The Circulation of the Insane: The Pauper Lunatic Experience of the Garlands Asylum, 1862-1913

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Within the vast array of literature concerning the county lunatic asylums of the late nineteenth-century, historians have tended to focus on the larger, urban asylums. This thesis presents the experience of pauper lunatic patients at the previously un-researched Garlands Asylum. Using the large repository of records, the thesis focuses on the county institution constructed to jointly serve the counties of Cumberland and Westmorland. Centring on the patient experience, detailed cross-referencing of records have made it possible to map the institutional lives of those who were admitted for treatment. Conducting the study in this way has made it clear that mental health provision in the late nineteenth, and early twentieth centuries was not a static experience. At the heart of the examination is an analysis of the circulatory nature of asylum care. Previous research has identified that there was a network of institutional responses to mental illness in this era. Using core themes identified in the historiography, this thesis has addressed four gaps in the literature. First, a geographical imbalance exists as no English lunatic institutions of the far North have been the focus of detailed scholarly attention. Second - the overarching theme of the thesis – the treatment of pauper lunatics has been presented as a static one. Third, as a result of relying upon patient records for this examination, a greater understanding of the pauper experience will be gained, as at present, mainly due to the scarcity of records, this remains thin. Finally, the experience of marginal groups in the asylum, in terms of increased levels of transfer, is lacking. Addressing these four gaps will extend the historiography, and will provide a more comprehensive understanding of mental health provision for pauper lunatics in the period of study.

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Abbreviations

CACC	**Cumbria Archive Centre, Carlisle**
CACK	**Cumbria Archive Centre, Kendal**
CACW	**Cumbria Archive Centre, Whitehaven**
TNA	**The National Archives**

Chapter One: Introduction

When there was no such Institution in the County, a lunatic Asylum was regarded with all the vague horror that was connected in the popular mind, with the cruelty and chains of the old Bedlams…But when the Asylum was built and occupied, and open to the inspection of everyone who chose to come and see it, and a realizing sense of the fact that it was only, after all, a useful institution for the cure of a certain class of complaints to which everybody is liable[1]

Overview

The historiography of madness and its treatment spans a wide thematic and chronological range, including theoretical and empirical commentary. The existing literature within the area highlights the considerable growth of institutional responses to insanity, particularly from the 1845 County Asylums Act.[2] To begin with, it is necessary to examine the work of Andrew Scull, who has authored several seminal texts that have provided the foundations of retelling the emergence of the county asylum network in the nineteenth-century.[3] His central argument is that the growing institutional response to insanity was a method of controlling unproductive members of society.[4] From this base, many researchers have undertaken work to expand the historiography further in a number of focussed areas. For instance, Leonard Smith has

[1] Cumbria Archive Centre, Carlisle - henceforth CACC – *Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1867*, THOS 8/1/3/1/5, p. 15.
[2] This legislation made it mandatory for each County and Borough in England and Wales to provide a public lunatic asylum for pauper patients, David Wright has argued that this was 'the defining piece of legislation in the Victorian era', D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001), p. 16.
[3] A. Scull, *Museums of Madness: The Social Organization of Insanity in nineteenth-century England* (London: Allen Lane, 1979); A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Yale University Press, 1993); A. Scull, *Masters of Bedlam: The Transformation of the Mad-doctoring Trade* (Princeton: Princeton University Press, 1996).
[4] Scull, *Museums of Madness*, pp. 13-18.

explored in detail the significance of the early asylums for the expansion of the institutional network.[5] Others such as Anne Digby, David Wright, Peter Bartlett and Akihito Suzuki (among many authors), have focused on researching particular institutions that catered specifically for Quakers and children, the role of the Poor Law in administering care for the mentally ill, and responses within the domestic setting to madness, respectively.[6]

Theorists such as Michel Foucault have viewed the growth of asylums in this period as a method of controlling social deviance.[7] Also important is Erving Goffman and his 'total institution' approach.[8] These viewpoints have been criticised for lacking a wider historical context,[9] as they suggest that the treatment of the mentally ill was solely delivered in asylums, workhouses and the like.[10] For example, *Madness and Civilisation* is heavily focussed on single institutions, and on individuals at the head of these, namely the Tuke's at the York Retreat, and Philippe Pinel at Salpêtrière.[11] He, along with Goffman, has largely neglected the patient experience, and the high numbers cared for at home by relatives. The key theoretical concepts Foucault was engaged with - power, social control, social uniformity, and the construct of deviance - have all been reconfigured to form different approaches, including that which underpins this thesis: history from below. Since Roy Porter's call, for the history of medicine to be conducted from below, recent research has focussed on drawing out the patient experience.[12] Yet, studies claiming to give a voice to asylum inmates are particularly confined to the literate, upper-classes that had the tools to record their experiences and speak out about

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[5] L. D. Smith, *"Cure, Comfort and Safe Custody": Public Lunatic Asylums in Early Nineteenth Century England* (London: Leicester University Press, 1999).
[6] A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985); Wright, *Mental Disability in Victorian England*; P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London: Leicester University Press, 1999); A. Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (London: University of California Press, 2006).
[7] M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London: Routledge, 2001).
[8] E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other inmates* (London: Aldine Transaction, 2007).
[9] A. Scull, 'Psychiatry and Social Control in the nineteenth and twentieth centuries', *History of Psychiatry,* 2:6 (1991), pp. 149-69, quoted in J. Melling, 'Accommodating Madness: New Research in the social history of insanity and institutions', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 1-30.
[10] H. Sturdy and W. Parry-Jones, 'Boarding-out Insane Patients: The Significance of the Scottish System', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 86-114.
[11] Foucault, *Madness and Civilisation*, pp. 35-60.
[12] R. Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society,* 14:2 (1985), pp. 175-98.

their confinements.[13] For literature on the institutional history of asylums, patients are presented using large datasets, which has been valuable in adding to knowledge of the widespread response to insanity,[14] but does not further the understanding of the experiences of the poor and marginal groups, such as the immigrants that came to Britain and found themselves in lunatic establishments.

When reviewing the historiography, four themes have emerged that are crucial for this thesis. First, the problem of overcrowding has been documented in almost all county asylums constructed throughout the nineteenth-century. This had major ramifications for the level and type of care the insane received.[15] Second, there has been a focus on the emergence of moral treatment within the county asylum system. This was pioneered in early establishments such as the York Retreat,[16] and later extended to include non-restraint at Hanwell under John Conolly.[17] Third, the literature has given a sense of the changing role of the family in asylum treatment. Throughout the nineteenth-century a shift occurred, after 1845 in particular, and the family were no longer the ones who accepted 'liability' for insane relatives.[18] This altered so that they became the ones responsible for signing the asylum admission papers of mentally ill members.[19] Another dimension that has been considered, is that county asylums were built around a familial framework, with medical superintendents playing a patriarchal role to their 'children', the patients.[20] Finally, it is apparent from the historiography that

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[13] For example, Louise Wannell centred her research on the letters written by those who were treated at the York Retreat in the later nineteenth-century, L. Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910' *Social History of Medicine*, 20:2 (2007) pp. 297-313; S. Chaney, '"No 'Sane' Person Would Have Any Idea": Patients' Involvement in Late Nineteenth-century British Psychiatry', *Medical History,* 60:1 (2016), pp. 37-53; C. Smith, 'Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics', *Family and Community History,* 9:2 (2006), pp. 109-24. Michael Ignatieff stated, 'the working classes are always seen as the objects of the process and never as its participants', M. Ignatieff, 'Total Institutions and Working Classes: A Review Essay', *History Workshop Journal,* 15:1 (1983), pp. 167-73.

[14] For instance, S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998* (Woodbridge: Boydell Press, 2003); P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003); R. Hunter and I. Macalpine, *Psychiatry for the poor: 1851 Colney Hatch Asylum – Friern Hospital 1973: A Medical and Social History* (London: Dawsons of Pall Mall, 1974).

[15] Scull, *Museums of Madness,* pp. 222-53.

[16] Digby, *Madness, Morality and Medicine.*

[17] Hunter and Macalpine, *Psychiatry for the poor,* pp. 13-14.

[18] A. Scull, 'A Culture of Complaint: Psychiatry and its Critics', in J. Reinarz and R. Wynter (eds), *Complaints, Controversies and Grievances in Medicine: Historical and Social Science Perspectives* (London: Routledge, 2015), pp. 37-55.

[19] Suzuki, *Madness at Home*, p. 153.

[20] See J. Conolly, *The Construction and Government of Lunatic Asylums* (London: Dawsons of Pall Mall, 1968), p. 144, quoted in E. Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago Press, 1987), p. 28.

there remained a considerable flow of paupers between the asylum, workhouse, and family home, after 1845.[21] For example, 'patient exchanges' were identified in the work of Catherine Cox, Hilary Marland and Sarah York, with regard to the transfer of Irish immigrants in the four Lancashire Asylums.[22] However, no studies have gone so far as to analyse the impact this had on the patients, in particular, pauper lunatics.

This thesis will examine these themes, to make it clear that the knowledge of these areas is being extended, and will focus specifically on the Cumberland and Westmorland Joint Lunatic Asylum – Garlands.[23] Through this thematic exploration, four gaps apparent in the literature will be addressed, at various points in the discussion. For chapters two, three and four, the focus will be to redress the geographical imbalance of the historiography. These chapters shall also outline the circulation through the respective themes, which will be analysed in depth in chapter six. Patient circulation will be the focus of the thesis, and in this analysis incorporates the wider population of the pauper insane. It has been used to reflect what was going on in the asylum as a whole.[24] Patients were constantly moving in and out. The makeup of the asylum population could vary greatly from week to week due to transfers being made out, and others being moved in. With regards to the patient sample, circulation is understood as those who were brought from another institution to the asylum, those who moved out of Garlands unimproved to another institution, or to the care of relatives. Additionally, circulation refers to those who were admitted on more than one occasion – those who originally left recovered, but came back. Others in the historiography have examined patient transfer, but the examination here will consider

[21] K. Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, c.1834-1900* (London: Bloomsbury, 2015), p. 127; A. Shepherd, *Institutionalising the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014), p. 69; Bartlett, *Poor Law of Lunacy*, pp.151-96. See also, L. Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the insane in West Midlands workhouses, 1815-1860', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20.

[22] C. Cox, H. Marland, and S. York, 'Emaciated, Exhausted, and Excited: The Bodies and Minds of the Irish in late Nineteenth-Century Lancashire Asylums', *Journal of Social History*, 46:2 (2012), pp. 500-24.

[23] The name 'Garlands' comes from the estate upon which the Asylum was constructed, three miles south-east of Carlisle. Carlisle Central Library Local History Reference Section, G. R. Wyld, *A History of the Garlands Estate and Garlands Hospital, Carlisle, Cumberland, 1757-1914* (n.pub, 1972), p. 2, quoted in C. Dobbing, 'An Undiscovered Victorian Institution of Care: A Short Introduction to the Cumberland and Westmorland Joint Lunatic Asylum', *Family and Community History*, 19:1 (2016), pp. 3-16.

[24] Just as Steven Taylor understood it in his examination of child lunatics, S. J. Taylor, *Child Insanity in England, 1845-1907* (London: Palgrave Macmillan, 2017), pp. 112-19.

this in terms of the wider process of circulation that engulfed the asylum and other Poor Law institutions.

Not only has Garlands remained unexamined by historians, but a study which centres on the movement of patients has never been carried out. At the heart will be the patients themselves, in order to address the relative absence of pauper experience in the literature. This is limited by the lack of available primary material containing the patient's voice, as has been the case previously. Most prominently, this will began to be addressed utilising patient letters in chapter five. Elsewhere in the thesis, information drawn from the casebooks has been cross-referenced to document the pauper experience in as much rounded detail as possible. An additional focus will be the research of immigrants, which is carried out in chapter six, specifically those of Irish birth, who found themselves in an English asylum, in order to assess the accelerated circulation they were subject to, and the reasons this occurred. The patient records from this rural institution will be used as the primary source of information for the thesis, and they will act as the starting point for further study into the transfer of patients between different institutions of care in Victorian England.

Literature Review

Four themes identified in the large and vibrant literature on madness, inform this thesis as suggested above. These are inter-related and a number of overlaps are apparent. Due to overcrowding, a substantial amount of cases would be sent back to the asylum as the conditions in the workhouse often caused their mental state to deteriorate.[25] The main facilitator of circulation was therefore overcrowding, which in turn hindered the effectiveness of moral treatment. This was further impacted by the role of families, as they became increasingly willing throughout this period to admit relatives, who had been previously unaccounted for, to the asylum and placed additional pressure on the availability of mental health provision. The initial three inter-connected themes will be considered in turn to assess what is already understood in the historiography about the movement of patients in the period. This focus forms the fourth theme to be analysed in the thesis, which is interwoven throughout the other three.

Overcrowding

[25] CACC, *Fortieth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1901*, THOS 8/1/3/1/39, pp. 14-15.

Overcrowding is a familiar theme which emerges from a majority of the literature. In recent decades a large number of asylums have been the subject of detailed analysis; which has subsequently formed the mainstay of research on pauper lunatics. These studies have focussed on the years following the legislation of the nineteenth-century which, initially recommended the building of a county asylum,[26] but then later made it mandatory for the construction of a pauper institution.[27] The examination of the earlier establishments has indicated that overcrowding was not an issue confined to the latter half of the nineteenth-century. Most built after the 1808 Act had, by 1844, grown in capacity since opening.[28] For example, Norfolk Asylum's average number had more than doubled from 71 in the period 1814-1819, to 159 in the decade 1830-1839.[29] By 1839, the largest asylum was Hanwell, Middlesex, with the capacity to accommodate 1000 patients.[30] It is no great surprise that the issue magnified in the institutions constructed after 1845.[31] Smith argued that the lunatic asylum was never the 'sole institutional receptacle' for the insane in England, and has termed this collective of institutions the 'tapestry of care'.[32] Before 1808, this tapestry was limited to the workhouse, the family home, and the private madhouse, and some early public asylums such as Bethlem.[33] Owing to a large majority of the population living in destitution, pauper insanity was most visible in the workhouse.[34] For those with families willing and able to care for them, many remained in the domestic setting, hidden from view in

[26] The 1808 County Asylums Act was permissive, which many counties ignored. By 1845 only 16 county asylums had been constructed. K. Jones, *Mental Health and Social Policy, 1845-1959* (London: Rouledge & Kegan Paul, 1960), p. 7.
[27] In 1845, Parliament introduced the County Asylums and the Lunacy Acts in England and Wales, 8 & 9 Victoria c. 100 and c. 126. Wright, *Mental Disability in Victorian England*, p. 16.
[28] J. Walton, 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-1870', in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 166-97; Smith, *Cure, Comfort and Safe Custody*, pp. 79-82, 173-5.
[29] Cherry, *Mental Health Care,* Table 2.1, p. 46.
[30] Smith, *Cure, Comfort and Safe Custody*, p. 63.
[31] A. Scull, 'The Social History of Psychiatry in the Victorian Era', in Scull (ed.), *Madhouses, Mad-doctors, and Madmen*, pp. 5-32. Overcrowding was not confined to English asylums. For the experience in the colonial context, see L. Smith, *Insanity, Race and Colonialism: Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838-1914* (London: Palgrave Macmillan, 2014).
[32] Smith, 'A Sad Spectacle', p. 103.
[33] For information on Bethlem see R. Porter, *Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Cambridge: Harvard University Press, 1987), pp. 121-9; for early public asylums see Smith, *Cure, Comfort and Custody.*
[34] A 1844 Report of the Commissioners in Lunacy found that 9000 insane paupers, or 75% of the total insane people of England and Wales, were in workhouses, private asylums or boarded out, R. Hodgkinson, 'Provision for Pauper Lunatics 1834-1871', *Medical History,* 10:2 (1966), pp. 138-54; D. Cochrane, '"Humane, economical, and medically wise": the LCC as administrators of Victorian lunacy policy', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III* (London: Tavistock Publications, 1988), pp. 247-72.

cellars, attics, and outhouses,[35] due to embarrassment.[36] As a result, in the years before 1845, pauper lunacy in Britain was often hidden from public view.[37] After the introduction of the County Asylums Act, a shift occurred in the primary response to pauper lunacy, [38] which saw a great movement of patients. The passage at the beginning of this chapter, from the 1867 Garlands annual report, summarises this shift in attitude, which put the asylum at the centre of mental health provision. This was reinforced by the introduction of the four shilling grant-in-aid: a central consolidated fund which was created to ensure local magistrates were not harbouring lunatics in workhouses to keep costs down. Thus, every pauper lunatic could be sent to an asylum to be treated with no extra cost to local rates.[39]

Once all counties adhered to the stipulation of the Act, and built their own institution, a greater number of pauper lunatics were visible than ever before.[40] As stated in most institutional histories, and notably by Scull, the new county asylums soon became overcrowded. Accompanying the rapid expansion of the number of available asylum beds, the amount of patients being admitted to the new institutions increased rapidly. Between 1844 and 1890, the population of England and Wales had increased by 78%, whereas the lunatic population had increased four-fold.[41] The Lunacy Commissioners were growing increasingly concerned over the 'crowded state of nearly all the County Asylums'.[42] This signalled the next great shift, as to alleviate the problem, suitable cases considered low risk were transferred to the wards of nearby workhouses. These were usually the cases labelled 'idiots', 'imbeciles' and elderly

[35] L. J. Ray, 'Models of Madness in Victorian asylum Practice', *European Journal of Sociology*, 22:2 (1981), pp. 229-64; See also R. Ellis, 'The Asylum, The Poor Law and the Growth of County Asylums in nineteenth century Yorkshire', *Northern History*, 45:2 (2008), pp. 279-93.
[36] C. Mackenzie, 'Social Factors in the admission, discharge and continuing stay of patients at Ticehurst Asylum, 1845-1917', in Bynum, Porter and Shepherd, *The Anatomy of Madness, Volume III*, pp. 147-74; See also J. K. Walton, 'Casting Out and Bringing Back in Victorian England: pauper lunatics, 1840-70', in Bynum, Porter and Shepherd (eds), *The Anatomy of Madness Vol. III,* pp. 132-46.
[37] See Scull, *Masters of Bedlam*, chapter 5; W. F. Bynum, R. Porter and M. Shepherd, 'Introduction', in Bynum, Porter and Shepherd (eds), *The Anatomy of Madness Vol. III*, pp. 1-12; Ellis, 'The Asylum'; D. Wright, 'Community Care and its antecedents', in Bartlett and Wright (eds), *Outside the Walls of the Asylum*, pp. 1-18.
[38] See V. Skultans, *English Madness: Ideas on Insanity, 1580-1890* (London: Routledge, 1979), pp. 98-127; Hodgkinson, 'Provision for Pauper Lunatics'.
[39] R. Ellis, 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century', *Social History of Medicine*, 19:1 (2006), pp. 55-71; see also E. Hurren, 'Belonging, Settlement and the New Poor Law in England and Wales 1870s-1900s', in S. King and A. Winter (eds), *Migration, Settlement and Belonging in Europe, 1500-1930s: Comparative Perspectives* (Oxford: Berghahn Books, 2013), pp. 127-52.
[40] This was also facilitated by greater enumeration of the insane, see Jones, *Mental Health,* p. 17.
[41] Scull, *Most Solitary of Afflictions,* p. 336.
[42] Commissioners in Lunacy, *Tenth Annual Report to the Lord Chancellor,* (1856), quoted in Scull, *Most Solitary of Afflictions,* p. 366.

dementia patients, with no prospect of cure or discharge.[43] Idiocy,[44] referred to those who were considered mentally defective from birth or for most of their lives. This reserved asylum care for those considered lunatics, and deemed the most curable.[45] Four main points of explanation for the problem are apparent from reviewing the historiography.

