KAMIKA TANEJA

WARTIME ASYLUMS

A HISTORICAL PERSPECTIVE (VOLUME 1)

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Understanding Civilians, Lunacy and the First World War

Britain declared war against Germany on 4 August 1914. For the next four years military priorities overrode those of civilians. The entire population faced hardships, but for those people designated "pauper lunatics" in public asylums, life became very harsh. At the beginning of the war, the asylums were a story of good intentions gone awry, the failed dreams of social reformers and psychiatrists. They had become "vast warehouses for the chronically insane and demented."[1] Richard Hunter and Ida Macalpine, in their history of Colney Hatch Asylum, commented about the gloomy picture: "Custodial care was forced on asylums as a way of life….paralysed by sheer weight of numbers of patients" and financial constraints.[2] "Nothing", they said, showed "more blatantly how relentless pressure for more and more beds forced the asylum further and further away from the idea of a hospital."[3]

Public lunatic asylums in England and Wales changed in the decades before the war, arguably for the worse. Reflecting Hunter and Macalpine's dismay, earlier good intentions such as implementing "moral treatment", a social intervention involving trust, sympathy and group activities, alongside good food, fresh air, occupation and exercise, disappeared, even though the approach benefitted patients with reversible disorders of recent onset and those chronically unwell on long-stay wards.[4] Alongside moral treatment, principles of "non-restraint" were valued, but not uniformly implemented. Both these methods were effective and gained

prominence in smaller institutions through the work of enthusiastic lay leaders, such as the Tuke family at the Retreat in York, and medical leaders such as John Conolly at Hanwell and Robert Gardiner Hill at Lincoln. The methods worked less well in larger asylums, and never achieved widespread implementation, remaining as an ideal rather than reality.

Many other aspects of the asylum changed, influenced by stakeholders with different opinions, including doctors, lawyers, social reformers and the general public. Sometimes they agreed on priorities, but often not. The role of the medical profession became more dominant, in part due to legislation which stipulated that every institution of more than 100 lunatics must have a resident physician.[5] No other profession vied for the leadership.[6] New lunacy laws became more rigid and complex, tending to focus on the safety of the public rather than on the wellbeing of those suffering from mental disorders.

By 1870, public asylums had an average of 500 beds. Total annual admissions rose steeply after 1890, associated with the new Lunacy Act, but then stayed roughly in line with demographic trends (Fig. 1.1).[7] The death rate remained stable, but the discharge rate declined.[8] There is no evidence that the type or severity of mental disorders accounted for the changes. The increasing size of asylums, beyond that which could be accounted for by demographic changes, is likely to have been due to the decades-long mental disability caused by chronic psychotic disorders, such as schizophrenia,[9] accompanied by a changing balance of therapeutic interventions and custodial care. By the beginning of the war, in England and Wales, an average asylum had 1000 beds[10] and over 100,000 people were certified as pauper lunatics. Wartime shortages of staff and material goods, and overcrowding after the War Office requisitioned asylums to use as military hospitals, were associated with a calamitous fall in standards of care for mentally unwell civilian patients. The situation was a sad commentary on the low social priorities attached to people identified as suffering from mental disorders.[11]

A substantial historiography exists on “shell shock”, the syndrome of mental disturbances suffered by war-traumatised soldiers during the First World War.[12] By contrast, the historiography of civilian asylums and their patients at the same time is meagre, featuring in a few academic journal articles and chapters in some general asylum histories.[13] No in-depth historical studies have specifically drawn together the various elements of the story to provide a contextualised and detailed analysis, as this book sets out to do. It tells the story of four asylums on the periphery of

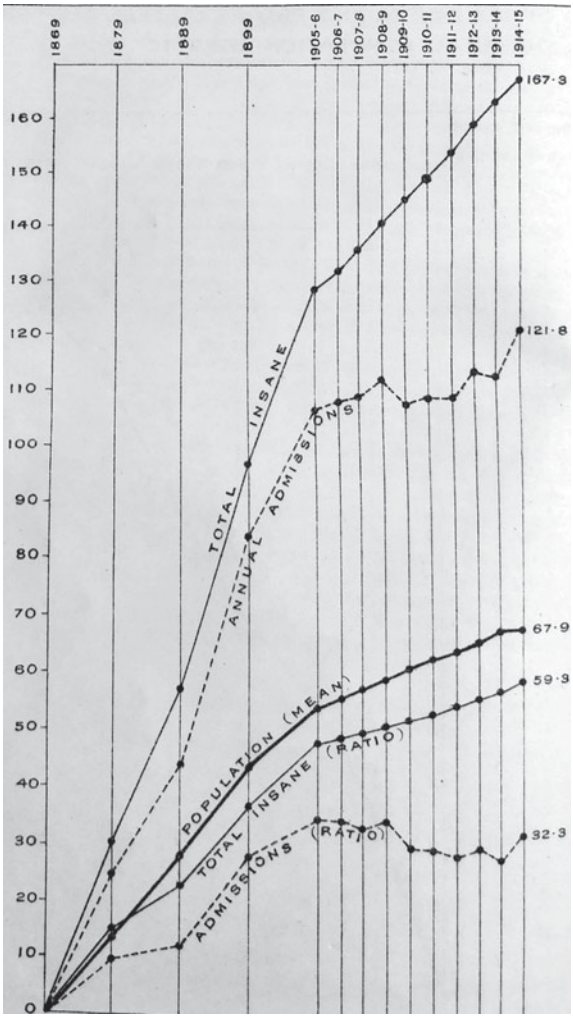

Fig. 1.1 Percentage change in "insane" patients relative to population of England and Wales (1869–1915). From top to bottom: Patients resident ("total insane"); Annual admissions; Population of England and Wales; Ratio of patients to population; Ratio of admissions to population. (*First Annual Report of the Board of Control, for the Year 1914* (London: HMSO, 1916), between pp. 8–9).

London to the north of the River Thames at a time of national turmoil, when intense austerity, deprivation and competing priorities affected those within them. The narrative overlaps with the direct effects of war on the mental health of military personnel and civilians living in the community, material which is used here to help contextualise and explain what happened in the asylums. The asylum story may also contribute to debate and shed light on the mechanisms and processes underlying standards of mental health services in other periods of austerity, including in the first decades of the twenty-first century.

This study covers the period from just before the conflagration through to the beginnings of post-war reconstruction. It tries to put the *raison d'etre* of the asylum—the patients and their mental health—in the foreground, with the people caring directly for them close behind. It explores the decision making and actions of those in authority over the asylums and the work of staff looking after the patients. It focusses on how the public asylum system provided care and treatment, how standards were envisaged and whether or not they were achieved. It brings together knowledge, ideas and attitudes about mental illness at the time, including political, scientific, medical, economic and popular cultural aspects.

Historiography of the Asylums

To comprehend how the asylums coped with the crisis of the Great War, it is necessary to understand their development, and disentangle fact from fiction. Mid- to late twentieth century historical interpretation of the lunatic asylums was contentious and damning, including the persuasive and influential analyses by Andrew Scull and Michel Foucault. Scull took as his starting point that the asylums, mainly established in the nineteenth century, were associated with defining a problem population and incarcerating them "in a specialised, bureaucratically organised, state-supported asylum system which isolated them geographically and symbolically from the larger society."[14] Foucault also attributed asylums' rural locations to the public desire to segregate "mad" people from the majority of the population, drawing analogies between asylums and leper houses of the middle ages.[15] Even though, like leprosy, mental disorders were tainted by fear and stigma, in the nineteenth century there was also a public perception that people with disturbed minds required protection, care and compassion. These notions contributed constructively to new lunacy legislation, asylum building and asylum care in England.[16] Despite

good intentions of the reformers, as sometimes revealed verbatim in their reports in *Hansard*,[17] Scull and Foucault identified the underlying ethos of the asylums as inherently and inevitably damaging to those within. Their conclusions linked to the theoretical and ideological standpoints which they held. Scull took a Marxist perspective in his analysis,[18] which fits with his description of asylums as "Warehouses of the Unwanted", "largely receptacles for the confinement of the impossible, the inconvenient and the inept",[19] the economically unproductive sector of the population. Foucault's analysis was cotemporaneous and convergent with that of the anti-psychiatry movement, which regarded mental illness as socially fabricated and those afflicted as wrongfully confined and medicated. Anti-psychiatry activists who wrote at the same time as Foucault included RD Laing and Thomas Szasz who expounded on social causes of insanity, and Erving Goffman, who scrutinized regimes of institutional living, with particular attention to their harmful effects.[20] David Cooper, the psychiatrist said to have coined the term "anti-psychiatry", wrote the introduction to Foucault's *Madness and Civilisation* when published in England, endorsing its link to anti-psychiatry ideology.[21]

So contentious were the writings of Scull, Foucault and others in the second half of the twentieth century, that historians since then have criticised their methodologies.[22] Joseph Melling and Bill Forsythe argued that Foucault displayed some "extravagant historical inaccuracies", such as in his analysis of confinement of the insane in early modern Europe.[23] Louise Hide described Foucault's study as "brilliant but flawed", such as his arguments about industrial society being increasingly intolerant of its non-productive members so beginning to lock them away in institutions.[24] Jonathan Andrews and Anne Digby regarded some twentieth-century historiography as too divorced from wider historical issues and "overly ideologised and unconvincingly theorised" in its approaches to asylums and psychiatry, lacking a firm and comprehensive grounding in archival sources.[25] Hugh Freeman found no evidence to support Scull's economic and social exclusion model of the asylums. Instead, he found severely ill patients whose relatives had done all they could to contain the situation before seeking admission.[26] Edward Shorter also criticised historians of the 1960s and 1970s, who

> constituted a kind of lost generation in that they have chosen to pursue puffs of smoke, displaying no interest in the question of just what happens historically to make mind and brain go awry. If we wish to tell the story

> of psychiatry empathetically, we must deal with the story of illness rather than arguing that it is a nonstory or that it is unknowable.[27]

Paul Tobia also argued that understanding asylums in depth can only be done by uncovering detailed source material, although that risks creating studies overly detailed and too divorced from wider historical issues.[28]

Another sort of historiography, which has coloured our understanding of psychiatric history, comprises accounts written by medical professionals about their own institutions.[29] These authors also conveyed biased perspectives, often as culprits of "whiggish" research, according to Juliet Hurn, adopting a "style of history-writing in which it is assumed that scientific progress can be charted through the approach towards an objective scientific truth."[30] Their work tended to be founded on hindsight, comparing the past with scientific evidence and medical standards to which they had aspired during their clinical careers.[31] They were also judgmental, praising the work of those perceived to have aided "progress" and dismissing others.[32] They tended to focus on the leadership rather than the patients and on what happened, rather than on analysing processes of why and how things occurred in broader contexts. John Crammer, a psychiatrist who wrote the history of the Buckinghamshire Asylum summarised: "the history of psychiatry was left to medical men with a fondness for anecdote, a reverence for pioneers, and a belief in 'progress'."[33]

Aware of the many concerns about the nature of the evidence and analysis used in historical studies of mental disorder and institutional care, this study uses standard historical methodology,[34] and draws extensively on archival and published sources, aiming to achieve a balanced understanding of the asylums, contextualised in the circumstances of the day.

From Broad Theories and Generalisations to Specifics and Diversity

Despite some historical analyses suggesting that the segregation and exclusion of mentally disturbed people was a key rationale for building asylums in rural areas, there are alternative explanations. One was the belief, in line with moral treatment, that the location would provide a healthy environment to benefit recovery and recuperation. Similar principles applied to building rural sanatoria for treating tuberculosis in the

pre-antibiotic era. Asylums were frequently located on the best sites—on a hillside and above urban pollution, and south-facing to maximise sunshine and give shelter from the prevailing winds—to allow employment and leisure in the fresh air. The building of many asylums in the early to mid-nineteenth century was also concurrent with the founding of specialist hospitals, each dedicated to a group of related diseases or a single bodily organ or organ system. In the London area, for example, specialist hospitals opened for eye and ear diseases, bowel problems, cancer and neurological conditions. They raised interest in the diseases on which they focussed, and the knowledge and expertise in treatment which developed in them were gradually adopted by general (physical illness) hospitals, thus becoming part of mainstream medicine and surgery.[35] There are parallels in the asylums, where the medical leadership sought to better understand the disorders they diagnosed and to find effective treatments, preferably cures.

The architecture of the asylums, the palatial façade of Colney Hatch (Fig. 1.2) or the prison-like central towers at Hanwell (Fig. 1.3) were emblematic of the diversity of the asylums in terms of practices and

Fig. 1.2 Colney Hatch Lunatic Asylum, Southgate, Middlesex: panoramic view, undated (Wellcome Collection CC BY licence)

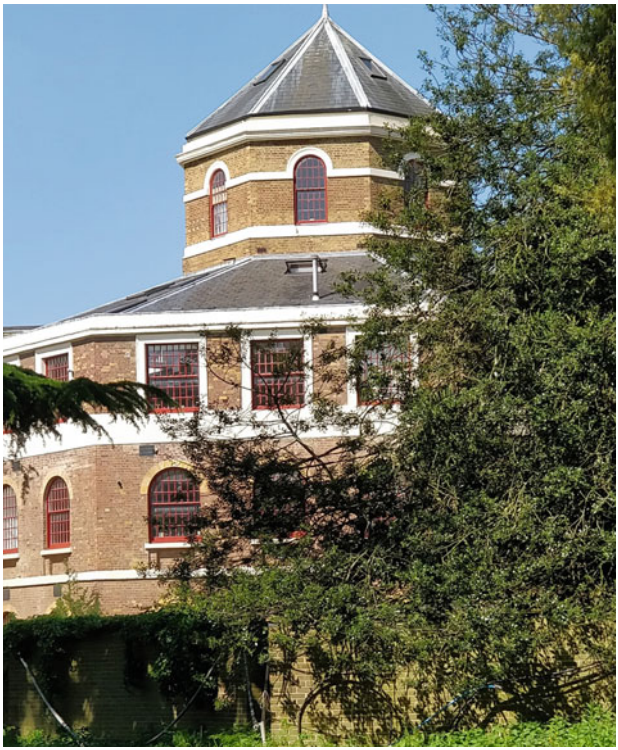

Fig. 1.3 Hanwell Asylum (Photograph by author, 2017)

standards within them. These varied despite the Lunacy Act 1890. The Act mandated legal, financial and organisational structures, and the hierarchy of authority, oversight and regulation stemming from the central government body, the Commissioners in Lunacy until 1914 and the Board of Control ("the Board") thereafter, which had responsibility for civilian asylums in England and Wales. The rigid, legalistic approach of the Lunacy Act also reflected increased societal and legal concerns about public safety, ensuring detention of "dangerous" lunatics while preventing wrongful incarceration of "sane" people. Beyond these requirements, the public generally distanced themselves from happenings inside the asylums, their perspectives reinforced by novels about lunacy

which tended to emphasise the frightening and the macabre, and rarely encouraged sympathetic interest in the asylums or their occupants.[36]

Historian Roy Porter wrote in 1991 that many dimensions of recent psychiatric institutional history "remain a blank".[37] Since then, understanding of the philosophy, uniformities and diversity of the asylums, has been enhanced by in-depth "hospital biography" investigations into individual asylums, or small groups of them, including in Hampshire, Norfolk, Bristol, Essex, and on the London borders.[38] These institutional biographies give nuanced insights into asylum organisation, patients, staffing, care and treatment within the wider societal context. In exemplary asylums shortly before the First World War, many patients reportedly undertook manual work appropriate to their pre-admission employment, participated in leisure activities, sports and entertainments, and had leave off the premises, including trial leave before discharge with a meaningful monetary allowance to help cover their personal expenses. Some asylums endeavoured to model their clinical approaches on practices in general hospitals. They placed patients on different wards according to whether they were deemed curable or chronic, used the most up-to-date treatments to ameliorate symptoms, and educated and professionalised their staff.[39] Diane Carpenter, however, in her comparison of two Hampshire asylums, described the "postcode-lottery" of variability of care and treatment, from custodial to rehabilitative.[40]

Hospital biographies challenge many generalisations made by Scull and Foucault, but they also demonstrate troubling variation, conflicts and mismatches between ideals and reality, intention and implementation, and numerous facets which came together to influence the functions of the asylums and the outcomes for individuals inside them. Mathew Thomson highlighted how individual and collective factors inside and outside the asylum system influenced policy and provision.[41] Knowledge, understanding and value systems of the medical profession, lawyers, architects, reformers, national and local government, macro- and micro- political networks, and the broader public, all interacted. Together they affected asylum practices and contributed to maintaining the *status quo* or pacing the speed and mapping the route of any significant change. In histories of psychiatry dedicated to a particular aspect of science, philosophy, psychopathology or individual mode of therapy, "single-issue mythologies" have evolved to explain change or stagnation.[42] To avoid these mythologies, the multiplicity of threads indicate the need for a multifaceted historiographical approach, digging deep into a range of archives

and published sources, to reach an understanding about whether, how and when aspects of asylum care altered.

Shell Shock: Historiography and Change

Regarding mental disorders and psychiatric services at the time of the First World War, historians of psychiatry have focussed on shell shock. Public sympathy for soldiers who became mentally disturbed while serving their country contrasted with fear and stigma concerning mental disorders of civilian pauper lunatics in asylums. The socially entrenched pattern of moral judgement of dividing needy people into "deserving" and "undeserving" was reshaped into provision for war-torn soldiers compared to civilians.

Commentators Anne Rogers and David Pilgrim inferred that shell shock plus industrial fatigue at home combined to "change irrevocably the face of twentieth-century psychiatric services". They proposed that shell shock encouraged environmental theories of aetiology and displaced bio-deterministic ideas: to describe soldiers—"England's finest blood"—as biologically "degenerate" and predisposed to mental disturbance "was logically impossible and tantamount to treason." They linked shell shock to the establishment of out-patient clinics and to neurosis becoming a focus of professional interest, although that was also associated with psychoanalytic theory developing pre-war.[43]

Shell shock may have contributed to re-conceptualising some mental disorders, but overall it stimulated little change in asylum treatment.[44] If anything, learning arising from the treatment of shell shock could be detrimental to patients with other severe, disabling mental disorders. Methods used to treat shell shock could be harsh, such as "bullying" electric shocks.[45] Psychological therapies for shell shock, such as cure by suggestion, promoted the idea that patients could control their symptoms, a view which would be inappropriate for people suffering from psychoses, such as schizophrenia, or from organic brain diseases such as general paralysis of the insane (GPI, brain syphilis).[46] Goals of treating shell shock, to send soldiers back to the front line, meant that medical ethics, humanity and measures of "success" were abstruse when compared to ideals of conventional aims of treatment to promote the health and wellbeing of individuals.

In contrast to Rogers and Pilgrim, Jose Harris and Peter Barham were cautious about attributing change in psychiatry primarily to shell

shock. Harris raised the question of how far the war itself transformed British society, or merely channelled and accelerated germinating seeds of change sown pre-war when "Britain appeared to be on the cusp of radical change".[47] Social welfare and universal suffrage, for example, had roots pre-war, but wartime priorities diverted good intentions away from peacetime objectives, and direct implementation ground to a halt. The war, however, generated debate on many aspects of life, including roles and opportunities for women, priorities for reconstruction and the meaning of "civilisation",[48] which informed public attitudes and helped shape the course of post-war policy.

Regarding mental health policy and provision, shell shock was just one factor alongside others, including clinical and scientific research; the psychiatric clinics in Germany envied by psychiatrists in England; and the rise of trade unions and disenchantment with conditions of employment in the asylums. Arguably, *The Experiences of an Asylum Doctor* by Montagu Lomax, a retired doctor in his late 50s and temporary wartime asylum assistant medical officer at Bracebridge Asylum, Lincolnshire and Prestwich Asylum, Lancashire (1917–1919), had a profound effect on instigating change in the asylums.[49] For this reason, and as we shall refer to the author, his book and its aftermath several times in the course of the present study, they deserve introduction here. Tim Harding and John Hopton appraised Lomax's work and its outcome.[50] Lomax was particularly critical of the conditions which he observed at Prestwich, although in his book he did not reveal the identity of the asylum. He advocated more active therapeutic interventions to secure the return of patients to the community, he called for wide-reaching changes in asylum management, and a complete reform of existing mental health legislation. Published post-war, when the public had more emotional energy for considering such matters, it raised public awareness and spearheaded further thought. The psychiatric establishment, however, rejected his descriptions of inhuman, custodial, and antitherapeutic conditions.[51] Despite publication coinciding with competing economic struggles nationally, likely to deflate interest in asylum patients' welfare, the aftermath of Lomax's exposé was an inquiry into the "administration of public mental hospitals" chaired by Sir Cyril Cobb in 1922. This led to the appointment of the 1924–1926 Royal Commission on Lunacy and Mental Disorder and to the enactment of the more therapeutically orientated Mental Treatment Act 1930.[52]

Placing the Patients Centre Stage

Some historians of psychiatry, as Roy Porter advocated, have succeeded in placing patients centre stage in their narratives.[53] Louise Hide's study about gender and class in asylums between 1890 and 1914 and Paul Tobia's study of the Bristol Lunatic asylum were both bottom-up and top-down, valuing the lives and experiences of patients and those in direct contact with them, as well as those in authority in the asylum hierarchy up to national level.[54] Allan Beveridge analysed 1000 letters written by patients at the Royal Edinburgh Asylum (1873–1908) which were retained by the authorities rather than sent to the addressee. A complex picture emerged in their accounts, which included both humanity and coercion. Many patients spoke warmly of the asylum and its staff and frequently thanked the medical superintendent for his kindness and concern. Some patients, rejected by family and friends, made some sort of life for themselves within the asylum which was more tolerant of their behaviour than the society outside. Letters, like many other single classes of document from the asylum world, have limitations, but Beveridge concluded that the contents should militate against painting too crude a picture of the asylum with staff in the guise of oppressors and inmates as innocent victims.[55] His conclusions contrasted with studies which create an overwhelmingly negative image of the asylums, such as those by Scull.[56]

Peter Barham also wove individual life stories into his history of shell shock, *Forgotten Lunatics of the Great War*. He placed the sufferers' mental disturbances in the context of their lives and the lives of their families and community, giving voice to their personal experiences. In contrast to the *forgotten* soldier patients during the war, civilian patients in the lunatic asylums were almost *invisible* and usually without a voice. Barham described his research experience, that "fossicking in the archival undergrowth frequently yields scraps that, once juxtaposed, deliver startling insights into what was at stake" for individuals.[57] The same was true when researching this study of civilians, which, like Barham's and Beveridge's work, aims to tell the patients' stories and how their needs were, or were not, met.

A variety of bottom-up sources are available to historians of asylums in the early twentieth century. Within individual asylum records, material written by patients, their families and friends can be found pasted into clinical notes and committee minutes. Some documents are positive,

including letters of thanks, but more relate to disputes about treatment, thefts, escapes, discharge and money, and other unfavourable aspects of asylum life. As in Beveridge's study, some accounts by patients derive from un-posted, asylum-censored letters. Regarding patients' letters to friends and family, staff had authority to read them. Staff justified their probing in this way as a means of finding out about their patients in order to help them, but this probably reflected, and caused, a lack of trust and face to face conversation between patients and staff. Patients who were aware of the censorship of their letters might also have adjusted their content and tone.

In contrast to personal letters, the Lunacy Act stipulated that letters from patients to the authorities who oversaw their certification and care should be forwarded unopened, but this correspondence was often destroyed after being dealt with.[58] A few patients wrote memoirs. Whereas letter writing is influenced according to who the recipient might be, memoirs can be shaped by time between the experience and the writing, affected by personal reflection, changing knowledge and social expectations giving new emphases. Diaries, generally written for the authors themselves, are the least likely to be tailored to an anticipated external readership. No diaries, however, were identified while researching the present study. Another source of patients' views was their evidence to the Cobb Inquiry as a result of Lomax's book.[59]

Some of the patient vignettes used in this study were identified serendipitously in clinical records or committee minutes. Others derived from a sample I gathered of 600 civilian patients from the national registers of asylum admission and discharge (1913–1918).[60] The sample consisted of every thirtieth patient (the last entry on each page) in the register. Each entry recorded the asylum's name, and patient's name, gender, dates of admission and outcome (recovered, relieved, not improved, died), but not age, date of birth, diagnosis or other clinical information. The method ensured that the sample was clinically, socially and demographically un-biased. In total, 58 of the 600 patients were admitted to Colney Hatch, Claybury, Napsbury and Hanwell. Detailed social and clinical data were sought for them, with the aim of analysing the reasons for their admission and their "journey" through the institution.

Standards of Care and How to Measure Them

Several historians have attempted to ascertain the standards of care achieved in asylums. Carpenter concluded that "basic determinants of the quality of life" for patients in the Hampshire asylums pre-war were "preferable to its alternatives": diet, cleanliness, personal hygiene and clothing, all compared reasonably with poorer private dwellings and the workhouse. Other living conditions were similar to many poorer homes, such as gas lighting, open fires, no electricity and lack of privacy.[61] Kathleen Jones, who investigated mainly social and legal aspects of mental health policy and practice, commented that for asylum patients who worked during the day and took part in social activities in evenings and weekends, "it was a full life – often much more so than their life outside."[62] She did not state a particular period to which this referred, or whether it was reality at times of greatest austerity.

Standards and quality of care, the parameters which underpinned them, and how and why they changed, often for the worse during the war, are explored thematically in this book. The Board had responsibility for setting and monitoring standards and determining the adequacy of the care provided. It benchmarked asylums against ideals and expectations which were often inferred from its annual reports and letters and circulars of guidance, rather than stated systematically. During the war, with pressure on resources and an assumption of compromise, the Board modified its ratings and accepted lower standards. Its methods of assessing asylum standards were also unconvincing: inspectors focussed on documentation and basic, easily observable physical matters, such as cleanliness. Less tangible and more complex human needs[63] were rarely assessed in a balanced way such as by talking frankly to patients. Patient-derived data is hard to identify and neither Carpenter nor Jones reflected directly on patients' perspectives of their treatment or quality of life.

Developments since the First World War in setting standards and parameters to evaluate healthcare quality can provide useful tools in structuring an historical analysis. Formal mechanisms for conceptualising and measuring healthcare standards originated in the United States of America in the 1930s, aligned to the insurance-based healthcare system.[64] Louis Reed and Dean Clark in 1941 defined healthcare quality according to the scope, quality, quantity and continuity of care, and coordination with social services.[65] In the 1950s, Mindel Sheps acknowledged the intangible nature of healthcare quality, and its assessors tendency to

focus on correcting abuses and setting minimum standards, rather than achieving excellence,[66] much as the Board did. Ideas about standards obtained a wider organisational acceptance from the 1960s, based on the work of Avedis Donabedian. Donabedian[67] wrote about the need to define dimensions of quality before specifying what constitutes "goodness" or "badness". However, since stakeholders value quality according to their own interests, defining dimensions is complex. Value for money, system capacity and outcome of treatment, for example, hold different salience for patients, policy makers, financial providers and clinical staff,[68] resulting in conflicting priorities underpinning distribution and utilisation of resources.

Additional concepts derived from new organising categories about mental health services, such as costs, risks, needs and values, and their use in historical analysis were discussed by John Turner et al.[69] He recommended their incorporation into historical research about modern mental health services, but the concepts are also useful markers for studying services in the more distant past. The Care Quality Commission, today's independent regulator of all health and social care services in England, aims to judge whether services are safe, caring, effective, responsive and well led, based on criteria founded on a human rights agenda.[70] Reports of asylum inspectors a century ago reveal their concerns on similar human matters, such as dignity, meaningful life, sense of community, as much personal freedom as possible, and contact with family and the outside world. Achieving a consensus regarding standards of healthcare is challenging. Although there was no consensus for the asylums, awareness of the multiple components of standard setting can assist with focussing historical analysis on a range of issues concerning formulating, prioritising and evaluating earlier standards.

