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CHAPTER TWO

The Social Landscape of a Victorian Asylum

On 8 March 1860, the new Three Counties Asylum admitted its first patients, six men and six women transferred from the Bedford Asylum. Only the sketchiest details survive about what life was like for those patients transferred to the new asylum. Nevertheless, we will attempt to give a flavour of daily life in the early years of the institution, both internally – what it was like to live and work in the asylum – and externally – its connections to the broader community and how it operated within the constraints of regulatory agencies. To do this we have looked primarily at the social relations of groups at all levels of the institution – patients, staff, administration, governing bodies, clergy and community residents. To understand the types of illnesses and life circumstances that brought patients to the asylum in the nineteenth century (often substantially different from twenty-first-century diagnoses) we first look at the context of insanity in mid-Victorian England.

Moral and Medical Treatment

Lunacy reformers of the early and mid-nineteenth century emphasised that the asylum was to be a place of treatment. The mentally ill were to be confined in an attempt to treat them and then returned to society. The approach to be used was that of ‘moral treatment’, which had been pioneered at the York Retreat. Moral treatment emphasised the role of the environment as the prime therapeutic tool. The asylum was to provide a safe and comfortable environment where the mentally ill could be treated in a humane way and actively assisted to recover. When the Three Counties Asylum opened, moral treatment remained an ideal, but a largely unattainable one. In reality, treatment in the Victorian asylum was minimal. Year after year the Lunacy Commissioners – the official ‘watchdogs’ of asylum care – had to acknowledge in their annual reports that the majority of asylum patients did not recover.¹

In the 1840s and early 1850s, the Commissioners focused their attention on curative issues. In 1847 they brought out a survey

of treatment techniques currently in use in asylums in the hope of stimulating further advances. Results were not forthcoming and the Commissioners turned their attention to administrative matters. By the mid-1850s, the success of an asylum in curing its inmates ranked considerably below such issues as the composition of the inmates' soup.²

The Commissioners' annual reports show clearly that a good asylum was one in which the bedding was 'clean and sufficient', the treatment 'humane and judicious', the patients 'orderly, free from excitement and satisfactorily clothed' and the institution 'clean and tidy', attendance at chapel high, mortality rates low and the entire place efficient and industrious.³ Asylum doctors were praised for their administrative abilities, their 'kindliness' and their perceived ability to make their patients comfortable. There was much emphasis on required paperwork and none on therapeutic initiatives, particularly those which might involve the risk of patients absconding or committing suicide. While the intention was to prevent the abuses of an earlier era, it was a stifling system which encouraged a monotonous and paternalistic environment where simply keeping patients alive became an end in itself.

At TCA the lack of medical treatment available in the 1860s is evidenced by the absence of any comments on treatment in the annual reports. The first annual report, for example, notes merely that while a padded room existed, no means of restraint were in use in the asylum.⁴ 'Restraint' in this context refers to mechanical restraint: the chains and manacles which were standard features of earlier asylum treatment. Seclusion and physical restraint were used in TCA and the rules and regulations published in 1878 provided clear guidelines for their use:

No instrument of restraint shall be placed on any patient: and no patient shall be restrained or secluded at any time, except by medical authority, and the same be recorded in the Medical Journal and Case Book; and no forcible means shall be used for giving food or medicine, except in the presence of one of the Medical Officers, or of the Head-attendant in each division.⁵

Restraint was necessary on occasions but used much more rarely than before the change in the law in 1845. Patients were usually restrained to their beds by wrapping the sheets tightly round the person and securing them to the bed-frame or, if this were not enough, leather straps might be employed or a strait-waistcoat (also sometimes referred to as a strait-jacket). Hence the need for strong iron beds rather than wooden ones. In all cases the use of restraint had to be entered into the hospital's record book and made available to the Visitors' Committee at their regular inspections.⁶