First, is that the methods of statistical analysis after 1845 became much more rigorous and widespread.[46] Those who had previously been overlooked were classed as insane by the new, thorough inspection of the Commissioners.[47] Many historians, however, argue that there is little evidence which suggests a rapid real increase of patients being moved to the asylum in this period.[48] Related to this, was that scientific advances of the field led to a growth in the number of people diagnosed as insane, increasing the number of classifiable conditions.[49] However, this did not necessarily mean the actual numbers of the insane had increased. Second, was the greater life expectancy of pauper lunatics, which was facilitated by the better treatment of care offered in the county asylums.[50] The authorities used this as a way of proving the success of lunacy reform,[51] thus positively viewing the growing problem of overcrowding rather than dealing with it directly. Third, the ambitious vision of the

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[43] Smith, 'A Sad Spectacle', p. 106, and p. 113; See also C. Philo, *A Geographical History of Institutional Provision of the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter: Edwin Meller Press, 2004), p. 248. For information about the elderly insane in workhouses see G. Yorstin and C. Haw, 'Old and mad in Victorian Oxford: a study of patients aged 60 and over admitted to the Warneford and Littlemore asylums in the nineteenth century', *History of Psychiatry,* 16:4 (2005), pp. 395-421, and also N. Goodman, 'Poverty, Old Age and Gender in Nineteenth Century England: The Case of Hertfordshire', *Continuity and Change,* 20:3 (2005), pp. 351-384.

[44] Wright stressed 'the permanence of idiocy in differentiating it from lunacy', C. P. Philips, *The Law Concerning Lunatics, Idiots and Persons of Unsound mind* (London: James Widly, 1858), pp. 1-2, in D. Wright, 'Familial Care of "Idiot" Children in Victorian England', in Horden and Smith (eds), *The Locus of Care,* pp. 176-97.

[45] The definitions used by psychiatrists of the era to classify the mentally ill were divided into the two broad categories of Idiocy and Lunacy. Lunacy referred to the wide spectrum of 'curable' insanity which was advocated to be treated in the county asylums. This included mania, depression, puerperal insanity, religious mania, and many more. A. Digby, 'The Rural Poor Law', in D. Fraser (ed.), *The New Poor Law in the Nineteenth Century* (London: Macmillan, 1976), pp. 149-70.

[46] The Commissioners in Lunacy 'contended [that], the methods of gathering statistics on insanity had previously been slipshod and inadequate', Scull, *Most Solitary of Afflictions,* p. 339; See also Ray, 'Models of Madness', p. 232.

[47] E. Hare, 'Was Insanity on the Increase?', *British Journal of Psychiatry,* 142:5 (1983), pp. 439-55; See also Jones, *Mental Health,* p. 17.

[48] Edgar Miller argued that the growth in the numbers of paupers housed in asylums increased linearly with no rapid expansion around 1874 or after, E. Miller, 'Variations in the official prevalence and disposal of the insane in England under the poor law, 1850-1900', *History of Psychiatry,* 18:1 (2007), p. 25-38. See also Ellis, 'The Asylum', p. 55; Ray, 'Models of Madness', pp. 252-3.

[49] Hare, 'Was Insanity on the Increase?', p. 440.

[50] Ray, 'Models of Madness', p. 232; See also Jones, *Mental Health,* p. 17.

[51] Scull, *Most Solitary of Afflictions,* p. 340.

burgeoning psychiatric profession led to promotion of the curative tendencies of the county institutions.[52] Thus, the creation of the asylum system added to the increased demand.[53] Finally, the introduction of the four shilling grant-in-aid scheme in 1874, was thought to have exacerbated overcrowding.[54]

Regardless of the cause, the literature is clear that the responses to overcrowding facilitated the largescale movement of patients. An amendment to the Lunacy Act in 1862 stipulated that harmless and incurable pauper lunatics could be detained the workhouse.[55] As indoor relief cost a third of asylum provision, long-stay chronic lunatics were cheaper to maintain in the Union house.[56] Medical superintendents, faced with situations of overcrowding, utilised the amendment by transferring patients already in the asylum, whose conditions had stabilised.[57] Considering the role overcrowding played on patient movement, interpretations such as Goffman's,[58] which regard the asylum as a 'total institution' that repressed individuals through incarceration, seem somewhat misplaced.[59] Overcrowding, and the large transfer of the insane this resulted in, features heavily in the historiography. However, analysis concerning the impact on patients has fallen through the vast amount of research conducted.[60] The movement effected the standard of care available for patients. The treatment in nineteenth-century asylums forms the second major theme identified in the literature.

Moral Treatment

[52] R. Adair, J. Melling and B. Forsythe, 'A Danger to the Public? Disposing of Pauper Lunatics in late-Victorian and Edwardian England: Plympton St. Mary Union and the Devon County Asylum, 1867-1914', *Medical History,* 42:1 (1998), pp. 1-25.
[53] Scull, *Most Solitary of Afflictions,* p. 363.
[54] Ellis, 'The Asylum, the Poor Law, and a Reassessment'.
[55] Lunacy Acts Amendment Act 1862, 25 & 26 Vict. Cap. Cxi, quoted in C. Cox and H. Marland, '"A Burden on the County": Madness, Institutions of Confinement and the Irish Patient in Victorian Lancashire', *Social History of Medicine,* 28:2 (2015), pp. 263-87; See also Wright, *Mental Disability in Victorian England,* p. 178; Bartlett, *Poor Law of Lunacy*, pp. 53-55, in Philo, *A Geographical History of Institutional Provision of the Insane,* p. 261.
[56] D. Wright, 'The discharge of pauper lunatics from county asylums in mid-Victorian England: The case of Buckinghamshire, 1853-1872', in Melling and Forsythe (eds), *Insanity, Institutions and Society,* pp. 93-112; A. Negrine, 'Practitioners and Paupers: Medicine at the Leicester Union Workhouse', in Reinarz and Schwarz (eds), *Medicine and the Workhouse,* pp. 192-211; Walton, 'The Treatment of Pauper Lunatics', p. 169; Bartlett, *Poor Law of Lunacy,* pp. 51-55.
[57] The stipulation of the lunacy legislation was that all 'dangerous' cases of insanity should be detained in an asylum, Wright, *Mental Disability in Victorian England,* p. 17.
[58] See also the Foucauldian interpretation in Foucault, *Madness and Civilisation.*
[59] See Goffman, *Asylums*.
[60] Hodgkinson, 'Provision for Pauper Lunatics', p. 150.

The historiography of madness has charted the emergence of an enlightened method of treatment in the late eighteenth and early nineteenth-centuries. Historians have debated the origins of moral treatment as a distinct form of asylum care, but have agreed that it involved psychological methods to aid mental disorders.[61] This was in response to the growing concern of the cruelty inflicted in the primitive asylums.[62] Scull attributed the immediate appeal of moral treatment to the fact that it brought to light the unnecessary cruelties of the existing responses to lunacy.[63] Later, non-restraint became widely adopted as an aspect of moral treatment, following the lead of John Conolly in the early 1830s at Hanwell Asylum,[64] and at Lincoln Asylum, under Dr Charlesworth and Dr Gardiner Hill.[65] Scull argued that Conolly, 'became the most vociferous champion of the system of "non-restraint"'.[66] As Hunter and MacAlpine have put forward, Conolly believed that active occupation of body and mind was essential to the success of therapy without mechanical restraint.[67] The practice was followed in some, but not all, early asylums, and in *all* of the institutions created after the 1845 Act.[68] By 1890, mechanical restraint was made illegal by the stipulations of the Lunacy Act. It stated that the use of 'instruments and appliances' was only to be resorted to when a patient displayed signs of intent to injure himself or others. A book also had to be kept by asylums documenting exactly how and when patients were restrained.[69]

The literature concerning, specifically, the institutional histories of asylums, all include explanations of the regime employed in these establishments. Naturally, they focus on the facets of moral treatment which emerged from the early pioneers. In

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[61] Digby, *Madness, Morality and Medicine,* p. 33; Skultans, *English Madness*, chapter 4; Wannell, 'Patients' Relatives and Psychiatric Doctors', p. 299.
[62] 1815-1816 Parliamentary Enquiry was borne out of abuses uncovered at the York Asylum and Bethlem, Scull, *Most Solitary of Afflictions,* p. 115; Suzuki, *Madness at Home,* p. 115.
[63] Scull, 'Psychiatry and Social Control', p. 154.
[64] R. G. Hodgkinson, *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871* (London: Wellcome Historical Medical Library, 1967), p. 184.
[65] Jones, *Mental Health,* p. 9.
[66] A. Scull, 'John Conolly: A Victorian Psychiatric Career', in A. Scull (ed.), *Social Order/Mental Disorder: Anglo-American psychiatry in historical perspective (London: Routledge, 1989),* pp. 165-98, quoted in Wright, *Mental Disability in Victorian England*, p. 32; this is echoed by Jones, 'John Conolly, perhaps the greatest asylum administrator of this period', in Jones, *Mental Health,* p. 9; See also Conolly, *Construction and Government,* quoted in Hunter and Macalpine, *Psychiatry for the Poor*, p. 14. Showalter argued that Conolly 'made moral treatment a world-known success', Showalter, *The Female Malady*, p. 33.
[67] J. Conolly, *Treatment of the Insane Without Mechanical Restraints. With an Introduction by Richard Hunter and Ida Macalpine* (London: Dawsons, 1973), in Hunter and Macalpine, *Psychiatry for the Poor*, p. 37.
[68] K. Jones, *Asylums and After: a revised history of the mental health services from the early 18th century to the 1990s* (London: Athlone Press, 1993), pp. 23-8.
[69] Jones, *Mental Health,* p. 38.

essence, moral treatment has become a term used to denote the routine of care offered in the nineteenth-century asylum, that encompassed a variety of treatments.[70] Medical superintendents employed regimes which encouraged the restoration of humanity through self-control and discipline.[71] One element was the useful employment of patients in the asylum,[72] as it was believed that it would aid the individual's successful return to society.[73] Male patients generally took part in outdoor tasks such as farm work and carpentry.[74] Females completed the domestic jobs of laundry, cooking and housekeeping.[75] Heavily documented in this area, is that patient employment was important to balancing the books.[76] Food cultivated on asylum farms, textiles and furniture made in the workshops, all eased the 'financial burden', as well as teaching the patients new skills and keeping them occupied.[77] Porter went further and argued that asylums became self-sufficient colonies, running their own laundries, farms and workshops, with the dual intention of economy and 'cure through labour'.[78]

As suggested in the last section, once asylums began to be overcrowded, the system of moral treatment was soon compromised.[79] To deal with excessive patient numbers, asylums had to adopt treatments which employed restraint though the use of sedatives.[80] In consequence, rates of cure were effected, which was a sign of embarrassment for medical superintendents.[81] Transferral to workhouses, which offered sub-standard treatment, had to be utilised as a method to control growing admissions. This interruption of moral treatment would, most likely, result in a patient's

[70] This could include the use of medicines, and the term moral management was also used to refer to a range of treatments employed to occupy patient's thoughts from their conditions. See Smith, *Cure, Comfort and Safe Custody,* pp. 187-226.
[71] Skultans, *English Madness*, p. 62.
[72] Hunter and Macalpine, *Psychiatry for the Poor*, p. 37. Scull refers to work as the 'cornerstone' of moral treatment, Scull, *Most Solitary of Afflictions,* p. 102.
[73] P. Bartlett, 'The Asylum and the Poor law: The Productive Alliance', in Melling and Forsythe (eds), *Insanity, Institutions and Society,* pp. 48-67.
[74] Smith states how asylum medical men favoured outdoor employment due to its 'connotations of healthy physical exercise', Smith, *Cure, Comfort and Safe Custody,* p. 236.
[75] A. Digby, 'Moral Treatment at the Retreat, 1796-1846', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II* (London: Tavistock Publications, 1985), pp. 52-72.
[76] See L. Smith, '"A Powerful Agent in their recovery": Work as treatment in British West Indian lunatic asylums, 1860-1910', in W. Ernst (ed.) *Work, psychiatry and society, c. 1750-2015* (Manchester: Manchester University Press, 2016), pp. 142-162.
[77] Wright, *Mental Disability in Victorian England*, p. 149.
[78] R. Porter, 'Madness and its Institutions', in A. Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), pp. 277-301.
[79] Adair, Melling and Forsythe, 'A Danger to the Public?', p. 2; See also Scull, *Most Solitary of Afflictions,* p. 277.
[80] Walton, 'The Treatment of Pauper Lunatics', p. 169; See also Scull, *Museums of Madness,* p. 203.
[81] Wright, 'The discharge of pauper lunatics', p. 104.

readmission, as they became violent and erratic in absence of asylum care.[82] The implications this had on the patients who had been transferred in the 'mixed economy of care' seem to have been forgotten in the historiography.[83] Scholars have been correct in identifying the facets of moral treatment, the individuals who pioneered them, and that workhouse provision was sub-standard. Thus, a gap exists in analysing the effect this shift in care had on the patients themselves.

Role of the Family

For historians who have recounted the experience of insanity, the continued role of the family has emerged, most notably through admission documents and letters. Both Len Smith and Louise Wannell have examined the relationship of families with doctors, whilst a relative was receiving treatment in an asylum.[84] Thus, evidence exists of family involvement throughout the asylum process, but understanding this fully presents a problem for researchers, as the availability of primary material is piecemeal, with this thesis being no exception. The lack of sources from the perspective of those of the lowest strata of society, has led to a predominant focus within the historiography on the role families played in the committal of relatives, and their involvement in the discharge process.[85]

Earlier literature focuses on the shift of the locus of care from the domestic setting to the county asylum. Scull, and others, have stressed that when lunatic asylums were in their infancy in the eighteenth-century, the insane had been 'a communal and a family responsibility',[86] and were primarily a domestic 'affair'.[87] After 1845, the creation of the Lunacy Commission transferred responsibility from relatives to local authorities. However, this did not signal the end of family involvement in the care

[82] See Cox, Marland and York, 'Emaciated, Exhausted and Excited', p. 506; Smith, 'A Sad Spectacle', p. 115; M. Levine-Clark, 'Dysfunctional Domesticity: Female insanity and Family relationships among the West Riding Poor in the mid-nineteenth century', *Journal of Family History,* 25:3 (2000), pp. 341-61; Walton, 'Casting Out', p. 137.
[83] Phrase quoted in L. D. Smith, 'The County Asylum in the Mixed Economy of Care, 1808-1845' in Melling and Forsythe (eds), *Insanity, Institutions and Society*, pp. 33-47.
[84] For instance, Wannell, 'Patients' Relatives and Psychiatric Doctors', and L. Smith, '"Your Very Thankful Inmate": Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine*, 21:2 (2008), pp. 237-252.
[85] Wright, 'The discharge of pauper lunatics', p. 98; See also Walton, 'Casting Out'.
[86] A. Scull, 'From Madness to Mental Illness: Medical Men as Moral entrepreneurs', *European Journal of Sociology,* 16:2 (1975), pp. 218-61, quoted in J. K. Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50', *Journal of Social History,* 13:1 (1979), pp. 1-22.
[87] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), p. 2. See also A. Suzuki, 'Lunacy in Seventeenth- and Eighteenth-century England: analysis of Quarter sessions records', *History of Psychiatry,* 2:8 (1991), pp. 429-36.

given to relatives, as they remained vital in the committal process. An insane member of the community would often come to the attention of the Poor Law officer at the instigation of a family, who provided the initial diagnosis.[88] Usually, the admission of a relative was triggered by some variance with normality in their capabilities to cope with everyday life.[89] Identified as signs of mental deficiency were problems dressing, toileting, feeding, and the general lack of being able to care for oneself.[90] As can be drawn from asylum casebooks, relatives were frequently asked to give evidence of insanity, and direct quotes from family members were recorded.[91]

From the historiography, explanations of the shift from the home to the lunatic institution centre on the 1845 Act, and the widespread construction of public asylums. Cathy Smith viewed this as a welcomed solution by poorer families, as the economic burden of an insane relative would be relieved, and argued that they were more willing to surrender care to the asylum.[92] The shift was facilitated by the insistence of the new medical superintendents that the home was no longer the best place to treat the insane. They reinforced the need for early admission to the asylum for the best chance of recovery. Linked to this was the belief among superintendents that removal from familiar surroundings would alter a person's mind-set and soothe the diseased manifestations causing their insanity.[93] Seclusion from family and friends was therefore facilitated by removal to an asylum.[94] For many pauper lunatics living in extreme poverty and destitution, some have argued that the asylum was a welcome departure from the constant struggle of survival as they were 'materially better off' than they would have been in the family home.[95]

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[88] Smith, 'Family, Community and the Victorian Asylum', p. 110; Miller, 'Variations in the official prevalence and disposal of the insane', p. 26; C. MacKenzie, *Psychiatry for the Rich*: *A History of Ticehurst Private Asylum 1792-1917* (London: Routledge, 1993), p. 102, quoted in Suzuki, *Madness at Home*, p. 92.
[89] Cherry, *Mental Health Care,* p. 10.
[90] D. Wright, '"Childlike in his innocence": Lay attitudes to "idiots" and "imbeciles" in Victorian England', in D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency*: *historical perspectives on people with learning disabilities* (London: Routledge, 1996), pp. 118-33.
[91] M. Finanne, 'Asylums, Families and the State', *History Workshop Journal,* 20:1 (1985), pp. 134-48.
[92] S. King and A. Tomkins (eds), *The Poor in England 1700-1850. An Economy of Makeshifts* (Manchester: Manchester University Press, 2003), quoted in C. Smith, 'Living with Insanity: Narratives of poverty, pauperism and sickness in asylum records 1840-76', in A. Gestrich, E. Hurren and S. King (eds), *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938,* (London: Continuum, 2012), pp. 117-41. See also Cherry, *Mental Health Care,* p. 23.
[93] N. J. Tomes, 'A Generous Confidence: Thomas Story Kirkbride's Philosophy of Asylum Construction and Management', in Scull (ed.), *Madhouses, Mad-doctors, and Madmen,* pp. 121-43.
[94] Ray, 'Models of Madness', p. 240.
[95] Showalter, *The Female Malady,* p. 27.

