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Introduction to Asylums, Mental health care and the Irish: Historical studies 1800-2010

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Chapter 1: Introduction

Pauline M. Prior

When Thomas Spring Rice, Whig politician and life governor of Limerick House of Industry, appeared before the Select Committee on the Lunatic Poor in Ireland, in 1817, he described the accommodation for people with mental disorders as unfit for dogs.

I hold in my hand a plan of the Lunatic Asylum of Limerick, in which the accommodation afforded to the insane will appear to be such as we should not appropriate for our dog- kennels; it consists of one arcade, an open arcade, behind which cells have been constructed with stone floors, without any mode of heating or of ventilating and exposed during the whole of the winter to the extremities of the weather. ¹

Spring Rice also told the committee that because of the overcrowding, disturbed patients were physically restrained in a way that led to them losing the power of their limbs.

The usual mode of restraint was by passing their hands under their knees, fastening them with manacles, fastening both about their ankles, and passing a chain over all, and then fastening them to a bed. ²

The appalling conditions in this and other establishments led to situations in which corpses lay for days without being removed, and female inmates were sexually exploited by those responsible for their care. ³ The report of the Select Committee added to the growing evidence of the terrible conditions under which most people with a mental disorder were cared for within the public system in Ireland. At this time, the facilities for this vulnerable section of the population consisted of the privately funded St Patrick's Hospital, Dublin, and the publicly funded Richmond Asylum (opened 1815), two small asylums at Cork and Wexford, and some beds attached to Houses of Industry and to gaols in other large towns. ⁴

Alongside the evidence of neglect and abuse, was a growing optimism about care and treatment. Another witness to the 1817 Select Committee, John Leslie Foster, Governor of the Richmond Asylum, Dublin, spoke of a 'new and an improved system of treatment' at his asylum. ⁵ He told the committee of the advances made by Dr Philippe Pinel in France. He had replaced coercion with a 'more gentle mode of treatment'. Foster also spoke of Mr William Tuke and the Quaker approach at the York Retreat in England. This new system was being tried out at the Richmond and was, according to Foster, very successful.

I beg to add as proof of this, that there is not in the Richmond Lunatic Asylum, to the best of my belief, a chain, a fetter, or a hand cuff.

And

I do not think, that out of the two hundred patients, there were above three or four to whom even the application of the strait jacket was found necessary: the disorder is treated not so much as a subject of medical care, as of the superintendence of the person, who is termed the moral governor, and whose particular business it is to attend to the comfort for the patients, to remove from them the causes of irritation, to regulated the degrees of restraint, and to provide occupation for the convalescent. ⁶

It is highly likely that there was some exaggeration in Foster's positive view of treatment at the Richmond, given the constraints of a high level of demand for places and a low level of funding. However, what this submission to the Select Committee showed was a new

optimism about the possibility of caring for people who had been regarded up to then as incurable and dangerous.

As a result of the work of this Select Committee, and of the political will of Sir Robert Peel, appointed Chief Secretary for Ireland in 1812, district asylums were set up throughout the country. By the mid-century, there were ten district asylums providing over 3,000 beds in total⁷. By then, the management of asylums had passed out of the hands of lay managers. By the 1860s, all of the asylums had medically trained managers (known as the Resident Medical Superintendent), who were assisted in relation to the physical health of patients by an independent doctor (known as the Visiting Physician).

However, there were still problems in meeting the growing demand for places for people suffering from mental disorders. These problems were articulated in the evidence presented to the Commissioners of Inquiry into the state of Lunatic Asylums in Ireland in 1857.⁸ According to the report from this inquiry, there were 9,286 insane poor in Ireland in January 1857. This number was made up of 5,934 'maintained at the public charge' and 3,352 'at large'. Of those in public institutions, 3,824 were in district asylums and the remainder were in workhouses (1,815) or in prisons (295).⁹ The commissioners deliberately omitted those from 'the wealthier class' from this number, as this would confuse the estimate for public provision. However, they did note that there were 459 patients in 'Licensed Houses and Benevolent Institutions' at this time.¹⁰

As the purpose of this inquiry was to examine the state of asylums, we get a very detailed picture of the improvements that had taken place since the beginning of the century. District asylums built in the early years were, understandably, less well appointed than those built in the 1850s. Many of the early asylums had no water, no place of worship, no ventilation and no water closets.

The patients, as in Carlow, being left to wash in the open courts under shelter of a shed: and, at most, one bad and imperfectly constructed bath being provided, for each side of the building.¹¹

Some of these faults were rectified in asylums built in the 1850s:

Improvements are perceptible in the provision of lavatories and bath rooms, with a proper supply of water, of recreations halls, chapels, and vastly superior kitchens and offices, as well as infirmaries and arrangements for ventilation.¹²

However, all was not well. Airing courts and day rooms were usually on the northern side of the building and were 'cold and cheerless', the sewerage system and water supply was often 'imperfect or ill-planned', and the quality of water often questionable. Even where there were water closets, they were often kept locked so that the patients could not use them. The same held for fire-places – some were never used, serving only as ornaments, while others were so badly situated that they were 'of little effect'. The list went on – ventilation systems did not work, recreation halls were not used, and walls were bare and cheerless.