The Language of the Asylums

There are many other methodological considerations when writing the history of psychiatry and its institutions, but the use of language looms large. The term "asylum" was itself was controversial. In 1841, a handful of psychiatrists proposed replacing it with "hospital".[71] In 1908, the Royal Commission on "the feeble-minded" also recommended the substitution. It reasoned that the word asylum was misleading as it "savours of the mere detention of extreme cases". Treatment was the goal, so they

should be called hospitals.[72] The term was already permitted for privately-run and military psychiatric establishments. A name change alone would not change practice, but it had the potential to influence expectations about treatment and recovery from mental disorders.

Attitudes towards people suffering from mental disorders were expressed by the language of public and official discourse. The public referred to asylum staff as "keepers", more in line with prisons or zoos than hospitals.[73] An "escaped" patient might be described as "at large", a term generally used to refer to a criminal or dangerous animal, and a resident staff member might be "absent without leave", a military term.[74] Patients conflated their asylum experience with prison jargon, substituting seclusion in a side-room or "padded" room with solitary confinement in a "cell".[75] The Lunacy Act designated asylum patients "pauper lunatics", the "pauper" label adding an extra layer of stigma to their "lunacy". Much of the Act's vocabulary resembled that of prisons and workhouses, such as detention, parole, escape and recapture. Nevertheless, the Act used the word "patient" or "lunatic", reserving the more derogatory word "inmate" for occupants of workhouses, although "inmates" continued to appear in asylum committee minutes during the war years when referring to people under their care.[76] Overall, deprecatory language articulated apprehension and fear of asylums and mentally disturbed people, and lack of empathy and compassion, distancing those outside from the human needs of those within.

Another word, "control", commonly features in historiography of asylum practice. The Lunacy Act used the word "control" in several contexts: concerning the administrative control of asylums; when a person in the community was "not under proper care and control, or is cruelly treated"; and for defining the need for urgent admission to a workhouse when behaviour due to a mental disorder risked causing direct harm to the disturbed individual or to others.[77] Control can be an emotive word with multiple connotations which beg the question of who controlled whom, and how and why. The word itself gives no indication of the rationale (such as to protect the patient or others) or the means (humane or coercive) to achieve it, but critics interpret it to imply abuse. Scull described the asylum as "the new apparatus for the social control of the mad", with control the primary objective.[78] This contrasts with the stated aims of the Act for asylums to provide "care and treatment",[79] which inevitably included control of a patient's disturbed behaviour. The aims, means

and outcomes of therapeutic and harmful control of asylum patients, are recurring themes in this book.

How to deal sensitively with stigmatising terminology is another conundrum for historians. This is particularly problematic in the history of psychiatry as language associated with mental disorders changes in attempts to discard associated stigmata and to dispel prejudice and discrimination. These attempts often fail: new names selected to replace them tend to acquire old humiliations, while the old language can linger colloquially and in official documents and debates, including in parliament.[80] Old technical terms which perpetuate may acquire broadly derogatory meanings, such as the words imbecile, idiot, spastic and mongol, and may indicate out-dated attitudes of the speakers.

Many historians, including Foucault, Porter and Scull loosely referred to "madness", a generic term for mental symptoms.[81] This may have been appropriate to earlier centuries but was outdated by Edwardian times when "insanity" or "lunacy" were the characteristic generic terms.[82] For historians of psychiatry, antiquated terms may best help understand highs and lows and obstacles and opportunities facing those who tried to cope with, survive in, or improve institutions and clinical practices. In this book antiquated term are therefore used, but with respect for patients and with the intention of illuminating how they fared at the hands of the asylum system.

Over the last century, the meaning of much psychiatric terminology shifted. "Mania", for example, as used in asylums a century ago, meant any mental disturbance characterised by overactivity. In contrast, today it refers specifically to a diagnosis of bipolar disorder. "Dementia", a chronic deterioration of intellectual and social function, was used to refer to GPI or chronic stages of schizophrenia. Dementia could also be categorised as primary, secondary or senile, but the word senile carried multiple meanings and assumptions relating to chronological age, ageing, old age or conditions assumed to be age-related.

Another pair of words, "illness" and "disease", have influenced the choice of language in this book. Eric Cassell, a public health physician, used the word "illness" to mean "what the patient feels when he goes to the doctor", and "disease", "what he has on the way home from the doctor's office."[83] From an anthropological viewpoint, a disease is an independent entity which has specific properties and a recurring identity in whichever setting it appears, and illness relates to the personal experience of it. A disease is assumed to comprise a universal "syndrome", with

pathology, causation, symptoms and signs, natural history, treatment and prognosis similar in whatever individual, culture or ethnicity it occurs.[84] If, as in mental disorders, brain disease may be undetectable, the boundaries between illness and disease can be blurred. With lack of clarity and inconsistency in some source material, I have frequently used the deliberately vague terms "disorder", "disturbance" or "distress", meaning a disruption of the individual's usual mental and bodily function.

Some diseases and illnesses can be identified historically if adequate evidence is available. Evidence may be found by careful examination of patients' clinical notes, revealing history, symptoms and physical and mental state examinations. For psychiatric disorders, ascertaining the patterns of symptoms over time is invaluable for determining the type of disorder. Many First World War asylum records allow this sort of clinical analysis. However, since precise psychiatric diagnostic criteria and illness classifications continue to be disputed and to change, detailed "retrospective diagnosis" comparisons with twenty-first century terminology lack meaning. Nevertheless, there is room to construct a "working diagnosis" relating to a class of disorders. A working diagnosis can assist in clarifying other historical evidence, such as about detention, recovery or chronicity requiring long term support. "Translations" into current terminology are sometimes given to enhance understanding for a readership more familiar with twenty-first century mental health vocabulary.

Other less contentious areas of asylum terminology, which nevertheless still require clarification, are professional designations, such as "psychiatrist" and "attendant". The Royal Society of Medicine established a "Section of Psychiatry" in 1912 and "psychiatrist", referring to a medical doctor who specialised in mental illness, replaced the older term "alienist", meaning a doctor who treated "mental alienation".[85] The term psychiatrist gained acceptance in the early twentieth century and is used in this book. Concerning asylum ward staff, "attendants" were generally male and "nurses" female, but this could be inconsistent, such as in the title of the textbook for both, the *Handbook for the Instruction of Attendants on the Insane*, a general training manual for asylum ward staff.[86] Historians have adopted various ways to deal with this gendered language, such as using the generic term "asylum nurse".[87] In this study, as far as possible, I have kept the terminology as it appears in archival sources, but when referring to the combined male and female ward workforce, I have generally called them "ward staff".

Other Methodological Considerations

Four asylums provide the core, in depth source material for this study: Claybury, Colney Hatch, Hanwell and Napsbury. Claybury, Colney Hatch and Hanwell were London County Council (LCC) asylums, and Napsbury served the county of Middlesex, particularly the more urbanised part, coterminous with the LCC's northern administrative border. Despite the distance between any two of these asylums being under 25 miles by road, each had a different institutional wartime footprint. Part of Napsbury was taken over as a war hospital in 1915, the rest in 1916. Colney Hatch had a large proportion of patients from abroad, including Belgian refugees, prisoners of war, interned foreign nationals, and Jewish people from the East End of London.[88] Claybury lost its prestigious scientific research laboratories during the war and suffered extraordinarily high death rates in 1917–1918.[89] Hanwell steered a middle path, receiving hundreds of patients from other asylums vacated for military use, but it experienced neither the diverse ethnic mix of Colney Hatch nor the extreme death rates at Claybury.

Each asylum has an extensive, but not too unwieldy, range of archived records. They provide a flavour of the challenges, contrasts and commonalities of each in a context of prolonged austerity. Some have unique records which were not preserved by the others. Only Colney Hatch, for example, has records of staff salaries and wages,[90] and only Hanwell has note books of staff misdemeanours.[91] Management committee minutes vary in their detail, such as Claybury's which list issues raised by the medical superintendent without giving particulars, contrasting with the others which generally record associated discussions.[92] Reasons for degree of thoroughness of minute keeping were not revealed, but they may have included staff availability to take minutes and to type them, or the wishes of the medical superintendent and management committee, but some give an impression of concealing problems.

Colney Hatch archives include albums of photographs of patients taken for identification purposes shortly after admission.[93] Photographing patients was a common practice in many asylums in the early twentieth century, but the images have received relatively little attention by historians of medicine. Katherine Rawling argued that examining the visual patient record can enhance, and even challenge, established histories of mental illness and medico-psychiatric practice: they may give clues to the doctor–patient encounter, to diagnosis and treatment, and to the

patient's experience.[94] In some asylums, photographs of patients resembled police mug-shots,[95] but those from Colney Hatch are varied. They demonstrate aspects of mental and physical health, and attitudes and attire, thus indicating something of the patient's experience. Ludmilla Jordanova recommends that images should be "integral parts of historical arguments" and that historians must be particularly aware of their ethical obligations to their sources, being reflective, accurate, compassionate and responsible.[96] Regarding ethics, all the images of patients conform to the 100-year rule for confidentiality of personal archives. In addition to this, to help preserve anonymity, surnames are not used when discussing them. First names are used to engender a sense of empathy and identification with them, to emphasise that each was a human being whose experience in the asylum we are attempting to understand. The images may also help reveal how the staff—doctors and others—would begin to understand their patients: "Much can be learned" staff were instructed, "from how a person looks, and the expression of the face, the attitude, the dress and other visible signs of a person's emotional and mental state."[97] The images also need to be interpreted in the context of the experience of having one's photograph taken. Some patients may never have been photographed before, so might have found the process unsettling or amusing, although in general, posing for a photograph was a formal event, with facial expressions usually emotionally neutral. Thus, patients in asylum photographs who are smiling may have had an abnormal state of mind, or the image reflected their interactions with the photographer or other staff. As with other sources, there are multiple layers of interpretation.

Another aspect of asylum archives concerns the historical usefulness of clinical notes. Tobia regarded them as bearing the "imprint and prejudices" of the asylum staff,[98] and Andrews suggested that clinical notes "convey more about the preoccupations of the asylum's medical regime than about the patients and their histories".[99] Although clinical notes need to be read critically using knowledge of prevailing medical theories and social views, Tobia and Andrews may have overestimated their subjectivity. Medical notes comprised two main components. First, demographic data plus biographical information, clinical history and examination which were largely objective and collected in a standard way. Second, the medical officer's interpretation of the findings to identify causes, formulate treatment plans and consider prognosis. The medical officer making the notes would have been aware that the Board might scrutinise them during

an inspection or the medical superintendent might peruse them when reviewing the patient sometime later.[100] The doctor compiling them would therefore have had a vested interest in demonstrating his (rarely, her) expertise and clinical objectivity in order to enhance his professional reputation. The overall uniformity of clinical note keeping, at least within the asylums investigated in the present study, suggests little scope for personal views.

Archives relating specifically to the four asylums focussed on in this book complement national records but cannot be assumed to be representative of asylums elsewhere across England and Wales. Eight of the nine LCC lunatic asylums had over 2000 beds each, making them larger than most others nationally. In addition, in most lunatic asylums, a significant proportion of patients had a "mental deficiency" (later known as learning disability). This was less so in the London area where the Metropolitan Asylums Board managed many health and welfare institutions, including those for mental deficiency, separate from the lunatic asylums which were the direct responsibility of the LCC.[101] Regarding other effects of wartime contributing to making London's asylums unrepresentative, this is hard to ascertain: according to Stefan Goebel and Jerry White, except for air raids, revisited from the standpoint of the Second World War, First World War London has had relatively little historical analysis.[102] The German bombing raids on London, initially by Zeppelins and later by Gotha bombers, were more intense than in other parts of the country, and induced fear and panic in civilians, but how that affected asylum admissions and the patients and staff within them, is less clear.[103]

Despite the differences, the four asylums did have commonalities with those elsewhere. Their patients suffered the same range of mental and physical disorders. They were all subject to the Lunacy Act, regulation by the Board of Control, and pressures to release staff to serve in the war and to provide beds for physically and mentally injured soldiers. Scotland had separate legislation and some of their asylum practices were more liberal than those south of the border. Scottish records can shed light on happenings in English and Welsh public asylums, as can developments internationally and sources relating to private and military mental hospitals.

In addition to archives relating to each asylum, the Board's records include minutes, unpublished documents and published annual reports. The annual reports have extensive statistical tables about asylums, including disease and death, but they are far from fool-proof. Their focus

and extent vary from year to year and administrative categories can be confusing: some tables, for example, include all patients detained under the Lunacy Act, others only those in public asylums. Data were collected according to information priorities, and during the war many details were abandoned due to lack of staff to gather, sort, collate and transcribe them.

Investigating the period 1914–1918 has pros and cons. One con is that much record keeping was abandoned due to staff shortages. A major pro is that archive sources are now beyond the 100-year rule for personal information. Many records, however, have been destroyed. The Board discarded records they considered obsolete, such as letters of complaint, registers of seclusion and restraint, and notices of discharge and death.[104] Survival of other Board records was partly governed by rules about disposing of papers for which preservation for the public record could not be justified.[105] In addition, with space for storing notes at a premium, and wartime paper shortages, some Board and LCC records were pulped.[106] Further destruction took place later. Three-hundred metres of files stored below King Charles Street, Westminster, became unusable by the 1930s: the air "was foul and stagnant" and periodically the vaults flooded necessitating using duck boards to avoid having "to wade in water to get to the shelving".[107] Later, the archiving of records from individual asylums was hardly systematic: Dawn Galer, archivist at the Redbridge Heritage Centre, recalled that most records from Claybury were incinerated when the hospital closed in 1997.

Overall, archives and published sources are available which relate to many aspects of the asylums, including the lives of patients and staff. To best understand what happened to the people, and to attempt to decipher how the asylums functioned during the war years, this book takes a thematic approach. The narrative and argument are clearest when beginning with the context of the relatively fixed infrastructure of the asylums (Chapter 2). The *raison d'être* of the asylums, and the central theme of this book, the people who suffered from mental disorders, their routes into the asylums, their difficulties, care and treatments, are discussed after that (Chapter 3). This is followed by exploring the challenges of staffing the asylums (Chapter 4) and obtaining goods and consumables to satisfy daily living needs during the war (Chapter 5). These themes come together to create an understanding of the patients' daily lives (Chapter 6) and to contextualise and inform the narrative of how physical illness, particularly potentially avoidable infectious diseases (Chapter 7),

and "accidents" and suicides and other undesirable outcomes (Chapter 8), affected the lives of those in the institutions.

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Management structure of Asylums and Lunacy Act

Introduction

Lunatic asylum practice shifted, arguably for the worse, in the first decade of the twentieth century. Sir George Savage informed his fellow psychiatrists in 1912:

> Fifty years ago we were proud in thinking that we English were the great protectors of the insane. We introduced humane treatments and were content that the patients should be protected, while also society was safeguarded from injury.[1]

In early 1914, the *Lancet* published a letter from psychiatrist Dr. Lionel Weatherly, concerned about declining rates of recovery in the asylums, and the problem of "large asylums for the insane, wherein individualism is so much lost and where, to a very large extent, patients are herded in large numbers together."[2] The asylums were submerged under countless pressures, partly stemming from the Lunacy Act 1890, and associated with long-term detention, overcrowding, and larger institutions having a diminished sense of community.[3] The Board of Control ("the Board"), the central government authority responsible for supervising and regulating the asylums, praised those which managed to preserve patients' individuality and make their lives meaningful,[4] but their praise suggests that high standards were noteworthy rather than universal. The Medico-Psychological Association (MPA, the asylum doctors' professional body,

forerunner of the Royal College of Psychiatrists) discussed how to overcome the "grave defects" in British psychiatry. Its recommendations, made in July 1914,[5] vanished amid the turmoil when war broke out a few weeks later.

Outside the asylums, a shifting landscape of national political, social and economic change preceded the war.[6] The Labour Party was formed in 1900. Some movement towards social reform emerged under the Liberal government which came to power in 1905. A state old age pension was first paid in 1909, and the National Insurance Act 1911 created health and unemployment benefits for the workforce, although not for their dependents. The poverty of working-class people more generally, however, received little practical attention. Society was still largely divided by class and functioned in a duty bound, paternalistic, conservative, gender segregated and moralising way. New knowledge and ideas, such as about science, belief in God, the unconscious, the global village and gender, affected outlooks, social interactions and behaviours.[7] However, regarding the asylums, well entrenched older attitudes persisted. In the view of psychiatrist Bernard Hollander in 1912:

> It is difficult to get rid of antiquated notions on the subject of lunatics. The popular impression would seem to be that the insane are generally raving and desperate people, whose actions resemble those of beasts and whose language is that of Billingsgate; that consequently they ought to be deprived of their liberty and kept in specially built places of safety where they are protected from doing harm either to themselves or others.[8]

Limited information passed between institution and community, creating a restricted and often unbalanced view of life inside, open to speculation by the general public and contributing to Hollander's "popular impression". The separate world of the asylums fitted with Erving Goffman's model of a "total institution", a place of residence and work where a large number of like-situated individuals, cut off from wider society for an appreciable period of time, together lead an enclosed and formally administered round of life.[9]

The London County Council (LCC) managed nine lunatic asylums of the total institution pattern, altogether comprising about 19,000 patents and 3500 staff.[10] The LCC aimed to achieve a ratio of about 1 staff member to 10 patients during the day and 1–70 at night, in accordance with the Board's advice. Montagu Lomax, however, based on his

wartime work as an asylum medical officer, regarded these ratios as insufficient to manage patients humanely[11]: they were scarcely enough to allow staff to know all the patients' names, let alone to develop therapeutic relationships.

The staffing situation deteriorated dramatically within weeks of the outbreak of war due to many male asylum workers volunteering or being called up as army reserves.[12] Whether any, let alone suitable, other staff could be obtained partly depended on competition with local industries which might pay better wages and have more desirable hours and conditions of employment.[13] Medical staff levels, already low because of a "shortage of qualified practitioners willing to enter this branch of their profession" worsened.[14] Reduced staffing, accompanied by financial constraints and problems obtaining supplies, risked prejudicing patient care.[15]

The LCC had oversight of staffing and other aspects of its asylums, although it generally delegated implementation to each asylum's lay management, or "visiting", committee (VC). One of the LCC's proposals in 1914 to improve the lives of asylum patients was to provide cinematograph lantern appliances to screen films for them.[16] The course of events goes someway to demonstrating the bureaucracy and complexity of making constructive changes in the asylums. Pre-war, noting that public audiences were reported to panic more frequently at "picture theatres" than in other places of entertainment, the LCC pondered over the likelihood that low levels of lighting required to watch the films might make patients panic.[17] However, the asylum engineers and medical superintendents agreed that lights "sufficiently bright for attendants to see their patients" with the hall having as many exits as public picture theatres, would suffice.[18] The war halted implementation, but the plan re-emerged post-war. A few VCs regarded film-shows as a therapeutic form of recreation and supported their introduction, but others opposed the idea, reiterating the pre-war rhetoric that patients would panic in the dark.[19] Their argument disregarded the fact that, during the war, asylums were bound by the same rules for low-level indoor lighting as domestic households, and they ignored the evidence that patients did not panic more than the general public in the dark, during air raids or if fires broke out at night.[20] Post-war, Herbert Ellis, a VC member who was also a magistrate, declared that he did not want patients "more mad than they are. I hope they won't have cinemas. I think that is what drives many patients in."[21] As well as VC discussions influenced by personal opinions rather

than evidence, other factors thwarted implementation, including the poor state of the economy and the Board's preoccupations about licences and legalities of film-shows more than their contribution to normalising patients' lives.[22] Rules, regulations and personal opinions influenced decision making, contributing to a mismatch between evidence, ideals of care and experiences of asylum patients who remained virtually voiceless.[23] Sometimes, the Board admitted, rules were too rigid,[24] and, inequitably, the patients and lowest tiers of staff, comprising the largest groups in the institution, had the least say in decisions and bore the brunt of the mismatch.

The introduction to this chapter sketches out some of the organisational challenges faced by the asylums in 1914, including: staffing difficulties; falling standards of care; bureaucratic and uninformed decision making; and the public keeping the asylums at arm's length. The rest of this chapter will explore in more depth aspects of asylum management which maintained the total institutions, exerted control over them and shaped the lives of patients and staff within them. The Lunacy Act was a *fait accompli*. Heavily legalistic and created with the needs of the general public rather than the patients in mind, it stipulated asylum rules which constrained practice in ways which some said made it unfit for purpose. In Kathleen Jones' view it was "out of date before it was passed."[25] The Act shaped the asylum organisational hierarchy, with the Board at the top and local tiers of lay management which coordinated the asylums day-to-day in association with senior asylum employees, particularly the medical superintendent. National and local government and professional organisations interacted with and influenced this hierarchy. As the war progressed, the asylums made compromises to meet military requirements, providing accommodation for both mentally and physically injured soldiers. These compromises revealed, and added to, the poor standards of care provided to civilian patients. Moving forward into the plans for post-war reconstruction, the government prioritised physical health over mental health.

The Lunacy Act 1890: "Red Tapism", Admissions, Finance, Reform and Change

James W, a 57-year-old middle class man from Sussex, was certified under the Lunacy Act and detained in Hanwell Asylum. Two weeks later he was "discharged not insane".[26] We know from court records

that his wife Mary petitioned for a judicial separation, raising suspicion that perhaps, vindictively, she tried to have him "put away".[27] Although wrongful confinement appeared rare, and as with James W, the decision could be overturned, when it occurred it frightened the public and jolted the authorities into considering ever more legalistic measures to avoid repetition.[28] Thus lawyers had played a major part in creating the Lunacy Act 1890, whereas asylum physicians with practical experience of treating insane people had little influence.[29] The outcome was an Act which prescribed everything in great detail with nothing left to chance or to professional discretion and provided little scope for future development.[30] It undermined the flexibility required for rehabilitation and compromised therapeutic interventions for patients.[31] It set penalties for infringements,[32] which fostered a risk-averse culture and created fears of punishment for staff and loss of reputation for the leadership. Mary Riggall, a patient, provided an example of the defensive, risk-averse stance in her memoir. She described how one woman was discharged then readmitted a week later after she hurled a knife at her family doctor. The medical superintendent told Riggall: "If people have to come back again as quickly as this, the doctors outside will say I don't know my job."[33]

Some psychiatrists openly criticised the Act. Daniel Hack Tuke, a psychiatrist at the time it became law, commented that "the great evil of the Act was that it was red tapism from the beginning to the end".[34] Some red tape was undoubtedly necessary, but administrative minutiae and bureaucratic form filling could detract from caring for patients and inhibit innovation. Sir Frederick Needham, a senior member of the Board, also reflected on the Act which may have suited the public but hardly worked in the patient's best interest:

> let the public feel the inconvenience of this Act which *they demanded* and has been passed in obedience to this demand, and as soon as the public have sufficiently felt the inconvenience of the Act, which we always objected to, I think they will demand a public remedy.[35]

Lionel Weatherly (Fig. 2.1), one of the most outspoken psychiatrists of his generation, regarded the Act as "obnoxious" and "To tinker with [it] is no use. It should be burnt on the rubbish fire of pernicious Acts."[36] Weatherly's book on lunacy law reform, *A Plea for the Insane*, was welcomed by his colleagues.[37] Tuke, Needham, Weatherly, Hollander and Lomax all challenged the value of the Act and its consequences for asylum practices and patient wellbeing.

Fig. 2.1 Dr. Lionel Weatherly (Copyright: Bradford upon Avon Museum)

The Act prohibited public expenditure on out-patient clinics or on using asylums as hospitals for voluntary patients who required treatment for their early, mild, or "borderland" (uncertain) mental disturbance.[38] Thus, only people who had the means to pay privately could consult a psychiatrist in the early stages of their mental disorder, a clinically unreasonable situation.[39] Psychiatrists regarded the private-public divide as invidious. They wanted more flexible access to their services. They alleged that mentally disturbed people sought help from alternative, ill-trained and inexperienced practitioners, such as "psycho-therapeutists", hypnotists, faith healers, occult magnetic healers, quacks who made money from selling cheap medication, and physicians "who not infrequently recommend a sea voyage for an early suicidal melancholic, who returns to

trouble them no more."[40] Hollander viewed delays caused by the Act's restrictions on early treatment as scandalous: "In no other form of disease is 'appropriate' treatment so tardily initiated and so difficult of attainment."[41] Drawing on his experience of continental clinics and private practice in London, he wrote that delaying treatment worsened outcomes, patients "becoming confirmed lunatics by neglect".[42] He wanted facilities for advice and early treatment for lower classes as well as the more well-to-do "which would do away with half of the difficulty we experience in treating the insane to-day."[43] Dr. Wolsely-Lewis of the Kent County Asylum, Barming Heath, argued that a less restrictive Act could prevent much suffering

> a wife who has a husband subject to attacks of recurrent insanity, with intervals of mental health, is obliged when the attacks are coming on and before the law can intervene to endure the misery of living with him as his wife, of seeing daily the evil influence he exercises on the home, and of watching his reason tottering to its fall – perhaps in constant dread for the safety of her children and herself; or, again, a husband whose wife suffers from recurrent attacks – finds his home and children neglected while he is away at work, well knowing from past experience what harm can be done before his wife again becomes certifiable.[44]

The Board agreed with Wolsely-Lewis, commenting that "the medical side of insanity was to some extent sacrificed to the legal".[45]

A certificate for admission was binding on an asylum to accept a patient, and without it, the asylum would turn a patient away. At one asylum: "A former patient came back in pouring rain and asked to be admitted, but had to be refused".[46] At another, the porter recognised a former patient when she arrived by taxi in a distressed state. He told the driver to take her to the police station and informed the medical superintendent about his action.[47] Under the Lunacy Act, "certifying" patients for admission usually fell to doctors who were general practitioners or workhouse medical officers who lacked specific expertise or post-graduate training in psychiatry, and to magistrates, more often associated with making judgments in criminal cases. Concurring with public concerns, the magistrate's role was to ensure that no one was unjustly deprived of their liberty. Delegating certification to non-psychiatrists aimed to prevent asylum doctors from admitting patients into their own institution which might provide them with personal or pecuniary advantage.

As a result, asylum doctors who had the specialist knowledge and experience of treating mental disorders were excluded from deciding who might be best placed in an asylum. The asylum admission process was closer to prison detention than an admission to a general hospital for a physical ailment, which was under the control of the patient and hospital doctor. Since asylum certification could be prolonged indefinitely, it could create more fear than a prison sentence of finite duration. Discharge from an asylum was also cumbersome. A medical officer and two VC members had to approve it for each patient. Coordinating this often delayed discharge, inadvertently increasing bed occupancy and overcrowding.

