expenditure. The asylum leadership obeyed directives, enforced national guidelines, and accepted negative outcomes—including a high death rate—as inevitable. Strictly obeying orders given by superiors effectively

displaced responsibility and accountability for adverse consequences from any one level of staff or leadership onto someone higher in the chain. The authoritarian management system may have inhibited lateral thinking, innovation and communication to find solutions, such as by consulting or working collaboratively with the prison service to overcome shared challenges. The rigidity of management was compatible with Erving Goffman's administrative structure of a "total institution",[152] but it contrasted with government tactics at the time, demonstrated in its initial attempts to involve the public in the war effort voluntarily rather than through compulsion.

Whether due to lack of scientific and nutritional knowledge, or deliberately disregarding it, the leadership demonstrated little awareness of potential interactions between diet, cold and illness. Some doctors opposed the decisions of VCs, or at least warned of the consequences, regarding reducing patients' food intake. Occasionally the doctors requested more food for patients, but most remedial action concerning food and warmth was minimal and sluggish at best. Potential adverse consequences were rarely used as a basis for arguing for more by VCs or the Board, but the supposition that no more would be provided was hardly an ethical reason for not asking for it. It is also hard to justify why ward staff were allowed to neglect the simple, cheap and valuable practice of weighing patients to detect malnutrition and chronic disease. Overall, these findings suggest a lack of care rather than just a lack of resources.

Frugality towards patients and obsequiousness to seniors were parts of asylum culture, and institutional culture was (and is) notoriously hard to change. The culture of an acceptable way to care for patients established before the war did not adapt in a humane manner to the extreme challenges of wartime. The hierarchical structure of the asylums created a discriminatory scenario when considering basic needs such as food and warmth. Senior staff, particularly medical superintendents, received excessive life-style privileges. This demonstrated to other staff that it was acceptable for those with greater authority to consume more than those lower in the pecking order. It may therefore have encouraged and perpetuated staff taking food intended for patients. Social class inequality was not unique to asylums, but hierarchical food provision, which was detrimental to patients, was a potentially avoidable situation.[153] The authorities, however, could justify prioritising the needs of staff by arguing

that the fragile asylum care system risked disintegration if they did not. They had no such incentive for patients.

The war time supply chain and distribution of food and fuel in the asylums is a study of the effects of austerity, rigid rules and questionable management methods by the authorities, concerning the lives of mentally unwell people. A *Times* leader in 1919 about the asylums asked: "Have we been sending some of our lunatics into the Army and starving the others?" It called the Board to account.[154]

Notes

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6. Oddy, *From Plain Fare*, 71.
7. William Beveridge, *British Food Control* (London: Oxford University Press, 1928), 1.
8. Beveridge, *Food Control*, 6.
9. Hardach, *First World War*, 127.
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11. Hardach, *First World War*, 124.
12. Hardach, *First World War*, 130.
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17. Beveridge, *Food Control*, 20.
18. Lunacy Act 1890 section 283.
19. Beveridge, *Food Control*, 2.
20. Oddy, *From Plain Fare*, 78.
21. Oddy, *From Plain Fare*, 72.
22. Director of the Horticultural Section of the Food Production Department of the Board of Agriculture, BoC W/FM, 21 March 1917, 98 MH 50/45 TNA.
23. Beveridge, *Food Control*, 1.
24. Jeremy Paxman, *Great Britain's Great War* (London: Penguin, 2013), 216.
25. Beveridge, *Food Control*, 217.
26. Beveridge, *Food Control*, 206–7.
27. Beveridge, *Food Control*, 221.
28. Beveridge, *Food Control*, 233.
29. LCC LCC/MIN/00580 Meeting, 6 January 1915, 163–64; Claybury LCC/MIN/00947 Meeting, 2 March 1916, 172; Claybury LCC/MIN/00948 Meeting, 15 March 1917, 54 LMA.
30. Rules made by the Commissioners in Lunacy 1907–1929, MH 51/682 TNA.
31. Claybury LCC/MIN/00948 Meeting, 21 June 1917, 201 LMA.
32. Claybury LCC/MIN/00949 Meeting, 23 May 1918, 78 LMA.
33. Committee on the Administration of Public Mental Hospitals (Chairman: Sir Cyril Cobb) (Cobb Inquiry), 24 February 1922 Dr. Perceval Q:426–32, MH 58/219 TNA; Ministry of Health (MoH), *Report of the Departmental Committee on the Administration of Public Mental Hospitals* Cmd. 1730 (London: HMSO, 1922).
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41. Cobb Inquiry, 30 March 1922 Edward Mason Q:2130, MH 58/220 TNA.
42. LCC LCC/MIN/00583 Meeting, 24 July 1917, 14 LMA.
43. Hanwell LCC/MIN/01097 Meeting, 24 September 1917, 181–83 LMA.
44. LCC LCC/MIN/00580 Meeting, 27 July 1915, 695 LMA.
45. Claybury LCC/MIN/00949 Meeting, 23 May 1918, 66 LMA.
46. LCC LCC/MIN/00582 Meeting, 27 February 1917, 441 LMA.
47. Beveridge, *Food Control*, 222.
48. LCC LCC/MIN/00580 Meeting, 27 July 1915, 694 LMA.
49. Cobb Inquiry, 11 April 1922 Rev WD Yoward (VC chairman) Q:3092–98, 3048–50, MH 58/220 TNA.
50. BoC, letter to MSs, 2 March 1917 MH 51/239 TNA; LCC LCC/MIN/00583 Meeting, 29 January 1918, 283 LMA.
51. BoC, letter to MSs, 19 January 1918 MH 51/239 TNA.
52. LCC LCC/MIN/00583 Meeting, 26 March 1918, 436 LMA.
53. Van Emden and Humphries, *All Quiet*, 196.
54. LCC/MIN/00759 Presented papers of sub-committee 1909–1923, Summaries of replies from asylums, 2 November 1915 LMA.
55. Van Emden and Humphries, *All Quiet*, 196.
56. Ministry of Food (Fish Section), "Pickled Herrings," September 1917, MH 51/239 TNA.
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63. Colney Hatch LCC/MIN/01001 Meeting, 6 June 1913, 111 LMA.
64. LCC LCC/MIN/00581 Meeting, 30 May 1916, 590 LMA.
65. Cobb Inquiry, "Reports of Visits to Mental Institutions: Dietary at Powick," 1922, MH 58/221 TNA.
66. LCC LCC/MIN/00582 Meeting, 25 July 1916, 33 LMA.
67. LCC LCC/MIN/00582 Meeting, 1 August 1916, 76–77 LMA.
68. BoC, letter to MSs, 13 February 1917, MH 51/239 TNA.
69. Oddy, *From Plain Fare*, 84.
70. Claybury LCC/MIN/00946 Meeting, 8 July 1915, 180 LMA.
71. Stoddart, *Mental Nursing*, 72.
72. LCC LCC/MIN/00580 Meeting, 27 July 1915, 699 LMA.
73. Hanwell LCC/MIN/01097 Meetings: 30 July 1917; 27 August 1917, 165 LMA.
74. Hanwell H11/HLL/B/35/006 Patients' records: male deaths 1936–1937 LMA.
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76. LCC LCC/MIN/00581 Meeting, 30 November 1915, 160 LMA.
77. Hanwell LCC/MIN/01098 Meeting, 23 September 1918, 140 LMA.
78. Claybury LCC/MIN/00949 Meeting, 23 May 1918, 71–72 LMA; *Fourth Annual Report of the Board of Control, for the Year 1917* (London: HMSO, 1918), 23.
79. Hanwell LCC/MIN/01097 Meeting, 11 March 1918, 323 LMA.
80. Hanwell LCC/MIN/01098 Meeting, 6 May 1918, 40; 3 June 1918, 61 LMA.
81. Hanwell LCC/MIN/01098 Meeting, 1 July 1918, 77, 86 LMA.
82. BoC, circular to superintendents, "Food Allowances," 23 July 1918 MH 51/239 TNA.
83. LCC LCC/MIN/00584 Meeting, 25 February 1919, 305–6 LMA.
84. Napsbury H50/A/01/026 Meeting, 17 February 1916, 262 LMA.
85. BoC W/FM 3 October 1917, 279 MH 50/45 TNA.
86. Cobb Inquiry, 23 March 1922 JR Smith Q:1286, MH 58/219 TNA; MoH, *Committee on Administration*.
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91. Colney Hatch LCC/MIN/01005 Meeting, 20 October 1916, 297–98 (*Islington Daily Gazette*, 15 October 1916) LMA.
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93. Claybury LCC/MIN/00948 Meeting, 8 November 1917. Between pp. 231–32, notes of conference on staff food, LMA.
94. *BoC AR 1914*, Part 2, Derbyshire Asylum 8 July 1914, 216.
95. Cobb Inquiry, 15 March 1922 AM Donaldson Q:619–21, MH 58/219 TNA.
96. Stoddart, *Mental Nursing*, 88.
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101. *BoC AR 1914*, Part 2, Nottingham City Asylum 29 January 1914, 370.
102. *BoC AR 1914*, Part 2, Cambridge and Isle of Ely Asylum 21 October 1914, 202.
103. Colney Hatch LCC/MIN/01001 Meeting, 23 May 1913, 93 LMA.
104. LCC LCC/MIN/00583 Meeting, 24 July 1917, 26 LMA.
105. LCC/MIN/00759 Presented papers of sub-committee 1909–1923 Suggested further economies, 4 August 1915 LMA.
106. LCC LCC/MIN/00581 Meeting, 30 November 1915, 166 LMA; and LCC LCC/MIN/00584 Meeting, 26 November 1918, 109: for Christmas; patients, 9d per head; staff 2s9d per head.
107. LCC LCC/MIN/00581 Meeting, 25 January 1916, 300–1 LMA.
108. Claybury LCC/MIN/00948 Meeting, 21 June 1917, 158–59 LMA.
109. Lomax, *Experiences*, 131.
110. Lomax, *Experiences*, 18.
111. Lomax, *Experiences*, 123.
112. Claybury LCC/MIN/00949 Meeting, 18 July 1918, 129 LMA.
113. Colney Hatch LCC/MIN/01007 Meeting, 11 January 1918, 16 LMA; Hanwell LCC/MIN/01095 Meeting, 7 June 1915, 97 LMA.

114. LCC LCC/MIN/00583 Meeting, 18 December 1917, 237 LMA.
115. Claybury LCC/MIN/00946 Meeting, 22 July 1915, 94 LMA.
116. van Emden and Humphries, *All Quiet*, 218.
117. Hanwell LCC/MIN/01096 Meeting, 5 June 1916, 85, 95–96 LMA.
118. Colney Hatch LCC/MIN/01001 Meetings: 25 April 1913, 53; 6 June 1913, 123 LMA.
119. Hanwell LCC/MIN/01094 Meetings, 26 October 1914, 113, 23 November 1914, 142, 1 February 1915, 219 LMA.
120. Hanwell LCC/MIN/01095 Meeting, 5 July 1915, 115 LMA.
121. Hanwell LCC/MIN/01096 Meeting, 27 March 1916, 19 LMA.
122. Hanwell LCC/MIN/01097 Meeting, 7 May 1917, 67 LMA.
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125. White, "Feeding the War Effort".
126. Hanwell LCC/MIN/01096 Meeting, 20 November 1916, 241 LMA.
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130. Hanwell LCC/MIN/01094 Meeting, 1 February 1915, 230 LMA.
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133. Lomax, *Experiences*, 123.
134. Napsbury H50/A/01/022 Meeting, 6 August 1914, 167–72 LMA.
135. LCC LCC/MIN/00581 Meeting, 18 April 1916, 523 LMA.
136. Beveridge, *Food Control*, 228.
137. LCC LCC/MIN/00583 Meeting, 27 November 1917, 181 LMA.
138. Hanwell LCC/MIN/01098 Meeting, 3 June 1918, 60; 26 August 1918, 127 LMA.
139. LCC LCC/MIN/00580 Meetings: 26 January 1915, 182, 23 February 1915, 263; 23 March 1915, 369 LMA.
140. Hanwell LCC/MIN/01094 Meeting, 15 February 1915, 250 LMA.
141. Colney Hatch LCC/MIN/01005 Meeting, 28 January 1916, 61 LMA.
142. Colney Hatch LCC/MIN/01003 Meeting, 25 September 1914, 105 LMA.
143. LCC LCC/MIN/00580 Meeting, 23 March 1915, 369 LMA; LCC LCC/MIN/00581 Meeting, 26 October 1915, 23–24 LMA.

144. LCC/MIN/00759 Presented papers of sub-committee 1909–1923, letter LCC to MSs, 5 November 1915 LMA.
145. Claybury LCC/MIN/00947 Meeting, 23 November 1916, between pp. 273–74 report on BoC visit, 17 November 1916 LMA.
146. LCC LCC/MIN/00583 Meeting, 30 October 1917, 143 LMA.
147. Claybury LCC/MIN/00949 Meeting, 12 September 1918, 169 LMA; LCC LCC/MIN/00584 Meeting, 29 October 1918, 25 LMA.
148. Colney Hatch H12/CH/A/08/001 Reports to sub-committee, 1 November 1918, 107 LMA.
149. Claybury LCC/MIN/00947 Meeting, 11 May 1916, 104 LMA.
150. John Walton, *Fish and Chips, and the British Working Class, 1870–1940* (London: Leicester University Press, 2000), 13.
151. Walton, *Fish and Chips*, 18.
152. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (1961; Harmondsworth: Penguin, 1980).
153. Carpenter, "Above All," 144: meat ration per week: male patients, 30 oz (0.85 kg, uncooked); female staff 5¼ lbs (2.4 kg); male staff 7 lbs (3.2 kg).
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Asylums: The Situation and Life of Patients

Introduction

When asylums were converted to war hospitals, scenes of departure of their civilian patients captured some sense of the asylum as a community.[1] Many patients lost their "home", and staff and other patients with whom they had supportive relationships. Dr. Thompson, a medical superintendent, wrote:

> The scenes on departure aroused varying emotions in myself, my medical colleagues, and the nurses. It was all interesting, some of it most amusing, and much sadly pathetic….[T]he whole gamut of emotion was exhibited by the patients on leaving, ranging from acute distress and misery, through gay indifference, to maniacal fury and indignation….I did not realise the strong mutual attachment till it was severed.[2]

Marriott Cooke and Hubert Bond, in their *History of the Asylum War Hospitals*, also acknowledged the distress of departures, for both patients and staff.[3] The asylums were by no means ideal, and the dependence which asylums created for their patients probably contributed to their sense of loss, but meaningful human relationships still existed within them.

The day Britain declared war against Germany, the Board of Control ("the Board") was inspecting Oxford Asylum. Patients were restless on

one overcrowded and understaffed ward, but the inspectors complimented the asylum because most patients were calm and the wards peaceful.[4] The inspectors interpreted their observations as indicating that patients were "evidently very well treated" and their insanities well managed.[5] The Board recognised that personal dignity and providing appropriate employment, social diversions and as much freedom as possible could alleviate patients' distress, lessen untoward behaviours and enhance wellbeing.[6] However, it appeared less aware of the damaging effects of institutional living or that a bullying or oppressive regime could produce apathetic and subdued patients. These only became widely acknowledged several decades later. In the 1950s, psychiatrist Russell Barton, working in England, regarded the quiet and submissive state of many mental hospital patients almost as an illness in its own right. He termed it "institutional neurosis". Others used the terms "prison stupor", "prison psychosis", "institutionalism" or "institutionalisation".[7] Erving Goffman in his ethnographic study of an asylum in the United States of America (USA), also in the 1950s, identified many of the mechanisms by which patients were institutionalised, beginning with admission processes which forced "role dispossession" and "curtailment of self" relative to life outside.[8]

The Board did not have recourse to uniform criteria to set and monitor healthcare standards of the sort which began to emerge in the USA in the 1930s.[9] The Board set its own standards, based on experience of what it knew could be achieved and ideals expressed by colleagues, such as those which psychiatrist Charles Mercier incorporated into his textbooks.[10] Disconcertingly, Mercier's books were published almost 20 years before the war, and two decades of relative prosperity failed to achieve many of the recommendations. In addition to comparing asylum standards to ideals stated by psychiatrists or to workhouse and domestic norms, wartime comparators included care considered acceptable for soldiers. In contrast to the minimal public attention paid to care for civilian "pauper lunatics", there was widespread concern about the necessity to provide dignified care for shell shocked men who had served their country.

When the Board recognised conditions which it deemed detrimental to patients, it encouraged the asylum management "visiting" committee (VC) to remedy them.[11] Despite this, and the asylums running according to tight rules, different standards of care were experienced from patient to patient, ward to ward and asylum to asylum. There was no such thing as an average ward, but we can still attempt to understand something of the

daily life of patients who spent days, or years, in them. In earlier chapters we discussed how the asylum system worked, the nature of the patients' mental disorders and their treatments, and issues around staffing and the provision and distribution of food and fuel, all of which underpinned and influenced daily life. In this chapter exploring facets of daily life, we begin by considering sources which reveal something of the patients' perspectives. We then move onto some specific aspects of their lives: clothing; cleanliness and provision of basic amenities; night times; links with the outside world; and the asylum work which they undertook.

Seeking the Patients' View

To understand patients' experiences, it is best to use sources which they created. Some wrote memoirs about their admissions. Mary Riggall, Rachel Grant-Smith and James Scott described their experiences in England; D Davidson wrote about his experience in England and Australia; and Clifford Beers about his in the USA.[12] They wrote their reminiscences months or years after discharge. Time for reflection, and their intention to inform the public about mental illness and to encourage improvements in prevention, care and treatment could have influenced their content and style.[13] Despite being situated on several continents before, during and after the war, their asylum experiences suggest that institutional psychiatric treatment and care across the English-speaking Western world had many commonalities. Their descriptions, when combined with those from more patients, such as in committee minutes and the Cobb Inquiry triggered by Montagu Lomax's book,[14] give a range of bottom-up, personal perspectives. All need careful interpretation: official minutes, for example, may be biased against a patient's testimony.

The value of patient-derived written sources is particularly important as senior asylum personnel and the institutions' inspectors largely ignored the patients' words. The Lunacy Act 1890 stipulated that asylum inspectors must "see" every patient, and "give everyone, as far as possible, full opportunity of complaint".[15] The Board interpreted this literally, probably a necessity during a typical two-day inspection of a large asylum. If inspectors entered a ward with patients and staff gathered, they could "see" everyone, and could then ask the group if anyone wanted to speak to them, thus giving them the "opportunity". It would be a brave patient

to indicate that he or she wanted to make a complaint. If staff accompanied inspectors on their rounds, a patient might not be permitted to speak with one in confidence. Also, if a staff member offered an alternative perspective, staff words usually had primacy over those of patients.[16]

The Board inspectors handed their written report to the asylum leadership at the end of their inspection and intended to publish it in their own annual report. The published narratives informed the public of standards expected, what was found, and the advice given to make improvements. Inspection reports for 1914 mentioned complaints from patients, but they were often trivialised: "We had but few complaints, and none of a serious character", or they were "evidently based on a delusional condition of mind", or were not "worthy of mention", or "we did not receive any complaints…which had any foundation of fact".[17] The rapidly written reports would have allowed little time for anything other than cursory discussion of complaints with senior asylum staff who tended to offer reassuring explanations, with the Board concluding that complaints required no further attention. Generalisations about patients' complaints were compatible with psychiatric opinion which regarded insanity as all-encompassing: patients needed guidance and supervision in all matters and their interpretation of events was distorted by their mental state.[18] Inconsistently, however, these assumptions disappeared if a patient complimented the leadership or made comments with which they agreed.[19] Positive comments were acknowledged at face value, despite the illogicality of accepting one sort of comment while automatically rejecting another. Allegations from patients of ephemeral, unprovable occurrences, such as dietary inadequacies or staff rough handling them, were particularly likely not to be believed by a self-assured, defensive leadership which assumed that staff behaved kindly and appropriately and patients were untrustworthy.