In corridor or day-room, the lunatic sees nothing but the one undiversified white wall – giving to these hospitals, intended for the restoration of the alienated mind, an air of blankness and desolation more calculated to fix than to remove the awful disease under which it labours.¹³

The cumulative effect of poor physical conditions, inadequate clothing, relatively little care of the sick and instances of neglect and restraint, was a situation of detention rather than of care. In spite of the existence of Privy Council Rules, requiring strict regulation and reporting of all instances of restraint, there was evidence of wholesale use of mechanical restraint without authorisation of the asylum manager or of the Visiting Physician.

In Armagh Asylum ... a patient on the female side, was strapped down in bed, with body straps of hard leather, three inches wide, and twisted under the

body with wrist locks strapped and locked, and with wrists frayed from want of lining to straps: this patient was seriously ill.¹⁴

And

In the Carlow Asylum, we found that a man suffering from dropsy was tied down to bed, and locked up in his cell, without the knowledge of the Resident or Visiting Physician.¹⁵

The commissioners made a number of recommendations based on the evidence gathered from witnesses and from their own visits to a range of institutions that housed people with mental disorders. Among these were proposals to build additional asylums and to improve the standard of care throughout the asylum system, by linking up with medical schools and by monitoring the implementation of existing Privy Council Rules through proper inspection.

Spurred on by this report and the work of the newly established Inspectorate of Lunacy (set up in 1845), money was made available by the government for the expansion of the asylum system, both in terms of numbers of asylums and size of patient population. By the beginning of the twentieth century, there were twenty two asylums in Ireland, providing over 16,000 beds funded from the public purse.¹⁶ In addition there were privately run establishments, which included 'benevolent institutions' and 'licensed houses'.¹⁷ The largest and most famous benevolent institution was St Patrick's Hospital, Dublin, but there were also two small Quaker Retreats in Ireland, at Bloomfield, Dublin and at Armagh.¹⁸ Though Ireland did not experience the expansion in private 'madhouses' characteristic of England at the time, there were twelve licensed houses which provided care for small numbers of patients.¹⁹

Alongside the growth in asylum size and number was the development of a new specialty within medicine.²⁰ Irish psychiatry emerged and flourished in the second half of the nineteenth century, helped in no small measure by the powerful influence at Dublin Castle of Dr Francis White, appointed as the first Inspector in Lunacy for Ireland. From 1841, White had special responsibility for asylums within the Inspectorate of Prisons. From the beginning, he was a strong advocate of a medical approach to the care and treatment of mental disorder. He worked tirelessly to establish a highly professional inspectorate which oversaw standards of care throughout the asylum system. As jobs in the asylum system increased, so too did the number of Irish doctors interested in this area of medical care. Some, like Dr Oscar Woods, Dr M. J. Nolan and Dr Conolly Norman, became active members of the Medico Psychological Association of Great Britain and Ireland and published their case histories in the *Journal of Mental Science* (later to become the *British Journal of Psychiatry*). It was not all plain sailing, however, as evidenced in the many disputes between Medical Superintendents and Visiting Physicians, and in the enquiries into the management of some local asylums by the Inspectorate of Lunacy.²¹

By the time Ireland became a state in its own right in 1921, the asylum system was in trouble. It was overcrowded, under-funded and marginalised. Mental health care was not a popular medical specialty in the early twentieth century. Since 1921, two different systems of health care and of legislation have been in operation in Ireland. The Republic of Ireland developed a dual system of public and private provision, while Northern Ireland moved towards a heavy reliance on the public sector, reflecting patterns of health service delivery in other parts of the United Kingdom. However, mental health services in both parts of Ireland have been influenced by the highly institutionalised system of care inherited from the nineteenth century.

By the mid-twentieth century, it became clear throughout the western world, that the institutional approach to mental health care was neither financially viable nor medically necessary. New drugs and technical advances in medical science, plus a greater understanding of mental health and illness, made care in the community a possibility.

However, it took another half century for the structures of the highly centralised, highly institutionalised care system set up in nineteenth century Ireland, to change. This was due largely to the economic and political interests surrounding the downgrading or closure of mental hospital services. Some of the special reports on mental health services in the Republic of Ireland highlighted the slow rate of progress. In 1984, the authors of *Planning for the Future* found psychiatric services to be below an acceptable standard.

At present, the psychiatric hospital is the focal point of the psychiatric service in most of the country. Large numbers of patients reside permanently in these hospitals. Many of them have lived there for years in conditions which in many cases are less than adequate because of overcrowding and capital underfunding. The hospitals were designed to isolate the mentally ill from society and this isolation still persists.²²

The report went on to recommend a total reorganisation of the services, with a view to moving to a new model of mental health care. As outlined in *A Vision for Change*, a report published in 2006, this new model of care would involve a radical shift in service delivery, from hospital to home.