The maintenance of familial relationships whilst in an asylum, and the emotions that accompanied this must not, however, be disregarded. It is easy to become drawn in by the literature which suggests that families were glad to be unburdened once the county asylum network increased,[96] and forget the attachment which prevailed.[97] As Wright stated, 'institutionalisation…was only one part' of the strategy.[98] Many families with mentally disabled members had coped with them since birth, and incarceration was only resorted to in times of prolonged erratic behaviour. Suzuki explored the treatment of insanity in the domestic setting. He examined the recorded Commission of Lunacy cases, in the period 1820-60. These were legal procedures, which were reported publicly in the local and national press, to determine if an individual was insane. Predominantly, these occurred for cases who were considered to be unwell and had financial assets that were in jeopardy due to their mental health. The relatives, neighbours and servants of these people would be heard in front of the Lord Chancellor and a committee of lawyers. This gives an insight into how insanity was defined and treated at home,[99] but not in terms of the pauper experience.

For the lower classes, the breakdown of families, and the wider dislocation of communities, has been explored as an explanation for the increased willingness to admit relatives to pauper lunatic institutions. Many have attributed this to the industrial revolution, which saw the transferral of labour from the rural setting to the cities.[100] Families became removed from each other and were crowded into inner-city slums.[101] Long working hours, inadequate housing, and a lack of relatives close-by meant that it became increasingly difficult for families to deal with insanity; therefore public provision in the form of asylum care was in greater demand.[102] In an attempt to alleviate the change from the private to public sphere, county asylums came to be modelled on the family. Scull termed this the 'domestication of madness', which

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[96] R. Adair, J. Melling and B. Forsythe, 'Migration, Family Structure and Pauper Lunacy in Victorian England, admissions to the Devon County Pauper Lunatic Asylum, 1845-1900', *Continuity and Change,* 12:3 (1997), pp. 373-401; see also Scull, *Most Solitary of Afflictions,* p. 353.
[97] See C. Dobbing (Forthcoming), 'The Family and Insanity: The Experience of the Garlands Lunatic Asylum, 1862-1910', in C. Beardmore, C. Dobbing and S. King (eds), *Family Life in Britain, 1650-1910* (London: Palgrave Macmillan, 2019).
[98] Wright, *Mental Disability in Victorian England,* p. 8.
[99] Suzuki, *Madness at Home,* p. 18.
[100] Scull, *Most Solitary of Afflictions,* p. 26; Walton, 'Lunacy in the Industrial Revolution'.
[101] M. Hanly, 'The economy of makeshifts and the role of the poor law: a game of chance?', in King and Tomkins (eds), *The Poor in England 1700-1850*, pp. 79-99.
[102] G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), p. x.

signalled the transition out of the home and into the asylum.[103] At Hanwell, Conolly came to regard his patients as his own children, and took on a figurative parental role.[104] The domestic setting created a familiar, ritualistic environment in which patients could feel comfortable during their treatment and recovery. Foucault viewed this domesticity as a form of exerting control over the patients, and argued that the power structures of the family were emulated in the institutional organisation of the asylum, with the medical superintendents assuming the patriarchal role.[105] However, Mark Finnane stated that the asylum also intervened in the lives of those without familial context.[106] The records of asylums and workhouses are full of cases that had an absence of relatives. Thus, the lunatic institutions gave those without familial context a sense of domestic belonging through the care they provided.[107] The literature is heavily skewed towards those who instigated and dealt with the transfer in care. What remains to be addressed are the wider implications for those who experienced it first-hand. This, along with the other identified gaps will be filled throughout this thesis by analysing the Garlands Asylum records.

Sources and Methods

Previous histories of the lunatic asylum tend to be somewhat inward looking. Typically, they focus on retelling a chronological history of the institution, providing details of how it came to be constructed, the treatments offered, the numbers/classifications of patients treated, and inform readers of what happened in the era of care in the community, when such establishments ceased to operate.[108] Only within the last decade have studies began to focus on comparing institutions.[109] To extend beyond this, the thesis will use existing research in order to fully explain the asylum practices in context with the wider institutional network. Finding a comparative framework for Garlands is

[103] A. Scull, 'The Domestication of Madness', *Medical History,* 27:3 (1983), pp. 233-48.
[104] Conolly, *Construction and Government,* p. 144, quoted in Showalter, *The Female Malady,* p. 28.
[105] M. Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage Books, 1979), pp. 293-4, quoted in J. Hamlett, *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* (Hampshire: Palgrave Macmillan, 2015), p. 17.
[106] Finanne, 'Asylums, Families and the State', p. 135, quoted in Wright, 'Familial Care'.p. 177.
[107] See D. Bennett, 'The Drive Towards the Community', in Berrios and Freeman (eds), *150 Years of British Psychiatry*, pp. 193-208.
[108] Cherry, *Mental Health Care*; Michael, *Care and Treatment*.
[109] For instance, L. Hide, *Gender and Class in English Asylums, 1890-1914* (Hampshire: Palgrave Macmillan, 2014; Hamlett, *At Home in the Institution;* Shepherd, *Institutionalising the Insane;* and that of Cox, Marland and York, who considered four asylums, Cox, Marland, and York, 'Emaciated, Exhausted, and Excited'; Taylor, *Child Insanity.* For an earlier comparative study see D. J. Mellett, *The Prerogative of Asylumdom: Social, Cultural, and Administrative Aspects of the Institutional Treatment of the Insane in nineteenth-century Britain* (New York: Garland, 1982).

more complex than it first appears, notwithstanding the considerable literature on private and public institutions. Geographically, the closest English establishment to Garlands to be researched is the Lancashire County Asylum. John Walton has examined admissions in Lancashire, exploring a range of Poor Law institutions in the county in order to investigate the role of the Industrial Revolution in the rapid increase of pauper lunacy.[110] Given the close proximity of the Lancaster Asylum to Garlands, it is easy to assume that their patients and experiences were similar. Lancashire was a county driven by industry, home to many of the 'mill towns', while Cumberland and Westmorland were predominantly rural counties with very little industry, therefore in practice this obvious analogy is confounded.[111] For instance, as mentioned frequently by the various medical superintendents of Garlands Asylum, the great reliance on agriculture in Cumberland and Westmorland often led to a larger number of admissions of farm labourers in the winter months than in the summer. Closely related to this was the notion that insanity was triggered by overwork, this was evident as farm labouring was physically exhaustive.[112]

Another region of northern England to be researched by historians is Yorkshire. Being such a large county, there are several lunatic asylums worthy of study. Digby's monograph on the York Retreat tells the story of how the small Quaker establishment transformed into a pioneer at the turn of the nineteenth-century.[113] Comparing Garlands to the Retreat is somewhat misplaced, as it was a small institution built specifically for the private care of mentally ill Quakers, not a county asylum primarily for paupers. In addition, the York institution was constructed almost a century before Garlands. Rob Ellis has also focussed his research on Yorkshire, but has looked instead at the West Riding Pauper Lunatic Asylum in Wakefield, and the North and East Riding Asylum in Clifton.[114] Although built in the same era as Garlands, these institutions had different experiences. For the North and East Riding Asylum, the demand for beds from pauper lunatics was comparatively low in the early years, and they instead offered private and out-county patients a high proportion of their capacity.[115] This contrasts greatly to the

[110] Walton, 'Lunacy in the Industrial Revolution', p. 5.
[111] Dr Clouston stated in 1864 that: 'The two counties contain chiefly an agricultural and mining population', quoted in CACC, *Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1864*, THOS 8/1/3/1/2, p. 9.
[112] Goodman, 'Poverty, Old Age and Gender', p. 361.
[113] Digby, *Madness, Morality and Medicine.* See chapter four for further information.
[114] Ellis, 'The asylum'.
[115] Ibid., p. 293.

overcrowding of pauper lunatics felt at Garlands throughout its history, having to refuse patients on many occasions from the outset. The Yorkshire Asylums researched by Ellis were opened before the passing of the 1845 Act, and were built in primarily industrial heartlands.[116] Similar to Walton's Lancashire Asylums, their patients were also drawn from towns clustered around Yorkshire. No histories of English asylums in the far North exist, leaving a large geographical gap in the historiography.

Suitable comparators for Garlands can be found in the work of Steven Cherry, with his research on the Norfolk Asylum, and in Pamela Michael's research on the North Wales Asylum, Denbigh.[117] Both of these county institutions were built to serve rural localities, providing this study with a patient population of similar backgrounds to those of Garlands. Norfolk, however, was built much earlier in 1814, and opened before moral management had become the accepted norm. Restraint and physical coercion were commonly used by attendants who lacked any specific medical training, for instance, in 1815 up to two-thirds of patients were mechanically restrained.[118] Over subsequent decades, punishment became increasingly focussed on the seclusion of troublesome patients in single rooms. This was in contrast to the commitment to moral management employed at Garlands on its opening less than 50 years later.[119] Norfolk had also expanded to such an extent that by 1862 it housed 390 patients, much more than the opening capacity of Garlands, which was 200.[120] Denbigh, on the other hand, was constructed much closer in 1848. The rhetoric of moral treatment was at this time becoming increasingly prevalent, and at Denbigh they avoided 'the slightest mechanical restraint'.[121] The patients of the Welsh institution were also predominantly admitted from the family home and the wider community prior to admission.[122] As noted, after 1845, families were increasingly encouraged to admit their mentally ill relatives to the new asylums to receive the correct level of care.[123] In an era of growing concern over the treatment and care of the insane, the Lunacy Commissioners increasingly felt that it was in the patients' best interests that they be sent to an asylum proximate to their

[116] Ibid., p. 279.
[117] The work of Joseph Melling and Bill Forsythe on the Devon Asylum would also be a useful comparator, see J. Melling and B. Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London: Routledge, 2006).
[118] Cherry, *Mental Health Care,* p. 43 and p. 48.
[119] Ibid., p. 43.
[120] Ibid., p. 82.
[121] Commissioners in Lunacy, *Eighth Annual Report to the Lord Chancellor,* (1854), p. 124.
[122] P. Michael and D. Hirst, 'Family, Community and the lunatic in mid-nineteenth-century North Wales', in Bartlett and Wright (eds), *Outside the Walls of the Asylum*, pp. 66-85.
[123] Adair, Melling and Forsythe, 'Migration, Family Structure and Pauper Lunacy', p. 374.

home, as travelling some distance may further weaken their mental state and their family would not be able to visit regularly.[124] Combined, the Norfolk and the Denbigh Asylums provide a comparative analysis for the evidence gathered in this thesis for Garlands, and will be referred to throughout.

The Garlands records are held at the Cumbria Archive Centre in Carlisle, Cumbria, and have escaped scholarly attention. The research for this thesis is based on the analysis of seven core sources, beginning with the patient casebooks. The passing of the 1845 Act made it mandatory for all English asylums to keep casebooks.[125] However a uniform system of record keeping was not laid down, and the information collected on each patient varied depending on the institution. The pioneering efforts of Dr Thomas Clouston, medical superintendent of Garlands, 1863-1872, meant that the patient casebooks in particular have been expertly kept, and record more detailed information than in other county institutions of the time.[126] This example was followed by subsequent superintendents, and as a result the Garlands collection provides extensive and detailed information about its operation, and its patients. The sample for the thesis has been compiled primarily from the data in the casebooks.[127] They provide in depth biographical and medical information for each patient, and give a starting point for historians attempting to discover why they became incarcerated, what happened during their stay, and how they left the Asylum, be it discharged recovered, removed or died.[128] Foucault viewed these documents as a form of social control imposed by the asylum, as they transformed each individual into a 'case', useful only for the scientific knowledge they could provide, from which further power would be exerted upon the

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[124] C. Philo, 'Journey to asylum: a medical-geographical idea in historical context', *Journal of Historical Geography*, 21:2 (1995), pp. 148-68.
[125] J. Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the nineteenth century', *Social History of Medicine,* 11:2 (1998), pp. 255-81.
[126] In 1871 the Lunacy Commissioners reported: 'Much credit is due to Dr Clouston for his management of the Asylum, and the careful manner in which he keeps the medical records', CACC, *Tenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1871*, THOS 8/1/3/1/9, p. 11. His career and high standing was cemented at Morningside Asylum, where he practiced after he left Garlands in 1873. He authored key influential texts, and was made Sir Thomas Clouston in 1911 for his contribution to the advancement of the treatment of the insane. Much celebrated was his record keeping, and his annual reports which were printed regularly in journals and the local press, practices he began at Garlands. A. Beveridge, 'Clouston, Sir Thomas Smith (1840–1915), Asylum Physician' *Oxford Dictionary of National Biography*, 8 October 2009 http://www.oxforddnb.com.ezproxy3.lib.le.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-38634 [accessed 2 March 2018].
[127] CACC, THOS 8/4/39/1-6 (males), and THOS 8/4/40/1-6 (females).
[128] Although useful, Smith stated the limitations in asylum records of hearing the voice of 'the most significant people', as they are 'notoriously hard to retrieve', and as a result, the evidence can appear parochial and idiosyncratic, Smith, *Cure, Comfort and Safe Custody*, p. 4 and p. 8.

institutional population.[129] However, asylum case notes are recorded in a shortened form and, as Jonathan Andrews put forward, these were not written as a source for historians, rather, they were kept for staff to trace a patient's treatment.[130] Also apparent when consulting these documents, is that these were written through the eyes of clinicians, sometimes lacking in emotion and sympathy.[131] What has provided valuable information for this thesis, in particular chapter five, are the patient letters that were attached to some of the entries in the casebooks. These give a first-hand perspective of the pauper experience, albeit for only a small number of patients.[132]

Second, another important set of documents were the reception orders. To enter the asylum, as stipulated by the 1845 Act, a medical certificate signed by two practitioners, otherwise known as the reception order, was required. The medical superintendent was legally obliged to ensure that all patients had a reception order and certificate of insanity before confinement in his asylum. These documents detailed the patient's history, name and address of the next of kin, and two statements from different individuals who had witnessed the person's insanity.[133] The Carlisle Archives hold all reception orders for the patients of Garlands in the period of study.[134] They are a useful way of showing who admitted an individual to the asylum, and the events that triggered committal, for instance a suicide attempt. Criticisms of these documents, centre on the fact that the 'indications of insanity' section was rather small, resulting in information relayed by relatives of asylum patients being shortened or filtered by the doctors writing the certificates, thus preventing a rounded understanding of working-class attitudes towards insanity.[135] However, in terms of recounting history from below, the reception orders provide quoted information detailing lay observations of insanity, which is extremely valuable in the context of the topic in providing evidence of the pauper experience. Utilising these in tandem with case notes, provides the researcher with a more comprehensive view of the circumstances surrounding committal, and are

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[129] Foucault, *Discipline and Punish,* p. 191, quoted in A. Suzuki, 'Framing Psychiatric Subjectivity: Doctor, Patient and record-keeping at Bethlem in the Nineteenth-Century', in Melling and Forsythe (eds), *Insanity, Institutions and Society,* pp. 115-36.
[130] Andrews, 'Case Notes', p. 266.
[131] Cherry, *Mental Health Care,* pp. 13-14.
[132] See chapter five for full analysis of these letters.
[133] These testimonies could be from a wide range of people including relatives, neighbours, workhouse masters, and police officers. Jones, *Asylums and After,* p. 90; For information on certification and reception orders see Wright, 'Familial Care', p. 178; Wright, *Mental Disability in Victorian England,* p. 7; D. Wright, 'The Certification of Insanity in nineteenth-century England and Wales', *History of Psychiatry,* 9:35 (1998), pp. 267-90.
[134] CACC, *Reception Orders 1862-1913,* THOS 8/4/1/4-55.
[135] Wright, 'Certification', p. 280.

important in the examination of this thesis. However, it must be noted that these are second-hand accounts of mental illness, as has been reiterated, the experience of those who lived through insanity, and treatment, in this period, are hard to recollect. As a result, these fragments of pauper experience can be put together with a variety of other archival documents to obtain as rounded view as possible.