People certified under the Act and admitted to public asylums were designated by the doubly stigmatising term "pauper lunatic". The word "pauper" was associated with poverty and destitution and the demeaning epithet of "undeserving". It came to signify any financial dependence on the Board of Guardians ("the Guardians"), the locally elected body which oversaw welfare in its neighbourhood, payed for by local taxation. The Guardians had direct responsibility for social welfare, public health and the workhouse infirmaries which functioned as local general hospitals. For the asylums, the Lunacy Act delineated the Guardians' obligations: to fund the treatment of patients usually resident in their locality, and to delegate the asylum's management to the VC.[48] Typically, when an asylum sought funding from the Guardians to support a patient, the Guardians would assess the patient's finances to determine if they were able to make means-tested contributions to their care. Despite the contributions, the patient was still designated a pauper lunatic. This was raised by Labour Member of Parliament (MP) John Clynes in the House of Commons in 1910, on the grounds that the term pauper lunatic was misleading and offensive to their relatives. The Home Secretary disregarded the emotional distress, blamed the Lunacy Act,[49] and stated that relatives' contributions did not cover the full cost of the patient's stay, so patients were still dependent on the Guardians.[50] The combination of lunatic and pauper designations with "undeserving" implications, plus the need for a magistrate to oversee admission to an asylum, created a multiple whammy of indignity. It also contributed to deterring people from seeking psychiatric help until they, or their family, could cope no longer.[51]

In the context of overcrowded asylums during the war, some leniency appeared in the way the Lunacy Act was interpreted, such as responding

to requests from relatives of patients for the patient to be discharged into their care. Some of these requests, refused shortly before the war on the grounds that the patient remained too unwell, were suddenly agreed when the war began, despite no clinical improvement. Other patients, less helpfully, were discharged from asylums, still unwell, into the care of relatives who had previously been unable to manage them.[52] By interpreting some sections of the Lunacy Act more flexibly, asylum admissions could be limited to the most disturbed civilian patients, while those considered, dependent, harmless or senile were placed in workhouses.[53] Marriott Cooke, who may have had some conflict of interest as a Board member delegated to work with the War Office, stated that long-term workhouse placements suited many asylum patients: they worked well, became attached to the Master and Matron, and had social networks in the local community which would not have been feasible had they stayed in the asylum. An additional motivation was that placements in workhouse were cheaper than in asylums. Conveniently for the Board and the budgets, as Cooke reassured the social welfare reformer Beatrice Webb, former patients "need never be returned to the more expensive asylum accommodation".[54] Occasionally, contingency plans necessitated ignoring the Lunacy Act altogether, such as when considering how to manage the worst scenario, that of a German invasion into Essex: for Severalls asylum near Colchester, the Board and medical superintendent agreed that helpless and violent patients would remain in the asylum under the Red Cross flag and the remainder would "take their chance with other inhabitants" of the area, free to leave without formality.[55]

The Lunacy Act stipulated the maximum amount that a VC could charge the Guardians for each patient: 14s (shillings; 70p) a week. This covered staff salaries and related expenses, some maintainance of the buildings and estate, and allowed for expenditure on consumables, such as food and clothing, at around the level of the poorest of urban households.[56] Asylum fees could only be raised above 14s if the proposal was first published in a local newspaper.[57] In the context of negative pubic perspectives and fear about mental disorder and its treatment which discouraged expenditure on anything other than the cheapest containment in asylums, the Guardians were reluctant to take steps which might make them unpopular with their electorate.[58] In Lomax' words, the "welfare of patients is pitted against the cost to the ratepayers".[59]

With almost no inflation between 1890 until 1914, the 14s maximum was tolerable, but fear of exceeding it ensured that many VCs strived to

minimise their expenditure. With wartime inflation, the asylums tried to remain within the 14s stipulated, despite having to increase staff salaries to cover the higher cost of living.[60] In mid-1915, the LCC was relieved to find that costs of care had risen slower than expected mainly due to economies in the asylums. It did not refer to the possibility that economies might be detrimental to patients, but warned that war time inflation would continue to rise and that asylums must comply with public retrenchment directives,[61] a tall-order for an already cash-strapped system. Financial constraints contributed to friction between VC members and medical superintendents who objected to being told to reduce standards which were "the result of many years of thought and experience" with the warning that "a lowering of standard does not necessarily lead to a saving".[62] Psychiatrist and pathologist Richard Gundry Rows berated the asylum authorities for their financial preoccupations. He expected that if mental disturbance was treated in the early stages (in line with provision for private patients) and that treatment was founded on science, the public would grumble less about expense, in the same way as they accepted rising costs of treating physical disorders.[63] Another psychiatrist, John Keay, then president of the MPA, put asylum expenditure into perspective: the war cost £6.8 million a day compared to £4.6 million annually for the entire UK asylum system. Keay argued that the country could afford better if it wished: prevention was preferable, for both mental disorder and war, but otherwise, like the war, care and treatment for mentally unwell people was a necessity.[64]

As well as minimising expenditure, the asylums tried many ways to subsidise their budgets, with practices established pre-war including recycling, selling or otherwise putting surplus asylum material to good use. These practices continued during the war, but with austerity and material shortages, lower standards were permitted when considering what should be repaired, condemned or recreated.[65] The LCC enquired of their asylums how they economised, such as whether they cooked potatoes in their jackets, and how many garments nurses were allowed to send to the laundry.[66] Some measures showed ingenuity and skill: Colney Hatch, for example, installed tanks in the sculleries to collect grease for making soap, and Hanwell sold hundreds of empty jam tins for 2d (old pence; 1p) each.[67] Colney Hatch also advertised tar, a by-product from the asylum gas-works, at 6d (2½p) a gallon and invited tenders for tons of unwanted lead which had accumulated.[68] Lead was used in munitions manufacture, so was in demand, but it was also a constituent of paint.

Asylums required permission to use their own stocks of paint, but only for essential maintenance, such as repainting rust-prone, out-door iron emergency staircases (Fig. 2.2).[69]

Lunacy law in England and Wales contrasted with that in Scotland which permitted less legalistic approaches to treating mental disorders in publicly funded institutions, ideas which the Board and other psychiatrists were keen to follow.[70] One manifestation of Scottish innovation was the "psychiatric observation unit" established in 1887 at Glasgow's Barnhill Hospital, the local "poorhouse", by John Carswell, a psychiatrist committed to improving public health.[71] Similar units followed in Edinburgh and Dundee. Their wards ran under psychiatric leadership, in contrast to similarly named "observation wards" in England which were led by non-psychiatrically trained workhouse infirmary physicians, and although they aimed to provide initial assessment of mental disturbance, this was often cursory. Standards varied and at times were "disquieting."[72]

Fig. 2.2 Emergency staircase at Hanwell (Photograph by author, 2017)

The model of having psychiatrist-led units outside the asylums and associated with universities was also part of the scene in Germany and Austria and much admired by psychiatrists in England. Emil Kraepelin, a physician, led one of these, a university-funded, research and teaching focussed, psychiatric "clinic" in Munich which allowed admission of patients with early stages of mental disorders on their own volition without legal procedures.[73] Kraepelin's clinic admitted over 1500 patients a year for early treatment.[74] It comprised 120 in-patient beds and out-patient facilities. Wards were quiet and un-crowded with no more than 10 beds in each, contrasting with wards of 50 or more beds in many English asylums. It was well-staffed, with 16 doctors and 53 ward staff plus out-patient physicians, compared to an English asylum, typically with 4 doctors and around 120 ward staff for 1000 patients.[75] High staffing levels were inevitably costly, but with thorough medical assessment and active treatment many patients were discharged, although local long-stay asylums backed up clinics when that was not feasible. Overall, avoiding long-term admissions meant that the clinics were financially sound. Rows commented that Kraepelin's model would enable psychiatrists in England "to take a more honourable position amongst those engaged in the conflict with disease." [76]

Psychiatrist Adolph Meyer in Baltimore was also an advocate of the clinic model. When Meyer addressed the seventeenth International Congress of Medicine in London in 1913.[77] he expressed hopefulness about the treatment of mental disorders, compared to the "pessimism and helplessness" of his English colleagues.[78] He recommended that clinics should be in hospitals familiar to local people, not in asylums. He noted the clinics' goals of "service to the patient rather than to an administrative system" and compared them to "wholesale handling" in asylums.[79] Placing psychiatrists in clinics alongside physicians and surgeons in major centres of clinical practice, teaching and research, could provide opportunities for better psychiatric training, help alleviate some of the professional isolation and acquired stigma of working in a typical rural asylum, and promote exchange of ideas across disciplines. Meyer attributed the slow rate of up-take of the clinic model in Britain to the moralising attitude of Anglo-Saxon communities, which aimed to regulate and remove, rather than to understand psychiatric conditions.[80] Although the observation wards in Scotland were superior to those in England, none of them provided the intensive assessment or treatment of their German counterparts.[81] A few German-style psychiatric clinics emerged in the USA,

founded on the understanding that they were as necessary to psychiatry as to any other medical discipline.[82] In England, Hollander criticised the inhumanity associated with the lack of similar facilities:

> The want of such an establishment in every great urban centre in the country is an expression of passive cruelty and indifference which can only be described as a blot upon our much vaunted civilisation.[83]

University teaching hospital psychiatric facilities were not alien to England,[84] but their value was debated, with particular concern that they might encourage neglect of incurable patients in asylums.[85] Teaching hospital facilities would be permitted under the Lunacy Act because these hospitals were funded from voluntary or charitable sources, rather than drawing on local authority public funds. By 1913, several London teaching hospitals had some sort of out-patient department, but still no in-patient facilities.[86]

Frederick Mott, a dedicated physician and researcher in psychiatry who directed the LCC's Central Pathological Laboratory, proposed the first publicly run German-style psychiatric clinic in England after visiting Kraepelin's clinic in Munich. A gift of £30,000 to the LCC in 1907 by another psychiatrist, Henry Maudsley, kick-started the project, with Mott facilitating the protracted negotiations behind it.[87] Negotiating and building this new "Maudsley Hospital" took eight years.[88] Planned for civilian patients, it became a military mental hospital in which Mott took a significant lead, and only when no longer required for that purpose, in 1923, were its doors opened to its original target population.

The Board of Control, Asylum Leadership and Their Challenges

The Lunacy Act delegated oversight and regulation of the asylums to the Commissioners in Lunacy. This body was reformulated as the Board of Control by the Mental Deficiency Act 1913, but the leadership remained largely unchanged, maintaining stability and expertise, but hardly introducing new blood. The Mental Deficiency Act stipulated Board membership: salaried lawyers and doctors; unpaid lay-commissioners; at least two women, one paid and one unpaid; and at least one member able to undertake inquiries in Welsh.[89] The Board had no direct health-related ministerial-level oversight but was accountable to the Lord Chancellor for some legal matters, and to the Home Office for many other duties

under the rubric of protecting the public and safeguarding rights and liberties of individuals. Within the asylums it worked with the medical superintendents, other senior asylum officers, and the VCs. The VCs were appointed annually[90] and consisted of well-meaning lay people of relatively high social standing in the local community but with little expertise in subjects on which they were expected to make decisions.

In addition to monitoring and regulating public lunacy and mental deficiency institutions, the Board directly managed the criminal lunatic asylums and oversaw many small private establishments which consumed a disproportionate amount of its time. Its lunacy, mental deficiency and criminal asylum roles developed separately, reflecting public understanding. The public regarded mentally deficient people as unfortunate and generally harmless, thus worthy of compassion and philanthropic co-operation with the statutory services. By contrast, according Kathleen Jones, "emotions aroused by the thought of mental illness were so painful that the whole subject tended to be blocked". The public offered little support for mentally disturbed people, for whom care was largely provided by statutory organisations and salaried workers.[91] One small charity, the Mental After Care Association (MACA), functioned mainly in the London area and aimed to assist people regain their confidence and independence after discharge from lunatic asylums.[92] As a further indication of the pecking order of sympathy, philanthropic support was more readily available to criminals on release from prison than pauper lunatic patients on discharge from asylums.[93]

A time-consuming and prolonged dispute about a single patient greeted the Board at its first committee meeting in April 1914, just four months before the war: which institution, a workhouse infirmary or a lunatic asylum, should provide care for 80-year-old Ellen Q? The stalemate was attributed to an invalid Lunacy Act certificate.[94] Since a certificate was normally binding on an asylum to accept a patient, questioning its legality was a convenient way to allow the asylum to refuse to do so, but the deadlock allowed other more fundamental concerns to surface.

The Barnet Guardians approached the Board to intervene in the dispute between them and Napsbury's VC who refused to admit Ellen Q from their workhouse infirmary. Ellen's disturbed behaviour had necessitated the Guardians employing two nurses specifically to look after her over several months "at a cost of Two Guineas a week for salaries besides rations and other expenses."[95] From Napsbury's perspective,

a shortage of female beds meant that "senile" women should not be admitted for care; vacant beds "were to be reserved for patients obviously requiring Asylum care and treatment," a recurrent theme in the twentieth century, of excluding older people on the assumption that they would not benefit from care and that younger people were automatically more deserving of expert attention.[96] The Board objected to this discriminatory stance, stating that Ellen's on-going disturbed behaviours meant that she required admission and should not be "deprived of such care merely on the score of age."[97] Napsbury's VC did not budge.[98] The Board expressed "grave dissatisfaction"[99] stating that the VC showed "a callousness and indifference to the welfare of the insane, which the Board cannot consider creditable to any lunacy authority."[100] Eventually Dr. Rotherham from the Board, and Dr. Rolleston, medical superintendent at Napsbury, jointly assessed Ellen, but we are not privileged to know their opinions: minutes at Napsbury and from the Board fell silent on the matter as the country moved into war.[101] Bed shortages, monetary concerns, rejection of older people from hospitals and asylums, and rigid but opposing perspectives of different players in the fragmented healthcare system were among the tension-creating issues looming large when war broke out.

Visiting committee minutes chiefly recorded practical problems of asylum management and attempts to solve them. Minutes at Colney Hatch demonstrated a range of wartime challenges, such as: providing for refugees, enemy aliens and military patients; managing staff sickness, vacancies, salaries and "war bonuses"; and dealing with infestations of rats, mice and beetles and an outbreak of typhoid fever.[102] Minutes which reported more problems and the actions taken to remedy them could be interpreted in several ways, including that those asylums had higher, rather than lower, standards. The VC's minutes rarely mentioned individual patients, except in the context of discharge or untoward incidents, although occasionally they recorded gifts from former patients, their relatives and staff, grateful for care and support given. Overall, however, since the management hierarchy assumed that asylum care was humane, good practice and kindnesses received little direct comment. Minutes also give insight into activities arranged for patients, and asylum practices such as arranging trial leave before discharge and providing a monetary allowance to assist the patient during it. The Lunacy Act recommended this leave plus the allowance, but VCs often overlooked it, even if the patient had no other means of support, reinforcing the impression that VCs cut corners

on short-term expenditure, even if that might hamper recovery in the longer term.[103]

The Board desired to solve problems in asylums and to ensure good standards, to promote innovation, staff education, research into mental disorders and more liberal lunacy legislation, but it only had authority to advise and lacked power to mandate change.[104] It relied on naming and shaming, suggestion, cajoling and using "informal tactics of persuasion".[105] It did not shy away from criticising medical superintendents and VCs. The Board, for example, pointed out that the medical superintendent at Colney Hatch needed to keep a close eye on ward safety and "impress upon the nurses the absolute necessity of refraining from anything in the nature of rough treatment", with the implication that rough treatment had occurred under his leadership.[106] The Board described another superintendent as "able and energetic in the discharge of his duties" but he needed to develop his asylum "on enlightened modern lines",[107] implying that he was behind the times. The Board could be precise and targeted, verging on harsh, with their criticism sometimes rejected hostilely by the recipient.[108]

To help monitor asylums the Board undertook annual inspections of all the institutions in its charge. However, without formally defined or agreed concepts and criteria for standards of care, Board members judged quality against ideals and expectations inferred from the annual reports, and letters and circulars giving guidance, and from their own experience, including from previous inspections and discussions in their regular team meetings. The effect of subjective, non-standardised values for determining standards could be moderated when two inspectors worked together, but it was problematic when an inspector worked alone. Aware of this, pre-war, the Board delegated two people, usually a doctor and a lawyer to undertake inspections together, but, by 1915 staff shortages reduced this to one.[109] That a lawyer could undertake an inspection alone indicated the emphasis placed on law, rules and regulations, rather than the care and treatment provided and the patients' mental and physical wellbeing. Lawyers were confident that they could undertake the task, although it is hard to believe that they could advise on clinical matters, make judgements on patterns of illness or death statistics or judge conclusively that a patients' complaints were "evidently based on a delusional condition of mind"[110] so that they could justify ignoring them.

Asylum inspections were meant to be unannounced, to give a true understanding of practices within. However, a "mysterious telepathy"

between asylums could provide a couple of hours warning during which time staff were stirred into action, getting patients up, sorting out bed covers, cleaning side rooms, tidying, and improving the visual impression to which the inspectors paid particular attention. A message from the porter's lodge, or a warning along a corridor of approaching senior people, or even an unexpected turn of the key in a locked ward door, could alert staff to their approach.[111] Inspections often lasted one or two days, providing ample time for further window-dressing.[112] Many Board members had previously worked as medical superintendents, so were likely to be aware of the mechanisms by which an asylum could demonstrate high standards during an inspection. If the Board challenged those practices it risked exposing past practices of its own elite membership. By not doing so, the Board contributed to perpetuating the inspection culture and its drawbacks which could undermine rather than enhance patients' wellbeing. Ultimately, a good rating mainly reassured the leadership and the public that all was well, fitting with Goffman's assertion that total institutions present themselves to the public as rational organisations designed "as effective machines for producing a few officially avowed and officially approved ends."[113] Beyond those endpoints, few questions were asked about asylum processes and outcomes.

Preoccupied with asylum safety and disasters which could generate adverse public opinion, the Board scrutinised management of dangerousness and risks of all sorts.[114] Inspectors might initiate a fire drill,[115] aware of the high fire risk with asylums typically having coal fires and gas lighting in wards with wooden floorboards shined with inflammable floor polish and where patients smoked.[116] In 1914, the Board was encouraging installation of central heating, electric lighting and electric fire alarms.[117] Later that year it added telephones and chemical fire extinguishers, both necessary in the event of bombing, with extinguishers essential in the event of a bomb destroying the water mains supplying the fire hydrants.[118] Asylums which lacked the new technologies devised their own fire and air raid warning systems: at Colney Hatch in the event of an air raid warning, the police informed the gate porter or the attendant manning the switchboard who informed the medical superintendent[119]; at Hanwell, if the boiler house engine driver heard a local explosion, he sounded the hooter to summon attendants and workmen who were off duty.[120]

Lomax described inspectors as hurried and blasé, ward staff as constrained and anxious, medical superintendents bored and indifferent,

and lunatics composed and critical, realising that it was all staged.[121] Inspectors focussed largely on the fabric and facilities and what could be observed directly, and senior asylum staff generally accompanied them around the site.[122] This gave patients little chance to speak to inspectors in confidence. Officials who spoke with patients tended to accept their compliments but discount their criticisms, which they attributed to distorted judgement due to their mental disorder. This selectivity was illogical. It also meant that formal inspections were unlikely to detect abusive practices which left no visible bodily or documentary trace. In addition, quiet patients were interpreted as being well cared for, rather than intimidated into submissiveness. Although Lomax referred to the eminent psychiatrist Henry Maudsley using the term "asylum-made lunatics",[123] there was little acknowledgement of the effects of institutionalisation on the behaviour and mental state of patients. That understanding developed several decades later, particularly from the work by Russell Barton in the UK and Erving Goffman in the USA.[124]

As well as ignoring most criticisms by patients, the Board was intolerant of other negative comments, particularly from people of lower social or employment ranks. The Board received a report written by some temporary attendants during the war which mentioned harsh treatment of patients. In response, the Board justified cold-hearted practices and low standards as inevitable due to wartime constraints.[125] Attributing poor care to the war, passed the buck and alleviated pressure on the Board to attempt to advocate for the patients and remedy the situation. Abdicating responsibility was more comfortable psychologically than the uncertainty of having to deal creatively and effectively with substandard care. However, their responses were questionable ethically: physician-members of the Board would have been familiar with the medical ethics principle *primum non nocere*, first do no harm. Denying or hiding problems gave the outside world the impression that all was well. The leadership feared adverse publicity which might undermine the reputation of the asylums and their own status. When the press reported that food at Colney Hatch was "abominably cooked", and when Graylingwell Asylum appeared in the *Times* as "Graylingwell Hell", they responded with rebuttal rather than planning to investigate.[126] After the war, at the Cobb Inquiry, deeper probing into the standards of care and treatment provided in asylums revealed both evasiveness and ignorance of some of the leadership about the poor care they provided for patients.[127]

As with other criticisms of the asylums by those of lower rank, when faced with Lomax's critique of wartime Prestwich Asylum, the Board maintained its usual tactic of downplaying the allegations.[128] This contrasted with the stance taken by Chief Medical Officer Sir George Newman, who acknowledged the variable asylum standards. Newman wrote that Prestwich was one of the least satisfactory asylums:

> buildings are antiquated, and the Medical Superintendent is not conspicuously efficient.…Dr Lomax saw the English asylum system at its worst, the normal defects of Prestwich being aggravated by shortage of staff and strict rationing of food.…Broadly speaking it is true that our asylums are barracks rather than hospitals and the insane are treated more like prisoners than patients.

Newman attributed the difficulties to broader organisational factors pre-war, including: the Lunacy Act; local funding without central government funding; penny-pinching VCs; and the Board being expected to undertake "police duties." He asserted that the issues Lomax raised were well known, an indictment of a government which failed to remedy them. He was pleased that Lomax's book "directed public attention to the defects of a system which has hitherto been taken on trust."[129]

Another aspect of the Board's work concerned collating data, aimed to detect trends to help guide the asylums. Pre-war, asylum staff filled numerous registers and forms which the Board then examined, including about infectious diseases, suspicious deaths, suicides, disciplinary matters, finances, facilities and numbers of "escapes".[130] The Board's first annual report, for 1914, made information available concerning benchmarks, pitfalls to avoid and goals to emulate. The report included quantitative statistical tables and rich narratives of each asylum's inspection: strengths and weaknesses, innovation and stagnation, praise and criticism. Some asylums were good, others far from ideal, but overall, the Board described them as "creditable", even though, by the end of the year, the war had "affected the Asylums to a serious extent".[131] Unfortunately, the asylum narratives were omitted from the annual reports from 1915 until after the war due to staff and paper shortages. The Board also recognised the time-consuming nature of data collection and suspended much of it during the war. As with inspections undertaken by a lone non-medical inspector, amid many other changes occurring simultaneously,

it is unclear whether, or how much, these data and publishing cutbacks affected patients' wellbeing.

General histories of psychiatric services express divergent views about the Board, from Kathleen Jones' praise for their good work, to criticism, such as by Charles Webster, that under its "jealous eye…the system ossified."[132] Marriott Cooke, a member of the Board (and its chairman 1916–1918),[133] was cited as saying that it regarded itself as "the particular friends of the lunatics".[134] Sir Robert Armstrong-Jones, medical superintendent at Claybury until 1916 (knighted in 1917), concurred:

> It may be said without fear of contradiction or exaggeration, that the Board of Control are the best friends of the Insane, and it is to this Board that is due the credit for the high place that the treatment of the Insane is known to occupy in the mind of the informed public in this country.[135]

Armstrong-Jones wrote this just after the Cobb Inquiry. He may have written it to counteract negative public opinion at that time, but it is difficult to justify his sentiments.

Special Care? Service Patients and Other Groups

In contrast to lack of public interest in the welfare of mentally disturbed civilian patients in the asylums, public concern and sympathy was aroused by distressing mental symptoms presenting in soldiers fighting in the front line early in the war. In February 1915, Captain Charles Myers of the Royal Army Medical Corps described three soldiers suffering from mental and physical disturbances but without physical injury. Their symptoms were attributed to shells bursting close to them, but curiously, despite the noise of the blast, their hearing was not disturbed. This observation contributed to Myers concluding that the condition resembled hysteria. The term "shell shock" was already used by the soldiers, and Myers adopted it in his report.[136] The War Office intended to treat men with this condition in the "mental section" of Netley Military Hospital near Southampton and, when faced with growing numbers, in the 2000 beds allocated for the purpose within the war hospitals.[137]

The challenges of providing care and treatment for shell shocked soldiers also inform us about patients and practices in civilian asylums and public perceptions of them. The public, and some members of the medical profession, opposed mentally disturbed soldiers being treated as,

or alongside, pauper lunatics whose care could be demeaning: it would be disrespectful to men whose mental distress was caused by fighting for king and country. Dr. White, "a lady member of the profession", protested in 1917 against nerve-stricken soldiers being sent to lunatic asylums, "worse prisons", she said, than Germany provided for prisoners of war. An anonymous report in the *Journal of Mental Science* expressed outrage at her criticisms, describing them as "unjustified…likely to make a very unfavourable impression on the minds of the public, and [they] are not creditable to any person who makes them."[138] Dr. White's colleagues dismissed her comments, appearing more concerned about adverse publicity. Shooting the messenger for exaggerating or making unjustifiable comparisons allowed the message to be rebutted, the public to be reassured by those with greater authority, and the reputation of the institutions to remain intact.

Many others wanted to prevent traumatised soldiers from entering the asylum system. Robert Cecil MP argued that soldiers with "nerve strain" should "not be placed under asylum administration or in charge of officials connected with lunacy",[139] indicating his lack of confidence in a system regarded as tainted with stigma. Cecil Harmsworth MP proposed a Mental Treatment Bill, to facilitate treatment of mentally disturbed soldiers outside the authority of the Lunacy Act,[140] but it was dropped when it became clear that the Army Act 1881 covered these contingencies.[141] The Army Act gave soldier lunatics the special status of "service" patients, unencumbered by certification or the pauper lunatic label. Some medical superintendents argued that all patients should have the same status, and some VCs responded with objections to *any* patient having the opprobrious label of pauper.[142] According to Marriott Cooke and Hubert Bond, members of the Board who wrote a government endorsed report on the war hospitals, the Board approved avoiding Lunacy Act certification for soldiers as it was "a boon and a solace to the men and their relatives". Alongside this, they promoted the cause of civilian asylum patients, noting long-term problems of negative public attitudes "to be recognised and reckoned with," and that the standards for soldiers should "be extended at the earliest practicable moment to the civilian population."[143]

Military hospitals and dedicated shell shock beds in the war hospital were insufficient to treat large numbers of soldiers so some were transferred to civilian asylums. In these cases, the Ministry of Pensions (created to handle war pensions for former members of the armed forces and their

dependants) would pay the asylum charge, rather than the Guardians.[144] It also paid 3s9d (18½p) a week over and above the usual asylum charge—a third more than the average for a pauper lunatic—plus half-a-crown (12½p) to the individual patient for extra comforts, plus financial support when on trial leave and a war disability pension. These benefits emphasised the meagre provision for civilian patients. On the wards, the special privileges could create jealousy and resentment.[145] For the Treasury, the care package was seen as too lavish and it proposed that the service patient status should expire after one year, to which the Board responded: "Do they then become "paupers" through no fault of their own, indicating the short lived nature of the country's gratitude to them?"[146] An assumed hopeless outlook for lunatics, and qualms about asylums syphoning off public resources which could be spent more constructively on non-psychiatric health and welfare needs, coloured the decisions of those in power.

Within the asylums, particularly Colney Hatch, refugees, prisoners of war (PoWs), "undesirable" aliens under the Aliens Act 1905, and enemy aliens were treated alongside service and pauper patients. For the authorities, the different groups created administrative work as each had a different legal standing with time-consuming bureaucratic technicalities and financial implications. Financing refugees in asylums was relatively simple as they were directly chargeable to Whitehall's Local Government Board, thus imposing no additional expenditure on local authorities.[147] Regarding PoWs, Swiss officials inspected to check their well-being[148] and Colney Hatch's medical superintendent resented the amount of Home Office paperwork associated with monitoring them, the need to liaise with the police who inspected their belongings and interviewed them, and the time spent making plans to ensure their safe departure.[149] Sometimes staff were required to escort them to the port of embarkation or to another destination, creating further demands on the asylum.[150]

A different set of rules regarding residency and finance applied to patients who fell under the Aliens Act 1905. Prompted by concern over mainly Jewish immigration from Eastern Europe, this Act was the first attempt to establish a system of immigration control.[151] Under it, if an immigrant became dependent on poor law relief, which included asylum admission, within 12 months of arriving in England, they could be deported as an "undesirable" alien.[152] This aimed to avoid cost to ratepayers.[153] Mayer L, a patient at Colney Hatch, was Jewish and from

Jerusalem, then under rule by the Ottoman Empire. Just before war broke out, the Home Office decided not to deport him[154]; the VC appealed, but the Home Office stuck to its decision stating that it would be inhumane to do so as he was unlikely to receive adequate treatment in Jerusalem.[155] Mayer L remained in Colney Hatch for two years, and was discharged to the Jews Temporary Shelter, funded by the Jewish community, to avoid him becoming dependent upon poor law relief.[156] After war broke out, as well as being undesirable aliens, people from Germany, Austria-Hungary or Turkey were also designated enemy aliens.