It was to be comprehensive, with a multidisciplinary approach, provide continuity of care, and be effectively coordinated. This new service was to be community-oriented to the extent that care should be provided in an individual's home, with a variety of community-based services, and was to provide support to families.²³

By 2006, when *Vision for Change* was published, there had been considerable progress. Psychiatric units in general hospitals had increased, as had community based residences and day care centres. Some of the large mental hospitals, originally built as asylums, continued to function as psychiatric hospitals but the total number of psychiatric beds had decreased by approximately 67% (from 12,484 in 1984 to 4,121 in 2004) as had the rate of psychiatric admissions.²⁴ However, the community care model as envisaged in *Planning for the Future* in 1984 had not materialised. Multi-disciplinary community based mental health teams responding flexibly to the needs of people seeking help from the psychiatric service remains a dream for the twenty first century.

The studies in this collection

In spite of the radical changes in mental health care in Ireland in the past two centuries, many aspects of the service have not been fully explored by historians. This book presents a collection of essays from scholars working on a range of topics surrounding the care of Irish people with mental illnesses as well as some poetry and prose from service users. Most of the studies are based in Ireland, but two explore the problems faced by Irish people who emigrated to Australia and New Zealand in the nineteenth century. The data for the studies comes from a variety of sources. In the twentieth century, these include newspaper reports, hospital newsletters, government reports and personal experiences of staff and patients. In the nineteenth century, they include asylum records, annual reports of the lunacy inspectorate, reports of select committees, and articles in medical publications such as the *Journal of Mental Science* and the *Dublin Quarterly Journal*. All of the research presented in this collection builds on the early work of Finnane, Malcolm, Robins and Williamson and the more recent work of Kelly, and Prior.²⁵ The book is far from being a comprehensive account of the history of Irish mental health services. Rather, it is an introduction to this under-researched area of Irish history.

In Part One of the book, which covers the twentieth century, we get a flavour of what was happening in two large mental hospitals (former asylums), one in the Republic of Ireland and one in Northern Ireland. These are two quite different stories, the first based on newspaper coverage of a single event and the second on accounts of everyday life published in a hospital magazine. In Chapter 2, Anton McCabe and Ciaran Mulholland tell

the story of a nursing strike in 1919 that captured the imagination of the public and led to the great improvements in salaries and working conditions for psychiatric nurses throughout Ireland. At the time of the strike, Irish asylum attendants/nurses experienced low wages and poor conditions, were mostly untrained, and were regarded with disdain by physicians and asylum management committees. Early attempts to organise trade unions for asylum attendants met with official hostility and summary dismissals. The unions had only a precarious toe-hold, and had achieved little by the time of the first all-out strikes in Monaghan and Letterkenny in March 1918. A few months later, the Monaghan attendants seized their asylum and ran it as a Soviet, an event which shook the asylum system. Not only were improved wages and conditions achieved locally, but the Monaghan events led directly to the establishment, for the first time, of national terms and conditions for all attendants/nurses in asylums in Ireland. The 'Monaghan Asylum Soviet' served notice that the attendant/nurse could no longer be treated with contempt. The action of this brave group of staff had a profound impact on the future of the mental health nursing profession and on the mental hospital system as a whole.

In Chapter 3, Gillian McClelland takes us to a different place, both in time and perspective. Here, we get a glimpse of patient life in the 1960s, a time of great hope and renewal in the mental health services in Northern Ireland. Hospital magazines were a feature of hospital life during this period. The magazine in Holywell Hospital, Antrim (formerly Antrim Asylum), called *Speedwell*, was published from 1959 to 1972. It became the voice of patients and staff during this time of great change in Holywell Hospital and in all six large psychiatric hospitals in Northern Ireland. Anti-psychotic drugs were introduced in the late 1950s, making care in the community a possibility; the idea of the 'therapeutic community' was just emerging; and new mental health laws gave patients more protection and enhanced rights. As ward doors were unlocked and high walls dismantled, public attitudes towards mental illness began to change. As a result of this, large mental hospitals became less isolated from society. The realities of everyday life in Holywell Hospital, which had almost 800 beds at the time, are described in poetry and prose by staff and patients. The hospital was changing from what Erving Goffman describes as a 'closed' community to one which was more open to outside influences. However, it continued to be a 'community' for a large number of people, many of whom had been patients for a long time.²⁶ During the 1950s and 1960s, this community had employment opportunities within its walls - on the hospital farm, in the gardens and in the laundry. It also had a wide range of leisure activities, including regular outings to the beach and to concerts, competitive sporting events involving staff and patients, and regular performances from the resident hospital dance band and amateur theatre group. At this time, Holywell also boasted a beauty salon and a branch of the Women's Institute. In *Speedwell*, patients expressed their feelings about their lives in this community through prose and poetry. These were lives that included medical treatment but were not defined by it. Gillian McClelland explores some of this material, providing the reader with a unique insight into everyday life in a mental hospital at this time of major change.