Third, the rules and regulations of the Asylum have supplied a key starting point with regards to the regime employed in Garlands, and the duties of the various staff members. As Smith has found, the rules were intended to outline staff responsibilities and to protect the interests of patients.[136] Two sets of rules and regulations for Garlands have survived, 1861 and 1870. They provide a great sense of the prevailing regime of moral and therapeutic treatment of patients.[137] Fourth, the ordinary routine of care and overall approach to treating the mentally ill has also emerged from the Asylum annual reports, which have been an extremely valuable source of information throughout the research of this thesis.[138] They provide an insight of how the Commissioners in Lunacy and Committee of Visitors, both external bodies, viewed the Asylum and how well they believed it was being managed. The reports provide important evidence of the work of the medical superintendents. They detail the statistics of the patients who were admitted, discharged, relieved, and died throughout the previous twelve months, and reflect on how they have overcome any problems in the past year. The statistical information provided demonstrates the high level of transparency which operated in the Asylum. Detailed tables of stock held by the institution are given to show the rate payers exactly how their money was spent. Additionally, the annual report also gave superintendents a way of communicating any revolutionary treatments they may have been experimenting with, and the effect this was having on the patients. The reports have been an important source when noting any changes in the Asylum operation, and with regards to the daily routines carried out.[139]

Fifth, in addition to the primary material held at the Carlisle Archives, other sources have also been consulted. The annual reports of the Commissioners in Lunacy have been a valuable source of information because they provide a detailed view of the English asylum system as a whole, and give a clear picture of how typical, or untypical,

[136] Smith, *Cure, Comfort and Safe Custody*, pp. 56-7.
[137] CACC, *Rules and regulations for the management of the Cumberland and Westmorland Asylum, Garlands, 1861*, THOS 8/1/1/1; CACC, *General Rules for the Government of the Asylum at Garlands, 1870*, THOS 8/1/1/3.
[138] CACC, *Annual Reports 1863-1913*, THOS 8/1/3/1/1-51.
[139] Ibid.

Garlands was, when compared to other county institutions.[140] Sixth, the examination of contemporary medical journals has been important in gaining an understanding of the role the county asylum played in the wider development of the field of psychiatry. Superintendents used their experience of treating patients in asylum wards to write informative articles of any findings/techniques they developed. Those written by doctors employed at Garlands have therefore provided a valuable insight into the development of treatment, both in the Asylum, and in the wider psychiatric profession.[141] Finally, local newspapers have been an extremely helpful source of information regarding how the Asylum was viewed by the local community. Two local publications, the *Carlisle Journal* and the *Carlisle Patriot* have been useful for gaining a community dimension, as they both covered the events of the area immediately surrounding the asylum.[142] Both papers include quarterly reports of the Board of Guardians regarding the workhouses and Garlands. Prior to opening, the various stages involved in the erection of the asylum were reported. These provide detailed evidence of how long it took, and what was involved in building a county lunatic asylum. National newspapers have also been an excellent resource, as they give a sense of how events in Garlands were reported nationally, and the attitudes which existed toward lunacy and asylums. The national press also provides a sense of how people perceived the increasing problem of overcrowding and seemingly never-ending expansion of asylums.

As the Garlands archive is extensive,[143] the period spanned by the patient sample has been limited to 1884-1903.[144] In the wider context of the historiography, these dates are significant because they encompass the 1890 Lunacy Act. The events prior to, and in consequence of, this will offer a fascinating insight into the themes discussed above. Widespread overcrowding had been common since the 1860s, the breakdown of the asylum as a curative institution was being realised, and families were increasingly willing to admit relatives, thus offering a mixture of factors worthy of

[140] Commissioners in Lunacy, *Annual Reports to the Lord Chancellor* (1847-1910).
[141] For instance, *The Lancet* or the *Journal of Mental Science*. See bibliography for full list consulted.
[142] At the time of research, these publications were not digitized (have since been made available on www.britishnewspaperarchive.co.uk) and were consulted on microfilm at both Carlisle Central Library, and Carlisle Archives. For the full list of newspapers used for the thesis, see bibliography.
[143] Patient records including casebooks, reception orders, admission registers, discharge registers, death registers, post mortem registers all survive from the inception of the Asylum in 1862 until the mid-twentieth century. This is in addition to the numerous volumes detailing the staff information, and administrative data for the institution. For the full extent of the archive, CACC, THOS 8.
[144] Please see Appendix 5 for full explanation as to how the sample was constructed, and a discussion of representation.

research. Patients who entered the Asylum between these years will be the primary source of information for this thesis, and the close mapping of their institutional lives will provide evidence of the circulation between different institutions of care. The years of study have been selected from a methodical perspective because the annual reports only give figures for the different nationalities in the Asylum during this period.[145] This is to provide a fair analysis of the circulation of patients classed as Irish, and have been identified as those belonging to the Roman Catholic faith.[146] To create the sample, 80 patients of each gender were chosen at random from the casebooks, with two from each sex being chosen from the Protestant religion, and two from the Roman Catholic faith for each year. For example, for 1884, the four females that were chosen at random were Catherine B and Jane H from the Protestant sect, and Eliza B and Mary C from the Roman Catholic religion.[147] Thus the patient sample is made up of 160 randomly chosen cases.

In comparison to research such as that of Michael, who analysed 2000 case histories, the number of the sample seems small.[148] Where this thesis will differ is by examining each of the 160 patients in depth, rather than using a large number of cases to create a broad overview. The historiography has tended to employ a quantitative approach when analysing patient data. The result is that only brief glimpses of each individual is gained, and detailed understanding of the patient experience is confined to general trends.[149] Recent research has begun to state the benefits of employing a mixed method of analysis in recounting the history of asylum patients.[150] For instance, the work of Taylor, who cross-referenced 773 child insanity cases with various institutional

[145] For instance in 1884 it was stated that present in Garlands were 441 English, 63 Irish, 29 Scottish, and 2 German patients, CACC, *Twenty-Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1884*, THOS 8/1/3/1/22, p. 17.
[146] When referring to a patient of the Roman Catholic faith, it cannot be assumed the individual was of Irish birth. Some were, but for the majority, they were of Irish descent. Those who had migrated to England after the Famine had settled and had offspring, therefore most of the Roman Catholics in the sample were second or third generation Irish, but were still regarded as Irish in the nationality statistics in each annual report.
[147] CACC, *Female Casebook 1884-1888*, THOS 8/4/40/1, admission numbers 31, 2554, 2612, and 2630, respectively.
[148] However, similar to the number examined in this thesis, Suzuki utilised 196 Commission in Lunacy cases, which were largely drawn from newspaper and court records, Suzuki, *Madness at Home*, pp. 185-90.
[149] As Michael stated, only 'a small fraction of the individual case histories are cited [in her book]', Michael, *Care and Treatment*, p. 7
[150]A. McCarthy, C. Coleborne, M. O'Connor, and E. Knewstubb, 'Lives in the Asylum Record, 1864 to 1910: Utilising Large Data Collection for Histories of Psychiatry and Mental Health', *Medical History*, 61:3 (2017), pp. 358-79.

records.[151] Although the sample for this thesis forms the core evidence presented throughout, as will be seen in each chapter, additional cases and groups of patients have also been researched. As a result, the number of patient histories examined in the entire thesis extends 400.[152] The information for each case has been drawn in the first instance from the casebooks, and has then been cross referenced with other records, for example reception orders, discharge registers, death registers, also with census material and birth/marriage/death certificates to gain a wider understanding of the personal profile of each patient. *Ancestry* has been important in the data gathering process for each patient, and the family tree tools have been valuable in collating information of the family background of the sample.[153] When attempting to construct a complete picture of an individual's family life and background, a certain degree of logical estimation is required to fill any gaps. The problem with pauper patients is that they left behind very few documents, meaning that record linkage is vital in gaining full knowledge of every patient. However, the extensive records kept provide detailed medical and personal information for each patient, as well as their family history of mental illness, and the address of their next of kin.

This empirical approach to data collation and analysis is widely accepted within the historiography. Theoretical frameworks, such as that of Foucault, do not fit with the evidence that has emerged from institutional histories. His notion that the asylum was intended to confine social deviants, and that the employment of moral treatment was utilised to further control them using structures of reward and punishment, have been proved to be flawed.[154] When the archival sources have been researched, cases have emerged which demonstrate that the sites constructed for the treatment of insanity were used as curative establishments, in which patients could thrive and be discharged recovered from. Foucault's assertion of the great confinement is unfounded, as so many asylum patients left after relatively short periods, encouraged by superintendents keen to publicise their high rates of recovery. Revisionist narratives reconsider these unfounded theories, which have been carried out through empirical study of archival

[151] Taylor, *Child Insanity*, p. 10.
[152] Where cases have been used that are not in the core patient sample, this is indicated in the footnotes throughout the thesis.
[153] www.Ancestry.co.uk
[154] See Foucault, *Madness and Civilisation*; and M. Foucault, *History of Madness* (Abingdon: Routledge, 2006).

material.[155] In essence, the research undertaken in this thesis will be a reconstruction of asylum life through detailed case study analysis.

Interest and Structure

Within this chapter a number of gaps within the crowded historiography have been identified. First, histories of the institutions of insanity have focussed on pioneering establishments, and those at the forefront of advancing the psychiatric field. No examination exists of a county asylum north of Lancashire or Yorkshire. Second, the literature presents mental health provision in the later nineteenth-century as a static experience, whilst at the same time stating that, due to overcrowding, the workhouse, and other institutional responses, remained important. Thus, the reasons for the movement of patients has been explained, but analysis of the effect this shift had is absent. Third, the pauper experience of insanity, and the conduct of 'history from below' is lacking. Large data sets and statistical analysis have been relied upon to present the general experience of institutional life, instead of focussing on the impact on the patients themselves. In depth analysis of smaller samples, have been confined to the experience of the wealthier classes, who left behind a greater amount of primary material. Finally, lunatic asylum care has been largely presented by distinguishing between pauper and private patients. Unheard are groups within the pauper class who experienced asylum treatment differently, for instance immigrant populations who came to England and were considered unworthy of Poor Law provision. These four main gaps will be addressed through the subsequent five chapters, at various points. In addition, the conclusion will provide a comprehensive analysis of these findings.

In the following chapter, a brief background of Garlands will be explored in order to assess the significance in studying a Northern, rural asylum. Not constructed until 1862, the insane of Cumberland and Westmorland were, largely, sent to a private establishment in neighbouring Gateshead prior to opening. This chapter shall examine why the magistrates of these counties refused to implement their own provision until so late, and outline the transfer of patients once opened. The experience of Garland's initial decade will be presented, and some of the patients will be examined to give a sense of the population from which admissions were drawn and the types of insanity that were experienced. In addition, the members of staff who were responsible for the

[155] Melling, 'Accommodating Madness', p. 2.

operation of the Asylum will be analysed, to provide an insight to the environment in which patients were treated, and who by. The research gaps to be addressed in this chapter will centre upon redressing the geographical imbalance of existing asylum histories.

The third chapter shall explore the persistent problem of overcrowding experienced at Garlands throughout the period of study. Overcrowding was the main facilitator of patient transfer, therefore the analysis of this chapter will be important in beginning to address the second identified gap. The reasons will be explored, and the responses offered will also be examined. As the workhouse remained an important receptacle of the insane, this chapter will, in part, explore the experience of lunatics who were removed there to relieve overcrowding in the asylum. It will be necessary here to make a distinction between the 'harmless', chronic patients deemed fit for workhouse provision, and the 'dangerous', recent cases of insanity treated primarily in asylums. Researching in order to explain the effect overcrowding had on the individual pauper patient in terms of their displacement when undergoing treatment for insanity is where this thesis will differ from other asylum histories. Administration documents will be important in the discussion here, to present the unrelenting problem from the perspective of the staff.

The fourth chapter will extend the research presented in the previous one by examining the treatment employed at Garlands, and exploring when this could be compromised. To begin with, an outline of the regime will be given, building on the information gathered in the second chapter. It will be necessary to look at the extent to which the Garlands Asylum employed these methods of treatment, to determine their use in an un-researched institution. This will be necessary to highlight the absence of any real 'cure' for insanity throughout the period, which led to a reliance on these methods, and in turn, a heavy burden placed on the ordinary attendants. In addition, the chapter will look at the implications when moral treatment failed to be delivered uniformly. Previous histories detailing the advantages of moral treatment have neglected the circumstances in which care could be compromised, in particular through patient agency, thus offering an additional consideration.

The fifth chapter will provide an examination into the role of the family in the treatment of a relative whilst in an asylum. Their role in admission, discharge, and care of the insane will be looked at through the experiences of the patient sample. The change which occurred in the role of the family as asylum provision expanded will be

the main focus. Patients who lacked a familial context will also be explored, to ascertain the extent to which they came to rely on institutional care. Letters found attached to patient case notes will be valuable in this chapter in addressing the gap of pauper experience. Although only small in number, the voice of the patient, in terms of their communication with relatives, will be evaluated. In addition to the sample, a book detailing the visits of relatives to the Garlands patients, 1900-1904,[156] will be consulted to provide first-hand information of the familial ties which remained the strongest during a patient's incarceration. Thus, in addressing the third identified gap, this chapter offers an exploration of the experience of working-class families with mentally ill relatives in an asylum.

The sixth chapter will bring together elements of each of the preceding ones and shall fully explore the circulation of pauper lunatics. Discussions begun throughout the thesis will culminate in this chapter, in which the mainstay of analysis is offered. It will determine how the lunatic population were circulated, and why. Central to this will be utilising patient information and case histories to present the effect it had at the lowest level. An additional dimension which will be explored, is the experience of Roman Catholic immigrants and the problems they posed to the increased circulation of patients in this period. Although this aspect has been explored by Marland and Cox, they have done so only for Lancashire.[157] Thus, this chapter, in forming the core argument of this thesis, offers a new aspect of asylum research. This will provide the main analysis of the second and fourth identified gaps in the historiography, and will be a precursor to the evaluation offered in chapter seven.

The concluding chapter shall bring together all the gathered evidence of the previous ones to answer the questions set out in this introduction. Following the themes identified, the conclusion will attempt to understand the circulation of the insane in the latter half of the nineteenth-century, and ascertain how the research aims set out in this chapter have been presented and addressed. The central conclusion will be that, contrary to the portrayal of previous insane institutional histories, the lunatic asylum in this period was not a static entity. This chapter will assess how the historiography changes in view of the research conducted here, and will justify the importance of the findings. Finally, the conclusion shall make recommendations for areas of further study, which, following this research, have been highlighted as being worthy of more in

[156] CACC, *Patients Friends Book 1900-1904*, THOS 8/4/24/1.
[157] Cox and Marland, 'A Burden on the County'.

depth analysis. Going forward, the ultimate importance of this thesis, is that an understanding will be gained of the reasons why the insane were circulated in the nineteenth-century, and a platform for further study will be created.

Chapter Two: Background[1]

Of every ten patients who have come in, 4 have gone away recovered, 1 has gone away relieved, 2 have died, and three remain inmates of the establishment.[2]

Overview

Garlands[3] opened in an era when asylum construction was particularly accelerated. In recent decades, the county lunatic institutions that emerged have received increasing scholarly attention. This has predominantly focussed on the larger, more well-known asylums that were famous for pioneering techniques, or which had prominent doctors at the head of their institution. As outlined in the introduction, no English asylum north of Lancashire[4] and Yorkshire has been researched in any great detail by historians of the area. Attention has focused on the public establishments that operated in the increasingly industrial heartlands, which had large populations that relied on their institutions for care. Less common in the literature are county asylums which had a relatively small population from which their patients were drawn, and who were rurally situated. Surprisingly, Garlands has not been studied previously, which is not due to a lack of surviving records. Utilising the well preserved archive of this Asylum lies at

[1] The following article is, partly, based on the research conducted for this chapter, C. Dobbing, 'An Undiscovered Victorian Institution of Care: A Short Introduction to the Cumberland and Westmorland Joint Lunatic Asylum', *Family and Community History*, 19:1 (2016), pp. 3-16.
[2] Dr Clouston remarking on the first ten years of the Garlands Asylum, CACC, *Eleventh Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1872*, THOS 8/1/3/1/10, p. 20.
[3] Garlands was the estate on which the Cumberland and Westmorland Joint Lunatic Asylum was built. Before opening, whilst under construction, from 1857 within the local press it became known as the asylum at Garlands, and the earliest mention of it being referred to as Garlands Asylum can be found in June 1862. It's original name was used on official forms and reports, but in contemporary newspaper and journal articles, and within the surrounding community, it became widely referred to as Garlands Asylum. See *Carlisle Journal*, 09 January 1857; *Carlisle Patriot*, 14 June 1862.
[4] Bernard Melling asserted that the Lancashire Asylums received a large amount of attention as they 'were at the forefront of the Asylum Reform Movement', B. Melling, 'Building a Lunatic Asylum: "A question of beer, milk and the Irish"', in T. Knowles and S. Trowbridge (eds), *Insanity and the Lunatic Asylum in the Nineteenth Century* (London: Pickering & Chatto, 2015), pp. 57-70.

the centre of this thesis and will go some way to filling the geographical gap which exists in the history of psychiatry and its institutions.

As chapter one suggested, previous work has tended to consider the asylum as an insular concept that provided treatment to patients, and they either left recovered, were removed unimproved, or died in the institution's walls. Absent from the literature is an examination of the lunatic asylum as a fluid notion, that had numerous factors affecting its operation. Admitting its first patients on 2 January 1862, Garlands opened in response to the 1845 Lunacy Act, and was constructed in an era in which most existing asylums had *already* sought extensions to their institutions as a result of the steep rise in admissions. For example, opened in 1848, Denbigh Asylum required further accommodation due to patient overcrowding in 1859.[5] In Garland's first two months of operation, 168 pauper lunatics chargeable to Cumberland and Westmorland were transferred from, predominantly, Dunston Lodge in nearby Gateshead, other northern lunatic institutions, and workhouses.[6] From the outset, then, other establishments were important in the origins of the initial population. The majority of the 196 patients who resided in Garlands by the end of 1862 had already undergone a transferral of care from other institutions. Therefore, the process of circulation was present from the beginning. Previous research, such as that of Pamela Michael, does mention where the first wave of admissions received treatment prior to opening, however the effect of this transfer has not been analysed.[7] The full implications of this will be considered in chapter six.