Neglecting complaints on the basis of a patient's mental disorder was a recurring grievance expressed in memoirs. Grant-Smith reflected: "Once tainted with a certificate of madness, every statement made by the so-called lunatic can be characterised as a further sign of his or her unsoundness of mind."[20] When she complained, the authorities transferred her to another asylum[21]: it was easier to move a so-called troublemaker than to deal with their concerns.[22] When she wrote to the Lord Chancellor (her right under the Lunacy Act), he replied two days later, stating that he had made inquiries into her complaints and "sees no reason for thinking they are well founded". No one had discussed her

complaints with her during that time and she found it hard to believe that such speedy inquiries were meaningful.[23] The impression given was that she was fobbed off.

Despite questioning the validity of patients' opinions, the Board expected VCs to listen to their patients, although VCs tended to follow the Board's example rather than its advice.[24] The Cobb Inquiry took evidence from patients but rationalised that they would only want to speak if they were aggrieved at their experience, about which their memories would inevitably be distorted because of their mental state. Otherwise, if happy with the treatment they received, they would want to avoid the risk of inquiry-related publicity about them ever having suffered from a mental disorder which required certification.[25] Thus, preconceived ideas affected the analysis of the inquiry's evidence, with negative accounts from patients documented in the transcript, but overlooked in writing the inquiry report. Similar happened at the Royal Commission on Lunacy (1924–1926) which followed the Cobb Inquiry.[26]

Patients continued to complain, despite their words being rejected. One woman, Elizabeth T, an in-patient for over 20 years, transferred to Claybury from Horton when it became a war hospital in 1915, alleged that staff stole some of her money and belongings. Her doctor explained away the allegations, saying that she was "subject to frequent lapses and loses her property, and as it is necessary to prevent her from collecting rubbish, she imagines her money is taken". His analysis meant that allegations of theft could be overlooked, protecting his colleagues, but if Elizabeth was correct, in effect he was condoning criminal activity. The doctor also did not acknowledge that his perception of rubbish might have included objects meaningful to Elizabeth.[27] As Goffman explained, in an institution where everyone was stripped of their possessions on admission, they were also stripped of their personal identity, so that when a patient

> fills his pockets with bits of string and rolled up paper, and when he fights to keep these possessions in spite of the consequent inconvenience to those who must regularly go through his pockets, he is usually seen as engaging in symptomatic behaviour befitting a very sick patient, not as someone who is attempting to stand apart from the place accorded him.[28]

Rather than talking to patients, inspectors focussed on the asylum environment, activities they witnessed, ledgers of standardised forms, and

reports from VC members and a few senior staff. This was less taxing, time consuming and conflict-laden than speaking to patients. Similarly, in the absence of the patient's voice, Diane Carpenter, historian of asylums in Hampshire before 1914, based her study on objectively quantifiable material commodities as proxy indicators of standards.[29] When she compared them to domestic dwellings and workhouses, she found that the asylums' basic provision was relatively satisfactory. Asylum cleanliness and personal hygiene, for example, usually compared favourably with other living environments, and clothes, though institutional, provided warmth and were of good quality. Carpenter concluded that "In every respect improvements occurred as time progressed."[30] As we shall see in this chapter, standards varied, and when wartime priorities engulfed the country, with resources diverted away from civilian needs, especially from people considered a burden on public funds, any pre-war improvements did not continue.

In-Patient Life

Mary Riggall expressed her feelings about being admitted to an asylum in 1918 and being confined there for 18 months: "It seems to me that Liberty is one of the best things in the world – Liberty in the truest sense of the word, I mean, and not licence."[31] As with other aspects of asylum life, the Lunacy Act underpinned decisions about freedom for patients, but it did not define if "asylum" meant the ward, the buildings or the entire estate within the perimeter wall. The VCs tended to interpret it narrowly, but the Board regarded confining patients to the wards and their adjacent "airing courts" as unacceptable, unless they were physically unwell.[32] Psychiatrist Bernard Hollander, took a stronger line: he described locked doors as "a torture", and deprivation of liberty for less ill patients as "cruel and uncalled for."[33] Mercier cautioned staff to be ever vigilant about their patients to avoid catastrophe,[34] but also considered the blanket restrictions on patient's liberty as overly stringent and devoid of attention to individual need.[35] It was particularly difficult to achieve a balance of freedoms based on individual need with reduced staff levels and expertise during wartime.

The Board advocated for patients to have as "normal" a life as possible. Wards needed to be pleasant and homely, with "plants, birds and flowers" and pictures on the walls, with their frames made in the asylum workshops.[36] Wards with the most disturbed patients needed the same recreational facilities as those with calmer patients, even if items might

be damaged.[37] The Board emphasised that equipment such as pianos, billiard tables and bagatelle boards should be well maintained, and that staff should "be ready to start a game, such as skittles, quoits, bowls or badminton, and when it is started, to yield his place in it to a patient, and go on with some other duty".[38] The Board expected wards to be "well supplied with books and bound periodicals", including some suitable for "demented patients" and for patients of lower intellectual ability, so all can "be improved and ameliorated".[39] Books on the wards required changing regularly and were never to be kept in locked book cases.[40] One asylum subscribed to a braille lending library for a blind patient.[41] Asylums purchased newspapers and magazines to suit diverse interests, although good intentions fell foul to war time austerity and rising prices when many "half-penny dailies" became "penny dailies".[42] Staff were directed to read newspapers to patients, if required, and ensure that papers were neither monopolised by a few nor destroyed by those with destructive tendencies.[43]

Life was influenced by rules and expectations about gender segregation. Separate gender spheres reflected societal attitudes that women were best equipped for private or domestic realms, while men were naturally suited to active, aggressive and intellectual domains of public life.[44] Lives of most women were constrained by reproduction and domestic duties, gendered educational opportunities, workplaces and types of employment. Outside asylums, respectable young unmarried women were chaperoned during social encounters with men. As middle-class Vera Brittain wrote in her wartime autobiography, it was "considered correct and inevitable that my aunt should cling to me like a limpet throughout the precious hours" that she spent with her special male friend.[45] In asylums, the Lunacy Act forbade male staff having responsibility for female patients,[46] and the architecture reinforced gender segregation, typically separating men from women, both staff and patients, on either side of a central administration block.

Both inside and outside the asylums, a perceived vulnerability of women imposed greater restrictions on their activities compared to those of men. Riggall envied the male patients their cricket matches and long walks.[47] Trustworthy male patients might be accorded parole within or outside the grounds, a privilege usually beneficial and seldom abused.[48] Male and female patients were not usually allowed to be together in the asylum's designated patients' gardens (Fig. 6.1) as trees and well-matured shrubs created "risk in the opportunities afforded for the mixing

Fig. 6.1 Patients' garden at Claybury, before 1917 (Armstrong-Jones collection, Royal College of Psychiatrists' Archives)

of the sexes".[49] Occasionally a sexual assault occurred, but those reported in minutes identified staff as perpetrators, not patients. One male staff member was sentenced to six months hard labour for a sexual assault on a woman patient.[50] This sort of offence reinforced the asylum authorities' determination to "prevent the association of the sexes" except under "complete and careful supervision".[51]

As Riggall found, options for physical exercise differed for male and female patients. Some gender segregated outdoor exercise was feasible in each ward's airing court. An ideal airing court was about one acre (¾ of a football pitch) for a ward of 50 patients, properly laid out as a garden, not asphalted or paved, and not like a "bear pit", as one low lying airing court at Hanwell was known.[52] Wire fences with evergreen shrubs were attractive and therefore preferable to a high wall.[53] Elsewhere on the estate, accompanied walks for the men provided fresh air and were convenient for staff, with just a few of them required to observe many

patients. After a patient escaped from a group of 90 accompanied by five staff on a "boundary walk" at Claybury, the VC grudgingly listened to the patients who disliked these large group walks, and proposed a maximum of 50 patients accompanied by five staff.[54] We are not privy to know whether that satisfied the patients or achieved the VC's goals of preventing escapes, but 50 was still an enormous group for a walk. Such groups may have provided physical exercise, but hardly contributed to a therapeutic staff–patient relationship.

Since asylum activities were part of treatment, Mercier cautioned against punishing patients by preventing them from joining in, as participant, performer or spectator.[55] On the other hand, activities were used as rewards, such as tram outings to Uxbridge for working patients at Hanwell (Fig. 6.2).[56] Entertainment programmes continued as usual in the early months of the war, including the annual patients' fancy dress ball at Claybury and a Vaudeville show at Colney Hatch. By Christmas 1914, celebrations faced disruption because of night-time lighting restrictions and risk of cancelation at short notice in the event of an air raid

Fig. 6.2 Tram, a few minutes' walk from Hanwell Asylum c.1910 (Public domain), https://en.wikipedia.org/wiki/Hanwell#/media/File:Tram_in_hanwell_boston_road.JPG

warning.[57] Social events declined further as the war progressed. Cricket matches were curtailed at asylums where pitches were ploughed or used for billeting troops.[58] If a pitch was available, a diminished workforce precluded staff from working with patients to prepare it and to provide a team, and match refreshments were considered an unnecessary luxury.[59] Other out-door events, which allowed staff, patients, their relatives and local people to mix and glimpse a display of positive features of asylum life, such as the annual fete, were curtailed by austerity: Claybury budgeted £80 for a fete pre-war and £10 during it.[60] At Colney Hatch, special grants for events and entertainments ceased for the duration of the war.[61]

Spiritual as well as social needs needed to be attended to. The Lunacy Act stipulated that each asylum employ a Church of England chaplain.[62] Riggall described that she did not go to the laundry to iron on Sundays.[63] Instead, she went twice to the church in the asylum grounds, where she enjoyed the organ, the singing and "orderly services". Male patients sat on the right with the attendants, and women on the left with the nurses. She compared patients to St. Peter in prison:

> I said, one day, to a companion, "Prayer was made for St Peter when he was in prison, and God sent an angel and delivered him – therefore it seems to me that we had better pray that we may recover and be allowed to go home." So two other women and myself used to meet in a quiet corner of the grounds for prayer. And who will dare to say we were not helped and blessed by doing so.[64]

The Lunacy Act also advised that appropriate ministers of religion should be available to visit patients of different denominations and faiths.[65] Colney Hatch admitted many patients from the East End of London which had a large immigrant Jewish community and for whom it made suitable arrangements. The asylum had a supply of skull caps for the men.[66] There was a kosher kitchen.[67] Special arrangements were made for fasts such as the Day of Atonement[68] and for festivals. Just before the war, 241 patients attended a Passover "seder" service and meal with the visiting chaplain, Reverend Solomon Lipson, who provided the additional, special foods for the ceremony.[69] During the war, kosher meat was prohibitively expensive[70] so Lipson advised on dietary changes, with the asylum eventually substituting fish and haricot beans for meat.[71] If Jewish patients had limited knowledge of English, they were placed on wards

with other Yiddish speakers.[72] The asylum also organised interpreters for these patients and for others, through the relevant community, or by a staff member who received a salary supplement for his services, or on an *ad hoc* basis.[73]

The London County Council (LCC) encouraged admission to Colney Hatch of people belonging to various minority groups, as, based on their experience of catering for the Jewish community, it deemed the asylum's arrangements for "foreigners" better than elsewhere.[74] Thus, alongside civilian patients who normally resided in the London area and "service" patients, Belgian refugees, prisoners of war and interned enemy aliens were admitted, sometimes transferred from as far afield as Scotland or the Isle of Man.[75]

Over 200,000 Belgian refugees who had fled "the rape of Belgium", the German army advance through their country, arrived in England in the first months of the war. Many were initially taken to one of the British government's largest refugee reception centres, Alexandra Palace, in Hornsey,[76] two miles from Colney Hatch, before being dispersed throughout the country. Some required asylum admission, either directly from the reception centre or after being housed further afield. If refugee lunatics or their families wished, they could opt to be admitted directly to, or transferred to, Colney Hatch where they had access to an interpreter and they "could be amongst patients who would be able to converse with them and also be visited by their country people".[77] The asylum authorities worked closely with voluntary committees to support the refugees.[78] Occasionally, "foreigners" caused concern to civilian patients, such as one who believed he would be harmed by "Germans". It is unclear whether that was part of his psychiatric disorder, but the VC approved his wife's request to transfer him to another asylum.[79] Colney Hatch minutes recorded little about how the new groups of patients were distributed within the asylum, or how they interacted, suggesting that the social diversity was harmonious. The Board's annual reports raised no concerns.[80]

Clothing

Exchange of a patient's own clothes for institutional garments, alongside relinquishing most personal possessions, was part of the asylum admission process. This was problematic as clothing and grooming tools, in Goffman's words, are part of an individual's "'identity kit' for the management

of his personal front".[81] Removing personal identity was convenient for the institution as it could help ensure patients' compliance with the regime and simplify the organisation of batch-living. In addition, uniformity meant that the leadership could achieve a neat and tidy appearance of their patients as a whole, propagating an image of enlightened care.[82] This contrasted with the patients' view about asylum clothes. According to Lomax:

> Few things are more deeply resented by the ordinary pauper lunatic and his friends than the depriving him of his own clothes, and the compulsory wearing of what he and they regard as "prison" attire.[83]

Asylum clothes differed from both prison attire and workhouse uniforms, but they were institutional, rarely met recommendations about variety, and had little "regard to appearance".[84] Lomax concurred with the patients and explained that asylum clothing destroyed self-respect, intensified stigma, and gave the impression that admission to an asylum was a crime and disgrace, contributing to patients and their families trying to avoid seeking treatment until late stages of illness.[85] Jane Hamlett and Lesley Hoskins, in their study of asylum clothing, agreed with Lomax's understanding, but they also argued that despite uniformity or standardization within each asylum, there was no "uniform" as such, and although the clothes identified those who wore them as institutionalized pauper lunatics, clothing was not deliberately used to shame or punish patients or to represent or develop identification with the institution.[86] Hamlett and Hoskins also argued that by the early twentieth-century the provision of standardized apparel was increasingly criticized and representations were made (though not generally adopted) that patients should be allowed to wear their own clothes.[87]

The Board preferred some variety in attire for both for men and women, such as men's caps being provided in various shapes and colours.[88] Asylum clothing appeared more uniform if a particular style, fabric or colour became identified with a specific ward. This was convenient and practical, particularly for laundry staff, and ease for staff carried greater weight than choice for patients.[89] Similarly, for staff convenience, women patients in some asylums had uniform short haircuts, even though in the community women tended to wear their hair long, often plaited or pinned in place. Although Mercier advised only to cut women's hair short "for medical reasons", and the Board criticised asylums where short hair

for women was commonplace, staff priorities overruled patient choice.[90] Shared hairbrushes and combs, sometimes less than three of each for over 30 patients[91] were unlikely to inspire Stoddart's standard that "the hair should be neatly dressed."[92]

As well as having some variety, asylum clothes were meant to be durable, washable and suitable for summer and winter. For women, clothes were often old fashioned. Sufficient supplies were needed for them to have a change of dress once a fortnight and clean underwear twice a week, with more underwear allowed for patients of "faulty" or "dirty" habits (incontinence).[93] In contrast to Carpenter's findings on quality of asylum clothing, the LCC admitted that women's clothes were often "very bad quality", and replacements were low on the agenda, even post-war.[94] Male patients were allocated two clean shirts a week and a weekly change of undershirt and drawers.[95] Their clothing could be threadbare or otherwise inadequate, and in some wet and windy locations, overcoats were not distributed, even to men working outdoors.[96] Men's asylum garb resembled workmen's clothes so they might be indistinguishable from any other workman beyond the asylum walls.[97] However, there was still a risk of being identified as a patient if attempting to escape, so some men devised ingenious ways to change their clothes: Frederick S probably hid in the grounds for one night, returning the following night to deposit his hospital garb and take workshop clothes belonging to a paid worker.[98]

Asylum clothes were often crumpled, baggy, and fitted poorly. Admission photographs of women patients at Colney Hatch reveal much about their clothes, indicating ways in which they tried to convey their individuality and exert a degree of choice. They also provide clues to their physical health and state of mind.[99] Regarding clothing, Jenny K's and Rachel K's clothes were identical, apart from some mismatched, probably replaced buttons, and a blouse under Jenny's dress (Fig. 6.3). Jenny's blouse may have been her way of projecting some individuality, despite expected uniformity, while others tucked in their collars to make v-necks, or added detachable lace collars or bows (Fig. 6.4). Importantly, staff respected these individual choices of clothing adjustments. Photographs of most male patients at Colney Hatch show greater uniformity in the design of their clothes, although variation in colour cannot be assessed in the images. Slightly built 15-year-old Harold H looked nonplussed in his

Fig. 6.3 Jenny K and Rachel K: uniform asylum clothes (Photographs of female patients at Colney Hatch 1918–1920 H12/CH/B/18/004 LMA)

Fig. 6.4 Annie L and Annie S: detachable lace collars (Photographs of female patients at Colney Hatch 1918–1920 H12/CH/B/18/004 LMA)

over-sized asylum-issue of shirt, tie, waistcoat and jacket. Unusually, Max G, was photographed in his shirt sleeves, failing to make eye contact and in a defiant pose (Fig. 6.5).[100]

One patient, Margarita K (Fig. 6.6), had a tear in her sleeve and a steadying hand on her shoulder, and a dress with no buttons on the front, unlike most of the other women's clothes. We do not know how the sleeve was torn, but the hand on Margarita's shoulder suggests a staff member trying to settle her, and the lack of buttons may have been to prevent her from removing her clothes. The pose suggests genuine care of the staff member attending to her.

Other aspects of clothing management could be undignified and detrimental to well-being and recovery, such as staff searching patients' clothes every night, in case they had concealed a home-made weapon in them.[101] However, a new dimension was added to discussion on dignity and patients' clothing with the arrival of service patients. Initially, the Board

Fig. 6.5 Harold H and Max G: bewildered and defiant (Photographs of male patients at Colney Hatch 1908–1920 H12/CH/B/19/003 LMA)

agreed with the military authorities that they would have a distinctive uniform, to avoid the stigma of pauper lunatics' asylum clothes and distinguish them as war-traumatised.[102] The uniform was abandoned when many refused to wear it, as it triggered memories of their army uniforms and their traumatic experiences, and it had a detrimental effect on recovery.[103] As an alternative, service patients wore tweed suits, "to distinguish them from the others, and to mark the appreciation of a grateful county for their war services".[104] By providing better and less workman-like clothes for service patients and commenting that their clothing could affect recovery, the authorities tacitly acknowledged the drawbacks of the garments provided to pauper lunatics.