Chapter 4 is written by one of the best known mental health professionals in Ireland, Dr Dermot Walsh. From his position as Inspector of Mental Hospitals for many years, he had a bird's eye view of developments in mental health services in the Republic of Ireland. In this chapter, he shares with us some of his thoughts on the changes that occurred in policies and services between 1959 and 2010. It describes these in some detail and identifies some of the forces - social, political and professional that underpinned them. He also highlights the interplay of public concern and legislative change which shaped a vision for Irish mental health services in the future.

In 1959, there were almost 20,000 in-patients in Irish psychiatric hospitals. All but one of these hospitals had been built in the preceding century and the mores and

traditions of that era still governed their daily operation and culture. Physically isolated from their communities by high walls and 'sentry' entrance gates, they represented a socio-economic reality of considerable local importance providing employment and supporting local trade. However, the aloofness of their complacency was being threatened elsewhere, notably in the neighbouring island of England, where their replacement by general hospital psychiatry and care in the community was not only being mooted, but being operationalised. Furthermore, it was becoming apparent even to the only moderately critical eye that living conditions behind the walls were less than acceptable in a modern state. From this situation emerged the Commission of Enquiry on Mental Health. Established in 1961, it called it as it saw it and it was not a pretty picture. Institutionalisation was the norm to which there was little alternative, and professionalism in care was poor and limited to doctors and nurses. Child psychiatric services did not exist and almost one fifth of residents were hospitalised, not because they were mentally ill, but rather because they were 'mentally handicapped'.

Further government bodies reported in 1984 and 2006 and White and Green Papers on services and mental health legislation appeared in 1992 and 1996. Meantime, the Medico-social Research Board, later to become the Health Research Board published annual reports of the activities of inpatient services and carried out censuses of residents periodically. The Inspectorate of Mental Hospitals and later the Mental Health Commission reported annually on conditions, and the latter body used statutory powers to remove approval for the reception of patients from at least one service. Legislation, too, underwent change, with the full implementation of the Mental Health Act 2001 in November 2006, allowing the setting up of tribunals to review involuntary admission and detention. The Criminal Law (Insanity) 2006 was also commenced in that year also.

The impact of these initiatives, together with greatly improved staffing, training and professionalism of those in the service, led, inter alia, to a service that now had moved towards community care, so that residents had dropped below 3,000 by 2010 and several of the nineteenth century hospitals had closed. Nonetheless, there was little room for complacency as many services still lacked multi-disciplinary teams and community physical provision, such as day hospitals and rehabilitation units were still lacking in many locations. In addition, some of the general hospital units of an earlier generation were becoming obsolete for their purpose. Budgetary constraints on professional recruitment and the acquisition of community structures determined by the looming recession were casting a considerable shadow which only increased commitment and sustained endeavour could counter.

We end this section with some poetry written by former service users/survivors of the psychiatric system, and some articles by patients and staff which appeared in hospital magazines, giving us another perspective on mental health services during the second half of the twentieth century.

In Part Two of the book, we move back to the nineteenth century, with research covering various aspects of mental health policy and service delivery. As the contributors to this volume come from different disciplines (history, medicine and social policy), the chapters reflect a miscellany of interests and of approaches. In Chapter 6, Elizabeth Malcolm, using Australian archives, examines the cases of Irish people committed to several large asylums in the colony of Victoria, Australia, during the late nineteenth century. The asylums studied include Yarra Bend (opened in 1848) and Kew (opened in 1871), both in Melbourne, and Ararat (opened in 1867) and Beechworth (opened in 1867) in rural Victoria. The English asylum expert, Henry Burdett, claimed in 1891 that 'lunacy is more general in Victoria than in the other Australian colonies', and he provided statistics on asylum populations to support this assertion. During the 1870s, it was estimated that 70%-80% of those in Victoria's asylums were immigrants, many having been lured to the

colony by the 'gold mania' of the 1850s and 1860s. A significant number of these new arrivals were Irish immigrants, with the Irish forming nearly one-quarter of the colony's population by 1871. Critics of Irish migration suggested that they were heavily over-represented in the asylums. However, this claim has not been systematically investigated.

In this chapter, Malcolm explores the records of Irish people committed to Victoria's asylums during and after the gold rushes, in order to understand who they were, why they were committed and in what ways they differed from their fellow inmates. In common with asylum committals in Ireland and elsewhere, post-natal depression, grief at the deaths of children, alcoholism, head injuries and poor physical health, are all evident as precipitating factors in Yarra Bend Asylum's patient records. In addition, the records of Yarra Bend do offer some evidence that 'gold fever' did play a role in the high committal rates evident in colonial Victoria. The rushes certainly left many 'disappointed' as very few achieved the wealth that they had dreamt of. Most overcame their disappointment, married, and moved on to other jobs or to other places – even, in the case of the perennially optimistic, to other rushes. But for a number, the disappointment was too devastating for them to be able to transcend it. Perhaps this was especially true of those Irish men who had no family in the colony, but parents and siblings back 'home' with high expectations of a regular flow of remittances.