Against the broad institutional, chronological and comparative backdrop outlined in the introduction, this chapter will begin by highlighting the reasons why Garlands was built so equivalently late, and will look at where the majority of pauper lunatics were sent prior to its opening. Next, the chapter will explore the Asylum's practices and analyse the stories of some of the first patients admitted. Here the moral methods of treatment used will be outlined, but shall be explored fully in chapter four. The third section will explore the types of insanity experienced at Garlands. Previous historians of madness and its treatment have sought to explain the complex nature of lunacy classification by launching into lengthy descriptions of the evolution of medical

[5] P. Michael and D. Hirst, 'Recording the many faces of death at the Denbigh Asylum, 1848-1938', *History of Psychiatry*, 23:1 (2011), pp. 40-51.
[6] CACC, *Visitor Book 1862-76*, THOS/8/2/1, first entry dated 11 April 1862.
[7] P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003), p. 68.

knowledge. However, this analysis shall not attempt to do this, instead a sample of the range of conditions that were common in the Garlands admissions will be examined to demonstrate the types of insanity experienced by the population from which the patients were drawn.[8] In the final section, the staff will be addressed in terms of their role and responsibilities. The focus will fall onto the medical superintendents as they held ultimate power over the running of asylums, but the role of the attendants and the chaplain in assisting in this regime of care will also be discussed. In the context of this thesis, examining the origins of the Garlands Asylum is important to ascertain that patient transfer was present from the beginning, a theme which will be revisited later in chapter six. The importance of this chapter lies in assessing the context which surrounded Garlands, and the patients who were admitted, which reasserts the value in adding such a northern asylum to the historiography.

Before Opening and Construction

Before the joint counties of Cumberland and Westmorland[9] built their own facility for lunatic paupers, their insane population was either kept in workhouses, at home in the care of family members,[10] or in other asylums, at a charge to the local ratepayers.[11] In the case of the latter, most heavily relied upon was Dunston Lodge, a private asylum built in 1833, situated just outside of Gateshead.[12] In 1841 it housed 84 patients, swelling to 157 in 1851, many of whom were chargeable to Cumberland and Westmorland.[13] Due to several counties and boroughs failing to provide an institution after the 1808 Act, private madhouses increasingly catered for paupers funded by their respective parishes.[14] Government inspectors collected statistics detailing the numbers

[8] Something that is missing in Michael's exploration, for instance, as she focussed on those who suffered with chronic mania, Ibid.
[9] The counties formerly known as Cumberland and Westmorland, since 1974 have been united as the county of Cumbria. In this thesis Cumberland and Westmorland will be use to refer to the two counties as they were known at the time, and before unification.
[10] Frank Hughes stated that 'rural counties were more likely to place lunatics with their families', F. Hughes, 'Was Lunacy and Idiocy a rural or an urban condition? A comparison of two county asylum services 1845-1900', *The Local Historian,* 44:4 (2014), pp. 301-11.
[11] CACC, *Reception Orders 1841-1862*, THOS 8/4/1/2-3.
[12] Due a lack of surviving archival material, Dunston Lodge has not been the subject of any detailed historical research. That gathered in addition to the research of this thesis, therefore takes the understanding of the establishment further than has hitherto been presented.
[13] J. A. Davidson, 'Dunston, Gateshead, Tyne and Wear: Lunatic Asylum', 9 Feb. 2014 http://dutsfc.wordpress.com/2014/02/09/lunatic-asylum/ [accessed 26 Feb. 2014].
[14] For specific information on Gateshead and its private asylums, including Dunston Lodge, W. Parry-Jones, *The Trade in Lunacy: a study of private madhouses in England in the eighteenth and nineteenth centuries* (London: Routledge Kegan and Paul, 1972), pp. 59-61; L. Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the insane in West Midlands workhouses, 1815-

of lunatics in each county and decided which districts required joint provision and where it would be situated. The counties of Cumberland, Westmorland, Northumberland and Durham were grouped together, and because Durham was the most highly populated, the lunatic asylum would be situated there.[15] This relieved the counties of Cumberland and Westmorland from the burden of providing an asylum, and no plans were made to erect their own institution.[16]

Fig. 2.1. Dunston Lodge Asylum, 1842.[17]

The agreement to send the insane of Cumberland and Westmorland to Dunston Lodge originated soon after the private asylum was opened in 1833. Several documents survive detailing the agreements between the Committee of Visitors of Cumberland and Westmorland and the proprietor of Dunston Lodge, John Etridge Wilkinson, and later Cornelius Garbutt. Letters sent between the parties detailed a term of three to five years

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1860', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20.

[15] Cumberland had 117230 in habitants, Westmorland 41617, Northumberland 157101, and Durham 160361, *Report from the Select Committee Appointed to Enquire into the State of the Criminal and Pauper Lunatics in England and Wales*, 1807, Parliamentary Papers II, pp. 84-85, Appendix 8, quoted in C. Philo, *A Geographical History of Institutional Provision of the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter: Edwin Meller Press, 2004), p. 531.

[16] Cambridge University Library, Anon., *Report of the Cumberland Lunatic Asylum at Dunston Lodge, Gateshead-on-Tyne* (Edinburgh: Neill & Co., 1847), p. 27, quoted in C. Philo, 'Thoughts, words and "creative locational acts"', in F. W. Boal and D. N. Livingstone (eds), *The Behavioural Environment: Essays in Reflection, Application, and Re-evaluation* (London: Routledge, 1989), pp. 205-34.

[17] J. E. Wilkinson, *Reply to the Statements contained in a pamphlet and letter by Dr Oliver, Carlisle, on the Expediency of Erecting A Public Asylum for the Insane, Belonging to the Counties of Cumberland and Westmorland* (Newcastle Upon Tyne: T & J Hodgson, 1842), https://archive.org/details/39002086345437.med.yale.edu [accessed 27 May 2018].

in which the pauper lunatics of the two counties would be sent for a fixed weekly sum. For instance, a letter dated 26 June 1846 stipulated that Dunston Lodge would receive Cumberland and Westmorland's pauper lunatics for the next five years at a cost of eight to twelve shillings a week.[18] The patients in Dunston Lodge from the two counties had become such a large proportion of the total that in 1846 the institution was officially adopted as 'the asylum of the County of Cumberland' – which also included Westmorland as the two counties had a unifying agreement.[19] On a visit to Dunston Lodge on 2 July 1846, the Justices of Cumberland found the conditions at the asylum extremely satisfactory, and they regarded this arrangement as 'relieving them from the duty of building a county asylum'.[20]

Renewal of the agreement, during these years, did not occur without some contention. For those at the forefront of the issue, the impetus for Cumberland and Westmorland to provide their own institution was high. In 1842 a series of public letters appeared in the local press, written by Dr Richard Oliver, who later became superintendent of the Salop and Montgomery Asylum, to Edward Williams Hasell, Chairman of the Cumberland Quarter Sessions, that stated: '*The Expediency of Erecting a Public Asylum for the Insane'*.[21] From the outset, Oliver argued that it was a 'serious inconvenience' to be without an institution for the care of insane paupers, and that there were 'probable advantages' to be gained from the construction of their own asylum. He believed that the problem was that the authorities were not aware of the extent of the issue, due to the lack of statistics regarding insanity in the two counties. Oliver attempted to reinforce the plight of pauper lunatics that were sent to private asylums, as he argued that 'the accommodation…is very inadequate', resulting in a higher mortality rate than the fee-paying patients.[22] This pamphlet was met with a public reply from Wilkinson, the Dunston Lodge proprietor. He particularly objected to the 'sweeping observations' made about his licensed house. However, he did state, that as paupers admitted from Cumberland and Westmorland had to travel a great distance to receive

[18] CACC, *Agreement for the reception of pauper lunatics at Dunston Lodge, Co. Durham*, THOS 8/1/8/5, letter dated 26 June 1846.
[19] Anon., *Report of the Cumberland Lunatic Asylum*, p. 3.
[20] An extract from the *Reports of the Honourable the Visiting Justices of the County of Cumberland,* 2 July 1846, Appendix in, Anon., *Report of the Cumberland Lunatic Asylum*, p. 22.
[21] Letters can be found collated in the following pamphlet, R. Oliver, *Suggestions as to the Expediency of Erecting a Public Asylum for the Insane, Belonging to the Counties of Cumberland and Westmorland, in a Letter to Edward William Hasell Esq.* (Carlisle: James Steel, 1842). https://archive.org/details/b22387171 [accessed 27 May 2018].
[22] Oliver stated that 'annual mortality of paupers in the licensed asylums…is 21 per cent - nearly double that of the rich patients', Oliver, *Suggestions as to the Expediency of Erecting a Public Asylum,* p. 3.

care, it was a disadvantage to their recovery.[23] This suggests that, if the best interests of the patients were at the centre of this arrangement, then the two counties would have made plans for an asylum much earlier.

With the passing of the 1845 County Asylums Act, demand for Cumberland and Westmorland to provide their own institution began to increase.[24] Denbigh Asylum was constructed as five North Wales counties agreed to provide a joint institution. Initial proceedings began in 1810, but failure to create an agreement for a unified asylum resulted in the issue being overlooked for the next 30 years.[25] Len Smith has identified that delays in providing an asylum were common, as arguments often arose over finance and the correct site for the construction of an institution.[26] For Cumberland and Westmorland, their arrangement with Dunston Lodge was threatened. Multiple bargains had to be struck extending the time in which they had to build their own asylum, which was intensively documented in the quarterly reports of the county sessions in the local press.[27] Further delays were created by arguments among the magistrates over a suitable site for construction. Several proposed sites around Carlisle were rejected on various grounds such as, poor soils, poor water supply, and poor drainage, but it was agreed that the institution should be set away from 'nuisances' such as public footpaths, and should have access to a good supply of water.[28]

In 1851, plans were finally drawn up for construction of their own asylum.[29] However, by 1854, the Commissioners in Lunacy remarked that the counties still

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[23] Wilkinson, *Reply to the Statements*, p. 9.

[24] It was agreed shortly after the Act that the two counties would unite in providing an asylum, Philo, 'Thoughts, words and "creative locational acts"', p. 225.

[25] Michael, *Care and Treatment*, p. 30.

[26] L. D. Smith, *"Cure, Comfort and Safe Custody": Public Lunatic Asylums in Early Nineteenth Century England* (London: Leicester University Press, 1999), p. 284. Cherry also found that in the planning stages of the Norfolk county Asylum bureaucratic delays were common due to the large costs involved, S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998* (Woodbridge: Boydell Press, 2003), p. 28.

[27] For instance, one article in 1851 stated that the county magistrates had been 'threatened with a compulsory order for erecting a Lunatic Asylum for the County', 'County Business', *Carlisle Patriot,* 10 January 1851.

[28] Philo, *A Geographical History of Institutional Provision of the Insane*, p. 590. The Garlands Estate was considered along with fifteen other proposed sites around Carlisle, but combined 'more requirements than any of the others', 'Lunatic Asylum for the Counties of Cumberland and Westmorland', *Carlisle Journal*, 27 October 1854.

[29] G. Brooks, 'The Building of the Cumberland and Westmorland Joint Lunatic Asylum', *Transactions of the Cumberland and Westmorland Antiquarian and Archaeological Society,* 4 (2004), pp. 229-44. This same year there was an inquiry into the cruelty inflicted upon a patient at Dunston. Proprietor John Wilkinson had his license revoked and was replaced by Cornelius Garbutt, Parry-Jones, *The Trade in Lunacy*, p. 247. There seems to have been little effect of this episode on the impetus for Cumberland and Westmorland to build their own asylum, as in 1854 it was reported by the Committee of Visitors that Dunston was 'in a very satisfactory state', *Westmorland Gazette*, 28 October 1854.

without their own asylum provision were: Northumberland, Durham, Cumberland and Westmorland, Cambridge, Sussex, Glamorgan, Cardigan, Carmarthen, and Pembroke.[30] This same year, the committee responsible for overseeing the construction of the institution offered £200 for anyone who could submit suitable plans for the Asylum. Several architects were considered, and Thomas Worthington, with his £17000 plan for a building, situated on the Garlands estate, three miles outside of Carlisle to accommodate 200 patients, was chosen.[31] At the time, an anonymous author in the *Asylum Journal* documented how Dr Oliver believed that the winning plan was not chosen on its suitability, but for its success in meeting their budget.[32] The final cost of Garlands was £32043 7s 4d.[33] The Commissioners in Lunacy, described its design features in their 1862 Annual Report:

> The style of the building, which is for 200 patients, may perhaps be described as nineteenth century Italian, some of the simpler elements of Italian architecture having been introduced so far as could be done consistently with the nature of the climate of the Northern counties of England…The central building of the southern façade contains the Dining Hall and Chapel, flanked on each side by a water tower. Right and left of the centre are the exercise galleries, presenting externally an arcaded appearance from the numerous arched headed window which continue in series until the infirmaries and day-rooms project and form masses at the eastern and western extremities of the building.[34]

The Asylum welcomed its first patients on 2 January 1862 with great optimism.

Formative Years

[30] Commissioners in Lunacy, *Ninth Annual Report to the Lord Chancellor,* (1855), p. 4. Neighbouring asylums at Sedgefield and Morpeth had opened in 1859, N. McCrae and P. Nolan, *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors* (London: Routledge, 2016), appendix: Mental Hospitals in Great Britain, pp. 304-309.
[31] An engraving of the Asylum by Thomas Worthington can be seen on the front cover.
[32] Anon., 'Proposed County Asylum for Northumberland and Cumberland', *Asylum Journal,* 1 (1854), pp. 61-2.
[33] Brooks, 'The Building of the Cumberland and Westmorland Joint Lunatic Asylum', p. 241.
[34] Commissioners in Lunacy, *Copy of the sixteenth report of the Commissioners in Lunacy to the Lord Chancellor,* (1862), p. 207.

The comparatively late opening of Garlands meant that demand on its services was high. As already noted, the first patients were transferred directly from other institutions, and had to undergo an initial process of circulation.[35] On the day of opening, 18 patients were admitted immediately from Dunston Lodge. Similarly, a large proportion of Denbigh's initial patients were long-standing cases of insanity brought from neighbouring asylums and workhouses.[36] In this section, some of the Garlands first admissions will be examined as a starting point of the later assessment of patient circulation in chapter six. It is necessary to present these to outline the types of cases which can be found in the Garlands records. This reinforces the individual circumstances acting on each patient, and reasserts the value in examining an institution absent from the literature. Understanding the population from which the Garland's patients were drawn, and the conditions they suffered, adds an additional element to the wider historiography, which is dominated by research of the larger institutions south of this area.

One of Garland's first patients was 22 year old Matthew D. Transferred from Dunston on 2 January, he was in weak health which was attributed to melancholia. His case notes stated that he experienced delusions pertaining to his master's daughter, who he believed was in love with him and would elope.[37] Delusions, the majority of which were harmless, were a common feature among mentally unsound patients, and were a diagnostic tool employed by medical officers.[38] He was the first patient to be discharged on 19 March 1862, but had not 'not quite recovered in his mind'. A full recovery outside the Asylum was rare and Matthew returned to Garlands in December 1862 once again suffering delusions which were recorded as 'worse than when first brought here'. He was of the belief that the clergyman of his local parish should publish a certificate of marriage for him and a female named Margaret who was unwilling to marry him. His mental state had also worsened as he had threatened to kill his father and an individual named Francis. It can be assumed that his removal from the family home was to ensure the safety of those around him due to his violent threats.[39]

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[35] This initial movement of patients will be analysed later in chapter six.
[36] Michael, *Care and Treatment*, p. 68.
[37] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 24.
[38] V. Skultans, *Madness and Morals: Ideas on Insanity in the Nineteenth Century* (London: Routledge & Kegan Paul, 1975), pp. 82-3.
[39] Oonagh Walsh suggests that for a number of readmissions the asylum became a refuge from their 'stressful, violent or otherwise uncomfortable lives', O. Walsh, 'Lunatic and Criminal Alliances in the nineteenth-century Ireland', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The*

Matthew's second stay in Garlands was this time much longer, and he was discharged, assumed to be recovered on 21 November 1863.[40]

In the Norfolk Asylum, during the 1860s, over a fifth of admissions were readmissions.[41] Dr Thomas Clouston, Garland's medical superintendent (1863-1872) stated that: 'It is often quite impossible to tell if a patient is quite recovered until he is put among his usual surroundings, subjected to his ordinary temptations, and has to do his usual work.'[42] In addition, Clouston believed that melancholy patients, such as Matthew, presented a difficulty to attendants in being able to ascertain when their soundness of mind had returned. To visiting families, they seemed themselves, provoking relatives to insist on their removal. It was only once they returned to the wards that their anxieties and depressive tendencies resurfaced, warranting further treatment. As can be seen here, these cases were often misdiagnosed as recovered and discharged, only to be readmitted a number of days or weeks later.[43] This case demonstrates that pauper lunatic care in this period was not static. Matthew had been moved from Dunston Lodge, to Garlands, discharged to the family home, and readmitted in the space of a year.

A small number of Garland's first patients also came directly from the workhouse, where the chronic insane were housed.[44] This demonstrates the 'tapestry' of responses in already in place to treat insanity.[45] The 1860 Commissioners in Lunacy report detailed the adverse conditions experienced by patients in Kendal Workhouse:

> The larger of the day-rooms is gloomy and cheerless, dirty, wretchedly furnished, and destitute of every comfort…The only furniture it contains, is a small table and bench fixed to the stone floor. The window is protected by iron bars, and the door lined with sheet iron…A strong iron ring is fixed in the wall to which violent Patients may be secured by iron handcuffs. The bed-rooms in this part are flagged, and in winter must necessarily be cold

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History of Care in the Community, 1750-2000 (London: The Athlone Press, 1999), pp. 132-52, particularly p. 146.

[40] CACC, *Casebook 1862-1865,* THOS 8/4/38/1, admission no. 244. This case, along with all others presented in this chapter, has been researched in addition to the core sample.