Fig. 6.6 Margarita K, with a steadying hand on her shoulder (Photographs of female patients at Colney Hatch 1918–1920 H12/CH/B/18/004 LMA)

Cleanliness

From time to time, asylums sought assistance to help rid their buildings of beetles and cockroaches which occasionally appeared in the food.[105] Some asylums employed rat catchers,[106] and at Hanwell, rats bred in the asylum tip and escaped along the railway bank if the rat catcher disturbed them. To use rat poison, also a risk to humans, required special permission, and in this instance, it was granted.[107] In the pre-war decades, discoveries in microbiology increased understanding of disease prevention and the need for hygiene and public health measures. The Board was aware of these developments, but this knowledge was a far cry from the conditions on asylum wards, where practices were often unhygienic and neither met recommended standards nor those described by Carpenter.[108] Poor hygiene contributed to spread of infection in asylums, such as tuberculosis (discussed further in the next chapter). Some patients with that disease coughed up sputum, spat it on the floor where it dried and mixed

with dust, creating conditions for it to be inhaled by others.[109] Wartime overcrowding hindered Mercier's goal that "The wards of a lunatic asylum should be as clean as a man-of-war".[110]

As well as inadequate hygiene measures to curb spread of infectious diseases, facilities to ensure personal cleanliness were far from enticing. For example, asylum patients often had to share toothbrushes with other patients. Not only was this unhygienic, but it was incompatible with expectations on the outside: a soldier's kit, for example, included a toothbrush for his personal use.[111] The Board praised asylums in which each patient had their own toothbrush labelled with their name, highlighting that other asylums did not do the same.[112] Some patients did not have their own hand towels, even on infirmary wards. One former patient recalled 3 towels for over 30 patients.[113] At Long Grove, patients had their own towels, but only had cold water for washing.[114] A nurse who gave evidence at the Cobb Inquiry mentioned that some wards where she worked lacked washbasins and patients washed in a shared trough. Those patients also lacked towels, so dried themselves on their night clothes or on a soiled sheet from the dirty linen cupboard.[115]

In Goffman's analysis, "territories of the self are violated" in institutions, with removal of the boundaries which a person would put between himself and the next person if living in the community: contamination could be physical and psychological.[116] Alongside shared toothbrushes and towels, undignified asylum bathing routines fit this model. Despite acknowledgement that bathing could be beneficial for more than just ensuring cleanliness, its therapeutic potential was frequently neglected. An asylum chaplain, giving evidence to the Cobb Inquiry, described it as "positive indecency" with patients "treated more like animals" than human beings.[117] His report was incompatible with Mercier's stipulation that staff should never allow a "crowd of naked patients [to] accumulate".[118] Mercier also criticised the lack of privacy due to an absence of curtains between baths and "spray baths" (showers),[119] and Stoddart criticised the rigid weekly bathing regime as punitive and "unnecessary tyranny" and requested flexibility for patients accustomed to bathing daily.[120]

The mechanistic rules for safe bathing which were displayed in the bathrooms had to be followed even though they disregarded the psychological wellbeing of patients.[121] They included directions on how to fill the bath to avoid scalding (although that still occurred), the need to change the bath water between patients, never to put a patient's head

under water, and only to give cold baths on medical advice.[122] The rules also required staff to supervise patients when bathing even though they did not all require it, and to inspect patients' bodies for bruises.[123] In reality, bruises told the staff little, as examination would not disclose their causes. The weekly mass bathing ritual in accordance with the bathing rules was convenient for staff. Checking for bruises legitimised it as a pseudo-medical routine, but the process undermined dignity, individuality, autonomy and rehabilitation, and the rules probably protected staff more than patients.

Carpenter noted that, pre-war, sanitary facilities in the Hampshire asylums compared favourably to those which Benjamin Seebohm Rowntree found in working-class York around 1900.[124] However, judging by the Board repeatedly cajoling asylums to improve sanitary facilities,[125] this was not the asylum picture nationally. In some asylums, water closets (WCs) merely required decorating.[126] In others, more were needed, ideally one for 12 patients, because "insufficiency leads to constant squabbling and contention among the patients".[127] Elsewhere, WCs had no doors.[128] Fearful of being negligent in their duty to observe patients to keep them safe, VCs repeatedly argued for toilets without doors, although the Board recommended "dwarf doors" as a minimum.[129] Mercier stipulated that the top of closet doors should be at least 5 ft 6 inches (1.7 m) from the floor, to ensure that the occupant was "decently concealed". There could be a gap at floor level up to 1 ft (30 cm) so it was obvious if it was occupied,[130] which would also allow staff to monitor patients who "Must not get the opportunity of loitering and spending their time in the closets – a time which is frequently occupied in evil practices."[131] Perhaps the greatest fear for staff was to be blamed if a patient took their own life by hanging on exposed pipework. That risk, however, was remediable as pipes could be enclosed. Nevertheless, some VCs ignored the Board's instructions to do that, even after a suicide by hanging in their own asylum. Reasons given included that it "would involve too great a cost".[132] Even the Board naming-and-shaming to indicate its disapproval of negligent VCs,[133] did not ensure action, raising questions about the principles upon which those running the asylums made their decisions.

Another upgrade required for lavatories in some asylums was to replace earth closets (ECs) by WCs. Public health experts had recommended this since the turn of the century, particularly in population-dense towns and cities, where, by 1914, ECs were rare.[134] Asylums, despite their rural locations were mini-population dense areas and required similar facilities.

Mercier did not mention ECs in his book of asylum management in 1898, appearing unaware of their continued asylum use.[135] The Board criticised their on-going use pre-war, such as at Prestwich, where patients used ECs while the medical superintendent and senior staff had WCs. Lomax drew attention to the ECs and the "closet-barrow gang" of patients who emptied them.[136] Prestwich's VC made no changes between the time of publication of Lomax's book and the Cobb Inquiry nine months later, despite the asylum being under scrutiny of the Board and of the Ministry of Health. When the inquiry panel asked the chairman of Prestwich VC what he was doing about the ECs, he answered: "I have made a note of it. We are getting the contract in now."[137] The inquiry indicated the VC's apathy towards improving sanitation, hygiene and personal dignity of patients and eliminating the need for the closet-barrow gang, in stark contrast to it providing modern facilities for those at the top of the asylum hierarchy. The inquiry risked creating adverse publicity for Prestwich concerning their standards of care in a way that Lomax's book (where the asylum was unnamed) had not.

Night Times

In overcrowded asylums, mattresses were placed on floors and beds made up in washing areas and store-rooms.[138] Straw paillasses on old fashioned wooden bedsteads without springs, a shortage of sheets and blankets, and sometimes two patients in one bed with a pillow at each end was hardly conducive to a good night's sleep.[139] Some wards lacked blinds, so light could disrupt patients' sleep in summer time.[140] Some asylums allocated night-wear to individual patients, a practice which the Board wanted more widely adopted.[141] Elsewhere, the patients' nightwear was bundled-up in the morning and re-distributed randomly the following night.[142] Even just numbering garments could have ensured more hygienic and dignified redistribution.[143] Patients might also be moved from one bed to another, but when sheets were only changed once a week, they could be sleeping in a stranger's bed linen.[144] Mercier and the Board made other practical suggestions to overcome some sleep-disturbing environmental factors, such as providing individual chamber pots for night use since toilets were often at a distance, and instructing attendants to wear "noiseless slippers", not to flash their lanterns in patients' faces and not to wake sleeping patients to give them medication.[145]

Typical asylum bed time for patients was about 8 p.m., when the night shift came on duty, but Board inspectors were "more than pleased" when they saw patients socialising until 10 p.m.[146] At Horton, before it became a war hospital, the Board wrote: "We might from all appearances have been in the rooms of a working men's club, where the amusements and recreations of an ordinary social evening were in progress." The patients were reading, playing billiards, cards or dominoes, and singing songs round a piano.[147] Smoking was encouraged as a social pass-time.[148] Some women also had evening privileges, with gender suitable activities such as needlework.[149] The Board praised asylums which instigated evening socialising. It encouraged others to follow suit, but by 1922, the practice was still not widespread.[150] Implementation of Board suggestions was neither promptly nor consistently followed, much to their chagrin at subsequent inspections.

Despite the Board's encouragement for evening socialising, most patients spent over eleven hours in bed each night. Patients considered this regime "monstrous".[151] The theory that acutely mentally unwell patients needed to rest their brain was extrapolated from the common practice of resting a diseased part of the body to aid recovery, linked to the understanding that mental and physical disorders were caused by similar biological mechanisms. Mercier explained that in acute mental disorders, "the demand upon the energy of the brain is greater than it can supply; it becomes so depleted that it cannot carry on its current function, and the depletion manifests itself in some form of insanity."[152] Although Mercier's explanation was for acute mental disorders, the regime frequently extended to the whole asylum. This was irreconcilable with the Board's objective that patients should have as normal a life as possible and with their praise for asylums which allowed patients to stay up late.[153] Time in bed, like other aspects of asylum culture, was justified by theories, rather than evidence, and dovetailed with asylum organisation and staff convenience. In this instance, it was easier to supervise patients if they were expected to stay in bed, and eleven hours aligned with the seven-times fewer staff on night shift compared to day shift. As with shared bed linen and nightwear, practices convenient for staff and economical for VCs became accepted and therefore unquestioned as part of asylum life even when not in the patients' best interests.

Patients' Links with People Outside

Riggall described "those unfortunate folk, who, through no fault of their own, are doomed to live [in an asylum], cut off from their friends and the outside world. No one could possibly explain the monotony of such a life. It has to be experienced to be believed."[154] Having visitors was important, Riggall said, "one can form no idea what these visits mean to people"; and for those without visitors, "I have seen them cry with disappointment on visiting days as they heard the more fortunate ones called out to go down to the visiting-room."[155]

Visiting hours were restricted, typically a couple of hours on a handful of days each month, unless a patient was dangerously ill, when relatives might be invited to stay day and night.[156] At Hanwell, patients could have up to 2 visitors at a time, but no infants, and caution was advised about bringing in "children of tender years". Visitors were instructed that conversation with the patient should be comforting and reassuring. They had to obey rules: they must not post patients' letters nor give them money, nor give gratuities to staff who could be dismissed for accepting them.[157] At Hanwell, visitors were permitted to bring fruit and cake for patients, but that was sometimes prohibited, such as during an outbreak of typhoid when the authorities could not identify a source for it inside the asylum.[158] Through much of the war, visitors could purchase cake at Claybury, or tea for 1½d (0.6p) and "two small dry biscuits" for ½d at Colney Hatch.[159] When flour and tea were in short supply, these refreshments indicated recognition of the visitors' often arduous journeys on public transport, and were significant gestures of welcome.

Despite infrequent visiting times, the Board recognised the importance of maintaining contact with family and friends. For patients transferred from their usual asylum to one further away in the process of creating war hospitals, the Board negotiated for the War Office to cover the additional travel costs incurred by visitors, and by patients returning to their home area for trial leave pre-discharge.[160] The Treasury initially opposed the subsidy, only agreeing after the Board gave them an ultimatum that it would otherwise cease to cooperate to provide accommodation for wounded men.[161] This was a rare example of timely advocacy by the Board for its asylum patients and their families. The Board also issued instructions to VCs to be lenient when judging if reimbursement should

be made: assessment should be based on whether visitors were "reasonably able to afford" the additional cost, not on whether they could "scrape together a sufficient amount of money" to do so.[162] Admirably humanely based, it is less clear how the VCs interpreted the directive or if they informed relatives about the scheme.

Another means of communication with the outside world was by post. The Board criticised wards which failed to provide writing materials, envelopes and stamps. In some asylums, paper was available, but not envelopes, so the patient would write the address on the foot of page and the letter would be taken to the office to be put in an envelope. This was hardly compatible with the Lunacy Act which permitted patients to communicate in confidence with the asylum authorities in charge of their detention, treatment and care.[163] Sometimes a medical superintendent authorised staff to read all letters so that they knew as much as possible about their patients.[164] Elsewhere, attendants read them unauthorised.[165] Staff also opened in-coming letters and parcels, fearing that patients might receive plans for escape or money which might help them do so. It was a pointless intrusion into the patients' privacy in that patients could receive the same from determined visitors. It also contributed to distrust between staff and patients. Practices of staff reading incoming mail seemingly functioned more to protect staff in the event of an escape or other breach in the Lunacy Act rules, by proving that they had done everything in their power to prevent it.

The *Journal of Mental Science* cited an opinion that letter writing was "highly dangerous" during acute mental disturbance: it could make the patients' condition worse due to

> jangling intellects [being] taxed by futile efforts to co-ordinate thought.…A patient should not be permitted to tax his diseased brain any more than a patient with pneumonia should be permitted to join in a game of football. This is in reality a question of medicine, and not one of legal ordinance.[166]

This was consistent with other biological hypotheses about resting the disordered brain.[167] Although it was less overtly compatible with minimising staff effort when compared to the argument about time in bed, it did create one less demand on staff, that of providing patients with writing materials.

Patients at Work

In Edwardian times, in the community, working outside the house for men and household duties (or their organisation with tasks delegated to servants) for women, were regarded as civic obligations which could be empowering.[168] The asylums reflected these social norms in the work opportunities given to patients. In addition, it was recognised that suitable asylum work could help self-esteem, distract patients from introspective brooding and provide a barometer of a patient's mental state and recovery.[169] The laundry, for example, was "the stepping stone to liberty for more patients than any other workshop", according to Lomax, because only the most trustworthy could be placed there.[170]

Mercier regarded work for patients as therapeutic, whether or not useful to the asylum economy.[171] Likewise, Lomax acknowledged that work had intrinsic therapeutic benefits, although it also subsidised the asylum and could be exploitative, such as the most menial and dirty tasks often falling to patients, whether the closet barrow gang, or others carrying sacks of coal to the wards or distributing patients' chamber pots each evening.[172] The Board recognised the dual aspects of work, dividing it into categories "daily" and "useful", or work which was solely therapeutic and that which also subsidised the economy. In 1914, the Board praised asylums with work rates of around 90 per cent in daily employment or 75 per cent usefully employed.[173] Some work necessitated close interaction with staff, such as in the asylum fire brigade, which rapidly became depleted during the war, necessitating training patients and female staff.[174] Batch-living on overcrowded and understaffed wards contrasted with work-place supervision which provided staff attention to individuals or small groups which could be therapeutic even after decades in the asylum.[175] However, as Andrew Scull commented, and Kathleen Jones concurred, the purpose of employment in asylums shifted, away from the primary goal of benefit to the patients, to enabling the institution to run more smoothly and cheaply.[176]

For many working class patients, their asylum work mirrored their pre-admission daily activities.[177] However, this was less likely for patients from a growing middle-class population such as governesses, teachers, shop keepers, nurses and office workers.[178] Within the asylums, male patients had greater occupational diversity than female, although both helped on the wards. Male patients might work with the asylum's craftsmen and tradesmen, but employment for women was usually restricted to domestic

tasks, mainly in the needlework room, laundry and kitchen. When male staff began to enlist, patients and existing staff took on new roles, and whole teams might change, in line with the principles of asylum gender segregation.[179] Women took over heavier work previously undertaken by men,[180] and when female staff began to work on the farms, they supervised female patients working alongside them.[181] Women patients, as women outside the asylums, took on new roles.

During the war, patients also contributed to the war effort, although sometimes, external policies, politics and opinions impinged on asylum activities, not necessarily in the patients' best interests. For example, the LCC decided that patients would not make garments for soldiers, even if they had the skills, as that risked putting women in the community out of work.[182] Asylums did, however, purchase wool which allowed patients to knit socks for men in the forces, and some patients helped on war hospital farms, as at Napsbury.[183] Patients at Colney Hatch collected about 30,000 horse chestnut "conkers" (about 240 kg) from the asylum grounds for the Ministry of Munitions to produce cordite, the smokeless powder used as a propellant in ammunition.[184] Late in the war, asylums collected fruit stones and hard nut shells which were burnt to produce charcoal for gas-mask filters, more effective than standard wood-charcoal.[185]

In addition to these contributions, some asylums undertook paid war work. Claybury took on munitions work, "roughing out" shells, as they had the correct size machinery or furnaces in the boiler room.[186] A photograph of the boiler room from the medical superintendent's personal collection was labelled "Claybury – making shells, 1915" (Fig. 6.7). Claybury produced 4000 shell bodies which generated £450 for the asylum.[187] At another asylum, trustworthy male patients worked with local farmers, who escorted them to the farm and back each day, and who paid a "small charge" to the asylum. A report about the scheme did not mention whether the patients received a share of the fee paid, although we hear that they, and the farmers, found the experience gratifying and neither party abused the system. The Board encouraged other asylums to do the same, but Board archives do not indicate whether that happened.[188]

As with making shells or keeping the boiler furnaces alight, asylum work on an industrial scale could be hazardous. Asylum premises were subject to the Factory and Workshops Act 1907 which aimed to promote health and safety.[189] Nevertheless, accidents happened. One patient

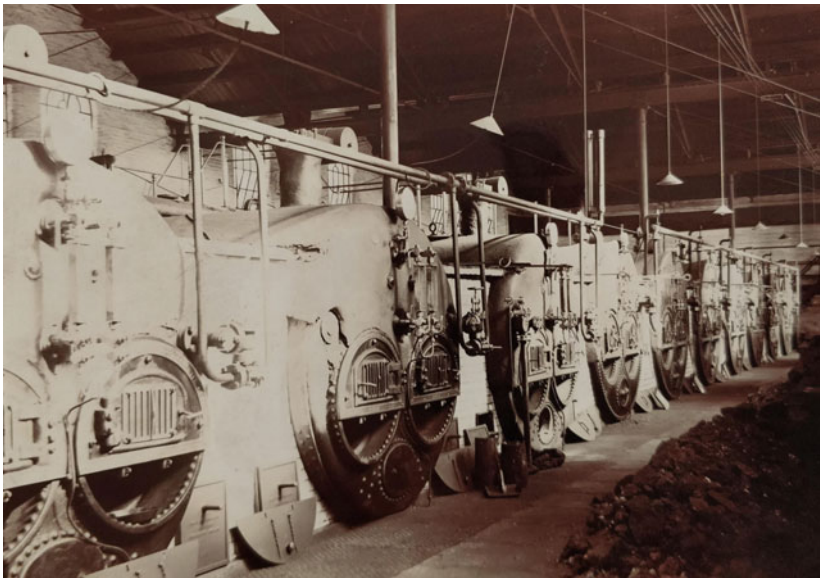

Fig. 6.7 "Claybury – making shells, 1915" (Armstrong-Jones collection, Royal College of Psychiatrists' Archives)

sustained a fracture when his arm caught in the hair-picking machine,[190] the device used to separate out different sorts of horsehair for stuffing mattresses. Laundry work was also dangerous: inadequate training before using the machinery, unhygienic processing of soiled linen, and lack of opportunity or encouragement for hand washing after handling it, all contributed.[191] Following Henrietta S's death in the laundry at Wakefield Asylum by scalding, the Board criticised the "persistent disregard" of laundry safety regulations.[192]

The VCs were concerned less about patients being injured at work and more that they might escape, the latter indicating that the asylum had failed in its duty under the Lunacy Act. Louis Z escaped from a party of four patients working with a farm labourer in the cow sheds, and Eugene T, working in the grounds at Colney Hatch, asked the attendant if he could go to the WC then scaled the boundary wall. Eugene was probably not "recaptured", judging by the dates when the VC discussed his escape and his discharge a week later.[193] In neither case were staff blamed, but

as a precaution, attendants were issued with whistles should they needed to summon help outdoors.[194]

Mercier justified patients receiving inducements to work, partly to overcome reluctance to work in a system which they did not like and did not want to support. He, like Lomax, disapproved of the widespread practice of giving rewards in kind which were demeaning rather than having the desired objective of promoting self-esteem.[195] Rewards in kind at Hanwell in 1918 were given to patients who washed the dishes on their ward for a week without any breakages: men received ½ oz (14 g) tobacco, and women, 1 oz tea or ½ oz sugar.[196] Since sugar was rationed, using it in this way suggests that it was removed from the pooled supplies and that others did not receive their full allocation.

Patients disliked being paid in kind, and preferred to receive money.[197] Regarding rewards for working patients, Lomax was among those who advocated for useful payment which patients could use to choose and purchase items in an asylum shop, helping to "increase self-respect and sense of personal value, which the present soulless and machine-made system of asylum administration seems specially designed to destroy."[198] Around this time, the idea of using tallies or tokens, rather than real money, was gaining ground. As well as spending tokens, they could be used as fines for wilful misdemeanours or saved and converted to real money at the time of discharge.[199] Half-a-crown (2s6d, 12½d) was a convenient reward or incentive for many people to undertake an activity. Patient Joseph P, who stayed up all night to assist with "re-adjusting the clocks in the Institution for 'summer time'" received half-a-crown.[200] It compared with the daily remuneration of a washer woman in Kensington, west London.[201] It was also the flat-rate reward which asylums gave to a member of the public who "recaptured" and returned an "escaped lunatic".[202] In the context of the asylum, probationer nurses were among the lowest paid, and in 1916, after deductions for living-in, they received 8s a week.[203] Patients did not work the long and anti-social hours of nurses, so although half-a-crown was low, it was a meaningful amount.