Creating Military Hospitals from Asylums

The War Office requisitioned asylums for billeting soldiers and treating military casualties, creating challenges for the whole asylum system.[157] In 1914, 300 men, 400 horses and "a park of guns" arrived at one Kent asylum and Severalls billeted 4000 troops.[158] The Board transferred newly built but unoccupied asylums, including Moss Side State Institution, Liverpool, and the Maudsley Hospital, to the War Office for treating mentally traumatised soldiers.[159] With the intention of freeing initially 2000 asylum beds for military use,[160] the 97 county and borough asylums were divided geographically into groups, to facilitate the transfer of patients to alternative asylums as locally as possible. Eventually 24 asylums were vacated, comprising over 23,000 beds, almost one quarter of the asylum total.[161] The Board complied with War Office requests half-heartedly, with occasional rhetoric but little more forceful advocacy on behalf of their civilian patients.[162]

Many asylums had to make space for patients transferred from others which were vacated when the War Office requisitioned them. The Board authoritatively stated that 20 per cent overcrowding (i.e. 120 beds in the space usually allocated to 100) would not incur "serious detriment" to the health of civilian asylum patients.[163] Their reassurance was speculative, if not fraudulent, but with their foremost priority being to support the country during the crisis.[164] In mid-1916 Sir William Byles MP asked in the Commons about the degree of asylum overcrowding, receiving the official response that no further reduction in accommodation was proceeding or contemplated.[165] That plan did not hold.

The War Office was particularly keen to take over asylums which had their own railway sidings, useful for transporting wounded men, coal, stores and other essentials. Of the LCC asylums, the "Epsom cluster"

of four, south-west of London, was linked by the Horton Light Railway to Ewell West main line station. It was an obvious location for a war hospital. The LCC negotiated with the Board about providing beds for injured soldiers, contingent upon the Board "giving definite assurance that they will not raise objection to the infraction of rules and regulations" particularly concerning overcrowding and omissions in routine paper-work.[166] Thus Horton Asylum became "The County of London War Hospital Epsom", mainly for soldiers with physical injuries, and the LCC was reassured that compromises were acceptable when providing for civilian patients in its other asylums.

The peace-time arrangement whereby asylums receiving out-of-county patients could demand a higher fee from the requesting authority,[167] ceased for transfers made when creating war hospitals. In theory, within the Epsom cluster, it should have been straight forward to empty one asylum by transferring patients to the others. In practice, many were transferred further afield, in open-top "motor char-a-bancs and by omnibuses."[168] Hanwell accepted 173 patients, using basements, halls and whatever other space could be found.[169] Colney Hatch took 300 patients who all arrived on one afternoon.[170] The influx of patients added to the worsening staff-to-patient ratios.[171] Decisions to transfer patients long distances, over 150 miles in some cases, were taken locally, a difficult task for the VCs, disapproved of by the Board, and resented by patients and their families.[172] However, where possible, asylums took account of people's personal circumstances before moving them: when James R was transferred from Cane Hill, a LCC asylum in Surrey, to Gateshead in County Durham, his brother requested his return so that he could visit him: the VC refused, on the grounds that no one had visited him since his admission 14 years previously.[173]

Patients moved from their asylum lost their "home" and many familiar faces associated with it. The VC and medical superintendent usually remained at the vacated asylum, to equip the hospital, engage more staff and manage it under the direction of the War Office which also defrayed additional costs and provided "fully trained nurses".[174] Most asylum doctors and ward staff remained at their asylum, rather than accompany their mentally unwell patients elsewhere.[175] Ward staff retained their salaries, but were demoted: experienced nurses to probationer grade, and attendants to orderlies, reflecting the standards of their physical-disorder nursing skills. The War Office also agreed to make available additional

surgical support for "serious operations", although routine surgical procedures and anaesthesia, as when pauper lunatics required comparable interventions, continued to be undertaken by the asylum medical officers based on their medical student training.[176]

Many modifications, of various sorts, were made to convert asylums into war hospitals. Work undertaken improved the ward lighting and heating; introduced electricity (ostensibly for X-ray equipment); and provided more toilets and bathrooms and better internal décor.[177] This upgrading had the implication that mentally unwell civilian patients, and their staff, could cope with antiquated facilities but wounded soldiers and those tending them deserved better. Regarding asylum paraphernalia, "everything in the buildings which might be objectionably reminiscent of their normal purposes" had to go, such as padded rooms, blocks on windows to prevent escape, and the excessive number of doors locked with a key. Lunacy stigma might also taint soldiers in death: if they died in a war hospital they were to be buried with military funerals and "In no case should a soldier be buried in that part of a local cemetery which has been specially set apart for insane patients dying in the Asylum".[178] A rare glimpse of equality between asylums and war hospitals was indicated in the decision that labour-saving devices installed in war hospital kitchens and laundries would remain on site when the building reverted to civilian use.[179]

Horton received mainly physically injured soldiers. Additional beds were required for those with mental disturbances. Napsbury Asylum, like Horton, had a dedicated railway siding so was favourable to the War Office. Napsbury also had 1500 civilian patients, with 1200 in its main building and 300 in a separate admissions unit. Initially, the War Office acquired the smaller building for mentally traumatised soldiers, its civilian occupants being transferred to the main asylum.[180] A high fence separated the new 300-bed Middlesex County War Hospital from the main asylum a few metres away,[181] protecting the sensibilities of the soldiers and their visitors from association with the pauper lunatics. The war hospital also provided a superior level of leisure facilities for the soldiers compared to the civilian patients: new purchases included 2 billiard tables with all accessories at a cost of £73, more than the annual salary of many asylum staff.[182]

The rest of Napsbury was vacated to become a war hospital for physically injured soldiers in May 1916.[183] In line with the Board's guidance, Napsbury aimed to transfer its asylum patients as short a distance as

possible.[184] However, many were transported 70 miles away to Severalls, with others scattered across at least 18 asylums, mainly in south east England.[185] Eighty civilian patients remained at Napsbury to work the 426 acre farm and gardens.[186] The Edgware Guardians queried this: surely if these patients were working, the Guardians need not pay for them? There was no flexibility when it came to these costs: the VC informed the Guardians that the standard fees covered all patients, whether usefully employed or not.[187]

Almost half a million men received treatment in asylum war hospitals, more than one-sixth of the total number of those sick and wounded from all fronts,[188] including 38,000 with mental disturbances.[189] In April 1919, Napsbury still had over 1000 military patients, and VC minutes gave no clue as to when civilian patients might return. Staff were restless, still working wartime shifts, longer than their pre-war hours.[190] Contrary to promises earlier in the war,[191] the authorities planned to remove the kitchen and laundry labour-saving devices before the civilian patients returned, on the grounds that patients would otherwise be unable to take up their former roles, and because machinery would "reduce the useful work upon which patients can now be employed."[192] With a high turnover of civilian patients—admissions, discharges and deaths—in the intervening years, how many would actually return was unclear. Unrealistically, the authorities wanted to pick up where they had left off, bizarrely seeming to regard patients as a group whose insanity was so all-encompassing that it made them oblivious to the war and unaffected by the changes imposed on their lives.

Reconstruction

The Cabinet established a Reconstruction Committee in 1916 to plan for after the war. Demoralisation at home and devastation abroad made planning essential, for economic and social welfare recovery, and to convince people that things could get better.[193] The Committee sought advice from numerous statutory bodies, including the Board, but the Board was disturbed by its emphasis on physical health without mental health. The Committee's stress was probably due to competing priorities, with deep concern about maternal ill-health, high infant mortality and a declining birth-rate, and because between 40 and 60 per cent of recruits for the British Army were turned down as physically unfit for service.[194] Failing to mention mental health, however, suggested that the

Committee did not appreciate the incapacitating nature of severe mental disorders, whether suffered by soldiers or civilians. The Board did not reply to the circular until prompted by the Committee to do so.[195] The Board's reply respectfully stated that it hoped the Committee's expression "health of the population" included both mental and physical health and that the Committee agreed that they were equally important. It informed the Committee of the benefits of admitting mentally disturbed soldiers without certification to allow early treatment which could facilitate recovery and it reiterated the need for similar admission procedures for civilian patients, which had so far only been achieved to facilitate admission to the Maudsley Hospital when it could eventually open its doors to them.[196]

Alongside seeking advice for post-war health priorities, the Reconstruction Committee was interested in plans to create a Ministry of Health, to improve and coordinate health care and public health more generally, which, according Walter Holland and Susie Stewart, were "something of a patchwork of ramshackle and uncoordinated services".[197] Public opinion also favoured the creation of the Ministry, which came into being post-war after "much political machination".[198] The Board feared that the new Ministry might remove its independence, but it also envisaged advantages of mental health being part of a comprehensive national health scheme, giving opportunities for prevention and treatment, and reducing stigma.[199] The Board had insightful ideas to improve services and to counteract damaging public opinion, but its ability to implement them was questionable.

For public opinion to benefit patients, the authorities had to take it seriously. Occasionally this happened. In 1917, the LCC noted that patients, their relatives and the wider public preferred the designation "hospital" over "asylum" and acknowledged their backing as "an important factor in the success or failure" of planning. LCC asylums thus became "mental hospitals".[200] A year later, other asylums followed.[201] For economy's sake, the Board insisted that supplies of old headed paper would have to be used before ordering new, and legal documents would retain the old designation until altered by law.[202] The law, by then almost 30 years old, was a stumbling block to fully implementing this change, as it was to allowing a more flexible system of admission.

Also linked to public opinion, the MPA was optimistic about the speed at which legal reform might materialise:

> public attention has been awakened by the mental cases resulting from the war, and that during the era of reconstruction that must inevitably follow when peace is finally declared….a more enlightened opinion may prevail which may lead to better provision being made for the treatment of certain types of mental disorder.[203]

In 1920, however, the Board acknowledged its failure to achieve prompt amendment to the Lunacy Act to enable early and voluntary treatment and to establish psychiatric wards and out-patient clinics in general hospitals. The Board suggested other ways for VCs to fulfil their duty to ensure that patients received "treatment on modern lines". These included encouraging VCs to make postgraduate psychiatric training with paid study leave mandatory (a financial issue), and setting a maximum of 50 new patients to be under the care of a single medical officer (with both recruitment and financial implications).[204] These recommendations hardly reached the standard of Kraepelin's clinic established 15 years earlier, and the competing pressures meant that the reality of implementing them was far from certain.

In October 1918, with the expectation that the war was nearly over, the Board met with VCs from across the country. Much of their discussion consisted of reiterated, unimplemented ideas, such as: the need for more research; better public and staff education on mental disorders; administrative support for medical superintendents, as in general hospitals; standardised wages, terms of employment and hours of duty; and abolishing the stigmatising labels of pauper, lunatic and asylum.[205] Novel recommendations derived from wartime experiences were lacking. The Cabinet Committee on Post War Priority, and its successors, would help shape if, how and when the ideas could be taken forward.[206] Mental health had never been at the top of the national priority ladder and it seemed unlikely to reach that position soon, despite MPA optimism.

Lack of priority for asylum change was likely to have been associated with the fall in number of civilian patients during the war. Admissions fell from over 23,000 a year in 1914 to around 20–21,000 annually during the war. Lower admission rates were attributed to better population mental health linked to greater social cohesion and high employment rates, a notion which has some support from the international decline in suicide rates in countries directly involved in the conflict.[207] Alcohol related admissions also declined, associated with restricted licencing hours and reduced liquor consumption.[208] High asylum death rates also

contributed (see Chapter 7), and doctors and magistrates may have interpreted the Lunacy Act more liberally, being reluctant to certify patients into overcrowded, understaffed and sub-standard facilities. Also, men who became mentally unwell while on military service were initially admitted to war hospitals, beyond the Board's statistical radar.[209] Optimistically, or perhaps naïvely, the Board did not envisage an more patients post-war, with the consequences that it took a *laissez faire* approach to seeking more resources in the reconstruction period.[210]

Bedford Pierce, medical superintendent at the York Retreat and president of the MPA in 1919 wrote optimistically in the *Journal of Mental Science*:

> I cannot but think that the old days of autocratic management are over, and though some who think a beneficent autocracy is the best form of government may lament the change, we can nevertheless look forward without dismay to the new era of democratic control if the proletariat recognises its responsibility.[211]

His political insights aligned with other social and political changes. From abroad came news of the Russian Revolution.[212] At home changes included the Representation of the People Act 1918, the Education Act 1918, the Ministry of Health Act 1919 and the Sex Disqualification (Removal) Act 1919. These changes had potential to expand social opportunities and wellbeing for people with the least voice, both inside and outside the asylums. On the other side of the coin, post-war, the government had to pay off an enormous national debt. Local authorities curbed spending in every direction and the Board only authorised capital expenditure for essential maintenance of the fabric of asylums or for "promoting the health of the patients and the staff."[213] "Geddes Axe", the outcome of Sir Eric Geddes' Committee on National Expenditure in 1922, further restricted public spending. Without public demand, despite being chronically underfunded, the asylums were "low-hanging fruit" whose fortunes were unlikely to improve. [214] Public support for mentally disturbed soldiers during the war dwindled, and provision for them gradually merged into the existing asylum system rather than leading to asylum reform. By 1922, 5000 soldiers resided in public asylums in England and Wales alongside the pauper lunatics.[215] The same year, the report of the War Office committee of enquiry into shell shock, made no recommendations about reform of civilian asylum law or practice.[216] A further

eight years would elapse before the Mental Treatment Act 1930 which created a less legalistic approach to admission and discharge. Overall, the shell shock legacy added little to debate on post-war improvements for patients in civilian asylums and mental hospitals. Lomax's critique, the voice of a low status temporary member of staff whose views were typically discounted by the asylum leadership, ultimately proved more effective.[217]

Conclusions

The process of creating the war hospitals and the military, political and public responses to shell shock indicated inadequacies of the asylums and the lunacy system, but did not directly trigger reform of asylum culture and practices.[218] The Board lacked authority to prevent low standards or enforce the best practices for which it and a few psychiatrist-reformers advocated. The tactics of persuasion allowed to the Board were insufficient to change a complex conservative culture where multiple stakeholders had divergent concerns, lay VCs were insufficiently trained to make the decisions expected of them, patients' voices were barely audible or credible and a moralising public was largely unsympathetic, including as ratepayers. The top-down hierarchical management structure meant that the Board obeyed, almost without question, the obligations placed on it by its task masters in central government and by the Lunacy Act, passed a quarter of a century earlier and criticised at the time by psychiatrists as unfit for purpose. The Board policed compliance with the Lunacy Act by its bureaucratic monitoring of all aspects of asylum practices. The importance of this legal role was demonstrated when lawyer Board members inspected asylums alone. Policing and legal compliance helped transmit an authoritarian culture into the asylums, which neither inspired nor encouraged lateral-thinking, creativity or innovation. A few chinks of flexibility appeared in the Lunacy Act, apparently without adverse consequences.

Occasionally the Board challenged its superiors, but it is debatable how much it could do this without threatening its own reputation as a compliant and effective body. Its position was particularly difficult when higher-ranked authorities, such as the Reconstruction Committee, lacked understanding of mental disorders and asylums. The hierarchical assumption within the asylum system that the most senior knew best, meant that criticism, especially from people lower in the hierarchy was explained away rather than evaluated. Despite rhetoric about tackling asylum problems,

the top-down approach inhibited the leadership from engaging with lower ranks to understand what needed to be done.

In Peter Barham's view the Board was "squeezed between conflicting interests and visions of its objectives".[219] The Board and other leaders in the asylum hierarchy appeared satisfied to stick with what they knew best, which maintained the organisational *status quo* as far as possible. But as circumstances changed, the *status quo* was not necessarily fit for purpose.

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Insanity: Interpretive Practice and Treating Patients

Introduction: Lily's Story

Henry R was concerned about his wife Lily, a 43-year-old mother-of-two. She had been nursing his stepmother "which was very trying" and it had "unhinged her mind". Mindful of the stressful domestic environment, the family sought no treatment until the situation was desperate. The stigma of certification, the pauper lunatic label, and the belief that the war was nearly over so the stress would diminish, were likely to have contributed to their decision to wait. Lily was admitted to the mental observation ward at St. John's Road workhouse infirmary in Islington in July 1918, and from there to Colney Hatch Asylum.[1] Mentally disturbed people were frequently admitted first to an observation ward, likely to be relatively close to their home compared to an asylum beyond the suburbs. However, these wards were often ill-equipped and "without means of classification of maniacal, suicidal, or mildly affected patients".[2] Interactions between staff and patients could be unhelpful: a former asylum patient who had been certified while in an observation ward recalled that the workhouse medical officer was "a gentleman and very kind", but the head attendant was "a complete savage in every way".[3]

From observation ward to certification under the Lunacy Act 1890 was a small medico-legal step with profound implications for the patient. Once a person was certified under the Act an asylum was obliged to accept them, regardless of any underlying physical disorder causing their mental

disturbance. The most experienced psychiatrists, those working in the asylum, had no part in deciding who would be admitted under their care. This was inequitable with the authority given to general hospital doctors treating physical conditions, who decided which patients to admit to their wards. The system favoured the opinions of general hospital doctors who did not want to treat disturbed patients, especially if perceived as elderly or likely to have an unfavourable prognosis. As John Keay, president of the Medico-Psychological Association (MPA), commented in 1918: "the most trifling mental abnormality is used as the pretext for sending to the asylum".[4] One neurologist proposed that every general hospital should provide wards to treat mentally disturbed patients who had underlying physical disorders, including isolation wards where quiet was not essential, to ensure that they received the most appropriate treatment.[5] The existence of such wards is elusive.

Attitudes of senior doctors in general hospitals contributed to increasing the proportion of older people in asylums who were regarded as senile and untreatable. By the time war broke out, over 15 per cent of asylum patients were over 60 years old, drawn from five per cent of the population of the same age group.[6] Some, such as Emma Matilda L (Fig. 3.1), were admitted "in a dying condition and all [were] in a very reduced bodily condition."[7] Asylum staff were perplexed why such physically ill people were sent to their institutions rather than treated in the local general hospital.[8]

Returning to Lily, the obligatory doctor's certificate required for asylum admission recorded her disturbed behaviour:

> highly amused with herself; when asked questions she starts quoting some simple rhyme and keeps time to the metre by shaking her head from side to side and ends with an emphatic nod and then glares at you. She is sometimes very noisy and destructive, smashing the mug she is drinking from.

On arrival at Colney Hatch the medical officer examined her and summarised:

> She is suffering from mania. Is very noisy, restless and agitated – wanders about the room talking incessantly to herself, and is at times resistive to attention. She has obvious hallucinations, both visual and auditory – hears and answers the voices of imaginary persons, and describes the wonderful

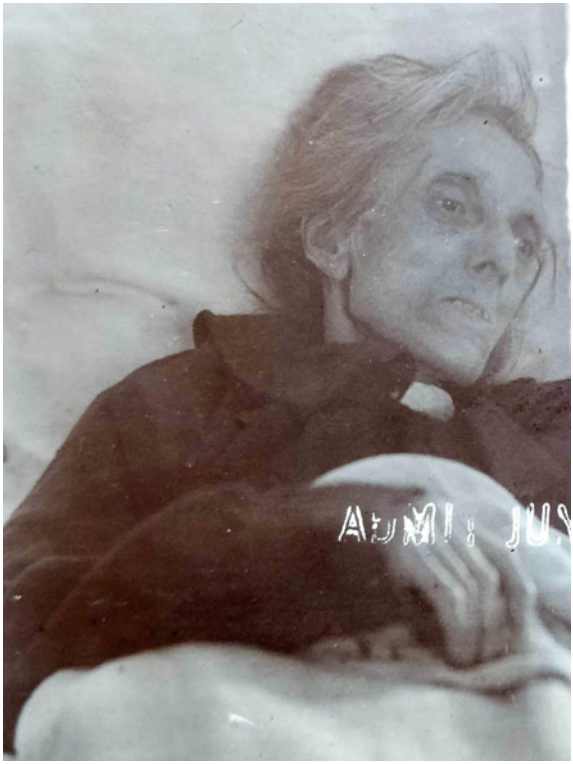

Fig. 3.1 Emma Matilda L, just after admission to an asylum (Photographs of female patients at Colney Hatch 1918–1920 H12/CH/B/18/004 LMA)

> coloured lights which appear in the padded room at night and by their movements convey messages to her. She mistakes identities recognising strangers as old friends and is faulty in her personal habits. She is in great impaired health suffering from advanced Pulmonary Tuberculosis and is regarded as not likely to live long.[9]

The term mania indicated a general state of mental and physical over-activity, rather than the specific diagnosis of manic-depression (bipolar disorder).[10] Lily's mania was probably "acute delirious mania" or "acute delirium", both terms used at the time.[11] It was often rapidly fatal because it was associated with underlying severe physical illness, a relationship

recognised since antiquity.[12] The workhouse infirmary did not mention Lily's tuberculosis in its handover to the asylum. They may have overlooked it or ignored it in the course of their preoccupation with her mental state. It is doubtful that Lily's physical illness trajectory could have been reversed, but for other people with less advanced or different illnesses, treatment in a general hospital might have secured a better outcome. Lily's transfer to an overcrowded asylum which lacked isolation facilities also jeopardised other patients who were put at risk of catching her infection. Lily died a few weeks later. Her post-mortem confirmed the diagnosis: "Both lungs riddled with tubercle with cavities of varying sizes in both lobes."[13]

Lily's journey from community, via the observation ward and into the asylum raises many issues about the mental disorders suffered by people admitted as pauper lunatics. This chapter seeks to explore some of them. The chapter begins by touching on the stresses of wartime life in the community, even though the Lunacy Act did not permit asylums to undertake out-patient or community work. It then focusses on mental disorders more generally, but with special reference to the patients in the public lunatic asylums: classification; research; nature and nurture hypotheses; treatment and convalescence.

Air Raids and Other War Stresses in the Community

During air raids early in the war, while some people ran for their cellars, others flocked onto the streets to watch the airships illuminated by search lights and to see their shells exploding. Anticipation of further raids caused some people anxiety, nightmares, insomnia and exhaustion. There was real danger, but Freudian interpretations also circulated, relating to the airships' phallic shape.[14]

Medical historians interested in the First World War have tended to focus on shell shock or the population's physical health, as reflected in national agendas at that time.[15] Concerning civilian mental health, there is little historical research about it, in contrast to much appertaining to it during the Second World War. Historical analysis about the latter provides some clues about issues likely to have been present in the earlier war, such as civilian morale, responses to threats of air raids and the presentation of symptoms. Edgar Jones and colleagues in their Second World War study,

found that predictions of mass air raid neurosis failed to materialize: civilians proved more resilient than planners had predicted, largely because they had underestimated public adaptability and resourcefulness.[16] Hazel Croft, in a study of civilian neuroses also in the Second World War noted that wartime camaraderie, full employment, active roles in civil defence and war work may have assisted wellbeing. Reluctance to admit to mental symptoms which could be seen as personal failings, the incentive to be an ideal, stoical citizen, and that many people would not have taken their worries as a health matter to their family doctor, may have both concealed the true amount of mental disturbance and kept the sufferer away from mental institutions.[17] Croft's and Jones' analyses cannot be directly extrapolated backwards to the First World War, but they provide some possible explanations in support of the data which point to relatively few civilians being admitted to asylums due to unmanageable mental stress.

Of a random sample of 49 First World War civilian admissions to Colney Hatch, Claybury, Hanwell and Napsbury,[18] stress, worry, fright and fear relating to daily life in London were identified as presumed causes in five. On the one hand, this may be an under-estimate because attributing causes was an in-exact science and asylum records were incomplete. On the other hand, of these five, possibly three whose conditions were initially attributed to stress had other disorders to explain their symptoms. Lily was one. James N was another who was subsequently diagnosed with general paralysis of the insane (GPI, brain syphilis). He is discussed later in this chapter. Arabella M (Fig. 3.2), a 53-year-old house-

Fig. 3.2 Arabella M, admitted with "Worry and Zeppelin fright" (Photographs of female patients at Colney Hatch 1908–1918 H12/CH/B/18/003 LMA)

wife, was admitted to Colney Hatch, with mental distress attributed to "Worry and Zeppelin fright", but her case records also suggest overlap with physical illness.[19]

The figures do not suggest that the asylum population in the London area was overwhelmed with psychologically distressed patients. In contrast, in a study of the Denbigh Asylum serving north Wales, Pamela Michael identified 19 per cent of admissions in 1918 associated with "war worry".[20] Fear of raids in Wales may have caused more mental disturbance than for Londoners who developed strategies to deal with them. Similarly, as Harry Bernstein, born in 1910 and growing up almost 200 miles from London in Stockport, Cheshire, wrote: "The German zeppelins were bombing London and fear hung over us constantly."[21]

Threats other than bombs also created stress. Some people developed anxiety and depression fearful of the consequences for their loved ones fighting in the trenches or devastated by their deaths. For some women, keeping intensely busy was another way of coping, including making the most of new opportunities to work outside the home.[22] For others changes in roles and employment, and consequent financial difficulties, were traumatic. For Louise F (Fig. 3.3), a single 34-year-old Turkish "enemy alien", a financial crisis precipitated her admission to Claybury.

Fig. 3.3 Louise F, an enemy alien (Claybury: Female Patient Case Notes 1917; Redbridge Heritage Centre, 2020)

Louise had worked in England for 12 years, but in 1917 she was unemployed, her status making work hard to find. She sold her belongings to support herself. Almost destitute, when the coal merchant failed to deliver her coal, she smashed his shop window in despair and anger. The magistrate sentenced her to a week in Brixton Prison from where she was released to the workhouse. There, she was distressed and refused to eat, and was certified for asylum admission. Six months later, she was discharged fully recovered via a Mental After Care Association convalescent house.[23] The asylum had provided care and time for her to recover from her ordeal. She returned to work as a nurse and dress designer.[24]

Undoubtedly some people were admitted to asylums suffering directly from the effects of war time stress, but given the limited data collected during the war by the asylums' Board of Control ("the Board"), the patchiness of case notes, plus inaccuracies in specifying the causes of mental symptom and other factors affecting bed occupancy, it would be imprudent to estimate the number of asylum patients admitted directly and solely due to the stresses of war. Overall, asylum case notes suggest that they were admitted infrequently, and, as for Louise F, those whose symptoms were really due to stresses in civilian life, they improved and were discharged. This contrasts with the many admitted with life threatening or incurable mental and physical disorders.

Understanding Mental Disorders: Classification

Concerning the healthcare of sick people in England, psychiatrist Adolph Meyer, looking on from the USA, commented:

> One comes closest to the truth about English medicine in saying that it's conceived as the art of healing, to which science is subordinated. Practical matters receive priority everywhere.[25]

Doctors were trained as apprentices to treat patients to the best of their ability guided by their professional ethics, with hypotheses less important. In asylum practice, the Lunacy Act undermined the tradition of medical empiricism, of helping people when they needed help. It introduced conflict for doctors between providing timely treatment when the sufferer sought it or needed it or might benefit from it, and delays because certification was only possible with more severe symptoms. Clinical records reveal patients' disabling psychiatric symptoms and the suffering of those

admitted to the asylums. Sarah F's tortured expression indicated her anguish (Fig. 3.4).[26] She, and others unwell due to mental disorders, required compassion and help in the broadest sense, regardless of theories and legalities.