[41] Cherry, *Mental Health Care,* p. 90.

[42] CACC, *Tenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1871*, THOS 8/1/3/1/9, p. 15.

[43] CACC, *Second Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1863*, THOS 8/1/3/1/1, p. 11.

[44] Only 2% of patients admitted in January 1862 came from workhouses, see table 6.1.

[45] Smith, 'A Sad Spectacle'.

> and damp…The sheets throughout were worn and ragged. Two men are, in several instances, placed to sleep in the same bed, and one man of dirty habits sleeps in a trough bedstead filled with loose straw. The two men noticed as being locked up in the strong room, are placed to sleep in a room by themselves, and they are stated not unfrequently to attack each other during the night. The personal condition of the Male Patients was very unsatisfactory. Their clothes were dirty and much worn; one man was sitting without shoes or stockings, and they were generally dirty and untidy in their persons…two men are placed in the bath at the same time…about 10 Patients use the same bath…There is no paid nurse in any part of the Workhouse, and the porter, assisted by Pauper Inmates (one of the most active being himself of unsound mind) has the care of the Insane Patients.[46]

This was a great departure from the moral treatment advocated in asylums, and the implications of this on the patient's health, will be explored in chapter four.

One example of Garland's initial patients who was admitted from the workhouse was Mary F on 27 January 1862. She had been in Cockermouth Workhouse where it was she was stated to have been suffering with mania for fourteen years, and when she came to Garlands was in a weak state of health.[47] She was a sailor's wife, and on inspection of the census material it seems that her husband Edward worked almost permanently on board the R. H. Knight.[48] She also spent time at Dunston Lodge. Admissions from the workhouse to the asylum were often triggered by the unruly behaviour of inmates upsetting the rigid structure of the house.[49] Whilst in Garlands, Mary had a disruptive influence on the other inmates. She threw food around, was extremely noisy, was 'an idle untidy woman', and the other patients even made fun of her. Mary remained mentally unchanged for the next 30 years, throughout which she remained in the Asylum, and died on 2 May 1892.[50] What is interesting about Mary's case is that she and Edward had a child, John, in 1847, four years after their marriage,

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[46] Commissioners in Lunacy, *Fourteenth Annual Report to the Lord Chancellor,* (1860), p. 120.
[47] CACC, *Reception Orders 1862*, THOS 8/4/1/4.
[48] Ancestry.com, *UK and Ireland, Masters and Mates Certificates, 1850-1927* [database on-line]. Provo, UT, USA: Ancestry.com Operations, Inc., 2012, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=2271&h=444037&ssrc=pt&tid=84254089&pid=48495788474&usePUB=true [accessed 20 January 2017].
[49] P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London: Leicester University Press, 1999), p. 154.
[50] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 147.

and in the 1851 census he is listed as residing with his maternal grandfather in Workington.[51] By the time of the 1861 census Mary was confined in Cockermouth Workhouse, missing her child's formative years. There was reconciliation between John and his father as he followed in his footsteps to become a sailor at 16, and progressed to work with Edward on board the R H Knight.[52] Despite Mary's illness life carried on for those outside the asylum walls.[53]

By the end of the first year, Garlands had almost reached its 200 patient capacity with only four spare beds.[54] As the high admission rates for 1862 would produce heavily skewed and untypical results, the admission and discharge rates for the following year, 1863, will be analysed. In this second year a total of 68 patients were admitted, 28 were discharged, and eleven died. Of those discharged, 17 had fully recovered, equating to a quarter of those admitted during this same year. Recovery was reached within 18 months for all the patients, with two-thirds being said to have been cured within just four months.[55] However, three of these were readmitted shortly after discharge displaying similar mental derangement as when they were first brought in. In light of this, Clouston stated the importance of keeping a patient in the Asylum for a period of time after they have apparently returned to their normal selves. He believed that the lack of useful employment and returning to previous associations caused patients to relapse.[56] In comparison to similar institutions, these rates of recovery were normal, as the average was between 20-30%. The Norfolk Asylum's cure rates for 1835-45 stood at a mere 13.1%, placing it in the lowest third of county asylums.[57] The ideal of the 1845 Act that 'the recovery or improvement of the inmates is to be the primary consideration', became increasingly remote as the number of 'incurable' cases

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[51] FreeBMD. *England & Wales, Civil Registration Marriage Index, 1837-1915* [database on-line]. https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8913&h=9452447&ssrc=pt&tid=84254089&pid=48495788474&usePUB=true [accessed 20 January 2017]; Ancestry.com, *1851 England Census* [database on-line]. Class: *HO107*; Piece: *2435*; Folio: *255*; Page: *25*; GSU roll: *87115-87116*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8860&h=15205468&ssrc=pt&tid=84254089&pid=48495791328&usePUB=true [accessed 20 January 2017].

[52] Ancestry, *UK and Ireland, Masters and Mates Certificates, 1850-1927.*

[53] D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001), p. 60.

[54] *Annual Report 1863*, p. 7.

[55] Recovery throughout the thesis will be understood in the context of the documents studied. As there is no way of proving if the patients were definitively cured, the contemporary assumptions of recovery will be adopted.

[56] Ibid., p. 10.

[57] J. Conolly, *The Construction and Government of Lunatic Asylums* (London: Dawsons of Pall Mall, 1968), Table III, p. 151 and notes, quoted in Cherry, *Mental Health Care*, p. 46.

swelled to fill the asylums.[58] David Wright echoed this, suggesting that the 'long-stay patients, combined with a constant rate of admissions, simultaneously made the resident population appear increasingly custodial'.[59] Andrew Scull went further, and suggested that low cure rates experienced by county asylums 'rendered implausible the claim that psychiatrists possessed even non-pharmaceutical remedies with any real efficacy'.[60] The full implications of growing admissions will be considered in the next chapter.

The majority of Garland's patients were drawn from the agricultural and rural labouring classes. With very few towns, and only one principle city, Cumberland and Westmorland was mostly farmland. The industries which thrived most in the towns were textiles, metals, and domestic service.[61] The number of people employed in agriculture in England dropped from 312,000 in 1861 to 280000 in 1911.[62] The decline caused many to fall into poverty, which was considered to be one of the primary factors of insanity.[63] Some have argued that in rural areas the asylum was used by the Poor Law as a response to increased insanity during periods of agricultural decline.[64] Often reinforced by Dr John Campbell, medical superintendent 1873-1898, in the annual reports, was that casual labourers, not of the agricultural class, when in employment and experiencing times of increased income, often succumbed to the temptation of alcohol which led to incarceration in the Asylum.[65] This is precisely the inverse of the trend in admissions of agricultural employees, thus reinforcing the point that no two asylums, no matter how geographically close, experienced the exact same patterns of admissions. For instance, Denbigh Asylum, although situated in a substantial market town and on a major travel route from London to Ireland, was surrounded by very little

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[58] A. Scull, *Museums of Madness: The Social Organization of Insanity in nineteenth-century England* (London: Allen Lane, 1979), p. 211.
[59] Wright, *Mental Disability in Victorian England,* p. 91.
[60] A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Yale University Press, 1993), p. 246.
[61] S. Towill, *Georgian and Victorian Carlisle: Life Society and Industry* (Preston: Carnegie Publishing Ltd, 1996), p. 177.
[62] C. S. Orwin and E. H. Whetham, *History of British Agriculture 1846-1914* (Cambridge: Longmans, 1964), in C. Ó Gráda, 'British Agriculture, 1860-1914', in R. Floud and D. McCloskey (eds), *The Economic History of Britain Since 1700, Volume 2: 1860-1939* (Cambridge: Cambridge University Press, 1994), pp. 145-72.
[63] P. Bartlett, 'The Asylum, The Workhouse, and the voice of the insane poor in nineteenth century England' *International Journal of Law and Psychiatry,* 21:4 (1998), pp. 421-32.
[64] C. Smith, 'Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics', *Family and Community History,* 9:2 (2006), pp. 109-24.
[65] In 1877, Campbell noted that: 'A sudden great rise of wages…gives means for expenditure in excesses which increase insanity', CACC, *Sixteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1877,* THOS 8/1/3/1/15, p. 13. See also C. Cox and H. Marland, '"A Burden on the County": Madness, Institutions of Confinement and the Irish Patient in Victorian Lancashire', *Social History of Medicine,* 28:2 (2015), pp. 263-87.

industry in a rural locality, which was not serviced by the railway until 1862, making it more remote than Garlands.[66] This makes it worthy of study as it had an agricultural class of patients drawn from the rural localities, but also had casual labourers drawn from the coastal ship-building towns – principally Whitehaven, Workington and Maryport - and from Carlisle itself.[67]

The treatment undertaken at Garlands encompassed aspects that underpinned a moral regime of care, as adopted in other asylums of the time, as outlined in the opening chapter.[68] The following statement in the 1863 annual report underlines these founding principles:

> To treat the patients kindly, to maintain good order and discipline in the house, to provide healthy and suitable employments for all who can employ themselves, to endeavour to get those to work who do not do so, to provide suitable entertainments for their leisure hours, to endeavour to get them all roused into taking an interest in something, thus exercising and strengthening the mental faculties they have left, and to keep up the bodily health and strength in all of them.[69]

Around three quarters of the Asylum population were regularly employed, and the importance of this was continually reinforced in aiding the recovery of patients as routine and order was essential those with disordered minds. Tasks in the workshops, on the farm, and in the house itself were largely carried out by the patients. 'Suitable employments' ranged from a rich supply of books and newspapers, knitting and sewing materials, to invited visitors appearing to read funny stories or to perform a dance act. A nourishing diet was advocated for its benefits to a patient's health. Also encouraged was religion, and participation in ceremonies was another condition on which asylums

[66] Michael, *Care and Treatment*, p. 39.
[67] When referring to the pauper class of patients drawn from Cumberland and Westmorland, these were not all destitute and classified as typical paupers who would be found in workhouse wards for instance. For asylum provision, to be classed as a 'pauper' lunatic, it meant that the patient, or their family could not afford to cover the cost of their maintenance. If they could, they would be transferred to the private class. Therefore, patients had a wide range of occupations, for example in 1863 there were 34 labourers, 21 domestic servants, 7 shoemakers, 30 housekeepers, and only 17 listed as paupers. For the full list of occupations of patients resident in 1863 see *Annual Report 1863*, table XXII, p. 25. See also A. Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014), p. 8.
[68] Among this regime were psychological or 'moral' treatments, but also medicines were used. Non-restraint of patients was a key principle of the moral regime. See discussions in chapters one and four.
[69] *Annual Report 1863*, p. 12.

were assessed by the Commissioners in Lunacy.[70] The full extent and impact of moral treatment will be analysed in chapter four.

Due to available accommodation, made possible by extensions to the building, in 1868 Garlands began to accept private and out-county patients. These were charged fourteen shillings per week compared to the nine charged for those from Cumberland and Westmorland.[71] This occurred because there was nowhere in the two counties for the reception of private patients:

> There is no suitable provision in this district for the care and treatment of insane persons in the class of small farmers, or tradesmen, or better-class mechanics, who would be able and willing to pay ten or twelve shillings a week so that their mentally afflicted relatives might not be classed as paupers.[72]

The reason for accepting private patients was twofold: First, the lack of a private asylum in either of the two counties, resulted in a long journey which may have been further detrimental to the patient, and very difficult for visiting relatives.[73] Second, the income generated by private patients was used to finance the upkeep and extensions to the Asylum. In addition, the increased charges were used to subsidise the rates charged for pauper patients.[74] Once capacity was becoming an issue it was the private patients who were the first to be forfeited and transferred elsewhere due to the Asylum's primary insistence that it was an institution for paupers.[75] However, this did later change, as the monetary value of the fee-paying patients was given higher importance as the turn of the century approached.[76]

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[70] J. Hamlett, *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* (Hampshire: Palgrave MacMillan, 2015), p. 23.
[71] CACC, *Seventh Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1868,* THOS 8/1/3/1/6, p. 5. The phrase 'mixed economy of care' has been used by Len Smith to refer to the dual function of county pauper lunatic asylums, L. Smith, 'The County Asylum in the Mixed Economy of Care, 1808–1845,' in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 33-47.
[72] CACC, *Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1867,* THOS 8/1/3/1/5, p. 18.
[73] Ibid., p. 15.
[74] Smith, 'The Asylum in the Mixed Economy of Care', p. 37. Cherry also found this occurred in the Norfolk Asylum to lower the cost of pauper patients below the actual amount to maintain them, Cherry, *Mental Health Care in Modern England*, p. 42.
[75] Bartlett, *Poor Law of Lunacy*, p. 205.
[76] Further explanation given in chapter three.

The first private patient admitted into Garlands was Mary I, on 19 November 1868. Aged 20, Mary's condition had been attributed to mania, which she experienced for the previous six years. Her condition worsened due to the sudden death of her sister, and her family took the steps necessary to admit her to Garlands, paying for her maintenance.[77] Her father, William, was a man of some means as he was a clog-maker employing four men.[78] Mary's behaviour deteriorated to the point whereby her family could no longer cope. On admission her father stated, 'she has lost all interest in herself and family'. This must have worried them greatly as they had lost one daughter, and to see the deterioration of another so soon after was an upsetting prospect. Also in Mary's case notes, it is stated that two of her uncles had died of consumption, resulting in her suspicions of disease and that she would often unexpectedly launch down on the ground and pray. However, her father removed her from the institution just four weeks after admission, on 24 December, and she was stated to have been unimproved. Given the date, it is understandable that William would want his daughter home for Christmas, but it seems he was willing to do so at the great risk to Mary's mental wellbeing.[79] She was not readmitted to Garlands, and in the 1871 census was still living with her parents, listed as being employed in domestic work, and labelled as a lunatic, suggesting that she had not regained her sanity.[80] Cathy Smith's research into familial ties and insanity gives the sense that Mary's case was common. She stated that, as many patients came from home to the asylum, the family was at the core of the committal process.[81] This will be investigated fully in chapter five. The classifications of lunacy given to the patients of Garlands, will be explored to provide an indication of the circumstances which could lead to asylum committal.

Classifications of Insanity

[77] CACC, *Reception Orders 1868*, THOS 8/4/1/10.
[78] Ancestry.com, *1861 England Census* [database on-line]. Class: *RG 9*; Piece: *3899*; Folio: *7*; Page: *7*; GSU roll: *543204*, *https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8767&h=13124778&ssrc=pt&tid=84251982&pid=34497987205&usePUB=true* [accessed 30 November 2016].
[79] CACC, *Casebook 1865-1870*, THOS 8/4/38/2, admission no. 676.
[80] Ancestry.com, *1871 England Census* [database on-line], Class: *RG10*; Piece: *5200*; Folio: *5*; Page: *3*; GSU roll: *849458*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7619&h=3416693&ssrc=pt&tid=84251982&pid=34497987205&usePUB=true [accessed 30 November 2016].
[81] Smith, 'Family, Community and the Victorian Asylum', p. 110.

By the nineteenth-century the focus was predominantly on the physical manifestations of mental conditions,[82] and people were classified using the broad labels 'lunacy' and 'idiocy'.[83] This section, and the rest of the thesis, does not aim to explain the complex nature of the understanding of mental illness from a scientific perspective. Instead, this examination shall attempt to simplify the complexity surrounding the diagnosis and differentiation of mental conditions from the perspective of asylum doctors. It is important to note that the conditions diagnosed by doctors in the patient records are not understood to be definitive, as they were limited in their knowledge of mental illness, and therefore the contemporary classifications will be used to reflect what was observed at the time. Patient examples shall be used throughout this section, from Garlands first year of admissions, in order to demonstrate the two main categories of diagnosis, and the implications this that on those that experienced it first-hand.