In contrast to the civilian patients, service patients automatically received half-a-crown a week pocket money, whether or not they contributed to the asylum economy. Jealousy and theft by patients without the allowance was reported, and some service patients used the money to gamble, which caused arguments.[204] Asylums were unsure how to deal with these problems: communal living without safe personal storage space was unconducive to a monetary or a token economy.

The Board gave no guidance.[205] Lomax challenged the conclusions of the authorities that patients were inevitably untrustworthy with money. In his view, the more you trust the patients, the better they respond, but "Asylum authorities, of course, are far from believing this; the principle they act upon is just the opposite."[206]

Conclusions

According to Kathleen Jones, the asylum regime suited some people.[207] For others, the standard of care was sufficient for them to live many years beyond the average life expectancy for their generation.[208] In the asylums, compassion existed, and patients could experience a sense of community. There are indicators that individual staff showed kindness to their patients despite the pressures under which they worked. Asylums also attended to aspects of the diverse religious, linguistic and cultural needs of their patients. Sometimes, following the death or discharge of a patient, relatives donated money or presented a gift to the asylum in gratitude for their care.[209]

Among those in authority, there was limited acknowledgement of the harm which institutions could cause to patients. However, critics mainly from outside the ranks of the public asylums, indicated dismay at practices which were undignified and disrespectful of patients and undermined their self-esteem. Their words often passed unheeded. The Board advocated for patients to have as near normal a life as possible and there were ample guidelines about what a modern asylum should provide. However, these were interpreted and achieved variably, balanced against other needs, particularly cost of provision, constraints of the Lunacy Act, and convenience for staff and leadership, all of which shaped the patients' daily life. Staff convenience also affected the application of practices derived from unproven theories about mechanisms of mental disorder which could hinder the wellbeing of patients.

The Lunacy Act set a financial cap and promoted rigid risk-avoidance. Innovation risked overstepping both of these: it was safer to maintain the *status quo* than to deviate from it. Thus, the Act encouraged a conservative and *laissez faire* culture and lethargy towards changing practices. The culture, as demonstrated at Prestwich regarding modernising the ECs was ongoing, rather than just specific to the war years. Some things could not be changed, such as the architecture and external societal pressures, but for many aspects of care, knowing what needed to be done but making

little effort to do it, was negligence of a particularly distressing kind. Visiting committee minutes repeatedly convey an attitude that anything-would-do for the lunatics. Some staff and patients spoke up about the deficits, but usually after they had left the asylum.[210] Relatives and friends of patients rarely appeared to complain. Some had no concerns, but others feared repercussions against the patient if they made a fuss.[211] Lack of evidence about their concerns might also be due to the authorities destroying correspondence when satisfied that the problem had been dealt with.[212]

In contrast to improving the pauper lunatics' lives, for whom ideas were tardily implemented, or not at all, providing more dignified care, pocket money and better clothing for service patients reflected public concern and received speedy attention. Finding the will and the way was associated with outside interest and the leadership's concerns about adverse publicity. This was evident at Prestwich where the VC began to deal with the ECs only after the Cobb Inquiry. With regard to benefits from public exposure, it is unfortunate that the Board's annual reports were truncated during the war and during the period of post-war reconstruction.

With the Board's tools being persuasion and suggestion, its effectiveness was dubious for motivating unenthusiastic VCs to implement change. The methods were likely to be more successful with asylums whose VCs and medical superintendents were already motivated. Decisions on care were influenced by wider social demands which were not necessarily in the patients' best interests. In austerity, public authorities had to decide who to support, and pauper lunatics were low on the list, hardly helped by their stigmatising designation and by public fear of the disorders from which they suffered and of the asylums where they were confined. Practices introduced for service patients had the potential to underpin improvements for all patients, but they could also inhibit change by creating practical challenges which appeared insurmountable, such as the need to provide safe personal storage space to prevent theft of cash allowances. The war gave everyone additional worries and distractions, making it easy for the public and the authorities to neglect standards of care for pauper lunatics in a culture where minimal provision was accepted as the norm.

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180. Hanwell LCC/MIN/01096 Meeting, 23 October 1916, 214 LMA.
181. Claybury LCC/MIN/00948 Meeting, 1 March 1917, 41 LMA.
182. LCC LCC/MIN/00579 Meeting, 29 September 1914, 647 LMA.
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186. LCC LCC/MIN/00580 Meeting, 29 June 1915, 615–16; LCC/MIN/00581 Meetings: 21 December 1915; 29 February 1916, 395–96 LMA.
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Excessive Infections in Asylums: Spreading of Diseases Like Tuberculosis

Introduction: Elsie and Mohammed

A Muslim couple, Elsie and Mohammed, arrived at Victoria Station, London, in January 1915. They were refugees fleeing war-torn Belgium. Born in 1883, Elsie was a dressmaker and "artistic worker". Her mental troubles began following the birth of her daughter:

> She was very depressed, weeping and covering her face with her hands. She kept getting out of bed and attempting to escape. She refuses her food at times. She has been in this depressed condition for some time and shows no improvement.

After two years in Hanwell she moved to Colney Hatch, the London County Council (LCC) asylum which admitted many patients born abroad and for whom English was not their mother tongue. At Colney Hatch, she could be alongside other Belgian refugees, which might provide a more favourable social and therapeutic environment for her than Hanwell. Elsie suffered an episode of dysentery in October 1917. A few weeks later physical examination revealed some weight loss and dullness in her left lung. She died of tuberculosis in April 1918.[1] The post-mortem noted "bed sores" (today, pressure sores or ulcers), which, according to psychiatrist Charles Mercier, were "a discredit to an attendant, and ought never be allowed in an asylum patient", a statement with which the asylums' Board of Control ("the Board") concurred.[2] Elsie's

weight loss could have been due to dysentery or tuberculosis or to her mental state. Tuberculosis was alarmingly frequent in asylums, and dysentery was "deplorably common",[3] although almost non-existent in the general population, to the extent that one asylum medical officer argued that fear of catching it reduced asylum admissions.[4]

Elsie's family arranged for a "Muslim priest" to officiate at her funeral.[5] A few weeks later, Mohammed wrote to the authorities:

> Kindly return to above address all belongings from late Elsie M—s. Should the Medical Superintendent, the Committee, etc., etc., think the belongings are not fit for discharge, they may do what they have done with Elsie M—s.

Mohammed's message reverberates with distress. The asylum sent him her belongings, a wedding ring and dress ring, by registered post. They forwarded her "plate of artificial teeth" to the Paddington Guardians, their rightful owners. Her clothes and other day-to-day items were asylum property.[6]

Deaths in asylums, particularly from infectious diseases, escalated during the war. The increase may have been related to the many wartime changes we have seen so far, including: vacating asylums to create war hospitals which resulted in overcrowding of those remaining; many inexperienced staff and low staff morale; and inadequate food, fuel, clothing, bathing routines and other basic amenities. In this chapter we shall explore aspects of medical and scientific knowledge concerning infectious diseases and how that knowledge was applied in the asylums. The various themes all relate to Elsie's story: death rates; post-mortems; tuberculosis; and other infectious diseases.

Death Rates and Post-mortems

In 1914, based on diagnosis during life plus post-mortem evidence, tuberculosis, general paralysis of the insane (GPI, brain syphilis), and the vague category of "senility" accounted for over one third of total asylum deaths in England and Wales.[7] GPI was discussed in Chapter 3, and aspects of the other two categories are discussed below. The overall annual asylum death rate of under ten per cent rose to 12 per cent in 1915–1916, leaped to over 17 per cent in 1917 (resulting in the LCC discussing paying overtime to asylum mortuary attendants[8]) and peaked in 1918 at 20 per cent

(Table 7.1).[9] There was little alarm, because the causes of death were the same as pre-war and the rise did not point to staff directly failing in their duty of care according to the Lunacy Act, resulting in suicide or injury. The total asylum population in England numbered around 100,000 and the national population over 32 million, but during the war half the total national increase in tuberculosis deaths occurred in the asylums.[10] Regarding the incidence and death rates of other acute infectious diseases, asylums compared unfavourably with the general population, including in London, where they remained comparatively low throughout the war.[11]

Table 7.1 Deaths in asylums: mortality per 1000 resident patients and total deaths

	1913	*1914*	*1915*	*1916*	*1917*	*1918*	*1919*	*1920*
				Mortality per 1000 resident patients				
General Paralysis		15.7	16.5			17.5		13.6
Dysentery	2.2	2.5	4.0	5.0	10.0	9.0		2.6
Typhoid	0.3		0.6	0.5	1.2	1.1		0.4
Tuberculosis	17.0	12.5	19.0	23.0	37.0	51.8		15.8
			Tuberculosis mortality per 1000 community residents, not age adjusted					
Tuberculosis	*1.35*		*1.51*	*1.53*	*1.62*	*1.69*		*1.13*
				Total asylum deaths				
a. Total asylum deaths	10,075	10,594	12,710	12,888	17,130	18,330	11,217	7945
b. Total asylum patients	104,868	106,451	105,858	103,574	98,621	90,459	86,950	90,950
Deaths (a/b) per cent	9.6	9.9	12.0	12.4	17.4	20.3	12.9	8.7

Sources BoC, "Increased Annual Death Rate in Asylums," 15 January 1919, 532 MH 51/239 TNA; *Second Annual Report of the Board of Control, for the Year 1915* (London: HMSO, 1917), 12–13; *BoC AR 1918*, Appendix A, 27; *Seventh Annual Report of the Board of Control, for the Year 1920* (London: HMSO, 1921), 26; Drolet, "World War I and Tuberculosis": 690

Death rates provide important evidence about disease, but like other data, they are not infallible, they have limitations and require careful interpretation. They do not measure new occurrences the disease, neither how long it lasts nor how severely it incapacitates the sufferer. They are therefore somewhat crude measures of disease activity. Waltraud Ernst, in his study of death rates in asylums, noted problems of "the nature of the statistics on which they are based and the categorizations underlying them", associated with doubtful validity and reliability of the figures collected.[12] Caution is also needed when comparing rates of disease and death between asylums and community because figures may not be adjusted for different age distributions. Death rates, however, were not confounded by transferring seriously physically ill asylum patients to general hospitals or sanatoria as they were treated in-house. Also, comparing two relatively small asylums, in 1914, Northumberland Asylum to the east of the Pennines had the highest annual death rate nationally (38 per cent) and Cumberland and Westmorland to the west had the lowest (nine per cent),[13] suggesting that death rates were not directly related to asylum size.

A patient who died in an asylum was typically subject to a post-mortem examination.[14] Post-mortems indicated to the rest of the medical world that the care of lunatics was part of medical practice and that asylum doctors sought to improve their understanding of cause and pathology of the disorders from which their patients suffered, just as their colleagues in general hospitals. However, interpretation of post-mortem examinations and the terminology used in reports could be ambiguous.[15] Differences were likely to have been due to the skills and understanding of individual pathologists, as illustrated by the use of the terms derived from the word "senile".[16] "Senility" was often used synonymously with old age, when the body's organs shrink or "atrophy" in later life. Not only was there was no specified chronological age designating "old", but senility might affect only one part of the body, such as baldness, a type of "early local senility".[17] At Hanwell, reports from a consecutive sample of ten post-mortems of men age over 60 concluded that the main cause of death for all of them was "senile decay", of whom three were also labelled as having "senile dementia".[18] In contrast, in a similar series of ten at Colney Hatch carried out by a different pathologist, none mentioned senile decay. Only three included the term senile in any form, but each was used in a different way: senile debility, senile dementia

and senility.[19] Drawing on all twenty of these post-mortems, three of the four whose cause of death was attributed to "senile dementia" had normal weight brains, making that conclusion unlikely. Overall, when incorporated into death certificates, imprecise senility-related terms lacked scientific or clinical meaning. The label was convenient, subjective and detracted from the need to acknowledge other pathology which might have more accurately explained the death. The post-mortem of James K age 64 demonstrates this. The pathologist found his brain to be normal but intestines "congested and inflamed", suggesting dysentery, but the report concluded that the primary cause of death was senile decay with dysentery secondary.[20] This sort of conclusion would under-estimate the number of deaths due to preventable infections.

Routine post-mortems were controversial, taking little account of their emotional significance for bereaved relatives. The Board advised seeking consent from a patient's relative at the time of admission to the asylum, to agree to a post-mortem in the event of their death. The request for consent appeared in the standard admission letter sent to the relative, alongside information on more immediate matters, such as visiting times. At the time of admission to an asylum, which portrayed itself as an institution offering hope of recovery and not as somewhere that patients were sent to die, the relative was more likely to be concerned about current problems and recovery, making them unlikely to pay attention to information about death. However, unless the relative objected in writing to the post-mortem, consent was inferred.[21] With the original notification long forgotten, a post-mortem could distress relatives who were under the impression that they had not consented to it.[22] Fulham Board of Guardians sharply reprimanded Hanwell asylum's "visiting" committee (VC) for neither informing a husband of his wife's death nor explicitly requesting consent at that time concerning performing a post-mortem. The VC discussed the Guardians' letter and replied that it would not change its practice.[23] As with other practices, the process reflected institutional convenience rather than the wellbeing of the patient or his family. The asylum did not have to respond in such a callous way. Pamela Michael and David Hirst described how customs and rules about communication concerning deceased patients at Denbigh Asylum in Wales were influenced by local culture.[24] Doing the same at Hanwell for a diverse urban population would have been more complicated, but feasible. The different approaches suggest that asylums interacted in different ways with the populations they served. The Denbigh leadership showed more

compassion and flexibility in this matter than the Board recommended, or Hanwell VC applied.

Tuberculosis

The wartime rise of asylum tuberculosis needs to be contextualised in its pre-war course and how the authorities responded to it. For over a decade, rates of asylum tuberculosis were approximately ten times higher than in the community.[25] There were two hypotheses to explain this: either insane people had an inherent predisposition to tuberculosis alongside their mental disorder in accordance with "degeneration" theories; or, asylum conditions predisposed to it.[26] Dr. Francis Crookshank, in 1899, blamed the asylums, "the fault lies with the institution harbouring the germs. It is no excuse that the person infected has 'family tendencies.'"[27] He attributed high rates to overcrowding, poor ventilation, lack of out-door activity, unhygienic wards and "a certain quality of diet."[28] To Crookshank, environmental and dietary remedies were needed, and were morally and economically justified on the grounds that improvements would enable long-term patients to work better and acute patients to recover faster. He also recommended segregating patients known to be infectious, and weighing all patients every three months since weight loss often accompanied early stages of tuberculosis.[29]

Soon after Crookshank's critique, the Medico-Psychological Association (MPA) appointed a Tuberculosis Committee to investigate. It concluded that high rates of tuberculosis in public asylums called for urgent measures.[30] It made recommendations, but implementation was hardly detectable. Psychiatrist William Stoddart blamed the asylum leadership, "underfeeding and overcrowding, enforced…by lay committees with excessively economical tendencies".[31] Psychiatrist and researcher Frederick Mott, based on his pre-war study of tuberculosis, stressed the importance of early diagnosis with a view to ensuring the patients' "isolation and treatment" and that they expectorated into "proper receptacles".[32] He also specified the need, with which the Board concurred, for asylums to provide wards with verandas deep enough to shelter beds for outdoor nursing (Fig. 7.1).[33] Mott reassured the LCC asylums that they were already taking adequate dietary and environmental measures to prevent tuberculosis,[34] which, in view of his standing regarding science and asylums, risked encouraging complacency even if his view was accurate and appropriate for some. The Board encouraged, and reiterated

Fig. 7.1 Verandah for nursing patients with tuberculosis in the open air, at Horton Asylum. Given to Mott by the medical superintendent. Photographer unknown (Mott, "Tuberculosis in London County Asylums": opposite, p. 116)

during the war, the need to regularly weigh patients, as Crookshank and others had advised, but implementation varied.[35] Also in the war years, most experts recommended physical examination rather than X-ray screening to detect lung tuberculosis, but with medical staff shortages the standard three-monthly physical health checks for patients were abandoned, with the risk of overlooking new or emerging cases.[36]

In the community, many adults harboured the mycobacterium causing tuberculosis, so some asylum deaths would have included patients admitted with latent, smouldering, quiescent, or inactive disease which ripened into a full-blown, rapidly fatal condition activated by wartime asylum deprivations.[37] Some patients arrived in asylums suffering from tuberculosis, such as Lily R, whose story appears in Chapter 3. Others, such as Elsie M probably acquired it after admission. Numerous asylum practices, known to be unhygienic, risked spreading it and other infectious diseases. Practices included: treating healthy and infectious patients together in open wards; patients not washing their hands before meals or after using the lavatory; inadequate hand washing by people preparing food and working in the laundry; lack of measures to prevent inhalation of mycobacterium tuberculosis; and drying soiled underclothing in the ward to be worn again without washing.[38] Some asylum laundries used washing machines and the disinfectant chlorine, which could be produced by electrolysis of brine at the asylum,[39] but foul linen was handled too often, including counting items into the laundry to ensure accountability for losses. Many asylums had insufficient isolation wards, especially during the war, lacked laboratory facilities to confirm infectious diseases, and communicated poorly about patients with the disorders when transferring them between wards or asylums.[40]

Asylum ward staff were expected to be able to take patients' temperatures, identify physical symptoms and inform the doctor about them, and to be able to nurse patients with tuberculosis, including 24-hours in the open air.[41] Temporary and untrained ward staff during the war were less likely to have these and other nursing skills, which may have been a factor in Elsie M developing not just tuberculosis, but also bed sores.

The LCC instructed asylums late in 1914 to vacate their detached villas, including some in use as isolation wards, as they were required for war purposes. Infectious patients were moved back into the main buildings.[42] With inadequate isolation and an under-trained workforce, standards of infectious disease management fell. The LCC may have had patriotic intentions but it is less clear that it understood the health risks associated with the instructions it gave.

Although notification of new cases of tuberculosis to the local authority Medical Officer of Health (MOH) became mandatory from 1912,[43] not all asylums and MOHs complied. Some MOHs allegedly discouraged the asylums from notifying them. Even where asylums sent notifications, the

MOH did not always transfer them to the official responsible for treatment in the locality where the asylum was situated, forwarding them instead to the MOH of the area from which the patient was admitted.[44] The Board received copies of death notices, but not copies of new diagnosis notifications.[45] This could have affected the Board's perception of the situation, diminishing its concern and reducing the likelihood of it endeavouring to provide prophylactic measures or better treatment. Overall, nobody in authority had a comprehensive picture of tuberculosis in asylums, nor took responsibility to counter the rising rates. Without being informed about diagnoses, the Board was also unlikely to know that over 90 per cent of asylum tuberculosis occurred in the lungs rather than in other parts of the body, compared to 75 per cent of community tuberculosis.[46] This meant that asylum tuberculosis was transmitted disproportionately by inhalation, associated with poor hygiene and lack of ventilation, rather than by it being ingested in infected milk or meat.[47]

Psychiatrist and historian John Crammer attempted to unravel the underlying causes of high tuberculosis incidence and mortality in his analysis of wartime deaths at the Buckinghamshire Asylum. He noted that the escalating deaths received little attention from the Board or the VC.[48] Wartime understaffing of the Board meant that one, rather than two, inspectors carried out asylum inspections, often a lawyer unaccompanied by a doctor. It is questionable whether lawyers had enough medical knowledge to respond adequately on matters of disease and death, but the annual inspection box had to be ticked, and a lawyer's inspection ensured that this happened. In 1917, medical superintendents made their concerns known to the Board, attributing rising death rates to food restrictions which predisposed patients to succumb to infection.[49] The Board appeared complacent, but the LCC was sufficiently alarmed to commission Mott to re-investigate tuberculosis in its asylums, although the minutes do not report his conclusions.[50] The LCC commissioned its investigation over a year before the Board began its study.[51]

Crammer identified overcrowding and poor nutrition as important causes. Overcrowding may have contributed to spreading tuberculosis but did not relate directly to death rates which peaked at the same time in asylums with and without it.[52] Concerning food, Crammer focussed on the reduction in the bread allowance, and thus the calorie intake, causing slow starvation resulting in lethargy, apathy, lowered vitality and impaired resistance to infection. He argued that Scottish asylums had a less steep rise in tuberculosis than English because the former had better food.[53]

However, the picture was more complicated: the rise outside the asylums in Scotland was also smaller than in England.[54] Elsewhere, diet and tuberculosis mortality showed poor correlation: in Germany, for example, severe wartime malnutrition was unaccompanied by a proportional rise in tuberculosis.[55] Returning to England, asylum death rates diminished post-war before the diet improved (Table 7.1),[56] also suggesting factors other than diet contributed to the tuberculosis death rate.