In Chapter 7, Angela Mc Carthy brings the reader to New Zealand, where Irish migrants also featured in asylum records. Mc Carthy explores the records of two asylums, Dunedin and Seacliff, during the period 1863-1909, with a particular focus on the family. She suggests that though the interaction between family issues and madness has received considerable attention in studies of the asylum, there are two significant omissions in the research. First, the actual constitution of the family is rarely discussed explicitly, at least not in detail or quantitatively. For example, we are rarely told if the term 'family' includes or excludes spouses, siblings, parents, children, or other extended family members. Such an omission is surprising in the light of David Wright's reflections on this very issue more than a decade ago, querying whether nuclear or extended family members undertook the committal of an individual to an asylum.²⁷ Mc Carthy suggests that a deeper investigation of the family involved in this process is also critical in light of the influential 'atomisation' thesis put forward by historian Miles Fairburn - that 'most colonists had already severed their links with place, family, friends and community in the great uprooting that led them to New Zealand'.²⁸ A second area of under-reporting in current research, according to Mc Carthy, is the link between the patient and family members who live in a different country. Family connections explored in studies of the asylum are predominantly confined to the country in which the asylums are located. The operation of transnational communications between home and abroad is strikingly absent.

In this chapter, Mc Carthy seeks to redress the balance in current research by examining family networks that existed for Irish patients in New Zealand asylums, and by exploring efforts made by patients to maintain and/or restore their family networks, including their connections to Ireland. Her study shows that many Irish migrants confined to the public asylums in New Zealand, moved within networks of family and friends and did not operate as 'atomised' beings. While Irish people who came to the colony as young adults lost their parental connections, they were often able to link up with siblings and become part of an extended network, comprising aunts, uncles and cousins. Though most relationships cited in asylum records were those of spouse or offspring, this does not mean that Irish patients were without other wider networks in the colony. It may merely reflect the fact that this was the prime relationship noted in the documentation.

In the next six chapters, we return to Ireland, to look at what was happening in the inspectorate and in four district asylums – Belfast Asylum, the Richmond Asylum, the Central Criminal Lunatic Asylum, and in Ballinasloe Asylum. In Chapter 8, Pauline Prior and

David Griffiths, examine official reports, minutes of asylum meetings and newspaper articles, to uncover the unholy war waged by the governors of the Belfast Asylum against the Lord Lieutenant of Ireland in an effort to avoid appointing chaplains. All asylums were required to employ and pay chaplains to look after the spiritual wellbeing of patients. In most asylums, this meant the appointment of two chaplains – one Catholic and one Protestant. However, in Belfast, matters were not so simple, due to the presence of more than two religious denominations and to the fact that the Resident Medical Superintendent at the time, Dr Robert Stuart, had always regarded it as his responsibility to look after the spiritual health of his patients. In order to prove that their stance was legally correct, the governors entered into litigation against the Lord Lieutenant of Ireland, a case that was heard in the Dublin courts. This chapter investigates the motives that inspired the board to defy such a powerful opponent. Documents of the period reveal a solid network of social support for the Belfast governors, based on a deep seated resentment of colonial administration; opposing views on the role of religion in the treatment of the insane; and professional rivalry between Dr Francis White, Inspector in Lunacy, and Dr Robert Stuart, Resident Medical Superintendent of the Belfast Asylum. It is a fascinating story of the power struggle between local and central government over an issue (religion) that continued to dominate political life in Belfast for another century.

A completely different problem is the focus of the study presented in Chapter 9, by E. Margaret Crawford, whose expertise in dietary matters during and after the Famine in Ireland is well recognised.²⁹ This was an outbreak of a ‘mysterious malady’ in the Richmond Asylum in Dublin during the period 1894 to 1898, a malady which brought many experts from other countries to explore the possibility of an occurrence of beriberi among patients and staff. According to Crawford, institutions in nineteenth century Ireland – prisons, workhouses, and hospitals – were often faced with episodes of epidemic diseases, normally listed under the omnibus category of ‘fevers’. However, an unfamiliar disease affecting more than 500 patients and a few staff in the Richmond Asylum was diagnosed, rather bizarrely, as beriberi. Beriberi is caused by a deficiency of the B vitamin, thiamine, and is most commonly found among rice-eating populations in Asia. The link between rice consumption and beriberi was known in the 1890s, but not the association with thiamine.

In this chapter, Crawford poses the question: How did it happen that the symptoms suffered by patients in the Richmond were thought to be connected to an exotic Asian disease? To answer this question, she explores the debates about the outbreak found in the records of the lunacy inspectors, in medical journal articles and in parliamentary papers, as the unusual nature of this illness attracted the attention of the inspectors, of politicians and of newspaper editors. The Resident Medical Superintendent of the Richmond, Dr Connolly Norman, was so concerned by the outbreak that he sought the advice of several eminent medical specialists from Dublin, London and the Netherlands, some of whom had experience of treating beriberi in the Far East. The question was whether or not the symptoms exhibited by the sick in the Richmond were characteristic of beriberi. Having studied the debates in parliament and in the medical literature of the time, and having reflected on the evidence, including dietary information from the Richmond during the period of the outbreak, Crawford proposes a new explanation for this extremely unusual medical episode.