The new field of mental, or psychological, medicine emerged in the nineteenth-century and was developed in the county asylums, and the term psychiatry became more widely adopted into the twentieth-century.[84] In the period in which Garlands was founded, the profession was still evolving, and so too was the understanding of the conditions suffered by patients. On examination of the case notes, it is clear that, in the beginning, the majority of causes of mental illness were a mystery. In 1862, 59% of patients admitted to Garlands were stated as having an 'unknown' cause of insanity.[85] Whereas, Steven Cherry found that only around one-third of the 1870-1 admissions to Norfolk were attributable to unknown causes.[86] Clouston, in the 1863 annual report, believed that a certain circumstance was frequently referred to as the apparent cause, when in fact it simply triggered an existing mental derangement which had gone unrecognised.[87] The confusion over the onset of an individual's condition is evident in the high level of disparity between the causes of insanity given on the reception orders

[82] In their 1847 annual report the Commissioners in Lunacy defiantly claimed that 'insanity never exists without a physical cause', Commissioners in Lunacy, *Second Annual Report to the Lord Chancellor,* (1847), p. 229, quoted in Scull, *Most Solitary of Afflictions,* p. 241.
[83] See introduction. Along with 'insanity', these were the contemporary classifications of mental disorders. L. Smith, 'Lunatic Asylum in the Workhouse: St Peter's Hospital, Bristol, 1698-1861', *Medical History,* 61:2 (2017), pp. 225-45.
[84] Debates surround this as to whether county asylums were built specifically for the development of psychiatry, A. Scull, 'A Culture of Complaint: Psychiatry and its Critics', in J. Reinarz and R. Wynter (eds), *Complaints, Controversies and Grievances in Medicine: Historical and Social Science Perspectives* (London: Routledge, 2015), pp. 37-55.
[85] 145 patients were assigned an unknown cause out of 245 admissions in 1862, CACC, *Casebook 1862-1865*, THOS 8/4/38/1. This was similar to Shepherd's findings for Brookwood Asylum, that two-thirds were noted as having 'unknown' conditions, Shepherd, *Institutionalizing the Insane,* p. 124.
[86] Cherry, *Mental Health Care,* p. 90.
[87] *Annual Report 1863*, p. 8.

and in the casebooks. It is for this reason that for all patients analysed throughout the thesis, an attributed or assumed cause will be stated, as it would have been in the case notes. For example, Elizabeth B, admitted 24 December 1862, was recorded as suffering from 'brain disease', which she had experienced since birth. However, on her record in the casebook the cause was given as 'congenital malformation'.[88] This indicates the complex terms attributed to conditions, and the disparity in understanding of mental illness. As a result, diagnosis relied heavily on physical symptoms, appearance and demeanour.[89] Casebooks detailed the patient's general bodily health by recording their temperature, pulse, state of their appearance, bowel movements, bodily injuries, and, for women, the regularity of menstruation, as these were all believed to affect mental faculties.[90] To treat the physical manifestations a number of methods were employed, such as purgatives to remove impurities in the body, morphia injections, the Turkish bath, and several other chloride and bromide medicines.[91]

There were two given diagnoses of a person's mental illness; the form and the cause of insanity, which provide distinct groups of classification. The form of insanity was largely confined to the umbrella terms of mania and melancholia.[92] Mania 'entailed "an irrationality on all subjects"', and melancholia was '"an attachment of the mind to one object, concerning which the reason is defective"'.[93] From the statistical tables given in the annual reports the variety of the forms of mental disease were given as: acute mania; mania; epileptic mania; puerperal mania; melancholia; dementia; epileptic dementia; general paralysis; idiocy, and congenital imbecility.[94] The cause of insanity encompassed a greater number of terms, and were further broken down into having physical or moral origins. Those attributed to physical disturbances were much more numerous among the agricultural class of patient treated at Garlands. Most common were, excess drinking, epileptic fits, childbirth, and other traumatic experiences, which

[88] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 249.
[89] Cherry summarized how patients were considered on arrival: 'Judgements, rather than the semblance of prognosis, were generally based upon social criteria, the patient's ability to conform with accepted rules and standards of human behaviour,' Cherry, *Mental Health Care*, p. 43.
[90] R. Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981), p. 60.
[91] D. H. Tuke, *Chapters in the History of the Insane in the British Isles* (London: Kegan Paul, Trench & Co., 1882), p. 485, quoted in Scull, *Most Solitary of Afflictions*, p. 243. See also J. Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients and Practices* (London: Palgrave Macmillan, 2017).
[92] Conditions also found in this section of case notes, among others, are imbecility, idiocy, epilepsy, and dementia.
[93] W. Falconer, *A Dissertation on the Influence of the Passions Upon the Disorders of the Body* (London: Dill, 1788), pp. 77, 82, quoted in Scull, *Most Solitary of Afflictions*, p. 72.
[94] *Annual Report 1872*, p. 36.

will be explored in turn. To offer a comparison of how typical Garlands was in its proportion of sufferers of each condition, Clouston provided statistics in the 1872 annual report of thirteen other asylums and their admissions of different varieties of insanity. He grouped these institutions by their demographic. 'Rural' referred to the Wiltshire, Worcester, Somerset and Salop Asylums. 'Town' was used to categorise the Newcastle, Liverpool, Birmingham, Bristol and Surrey Asylums. 'Mixed' referred to those with both rural and urban admissions, specifically the Durham, Glamorgan, Stafford and Sussex Asylums. These percentages have been indicated in the footnotes, where applicable, throughout this section.[95]

First, cases of alcoholism at Garlands stood markedly 'above average as a cause, being 15 per cent [on admissions] instead of about 12', and the sobriety or insobriety of patients on admission was frequently commented on in the case notes.[96] Drinking within the working-classes was a ritualistic culture; only in times of excess did it cause bouts of insanity.[97] Common practice in most other asylums, the inclusion of beer and spirits in the patient's diet was ruled out at Garlands from the outset, and was only administered for medicinal purposes.[98] An article in the local newspaper told readers how at Garlands milk was to be substituted for beer at meal times.[99] This was not surprising due to the prominence of the temperance movement in Cumberland and Westmorland.[100] A local handbook stated that; 'through drink, every glass of spirit taken having done its small share in altering the brain substance, and producing insanity'.[101] One example from 1862 of insanity thought to be caused by intemperance

[95] Within this comparison, Clouston considered Garlands to be in an 'intermediate position between the highest and lowest of those in regard to the total numbers of insane to the population, having fewer than the rural counties and more than the urban and manufacturing', Ibid., p. 16.
[96] CACC, *Ninth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1870*, THOS 8/1/3/1/8, p. 12.
[97] Smith, *Trial by Medicine*, p. 50.
[98] Written into the rules and regulations of the Asylum was that 'no beer, wine, spirits or any intoxicating liquor…will be allowed', CACC, *Rules and regulations for the management of the Cumberland and Westmorland Asylum, Garlands, 1861*, THOS 8/1/1/1, quoted in Dobbing, 'An Undiscovered Victorian Institution of Care', p. 9.
[99] *Carlisle Patriot*, 4 Jan. 1862, quoted in Dobbing, 'An Undiscovered Victorian Institution of Care', p. 7.
[100] One leading member of the temperance movement was Lady Rosalind Howard, along with her husband George Howard, who later became the Countess of Carlisle. As prominent landowners in the area, their influence was widespread, especially in North Cumberland. On their estates, by 1883, they had closed all the public houses, and instead established fifteen reading rooms to promote temperate habits and education. D. Moorat, *Life in Brampton with 63 Public Houses* (Studley: Brewin Books Ltd, 2007), p. 217.
[101] R. M. Lidbetter (ed.), *A Temperance Handbook for Boys and Girls: Text-book for the annual competitive examinations of the Cumberland Band of Hope Union* (Carlisle: W. Etchells & Son, 1912), p. 26.

was Elizabeth W, aged 25. She was admitted in October in a state of intoxication, triggered by her disappointment in marriage. She held her friend, Mary, up by the throat as she refused to give her anymore alcohol, and continued to shout for about half an hour. From Elizabeth's case notes it is apparent that her Asylum stay was to instate sobriety. On admission she was vomiting, experiencing cold sweats, and had a weak pulse. For several weeks after her stomach remained weak, but her delusions subsided, and once she had 'dried out' she was discharged stated to be recovered to the charge of her aunt in December 1862.[102]

Secondly, epilepsy[103] was cited among the Garlands case notes as a physical cause.[104] This disease was 'seldom curable' and Clouston believed that 'the patients are on the whole the most dangerous and troublesome class of our inmates'.[105] Epileptic insanity was believed to be passed on by close relatives, and hereditary factors were considered in diagnosing the condition.[106] Due to its incurable nature, the adopted treatment was the avoidance of factors which triggered violent and unruly behaviour, a nourishing diet, supressing outbursts through seclusion, and the use of sedatives.[107] Admitted 26 November 1862, an example of insanity attributed to epilepsy was Jospeh K, aged 26. He had been suffering from fits since the age of nine. These only appeared after he was struck with typhus fever, and had continued throughout his life. Joseph remained in the Asylum until his death in June 1866 from tuberculosis.[108] In 1869 Clouston noted an effective 'cure' he had trialled on the patients that year: 'By means of the bromide of potassium…the number of fits taken by them have been immensely reduced, and their mental condition much improved'.[109] However, Potassium Bromide was only a sedative, rather than a medicinal cure-all for the condition, and was widely

[102] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 225.
[103] Treated widely in lunatic asylums in this period. Towards the end of the nineteenth-century, epileptic colonies were constructed to specifically treat this class of patient. For instance, Starnthwaite Epileptic Colony opened in Kendal, Westmorland, in 1903, 'A New Home for Epileptics', *Lakes Chronicle and Reporter*, 08 April 1903, p. 5.
[104] Epileptic Insanity given as a cause for 5.6% of cases, 1862-72, whereas in the rural Asylums it was 11.3%, in the towns it was 8.2%, and in the mixed Asylums it was also 5.6%, *Annual Report 1872*, p. 17.
[105] CACC, *Seventeenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1878*, THOS 8/1/3/1/16, p. 18.
[106] Smith, *Trial by Medicine*, p. 55. The hereditary nature of insanity will be explored in chapter five.
[107] T. S. Clouston, *Clinical Lectures on Mental Diseases* (London: J & A Churchill, 1904), p. 437. Both the Norfolk and Denbigh Asylums utilised seclusion to calm epileptic sufferers after a maniacal outburst, Cherry, *Mental Health Care*, p. 97; Michael, *Care and Treatment*, p. 69.
[108] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 237.
[109] CACC, *Eighth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1869*, THOS 8/1/3/1/7, p. 16.

used in asylums as a way of calming patients (more on its uses and implications in chapter four).[110]

Thirdly, insanity brought on by child birth (puerperal mania)[111] was a common physical cause of mental illness for women in this period.[112] Childbirth was steeped in danger and puerperal insanity became one of its many complications. Puerperal insanity, along with its sister condition insanity of lactation, was regarded as a temporary condition which was relatively easy to cure, as patients tended to be discharged within six months to a year.[113] One example was Elizabeth W,[114] admitted to Garlands on 28 April 1862. Aged 17, her case notes state how she was seduced out of wedlock by someone she knew from the Inn at Ambleside in which she worked, and immediately after her child was born she began to show the symptoms of becoming insane. In the first instance she was sent to Kendal Workhouse. Having resided there for five weeks showing no improvement, she was transferred to Garlands. After eight months treatment, she was discharged as recovered. What is interesting from Elizabeth's case notes, is that her recovery was measured in part on her appearance. On admission she was said to have been unwell and her stated appearance reflected this: 'Untidy in her dress...lets hair dangle all her face.' This contrasted greatly to the report of her condition two weeks before being discharged: 'Getting well fast. Has picked up her good looks'.[115] Psychiatrists, and wider Victorian society, had certain views as to how women should look, and how they should take pride in their appearance. Elaine Showalter notes how: 'Inmates who wished to impress the staff with their improvement could do so by conforming to the notion of appropriate feminine grooming', which seems to be proven by Elizabeth's case.[116] Confirming that medical understanding of mental illness was based on the visible symptoms that manifested.

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[110] McCrae and Nolan, *The Story of Nursing*, p. 30.
[111] The illness could display itself in either a melancholic or maniacal form. Hilary Marland noted that 'although mania was more flamboyant and disturbing, the melancholic form was the most difficult to cure.' H. Marland, 'At Home with Puerperal Mania: the Domestic Treatment of the insanity of childbirth in the nineteenth Century', in Bartlett and Wright (eds), *Outside the Walls of the Asylum*, pp. 45-65.
[112] Accounted for 8.2% of the total admissions, 1862-72, whereas in the rural Asylums it was 3.6%, in the towns it was 2.6%, and in the mixed Asylums it was 3.9%, *Annual Report 1872*, p. 18.
[113] Marland, 'At Home with Puerperal Mania', pp. 46-8.
[114] This Elizabeth W is different to the patient on the previous page.
[115] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 177.
[116] E. Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago Press, 1987), p. 84.

Finally, traumatic physical events which were believed to cause insanity were primarily those involving the head.[117] Injuries close to the brain were thought to trigger a breakdown of a person's mental health. In the casebooks, events such as 'injury to head from fall on a rock', were cited as the cause of insanity. In this instance, the patient, Christopher S, had suffered a head injury, which bled profusely at the time, but no one considered it a serious threat to his health. Two years passed before he was admitted to the Asylum, which was triggered by the violence towards his wife, to such an extent that she was afraid of him. Although the cause of Christopher's insanity was attributed to the injury, his form of insanity was given as dementia.[118] On examination of his case notes, he experienced memory loss and confusion as to where he was: 'Completely lost. Says he is now at Kendal. Does not know the month or day...Says he is 32 years old...thinks wife is here and that he saw her in the dining hall, and that she told him she would take him home on Tuesday.' Despite his condition, Christopher was discharged on 5 December 1862 as recovered, only nine weeks after admission.[119] However, over the next 18 months his condition evidently deteriorated outside the Asylum as he died, aged 44, in April 1864.[120] Conditions considered to be caused by purely mental triggers, although for a substantially lower proportion of the patients, form the next exploration of this section.

The absence of physical symptoms was deemed to be caused by 'emotional' or 'moral' traumas,[121] and were attributed to around one quarter of patients admitted to Garlands in the first decade.[122] Clouston believed this was due to a different class of patient coming to the institution: 'the people of these two counties are very exempt from the anxieties and worries…that so elsewhere commonly cause insanity'.[123] Although small in number, in terms of their occurrence in Garland's admissions, moral

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[117] Smith, *Cure, Comfort and Safe Custody*, p. 107.
[118] It is important to note that the contemporary use of dementia was applied to people of all ages, and should not be taken to have the same meaning as is understood today.
[119] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 221.
[120] FreeBMD. *England & Wales, Civil Registration Death Index, 1837-1915* [database on-line], https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8914&h=30023879&tid=&pid=&usePUB=true&_phsrc=SNv26&_phstart=successSource [accessed 10 July 2015].
[121] M. Levine-Clark, 'Dysfunctional Domesticity: Female insanity and Family relationships among the West Riding Poor in the mid-nineteenth century', *Journal of Family History*, 25:3 (2000), pp. 341-61.
[122] Clouston stated that the rural Asylums also experienced moral causes in a quarter of cases, the towns felt it in a third of cases, and the mixed Asylums experienced it in a fifth of admissions, *Annual Report 1872*, p. 19.
[123] CACC, *Fifth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1866*, THOS 8/1/3/1/4, p. 11.

causes[124] included poverty, bereavement, religious mania, and disappointment of affections, and will be considered in turn.[125] Firstly, poverty could be attributed to a patient's mental disorder, particularly as Garlands was an institution that catered specifically for paupers. Many were admitted in a poor state of physical health due to living in destitute circumstances, and suffered mental anguish at their living conditions. Failure in employment could be a factor which drove people insane, and ultimately to Garlands.[126] In one particular case, Richard A was brought to the Asylum on 4 October 1862, and was said to have been driven insane by his 'anxiety of mind for want of work'. He lacked a hereditary predisposition to the illness,[127] therefore the cause of Richard's mental instability was attributed to his lack of work and food. Within six weeks Richard was discharged as recovered, restored to full health simply by eating, sleeping well, and being usefully employed in the Asylum workshop.[128] As discussed in the previous section, periods of economic decline, specifically in agriculture, effected, not just a person's income, but also their mental health. Farmers and casual agricultural labourers were at times merely surviving, and, in some cases, the threat of losing work was enough to trigger insanity. Secondly, linked to economic downturn, another moral cause of insanity was bereavement. One example was William T, admitted 15 April 1862, presumed to be due to the death of his wife, which had led to him harbouring suicidal tendencies.[129] Widowed two years previously, he was left as a single father to two young children, and had moved in with his parents.[130] Unable to cope with his bereavement, he began having delusions that people were against him and on several occasions had tried to take his own life. William remained in Garlands for a year, and on 6 April 1863 he was discharged back home as recovered.[131]

Thirdly, religious mania, or fanaticism, could also be given as a moral cause on a patient's notes. For instance, Sarah S, aged 33, was admitted 30 April 1862 diagnosed with religious mania, which she had experienced for nine weeks. She suffered from

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[124] Moral causes refers to factors which today would be considered social or psychological conditions.
[125] Cherry, *Mental Health Care,* p. 91.
[126] Levine-Clark, 'Dysfunctional Domesticity', p. 347.
[127] Hereditary predisposition to insanity will be explored fully in chapter five.
[128] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 226.
[129] Supposed cause on Reception Order given as 'Death of Wife', CACC, *Reception Orders 1862*, THOS 8/4/1/4.
[130] Ancestry.com, *1861 England Census* [database on-line]. Class: *RG 9*; Piece: *3922*; Folio: *50*; Page: *3*; GSU roll: *543207*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8767&h=13204253&tid=&pid=&usePUB=true&_phsrc=SNv27&_phstart=successSource [accessed 01 August 2015].
[131] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 170.

several delusions which led the doctors to state that she was affected by religion. In the casebook it stated: 'Says she is to live forever in hell and to eat the serpents meat'; 'saying she was "damned to all eternity"', and 'says the Devil…possesses her body'. Her Mother later informed the doctors that her insanity was caused by religion and 'reading books too much', but that ultimately Sarah was driven to this by her fiancé leaving to go to Australia. She was engaged to a man named Henry, but Sarah's mother seemed insistent that he did not reject her, that it was a mutually agreed parting. Although stated as suffering from religious mania, the form was on admission described as; 'A painful case of acute melancholia…says she is lost forever'.[132] Jonathan Andrews stated how melancholia displayed through religious fanaticism was often a sign of fear, be it the fear of poverty, death or loss.[133] In Sarah's case the fear could have been that of being alone after Henry had left as she displayed signs of pushing her family away and feeling helpless. After a number of violent outbreaks in her first year, smashing plates and furniture, and destroying clothing, Sarah began behaving better, eventually being discharged as recovered on 13 August 1865 after a month on trial at home.[134] The case of Sarah demonstrates how the circumstances leading to committal could be complex, and presumptions of correct diagnosis cannot be assumed.

A final moral cause that could be given in the casebooks was 'disappointment' or 'disappointment in love'. Specifically, this was used to describe the experience of women who were cheated or abandoned by men which led to their mental unrest.[135] An example was Elizabeth Q from Whitehaven, admitted to Garlands on 22 November 1862. Previously, she had been treated in Rainhill Asylum in Lancashire, and was transferred to Garlands from there. She was categorised as suffering from melancholia due to a 'disappointment of affections'. Elizabeth had made several attempts to take her own life whilst in Rainhill. No record was kept of the circumstances of her disappointment, but it seems that she came to Garlands bearing a child conceived out of marriage, as it was noted on admission that she had not menstruated for four months. Two months after this observation, Elizabeth suffered a miscarriage in the Asylum

[132] Ibid., admission no. 178.
[133] J. Andrews, 'Cause or Symptom? Contentions Surrounding Religious Melancholy and Mental Medicine in Late-Georgian Britain', *Studies in the Literary Imagination,* 44:2 (2011), pp. 63-91.
[134] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 178.
[135] The broader sense of 'disappointment' referred to both men and women that became insane due to a number of economic, social or emotional factors, M. Finanne, 'Asylums, Families and the State', *History Workshop Journal,* 20:1 (1985), pp. 134-48.

infirmary gardens, and in an attempt to keep the event a secret, 'put the foetus in her pocket'. Her miscarriage worsened her melancholic state, and she remained in Garlands until her death in October 1868 of pneumonia, aged 34.[136] Recounting the individual patient histories is important in order to place the pauper experience of insanity at the centre of this analysis. Detailing specific cases of mental illness brings to life the conditions cited in the contemporary psychiatric journals. Providing such insight is necessary when considering the wider impact circulation had on the patients themselves. The chapter will now explore the role played by the Garlands staff in the asylum regime.