Meyer's observation fits with Tracy Loughran's argument that "British doctors were self-consciously proud of the empiricism of their medical tradition", in contrast to the "French and German taste for abstract theorisation."[27] Nevertheless, British psychiatrists were active in debates on some philosophical questions, such as the nature of insanity. There was no accepted single definition; all were unsatisfactory, vague and subjective with their value debated and with unclear dividing lines between normal, abnormal and eccentricity.[28] The Lunacy Act was unhelpful, stating that "'Lunatic' means an idiot or person of unsound mind".[29] Psychiatrist Charles Mercier wrote on the difficulties of defining insanity:

> No doubt we all have a certain vague notion in our minds, but the fact that we cannot put the notion into words shows that the notion is but vague and cloudy, sadly lacking in precision and definiteness.

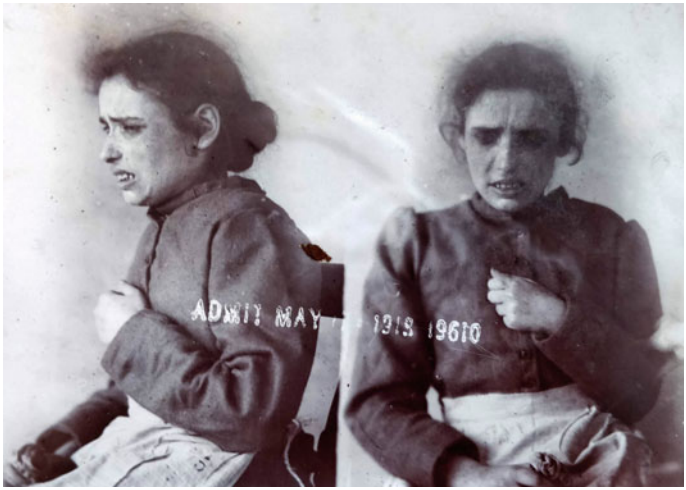

Fig. 3.4 Sarah F, in need of help (Photographs of female patients at Colney Hatch 1918–1920 H12/CH/B/18/004 LMA)

With his own characteristic eccentricity and boldness, lack of clarity did not stop him declaring that his own equally vague definition of insanity, an all-encompassing disorder of mind and conduct, was the best.[30] John Turner, medical superintendent of the Essex County Asylum at Brentwood, aimed for more precision and defined a "certifiable lunatic" as "one whose conduct (owing to disease) is persistently out of harmony with his environment, and who is, or may become, a source of harm to himself or a danger or annoyance to the community."[31] It too was inadequate, raising questions about the meaning of psychiatric "disease" and introducing social factors which could vary across place and time. Another physician, Edward Younger, advised that a doctor giving evidence in a law court should refuse to define insanity.[32] The difficulty of defining it was also a concern outside the medical profession. Earl Russell, perhaps influenced by personal experience, his own behaviours from time to time being on the fringes of public acceptability, commented in the House of Lords in 1914 that "whether a person is sane or insane is one of the most difficult matters that doctors have to decide, the dividing line being so fine".[33]

Not only was the overall definition of insanity inadequate, but classifying the array of different disorders within it was likewise problematic. Disease classification was founded on the system of the biological sciences. Meaningful categories depended upon whether symptoms were consistent across time and culture: if they had a biological basis they would exist in the same form in different places and times. This bore out the need to identify the *form* of symptoms, rather than their culture-bound *content* which varied across time and place, influenced by contemporary cultural issues and belief systems.[34] Classification was challenging for psychiatric symptoms which often lacked a clear underlying physical pathology, but identifying the type of disorder was important as each type would be expected to behave in a characteristic way with regard to causes, prognoses and treatments. Without clear physical pathology, psychiatric classification was (and is) based on clinicans' expertise in psychopathology, influenced by social and cultural expectations of disease and normality.[35] A degree of subjectivity was inevitable. Recognising these uncertainties could also contribute to public fear of wrongful confinement due to inaccurate medical assessments.[36]

Classification of psychiatric disorders was not just of interest in England, but was under consideration in Germany. Many psychiatrists outside Germany desired to emulate Emil Kraepelin's "clinic",

but responses to his psychiatric classification varied.[37] Meyer initially welcomed Kraepelin's diagnostic classification, particularly concerning manic-depression and dementia praecox (later known as schizophrenia), as the break-through which psychiatry was waiting for, but he later criticised it for being too neurological and failing to take into account the context of the patient's life story.[38] Mercier accused his colleagues of following "Continental fashion"[39] and Havelock Ellis, a physician, better known for his studies on sexuality, acknowledged the snags of psychiatric classification generally and Kraepelin's classification in particular:

> It is impossible to consider the miscellaneous cases brought together by Kraepelin under the heading of manic-depressive insanity as a single disease….We learn nothing by placing a case in a "natural classification" which has no existence, and can have no existence, in the sense understood by Kraepelin.[40]

The war may have influenced negativity towards German psychiatric research. Near the end of the war, president of the American Medico-Psychological Association, James Anglin, described his colleagues as "infatuated with German pseudo-discoveries". Subjectivity associated with personal anguish may have clouded his views, mentioning in that lecture, the death of his eldest son at Vimy Ridge, his second a "permanent cripple", a third still fighting, and another preparing to travel to war.[41]

During the First World War and through to today, uncertainties in knowledge and understanding reflect different and evolving psychiatric classification systems and a thirst to find meaning, order and clinical guidance. In the context of many divergent views, the Board classified mental disorders based on their presumed causes, in the hope that it could reveal information useful for prevention and treatment.[42] Regarding causation, psychiatrist Bernard Hollander drew attention to the importance of environmental and social factors, Mercier emphasised concepts drawn from understandings about physical illness, while others favoured inherited risks.[43] A search for causes fitted with the belief that mental disease originated beyond skull and brain, in line with recent discoveries of invisible causes of physical disease identified through studies of physiology, pathology and bacteriology.[44] This was also compatible with observations that physical and mental disturbances overlapped, as in Lily's case, and that they had common causes, despite mechanisms remaining obscure.[45]

These overlaps encouraged the practice of carrying out post-mortems on almost all asylum patients (discussed further in Chapter 7): if causes could not be determined during life, it was appropriate to search for them after death. Biological explanations also had other advantages, such as the potential to avoid blaming patients for their own mental problems and reducing punitive responses to their otherwise inexplicable behaviours. The colloquialism "pull yourself together" was known by the mid-nineteenth century,[46] indicating that the speaker believed that a mentally disturbed person could immediately revert to normal. That was no truer for severe mental than physical illness: as Dr. Montagu Lomax advised in his critique of war time psychiatric practice: "it is as rational to punish a mental patient for refractory behaviour as it would be to punish a typhoid fever case for a rise in temperature."[47]

For each patient admitted, the Board pragmatically sought to record "predisposing" and "exciting" factors which could occur alone or in combination. These fitted with the need to disentangle multiple theories of causation, but as indicated for Lily R, Arabella M and James N, attributing causation was prone to inaccuracies. Before the war, from 1907 to 1911, the Board identified the main causes of admission to be alcohol, prolonged mental stress, "insane heredity", senility, GPI and epilepsy, with some gender variation for each (Table 3.1).[48] Pre-war data is the best available because the Board discontinued its multi-page tabular compilations of causation as part of reducing the administrative workload

Table 3.1 Yearly average of the total incidence of each cause (for first admissions) assigned without any correlated cause or factor, 1907–1911

	Males		*Females*	
	n	%	*n*	%
Alcohol	707	20.5	311	8.5
Prolonged mental stress	567	16.5	642	17.6
Insane heredity	399	11.5	538	14.7
Senility	328	9.5	416	11.4
Acquired syphilis (GPI)	311	9.0	40	1.1
Epilepsy	220	6.4	165	4.5
Total	3443		3649	

Source Commissioners in Lunacy, Tables xvii (male), xviii (female): causes of first admissions, excluding to idiot establishments, 1907–1911, MH51/687 TNA.

during the war. Of note, very few people were admitted with so-called "moral insanity", a subject which has entered recent public discourse through early twenty-first century novels depicting women incarcerated for no other reason than having given birth to an illegitimate child.[49] There is little evidence that unmarried mothers were admitted to asylums in the war years unless they also had mental symptoms, or they fell under the rules of the Mental Deficiency Act (MDA) 1913. The MDA, but not the Lunacy Act, obliged authorities to admit to an institution a woman known to be mentally defective "who is in receipt of poor law relief at the time of giving birth to an illegitimate child, or when pregnant of such child".[50] Objectives of this rule included preventing further pregnancies and preserving the woman's health and the ratepayers' pockets. Punishment was not integral to the plan, on the assumption that the pregnancies resulted from vulnerable women being exploited by men. The women tended to be admitted to mental deficiency institutions, lunatic asylums being considered inappropriate for their long-term detention.

Despite treatment implications derived from classifications based on symptoms or causation, they had little part in informing the organisation of asylums. Asylums adopted patient classifications based on "conduct, habits and bodily states" to place patients into "infirmary", "quiet", or "troublesome" wards.[51] These categories often had little to do with the individual's treatment or prognosis, but were convenient for the asylum. Some new patients were placed on wards appropriate to their needs, but others, such as some who were very disturbed, could be placed on wards with the most difficult to manage long-stay patients who had different disorders and therapeutic needs.[52] If the acutely disturbed new patient settled while on a ward of mainly long-stay patients suffering persistent behavioural symptoms, he could be overlooked relative to those who demanded more attention. Alternatively, if a new patient saw that difficult behaviours attracted staff attention, this could accentuate his disturbances, which could bring about the assumption that he had a similar chronic disorder. Either way, the new patient would be disadvantaged. The outspoken psychiatrist Lionel Weatherly criticised the combination of inadequate classification together with overcrowding.[53] The worst scenario, according to Nurse Jane Dagg who gave evidence to the post-war Cobb Inquiry, was overcrowding with no classification, as in the asylum where she had worked.[54] Little attention was paid to the merits of clinically focussed classifications or the understanding that acute disorders were more likely to improve than chronic. According to Weatherly, and to

Herbert Ellis, a magistrate and asylum management "visiting" committee member, the way patients were classified in asylums was influenced by short term financial considerations.[55]

Researching Mental Conditions

"Scientific" classification of mental disorders was an aid to undertaking meaningful research, and its haphazard utilisation may have been one factor contributing to Hugh Freeman's analysis that British psychiatrists produced relatively little of importance from their research.[56] Despite this, the *Journal of Mental Science* (*JMS*),[57] published by the Medico-Psychological Association (MPA), brought together much research from home and abroad, pointing to diverse concerns and priorities, including a tendency for researchers to grapple with somatic, bodily processes thought to be associated with mental disorders, rather than the mental disorders themselves. Reports in the *JMS* on "vaccine therapeutics", dysentery, enteric fever (typhoid) and inflammation, read more like a journal of microbiology, rather than psychiatry.[58] Alongside the *JMS*, the *Lancet*, published for a broad medical readership, indicated other psychiatric preoccupations, including shell shock, lunacy legislation,[59] sedative medication[60] and "sexual perversion".[61] Weighing up the multiplicity of often contradictory research findings was far from straight forward, itself a demonstration of the lack of a secure scientific knowledge-base for clinical, policy and administrative decision making. Randomised controlled trials were not yet established in medical research, and together with embryonic statistical methodology, these factors often made conclusions hard to draw. George Savage commented that new discoveries challenged earlier certainties: "we must 'wait and see'; that we are prepared to follow truth where it leads, and that a dim light is better than none in such darkness as the realms of life and consciousness."[62]

Another factor contributing to the paucity of psychiatric research in England was the lack of an academic backbone for psychiatry, in contrast to the world-leaders in the field in German speaking countries.[63] Also, in contrast to the trend in much of western Europe, English-speaking countries separated the medical specialties of psychiatry (brain: mainly mental and behavioural manifestations) and neurology (brain: mainly bodily manifestations), despite much clinical overlap. British neurology became a discipline with high prestige and impressive clinical and scientific standards, in contrast to psychiatry. Many neurologists worked in

private practice and had time for research. Most lacked experience of, or clinical responsibility for, patients in asylums although their research was pertinent to them. Neurologist John Hughlings Jackson, for example, researched epilepsy, yet he was unlikely to look after people with the severest forms of the disorder who frequently resided in asylums. In contrast to neurological research, little took place in asylums which were cut off, geographically and intellectually, at a distance from teaching hospitals and universities, and with their staff submerged by heavy workloads.

Despite lack of participation in research, as the content of the *JMS* indicated, psychiatrists sought answers to many of the problems faced in their clinical work. In 1912, almost every asylum authority in England and Wales sent delegates to a conference in London to discuss improving research into mental diseases. The conference stressed the importance of government funding for research (as provided in Germany) and informed the Prime Minister and Chancellor of the Exchequer of that.[64] Just before war broke out, the Board and MPA planned further discussions on taking research forward.[65] Later in 1914, the Treasury granted the Board £1500 to spend on research.[66] This was a pitiful proportion of the overall government medical research budget of £58,000.[67] The many applications for funding suggested interest in undertaking psychiatric research but limited expertise to carry it out.[68] Around the beginning of the war, the *JMS* and the Board reported on progress made in research from the asylums, including on the perennial enigmas of asylum dysentery, biological markers of insanities, and the relationship between insanity and mental deficiency.[69] Research on mental disorders was challenging, but financial priorities may have contributed to John Keay's frustration: "Why should insanity be left behind when so much forward endeavour is made in general medicine?".[70]

Most psychiatric research ceased during the war but a fresh clinical challenge loomed at its end: to unravel the new, disabling condition of encephalitis lethargica, later immortalised in Oliver Sacks' *Awakenings*[71] and Harold Pinter's *A Kind of Alaska*.[72] Despite an early consensus that the disorder resulted from the 1918–1919 influenza pandemic, evaluating the evidence was tricky and the hypothesis was gradually replaced by scepticism.[73]

GPI: Clinical Challenge, Research and Cautious Responses to Innovation

Research guided by the desire to identify physical causes of mental disorders had direct relevance to the welfare of patients in the asylums. General paralysis of the insane (GPI) provides an illustration of this. GPI could be difficult to diagnose from the patient's history and mental state examination, hardly surprising given that its symptoms were multiple and variable. The Wassermann blood test introduced in 1907 helped, but could give false positives. In 1913, Noguchi identified the spirochaete treponema pallidum, a bacterium, in the cerebro-spinal fluid surrounding the brain, thus verifying that syphilis caused GPI. Cautious psychiatrists in England, however, remained wary of both the Wassermann test, which moved slowly and erratically into asylum use,[74] and of Noguchi's evidence, acknowledging in 1918 that the spirochaete "probably" caused GPI.[75]

Some patients with GPI were women but most were men, often described as "powerful, hearty men, who had lived hard and never ailed…had 'burnt the candle at both ends,' and had led irregular if not debauched lives".[76] Syphilis was acquired sexually, but the spirochaete could spread to many body organs. When in the brain, its array of symptoms often included delusions of grandeur, which could result in financial ruin for a family.[77] Salvarsan, an arsenic-based drug, could cure bodily syphilis[78] but had no effect on the spirochaetes once they had entered the brain.[79] Some men so feared developing GPI that, after an "indiscretion with a woman", they developed another psychiatric disorder—syphilophobia—which could "drift into insanity" or lead to suicide.[80]

GPI was inevitably fatal: disinhibited behaviour, restlessness, seizures and difficulty swallowing food were associated with an undignified asylum death, such for Emma Sarah M who gave birth at Claybury in November 1914 while suffering from seizures caused by the disorder. Her baby survived, and, aware of the stigma derived from insanity, the asylum arranged a birth certificate which did not state the place of birth.[81] James N, a more typical patient with GPI, was a single, 34-year-old clothing factory machinist,[82] admitted to Colney Hatch. He was described as suffering from stress, and was sullen, melancholic, and restless. He refused food, likely associated with his "delusions that he is 'full up' to the neck and that he cannot pass his water or faeces." He developed seizures and died shortly after admission.[83]

Given the progressive and fatal nature of GPI, finding effective treatment was essential, even if the treatment itself had risks. During the war, Julius Wagner-Jauregg in Vienna, inoculated patients with malaria parasites to induce high fevers to kill the heat-sensitive spirochetes. He published his findings in 1919.[84] Malaria treatment was dangerous, but until penicillin became available nearly three decades later, it was the only hope. Malaria treatment, alongside other clinical innovations, received a characteristically cautious reception from psychiatrists in England. Drastic treatments in psychiatry were appearing around the same time as risky interventions for other fatal disorders. William Halstead, for example, introduced the "radical" mastectomy for breast cancer, in the belief that cure was more likely with ever wider surgical resection.[85]

Caution and scepticism about innovative clinical methods was a double-edged sword. On the one hand it could prevent harm by avoiding insufficiently proven new methods, and on the other, it could cause harm by rejecting new and effective procedures. In contrast to the conservative approach of psychiatrists in England, and in the context of multiple hypotheses about infections combined with ideas about the benefits of radical treatments, less conformist colleagues risked generating over-zealous and unregulated treatments. This happened in the USA. Henry Cotton at Trenton State Asylum instigated a programme of radical surgery for psychiatric patients, to remove various organs harbouring suspected "focal infection" which supposedly produced or perpetuated their mental disorder.[86] Some of Cotton's patients, probably coincidentally, recovered mentally after his interventions, but evaluation of the treatment neglected the overall balance between healing and harm, including death. Surgery for focal infection, however, was not confined to psychiatry. It was also used for preventing physical disorders, such as "routine" tonsillectomy in children, once commonplace but later discredited as a prophylactic public health measure.[87] Despite some admiration for Cotton's work in the UK, his regime was not replicated on this side of the Atlantic where psychiatrists were arguably less innovative and more restrained in their treatments.[88]

English psychiatrists weighed up risks in a generally risk-averse asylum culture. They took clinical risks from time to time, usually in desperation. Tube feeding, is one example, undertaken on patients usually gravely ill, likely to have severe mental illness, stupor, food refusal and dehydration, all compounding the risks of the feeding.[89] English psychiatrists also adopted some fashions or fads used for treating physical illness. The Royal

Society of Medicine (RSM), alongside its more traditional medical and surgical sections, had a "Section of Electrotherapeutics", which advocated the use of X-rays and therapeutic electricity, the latter compatible with the understanding of electrical impulses in the nervous system. It also had a "Section of Balneology and Climatology" which included therapeutic bathing considered beneficial for many physical and mental disorders. Accepted but unproven, balneological therapeutic measures in asylums included prolonged warm baths for "motor excitement", Turkish baths for "simple melancholia" and brief cold showers or baths "to overcome certain resistances in the nervous system" in stupor.[90]

Use of electricity became an attractive therapeutic tool, acceptable to professionals and public, and of interest even to cautious asylum doctors. Shifting from simple therapeutic bathing, more risky methods evolved, such as combining bathing plus electricity in an "electric bath".[91] This was believed to stimulate stuporose patients and to help excretion of toxins in schizophrenia. Using baths specially constructed from earthenware or wood, with a large flat copper electrode covered with towelling at each end connected to a battery, the procedure was considered safe. Twenty-two-year-old Annie H reportedly benefitted from electric baths, then died suddenly after a treatment. According to the Board, procedures had been followed correctly, staff supervised the bathing and applied the correct current. At post-mortem Annie was found to have "status lymphaticus", characterised by large thymus, thyroid and lymph glands, and bone marrow hyperplasia. The coroner concluded that her death was due to sudden paralysis of the heart due to status lymphaticus, unrelated to the bath.[92]

But what was status lymphaticus? Detected at post-mortem, usually after a sudden death when under medical care, its incidence increased in parallel with the use of anaesthetics. It was a convenient post-mortem diagnosis. For bereaved relatives, scientific explanations were more acceptable than "a visitation of God" in an increasingly secular society. It also provided a way for coroners to justify a verdict of death from natural causes, much to the relief of the medical profession. The existence of status lymphaticus was debated during the first half of the twentieth century, then disappeared from the medical corpus.[93] In reality, it never existed. It deflected blame for medical failure onto the patient. It was a diagnostic label created to fulfil professional and social needs. In this instance, it primarily protected the medical profession. Post-mortem findings were probably extremes of normal, modified by age,

and mis-interpreted as abnormal, but with credibility compounded by the ferocious search for physical aetiologies.[94]

Nature and Nurture: Biological, Social and Psychological

In their style of pragmatic and cautious consideration, psychiatrists in England tried to fathom out which vulnerabilities predisposed to mental breakdown, and why people responded differently to similar hazards, such as infective organisms, social circumstances, alcohol, or war stresses. In their clinical practice, according to Loughran, they took a "magpie approach", choosing apparently useful aspects of particular theories without any one predominating.[95] Meyer's work also advocated a combined biological, psychological and social ("bio-psycho-social") approach to mental disorders, and looked beyond single issues and promoted an eclectic approach to treatment.[96] There was little consensus on the relative contributions of heredity, brain disease, infection, psycho-social, spiritual and other medical and non-medical factors to causing mental disorders. Debates on causes of mental disorder in civilian patients dovetailed with those concerning aetiology of shell shock—commotion, emotion or both—which continued throughout the war.[97] Baffled by the lack of clarity on causation of mental disorders, the Ministry of Pensions asked the Board for a simple rule to help clerical staff determine pension eligibility for mentally disturbed soldiers: the Board declined to provide one.[98]

Prominent biological theories of heredity included "degeneration", a downwards movement of health and wellbeing of individuals, families and society. Degeneration theories had punctuated Western philosophy, politics and religion for centuries,[99] and according to George Rosen, ideas included that once degeneracy set in, "the various generations of a family went inexorably to their doom."[100] Bénédict Morel introduced his *Dégénérescence* hypothesis in the 1850s, using it to explain mental and social disturbances.[101] The theory gained ground, among public, politicians, physicians and scientists including the influential psychiatrist Henry Maudsley who regarded degeneration as a threat to the prevailing culture of the British Empire and to European "civilisation".[102] As well as being founded on dubious scientific evidence, degeneration had racist and eugenic interpretations.

Benjamin Seebohm Rowntree proposed an alternative causal explanation for the numerous problems experienced by working class people: poverty.[103] Since poverty tended to affect whole families, it complicated differentiating between nature and nurture, intrinsic and extrinsic causes. In contrast to poverty being a primary cause, degeneration provided excuses, convenient for the elite, for failures of society. Blaming the constitution of the individual rather than intervening to alleviate poverty assuaged the consciences of the ruling classes. Degeneration theory, by its message of inevitable decline, could also discourage public interest in people in asylums whose problems were attributed to it. It added to stigma and gave a sense of hopelessness, a lost cause.

Degeneration had other effects on attitudes and practices in asylums. It was a reassuring and comforting "scientific" explanation for psychiatrists who failed to cure their patients. Nevertheless, many psychiatrists were also aware that theories of degeneration or heredity did not always hold: children of insane parents did not necessarily become insane or show other predicted decline or deficits.[104] Ideas of degeneration or heredity, or as Bill Bynum characterised it, a "concept of progressive hereditary degeneration",[105] did not deter psychiatrists from treating their patients labelled in this way, nor did it preclude rehabilitation, discharge or normal life events, as in the case of Dorothea S, a 33-year-old a single woman from Islington who assisted her mother Adelaide to run a boarding house before her admission to Colney Hatch.[106] Discharged after 18-months, labelled as suffering from "Mental Stress. Insane Heredity", three months later she married George M, a clerical worker, one of the residents of the boarding house.[107]

Although degeneracy and hereditary labels were ignored in terms of prognosis and treatment for individuals, according to Richard Walter, in his essay "What became of the degenerate?", eugenicists "adopted many of the claims of the devotees of degeneration."[108] Eugenics encouraged the reproduction of people with "desirable" traits, and discouraged reproduction of those with "undesirable". Eugenic proposals included sterilising the "unfit", such as insane people.[109] The war added other dimensions to the degeneration debate: if British soldiers were not degenerate, why did so many succumb to shell shock? Conversely, if they were degenerate, how did they win the war? Edward Shorter argued that degeneration theories were being discredited within psychiatry before the war,[110] although in England psychiatrists had never unanimously accepted them. Daniel Pick argued that the war "put paid to the dominance of

dégénérescence within psychiatry and shifted the language of debate."[111] Nevertheless, the Board received the following statement before it was put to a meeting of the Board of Guardians at Sevenoaks in Kent in 1918:

> The War has taken an appalling toll on the lives of the noblest and best of our manhood, yet, today, too little or nothing is being done to safeguard the Race from the menace of the weak and dependent who constitute an ever growing financial burden on the Ratepayers, who, in themselves, are becoming yearly less able to bear the strain.[112]

The Board of Control stood its ground against eugenic proposals, including from psychiatrists, to sterilise insane patients, and against public opinion which surfaced advocating for it.[113] The war may have undermined degeneration theories, but related ideas around eugenics continued.

Biological and degeneration theories had the potential to profoundly affect the wellbeing of patients, but over-enthusiasm in that direction was tempered by the conservative culture of the medical profession and ideas on causes and treatment of mental disturbance arising from new mind-focussed disciplines. Concepts of psychology, psychoanalysis, and suggestive therapies were expounded by new professional groupings.[114] Some psychiatrists, such as Bernard Hart, medical superintendent of a private asylum and lecturer at University College Hospital, London, advocated for their methods as integral to the practice of psychiatry.[115] Lomax also recommended a psychological approach, such as placating and reasoning with patients to modify their behaviours.[116] At a basic level of psycho-social treatment, asylum staff were meant to demonstrate exemplary conduct to help correct patients' behavioural disturbances. While some staff used psychological skills acquired from experience, such as to diffuse a difficult ward situation, more widespread use of psychological methods would require more, and better trained, staff.[117]

Psychoanalysis gave new perspectives on causes and treatment of mental distress. It became better known in England concurrent with the war. Sigmund Freud's theories were translated into English by Ernest Jones, his disciple in England.[118] Carl Jung's British followers began promoting his views, arguing that his more optimistic and less sexually oriented conception of the unconscious was preferable to Freud's. However, mid-war, the *JMS* gave an airing to French zoologist Yves Delage who likened Freud's theories to an army or infectious disorder:

> This new affection, which threatens to invade France, had its birth in Austria, at Vienna, some twenty years ago. Its progress, at first very slow, soon became rapid, and the spread of the evil generally now knows no pause….it would be imprudent to allow ourselves to be lulled to sleep under a delusive sense of security.[119]

Mercier also ridiculed Freud's theories of sexual excess, repressed complexes and infantile sexual longings, and asserted: "I do not hold that there is only one cause of mental disease. If I did so hold, I should be little better than a psycho-analyst."[120] Some doctors found psychoanalytic theories meaningful in their private work and when working with shell-shocked patients, such as WHR Rivers whose broadly psychological approach included catharsis, re-education, faith and suggestion.[121] However, as with much of psychiatric practice, clinicians used different methods. Lewis Yealland, for example, in contrast to Rivers, advocated a "disciplinary" and physical approach to shell shock and administered electric shocks.[122] More widely, psychoanalytic concepts and methods gained popularity mainly among the educated lay public.[123] Psychological and psychotherapeutic processes were far-removed from asylum practices even though they fitted with ideals of practice recommended by psychiatrists, that treatment for insanity must be humane and "individual".[124]

Treatments: Moral and Medical, Restraint and Seclusion

Within the asylums, despite psychiatric recommendations for treatment to be individual and commenced as early as possible, just as for physical illnesses,[125] achieving this was beyond imagination. With the country's military needs taking precedence asylums were short staffed, losing the precious commodity of staff time to build therapeutic relationships and use their existing psychological skills to manage the most difficult, and potentially dangerous, patients. Lomax wrote: "To crowd lunatics into asylums is worse than useless unless we have some recognized principles of treating them when once we have got them there".[126] At the Cobb Inquiry, one former patient said: "If a man gets better it is in spite of the treatment, not because of it".[127] Another declared that in the asylum where he was admitted "There was no mental treatment at all".[128]

"Moral" treatment, which emphasised achieving mental and physical well-being, emerged as an ideal way of treating psychiatric disturbance, but it was never adopted widely. It was particularly hard to implement in larger, impersonal, overcrowded and inadequately staffed asylums. The method was attributed to William Tuke, the non-medical founder of the York Retreat. Despite support from psychiatrists, Bynum argued that "Professional, social, and economic considerations coloured their own judgments and tempered the enthusiasm they showed towards moral therapy". They were prepared to adopt features of it into their own therapeutic programmes, but not to jettison their medical models.[129] Alongside medical models and some practices inspired by moral treatment, asylums used many other approaches including careful attention and watchfulness, dealing with "dirty habits" (incontinence), and preventing physical injury or suicide, or death due to "maniacal exhaustion, an ending which is looked upon in asylums as being something of an opprobrium to those who have had charge of the case".[130]

Curative medications were generally unavailable for psychiatric and physical disorders. The psycho-pharmacopoeia was limited. Iron, quinine, arsenic, and strychnine were used as tonics.[131] A range of sedatives were available, with lack of consensus on whether to use them, which ones, and at what dosage.[132] Suggested drug treatments were often accompanied by warnings of their limited usefulness and toxicity.[133] Relying on imported medication, which was sometimes delayed at the docks during the war,[134] could have benefits and drawbacks for patients.