Another medical diagnosis behind mortality statistics is examined in Chapter 10, by Brendan Kelly, who brings his medical expertise to bear on his re-examination of records on specific aspects of the phenomenon of tuberculosis in one asylum (the Central Criminal Lunatic Asylum, Dundrum, Dublin). His study is based on an original analysis of the archival clinical records of three patients who died in the asylum and whose deaths were attributed to tuberculosis. The mid to late nineteenth century saw a dramatic increase in the number of asylum beds in many countries, including Ireland. Notwithstanding these increases in

capacity, Irish asylums were quickly overcrowded, owing chiefly to the rapid increase in the numbers of individuals who presented to the asylums in search of treatment. Tuberculosis, which was a substantial problem in the Irish general population around the end of the nineteenth century, quickly became a problem in these increasingly overcrowded, unsanitary institutions. The cases examined by Kelly demonstrate many of the diagnostic challenges in relation to medical illness (in this case, tuberculosis) amongst asylum inpatients; some of the key therapeutic challenges in relation to both medical and psychiatric illness; and the possible role of the asylum environment in alleviating and/or contributing to the tuberculosis problem at the end of the nineteenth and start of the twentieth century.

In Chapter 11, Pauline Prior explores some of the issues that were of concern to the Lunacy Inspectorate in the second half of the nineteenth century and in the early years of the twentieth. Between the time of its establishment in 1845 and its transformation into a new organisation in 1921, seven doctors held the position of inspector. These were Dr Francis White, Dr John Nugent, Dr George William Hatchell, Dr George Plunkett O'Farrell, Dr E. Maziere Courtenay, Dr Thomas I. Considine, and Dr William R. Dawson. The inspectors visited each asylum at least once per year, and their annual reports are full of information on patients, on staff and on problems raised by managers or inspectors. In the mid century, the main issue dominating annual reports was that of overcrowding in asylums and the growing demand for more beds. A period of expansion began in the 1860s, leading to an increase in the size and the number of asylums. However, in spite of this expansion, the demand continued to exceed supply. Reports on the 'alleged increase in insanity' failed to come to any conclusion on what was causing the problem. In addition, by the end of the century, not only were the asylums overcrowded, but they were also underfunded, as Grand Juries struggled to keep up with the cost of a system that had far exceeded all earlier cost projections. These costs were discussed frequently in the reports of the inspectorate, but in spite of the building of some auxiliary asylums (which were cheaper to run) for chronic patients, the problem was not solved.

The final issue explored by Prior in this chapter is not new to those who monitor mental health services today – the possibility of abuse or neglect of patients. Although this was not an issue that was publicly debated in the nineteenth century, it featured frequently in the annual reports of the inspectors. Each asylum had to report all suicides and any cases in which patients were injured (either accidentally or maliciously), especially if this injury led to the death of a patient. The kind of problems discussed by the inspectors covered a range of situations, including the injury of a patient by an attendant; the death of a patient due to the neglect or during the absence of an attendant or servant; the abuse or injury of one patient by another in the absence of proper supervision by staff; the involvement of staff in the escape of one or more patients and, finally, evidence of a lax approach by a resident medical superintendant towards staff who transgressed. In the most extreme cases of abuse or neglect, the staff member was charged with a criminal offence and appeared in court. In less extreme cases, the courts were not involved, but the staff member was often dismissed or given a disciplinary warning. Overall, it appears that during the second half of the nineteenth century, the issue of physical abuse or neglect of patients was taken seriously by the authorities – the governors of the asylum and the lunacy inspectorate.

In chapter 12, we return to a district asylum, this time in Ballinasloe, Co Galway, a dominant institution in the west of Ireland. As earlier chapters have indicated, the development of the District Asylum system involved complex negotiations of power and authority, with staff, patients and the wider community seeking particular advantages from the institutions. From its origins as a regime predicated on moral therapeutic principles, the asylums gradually moved towards a more medicalised model, with the Resident Medical

Superintendent assuming a dominant role by the century's end. This chapter examines that process at the Connaught District Lunatic Asylum at Ballinasloe and focuses in particular on the experiences of two of that institution's physicians - Dr William Heise, the first such appointment (as the Visiting Physician) and Dr Robert Vicars Fletcher, who as the second Resident Medical Superintendent at Ballinasloe had a highly developed sense of the primacy of professional medical care. Their experiences are reflective of many others in the system throughout Ireland and illustrate the manner in which the asylums moved from a paternalistic, philanthropic model of care and containment, directed by the lay Boards of Governors, to scientific, medical institutions that depended on the acquisition of empirically based university training and which relegated non-specialists to predominantly administrative roles.