Workhouses in England had dietary regimes similar to those in asylums but did not experience a parallel escalation of tuberculosis. Before the war, many workhouses had vacancies,[57] and full employment in wartime may have emptied them further. Thus, although workhouses were requisitioned for military purposes like the asylums, those which remained as civilian facilities, did not suffer the same degree of overcrowding. Also, physical activity was strictly enforced in workhouses. This gave some protection against tuberculosis due to exercise being associated with better lung expansion. By contrast, asylums encouraged, but did not enforce, activity for people with severe chronic mental disorders such as schizophrenia and melancholia, for whom physical inertia may have increased their risk.[58]

Staff also risked contracting tuberculosis, but Mott could not demonstrate conclusively that they acquired it from patients.[59] All new staff were examined physically when they entered the asylum service. Some may have had undetectable, quiescent disease when they joined, and others may have acquired the infection while working there.[60] Staff also continued to work if the doctor decided that their disease was inactive,[61] and occasionally they died from the disease while still in service.[62] This raises questions of how ill and infectious a staff member might be while working with asylum patients. The LCC (General Powers) Act 1910 permitted asylum staff to receive sanatorium treatment, but this was not an option for patients. Asylum patients remained in the institution if they developed tuberculosis, but resident staff only remained there if their disease was considered unlikely to benefit from sanatorium treatment. Treatment for staff was inequitable with that for asylum patients, a situation unjustifiable on medical and public health grounds, but one to which the Lunacy Act contributed, because sanatoria were not licenced to accept certified lunatics. When a Banstead Asylum attendant, John Johnson, was too unwell to travel by rail to a sanatorium, the asylum paid 25s (£1.25p) to transfer him by car, and agreed to pay 35s a week for his in-patient treatment.[63] This weekly fee was over twice the amount spent on a patient in

an asylum, suggesting that staff were regarded as valuable to the community compared to mentally unwell people who were frequently perceived as a long-term burden on the state.

In September 1918, Board leaders met with chief medical officer Sir Arthur Newsholme, to discuss the high death rate. Newsholme promised his department's cooperation.[64] The Board delegated three of its medical members, Sidney Coupland, Arthur Rotherham and Robert Branthwaite, to investigate asylums with the highest death rates. The Board exempted them from all other duties, a major decision when it was short-staffed.[65] They examined data up to and including 1917, thus excluding confounding mortality figures from the 1918–1919 influenza pandemic. They visited 26 asylums and compiled a short report in January 1919. They acknowledged non-war factors including asylum administration. They reiterated previously identified theories about overcrowding and poor nutrition, and commented that staff were unable to recognise early stages of illness, nurse the patients, or have sufficient time to maintain ward cleanliness. They attributed inequitable food distribution to inexperienced or temporary attendants, although that is hard to believe: serving food was hardly a scientific or specifically nursing skill.[66] The Board acknowledged that War Office demands, such as transferring sick patients between asylums to create the war hospitals, could have contributed to the spread of infection.[67] It also considered relevant the effects of the bitterly cold winter of 1916–1917, coupled with unsuitable buildings, fuel shortages and inadequate ward heating, all causes outside the Board's direct control.[68] Overall, the Board's statements characteristically passed the buck, rather than arguing that it could have taken more responsibility for vulnerable people under its care. Some VCs ignored the Board's report.[69] However, the Board affirmed its faith in the VCs who had to deal with the many challenges, and stated that "Asylum Authorities are alive to these difficulties, and that, as far as possible, they will endeavour to improve existing conditions."[70] However, the long-term failure to implement changes to help control tuberculosis since Crookshank's paper, suggests that their hope was wishful thinking. Without the power to mandate changes or permit the asylums greater financial flexibility, the Board had little alternative but to trust the VCs.

Godias Drolet, a statistician, analysed patterns of death from tuberculosis during, before and after the war. He identified peaks of mortality in several European countries, including in Denmark, the Netherlands, Belgium, Ireland and the United Kingdom.[71] Tuberculosis mortality

peaked in 1917–1918 in many countries whether or not involved directly in the conflict, and allowing for different methods of data collection and a degree of error.[72] After the war, community tuberculosis rates fell to a level which would have been predicted if the rise had not occurred. When the rate across England changed, so did that in the asylums. Why the death rate fell to below its pre-war level so rapidly is an unsolved mystery for which material changes do not fully account.[73]

Crammer argued that, in its zeal for the war effort, the Board "abandoned the patients whose care they were supposed to safeguard" and that it was responsible for the excess mortality.[74] Crammer focussed on nutrition, overcrowding and understaffing, but did not discuss many other factors including the neglected high rates of asylum tuberculosis pre-war; inadequate processes of, and responses to, disease notification; poor hygiene and ventilation; lack of heating and harsh winters; inexperienced and temporary staff; complacent leadership; tuberculosis epidemiology; and budgetary constraints. It is easy to blame the wartime authorities—the Board, VCs, MOHs, MPA and medical superintendents—who let much pass, but if blame is due, it also falls on those who for over a decade pre-war were complacent and failed to make any serious attempt to reduce asylum tuberculosis.

Tuberculosis at Claybury and Hanwell: Case Studies

Pre-war, Mott identified more tuberculosis at Claybury than in other LCC asylums, although figures were partly dependent on post-mortems for which interpretation varied between pathologists.[75] Despite Mott's evidence, Claybury's medical superintendent, Robert Armstrong-Jones, asserted in 1914 that during his two-decade leadership the "tuberculosis death-rate was smaller than that of most of the other London asylums".[76] Typically, the VC did not challenge their medical superintendent's analysis, which lessened the pressure on them to examine or improve asylum practices.

Mid-war, Claybury faced numerous senior staff changes. Armstrong-Jones retired in 1916 and the VC appointed a succession of acting medical superintendents. First, they promoted the senior assistant medical officer, Charles Ewart, but he died soon after. The second, Thomas Fennessy, also already on the staff, left to serve in the forces[77] and was killed when the steamer Leinster was torpedoed.[78] In mid-1917, the VC

appointed Guy Barham from Long Grove Asylum. He had a broad clinical experience, having worked as resident medical officer in a general hospital and as emergency officer at the London Hospital, Whitechapel.[79] Other senior "acting" appointments included the head night attendant.[80] Matron Margaret Russell retired after 36 years' service,[81] and the steward left, suffering from mental problems.[82] The LCC research laboratories with their staff, including Mott, were relocated to the Maudsley Hospital.[83] The many changes of senior personnel may have destabilised asylum management, practices and monitoring, with adverse outcomes for patients.

Casting a new pair of eyes on Claybury, Barham noted some disturbing legacies from his predecessors suggesting low standards of care. Falls and "accidents" to patients were excessive, storage of dangerous drugs was unsafe, and observation of patients at risk of suicide was inadequate. In November 1917, he raised his concerns with the VC. A couple of months later, when an outbreak of dysentery caused 36 deaths, Barham took the unusual step, before seeking the VC's agreement, of asking the local authorities to suspend admissions temporarily.[84]

From late 1917, Claybury had almost 70 deaths each month (from all causes), compared to an average monthly death rate of 20 during the previous two decades.[85] In April 1918, the VC discussed an outbreak of typhoid and Barham announced that he was seeking advice from a public health expert, William Hamer, the LCC's MOH. Seeking external medical advice was rare: it might give the impression to the VC that a medical superintendent did not know how to do his job, making him vulnerable to criticism or dismissal. Barham and Hamer joined forces to investigate the deaths.[86] A lawyer, Lionel Shadwell, inspected Claybury in June 1918 on behalf of the Board, unaccompanied by a doctor. He noted the high death rate from "natural and ordinary" causes. He showed little concern about these deaths, noting that suicide and accident rates, which might require legal action, were acceptable. Overall, he described the asylum as "creditable".[87] Shadwell's comments give credence to the suggestion that legal Board members overlooked medical matters.

Deaths declined during the summer, attributed to the warmer weather. In September 1918, Barham warned that the temperature inside the building needed to be kept around 55–60 F (13–15°C), otherwise "a very high death rate may be expected."[88] A month later the VC minutes recorded: "With the approach of the cold weather, and the need for greater economy in the use of fuel even than last year, when

the heating of the building was kept low, a continued high death rate seems inevitable."[89] Despite Barham's concern, the VC appeared blasé. Later in the year, Barham announced the recommendations from his and Hamer's study, largely reiterating those from earlier research which had been ignored. At the same meeting, the VC said that it would consider requesting up to 300 more tons of coal above the rationed level.[90] The war had just ended, but intense shortages persisted. No reasons for the VC's abrupt about-turn were stated, but Barham's and Hamer's report was likely to open the asylum to further scrutiny by the LCC.

Hanwell also appointed an acting medical superintendent in 1917: Alfred Daniel replaced Percy Baily who had been on the staff since 1890.[91] Like Barham at Claybury, Daniel challenged established customs and practices, and cautiously and humanely advocated for the needs of patients in a way which was not evident in the later years under Baily's control.[92] Increasing tuberculosis mortality at Hanwell (10 deaths in 1913, 49 in 1917) alarmed Daniel. He attributed this to insufficient ward ventilation ("the general stuffiness that prevailed today cannot be healthy"[93]), lack of time in the open air, and unhygienic habits: "they spit about the wards promiscuously, the sputum dries and is inhaled by the healthy."[94] Painted windows to comply with lighting restrictions prohibited opening them in the evenings, and lack of heating and insufficient bed linen discouraged opening them at night.[95] In April 1918 the VC and the asylum engineer agreed to Daniel's proposal to erect two "tuberculosis shelters" using scaffolding and tarpaulins, so at least some of the 58 known cases could sleep out of doors.[96]

For both recently appointed acting medical superintendents, Daniel at Hanwell and Barham at Claybury, their assertive proposals to improve conditions for patients did not fall on deaf ears. This raises questions about the asylums' leadership strategy. Lay VCs appeared overly respectful of the judgement and expertise of their own medical superintendents, who may, in their long-term jobs-for-life roles, have been "burnt-out", associated with apathy, at a time when confronted by additional wartime challenges.

Other Infections: Dysentery, Typhoid and Influenza

During the war, dysentery and other forms of infective diarrhoea increased in many, but not all, public asylums.[97] Advice about prevention and treatment included isolating patients, preferably in a separate building, disinfecting all items in contact with them, and prescribing small quantities of neat brandy orally and starch-and-opium enemas if diarrhoea was severe.[98] It is unclear whether the advice was followed at Colney Hatch in 1917 when 130 people caught dysentery, half of whom died.[99]

The Board was keen to discover why, according to Mott's records since 1902, some asylums had no dysentery, while in others it was endemic and in others intermittent.[100] In the community, dysentery was rare.[101] It was also rare in private mental hospitals,[102] pointing to the infection being a factor of the institution, rather than an intrinsic risk of mental disorder as proposed by degeneration theories of a single predisposition to both. Staff also caught it, including kitchen workers, with an alarming potential for transmitting it.[103] Dr. Shaw Bolton, subsequently medical superintendent and professor at Wakefield Asylum, learnt the hard way about its transmissibility while an assistant medical officer at Claybury:

> He had started his tea one afternoon in the medical officer's room, when he was sent for to go and see a patient who had suddenly collapsed, a woman. After seeing her he gave instructions for the usual treatment, and went back to finish his tea without first washing his hands. Five days later he had an unpleasant attack of dysentery. At Claybury, about 1900-1903, it was not the fashion to believe that sane persons could catch the disease![104]

The bacterium shigella was the usual causal agent of dysentery. Signs and symptoms included fever, stomach cramps, ulceration of the large intestine, haemorrhage and bloody diarrhoea.[105] In 1914, the Board funded research into its nature, prevention and treatment.[106] The research took place at Wakefield Asylum, then under Shaw Bolton's leadership, where dysentery had been endemic since the asylum opened in 1818.[107] The pathologist there, Harold Gettings, aimed to detect carrier status, preferably by a blood test since it was "impossible to get officers in large asylums" to test faeces, even where suitable laboratory facilities were available.[108] Gettings modelled his goal on other tests for detecting early infections and carrier states[109]: the tuberculin test for tuberculosis,

Wassermann test for syphilis, and Widal test for typhoid. Unfortunately, Gettings did not know that asymptomatic carrier status for dysentery was rare.[110] He also aimed to produce a vaccine to prevent the disorder, although a century on, this has still not been achieved.[111]

In 1915, the Medical Research Committee (MRC, predecessor of the Medical Research Council) criticised the Board for sponsoring Gettings' dysentery research, a physical illness. It did not understand the diversity and complexity of physical and mental conditions coexisting in the asylums, or that the Board wanted research to benefit patients directly and promptly. Around the same time, the War Office wanted the MRC to provide solutions for the crisis of dysentery affecting troops in the Dardanelles, so the MRC took over funding Gettings' research. This allowed the Board to use its resources for other projects with a more specific mental health focus. The Board and the MRC also created a longer-term plan of collaboration "to establish a wider national scheme for research into mental diseases".[112]

Typhoid (enteric fever), another infectious disorder, was also far more common in asylums than in the community.[113] As with tuberculosis and dysentery, typhoid affected staff and patients.[114] As with dysentery and tuberculosis, good hygiene and quarantining could help prevent transmission.[115] Typhoid carriers could be identified by the Widal test and immunisation was available, unlike the options for dysentery.[116] At risk patients, and staff such as laundry women dealing with foul linen, were offered and usually accepted immunisation, although occasionally one refused and succumbed to the infection.[117] Occasionally and unexpectedly, patients who were predicted to become long-stay, improved mentally after an episode of typhoid, allowing them to be discharged. This outcome reinforced the belief in overlapping aetiologies of mental and physical illnesses, giving rise to speculation about the effects of infection, inflammation and immunisation and the possibility of prevention and treatment of mental disorders.[118]

"Spanish" influenza, another devastating infection, added to wartime adversities. Influenza prevailed among soldiers on both sides of the conflict in spring 1918. In mid-1918, mortality from the disorder increased world-wide. The unusual summer timing of the first outbreak worried public health officials who predicted a second wave.[119] It came: the biggest and most fatal, in autumn 1918, and a third in spring 1919.[120] The magnitude and unexpectedness of the pandemic overshadowed the end of the war. The war took the lives of 10 million people, and

the pandemic killed over 40 million world-wide. About 700,000 British soldiers were killed in the war, and 225,000 people died from 'flu in Britain, 70,000 in November 1918 alone.[121] The nation did its duty according to expectations inculcated into it during the war: it stoically "carried on". The Local Government Board in Whitehall, responsible for public health, did little apart from issuing an occasional memorandum.[122]

A combination of military and civilian hardships probably increased people's vulnerability to 'flu: insanitary trenches; overcrowded military ships and trains; women exhausted from war work plus their domestic chores; and a medical system largely geared to military needs. The 'flu was particularly lethal to young adults, but there was little association between mortality and social class or overcrowding in domestic dwellings. The Board was unable to explain the pattern of influenza incidence and mortality in the asylums. Eleven asylums had no deaths during the most devastating wave, including one asylum which otherwise had extremely high mortality rates.[123] In some, either men or women died, but not both.[124] At Claybury in November 1918, female staff were affected disproportionately more than male staff or patients and, along the lines of the example set by Barham at the time of the dysentery outbreak a few months earlier, the asylum took the precaution of suspending female admissions.[125] Some potentially harmful practices continued, such as certifying and transferring severely physically ill patients from the community and general hospitals to the asylums.[126] Some were so ill at the time of transfer that they died soon after. The Board advised against moving such patients, whose mental disturbances were probably due to delirium resulting from the 'flu. It used the opportunity to highlight the inadequacy of general hospital facilities, particularly for treating people with physical disorders whose associated mental impairment was likely to be temporary.[127]

Conclusions

Reflecting on the chronic high levels of asylum tuberculosis pre-war, and the tragedy of the devastation it caused during the war, psychiatrist Lionel Weatherly commented in 1919: "the death-rate of tuberculosis in our large asylums is a standing disgrace to our country, and I earnestly hope something will soon be done to mitigate this crying evil."[128] Managing infectious diseases in asylums was characterised by poor coordination, fragmented and poor communication and leadership indifference.

There were scientific uncertainties, but much was known and was not applied. The system was peppered with inequalities, unjustifiable on medical or public health grounds, such as providing sanatorium treatment for asylum staff but not for patients. This gives the impression of clinical decision-making being related to an individual's or a group's perceived social and economic value: staff were seen as workers who could contribute whereas mentally unwell people were a drain on resources. The focus on employment was compatible with the National Insurance Act 1911 which provided health insurance for breadwinners but not for their dependants.

Crammer asked why the Board failed to solve the problem of rising deaths. He answered that in its zeal for the war effort, the Board "did not try very hard" and it "abandoned" its patients.[129] The Board passed the buck on some health-related issues. It acted sluggishly on others. The culture was to make do and continue, to self-justify and not to seek more, although at some point that conflicted with the medical ethical principle of *primum non nocere*, first do no harm. The Board had a duty to ensure humane care in its asylums, but it appeared to lack the skills and assertiveness to tackle some of the tasks demanded of it. Its decisions at the beginning of the war may have been suitable for a short-term conflict—and many believed that was what it would be[130]—but evidence is lacking to suggest significant revision of plans in the context of a prolonged war. In addition, if Board inspections were to be meaningful, they needed to be undertaken by people who had sufficient clinical experience and judgement, otherwise they would fit the requirements of administrators rather than the needs of patients and staff.

Some well-established medical superintendents, despite their expertise, appeared complacent or burnt-out after two decades of consistently taking enormous responsibility. With complacent medical leadership, it is hardly surprising that the lay VCs ignored potentially relevant scientific findings which were difficult to weigh up and interpret. In contrast to the long-established medical superintendents at Claybury and Hanwell, their newly appointed replacements challenged the VCs and advocated more for their patients.

Excessive infections in asylums during the war were probably associated with a large pre-war reservoir of infective micro-organisms. This baseline helps explain their relative frequency and rise during the war compared to the same diseases in the general population. For tuberculosis, the authorities had failed to act on the advice of the MPA and others to attempt

to reduce infection and mortality by any means known. Asylums knew what to do, but did too little, too late. Post-war, the Board made recommendations based on its report about asylum mortality, noting that war conditions alone did not account for the "alarming increase" in asylum sickness and that the asylums should improve their hygiene and public health measures.[131] It advised the asylums what to do, much as it and its predecessor, the Commissioners in Lunacy, had done unsuccessfully for over a decade pre-war. *Plus ça change, plus c'est la même chose.*

Notes

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19. Colney Hatch H12/CH/B/23/013 Autopsy book for male patients 1916–1918 LMA.
20. Hanwell H11/HLL/B/31/006 Post-mortem register, males, 1915–1917 LMA.
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Abuse in the Asylums: Allegations and its Consequences

Introduction: A Culture of Kindness or Harm?