Laxatives were an ancient remedy for mental disturbance still within the psycho-pharmacopoeia. John Haslam, an eighteenth-century physician, referred to laxatives as "cathartics", the cleansing process of catharsis referring to purging bowels or mind.[135] They were also used to sedate, in the sense that profuse diarrhoea would temporarily weaken a patient, rendering him less liable to aggressive outbursts. Some doctors prescribed tiny doses of the laxative croton oil, up to 1 minim, the volume of a single drop of water, for constipation in patients who would not, or could not, cooperate with taking medication.[136] However, the tiny volume also made croton oil liable to misuse, easy for staff to dispense on a whim or conceal in food or drink. Weatherly and Lomax alleged that potent laxatives, particularly croton oil, were given punitively without the dose being documented.[137] The Cobb Inquiry investigated this allegation. It obtained records of purchases of croton oil at several asylums during

1919. Prestwich, where Lomas had worked, purchased around 6500 minims, compared to 480 minims at Colney Hatch and none at other asylums.[138] Although drug purchases depended upon how much the asylum had in stock, this was unlikely to account for the enormous differences. Neither could asylum size nor different types of illness or symptoms account for it, adding weight to the suspicion that some asylums used croton oil to punish, exhaust and sedate. Punitive practices may have been deliberately malicious, but could also have reflected lack of training and a despairing staff body who could not cope with the demands placed upon them (see Chapter 4).

Lomax agreed with psychiatrist William Stoddart that hefty sedation was "a refined substitute for hitting [the patient] on the head with a club."[139] Another term for using medication to calm disturbed behaviour was "chemical restraint", with controlling effects comparable to "manual restraint" which required person to person contact or "mechanical restraint" which required equipment. Manual and chemical methods were usually initiated by ward staff in response to a crisis. These methods were not formally monitored but there were guidelines to ensure safety of both parties: "A violent patient must be overcome by weight of numbers and never by blows or any such form of retaliation" wrote Stoddart.[140] However, unregulated and transitory, chemical and manual restraint could be secretive, abusive and punitive, and manual restraint could cause severe injuries (see Chapter 8).

By the war, early forms of mechanical restraint such as chains and shackles had been replaced by devices usually of cloth or leather, such as straitjackets and strong dresses made of very thick material and fastened at the back with sleeves which could be tied to the patient's torso. Jane Hamlett and Lesley Hoskins, in their study of asylum clothing, explained that restraint in a strong dress was "theoretically, a means of management and a treatment rather than a punishment but it did mark out 'difficult' patients and was certainly open to overuse or abuse by ward staff."[141] Mechanical restraint could be applied for prolonged periods and was known to be used punitively, hence it was monitored by the Board under the Lunacy Act.[142] A senior staff member needed to authorise the procedure, to document the reasons for using it and the duration of use.[143] Another method of control was seclusion, with reasons for monitoring similar to those for mechanical restraint. Lomax and Stoddart disapproved of restraint and seclusion generally, and instead advocated

taking a disturbed patient out of doors to calm down, giving him a football,[144] or "turning him into the garden by himself and keeping him there till his aggressiveness has blown over".[145] Restraint and seclusion methods were commonplace during the war, as they were less labour intensive for staff than finding out the cause of a patient's restlessness, or providing social or psychological calming alternatives.[146]

Some asylums used either mechanical restraint or seclusion, some both, others neither.[147] Some differences in recorded usage may be accounted for by furtive completion of records.[148] At Claybury, for example, medical superintendent Robert Armstrong-Jones reported to his committee that when patient Harriet R was wrapped in a wet blanket, a recognised means of mechanical restraint, "her limbs had been quite free to move, and therefore the case had not been entered in the register",[149] despite rules that the reasons for using it had to be documented rather than the outcome of doing so. Soon after this, the Board inspected Claybury and commended it for not using mechanical restraint.[150] This sequence of events suggests that using methods of which the Board disapproved, encouraged deception, left the Board unaware of the extent of their use, and maintained appearances of good practice. Weatherly reflected on restraint procedures: "Whenever I see in the reports of the Commissioners the statement, "We are glad to see that there is no record of mechanical restraint," I often wonder what substitute has been used".[151] He also wrote:

> Nothing, to my mind, is worse than to see a suicidal patient struggling with two or three nurses or attendants, and I have often been told by such patients how much they appreciated the kindly supervised mechanical restraint that I had ordered.[152]

Perhaps self-congratulatory, and although his opinion was contrary to the Lunacy Act and the official standpoint of the Board, others agreed with him that the type of restraint was not as important as using it humanely.[153] Another method of mechanical restraint which by-passed official gaze was to sit particularly difficult patients against a wall with a heavy table pushed close in front of them, without amusement or employment, only allowing them out to use the lavatory. In this way, one attendant could observe several difficult patients. Lomax described this

as a "brutalizing form of restraint", "an inhuman device to save attendants trouble".[154] Established practices which made life easier for the staff persisted even when condemned as cruel: placing patients "behind the table" continued at Prestwich into the 1950s, according to a staff member witness speaking in an oral history interview.[155]

Seclusion was meant to provide "time-out", a cooling-off period for extremely disturbed people, but it could also be used punitively, resembling solitary confinement in prisons. Some seclusion rooms were padded, and many were unheated and lacked light and ventilation. Furniture was attached to the floor to prevent it being used to harm self or others. Each room generally had an observation window or peep hole in the door which was openable only from the outside.[156] Lomax advocated having an attendant always outside the door to avoid the patients' "horror of loneliness and darkness which make them worse."[157] In an autobiographical account of his experience in an Australian asylum, Mr. D Davidson described his isolation in a "cell" with an "eye-hole" through which a tall man occasionally squinted at him. Davidson linked his isolation and observation to the worsening of his terrifying beliefs that he would be tortured and killed.[158] Another patient, James Scott, wrote about "padded cells", and drew one with a patient naked inside (Fig. 3.5). It is unclear whether the "hideous" sounds he referred to were the reason for, or outcome of, the seclusion:

> The padded cells in an asylum are the most dreadful places imaginable; and the sounds which emanate from them, customarily, are hideous. I fervently ask the Almighty to spare me from ever again hearing such soul haunting noises, blasphemies, obscenities, cries and moans, as those which I so often heard during my four years imprisonment in the awful institution of which I am now disclosing the secrets.[159]

Fig. 3.5 James Scott's drawing of a seclusion room (James Scott, *Sane in Asylum Walls* [London: Fowler Wright, 1931], facing p. 102) (Copyright: owner sought but not found)

Recovery, Convalescence and Discharge

Despite inadequate and harsh treatment in asylums, a proportion of patients recovered sufficiently to be discharged. However, in 1916, Weatherly reminded his readers that "the recovery-rate of mental diseases is…no higher than it was in the 'seventies' of the last century."[160] The annual recovery and discharge rate from lunacy institutions declined, from around 40 per cent of admissions between 1889 and 1905, to 32 per cent by 1914, and 27 per cent in 1918 (Table 3.2). In 1913,

Table 3.2 Rates of recovery, 1878–1919, across all lunacy institutions in England and Wales

Years	*Men: % of annual admissions*	*Men: % of total resident*	*Women: % of annual admissions*	*Women: % of total resident*
1878–1882	36.1	10.6	43.7	11.4
1883–1887	35.6	9.7	44.5	10.6
1888–1897	35.3	9.8	42.5	10.4
1898–1902	34.7	9.2	40.4	9.3
1903–1907	33.6	8.2	40.6	8.9
1908–1912	30.8	6.6	37.7	7.6
1913–1917	29.1	5.7	35.9	6.7
1918	22.8	5.2	30.9	6.5
1919	25.0	6.5	38.0	8.4

Source Sixth Annual Report of the Board of Control, for the Year 1919 (London: HMSO, 1920) Appendix A, 22–23.

about 10,000 people were discharged, but some of them were classed as "relieved" (somewhat better) or "not improved", rather than "recovered". Recovery data are not straightforward, partly because the Board sometimes used the term synonymously with discharge. Data on recovery rates were also presented in two ways: as a proportion of the number of admissions in any one year and compared to the total asylum population (Table 3.2).[161] The first gave a far more optimistic view than the second. These data are also difficult to interpret because numerous factors contributed to the changing discharge rates, such as admissions of more patients like Lily, with disturbed behaviour due to underlying physical illness, and bed shortages so that only the most unwell were admitted. Overcrowding and understaffing hindered staff-patient therapeutic relationships, reinforced custodial practices and minimised occupational and social treatments, all of which had the potential to affect recovery. Other less well-founded explanations for reduced recovery included that mental disorders were becoming more incurable and that clinicians were getting better at detecting insanity making them reluctant to discharge patients until all their symptoms had resolved.[162] These explanations, convenient and credible to the leadership, exonerated the medical officers from failing to cure their patients while praising their expertise.

Although discharge became increasingly unlikely with longer duration of admission,[163] some discharges occurred after many years, such

as for Ida D (Fig. 3.6[164]). Ida was a single 38-year-old cork cutter who lived with her widowed mother in Whitechapel.[165] She was admitted to Colney Hatch in 1914 with a one-month history of mental disturbance. She was discharged "not improved" in 1951, 37 years later.[166] This preceded Ministry of Health policies on closing institutions and developing community care, suggesting that the discharge initiative came from the asylum itself or from friends or a charity outside the institution. Contrary to stereotypical assumptions, age was no bar to discharge, either for Ida after her long admission or for Albert A in 1914 (Fig. 3.6[167]). Albert was a 73-year-old widowed, former horse cab driver from Stoke Newington then working as a messenger.[168] He was admitted to Colney Hatch with his "first attack" of insanity attributed to alcohol and arteriosclerosis. Four months later, shortly before war broke out, he was discharged to the care of his son.[169] Despite overall poor discharge rates,

Fig. 3.6 Discharged contrary to expectations: Ida D and Albert A (Photographs of female patients 1908–1918 H12/CH/B/18/003 and male patients 1908–1920 H12/CH/B/19/003 at Colney Hatch, LMA)

the stories of Ida and Albert go some way to counteracting the impression of inevitable and permanent long-term confinement, even for patients considered to have an unfavourable outlook.[170]

As with other aspects of psychiatric care, asylum doctors aspired to the clinical methods of their colleagues who treated patients with physical illness or injury. In this case, a period of convalescence (from Latin, *con valescere*, to grow strong or well) was a frequent part of medical and surgical practice to enhance recovery. The concept of convalescence was widely understood including outside medicine, such as for national and economic health; Winston Churchill used it to describe the country's post-war recovery.[171] Some asylums had convalescent wards in the main hospital, others had villas set aside in the grounds for that purpose. Unfortunately, detached villas were particularly vulnerable to being taken over for other purposes during the war, compounding the staffing and overcrowding challenges which impinged on therapeutic social interactions integral to the process of rehabilitation.

Convalescence, as many other aspects of asylum life, has been criticised by social scientists and historians. Stephen Soanes summarised views of Erving Goffman, Andrew Scull and others, that convalescence was part of a system of control, an extension of the ward system, a disciplinary mechanism, and that it "had a subordinate and perhaps deceptive place in the asylum, as classification that pointed to imminent release, but actually formed part of a primarily carceral institution."[172] This criticism ignored the imperative to discharge as many patients as possible in order to vacate beds to allow new admissions. It also failed to take into account the extraordinarily slow pace of recovery from mental breakdown, to rebuild self-confidence and self-esteem, deal with fear of relapse, and rebuild fractured social and employment relationships, hurdles recognised by some asylums which did provide convalescence.[173]

Alongside convalescence, the asylums had the option of granting a patient up to four weeks trial leave to help identify their needs prior to full discharge, aiming to prevent "early relapses—so vexatious and dispiriting to the authority concerned".[174] Patients were described as being "on trial", a term with ambiguous judicial connotations. Hubert Bond, a senior member of the Board, advocated that asylums should follow the Lunacy Act, which permitted them to provide a monetary allowance for each patient during leave.[175] This could relieve financial stress and might help create a successful outcome. Despite these ideals, asylums varied in their approach to trial leave, from none,[176] to leave plus allowance.[177]

Some asylums would not provide the allowance, viewing it as unnecessary, or extravagant, even though many patients had no other financial support at that time.[178] During the war, austerity meant that the London County Council did not enforce the recommendation,[179] despite the risk of that impeding outcome.

To promote successful discharge, Bond also encouraged "after-care". The Mental After Care Association (MACA), was founded in 1879 by Henry Hawkins, chaplain at Colney Hatch. MACA mainly provided clothing, tools to help patients restart their trade, a place in a cottage home for convalescence, and assistance finding employment,[180] tailoring its support to individual needs.[181] It worked closely with local Guardians, who often had long-term knowledge about a family.[182] MACA described itself as a "unique charity…doing work untouched by any other Association",[183] but it was relatively small, its resources only stretching to about 600 discharges each year, mainly in the London area.[184] Bond encouraged medical superintendents to inform MACA of impending discharges, with the patients' agreement, and MACA liaised constructively with medical superintendents, even after discharge.[185]

Bond wanted MACA to serve all patients who were likely to benefit from its support in the course of their discharge from a public asylum.[186] However, there was diversity of opinion. Not all asylum committees agreed with Bond. One in Berkshire considered it inadvisable to have a dedicated "after-care committee" because

> when patients are discharged…they do not in any way wish to be considered as in need of after-care or different from their fellows….in many cases it is obviously to their advantage, that their residence in a Mental Hospital should be forgotten.[187]

This opinion contradicted MACA's experience. For example, in the employment-seeking advertisements which it placed in newspapers on the patients' behalf, it often stated: "Has been mentally ill, now perfectly well and strong".[188] This honesty did not preclude former patients from obtaining work, although not all placements lasted, due to employer, employee, or wider social factors.[189] Philanthropic donations also indicated public sympathy, rather than ostracism, towards people recovering from mental disorder, however, MACA's focus on London does not allow judgement about generosity or attitudes elsewhere. Despite donations, without statutory support, MACA lacked the means to satisfy demand for

its services. In Bond's understanding, after-care helped prevent relapses, so was "economically worthy of generous support"[190] and the Board requested funding for it in its proposals to the Reconstruction Committee in 1917.[191] The evidence that after-care could benefit patients and that MACA received public support for its work, raises questions about the attitudes and understanding of those people running the asylums who opposed it.

MACA was necessarily selective about whom it supported, but many of those it helped remained well.[192] Recipients were generally grateful, and some reimbursed the charity all that it had spent on them.[193] Some case studies are preserved in the MACA archive, but it is unclear if they form a representative sample or a successful-outcome sample. Nevertheless, they provide insights into the diverse and personal support given, and a few are therefore worthy of mention here. One, Norman B, a 36-year-old electrical engineer who worked well in the asylum engineer's workshop during his admission, wanted to be a ship's engineer. With some financial support from MACA, and their letters to potential employers, he got work on board a ship, and went to Ceylon (Sri Lanka).[194] Another, Annie Sh, was also helped by MACA. Her asylum admission was precipitated by her husband's marital infidelity. With MACA's help, Annie obtained a legal separation from him, custody of their three children and 15 shillings a week to support them.[195]

MACA also accepted a referral for George C who needed new clothes and sought work as a baker. It provided some clothing from its own store with the rest made-to-measure. It placed an advert in the *Daily Chronicle*: "Bakers.- Respectable young man, 20, seeks situation as assistant; experienced; good references."[196] George found a job quickly, but found the work too onerous, so left and enlisted with an infantry battalion in August 1914. Perhaps unsurprisingly, five months later he absconded, before embarking for France.[197] George's account is a reminder of the situation of many men who enlisted shortly after discharged from asylums. Later in the war, some recruiting offices requested the names of recovering patients and expected them to register for military service before leaving the institution.[198] Likewise, and contrary to Board recommendations, there was a drive to recruit young men registered as mental defectives.[199] Recruitment officials ignored advice from the men's own doctors that they were unsuitable to serve,[200] and a leader in the *Times* commented that physically fit men "were passed for service in the Army, when they were more fitted to be certified for asylums."[201] These criticisms point to

Army recruitment officers paying little attention to existing understanding of mental disorders and the psychological resilience servicemen required. Such recruitment practices arguably contributed to the catastrophe of shell shock.

But, returning to George C, his story has a happy ending. He survived the war and appears to have had a satisfactory life thereafter. In 1936, 22 years after his discharge from the asylum, he sent Christmas greetings to his former MACA worker, Miss Vickers, indicating his gratitude to her.[202]

Conclusions

Treating patients with mental disorder, the *raison d'être* of the asylum, was fraught with tensions. Understanding about mental disorders—their causes, classification, course and treatment—was subject to a mismatch between scientific evidence, opinions and practices. Psychiatrists were presented with contradictory hypotheses and information, with the significance of each difficult to evaluate. Psychiatrists in England, as a group, were at odds as to what to believe. Although they did little research, they questioned what was presented to them, from the UK and abroad. Much discussion appeared in the *JMS*, which was published regularly through the war. Caution and healthy scepticism and acknowledgement of the risk of harm from adopting new practices too readily, created a safety mechanism when faced with radical options. However, these collective traits were also associated with inertia, and lack of innovation when the opportunities arose for making other, constructive changes.

Psychiatrists were trained, as were their medical contemporaries, to improve the lives of their patients, preferably to cure them. There was a sense of frustration that scientific advances in other medical disciplines surpassed those in their own. The overlap in symptoms between physical and mental disorders and the discovery of invisible causes of physical illnesses reinforced beliefs that mental and physical disorders had similar causes. This gave asylum doctors hope of scientific breakthroughs for the most severe forms of insanity. Lack of clinically useful discoveries, demoralising on the one hand, spurred some doctors on to persist with research, determined to achieve better for their patients. Various aspects of the lunacy system militated against this, such as geographical and intellectual isolation of asylums from teaching hospitals and universities, a lack of scientific expertise and heavy clinical responsibilities which gave

no time for research. The paltry sum of money allocated for psychiatric research compared to that for physical illnesses was disproportionate to the challenge. It is arguable that heredity and degeneration hypotheses associated with negativity and inevitability about mental disorders may have deterred potential funders from sponsoring research. To achieve research-based improvements in clinical practice also required collaboration across professions and organisations—legal, medical, academic, asylum and governmental. That collaboration was absent before, during and after the war.

The Lunacy Act contributed to hindering asylum doctors from adopting patient-centred good medical practices expected of their counterparts in general hospitals. They were not allowed to offer out-patient treatment, to admit voluntary patients, or to decide who should be admitted to their beds, or at what stage of their illness. The Act did not serve the needs of many mentally unwell people. Convalescence, integral to treatment of physical illness and injury, was incorporated into some asylum regimes, but outside the asylum walls support was limited, mainly to that provided by MACA in the London area. MACA's work supported the notion of some public sympathy towards people seeking to resume their normal lives following an asylum admission.

Falling discharge rates (and high death rates; see Chapter 7) indicate declining standards in the asylums before the war. Pressures on the asylums during the war, particularly of overcrowding with a depleted staff, added to untherapeutic environments associated with more custodial care, some punitive practices, and a fall in therapeutic interventions. Overall, the impression given is of asylum practices pulled in all directions by scientific, legal, social, economic, military and other factors, sometimes floundering in uncertainty and at other times knowing what should be done but hampered by internal and external constraints. The voice of the patient and his family was missing. There is evidence that clinical practice was associated with a degree of self-justification by the medical and lay leadership, and that deception may have hidden harsh practices and affected statistics, possibly contributing to a more positive image of the asylums than they deserved.

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Medical Staff in Asylums: Doctors and Dilemmas

Introduction

A parliamentary select committee in 1911 discussed a London County Council (LCC) survey of its asylum staff. It showed that they did not become insane any more than members of the general public despite their proximity to insane people day after day. This finding surprised the committee. It challenged their assumptions about the transmissibility of insanity. The LCC explained that their staff were "specially selected for their mental and physical fitness",[1] and were therefore resilient, but the Medico-Psychological Association (MPA) challenged the ease of appointing suitable staff: asylums needed more staff who were "in sympathy with the insane" and who did not behave like "warder to convict".[2]

In 1914, the LCC employed 3500 staff across its ten asylums.[3] They were appointed with the aim of supporting patients who required medical, psychological and social forms of treatment to allow them to have the best possible quality of life, either long-term in the asylums, or by recovering and returning to the community. In addition to doctors and male ward attendants on the men's wards and female nurses mainly on the women's wards, there were shoemakers, tinsmiths, tailors, upholsterers and other artisans who worked alongside clergy, kitchen and laundry workers, and other who maintained buildings, farm, gardens and cemetery.[4] Sometimes whole families worked at an asylum, such as the Mingays

at Colney Hatch, who fulfilled roles of porter, organist, ward attendant and work-mistress responsible for finding and supervising daily activities for women patients.[5] This chapter seeks to explore the experiences of the staff, the challenges facing them, and how they coped. Many staff lived on the asylum estate. Some had their rooms adjacent to wards, others lived in nurses' homes, and others in staff cottages with their families. All were subject to strict disciplinary rules, in a similar way to their patients. Some had formal professional qualifications, others did not. The majority were low in the ranks of the hierarchical system of asylum management which threaded through from government, via the Board of Control ("the Board") and into the asylums. Staff life changed during the war, associated with many male staff serving the Colours, new gender roles, and the hardships of civilian life which were particularly intense in the asylums.

The Staff on the Asylum Front Line

In 1914, Viscount Wolmer MP asked Prime Minister Herbert Asquith whether he was aware of unrest among asylum staff in various parts of the country. Asquith informed the House of Commons that "there is no widespread unrest, though some dissatisfaction does undoubtedly exist."[6] This did not bode well for future stressful circumstances. The Board realised that wartime changes would cause staff anxiety and inconvenience, but they were sure that these "would be cheerfully borne" and not detrimental to patients.[7] In 1915, psychiatrist Sir James Crichton Brown said about wartime asylum staff:

> They have been left short-handed, they have had double duty thrown upon them, they have had to work overtime, they have had a most anxious and wearing experience,…their wages have been practically reduced, for the purchasing power of a sovereign is not now what it was twelve months ago.[8]

Some staff responded to the pressures of work and deprivation in unprofessional ways. The minutes of Colney Hatch asylum's lay management, or "visiting", committee (VC) recount how Nurse Hammond found Nurse Laycock in a ward storeroom drinking the patients' milk and Nurse Davies holding a cup of milk under her apron. Nurse Hammond reported her colleagues to a more senior nurse. Later that day, someone ransacked

Nurse Hammond's bedroom, and she was assaulted on a dark corridor, covered with a wet sheet then ducked in a bath of cold water. The alleged milk-thieves were summoned to the medical superintendent who was put in the invidious position of having to get to the root of the dispute. Numerous other allegations emerged including food being misappropriated and patients being dragged by the hair and hit by senior staff. Many of the backlog of accounts were inconsistent or contradictory, suggesting staff covering up or blaming each other in the context of a malfunctioning ward team. All three nurses resigned.[9]

Staff were expected to conform to strict regimes of discipline and control, imposed on them in both employment and personal spheres, a pattern common in "total institutions".[10] There were many ways in which VCs could detect infringements of rules, some simpler ones being to install "time clocks" which required staff to "peg in" their key to monitor punctuality, or using electric "tell-tale clocks" to make sure they did not fall asleep on night duty.[11] At a minimum, disobedience or a lapse of behaviour meant that the accused appeared before the VC or medical superintendent to account for their deeds. Internal inquiries gave staff no right of representation or appeal or other safeguards, risking unjust penalties. Being admonished by the medical superintendent or the VC chairman, and having their misdemeanour entered into a register of staff offences was humiliating,[12] but some misdemeanours were associated with severe penalties, such as being demoted, instantly dismissed, or prosecuted.[13] In 1916, Hanwell VC dismissed an attendant of long-standing "For ~~taking patients meat~~ neglecting to give to the Patients part of the meat issued".[14] The hand-written, altered entry in the harshly named "fine book", was compatible with reducing the allegation from criminal, which required a police investigation, to a misdemeanour which allowed dismissal. The latter was more convenient for the VC, and it was kinder to staff who, although losing their job and forfeiting their superannuation contributions, did not acquire a criminal record.[15] Dismissal removed the offender, and their threat to the asylum's reputation, but provided little stimulus for the leadership to learn from events, or consider systemic problems within their asylum, to prevent further transgressions. Dedicated staff were sometimes dismissed for a genuine error of judgement, although occasionally wartime constraints militated in their favour, such as for an attendant at Claybury of 14 years standing with a previous good work record, under whose watch a patient committed suicide: he

remained in post because the medical superintendent had "no better man to replace him with."[16]

Entries in Hanwell's fine book were few and far between compared to the number of staff employed, suggesting that most staff behaved according to expectations of the leadership. However, the data need to be interpreted cautiously as the entries indicate the staff caught and their misdemeanours judged appropriate for recording in the book, rather than the total number of subversive or aberrant staff whose behaviours passed unnoticed. Occasionally, alongside many reprimands for breaking rules, such as giving ward keys to a patient, or playing draughts or ball games with other staff while on duty, praise was put on permanent record: Joseph Taylor was "Commended for action taken whereby a patient's life was saved".[17] This type of entry was unusual, as staff were assumed to be dedicated and kind, and they received little, if any, praise. Bedford Pierce, medical superintendent at the York Retreat, criticised his colleagues who did not encourage their VCs to show appreciation to their staff whose work was arduous and pay "miserably poor".[18]

Regarding staff personal lives, the VC kept a close eye on comings and goings and regulated their staff in many ways: even matron had to seek permission to have a guest staying in her quarters.[19] Some asylums stipulated times for staff to go to bed and to get up.[20] Resident day staff were generally allowed out of the asylum between 8 and 10 p.m.,[21] after the night staff came on duty, although that freedom was regulated almost as stringently as parole for patients. Similar to patients, leave could be given as a reward, or withdrawn as punishment, such as happened to two nurses caught stealing fruit at Napsbury.[22] Staff were also disciplined if they mis-used their freedom, such as returning later than their night-pass permitted.[23] Eliza Maidman, a laundry-maid at Colney Hatch for over 25 years who lived-in,[24] had a pass to leave the asylum for an evening. It expired at 10 p.m., but she arrived back at 5.35 a.m. the following morning. Summoned to the VC to account for her behaviour, she stated that she was delayed by a Zeppelin raid. With heavy raids just north of London, the VC did not question her further.[25] Her determination to return in time to start work the following morning was admirable. She was loyal to her asylum—her home, workplace and community—and appeared accepting of its rules. It is disconcerting that, just as praise for Joseph Taylor was found in the fine book, an investigation into suspected misdemeanours was the route into discovering a staff member's commitment.