We end this section of the book with some extracts from official documents, such as asylum reports and Privy Council Rules, which reflect official thinking about the care and containment of people with mental disorders in nineteenth century Ireland, and some extracts from articles written by Irish psychiatrists in the *Journal of Mental Science*. These articles reflect some of the medical thinking of the time on issues such as the causes of mental illness (discussed in relation to General Paralysis) and on the reasons for the ever growing demand for more asylum places. The question asked in this last article continued to be asked right up to the late twentieth century – do the Irish have a higher incidence of mental illness than other ethnic groups?

Part Three of the book focuses on some general trends in mental health services in the past two centuries. In Chapter 14, Damien Brennan applies a sociological analysis to a study of the rise and fall in patient numbers in asylums/psychiatric hospitals in Ireland over the past two hundred years. While inpatient numbers may reflect an increase or decrease in mental disorders in the Irish population, Brennan asks us to look for other explanations for this pattern of service use. Building on evidence drawn from an original data-set, mapping the psychiatric in-patient population in Ireland from 1817 to 2000, he demonstrates that the Irish data reveals an overall trajectory of institutional residency that began at a low level in the early nineteenth century, increased rapidly between 1830 and 1890, continued to increase at a steady pace until 1956, and then began a steady decline that has continued until the present time.

While this is not an unusual pattern of asylum occupancy, the Irish case does not conform to established sociological theories or 'grand narratives' that seek to explain these patterns. These theories link asylum expansion and decline to classic trends in industrialisation. They also link asylum expansion to the involvement of private/commercial enterprise or of religious organisations in institutional ownership or management. However, the evidence presented here in relation to the Irish situation does not support any of these theories. In the light of this, Brennan suggests a new theoretical explanation, one that points to specific points of 'social conjuncture' at times of change in patterns of psychiatric bed occupancy. He identifies a number of core features that impacted on each point of social conjuncture - the political context; the relationship between church and state; the changing economic structures and social deprivation; the growth of professionalism; the impact of legal changes on systems of admission and discharge; changes in categorisation and diagnostic criteria; international developments in mental health care; and, finally, family dynamics. He argues that these points of 'social conjuncture' are seminal in understanding the shaping and reshaping of a social tendency to institutionalise people with mental illnesses in Ireland. Whether or not you agree with this new theoretical approach to understanding psychiatric institutionalisation in Ireland, the discussion will give you food for thought.

In the final chapter of the book, Pauline Prior gives a brief overview of legal changes which have formed the basis for the delivery of mental health services on the island of

Ireland from 1800 to 2010. Having come from the same position in the nineteenth century, mental health services and the legal basis for these services diverged in 1921, as Northern Ireland became part of the United Kingdom, with similar but not identical health policies, while the Republic of Ireland followed its own path. The legal basis for the provision of the first publicly funded mental health service in Ireland was laid in the early nineteenth century, with Lunacy Acts in 1817 (57 Geo. 3 c. 106), in 1821 (1 & 2 Geo. 4 c. 33) and in 1826 (7 Geo. 4 c. 14). These Acts gave power to Grand Juries to build and maintain a network of district asylums throughout the country. They also outlined the procedures for admission and discharge from these asylums - of people who were 'of unsound mind'. These laws also aimed to protect people from unlawful confinement and from financial exploitation by unscrupulous relatives. Within a few years, there were not enough asylum places for those seeking admission, leading to the introduction of legislation for 'dangerous lunatics' in 1838 (1 Vic. c. 27) and 1867 (30 & 31 Vic. c. 118), which allowed for the direct admission of those deemed to be 'dangerous lunatics' to prison, while waiting for places in an asylum. As discussed earlier, this served to increase the number of admissions and to link dangerous behaviour with mental disorder.

In the twentieth century, the focus of the law changed, from confinement to treatment, with the Mental Treatment Acts/Orders in Council of 1932, 1948, 1961, and 1986 in Northern Ireland, and the Mental Treatment Act of 1945 in the Republic of Ireland. These laws emphasised the need to facilitate access to treatment for someone with a mental illness. In order to do this, some of the legalistic restrictions contained in the laws of the previous century disappeared. Voluntary rather than compulsory admission to psychiatric hospital became the norm, as mental health services became more integrated into general health systems in both parts of Ireland. With developments in medical science, outpatient and community based treatment became real possibilities in the mid century. These developments were reflected in the debates that took place every time the laws were reviewed. Though many efforts were made to initiate change in the law in the Republic of Ireland, the rate of progress was much slower than in Northern Ireland. As the end of the century approached, new problems were emerging that were not adequately covered by the existing legislation in either part of Ireland - the Mental Health (NI) Order 1986 and the Mental Treatment Act 1945 in the Republic of Ireland. For example, the human rights lobby argued that patients and potential patients were not well protected; psychiatrists proposed the introduction of community service orders (i.e. powers to compel an individual to take medication at home); and the dementia lobby highlighted the need for protection for people who had lost capacity, but who were not covered by mental health laws. In the Republic of Ireland, the Mental Health Act 2001 and the Mental Capacity Bill 2009, provided legal guidance on some but not all of these issues. In Northern Ireland, the recommendations of the Bamford Review of mental health and learning disability services, which worked from 2002 to 2007, have not yet been translated into law. However, it is hoped that the next round of legislation in Northern Ireland will incorporate their recommendations, ensuring a much higher level of legal protection for people who are mentally ill or who have lost capacity, while not hindering access to services.