"The asylum exists for the benefit of the patients" Charles Mercier reminded staff when he summarised the approach they needed to take: to be kind, courteous, sympathetic, tactful, and not overbearing or bullying; to "cheer the unhappy", "soothe the excited" and "make peace between the quarrelsome".[1] Staff must never threaten, tease or frighten, mock, jeer, insult, disparage or deceive a patient, lose one's temper with or strike a patient or punish one in any way.[2] Mercier spelled this out because he was aware of harsh practices. He instructed staff (bold in the original), that: "**under no circumstances whatever should a patient be knelt on**. More broken ribs and broken breastbones are due to this practice than to all other circumstances put together".[3] Staff struck patients, but according to one wartime staff member, "the attendant who knows his business seldom leaves a mark on the patient he abuses", a state of affairs also referred to by Louise Hide in her study of late-Victorian and Edwardian asylums.[4] One former patient reported that when he dared to criticise his attendants, they punished him with concealable torments, including giving him strong laxatives, placing a live earwig in his porridge and heavily over-salting his soup then laughing when he spat it out.[5] Another former patient who became an attendant, described his colleagues as unsympathetic and harsh. He noted their abusive language, which he attributed to them being "under the delusion that almost

everything in the universe was composed of blood", repeatedly using a word "which rhymes with ruddy": "You have read of Moses and the old time necromancers of Egypt turning water into blood. They could turn everything into blood."[6]

Rachel Grant-Smith wrote about her experiences as an asylum patient. She alleged brutality and degrading nursing practices. She described being "forced" to take laxatives, for her "bad behaviour", and unless she cooperated "it meant my being forcibly laid down and three or four nurses pulling my mouth open and pouring it down."[7] She observed distressing scenes:

> Fanny Black and Miss Hurd were made to sit out of bed on the chamber utensil many hours in the night, quite naked, often for an hour at a time. Miss Hurd has lately died from consumption. A young nurse, named Green, promised me, after I had spoken to her about ill-treating patients, that she would not do it again, and subsequently told me that she would get into trouble for not kicking a patient, Mrs. Beverley, to keep her quiet when told by Nurse Rooke to do so.[8]

The British periodical *Truth* published a summary of Grant-Smith's report in July 1914.[9] Conveniently for the authorities, it disappeared from the public agenda when national priorities supervened.

The terms "rough handling" and "rough usage" appeared frequently in minutes and reports of the asylums' Board of Control ("the Board").[10] However, with reports from staff and patients usually given credence in a hierarchical fashion, if a patient alleged rough handling and a staff member denied it, the patient was rarely believed.[11] Staff expected each other to conform to their unwritten peer group rules of loyalty to colleagues, which included collusion in the event of a complaint. Inconsistencies in reports between patients and staff, and often agreement between ward staff of the same grade, suggest that loyalty to colleagues took precedence over patients' wellbeing.[12] Some of these issues, and some others, are illustrated by an incident in the life of Edith B, a 42-year-old schoolteacher admitted to Colney Hatch in 1913 (Fig. 8.1).[13] Edith had a psychotic illness and her "certified cause of insanity" was "religious mania".[14] In July 1915, her doctor wrote:

Fig. 8.1 Edith B, soon after admission (Photographs of female patients at Colney Hatch 1908–1918 H12/CH/B/18/003 LMA)

> She is very grandiose and exalted and believes that she is the Virgin Mary and that the archangel has visited her and greeted her with "Hail, Mary, full of grace." She states that she had a child afterwards. She is excitable, garrulous and spiteful and entirely irrelevant in conversation. She is in fair health.

Sometimes she "could feel the Holy Child leave her womb." Edith's clinical notes recorded ups and downs. Occasionally they mentioned injuries, allegedly inflicted by other patients, on one occasion a black-eye, and on another, cuts which required stitching. Later she had scabies, a skin condition associated with an unhygienic environment. Her delusions persisted, and she gradually became "demented, solitary, unemployable."[15]

In 1916, Edith reported that Nurse H hit her. Edith had a bruised face. Clear that something had happened, the visiting committee (VC) investigated. The nurse denied hitting Edith but admitted to pushing her in the lavatories (a common location for displays of anger, out of sight of others[16]) and Edith hit her face on one of the partitions. Nurse H apologised and said that she "did not mean to be rough". Nurse K, a more senior staff member, witnessed the incident, and gave another account, that Nurse H took hold of Edith by her neck in a very rough manner but did not strike her. Each person told a different story.

The VC insisted that Nurse H resign although it could have dismissed her.[17] Resignation was less harsh than dismissal. It was less damaging to her reputation if she sought another job, and it did not entail her forfeiting her superannuation contributions. The minutes did not mention her previous work record and her apology appears to have been

taken as an admission of guilt rather than an indication of remorse. The same VC adjudicated over allegations about another nurse in similar circumstances a few months later. In that case, the VC cautioned her as they were sure that she "had no intention of being unkind to the patients but that she must, in future, on such occasions be most careful in handling the patients".[18] The VCs' inconsistency in dealing with misdemeanours contributed to staff insecurity and their lack of trust in the leadership.[19]

Edith's story demonstrates some of the challenges faced by asylum authorities when trying to deal with untoward incidents, whether "accidents" or injuries, escapes or suicides. This chapter aims to bring together components of asylum life—the patients, senior and junior staff, the public, the law, the Board and the VCs—to create a broad picture about what happened when things went wrong. There are drawbacks, in that much of the material is necessarily anecdotal with inconsistencies and contradictions. However, cases provide enough evidence to identify patterns of attitudes, behaviours and decision making, from which conclusions can be drawn.

Abuse in the Asylums: Allegations and Outcomes

Most VC members had no specific training to help them evaluate allegations of abuse or maltreatment, although a few could draw upon their experience as magistrates. The VCs were often bewildered by inconsistent, contradictory and vague evidence, particularly from patients who changed their original statements.[20] They attributed this inconsistency to their mental disturbance being all-encompassing, a medically acceptable perspective. According to Mercier, "they are out of their minds and not responsible for what they do or say", even when their delusions and hallucinations were unrelated to the subject in hand.[21] Allegations made on their behalf by relatives or friends were considered similarly contaminated because of their source.

Evidence has not come to light that VCs or superintendents raised the possibility that inconsistent reports from patients were associated with them fearing repercussions from the staff they accused. Indications that this happened include a newspaper report, some years before the war, about the inquest into the death of Charles Andrews who sustained rib fractures while a patient at Colney Hatch. It stated that he had told his wife that he "had 'been knocked about' for an act which he could not

help, but he would not tell her by whom" suggesting that he feared retribution if he exposed maltreatment by staff.[22] Patients' fear was also likely to have been a factor in the VC's investigations into allegations that Attendant Frampton indecently assaulted young male patients in his charge. The patients had to give evidence in front of the accused. Evidence was conflicting, with some allegations "forgotten". The confusing picture led the VC to conclude that the allegations were false.[23] Shortly after, Frampton was arrested and charged with indecent exposure to some boys in Finsbury Park. The similarities between the behaviours supported the reality of the patient' allegations, but only then was Frampton dismissed from asylum employment. Scandalous allegations by patients, especially when accompanied by contradictory evidence, were particularly unlikely to be believed.[24]

Staff as well as patients might "forget" incidents. When allegations arose about Attendant Orton hitting and injuring a patient, both parties "forgot" what happened. Orton absconded from Colney Hatch, resulting in automatic dismissal and forfeit of his superannuation contributions.[25] Police traced him to Portsmouth, with the result that the asylum wrote to him about their concerns: the return of his uniform and keys. Nothing further was heard from him until he reappeared at Colney Hatch, seeking repayment of his superannuation. He maintained that he had no memory of any misdemeanours.[26] Sir John Collie, medical examiner for the London County Council (LCC) and author of a book on malingering, examined Orton and declared his memory loss genuine, thus salvaging the superannuation.[27] Other incidents did not end so well for the alleged perpetrator.

In addition to patients' words lacking credibility, so too did those of junior staff who were placed only just above patients in the asylum hierarchy. In consequence, after an untoward event, juniors were more likely to be disciplined than the seniors under whom they worked. This can be illustrated by the events around Mrs. I, a patient at Colney Hatch who was "under continuous observation because of suicidal tendencies." A probationer nurse, new to the ward that morning, was delegated to look after Mrs. I when the ward's qualified staff went to breakfast, but Mrs. I managed to break the glass door of a medicine cupboard and took a fatal dose of camphor. At the investigation, the qualified staff said they had told the new nurse specifically to look after Mrs. I, although there were no witnesses to that from outside their circle. The asylum informed the Board, which concluded that the new nurse was "careless and incapable",

and recommended to the VC that it "terminated her engagement."[28] There is no record about whether the Board questioned the appropriateness of the established staff in delegating responsibility to a probationer, or what they actually told her about Mrs. I. Staff closed ranks, and the words of those more senior prevailed, as if trustworthiness and judgement automatically increased with status.

Asylums provided different degrees of detail about their investigations into untoward events. However, minutes hint at clandestineness, such as when the VC at Colney Hatch decided to inform the Board about an incident only if asked directly. If that happened, it would report that the asylum had dispensed with the nurse's services, and "as all the corroborative evidence has been by patients, it is doubtful whether a conviction would be obtained."[29] Despite the recurring pattern of institutional secrecy in some cases of ill treatment, "wilful neglect" or allowing a patient to escape sometimes prompted the Board to contact the Director of Public Prosecutions.[30] Penalties for a member of staff found guilty of a misdemeanour under the Lunacy Act 1890 included imprisonment or a fine of up to £20.[31] This was a hefty punishment considering that a ward attendant's salary (after deductions for uniform and "living in") was under £40 a year.[32] If a case went to court, publicity was almost inevitable, risking criticism about the asylum and its leadership and creating a "blot on the copy book for what the asylums sought to provide".[33] Mercier emphasised that a lapse in staff vigilance could result in "catastrophe": injury or death to those under their care, and disaster to their own career.[34] For many male staff who lived in tied cottages with their families this was a huge concern, as dismissal or imprisonment would also wreck the lives of their family. Fear of the consequences probably contributed to staff perpetuating cultures of secrecy and dishonesty.[35]

Another mechanism of concealment occurred after altercations when attendants failed to follow instructions to "report the occurrence immediately to the Medical Officer" even if "in the attendant's own opinion no injury had been caused to the patient."[36] Sometimes in these circumstances the patient died, the injury being more serious than the attendant surmised. A doctor's examination of the patient soon after an incident could help clarify the course of events. The patient's words might be believed if they were compatible with the clinical findings, and while superficial injury such as red marks, bruises or scratches were still in evidence, they could indicate the recent timing of the injury. Without that early assessment, possibly fatal internal injuries identified later were

unlikely to be attributed to a particular attendant or shift, providing a degree of immunity for the perpetrator.

Despite secrecy around episodes of rough handling, patients could be remarkably up to date with asylum news which might then spread further afield, creating gossip and disrepute about the asylum and its leadership.[37] Short visiting times, ward staff reading patients' out-going letters, and most new junior staff being required to live-in helped guard against this. In addition, with time, both patients and staff could become institutionalised, moulded into the system and minimising protest, although, unlike the patients, staff who were uncomfortable with the regime were free to leave. Occasionally someone contacted an external body, placing an asylum's reputation on a knife edge of publicity, as at Colney Hatch in the case of a 33-year-old Spanish patient, Juan R, recorded as dying from "rupture of intestine caused by falling against a table."[38] Officially categorised as an accident, this seems an unlikely explanation since, in a fall, reflex contraction of powerful abdominal muscles would help protect internal organs from blunt trauma, a matter learnt, if not in anatomy classes at medical school, then on the sports field. There was no mention of loss of consciousness preceding the injury, which might have prevented reflex muscle action. If the patient had lost consciousness, the alleged perpetrators would probably have mentioned it in their defence. A patient-witness stated that two attendants had treated Juan roughly, but the attendants denied it, and staff words over-rode those of patients. However, someone wrote to the Spanish Consul General, asserting that a Spanish patient had been murdered in the asylum, prompting the consul to contact the asylum. The VC minutes only tell us that the medical superintendent was due to meet the consul, and in common with documentation of other complaints, they lack detail of the discussion and outcome.[39] It is likely that the superintendent reassured the consul that patients' were unreliable witnesses and that his attendants were, in words similar to those of the Board, "as humane and deserving a body of workers as can be found".[40]

In contrast to assumptions that staff were humane, patients were assumed to be irresponsible, untrustworthy and sometimes dangerous, requiring stringent safety precautions. Some precautions were obvious, such as ensuring the safe keeping of brooms, broken chairs, fire pokers and roller towels which could be used as weapons against self or others.[41] Others limited the freedom of patients, many of whom did not require the measures but were subject to them nevertheless. They could be

condescending, such as routinely counting patients in and out when being escorted between ward and work-place.[42] The value of others which were demeaning were debated, such as staff searching patients' clothes every night to check for concealed home-made weapons, perhaps a stone or other hard object in a sock, stocking or handkerchief.[43] When implemented as blanket precautions, rather than protecting patients and staff, they could hinder patients' self-confidence, self-esteem and (re)building of healthy social relationships necessary for achieving the best possible quality of life, whether inside or outside the asylum. The Board, however, supported many of these practices, erring on the side of caution, even though, for some patients, this contradicted its stated objective of providing as near normal a life as possible.

The authorities were alert to the problem that abuse and injury was not all one-way, and that, from time to time, staff sustained injuries at the hands of patients.[44] Most injuries to staff were minor but occasionally they could be life threatening, news of which sometimes reached the local or national press.[45] Newspaper reports could reinforce and perpetuate stereotypes of dangerous lunatics who needed to be confined to asylums, alongside gratitude and admiration of the asylums and their dedicated staff who endured such treatment. Some staff lost their jobs following injury, such as a probationer nurse who sustained a detached retina after being hit by a patient because "the loss of sight to an eye precludes the employee from being an efficient nurse".[46] Another nurse was too nervous to return to work after a patient injured her ear. She sought compensation, for which the asylum was liable under the Workmen's Compensation Act 1897.[47] No details are given of the ear injury, but "compensation neurosis" or "trauma neurosis", was recognised pre-war, including minor physical injury triggering mental symptoms which recovered on securing a financial settlement.[48] In contrast, the psychological consequences of physical abuse of patients appeared to be disregarded.

Louise Hide commented that it was impossible to quantify how often physical altercations occurred on the wards, among patients, between patients and staff, and among staff. Minor incidents which were resolved at ward level were unlikely to reach the ears of the VC, let alone the Board.[49] Nevertheless, the Board admitted to having to deal with allegations of brutality inflicted by attendants "almost daily and sometimes had to prosecute."[50] This comment was made in the context of the Board's response to concerns about asylums practices which Leonard Winter, a temporary wartime attendant, had raised with the Society of Friends and

the National Council for Lunacy Reform. The response indicated that the Board knew about ill-treatment and that it proposed disciplinary measures, a "bad apple" approach, removing individual staff who were considered undesirable in order to prevent spread of sub-standard practice to others.

Brutality towards vulnerable individuals was (and is) never acceptable, but if "almost daily" meant five times in a working week, that amounted to 250 incidents a year known to the Board affecting an asylum patient population of 100,000. This estimate may be the tip of the iceberg, but it also fits with anecdotal evidence given by former patients to the Cobb Inquiry into asylum practices. They described their attendants' behaviours in a variety of ways which suggest that physical abuse was neither an inevitable nor daily part of a patient's asylum experience. One patient recalled that he "never saw the attendants use more force on a man than was absolutely necessary for the way the man was acting".[51] Another described them as "decent Englishmen who do their best for everybody".[52] Others noted variable degrees of benevolence:

> some I found good,…did what they thought best for the patients; they are the salt of the institution. Then there is a second class who…do as little work as possible and do anything to make it a comfortable job.…And the third class, who are frankly brutal.[53]

The middle group were the majority, more likely to demonstrate "indifference and callousness" rather than malice.[54] Overall, it appears reasonable to conclude that most patients were not physically victims of brutality most of the time. However, it is harder to be conclusive about the extent of the emotional harm caused to them by experiencing, witnessing or hearing about abuse. It is still harder to determine the frequency of non-physical bullying and infringements of human dignity, such as bad language from staff ("I heard more filthy language in the asylum than in the slums of Liverpool and London"[55]). Bad language was unlikely to have been used in the presence of seniors and left no visible scratches or bruises.

Broken Bones and Cauliflower Ears: Facts and Fictions

In the contested narrative of harm to patients and the reputation of asylums, theories of fragile bones, haematoma auris (popularly termed "cauliflower ear") and status lymphaticus (discussed in Chapter 3) emerged to explain injury and sudden death. For two of the conditions, Latin names added authority; fragile bones did not acquire one, probably because "fragilitas ossium" was already used to describe a hereditary syndrome which presented in childhood.[56] Injuries sustained by patients demanded explanations which, from the perspective of staff and leadership, preferably laid the responsibility for them on patients rather than staff. Scientific theories assisted with this.

Emerging concepts of accident proneness and hypotheses that insane patients had generally fragile bones gained ground in the late nineteenth century, helping to deflect blame from staff accused of heavy-handed restraint or deliberate injury to patients.[57] Well-reasoned explanations, at a time of enthusiasm about scientific medical breakthroughs, could convince professionals and public. The fragile bone hypothesis was timely, coinciding with other discoveries about bone abnormalities, such as the effects of poor diet and lack of sunshine,[58] but distinguishing between science and supposition was tricky, partly due to research and statistical methodology. Not all authorities concurred that asylum patients had fragile bones.[59] Charles Macnamara, a medically qualified polymath writing in the late nineteenth and early twentieth centuries, was unconvinced by fragile bone theories accounting for injuries. His investigations into bone strength failed to identify anything to support increased fragility compared to sane people of the same age:

> It seems to me more probable that when several of the ribs are found to be fractured during life, or after death, in the case of lunatics, it is not impossible that the injury has been caused by the attendants kneeling on the patients' chests to keep them from moving [and it was] just as likely to happen…to a person in sound health as to one in an insane condition.[60]

Psychiatrist Lionel Weatherly also expressed scepticism of the fragility hypothesis alongside outrage about insufficient penalties imposed on attendants found to have broken a patient's ribs. He remarked scathingly: "We have Societies for the protection of children, cats, dogs and horses;

they are sent to prison. We find an attendant is fined £2 for breaking the ribs of a patient".[61] One late-nineteenth century newspaper report proposed that, in the absence of direct evidence of any other cause, asylum deaths associated with rib fractures should incur an automatic manslaughter charge against the attendant.[62] Jennifer Wallis commented that the Scottish physician, William Lauder Lindsay, argued that the disappearance of mechanical means of restraint during the nineteenth century had increased the risk of injury due to attendants single-handedly trying to restrain patients or convey them into a seclusion room.[63] Lauder's conclusion was cited by a colleague in France: "if England *is* the country of non-restraint, it is also the country of broken ribs".[64]

Regarding training for medical students and doctors in the subject of fractures and other injuries associated with insanity, one textbook of psychiatry which discussed physical conditions to which insane people were considered liable, mentioned neither fragile bones nor haematoma auris.[65] Similarly, some general textbooks of medicine and surgery did not mention them.[66] Other textbooks, such as Norman Barnett's surgical compendium, warned that "Lunatics are subject to fractures without marked cause, attendants often being wrongly blamed for having caused them." It gave reasons why asylum patients might have fragile bones, such as tuberculosis and syphilis.[67] However, neither caused generally fragile bones, and their circumscribed lesions were rare in ribs and would have been detectable at post-mortem.[68] Overall, there is little evidence that tuberculosis or syphilis would have accounted for the frequency of fractures.[69] Later, Edward Hare, a mid-twentieth century psychiatrist, recalled his experience of working with patients with brain syphilis (general paralysis of the insane, GPI): he "never met one with fractured ribs and [did not] recall reading or being told that this was a complication to be looked for."[70] If rib fractures were even a rare direct complication of GPI, it is likely that some echoes of them would have continued to appear in textbooks as something about which practitioners should be aware. More likely, GPI caused disturbed behaviours which made the patient liable to excessive force which was used punitively or during manual restraint by insufficiently trained and exasperated staff.