Sometimes VCs showed compassion to staff in difficulty, such as giving paid leave to a member of staff to care for her sick husband who was also an employee of the asylum.[26] At other times, compassion was wanting. When Nurse Gertrude Stephens, a single woman, was pregnant, the rules gave her no choice but to resign from her job. Her child was stillborn. Since she was no longer employed by the asylum, she asked, as she was entitled to do, for her superannuation payments to be returned to her.[27] The VC refused, on the grounds that her services were terminated "by reason of her own misconduct." She had no job, no child and no money to tide her over.[28] A comparable sort of callousness was shown towards a 19-year-old woman who had received an offer of work at Colney Hatch. Mid-war, she travelled from Ireland to take up her post, but probably due to head lice, she was rejected, and sent away penniless. She sought shelter in a convent. Since she was not the first to reach the nuns in similar circumstances, they relayed her story to a magistrate. He wrote to the medical superintendent saying that she had been "thrown to the wolves by one of [her] own sex".[29]

Other asylum rules concerned staff who wanted to marry. Female staff were expected to leave their job on marriage. However, with difficulty recruiting staff and soaring hasty marriage rates, particularly of soldiers tying the knot with their sweethearts before departing to the war front or while on leave,[30] compromises were needed. In this case, married nurses could return to asylum work, but only to temporary positions,[31] giving them little job security.[32] Male staff who wanted to marry also faced challenges, associated with limited married accommodation in the asylum grounds.[33] They too had to seek consent from the asylum leadership, with permission usually only being granted to those who had given 5 years' service, seniority giving priority for coveted accommodation. Similar marriage rules applied to doctors: without permission from the medical superintendent, doctors who married could be dismissed and forfeit their superannuation payments, even if the marriage took place while they were on military service.[34] Strict rules, about where staff lived, on- or off-site, began to change, in some places, before the war.[35] This was partly due to insufficient and unsuitable nurses' homes, such as one with only 2 baths for 79 nurses which gave nurses no option but to bathe on the wards.[36] More asylums permitted living-out during the war, influenced by the demands of temporary attendants who were concerned about the well-being of their own families in the event of an air raid.[37]

Regarding the work undertaken on the wards, the select committee in 1911 described it as "irksome", and Neil Brimblecombe, in his study of asylum nursing until 1910, described it as hard and often unpleasant.[38] The type of work, often with an 80-hour working week on a two-shift per day rota, combined with a punitive style of asylum leadership and strict discipline, probably contributed to the high turnover of asylum staff, in some places over 75 per cent annually. This resulted in an inexperienced workforce, potentially detrimental to patients, and with further recruitment being time consuming for the leadership.[39] The select committee recommended reducing the hours of work,[40] but the Board disagreed, arguing that more changes in staff through the day would be disruptive to patients.[41] The Board's stance altered, however, and by 1914 it considered an 80-hour week too onerous.[42] Around the same time, the LCC tried to implement a 66-hour week for ward staff. This was close to the 60-hour week worked by asylum staff in jobs off the wards, but still more than the typical working week of 50 hours in most industrial and agricultural labour sectors.[43] The LCC began to envisage benefits accruing from fewer hours, such as staff being less exhausted and therefore able to work more therapeutically with the patients, a change which might also encourage staff retention and recruitment. More staff, however, would be expensive.

Alongside challenges from the type and hours of ward work and asylum culture and accommodation, terms of employment were problematic and required improvement to secure the best possible staff.[44] The staffing situation was similarly "critical" in Scottish asylums. There, recommendations were made to relax over-rigid discipline and "systematic petty tyranny", and to improve accommodation, conditions of service, pay, and pension rights to match the higher standards achieved by other public bodies, notably the Prison Service.[45] However, the LCC was complacent when it came to improving these employment conditions, as were some VCs who appeared out of touch with their staff.[46] Harsh discipline and hierarchical management were unlikely to foster a trusting relationship between seniors and juniors[47] and the punitive culture aroused apprehension and "a general feeling of insecurity" among staff.[48] These factors probably also encouraged dishonesty and concealment, with inconsistent and contradictory reporting of incidents, such as the events around the milk-thieves. As the war edged on, little was done to remedy staff working conditions. Staff suffered high rates of sickness and absence, and many resigned.[49] They did not become insane, but constituted a fragile body

of workers. One temporary wartime attendant summarised his experience: "I was only there for a month – I could not stand it any longer."[50]

Hierarchies

Most staff were low in the ranks of the pervasive, almost feudal asylum hierarchy. The pecking order placed the medical superintendent at the top. He (there were no women in this role in the public asylums) had often climbed the medical career ladder in the same institution. Under him came the asylum "officers" including other doctors (hence known as "medical officers"), and senior staff in all disciplines, including matron, chaplain, steward (responsible for managing supplies, stores, staffing and day-to-day operation of the asylum) and farm bailiff. Below them came the main body of staff, then the probationers and finally the patients. Salaries and size of accommodation reflected the hierarchy. The medical superintendent at Colney Hatch received an annual salary of over £1000.[51] Required to live on site by the Lunacy Act,[52] he usually had a substantial house demonstrating his status within the asylum (Fig. 4.1). Its grandeur partly compensated for the freedom given to his medical and surgical colleagues of similar seniority who could choose their homes in more fashionable locations.

Junior doctors fared better than senior nurses, indicative of the overall medical hierarchy. A temporary assistant medical officer earnt about £300 a year, while matron's starting salary was around £100 plus emoluments.[53] The head attendant, who might have a cottage in the grounds if married, received about £80 plus £50 emoluments plus overtime. He might also be eligible for bonuses, such as the "war bonus" to help cover steep price rises.[54] The pay-roll at Colney Hatch showed that Miss Mingay, the work-mistress, received £46 plus £47 emoluments, and female probationer nurses earnt £20 plus board, lodging, laundry and uniform.[55] Although difficult to compare directly, for most staff, pay combined with emoluments was roughly equivalent to salaries of agricultural or factory labourers or domestic servants,[56] ranking their "worth" as employees among the lower tiers of the working class.

During the war, the VCs accorded the most junior ward staff, alongside temporary staff of almost all disciplines, a status only minimally higher than that of patients.[57] Also like the patients, junior and temporary staff were expected to be uncritical of asylum practices, or "to obey the 'God

Fig. 4.1 The medical superintendent's house at Claybury, photographed from the rose garden, before 1917. The chapel is behind the house, to the left (Armstrong-Jones collection, Royal College of Psychiatrists' Archives)

of things as they are,' not of 'things as they should be'", in the words of Montagu Lomax, whose book about his wartime asylum work subsequently triggered the Cobb Inquiry into asylum practices.[58] With the risk of being dismissed for criticising the authorities, Lomax was aware that he had to take a difficult ethical decision: either to complain and risk being dismissed, or to continue to observe while part of the asylum system for long enough to write about his experiences at a later date.[59]

For ward staff, a practical demonstration of their place in the hierarchy was provided by the quality of their uniforms which could be little better than the clothing supplied to patients: when one attendant left Colney Hatch wearing his second-hand uniform, the VC was not concerned as it

"would only have been fit to put in the rag bag".[60] Ward staff, however, regarding themselves as higher in the hierarchy than the patients, took it upon themselves to demonstrate their superiority and power over those in their charge. One way to do this was for ward staff to carry huge bunches of keys, sometimes 30 or more; the Board doubted that so many different locks were "really necessary" for security.[61] Monitoring ward staff, such as by them pegging in or recording their activities in registers, did not give oversight of the quality of their practice: behind locked doors on wards, staff were often unsupervised with their patients. One former patient observed that attendants had "almost unlimited power in dealing with patients unbeknown to the doctor"[62] and another commented: "The Visiting Committee are only a bit of eyewash; the attendants govern the asylum".[63] It is conceivable that ward staff, treated with little respect by their seniors in an authoritarian culture which did little to encourage kindness, would model their behaviours towards patients on the harsh and punitive ways in which they were treated.[64] The behaviour of seniors as models was particularly important for staff who had little formal training for the roles and responsibilities which they were expected to undertake. This would not foster practices which matched ideals of humane and attentive asylum care as promoted by forward-thinking psychiatrists and a wishful-thinking Board.[65]

Gender, Status and Staff Education

The Lunacy Act ruled on gender segregation in asylums. It forbade any "male person" from having "personal custody" of any female patient,[66] so attendants provided day-to-day care for male patients, and nurses for female patients. Of necessity, since most doctors were male, they were permitted to work with male and female patients, chaperoned on their rounds where appropriate.[67] Culture also influenced practices and debates on gender and ward staffing. In Scotland, but not in England or Wales, asylums encouraged female nurses to care for male psychiatric patients. One Scottish medical superintendent, George Robertson, later professor of psychiatry in Edinburgh, spoke about women's "mothering instincts, and natural gifts for the nursing and care of male patients", as in general hospitals. Women, he said, could manage disturbed men, because they used persuasion rather than a "show of force":

> Excited patients who are ready to fight any man who comes near them will often do anything they are told by a nurse, and they will become calm if they receive a word of sympathy from her.…it is absurd to assume that all feelings of chivalry and honour die in a man because he suffers from some derangement of the mind.[68]

Relatives also liked women nursing their menfolk as they feared less violence from them.[69] South of the border, many VCs considered it improper for women to nurse men and preferred male staff who could use their physical prowess to control patients if necessary. This contributed to propagating unwholesome images of asylums and mental disorders as synonymous with violence.

Asylum nursing in England not only differed from that in Scotland but it also contrasted with the model of "general" nursing for physical disorders and injury. General nursing was a respectable vocation for middle class women, developed by Florence Nightingale, the pioneering leader of modern nursing, and professionalized through education and organisation. Practices of asylum nurses had some commonalities with the Nightingale tradition, whereas attendants tended to adopt their model of care from military orderlies. Nevertheless, the low status of asylum ward staff made them uneasy that their better trained and middle class general nursing colleagues might take over some of their roles and responsibilities.[70]

Military demands dramatically reduced the availability of attendants,[71] necessitating further consideration of nurses filling their posts.[72] There were practical and moral considerations. In many asylums there were barely sufficient nurses to staff the female wards, let alone the rest of the asylum. Much discussion focussed on whether nurses should bathe insane men or if work with disturbed men was suitable for younger nurses, and what might be done in asylums where ward staff had their bedrooms on or adjoining the wards, an arrangement which aimed to facilitate them responding to an emergency at night.[73] Taking a lead from general nursing where women nursed physically incapacitated men, some VCs introduced nurses onto their male infirmary wards where the patients were also physically unwell, and onto wards "occupied mainly by senile cases".[74] Some asylums encouraged nurses to volunteer to work on the male wards, elsewhere they were dismissed if they refused orders do so.[75]

Until the war, domestic service was the likely previous employment experience of women taking up posts in asylums.[76] During the war,

with the wide range of employment opportunities available to women, some entered the asylum service having worked in day nurseries, hospitals, shops, munitions and other industries.[77] This gave them more skills and experiences of industrial-scale organisations and employment rights, which they used to further their own careers. When, for example, VCs told nurses that they could not be spared to undertake nursing of soldiers because of asylum staffing needs, they left anyway.[78] In the LCC's opinion "something should be done speedily" to make it worthwhile for women to remain on the asylum staff, rather than to move into jobs regarded as more glamorous or lucrative.[79] Gender had other implications for the asylums during the war years, as although more women than men were employed in lower ranks of asylum work, they were few and far between in the higher tiers. A few were appointed to roles which required specific training or expertise, such as doctors or pharmacists,[80] but more affluent women, who traditionally took on voluntary roles, remained under-represented: only six of 25 members of the LCC asylum committee were female.[81]

Other forces which shaped asylum practices included the trade unions. They favoured gender segregation in asylums as they feared that employing women in male roles might jeopardise jobs for men, and that since women received lower pay, VCs might maintain their wartime female workforce indefinitely as a cheaper option.[82] Women usually earnt about 20 per cent less than men for the same job, and only men were entitled to long-term service bonuses after five and ten years. The salary difference created unrest among women staff. Rarely, as in the case of experienced female agricultural workers on the asylum farms, they received the same wages as men, but capped so as not to exceed them.[83] The LCC ignored trade unions' war time requests about equal pay and stalled negotiations until after the war, on the grounds that such decisions warranted a government committee to consider the principles underlying it.[84] The LCC also debated female labour *versus* machines, such as for milking cows on the asylum farm, a task previously undertaken by men.[85] No-one appeared to advocate for fair-play for the cheapest option: patient labour. Patients replaced female staff on Claybury's farm when seven out of the eight staff left, dissatisfied with their wages. The patients who took over were allowed "extra cheese and jam for lunch and oatmeal water during the afternoon" but received no salary.[86]

Regarding education and training, a better trained workforce was assumed to be more productive and effective.[87] The MPA accepted that

ward staff needed training, although Vicky Long argued that this was associated with a degree of self-interest, psychiatrists recognising that their own image was inexorably bound up with that of other staff.[88] Even if psychiatrists' image was a major concern of the MPA, it is admirable that it established a mental nursing syllabus, examinations and the "Certificate of Proficiency in Nursing the Insane", in the context of the general nursing profession keeping itself at arm's length from the asylums and there being no comparable established system of asylum ward staff leadership to develop the training themselves.[89] Introducing formal training to a workforce which had had little opportunity for study after leaving school, typically at age 12 years,[90] was an achievement. It was also a challenge for some asylum doctors who were expected to train their staff, having had little formal psychiatric training themselves. They might perceive that giving staff a recognised specialist qualification, when they had none, was a threat to their own status.[91]

The MPA's *Handbook for Attendants on the Insane*, was updated regularly and reached its sixth edition in 1911.[92] Asylums purchased the *Handbook* by the dozen.[93] The doctors gave lectures, which in some asylums received sufficient priority to be continued during the war.[94] The subject matter of the course was mostly theoretical, a watered-down version of the medical curriculum, lacking creativity to take into account the different practical tasks undertaken by doctors and ward staff. Not everyone regarded formal training as important: one doctor cited a staff representative who said that formal training was un-necessary, because "to be boxed up with the insane means becoming a qualified nurse."[95] Some medical officers questioned whether it was necessary for "ordinary attendants" to know about scientific subjects, such as physiology, to help them care for patients.[96] Others hoped that it would improve practice and recruitment and "eradicate faults of character".[97] "Faults of character" appeared to be a euphemism for unkind behaviour.

Anecdotal evidence suggested limited effects of the training. A former patient reported that he asked an attendant "Don't they give you talks on psychology?" and the attendant replied "What is that, something to eat?"[98] The attendant may have intended to be witty, but his comment suggested that his training lacked relevant content. Psychological skills might have been learnt on the wards, but it is less clear that there were enough knowledgeable senior ward staff with time and ability to demonstrate or encourage relevant therapeutic approaches.

Staff interest in training varied, even though the certificate was key to promotion within the asylum system[99] and to a salary bonus, usually £2 a year.[100] At some asylums, such as Claybury almost one-third of ward staff held the certificate in 1914.[101] Elsewhere, none possessed it.[102] Pre-war, more attendants than nurses passed the exam,[103] probably because attendants were more likely to consider their work as a life time job, compared to nurses who were less motivated to study because of the marriage bar. However, during the war, exam successes reversed: temporary attendants probably had less incentive than nurses on permanent contracts.[104]

The MPA considered that the work of asylum nurses and attendants was equivalent to that of general nurses and should be recognised as such. Consequently, it wanted the Royal British Nursing Association (RBNA) register to include asylum staff who held the MPA certificate. The RBNA rejected their request as it did not consider asylum staff trained nurses. The RNBA would have provided some trade union representation for the asylum ward staff, similar to the way the British Medical Association acted for doctors.[105] Their rejection was associated with the establishment of a separate organisation the Asylum Worker's Association which became the National Asylum Worker's Union (NAWU) in 1910.[106] It represented a disheartened and under-trained body of staff, and it focussed primarily on the well-being of the workforce rather than directly on the patients. In contrast to the NAWU, the College of Nursing (later, Royal College), established in 1916, had educational objectives. Its nurses were beginning to take a greater role in teaching their own profession. However, general nursing textbooks, similar to general textbooks for training doctors, hardly mentioned psychiatric symptoms, further reinforcing the compartmentalisation of mental and physical nursing.[107] The College of Nursing and the NAWU indicated workers' needs: for general nurses, better education; for asylum workers, improved wages and employment conditions. Contrasting priorities indicated a self-confident general nursing profession, and an unsettled asylum workforce. In 1919 the establishment of the General Nursing Council, a regulatory body for the nursing profession in England and Wales, was heavily influenced by the RNBA leadership. It too did not recognise the MPA qualification, and in 1921 introduced its own. Soberingly, Kathleen Jones argued that "there were many mental nurses with neither the will nor the apparent ability to take either."[108]

Medical Staff: Doctors and Dilemmas

Medical students were taught a fairly standardised curriculum in "psychological medicine". Tracy Loughran analysed their education in psychological and psychiatric subjects in the context of her research on shell shock, arguing that medical students would have found it difficult to avoid acquiring some psychological knowledge in the course of their studies.[109] However, clinical work was (and is) a practical art backed up by science, and art requires practice, not just knowledge. Medical students received practical training in medicine, surgery, pathology, obstetrics and gynaecology, but rarely in psychiatry. Without practice, lectures were unlikely to give them a secure grounding in the subject for their future careers. In addition, senior asylum doctors usually taught their courses, focussing on mental disorders encountered in daily asylum work, rather than those which most doctors would face in their general hospital or community practice. Standard textbooks were also often inadequate concerning psychiatry. Whereas they contained descriptions of physical symptoms (e.g. coughs) and indicated the characteristics and clinical significance of each type, they were likely only to define a psychiatric term (e.g. delusion) but neither explain its significance nor indicate its subtypes.[110] Bernard Hollander, a psychiatrist, and Edward Younger, a physician with some psychiatric training, both questioned the relevance of the medical school curriculum.[111] Younger worked at London's Finsbury Dispensary, providing out-patient services for working-class people. His textbook in 1914 contrasted with usual teaching, particularly by emphasising early stages of mental disorder, clinical assessment and legal matters relevant to the work of general practitioners.[112]

Pre-war, with little psychiatric training in medical schools, doctors working in asylums needed, but received, little in-service training to supplement their clinical experiences. A few spent time away from psychiatry, working in general hospitals, and sat the examination for Membership of the Royal College of Physicians. The MPA, as it had done for asylum nurses and attendants, set the ball rolling in asylum doctors' education. However, the MPA's "Certificate of Efficiency in Psychological Medicine" had neither a published curriculum nor official recognition. Several universities began to provide teaching for asylum doctors,[113] giving them the opportunity to gain a Diploma in Psychological Medicine. That too was problematic. Although it went some way towards indicating a doctor's suitability to become a specialist,

the diploma lacked the rigour and status of the examinations of the medical Royal Colleges.[114] It thus did not increase the esteem of asylum doctors in the eyes of their physician and surgeon colleagues, for whom Royal College memberships and fellowships, and work in teaching hospitals, private clinics and charity-funded ("voluntary") general hospitals, comprised the pinnacle of professional clinical practice.

As with many other asylum staff, the doctors were dissatisfied with their terms and conditions of service. An anonymous asylum medical officer wrote to the *British Medical Journal* (*BMJ*) shortly before the war, drawing attention to medical staff vacancies: the recent pay rise was welcome but insufficient, and "Until some action is taken to improve existing conditions, the asylum medical officer will remain a professional pariah, whose life, like the policeman's, is 'not a happy one'." He ascribed some of the blame to medical superintendents who made little effort to improve matters.[115] Around the same time, the *BMJ* also cited an MPA report that medical work in asylums, "leads to the stunting of ambition and a gradual loss of interest in scientific medicine, and it tends to produce a deteriorating effect upon those who remain long in the service." It also commented that the problem "demands the earnest attention of public authorities and all interested in the welfare of the insane"[116]; asylum medical posts needed improving to attract and keep good staff. The MPA dedicated a half-day session to this at its annual meeting in July 1914, two weeks before war broke out. It recommended a greater variety of clinical responsibilities including investigating and treating new patients, better clinical supervision from senior medical officers, more training and study leave and some experience working in a general hospital. Medical officers should also be allowed to marry after 5 years' service and have house in the grounds; promotion should depend upon qualifications and personal qualities; and lay committees which lacked expertise to evaluate the clinical knowledge or skills of the applicant were unsuitable for appointing medical staff.[117] Implementing the changes would need collaboration between various bodies such as local authorities to fund locums to cover study leave; general hospitals to facilitate placements; and VCs to build more staff accommodation.

With numerous vacancies for asylum doctors, some took jobs in asylums when they were unable to find work elsewhere. This may have given Herbert Ellis, a magistrate and VC member, the impression that assistant medical officers lacked ability, interest and enthusiasm, contrasting with often impressive medical superintendents who

had high standards and knew their patients well.[118] Former patient, Charles McCarthy, a retired civil servant, was less charitable, describing one asylum doctor as "after the type of a low English navvy", and the medical superintendent as "an English snob with an imitation University accent."[119] Standards of asylum clinical work could be dismal. Medical assessments might not be entered in the patients' notes and a batch of mandatory clinical reviews might be added just before a Board inspection.[120] The Board nudged: "instead of making so many on one day (sometimes we observe over 100)" it would be better if "an endeavour were made to distribute them over the year, so that only a few fall due each day."[121] Neglectful, rushed and superficial clinical assessments may have been due to doctors' laziness or lack of skills or interest, but could also have been an effect of the asylum system, its values and economic restrictions, with unsuitable recruitment processes, medical understaffing and excessive workloads. As with the relationship between VCs and the asylum workforce generally, that between a medical superintendent and his junior staff could be equally fraught. The medical superintendent at Prestwich Asylum showed little respect for his junior doctors. He described them as "the flotsam and jetsam ~~and scum of the earth"~~, with the second part of the sentence deleted in the transcript of the Cobb Inquiry.[122] The comments from the superintendent about his medical staff seem excessive, even if some of them were second-rate.

Many doctors endeavoured to practice high standards of medicine, but things could still go wrong. In those circumstances, doctors appear to have been punished more leniently than their non-medical colleagues, probably because their professional status unfairly accorded them some immunity. Five women patients died one night in 1914 at the Bethlem Hospital, all by poisoning from amylene hydrate, a sedative. A seriously depleted staff at the beginning of the war resulted in the on-call doctor, Henry Jones, being called on to dispense medications from stock bottles. He poured amylene from the bottle containing the concentrated, rather than the diluted, solution, giving each woman eight times the usual dose. The *Times* reported the coroner's jury's verdicts of "death by misadventure".[123] The coroner recommended that medical officers should not have to undertake dispensing and a "qualified paid dispenser" should be employed. The Bethlem adopted this proposal and arranged for concentrated and diluted medications to be stored separately.[124] There is no evidence that Jones was punished for his error. Indeed, his career progressed, despite the disaster. Jones became medical superintendent at

Fulbourn Hospital, Cambridge, where his eccentricities and personal style received greater acclaim than his clinical leadership.[125]

In summary, poor standards of medical practice, scarcity of doctors willing to enter asylum work, plus many medical officers enlisting early in the war, were likely to prejudice patient care.[126]

Serving the Colours

Medical officers, alongside attendants and some staff who fulfilled unique roles in the asylum, enlisted or transferred to war work. When Hanwell's tin smith went to work in a munitions factory, colleagues at other LCC asylums covered for him.[127] From Colney Hatch, the "last permanent hand in the tailor's shop" and the upholsterer, whose jobs included furniture renovation and repairing blinds and mattresses,[128] left to join the army in the same week.[129] That was especially tricky when repair rather than replacement had become the norm. The Board complied with instructions, in line with national propaganda and public opinion, to release the maximum numbers of staff to achieve the overriding goal of bringing hostilities to a satisfactory close and return to a "proper standard" as soon as possible thereafter.[130] With many men serving the Colours, women, and men over military recruitment age, took over their duties.[131] Much leave was curtailed at the beginning of the war, with promises that annual leave would accrue and that overtime would be paid.[132]

Nationally, over one million volunteers were recruited into military service by the end of 1914, but more were needed. The LCC encouraged asylum staff to enlist.[133] By March 1915, over 500 men, about a quarter of the total male staff across all the LCC asylums, were serving with the military forces. At the end of 1915, the LCC resolved that any asylum employee who wanted to join the army under the scheme established by Lord Derby, Director General of Recruiting, should be permitted to do so. If he could not be spared immediately, his name would be transferred to the army reserve list, to provide time to find a substitute.[134] The LCC based its strategy on the premise that difficulties in the asylums could be overcome with careful financial management and a "helpful fluidity of staff". The latter implied that staff would move from asylum to asylum as required, although the LCC did not state how it might find enough adequately trained staff for this. The Board encouraged the LCC

scheme with a little flattery, that "the London Asylums, the pioneers in the Asylum world" would set an example to others.[135]

In March 1916 the Military Service Act introduced conscription except for those in essential occupations. Very few asylum jobs fell into this category. Of 6500 attendants in the asylum service in England and Wales before the war, a skeleton of 1500 were deemed indispensable.[136] Doctors were in demand to serve the nation, and almost half those working in asylums undertook military service. Many of those who replaced them had less asylum experience, were physically unfit, or had retired from clinical practice.[137] (Lomax was an older, retired doctor, working in this capacity at Prestwich Asylum.[138]) By mid-1916, the ratio of doctors to patients in the asylums deteriorated from an average of 1 to 250, to 1 to 390.[139] Medical staffing was so inadequate that some asylum doctors spent their leave from the army working in the asylum which had agreed to their military service and to which they expected to return. More clinical work fell on the shoulders of the medical superintendents. One asylum reported a "large amount of illness in the institution" which needed a "reliable permanent assistant who could relive him [the medical superintendent] of some of the very heavy responsibilities which he is now called upon to bear."[140]

The LCC offered financial support to military recruits, topping up military pay where necessary to its usual asylum level, including emoluments and increments.[141] The principle was that those undertaking military service should not be financially disadvantaged compared to those remaining behind. To ensure this, asylums also caped the salaries of existing staff, such as when "acting up" into more senior roles. However, as the war lengthened some asylums had to ignore the salary caps to allay staff unrest and to stem the tide of pay-related resignations.[142] Elsewhere, VCs deferred payment of additional wages, promising that the matter would be considered at some later date.[143] VCs were also prohibited from appointing new permanent staff. This was well intentioned, aiming to ensure that eligible staff on military service would have equal opportunity to apply for permanent posts on their return, but the consequences of temporary appointments, or rapid promotion into acting roles, risked sub-standard leadership and destabilising asylum function.[144]

In 1916, the MPA approached the Board, concerned about falling staff levels. It feared the consequences of lower standards of care, such as "extensive resort to seclusion and mechanical and chemical restraint which prevailed in the days when attendants were few and inefficient."

It asked the Board to help secure exemptions from military service "To save the already dangerously depleted asylums from the almost complete denudation of a skilled and physically fit staff of male attendants."[145] The Board appeared keener to follow the national priorities rather than more patient focussed advocacy of the MPA. In 1917, on behalf of the War Office, the Board appealed for more medical men from the asylums.[146] The LCC, which until then had encouraged military recruitment, uncompromising refused.[147] The Board reiterated the recruitment request early in 1918, continuing to comply with the War Office, "that every fit man of military age should be available for military service".[148] The Board rejected pleas from the LCC and MPA about falling standards of care.