¹ *Report of the Select Committee on the Lunatic Poor in Ireland, with Evidence.* Evidence, p. 14, given on 7/6/1817. HC 1817 (430) viii, 33. (Hereafter, *Select Committee 1817*).

² *Ibid.*

³ *Ibid.*

⁴ *Select Committee 1817.* Appendix to Evidence, p. 33.

⁵ *Select Committee 1817,* Evidence, p. 10, given on 25/3/1817.

⁶ *Ibid.*

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- ⁷ Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (London: Croom Helm, 1981), Table A, p. 227; Williamson, 'The beginnings of state care for the mentally ill in Ireland', *Economic and Social Review*, 10.1 (January 1970): pp. 281-90.
- ⁸ *Report of the Commissioners of Inquiry into the state of Lunatic Asylums and other institutions for the custody and treatment of the insane in Ireland. Part 1: Report; Part 2: Evidence and documents.* HC 1857-8 [2436] xxvii.1. (Hereafter, *Inquiry on Lunatic Asylums 1857*).
- ⁹ *Inquiry on Lunatic Asylums 1857*, Part 1, Report, p. 2.
- ¹⁰ Ibid.
- ¹¹ *Inquiry on Lunatic Asylums 1857*, Part 1, Report, p. 13.
- ¹² Ibid.
- ¹³ *Inquiry on Lunatic Asylums 1857*, Part 1, Report, p. 14.
- ¹⁴ *Inquiry on Lunatic Asylums 1857*, Part 1, Report, p. 16.
- ¹⁵ *Inquiry on Lunatic Asylums 1857*, Part 1, Report, p. 17.
- ¹⁶ Finnane, *Insanity and the Insane*, Table A, p. 227.
- ¹⁷ *Inquiry on Lunatic Asylums 1857*, Part 1, Report, pp. 33-39 and Appendix 1, p. 126.
- ¹⁸ For a history of St Patrick's Hospital, see Elizabeth Malcolm, *Swift's Hospital* (Dublin: Gill and Macmillan, 1989).
- ¹⁹ See William Parry Jones, *The Trade in Lunacy* (London: Routledge and Kegan Paul, 1972); *Inquiry on Lunatic Asylums 1857*, Part 1, Appendix 1, p. 12
- ²⁰ Mark Finnane, 'Irish psychiatry, Part 1: The formation of a profession', pp. 306-13, in G. E. Berrios and H. Freeman (eds.), *150 Years of British Psychiatry 1841-1991* (London: Gaskell, 1991); David Healy, 'Irish psychiatry, part 2: Use of the Medico-Psychological Association by its Irish members – plus ca change!', pp. 314-20, in Berrios and Freeman, *150 Years of British Psychiatry*.
- ²¹ See one example at the Central Criminal Asylum, Dundrum, in Pauline M. Prior, *Madness and Murder: Gender, crime and mental disorder in nineteenth century Ireland* (Dublin: Irish Academic Press, 2008), pp. 69-75.
- ²² Department of Health, *The Psychiatric Services – Planning for the Future* (Dublin: Stationary Office, 1984), p. xi.
- ²³ Department of Health and Children, *A Vision for Change – Report of the Expert Group on Mental Health Policy* (Dublin: Stationary Office, 2006), p. 54.
- ²⁴ Department of Health and Children, *A Vision for Change*, Table 6.1, p. 55.
- ²⁵ Finnane, *Insanity and the Insane*; Malcolm, *Swift's Hospital*; Kelly, B.D. 'Structural Violence and Schizophrenia', *Social Science and Medicine*, 61 (2005), pp. 721-30. Kelly, B.D. 'The Power Gap: Freedom, Power and Mental Illness', *Social Science and Medicine*, 63 (2006), pp. 2118-28; Prior, *Madness and Murder*; Joseph Robins, *Fools and Mad: A History of the insane in Ireland* (Dublin: Institute of Public Administration, 1986); Williamson, 'The beginnings of state care'.
- ²⁶ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (New York: Anchor Books, 1961).
- ²⁷ David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the nineteenth Century', *Social History of Medicine*, 10:1 (1997), p. 150.

²⁸ Miles Fairburn, *The Ideal Society and its Enemies: The Foundations of Modern New Zealand Society, 1850-1900* (Auckland: Auckland University Press, 1989), p. 94.

²⁹ L. A. Clarkson and E. Margaret Crawford, *Feast and Famine: A History of Food and Nutrition in Ireland 1500-1920* (Oxford: Oxford University Press, 2001).