It is hard to believe that the deaths of Henry M at Portsmouth Asylum, attributed to a fracture of the wrist, or of Lucy R at Bristol, with a fractured forearm following a struggle with a nurse, told the whole story.[71] These relatively minor injuries were unlikely to have been fatal, unless complications ensued, such as untreatable infection. Should that have

happened, it is likely that staff or VCs would have referred to it as an exonerating factor. The practice of not informing the asylum doctor about an altercation soon after it happened, plus reduced numbers of post-mortems during the war, may have resulted in only obvious injuries being recorded and more serious internal injuries remaining undetected. The fragility hypothesis allowed VCs to acknowledge that struggles took place between patients and staff, but to draw the conclusion that injury was due to physical vulnerability associated with insanity, and that the force used was appropriate to the degree of disturbed behaviour caused by their mental state.[72] The Board probably over-trusted VCs' analyses about injuries and failed to probe objectively. If a VC set out a convincing case, coroners tended to concur, recording a verdict of death by misadventure rather than manslaughter.[73]

Haematoma auris was another condition directly attributed to insanity. As Russell Barton, a medical superintendent in the 1960s, described:

> when I introduced the course for senior charge nurses I explained to them the curious condition known as auris haematoma, which was a big red swelling of the ear which usually occurred a little while before the patient died, and it was thought to be the blood pushed out of the brain. And so I explained this…
>
> the big market where they sold cattle and stuff. You see when they move a calf from one stall to another - 'e don't go calm like! So ya' grab 'im ba' the ears and ya pull 'is tail and then e's gotta go where ya' push 'im – and 'e does!
>
> And of course it immediately rang a bell.[74]

Haematoma auris occurred more commonly on the left than the right, suggesting that it was caused by the right hand of a person facing the patient and giving a blow, or using that hand to lead them by the ear. Hare explained that the disorder was most common in patients with the most disturbed behaviours. He referred to one asylum where attendants were held responsible for it and the condition disappeared.[75]

True accidents could happen, manual handling of patients could be inadvertently harsh, but excessive force could also be applied deliberately, disproportionate to the patient's needs. Too often the leadership turned a blind eye to the possibility of malicious injury. Medical-scientific explanations attributing injury to a patient's inherent predisposition were acceptable to public and professionals and allowed the asylum leadership to exonerate staff, reassure the public of the adequacy of the care

provided, and preserve the reputation of their institution, even when treatment was detrimental to the patients.[76]

Escapes

Patients discussed how to escape from asylums. At Hanwell, rumours were rife that the easiest way was to take advantage of low lighting levels at night while the main door was unlocked in order to enable evacuation in the event of a direct hit in an air raid. Only one patient, Alice B, was reported to have escaped this way, almost two years after the unlocked door policy began.[77] Montagu Lomax discussed issues around escape and patients' freedom of movement, noting that in some mental hospitals in other countries, many patients had "parole" of the grounds. Patients with parole seldom abused the privilege and, as at Hanwell, unlocked doors did not equate with attempted mass exodus. Lomax argued that the freedom of parole was "a restorer of hope and self-confidence to minds sadly in need of both" and that "It is not those patients who are most trusted who attempt to escape, it is those who despair of ever getting out, and who are reckless in consequence."[78] Lomax agreed with Mary Riggall, that patients on parole felt their discharge imminent so did not want to endanger its realization. In her own case, she was aware that any actions deemed misbehaviour could be misconstrued as part of her insanity and jeopardise her discharge, so she decided against trying to escape.[79]

The term "escape" was used in the Lunacy Act 1890 which stipulated:

> If any manager, officer, or servant of an institution for lunatics wilfully permits, or assists, or connives at the escape or attempted escape of a patient, or secretes a patient, he shall for every offence be liable to a penalty not exceeding twenty pounds nor less than two pounds.[80]

The Act also required an asylum to search for its missing patient for 14 days, after which time, if still at liberty, the patient was declared not insane and could no longer be detained under the original order.[81] Without outside help, such as advice, plans or money,[82] dressed in asylum clothes, almost penniless, and miles from home, a successful escape suggested that the patient was desperate alongside having courage, ingenuity and organisational skills. One patient climbed down a ward stack-pipe after throwing his bundle of clothes outside, another removed a window pane and lowered himself to the ground on knotted sheets.[83]

Mr. K helped his wife Elizabeth to escape, by walking out from Colney Hatch with her at the end of visiting time. He posted her asylum-owned clothes back to the asylum from Peterborough, with an address-less covering note explaining that she was doing well.[84] Possibly inspired by Elizabeth's success, two months later, Bertha B absconded with her visitor. She too went to a secret location.[85]

Some escapees were "recaptured", a word usually applied to criminals or animals, with language reinforcing notions that patients were dangerous.[86] Napsbury noted that of its eight escapees in 1914, four were recaptured within the 14-day time limit.[87] Often, a local person, sometimes a child, brought them back. Local people accepted the patients as needing help, although the expectation of a half-a-crown (12½p) reward might have encouraged them to assist. A sympathetic local acceptance of asylum patients was inconsistent with a more negative wider public understanding about them. VCs, however, had different concerns when patients escaped: one VC was less bothered about the escapee's wellbeing than about the asylum clothing he wore at the time, listing each item, including under-garments, which would have to be replaced.[88]

Escapes from asylums were uncommon, the Board's data indicating that a dozen or so of 100,000 detained patients escaped each week.[89] During the war, one medical superintendent commented that it was "extraordinary that accidents and escapes are so few in number seeing that our temporary staff are by no means in the prime of life, many in fact are elderly".[90] In addition to using the term "accidents" to mean "injuries" which the authorities deemed to be accidental, the statement indicated that asylums preferred to employ younger staff, partly because of their physical abilities. This gives insight into the leadership's perceptions of acceptable ways of managing disruptive patients. The possibility that older male staff, or women nurses working on male wards, could use non-physical methods successfully to manage disturbed patients, received little consideration. Neither did the low rate of escapes prompt an honest review of the feasibility of unlocking more doors. In the conservative and risk-averse culture of the asylum leadership, the easiest course was to not ask too many questions or make suggestions which might rock the boat. Occasionally, an escape ended in suicide,[91] an outcome which the authorities could use to further justify their caution.

Suicides

Before the war, the suicide rate for England and Wales was approximately one in 10,000 of the general population (all ages), about 3500 people a year.[92] In 1914, of around 100,000 patients certified under the Lunacy Act, there were 34 suicides nationally, about three in 10,000.[93] Twelve of these took place after certification, mainly in workhouse infirmaries, before transfer to an asylum.[94] Two occurred when on trial leave and two after escape, leaving 18 who were patients within the asylums at the time,[95] a figure little more than in the general population outside.

If asylum suicide rates were as low as reported, we need to understand how people of high risk of suicide were managed in the asylums. Anne Shepherd and David Wright's study of two asylums to the west of London revealed that between one quarter and one third of patients were classified as suicidal on admission. Vigilance was the main treatment, or sedation, particularly in understaffed asylums.[96] Mercier advised that "a suicidal patient must never be allowed out of sight" although the Board disputed this, recognising that a balance had to be achieved as constant supervision could also be detrimental to recovery.[97] Some of the practical aspects of observing patients were discussed in Chapter 6, such as the absence of doors on lavatories. However, to facilitate observation, adequate communication between staff was essential, as in the case of Mrs. I. To this end, asylums were expected to implement a standard procedure. Each "suicidally disposed patient" would have a separate "caution parchment" which the staff member responsible for observing the patient was expected to read, understand and sign, handing it on to the colleague taking over at the end of the shift or if the patient was moved to another location.[98] Textbooks also provided valid advice: if the patient was melancholic, "Favourite hours for suicides to make their attempts are the early hours"[99] and "the experienced nurse is always suspicious of the happy smiling face that conceals a heavy heart. Be especially watchful over such patients and also over convalescent patients".[100]

Suicide and "attempted suicide" were criminal acts until 1961.[101] This legal status could lead to concealment of the act, which could not only affect statistics, but more importantly would impact on the help sought by and offered to distressed and despairing people. The criminal designation of attempted suicide meant that the Home Office delegated to the police the responsibility for ensuring that the offence was not repeated. The police did not want this responsibility and considered it a medical duty;

the asylums did not want the person if they had physical injuries; neither did the general hospitals, on the grounds that they lacked the skills to calm a disturbed patient. These disputes about responsibility overlapped with financial concerns, as close observation was also costly.[102] Each organisation tried to pass the buck and responded in a way which was detrimental to the wellbeing of the troubled human being who required help.

In contrast to the police view, William Norwood East, a forensic psychiatrist during the war years, regarded conviction for attempted suicide as an effective way to secure appropriate treatment: for people not sufficiently insane to be certified, a prison hospital could provide rest, good food, quiet, and medical attention. It also provided a fixed period of detention, unlike Lunacy Act certification which risked an indeterminate period in an asylum. Once a prisoner, a second court appearance would precede release, allowing review of the situation. Another advantage was that more philanthropic resources were available to criminals released from prisons than lunatics discharged from asylums, including material assistance and help to secure employment.[103] This philanthropic provision fitted with Jose Harris's analysis that "late Victorian lower classes preferred to be thought bad rather than mad",[104] and that for the suicidal person and his family, a criminal record balanced favourably against the stain of lunacy certification. According to East, very few of those convicted returned except for malingerers and alcoholics, suggesting successful interventions, although other outcomes, such as suicide or death from other causes, rather than improvement in mental wellbeing, could have contributed to his statistics.[105]

The rehabilitative role of prison hospitals, as East advised, was compatible with other theories, notably those of Émile Durkheim who viewed suicide as a social, rather than psychiatric issue. Durkheim was reluctant to accept psychiatrists' claims that most instances of suicide were a consequence of insanity, an opinion based on their experience in the asylums with limited professional responsibilities in the wider community.[106] Durkheim regarded suicide as a social phenomenon, due to the interaction between the actor and society. He argued that each society had a collective inclination towards suicide and that, despite looking like a highly individual and personal phenomenon, suicide was explicable through social structures and functions.[107] This hypothesis fitted with lower suicide rates internationally during the war, a time of intense emotional pressure together with greater social cohesion.[108]

Although in the community attempted or successful suicide was designated a criminal act, within the asylum the rule of law focused on staff in immediate charge of the patient.[109] For those staff, William Stoddart spelt out a terrifying image of the worst scenario:

> a suicide in an asylum is regarded throughout the lunacy world as more or less of a disgrace, and the staff of a particular institution is in a state of depression and anxiety for days or weeks after the occurrence, even among those who did not know the patient. [Should a member of staff's] carelessness lead to such a catastrophe.…[he] is discharged from the asylum without a character and reported to the Board of Control, which enters his name in a black book, so that he may never more be engaged in mental nursing, and he is prosecuted in a court of law for criminal carelessness, and may be sentenced to a term of imprisonment.[110]

In contrast, even when a VC failed to implement the Board's safety recommendations to prevent suicide,[111] the leadership was not implicated directly or likely to be prosecuted. The onus fell on the staff of the lowest ranks who interacted with the patients face to face.

Conclusions

Ward staff were undervalued as individuals, paid at the level of unskilled workers and had little training in therapeutic methods. They were expected to work in a pressurised and stressful, overcrowded and understaffed, almost impossible situation, under an authoritarian regime where seniority was seen to equate with superior personal attributes. The style of leadership induced distrust between lower ranks of the workforce and their masters who also had the right to dismiss them summarily, for disobedient, or otherwise aberrant, behaviours. These systemic tensions prohibited lower ranks from verbalising their workplace difficulties to those in authority. If work became intolerable, the emotional fragility, vulnerability and frustration of staff could be expressed physically, typically against those with even less power than they themselves had. Expressing one's emotions in this way has acquired different labels at various times, from "kicking the cat" to "Munchausen's by proxy" and "displaced aggression".

According to Lomax, attendants failed to make patients their prime concern:

> It is the injury to themselves that most attendants are thinking of, much more than the possible injury to the patient….I don't suppose an attendant really cares twopence if a lunatic commits suicide or escapes, provided the blame for either cannot be brought home to himself.[112]

Within the asylum's hierarchical management structure, staff at the same level would rely on each other for support, including concealing, and thus perpetuating, each other's misdemeanours. The Board indicated that it knew about asylum rough handling, but apart from taking disciplinary measures it did not identify systemic problems which might require attention. Punishment of staff was used as a deterrent and to weed out supposedly "bad apples" to prevent contamination of the batch. The "resignation" or dismissal of the accused staff member appeared to satisfy the Board that the VC had done its duty, and the Board did not probe matters further.[113]

The asylum leadership demonstrated to staff that harsh and punitive methods were acceptable to control people considered to be of lower status if their actions deviated from what was expected. Rigid discipline, obedience and punishments, may have been exaggerated during the war, reflecting a more military style leadership. However, military methods which fostered discipline and taught aggressive tactics were unlikely to nurture kindness, emotional support and respect of the sort required in healthcare institutions with the objectives of providing, in the words of the Lunacy Act, "care and treatment". The Board, like the VCs, did not link harsh practices to their own authoritarian management style, but at its worst, the patients and ward staff had to cope with a punitive system characterised by a sanctimonious leadership, dysfunctional communication, distrust, dishonesty, secrecy and fear.

Notes

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11. Colney Hatch LCC/MIN/01007 Meeting, 9 August 1918, 131 LMA.
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18. Colney Hatch LCC/MIN/01006 Meeting, 18 May 1917, 179 LMA.
19. Hanwell LCC/MIN/01096 Meeting, 26 February 1917, 324–25 LMA.
20. Hanwell LCC/MIN/01093 Meeting, 27 April 1914, 189–90; Colney Hatch LCC/MIN/01003 Meeting, 4 December 1914, 198 LMA.
21. Mercier, *Attendant's Companion*, 2.
22. Anon. "London Gossip," *North-Eastern Daily Gazette* (Middlesbrough, England), 3 March 1887.
23. Colney Hatch LCC/MIN/01001 Meeting, 7 November 1913, 309–10 LMA.
24. Colney Hatch LCC/MIN/01002 Meeting, 21 November 1913, 12 LMA.
25. Hanwell LCC/MIN/01093 Meeting, 6 July 307–8 LMA.
26. Hanwell LCC/MIN/01094 Meetings: 20 July 1914, 10; 14 September 1914, 59–60 LMA.
27. John Collie and Arthur Spicer, *Malingering and Feigned Sickness* (London: E Arnold, 1913); Hanwell LCC/MIN/01094 Meeting, 26 October 1914, 103–4 LMA.
28. *First Annual Report of the Board of Control, for the Year 1914* (London: HMSO, 1916) (*BoC AR 1914*), Part 1, 28.
29. Colney Hatch LCC/MIN/01001 Meeting, 9 May 1913, 75–79 LMA.

30. Lunacy Act 1890 sections 322–24; BoC W/FM 17 March 1920, 80 MH 50/48 TNA.
31. Lunacy Act 1890 section 322.
32. Colney Hatch H12/CH/C/04/004 Male attendants' wages book 1917–1918 LMA.
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Conclusion

Then and Now

The past has continuity with the present and the future. The present can assist in formulating questions to help investigate the past, and the past can shed light on current policy, practice and culture, and inform debate on future health services.[1] Iron shackles and chains, once used to restrain mentally disturbed patients in asylums in England, were replaced by leather and strong cloth many years before the First World War. Today's shackles and chains are metaphorical, like heavy-duty polymer threads, nearly invisible but resistant to breakage. They limit the lives of people with severe enduring mental illness who live in the community. They also tie government, public and professionals to concepts and values from the past, such as the acceptability of resourcing mental health and social care services which barely reach the levels needed, and rarely exceed them. Threads also link research challenges past and present: neuroscience has still not disclosed answers to allow us to prevent or cure schizophrenia, bipolar (manic-depressive) and other disabling psychiatric disorders, despite an ever-increasing grasp of their underlying causative mechanisms. These age-old challenges continue to spur on researchers, to overcome obstacles and to achieve scientific, pharmacological and clinically significant breakthroughs. Psychiatrists and others supporting patients over the last century have worked amid ongoing clinical and scientific uncertainty. They have aimed to identify the best pathways to

alleviate their patients' suffering while grappling with shifting concepts, hypotheses and disease classifications, in the context of practice shaped by national and local events and government policy endeavours. Historians and clinicians need to be wary of disparaging our forebears' practices and understanding of scientific evidence through our lens of hindsight, just as we hope that future generations will analyse dispassionately the strengths and deficits of our less than perfect knowledge and its clinical application.

Other continuities bind past and present. Asylums had walls of stone, bricks and mortar and patients lived communally in barrack-like buildings segregated by gender. The system of community care since the asylums closed lacks physical walls, but metaphorical ones exist. People with severe chronic mental illness today have more privacy, personal autonomy and independence than those a century ago, and many respond well to new medical, psychological or social treatment approaches. But many are unemployed, have poor physical health, receive inadequate social welfare payments and insufficient support from suitably trained staff, and are separated from their families and from broader community involvement. Asylum care had, and community care has, downsides and upsides. Both need to be understood in the distinct cultural frameworks of their times and in the broader context of societal values, including about institutions, illness, treatment, care, autonomy, independence, risk and protection.

The Board of Control ("the Board") and some individual psychiatrists, notably Charles Mercier, William Stoddart and Lionel Weatherly,[2] advocated gold standards of humane treatment leading at best to recovery, otherwise to a fulfilling life for those with the most severe chronic mental disorders who were unable, according to clinical reasoning and lunacy law at the time, to leave the asylums. Best practice was recognised, but emulated insufficiently, and asylums spanned a range of standards from admirable to appalling, as community care does today. Despite shared ideals between the asylums and community care, particularly the importance of people with chronic psychiatric disorders having as near normal lives as possible, some constructive asylum practices have been lost in the community care system. To take the example of employment: paid or unpaid meaningful occupation has long been considered helpful in the context of mental disorders to build confidence and self-esteem and improve health and wellbeing. In praiseworthy asylums up to 90 per cent of patients were engaged in some sort of daily work in 1914[3] which could be linked to the skills they acquired pre-admission.[4] By comparison, in 2013, when the UK working-age employment rate was 71 per

cent,[5] only 10–15 per cent of people with schizophrenia were in employment although many more could, and wanted to, work.[6] This is a modern tragedy.

By the First World War, model asylum practices embracing humane and individually focussed psycho-social treatment had waned and care had become increasingly custodial, but even then, patients recovered and were discharged. Asylums were too often overcrowded, understaffed, unhygienic and warehouse like. This social warehousing was a consequence of long-term legal and financial constraints linked to values, knowledge and attitudes of professionals, policy leaders and the general public. Once it became accepted as normal, it perpetuated as a convenient way to proceed, unquestioned by most people. Similarly, when standards worsened, associated with wartime austerity, too often the state of affairs was accepted as the new normal and created little protest. When Lionel Shadwell, for example, inspected Claybury and noted high death rates, he was not alarmed as they were from "natural and ordinary" causes of the sort prevalent pre-war.[7] The continuation of pre-existing trends could be ignored, in contrast to the response when something unexpected appeared, whether shell-shock, or the Covid-19 pandemic as I write. Something new demands attention, but concurrently can expose the realities faced by vulnerable people living in deprived circumstances, whether pauper lunatics in the asylums of the past, or people living in poverty, or under community care, or in institutions today. At a time of crisis, long-lasting deficits temporarily become newsworthy.[8] The risk is that, after the crisis, in a period of reconstruction, the deficits fall back to their pre-crisis low priority. This happened to the asylums, perpetuating injustices and inequalities. We are yet to see what will happen after the Covid-19 pandemic.