At the end of the war, asylums were desperate for their staff to return, but there was no plan to demob asylum employees any earlier than anyone else.[149] By April 1919, most LCC asylum staff had returned to their peace-time work. However, despite concern by the asylum authorities about medical staffing levels, 26 of 28 medical officers from LCC asylums remained absent from their civilian posts, still not demobbed.[150] The asylums were not alone in their dissatisfaction about the slow rate of demobilisation and the inequities of its application. Demobilisation aimed to be in accordance with the strategic importance of an individual's civilian occupation: a coal miner, for example, was high priority.[151] Regarding asylum doctors, there seemed to be little official awareness of their civilian roles. This fitted with national understanding and priorities concerning civilian mental and physical health.[152] However, the return of doctors was probably also delayed because physical and mental war wounds did not disappear with the signing of the Armistice. Thus, in the established hierarchies of military needs and civilian mental health needs, it is hardly surprising that asylum doctors experienced late demobilisation. Nationally, one million men were still in uniform in September 1919 and 125,000 awaited return to civilian life in early 1920. The delays caused much distress,[153] not solely to asylums.

Through the war, the Board and VCs regularly reported on asylum personnel serving the Colours. News of their deaths, injuries, promotions and gallantry[154] may have motivated remaining staff to work harder, in line with propaganda and despite the challenges they faced. From the LCC asylums, 952 men (about half of the male workforce) served in the forces. Ninety-seven were killed, dead or missing, 160 wounded, and 31 gained military distinctions including three with the Military Cross.[155]

Others suffered physical illnesses and shell shock.[156] Some, such as attendant Thomas Wells received support when back at his asylum. Employed at Claybury since 1907, he served in the army for two years. On his return, he had difficulty undertaking some tasks. When he refused to bathe a patient, his seniors reported him to the medical superintendent. The superintendent recognised that he was suffering from shell shock and negotiated alternative, less distressing work for him on the farm.[157] Not all traumatised returning staff received sympathy. Attendant Franklin Graimes from Hanwell enlisted in 1914 age 26, and served for three years, and was invalided out of the army suffering from shell shock.[158] Back at Hanwell, he was too unwell to resume his duties. The VC showed little tolerance of his symptoms or willingness to modify his duties. Instead they encouraged him to resign, which he did.[159] Lack of sympathy towards people with mental disorders existed, including within the mental health service leadership, and even towards former soldiers who public mandate demanded were to be treated with respect.

The Board unswervingly followed the patriotic party line, despite intermittent opposition from the MPA and the LCC who were concerned about the risks to asylum patients. It was rare for the Board to advocate for patients in the face of competing national pressures, despite the image they sought to present of themselves as working in their best interests.[160] Rather, they seemed to prioritise their organisational and personal reputations: Marriott Cooke, chairman of the Board during the war, was knighted for his war services, not for his commitment to the asylums and their staff and patients.[161]

Towards the End of the War

Despite simmering staff discontent, the NAWU kept a fairly low profile until 1918.[162] By then, some ward staff were working 100 hours a week and there was a nadir of morale. At the same time, trade unions were becoming more influential across many occupational groups[163] and strikes by public service workers, including the police, took place before the war ended. The NAWU placed before the Lancashire Asylums Board (LAB) a list of nine requests, varying from permission to post their union notices in the staff mess rooms to improving pay and conditions for attendants and nurses. The LAB rejected them all. On 4 September 1918, 200 asylum staff came out on strike at Prestwich. The following day 449 attendants stopped work at Whittingham. At Winwick there was a go

slow and a suggestion that the strike would spread to asylums outside Lancashire. The LAB agreed to submit the items under dispute to arbitration by the Ministry of Labour (established in 1916) and promised that no employee on strike would be penalized. In the light of having organised this protest, despite the claims eventually being rejected at arbitration, the NAWU's prestige rose and its membership increased. Capitalizing on their success, at the end of September 1918 the NAWU adopted a national programme for the future. It included plans to implement a 48-hour week; a minimum weekly wage of £2 for the most junior nurses; equal pay for equal work for men and women; registration for the profession of mental nursing; and universal recognition by the asylum authorities of the union as a negotiating body.[164] The Board's fifth annual report for 1918 acknowledged the NAWU for the first time. The Board situated asylum changes in the context of a general "movement of the working classes" to secure better pay and employment conditions. It stated that it was already aware of the need to do this, but counterbalanced its argument by repeating the problem of economic hurdles concerning "the burden imposed on the nation by the mass of mental defect and disorder".[165] The Board, having done little to advocate for patients or staff over the previous 4 years, said that it knew what to do and paid short shrift to the NAWU.

Conclusions

Strict rules and attitudes of asylum leaders towards their staff echoed military discipline as a means of controlling lower ranks. This style may have been appropriate to soldiers on the front line in battle, but it was unsuited to the asylum front line where the aim was to improve the health and wellbeing of patients through "care and treatment". The "systematic petty tyranny" detected in Scottish asylums was also present in their English counterparts, a culture of excessively harsh and rigid attitudes and behaviours which passed through the asylums as far as the patients whose treatment often fell short of ideal. Insufficiently trained lower levels of staff were likely to perpetuate the tyranny, modelling their own behaviours and attitudes on their experiences of those in authority who demonstrated how seniors behaved towards subordinates.

Organisational rigidity imposed by the Lunacy Act and the leadership discouraged changes in asylum practices and inhibited creativity to deal proactively with new eventualities. Lay management committees running

the asylums, despite working closely with senior asylum officers, particularly the medical superintendent, may have contributed to this. Their lack of expertise may have made them uncertain in their decision making and more dependent on rules and regulations. Concerning staff, the management showed little interest in their wellbeing, although some helpful flexibility appeared regarding rules about marriage and about giving staff options to live beyond the perimeter wall, although that commenced pre-war. The motivation for these changes may have been the limited amount of married accommodation available, the cost and inconvenience of building more, and fear of further workforce depletion, rather than staff wellbeing as such. Albeit small, the changes were in line with staff needs, and did not precipitate disaster.

Goffman wrote about a two-way staff-inmate split in institutions:

> Each group tends to conceive of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive, and untrustworthy, while inmates often see staff as condescending, high handed and mean. Staff tends to feel superior and righteous; inmates tend, in some way at least, to feel inferior, weak, blameworthy and guilty.[166]

The wartime asylums appeared to have a three-way split: seniors including the VC; subordinate staff; and patients. The relationship between seniors and subordinate staff and that between subordinate staff and patients both fitted with Goffman's staff-inmate pattern. Neither facilitated a happy working relationship.

Although some staff worked long-term in the asylums and appeared settled within an institutional regime, many others were discontent, morale was low, and staff had a high turnover both before and during the war. The establishment of the NAWU indicated staff concerns—pay, hours, accommodation and other conditions of employment—in contrast to the education and professionalisation priorities in general nursing. By the end of the war, with increased staff unrest and higher union membership, the NAWU was a greater force for change. A similar shift occurred in other employment sectors.[167] The NAWU appeared to listen to staff feedback about their needs in contrast to the asylum leadership which was out of touch with its workforce.

Official status or rank carried significant weight in the asylums, affecting who listened to whom, and to whom punishment—or sometimes praise—was directed. Praise and punishment were doled out

inequitably, such as punishing doctors more leniently than ward staff for breaching rules or making errors. Responses to staff deemed unsuitable varied in other ways, such as how to support former soldiers who returned to their asylum employment while suffering from shell shock, or what to do when nurses were unhappy about working on male wards. Although we do not have details, such as about individual staff members' past work record, decisions on their employment status appear unfair, and sometimes lacking compassion.

The asylum leadership prioritised conforming to rules and expected everyone to do likewise. A conformist system could contribute to a sense of place and security for the leadership and belief that they behaved in the correct manner. This would reinforce existing practices, but would not encourage lateral thinking about alternatives, or querying whether some of the asylum's staffing difficulties were due to the system which they led. It is likely that the asylum leadership contributed to a dysfunctional system in which lower ranks of staff were undervalued and unappreciated.

Notes

1. Select Committee on the Asylum Officers (Employment, Pensions and Superannuation) Bill, *Report and Special Report Together with the Proceedings of the Committee* (London: HMSO, 1911), iv.
2. Dr. Pasmore in discussion about "Asylum Administration as Affected by Present Events," *Journal of Mental Science* (*JMS*) 65 (1919): 124–29, 127.
3. *First Annual Report of the Board of Control, for the Year 1914* (London: HMSO, 1916) (*BoC AR 1914*), Part 2, 154; Anon. *The LCC Hospitals: A Retrospect* (London: LCC, 1949), 108; LCC LCC/MIN/00754 Minutes of miscellaneous sub-committees 1915–1919: Summary of staff numbers required for a 48-hour week, LMA.
4. LCC LCC/MIN/00759 Presented papers of sub-committee 1909–1923: tradesmen in asylums 1910, LMA.
5. Colney Hatch LCC/MIN/01005 Meeting, 19 May 1916, 162; H12/CH/C/04/003 Male attendants' wages book 1915–1916, LMA.
6. Asylums Officers (Employment, Pensions, and Superannuation) Bill. *Hansard* HC Deb, 21 May 1914, vol. 62, c2132.
7. E. Marriott Cooke and C. Hubert Bond, *History of the Asylum War Hospitals in England and Wales* (London: HMSO, 1920), 2.
8. "Asylum Worker's Association, Extract from Sir James Crichton-Browne's Address," *JMS* 61 (1915): 479–80.

9. Colney Hatch LCC/MIN/01006 Meeting, 7 September 1917, 234–36 LMA.
10. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961; Harmondsworth: Penguin, 1980).
11. Colney Hatch LCC/MIN/01003 Meeting, 31 July 1914, 57 LMA.
12. Hanwell H11/HLL/C/06/006 Male attendants' fine book 1914–1935, 18 June 1917 LMA.
13. Colney Hatch LCC/MIN/01006 Meeting, 1 December 1916, 37 LMA; *BoC AR 1914*, Part 2, Salop Asylum 8 July 1914, 298; Peter Nolan, *A History of Mental Nursing* (London: Chapman and Hall, 1993), 57, 74.
14. Hanwell H11/HLL/C/06/006 Male attendants' fine book 1914–1935, 22 May 1916 LMA.
15. LCC LCC/MIN/00579 Meeting, 26 May 1914, 463 LMA; Colney Hatch LCC/MIN/01003 Meeting, 18 December 1914, 215–16 LMA.
16. Claybury LCC/MIN/00948 Meeting, 8 November 1917, 244 LMA.
17. Hanwell H11/HLL/C/06/006 Male attendants' fine book 1914–1935; 18 June 1917; 16 February 1914; 15 November 1920; 21 July 1913 LMA.
18. Bedford Pierce, "Some Present Day Problems Connected with the Administration of Asylums," *JMS* 65 (1919): 198–201, 198.
19. Colney Hatch LCC/MIN/01001 Meeting, 25 April 1913, 42 LMA.
20. Nolan, *History*, 74.
21. Colney Hatch LCC/MIN/01007 Meeting, 17 May 1918, 75 LMA; sometimes 10.30 p.m. in summer.
22. Napsbury H50/A/01/024 Meeting, 6 August 1915, 117 LMA.
23. Colney Hatch LCC/MIN/01002 Meeting, 27 March 1914, 183 LMA.
24. England Census 1891, 1901, 1911, https://www.ancestry.co.uk/search/categories/ukicen/.
25. Colney Hatch LCC/MIN/01005 Meeting, 7 April 1916, 122 LMA.
26. Colney Hatch LCC/MIN/01002 Meeting, 13 February 1914, 125 LMA.
27. LCC LCC/MIN/00583 Meeting, 24 July 1917, 35 LMA.
28. LCC LCC/MIN/00582 Meeting, 30 January 1917, 408–9 LMA.
29. Colney Hatch LCC/MIN/01006 Meeting, 17 November 1916, 57 LMA.
30. LCC LCC/MIN/00583 Meeting, 26 March 1918, 429 LMA.
31. Colney Hatch LCC/MIN/01005 Meeting, 19 May 1916, 165 LMA.
32. LCC LCC/MIN/00580 Meeting, 27 April 1915, 392 LMA.
33. *BoC AR 1914*, Part 2, Isle of Wight Asylum 21 April 1914, 319.
34. Montagu Lomax, *The Experiences of an Asylum Doctor* (London: Allen and Unwin, 1921), 117–18.

35. Colney Hatch LCC/MIN/01002 Meeting, 13 March 1914, 163–64 LMA.
36. Hanwell LCC/MIN/01093 Meeting, 22 December 1913, 27 LMA.
37. Hanwell LCC/MIN/01095 Meeting, 7 June 1915, 66 LMA.
38. Select Committee on the Asylum Officers Bill, *Report*, iv; Neil Brimblecombe, "Asylum Nursing as a Career in the United Kingdom, 1890–1910," *Journal of Advanced Nursing* 55 (2006): 770–77, 770.
39. Nolan, *History*, 75; *BoC AR 1914*, Part 2, Cumberland and Westmorland Asylum 23 July 1914, 212; Oxford Asylum 4 August 1914, 296.
40. *BoC AR 1914*, Part 2, Winwick Asylum 24 February 1914, 257.
41. Select Committee on the Asylum Officers Bill, *Report*, iii–v, vii.
42. *BoC AR 1914*, Part 2, Winwick Asylum 24 February 1914, 257.
43. LCC LCC/MIN/00579 Meetings: 16 December 1913, 94; 27 January 1914, 135 LMA; Department of Employment and Productivity, *British Labour Statistics: Historical Abstract 1886–1968* (London: HMSO, 1971), 28, 30, 39.
44. Select Committee on the Asylum Officers Bill, *Report*, iv.
45. Nolan, *History*, 75, 77.
46. Select Committee on the Asylum Officers Bill, *Report*, v.
47. *BoC AR 1914*, Part 2, Oxford Asylum 4 August 1914, 295.
48. Colney Hatch LCC/MIN/01004 Meeting, 2 July 1915, 155 LMA.
49. Hanwell LCC/MIN/01097 Meeting, 24 September 1917, 181–83 LMA.
50. Committee on the Administration of Public Mental Hospitals (Chairman: Sir Cyril Cobb) (Cobb Inquiry), 15 March 1922 AM Donaldson Q:576, MH 58/219 TNA.
51. Colney Hatch H12/CH/C/03/004 Officers' salaries book 1910–1917, LMA.
52. Lunacy Act 1890 section 276 (1) (b) (c).
53. Claybury LCC/MIN/00946 Meeting, 24 March 1915, 81 and between pp. 71–72 LMA.
54. Colney Hatch H12/CH/C/04/004 Male attendants' wages book 1917–1918 LMA.
55. Colney Hatch H12/CH/C/03/004 Officers' salaries book 1910–1917 LMA; Hanwell LCC/MIN/01096 Meeting, 5 June 1916, 83 LMA.
56. Department of Employment and Productivity, *British Labour Statistics*, 38–39; Brimblecombe, "Asylum Nursing": 770.
57. Leonard Smith, "Behind Closed Doors: Lunatic Asylum Keepers, 1800–1860," *Social History of Medicine* 1 (1988): 301–27, 327.
58. Ministry of Health, *Report of the Committee on Administration of Public Mental Hospitals* Cmd. 1730 (Chairman: Sir Cyril Cobb) (London: HMSO, 1922); Lomax, *Experiences*, 51.

59. BoC, "Memorandum for the Minister of Health on Mr. Montagu Lomax's Book *The Experiences of an Asylum Doctor*," 21 September 1921, MH 52/222 TNA.
60. Colney Hatch LCC/MIN/01002 Meeting, 30 January 1914, 113 LMA.
61. *BoC AR 1914*, Part 2, Dorset Asylum 12 May 1914, 222.
62. Cobb Inquiry, 15 March 1922 Mr. Cox Q:401, MH 58/219 TNA.
63. Cobb Inquiry, 30 March 1922 Edward Mason Q:2112, MH 58/220 TNA.
64. Lomax, *Experiences*, 84; Nolan, *History*, 83.
65. Charles Mercier, *The Attendant's Companion: A Manual of the Duties of Attendants in Lunatic Asylums* (London: J and A Churchill, 1898), 2.
66. Lunacy Act 1890, section 53.
67. Napsbury H50/A/01/026 Meeting, 22 July 1916, 37 LMA.
68. George Robertson, "The Employment of Female Nurses in the Male Wards of Mental Hospitals in Scotland," *JMS* 62 (1916): 351–62, 361.
69. Robertson, "Employment of Female Nurses": 362.
70. Nolan, *History*, 70.
71. Tom Walmsley, "Psychiatry in Scotland," 294–305, in *150 Years of British Psychiatry 1841–1991*, ed. German Berrios and Hugh Freeman (London: Gaskell, 1991), 303.
72. Hanwell H11/HLL/A/06/05 Draft annual report 1917 LMA.
73. *BoC AR 1914*, Part 2, Northumberland Asylum 4 May 1914, 292.
74. Claybury LCC/MIN/00946 Meeting, 14 October 1915, 241 LMA; *BoC AR 1914*, Part 2, Severalls Asylum 27 October 1914, 227.
75. Claybury LCC/MIN/00946 Meeting, 14 October 1915, 241 LMA; Hanwell LCC/MIN/01097 Meeting, 2 July 1917, 118–19 LMA.
76. Brimblecombe, "Asylum Nursing": 770.
77. Hanwell H11/HLL/C/03/001 Letters of recommendation and testimonials of female asylum staff 1903–1923, using sample from 1910 to 1919 LMA.
78. LCC LCC/MIN/00580 Meeting, 29 June 1915, 638–39; Colney Hatch LCC/MIN/01004 Meeting, 2 July 1915, 152: LCC/MIN/01005 Meeting, 22 September 1916, 270 LMA.
79. LCC LCC/MIN/00582 Meeting, 30 January 1917, 402 LMA.
80. Claybury LCC/MIN/00949 Meeting, 5 December 1918, 250 LMA; Napsbury H50/A/01/026 Meeting, 6 October 1916, 115 LMA; Louise Hide, *Gender and Class in English Asylums, 1890–1914* (London: Palgrave Macmillan, 2014), 45–46.
81. *BoC AR 1914*, Part 1, vi; LCC LCC/MIN/00581 Meeting, 14 March 1916, 424; LCC/MIN/00584 Meeting, 8 October 1918, 2–4 LMA.
82. Colney Hatch LCC/MIN/01004 Meeting, 27 August 1915, 197 LMA.
83. Claybury LCC/MIN/00948 Meeting, 15 March 1917, 57 LMA.

84. LCC: LCC/MIN/00581 Meeting, 30 November 1915, 178; LCC/MIN/00584 Meeting, 8 October 1918, 3 LMA.
85. LCC LCC/MIN/00581 Meeting, 18 April 1916, 484 LMA.
86. Claybury LCC/MIN/00949 Meeting, 20 June 1918, 130 LMA.
87. Nolan, *History*, 62.
88. Vicky Long, *Destigmatising Mental Illness? Professional Politics and Public Education in Britain, 1870–1970* (Manchester, UK: Manchester University Press, 2014), 67.
89. Thomas Bewley, *Madness to Mental Illness: A History of the Royal College of Psychiatrists* (London: RCPsych Publications, 2008), 115.
90. Age 14 after Education Act 1918.
91. Nolan, *History*, 62.
92. MPA, *Handbook for the Instruction of Attendants on the Insane* (London: Baillière, Tindall and Cox, 1885); MPA, *Handbook for Attendants on the Insane* (6th Edition) (London: Baillière, Tindall and Cox, 1911); Bewley, *Madness to Mental Illness*, 114.
93. Napsbury H50/A/01/024 Meeting, 16 October 1915, 220 LMA.
94. Colney Hatch LCC/MIN/01007 Meeting, 22 February 1918, 39 LMA.
95. Dr. Turner in discussion about "Asylum Administration as Affected by Present Events," *JMS* 65 (1919): 124–29, 129.
96. Bewley, *Madness to Mental Illness*, 114.
97. Nolan, *History*, 82.
98. Cobb Inquiry, 30 March 1922 Edward Mason Q:2138, MH 58/220 TNA.
99. Colney Hatch LCC/MIN/01007 Meeting, 22 February 1918, 39 LMA.
100. LCC LCC/MIN/00579 Meeting, 4 November 1913, 19 LMA.
101. *BoC AR 1914*, Part 2, 1914 Claybury Asylum 27 June 1914, 270.
102. *BoC AR 1914*, Part 2, Berks Asylum 6 May 1914, 198.
103. *BoC AR 1914*, Part 2, Brecon and Radnor Asylum 6 May 1914, 199.
104. Claybury LCC/MIN/00946 Meeting, 22 July 1915, 190 LMA; Colney Hatch LCC/MIN/01005 Meeting, 2 June 1916, 192 LMA.
105. Royal British Nursing Association, https://www.rbna.org.uk/.
106. Francis Adams, "From Association to Union: Professional Organization of Asylum Attendants, 1869–1919," *British Journal of Sociology* 20 (1969): 11–26, 12.
107. Georgiana Sanders, *Modern Methods in Nursing* (Philadelphia and London: WB Saunders, 1912), 703–9.
108. Kathleen Jones, *Mental Health and Social Policy, 1845–1959* (London: Routledge and Kegan Paul, 1960), 102.
109. Tracy Loughran, *Shell Shock and Medical Culture in First World War Britain* (Cambridge: Cambridge University Press, 2017), 23, 33.

110. G Elliott Smith and Tom Pear, *Shell Shock and Its Lessons* (Manchester: University Press, 1917), 111, 118–19.
111. Edward Younger, *Insanity in Everyday Practice* (London: Baillière, Tindall and Cox, 1914), 1; Bernard Hollander, *The First Signs of Insanity: Their Prevention and Treatment* (London: Stanley Paul and Co, 1912), 21.
112. Younger, *Insanity*, vii, 16–22.
113. Anon. "Facilities Provided for the Teaching of Psychiatry," *JMS* 59 (1913): 159–60.
114. Hugh Freeman, "Psychiatry in Britain c. 1900," *History of Psychiatry* 21 (2010): 312–24, 320.
115. An AMO, "Assistant Medical Officers in Asylums," *BMJ* 9 August 1913, 349.
116. Anon. "The Asylum Service," *BMJ* 29 November 1913, 1447–1448, 1448.
117. Anon. "The Medico-Psychological Association of Great Britain and Ireland," *JMS* 60 (1914): 644–95, 669–73.
118. Cobb Inquiry, 16 March 1922 Herbert Ellis Q:862, 872, MH 58/219 TNA.
119. Cobb Inquiry, 16 March 1922 Charles McCarthy Q:819, 823, MH 58/219 TNA.
120. *BoC AR 1914*, Part 2, Kesteven Asylum 27 January 1914, 263.
121. *BoC AR 1914*, Part 2, Hants Asylum 6 November 1914, 234.
122. Cobb Inquiry, 24 February 1922 Dr. Perceval Q:410, MH 58/219 TNA.
123. BoC W/FM, 11 November 1914, 236 MH 50/43 TNA; Anon. "News in Brief," *Times*, 13 November 1914.
124. *BoC AR 1914*, Part 1, 37.
125. David Clark, *The Story of a Mental Hospital: Fulbourn 1858–1983* (London: Process Press, 1996), 54, 192.
126. *BoC AR 1914*, Part 1, 15–16.
127. Hanwell LCC/MIN/01095 Meeting, 7 June 1915, 96 LMA.
128. Cobb Inquiry, 30 March 1922 Dr. Ogilvy Q:1806–7, MH 58/220 TNA.
129. Colney Hatch LCC/MIN/01006 Meeting, 17 November 1916, 12 LMA.
130. *Third Annual Report of the Board of Control, for the Year 1916* (London: HMSO, 1917) (*BoC AR 1916*), 10; BoC to MPA, untitled letter 17 May 1916, *JMS* 62 (1916): 637–38.
131. Initially 19–30 years, then 18–41. From April 1918, 18–51.
132. LCC LCC/MIN/00579 Meeting, 29 September 1914, 649 LMA.
133. LCC LCC/MIN/00580 Meeting, 22 December 1914, 131 LMA.

134. LCC LCC/MIN/00581 Meeting, 9 November 1915, 111, 128 LMA; *BoC AR 1916*, 9–10.
135. LCC LCC/MIN/00581 Meeting, 30 May 1916, 604–5 LMA.
136. *BoC AR 1916*, 9–10.
137. Kathleen Jones, *Asylums and After* (London: Athlone Press, 1993), 124.
138. Anon. "Montagu Lomax MRCS Eng, LRCP Edin," *Lancet* 25 March 1933, 668.
139. Anon. "Asylum accommodation," *JMS* 62 (1916): 827–28.
140. Colney Hatch LCC/MIN/01007 Meeting, 11 January 1918, 5–6 LMA.
141. LCC LCC/MIN/00579 Meeting, 29 September 1914, 646 LMA.
142. Colney Hatch LCC/MIN/01007 Meeting, 11 January 1918, 4 LMA; LCC/MIN/01005 Meeting, 2 June 1916, 173; LCC LCC/MIN/00584 Meeting, 8 October 1918, 2–4 LMA; Hanwell LCC/MIN/01094 Meeting, 15 March 1915, 284–85 LMA.
143. LCC LCC/MIN/00581 Meeting, 26 October 1915, 56 LMA.
144. Claybury LCC/MIN/00948 Meeting, 5 July 1917, 134–35 LMA.
145. MPA to BoC, untitled letter, 17 May 1916, *JMS* 62 (1916): 636–37.
146. BoC W/FM, 21 March 1917, 97 MH 50/45 TNA.
147. LCC LCC/MIN/00582 Meeting, 27 March 1917, 568–69; 3 April 1917, 589 LMA.
148. LCC LCC/MIN/00583 Meeting, 29 January 1918, 319 LMA.
149. BoC, circular to superintendents, 23 December 1918, MH 51/239 TNA.
150. LCC LCC/MIN/00584 Meeting, 1 April 1919, 432 LMA.
151. Richard van Emden and Steve Humphries, *All Quiet on the Home Front: An Oral History of Life in Britain During the First World War* (London: Headline, 2003), 297.
152. Pat Thane, *Divided Kingdom: A History of Britain, 1900 to the Present* (Cambridge: Cambridge University Press, 2018), 56–57; JM Winter, "Military Fitness and Civilian Health in Britain During the First World War," *Journal of Contemporary History* 15 (1980): 211–44, 211.
153. Van Emden and Humphries, *All Quiet*, 300.
154. Hanwell LCC/MIN/01097 Meeting, 17 December 1917, 251 LMA.
155. LCC LCC/MIN/00584 Meeting, 1 April 1919, 432 LMA.
156. Colney Hatch LCC/MIN/01006 Meeting, 30 November 1917, 301; Claybury LCC/MIN/00946 Meeting, 23 December 1915, 318 LMA.
157. Claybury LCC/MIN/00948 Meeting, 19 July 1917, 176–77 LMA.
158. British Army WW1 Pension Records 1914–1920, https://www.ancestry.co.uk/search/collections/britisharmy/; UK, Silver War Badge Records 1914–1920, https://www.ancestry.co.uk/search/collections/silverwarbadgemedals/.
159. Hanwell LCC/MIN/01097 Meetings: 22 October 1917, 19; 17 December 1917, 252–54 LMA.

160. Robert Armstrong-Jones, "The Eighth Annual Report of the Board of Control for the Year 1921," *Eugenics Review* 15 (1923): 426–32, 432.
161. HB, "Sir Marriott Cooke KBE MB," *BMJ* 31 October 1931, 829–30.
162. Nolan, *History*, 79.
163. Trades Union Congress, *A Short History of British Trade Unionism: A TUC Study Pamphlet* (London: Trades Union Congress, 1947), 21.
164. Adams, "From Association to Union": 19–20.
165. *Fifth Annual Report of the Board of Control, for the Year 1918* (London: HMSO, 1919), 4.
166. Goffman, *Asylums*, 18.
167. Trades Union Congress, *A Short History*, 21.