The wartime asylums, and limitations of community care today, demonstrate provision of health and social care services which fail to meet the needs of many of those whom they are meant to serve. During the war, the asylum leadership waited as long as they dared, arguably too long, before asking for more resources to prevent deterioration in disastrously poor asylum standards. Today, despite admirable campaigning by patient-led groups, voluntary organisations, the Royal College of Psychiatrists and others, in the present climate of austerity the needs of some of the most seriously mentally ill people are side-lined.[9] Dangers exist when complacency prevails within a mental health service system, then

and now. As Adrian James wrote in his forward to this book: "Continued self-reflection and challenge are vital. We could still do so much more."

Leadership: Attitudes and Standards

At the beginning of the war, speculation and hope that victory would be within easy reach informed asylum planning. Decisions made on that basis for a short-term national emergency may have been justifiable, but as time went on without compensatory adjustments for the prolonged duration, the asylum environment became harsher. Food declined in quality and quantity; care was more custodial and less rehabilitative; fewer and less well-trained staff were employed, often on temporary contracts; and many patients were moved from their "home" asylum to other overcrowded asylums at a distance, to make way for military casualties. The Board claimed at the beginning of the war that compromises in the asylums would not be detrimental to patients' well-being. This did not hold.

Despite the Board "policing" the asylums, it only had authority to advise and persuade medical superintendents and "visiting" committees (VCs) to make improvements. Responses of VCs fluctuated, arguably associated with insufficient knowledge about health and illness and the full purpose and intricacies of asylum function. Their level of activity appeared to be that which was the minimum required to conform to the Lunacy Act or other mandatory or closely monitored directives. They frequently attributed inactivity to financial constraints, which became more burdensome associated with wartime price rises. The asylum system was torn between how it assisted with wartime objectives and how it provided for the patients' needs. For the leadership, the war took priority. It was simpler to demonstrate patriotism and to go with public and government sentiment, rather than advocate for patients who were not valued by society.

At all levels, staff defended and justified their decision making, or passed the buck up or down the ladder, deflecting responsibilities away from themselves. The Board passed its dilemmas to the Home Office, War Office, Ministry of Food and other Whitehall bodies. The VCs passed theirs to the Board or medical superintendent, or to lower ranks of staff, who passed their discontent onto the patients. Risk of dismissal deterred low ranks of staff from criticising the asylum,[10] and some took out their frustration on patients by "rough handling" them, and then justifying their actions as being reasonable responses to the patients' needs.

Theories about patients being inevitably unreliable due to their insanity, and being susceptible to physical injury, such as by having fragile bones, helped staff avoid punishment for their heavy handedness. Complaints made by patients concerning their care, or by their relatives on their behalf, were typically ignored, interpreted as signs of mental derangement. Patients who reported maltreatment were liable to retribution. For them, it came in the form of further physical or psychological abuse from the staff on the wards. If VCs paid attention to the complaints, investigations were likely to be undertaken behind closed doors within the institution by senior people with potential conflicts of interest.[11] Rough handling was not unique to the wartime asylums: abuse by staff in hospitals and other residential institutions caring for vulnerable people has continued through the twentieth century and into the twenty-first.[12]

According to Adolph Meyer, the "rigidly moralising attitude" of "Anglo-Saxon" communities aimed to regulate and remove, rather than understand, mental disorders.[13] Removing mentally disturbed people to asylums placed them out of sight and out of mind, minimising community conscience and public interest and any sense of responsibility towards them as fellow human beings. Removing them also assisted with concealing institutional inadequacies and revealing as little as possible to the public. Little external oversight, interest and communication enshrined the asylum system, protected the reputations of institutions and leadership, and added to public perceptions of stigma and fear of asylums, of insanity and of those suffering from it. Theories of degeneration or hereditary predisposition to insanity added to overall negativity (but did not necessarily deter doctors from treating patients so labelled). It is unsurprising, amid the secrecy, fear and negativity, that the Boards of Guardians, who took decisions on behalf of their local communities, were reluctant to pay more to the asylums for the patients' care.

In contrast to a rigid asylum management system, there was flexibility for clinical debate. In the context of scientific uncertainty and needing to evaluate the murky waters of neuroscience hypotheses and research, discussion and debate were strengths which could help ensure a diversity of approaches with no single new method of clinical treatment being able to dominate practice. It could, however, contribute to the leadership's over-caution and conservatism verging on complacency about making changes. Combined with paternalism, a preoccupation with budgets, obedience to higher authorities and to the lunacy legislation,

the style of leadership contributed to sluggish responses in the face of changing needs and circumstances.

The Board kept its head down, usually complied with demands from above and only rarely advocated for patients in its asylums. Despite some openness from the leadership about science and psychiatry, it is hard to conclude with a contextualised and respectful analysis of the asylum management system. It was secretive, self-protective, shady, patronising, rejecting of ideas from outside (except from seniority or science), censorious of staff lower in the hierarchy, and neglectful of patients, despite care and treatment of those patients being the stated rationale of the asylums.

Patients, Outcomes and Austerity

Providing appropriate individualised care and treatment was influenced by powerful stakeholders who held diverse values and objectives and too often cut corners and services. Ongoing frugality in asylum management culture was particularly evident in the context of competing priorities associated with wartime austerity. The wartime asylums were characterised by a decline in standards rather than a cliff-edge change. Many defects pre-war became increasingly hazardous as the war progressed. Food, nutrition, fuel, hygiene, overcrowding, understaffing, staff discontent, and medical attention to patients were some of the aspects which deteriorated. The result was disastrous from the point of view of patient wellbeing.

Clinical notes reveal severe mental and physical illness in asylum patients which caused much suffering and disability. Some people entered asylums with rapidly fatal diseases, some were discharged (whether or not fully recovered), and others stayed as patients until they died months or years later, too often from potentially preventable infectious diseases. Despite recent popular fiction featuring women incarcerated for no other reason than giving birth to an illegitimate child, this was rare.[14] Neither did asylums seek to admit people purely because they were socially "impossible, inconvenient or inept" to create "Warehouses of the Unwanted", as Andrew Scull described.[15] Some troublesome people were dumped by families who had done all they could and had reached a point of despair, coping with an impossible domestic situation with insufficient guidance and support, but this does not mean that the patients were "unwanted". Others were dumped from within the healthcare system,

particularly patients who had serious physical illness complicated by hallucinations, delusions and disturbed behaviours, likely to have been due to delirium.[16] Transferring these physically ill patients to asylums from other institutions, particularly workhouse infirmaries or general hospitals, was medically illogical. The practice reflected the ongoing attitudes of many non-asylum doctors, to get a "hopeless" patient, especially if perceived as senile or delirious, off their hands as rapidly as possible.[17]

Despite the total number of asylum patients declining, mainly due to high death rates and fewer admissions, overcrowding worsened, associated with more custodial care and fewer discharges, linked to reduced bed availability for civilian patients due to asylums being converted into war hospitals. The reduced admission rates were multifactorial, likely to have been associated with: greater social cohesion in the face of national adversity; reduced alcohol intake; some men being admitted without certification to military mental hospitals; and awareness by the magistrates and doctors who oversaw admissions that there were fewer beds and standards had dropped.[18]

As opposed to aiming for prolonged detention, discharging patients from asylums as soon as possible was vital, to vacate beds to allow admission of new, acutely unwell, patients. Around 40 per cent of patients were discharged within a year of admission in the late Victorian era, but this rate declined when asylums filled up with many long-term, chronically ill people, and custodial care replaced more active, individualised treatment. By 1918, the discharge rate had fallen by one third.[19] The chronic course of many severe mental disorders, insufficient rehabilitative treatment combined with the Lunacy Act's cumbersome bureaucratic discharge procedures, and an excessively cautious approach to determining whether a patient might still be dangerous to themselves or to others, all contributed to obstructing discharge. With vague disease classification, and the Board's annual report for 1918 preoccupied with causes of death rather than of admissions, it is not possible to determine whether there were any significant changes in the types of mental disorder for which patients were admitted (except related to alcohol intake) which might have affected outcomes during the war. From the evidence available, it is likely that overcrowding and understaffing worsened from their pre-war levels and did not allow sufficient therapeutic attention to promote recovery. Other factors which contributed to custodial batch-living, rather than active and rehabilitative treatment, included poor staff morale and questionable methods of placing patients on wards according

to their behaviours, for organisational convenience, rather than linked to identified cause, or likely treatment requirements, or expected prognosis.

There was also a lack of after-care. One argument used against providing it was that former patients would not want any assistance which might reveal their asylum admission and pauper lunatic status to their local community, as it might lead to them being ostracised. This opinion, from some of the leadership, was convenient and in line with maintaining the *status quo*, but the Mental After Care Association's (MACA) papers suggest that the argument was flawed. MACA's archives may be biased in their own favour, but they nevertheless reveal that patients valued MACA's support, and that the charity had to turn people away as demand exceeded means. Generalisations by the asylum leadership about patients' views revealed their own negativity and lack of understanding of insanity. Concerning after-care, even if a patient's judgement was assumed to be inevitably impaired while they were mentally unwell, by definition, at the time of discharge their judgement would have recovered alongside their sanity, and their views should have been attended to. Negative attitudes towards insanity, not listening to patients, and a persistent desire to minimise short-term expenditure, were hardly ideal qualities for management teams supposedly working in the patients' best interests.

The way in which the asylum authorities dealt with the rising death rate from potentially preventable infections is also disturbing. Guidance was circulated to asylums for over a decade pre-war, based on scientific and public health evidence about what ought to be tackled to minimise the spread of infections, particularly tuberculosis, but implementation was neglected. At the beginning of the war, the asylum annual death rate from all causes hovered around 10 per cent. In 1915 the Board showed no inclination to investigate when deaths had risen to an unprecedented high of 12 per cent (Table 7.1). By the end of the war the death rate was 20 per cent, with relatively little of that due to the influenza pandemic. The general population, despite poverty and hardship, did not suffer the high rates of infectious diseases of patients in the asylums, before or during the war. The huge peak of tuberculosis deaths in the wartime asylums was multifactorial,[20] but included neglect.

Overall, patients suffered not just because of the disorders which led to their admission but because of the way the institutions were managed before and during the war. No doubt many people did their best, despite ambiguous science for mysterious and frightening mental disorders which often ran a chronic course. However, the leadership's negative attitudes

towards the people they were meant to serve, and, among other things, their rigidity, complacency and penny-pinching, impaired their patients' health and wellbeing, with death rates from preventable disorders far in excess of those in the community. Fighting the war was a necessity, but it is questionable whether the degree of asylum neglect was necessary, justifiable or compatible with basic principles of medical ethics.[21]

Failure to prevent and treat physical disorders suffered by mentally unwell people was not just a feature of the Edwardian era and the First World War: it happens today. As a century ago, diet, lifestyle and late diagnosis of physical disorders continue to contribute to inequalities in life expectancy for people with serious chronic mental illnesses.[22] The physical disorders in 2020 are primarily cardiovascular disease and diabetes,[23] different from those a century ago. It is conceivable, as some of our forebears argued, that people with severe mental illnesses also have a biological susceptibility to life-shortening disorders, but it is unlikely, as the types of disorders over time are so different. It is more likely that the acquisition of the various physical problems were, and are, associated with poverty, deprivation, lifestyle and other external risk factors, whether in the asylum or community. In 2018, a study of physical health problems in people with bipolar disorder and schizophrenia concluded that the mortality gap between them and the general population was widening.[24] There is recognition that people with these mental disorders can benefit from support to make healthy lifestyle changes,[25] but during the last decade of austerity, the increasing mortality gap suggests that resources are insufficient or ineffective. It is disturbing that any parallels can be drawn between the potentially preventable physical diseases experienced in First World War asylums and in mental healthcare in 2020.

Making Change

Public support for mentally disturbed soldiers was heartening. It initially helped the soldiers receive more dignified standards of care than those provided for mentally disturbed civilian patients, and it had the potential to encourage good care for all patients with mental disorders. During the war, public support extended to civilian patients as far as assisting the London County Council to change the designation of its institutions from "asylum" to "hospital".[26] This was an important symbolic step towards how the leadership intended the asylums to function, as well as indicating the effect which the public could have on the authorities for

making change. Public opinion, however, was not always welcome: in the judgement of those in authority, including the Board, trained personnel with scientific, clinical and legal knowledge already knew what to do and how to do it.

Shell shock reinforced earlier understanding that mentally disturbed people could recover and that benefits could be derived from early treatment, although the Lunacy Act obstructed that for civilians. Shell shock also encouraged new psychological methods of treatment, but those were only accessible to people who could afford private care because they required staff time, impractical in overcrowded and understaffed asylums. Having shell shocked patients in the asylums highlighted inadequacies of provision for their civilian counterparts, but the soldiers' special status, clothing and privileges also caused problems. These could detract from plans to improve the lives of civilian patients, such as by the gambling, jealousy and theft associated with soldier patients receiving half-a-crown a week, discouraging the authorities from introducing cash remuneration for working patients. This study points to the importance of pre-war ideals and psycho-social, cultural, administrative, financial, clinical and other factors arising from inside the civilian asylum system during the war, as slowly, but erratically, leading to changes in asylum culture and practice. Post-war, rather than changing asylums for the better, shell shock was swallowed up into it, with many long-term civilian and soldier patients treated similarly, side by side in the asylums.[27]

Reduced asylum bed occupancy after the war, particularly when the war hospitals began to revert to their pre-war use, diminished any sense of urgency to provide more or better facilities or to expand services, such as after-care, to meet civilian patients' needs. Post-war inflation also detracted from improving standards in the asylums. The cost of treating a patient in an asylum in 1921 was more than double that in 1914, necessitating lifting the Lunacy Act's cap on charges payable by the Boards of Guardians.[28] This rise mainly covered costs of higher staff salaries, reduced hours of work, and improved working conditions. Undoubtedly, these measures had the potential to improve care for patients. However, that was not their purpose. They were a response to the National Asylum Workers' Union (NAWU) campaign since 1918, cotemporaneous with the increased influence of trade unions on workers' lives. Spending more of the asylum budget on staffing risked reducing the amount spent directly on patients.

The Board was initially ambivalent towards establishing a Ministry of Health, partly as it was concerned about protecting its own role. Nevertheless, it eventually welcomed its transfer, and that of the asylums, from the Home Office to the new Ministry in 1919.[29] The Board reasonably expected the move to help "dispel prejudices which often arise against Lunacy authorities and administrations, and which often affect injuriously, patients under treatment or even after recovery."[30] Whether it did that, or to what degree, is outside the scope of the present study, but the move brought mental and physical illnesses closer together for administrative purposes. Alongside changing "asylum" to "hospital", it was another important step on the long path towards "parity of esteem", to fund services for people with mental and physical illnesses in proportion to the morbidity which they cause, a goal still not achieved.[31] Despite the move to the new Ministry, other branches of healthcare—public health, maternal and child health, medicine and surgery—remained priorities on professional, public and government agendas, as judged by recurring themes in the *Lancet*[32] and the concerns of the Reconstruction Committee. In 1920, the Minister of Health, Christopher Addison, introduced a bill into parliament covering a diversity of health-related needs, one of which was to permit voluntary admission to public asylums. The bill was rejected by the Lords, much to the disappointment of the Board.[33]

A tricky situation was that the Board only had the authority to recommend change rather than to enforce it. The Board suggested, cajoled, named and shamed, and used any other technique it could to persuade asylums to raise standards. Tactics of persuasion could succeed but were most likely to do so with the most motivated. Too often, the Board's informal approach, trusting the VCs and medical superintendents to do what was asked in the interests of the patients, did not work. The Board, for example, had repeatedly prompted the VC at Prestwich to replace patients' earth closets with water closets. This was only implemented when the deficit came under public scrutiny at the Cobb Inquiry in 1922, as a result of Montagu Lomax's book about his wartime asylum experiences.[34]

Witnesses at the Cobb Inquiry revealed many defects in asylum care, treatment and facilities, but the inquiry report concluded that "the care and treatment of the insane is humane and efficient" and "compares favourably with that in any other country". The first of these statements is incompatible with much evidence presented at the inquiry by former

patients and lower tiers of staff. The second is relative and raises questions about how it was derived, since the inquiry did not evaluate international evidence. Notwithstanding the report's reassurance, it also stated that there were "certain directions in which improvements and developments could be effected with advantage. It is of course obvious that these would involve increased expenditure", for which the community had responsibility.[35] It was good that Cobb acknowledged the importance of the public for making changes, but it was unfortunate that the country was in the midst of a financial crisis and that greater involvement would require major organisational and culture shifts by the public and the leadership, neither of which were on the horizon.

Cobb's report was not alone in its pattern of negating evidence from patients and lower ranks, reassuring the responsible authorities of the adequacy of their leadership, and then countering its own conclusions by arguing for improvements. In particular, it resembled the responses of the committees of inquiry into the *Sans Everything* allegations of scandalous care of elderly people in National Health Service long-stay geriatric and psychiatric wards four decades later.[36] Ultimately, the *Sans Everything* inquiries led to many improvements. Similarly, follow-up of the Cobb Report included a Royal Commission which led to the more patient-focussed Mental Treatment Act 1930.[37]

Forty years after the Lunacy Act and 25 after the first parliamentary attempt to reform it, the Mental Treatment Act permitted early and voluntary admission to the mental hospitals in line with long-term psychiatric understanding of its likely health benefits. This achievement and its implications meant that, more directly than psychological and clinical understanding derived from shell shock or from research into psychiatric disorders, Lomax's book stimulated processes which ultimately liberalised rules on admission and shaped treatment for patients in mental hospitals across the country.

Final Word

It is easy to imagine a nurse or attendant a century ago expressing sentiments similar to those of an anonymous mental health nurse in the *Guardian* in 2019:

> I'm a mental health nurse. There are no good decisions, only least bad ones. I often feel I'm letting my patients down, but I do this job because

> I believe in the healing power of small acts of kindness…. My day off. I go to the pub and see my friends, who make effort to give me space to talk about work. My answers are scant, because it would drain us all to go into detail, and I just want to enjoy my pint. I work in close proximity to so much suffering that I can never quite find the language to explain it all.[38]

Despite the problems in the asylums we must remember much care and many kindnesses. Kindness from staff members was assumed so it was not noteworthy. It was rarely mentioned specifically in official records, only coming to light in the context of some other pressing matter. Within the asylums we know about Nurse H's remorse for injuring Edith B, compassion shown to Louise F at Claybury, Eliza Maidman's loyalty to her asylum, and acting medical superintendents Guy Barham and Alfred Daniel who spoke up to provide better treatment for their patients. Colney Hatch sought to provide for the religious, language and cultural needs of the East End Jewish community, Belgian refugees, prisoners of war and others. Some patients had a sense of community with meaningful relationships within their asylum home, and maintained strong bonds with their families.

Outside the asylums, the Home Office refused permission to deport Mayer L, MACA pioneered individualised rehabilitation programmes, parliamentarians in both Houses challenged the government about inadequate provision for civilian patients with mental disorders, and Mercier, Stoddart, Weatherly and others advocated forcefully and repeatedly for humane and therapeutic treatment and lunacy law reform. We must be grateful too to the lower ranks of staff and the patients who stood their ground to say what needed to be said, especially at the Cobb Inquiry, and to a handful of patients, such as Mary Riggall, James Scott and Rachel Grant-Smith, who revealed their personal stories of asylum life, good and bad, with a view to encouraging change for the better.

Notes

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