Staffing

The historiography concerning the emergence of asylum medical superintendents in the nineteenth-century is heavily focussed on the small few who came to prominence in the burgeoning field of psychological medicine. The new profession was viewed with uncertainty, and was not considered a prestigious pursuit.[137] Unqualified lay practitioners had emerged with a growing interest in mental health. No specialist training was required, and all experience of insanity was gathered on the job. The asylum was the theatre for training and development for the superintendents, along with a growing number of journals in which lunacy professionals could share their experiences and approaches.[138] As touched upon in the previous section, treatment centred heavily on the physical symptoms of insanity.[139] However, as the asylum population grew, the superintendent became an increasingly remote figure, leaving the day-to-day care to attendants and nurses, and only dealing with the most interesting of cases to further his knowledge.[140]

The first medical superintendent, Dr William Kirkman, did not stay at Garlands for more than a year.[141] His successor, Dr Clouston, was instated in 1863, aged 23. He

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[136] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 236.
[137] McCrae and Nolan, *The Story of Nursing*, p. 16. See also Shepherd, *Institutionalising the Insane,* p. 47.
[138] R. Russell, 'The Lunacy Profession and its staff in the second half of the nineteenth century, with special reference to the West Riding Lunatic Asylum', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III* (London: Tavistock Publications, 1988), pp. 297-315.
[139] Scull, *Most Solitary of Afflictions,* p. 240.
[140] Scull, *Museums of Madness,* p. 182; see also, Nolan, *History of Mental Health,* p. 54. Russell stated that 'the nursing staff were indeed the backbone of the asylum' Russell, 'The Lunacy Profession', p. 312.
[141] Carlisle Central Library Local History Reference Section, G. R. Wyld, *A History of the Garlands Estate and Garlands Hospital, Carlisle, Cumberland, 1757-1914* (n.pub, 1972), p. 28.

later reflected that: 'a sort of boy physician, the youngest ever appointed'.[142] He had no prior experience in the post of medical superintendent, but had been working as an assistant at the Morningside Asylum since the completion of his degree at Edinburgh University two years earlier.[143] Clouston was keen to operate the Asylum along the moral methods employed by the Tuke's at York. Eager to stress the curative nature of his institution in order to repel the 'vague horror that was connected in the popular mind, with the cruelty and chains with the old Bedlams'.[144] The annual reports became a central method of publicising his findings, as the public and the wider medical profession were keen to understand the diseases treated.[145] Clouston's time at Garlands has been referred to as his 'formative years,'[146] as he developed his clinical abilities and furthered his career.[147] A year before his departure in 1872, he became co-editor of the *Journal of Mental Science* alongside Henry Maudsley.[148] Clouston left Garlands in 1872 to return to Morningside and become superintendent.[149]

On opening, Garlands employed 23 staff, ranging from the medical superintendent at the head of institution, to the lowest paid laundry maids and kitchen staff.[150] Thirteen ward attendants were employed to assist in the care of the patients, this equated to one per thirteen patients. These ratios were normal in comparison to other asylums operating at this time. At Norfolk in the same year, there was around one to fourteen patients.[151] Particularly for the attendants, work was exhausting as they were responsible for ensuring all aspects of moral treatment were employed.[152] Seventeen to 20 hour shifts were common, with sometimes as little as four hours sleep in between.[153] A great degree of trust was placed into the standards of care delivered by

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[142] Anon., 'Complimentary', *Journal of Mental Science,* 56:233 (1910), pp. 375-8, quoted in A. Beveridge, 'Thomas Clouston and the Edinburgh School of Psychiatry', in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 359-88.
[143] Anon., 'Complimentary', p. 376.
[144] *Annual Report 1867*, p. 15.
[145] *Annual Report 1869*, p. 16.
[146] Beveridge, 'Thomas Clouston', p. 364.
[147] T. S. Clouston, 'The Medical Treatment of Insanity', *Journal of Mental Science,* 16:73 (1870), pp. 24-30, in Beveridge, 'Thomas Clouston', p. 364.
[148] Beveridge, 'Thomas Clouston', p. 364.
[149] CACC, *Twelfth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1873*, THOS 8/1/3/1/11, p. 12.
[150] CACC, *Quarterly account of salaries and wages paid to named staff, 1861-1890*, THOS 8/2/7/1, 25 Dec. 1861.
[151] Cherry, *Mental Health Care,* p. 101
[152] K. Jones, *Asylums and After: a revised history of the mental health services from the early 18th century to the 1990s* (London: Athlone Press, 1993), p. 118.
[153] Russell, 'The Lunacy Profession', p. 308.

the attendants, as they exercised a certain power over the lives of the patients.[154] A statement in the 1870 annual report from Clouston highlights the demanding nature of their role and the responsibility placed on them:

> They are on duty from six o'clock in the morning till eight o'clock in the evening continuously, and after that are not allowed to leave the building, except a certain number in rotation…but generally have one afternoon in the week from two o'clock till ten at night, when they can go out, and every fourth Sunday, from nine o'clock in the morning. They are expected to exert themselves to make the patients comfortable, tidy, and contented, to get them to work and amuse themselves, to bear all sorts of bad language calmly, to strike or use a patient roughly under no provocation whatever, to do very disagreeable work for the purpose of keeping the patients clean, to observe the peculiarities in the patients and the changes occurring in their mental condition, and to report them to the doctors, and generally to exert a good influence on them, tending to their recovery.[155]

Peter Nolan's book, *A History of Mental Health Nursing*, gives a comprehensive insight to the experience of attendants. The profession was of extremely low status, as they were viewed as socially and intellectually inferior to the medically trained staff. The average weekly wage for a casual farm labourer was around fifteen shillings a week, whereas asylum staff would receive as little as three to four shillings. However, attendants would also receive lodgings, food, uniform, and occasional entertainment. These 'benefits' were an attraction to the females, who were largely drawn from those who had formerly been domestic servants. Asylum staff were expected to diligently record the general health of patients, including their height, weight, state of toe and finger nails, the presence of lice, and if any scars or marks were present. They also had to bathe patients, dress them, and were responsible for ensuring they received the correct medication, including enemas and suppositories. The major challenge for attendants was to provide care for violent patients without the use of force or

[154] Wright, *Mental Disability in Victorian England*, p. 101.
[155] *Annual Report 1870*, p. 18.

restraint.[156] Following on from this outline, the treatment regime, and its full implications, will be discussed in chapter four.

One additional staff member, who became increasingly important in the Asylum regime, was the chaplain. Anthony Ossa-Richardson, argued that the chaplain's role has been overlooked by historians. His research unearthed a recommendation in 1855 by the *Asylum Journal* of the appointment of chaplains, which placed them in the dual role of being a religious figure, while also providing medical counsel.[157] Their presence supported the notion of treatment through moral means, promoting a sense of self-help through prayers and worship.[158] For English county institutions, the chaplain was Anglican, but for those with a high proportion of Roman Catholic patients, priests were also brought in.[159] The full implications of religion, from the analysis of patients that identified as Catholic, will be explored in detail in chapter six. From the inception of Garlands, responsible for delivering the role of Asylum chaplain was Reverend J. F. Simpson. In the 1868 annual report, Clouston stated the importance of religion:

> the morning prayers and Sunday services exercise a soothing effect on the patients; they make them feel more as if they were at home, and consequently happier; they help to pass the time, which is apt to be monotonous to them; and they help to strengthen the habits of discipline and self-control from their having to sit quiet…they have an absolute right to religious consolation…[160]

Thus, religion was utilised as a form of distraction, and an aid to recovery.[161]

By 1872 Garlands had been open for a decade, and a total of 912 patients had been admitted, of which 39% had been discharged recovered, which seems

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[156] P. Nolan, *A History of Mental Health Nursing* (Cheltenham: Stanley Thomas Ltd, 1998), p. 39, p.47, p. 49, p. 50, p. 57, p. 61. On opening, the salary for the attendants ranged from three shillings per week (females), and seven shillings per week (males), CACC, *Quarterly account of salaries and wages paid to named staff, 1861-1890*, THOS 8/2/7/1, 25 Dec. 1861.
[157] A. Ossa-Richardson, 'Possession or Insanity? Two Views from the Victorian Lunatic Asylum', *Journal of the History of Ideas,* 74:4 (2013), pp. 553-75.
[158] *Annual Report 1867*, p. 7.
[159] Other denominations were also catered to in different asylums. McCrae and Nolan, *The Story of Nursing*, p. 23.
[160] *Annual Report 1868*, p. 19.
[161] The case notes do not always state when patients attended religious ceremonies, and did not state their benefit. Only in the annual reports were the numbers partaking in services noted. This was most likely to prove to the Commissioners in Lunacy it was being used as a popular method of treatment, in the regime of care recommended by them. Superintendents stated the benefits of religion, but any evidence in the casebooks is difficult to identify.

extremely high compared to Norfolk's recovery rate of just 14.6%. As a result, 405 remained on 31 December 1872, more than double Garland's original capacity.[162] The patient mortality rate was 26% in this period, which is higher than Norfolk's figure of 11.5%.[163] Denbigh's patients fared comparatively better, out of the 2711 patients admitted by 1875, between a third and a half were discharged recovered. On the other hand, the mortality rates were slightly worse than Garlands, as around one third died in the asylum.[164] The quote at the beginning of this chapter from the 1872 annual report sets out the fate which awaited those admitted to Garlands. Patients only held a 40% chance of leaving the institution cured, 20% would die, and 30% held a chance of remaining there long-term.[165] This fails to consider those who returned to the Asylum and were readmitted at a later date. The full implications of this on the staff, and the impact on the transferral of care will be explored throughout the following chapters, forming a core focus of the thesis in addressing the identified gaps in the historiography.

Conclusion

This chapter has given an overview of the context surrounding the construction of a county lunatic institution in the period after 1845. The 1860s was comparatively late for a county to be constructing its first institution, as most already had their own and were overcrowded. Garlands opened in response to the growing need for a caring institution which would provide the correct treatment for the increasing number of lunatic paupers in an area otherwise poorly served by such provision. The precedent for treatment in the county asylums, particularly after 1845, was ingrained in the ideals of moral treatment and non-restraint. Garlands followed both of these guidelines, and went further by advocating a temperate regime. The need for an asylum in this rural location was evident by the huge influx of patients in its initial few months, and by the fact that it became over capacity by the end of its second year. The problem of insanity had been hidden in the counties workhouses, family homes and in asylums further afield. The rich archival data provides a great insight into where the Garlands first patients were

[162] The full implications of overcrowding will be explored in chapter three. *Annual Report 1872*, p. 28.
[163] Ibid., p. 44; Cherry, *Mental Health Care*, Table 4.1, p. 98.
[164] Michael, *Care and Treatment*, p. 83.
[165] The patient sample differs slightly from these figures, as 49% left Garlands recovered (79), and 37% died in the institution (59). However, these do not account for readmissions, and they follow patients over a much longer period than were examined here.

transferred from, and where they had mainly been treated prior to the counties of Cumberland and Westmorland providing their own institution. In analysing some of the first patients to be treated, this chapter has gone some way in outlining the transfer of care that took place for some of the initial population.

Existing literature concerning the 'pioneering' centres are so widely quoted and commented on, that the individual stories of patients of a rural, and geographically northern, institution, such as Garlands, have fallen from academic gaze. Research of this area has become dominated by the larger asylums of Lancashire and Yorkshire, with the smaller institutions in the far North of England lying neglected. This chapter has provided a valuable background as to the reasons behind the late construction of Garlands. In the contextual analysis, it is apparent that the counties of Cumberland and Westmorland repeatedly unburdened themselves of the responsibility of constructing their own institution, for financial reasons. By continually relying on Dunston Lodge to care for their insane, they removed accountability for the accommodation of pauper lunatics set out in the Act of 1845. When Garlands finally opened, the 'problem' of lunacy was much more visible as the institution was soon in need of extension. The examples of patients admitted in Garlands formative years given in this chapter have provided a sense of how the specific circulation of patients will be explored throughout the rest of this study, and have given an insight into the types of insanity experienced in the institution.

This chapter has built upon existing research, as it has explored some of the initial patients that suffered from a variety of conditions. Although Cherry, for example, does use examples of individuals labouring under the different classifications of insanity, this is confined to a few sentences, as his focus is on retelling the extensive history of the Norfolk Asylum. The chapter, as well as addressing a geographically lacking area of the literature concerning asylums, has also provided a foundation for the rest of this thesis in examining the circulation of pauper insane patients in the later nineteenth-century. As has been shown, an initial process of transfer was necessary in order for most of the Garlands first patients to receive treatment. The full implications of this, and how the increased movement of patients was facilitated will be examined in the subsequent chapters. This is the fundamental gap to be filled by the research carried out throughout this thesis. Here. The beginning of the process has been presented, next, the following chapter shall fully explore the key facilitator of patient transfer.

Chapter Three: 'The Evils Resulting from Overcrowding'[1]

The asylums, workhouses, and prisons of the country to-day are crowded with feeble-minded, many of whom should never have been born into the world at all.[2]

Overview

Overcrowding came to be a central feature of all aspects of life towards the end of the nineteenth-century. With the advent of the industrial revolution and an increased birth rate, England's population grew rapidly from 12 million in 1820 to 30 million in 1890.[3] One article, in 1899, described the overcrowding of London as 'one of the darkest aspects of modern civilisation', and that its most disastrous result was the effect it had on 'the health and morals of the people'.[4] This era also came to be recognised as one of widespread institutionalisation, as hospitals, prisons, workhouses, and asylums, were constructed at an accelerated rate. A dependency emerged on these large, over-populated buildings that came to be synonymous with the late nineteenth-century, and they evolved into mere receptacles, rather than the sites for rehabilitation and cure, as was their initial intention.[5] As the problem of overcrowding grew, so too did the size of asylums; 'large soulless institutions' were constructed for patients in their thousands, which made fostering therapeutic relationships impossible.[6] Outlined in the opening

[1] CACC, *Twenty-First Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1882*, THOS 8/1/3/1/20, p. 19.
[2] CACC, *Fiftieth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1911*, THOS 8/1/3/1/49, p. 14.
[3] A. Scull, *Museums of Madness: The Social Organization of Insanity in nineteenth-century England* (London: Allen Lane, 1979), p. 224 Table 8.
[4] Anon., 'Overcrowded London', *The Review of Reviews*, 19 (1899), p. 496.
[5] M. A Crowther, *The Workhouse System 1834-1929* (London: Batsford Academic and Educational Ltd, 1981), p. 65.
[6] K. Jones, *Mental Health and Social Policy, 1845-1959* (London: Rouledge & Kegan Paul, 1960), p. 2. By 1839, Hanwell Asylum in Middlesex had become England's largest asylum with close to a thousand patients, L. D. Smith, *"Cure, Comfort and Safe Custody": Public Lunatic Asylums in Early Nineteenth Century England* (London: Leicester University Press, 1999), p. 63.

chapter, four contemporary explanations emerged to explain the overcrowding of asylums, which have been explored extensively in the historiography. This chapter shall move away from attempting to explain the problem, and instead examine the effect it had on a rural asylum, through administration and patient records. Two gaps will therefore be addressed, that of recounting the pauper experience, and that of presenting evidence from an institution that remains absent from the historiography.

As has also been stated, the overcrowding of asylums was the main facilitator of patient transfer. This has been outlined by several authors in the field, but the effect upon the patients, has failed to be considered in any depth. Previous literature has focussed on depicting the problem quantitatively. Accounts of individual asylums have tended to include the issue of overcrowding, as it was felt universally, but do not give a detailed explanation of the pauper experience. Once asylums began to be filled with previously unaccounted for cases of chronic mental illness, the real complexity and scale of the issue began to be realised. Instead of addressing the problem of insanity, policy makers simply supplied more institutions, and extended existing ones, to meet the growing demand.[7] To alleviate this, as previously noted, chronic cases of insanity were often refused entry to asylums and sent instead to the workhouse.[8] Patients that stood little chance of recovery were not made the priority, as doctors disliked incurable cases clogging up their institutions. The county asylums had altered from being the main receptacle of care for mental illness, to only for those deemed dangerous, and those afflicted with conditions considered recent and curable. Although government legislation was enacted in 1874[9] to stop the movement of patients from the asylum to

[7] By this date almost all counties had at least one asylum, and by 1870 all did. Many were opening their second or third by 1862, for instance, Lancashire had three lunatic institutions by this date, C. Philo, *A Geographical History of Institutional Provision of the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter: Edwin Meller Press, 2004), Table 7.2, pp. 540-3.

[8] J. Walton, 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-1870', in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 166-97; A. Digby, 'Contexts and Perspectives', in A. Digby and D. Wright (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London: Routledge, 1996), pp. 1-21. For instance, Denbigh began experiencing chronic overcrowding in the 1870s. To resolve the issue they could only afford to accommodate the most recent and serious cases of insanity, transferring any long-term, harmless cases to the care of workhouse infirmary wards. Despite this, its 400 patient capacity was exceeded in 1876 and calls for extensions were extremely urgent, P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003), pp. 84-5.

[9] See R. Ellis, 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century', *Social History of Medicine*, 19:1 (2006), pp. 55-71.

the workhouse, widespread transfer continued due to the strain on resources.[10] In attempting to address the problem, policy-makers were aware of the adverse effects on patients, but were unable to effectively prohibit its occurrence. This, as David Wright has argued, increased the turnover of patients, instead of encouraging the treatment of pauper lunatics in the county institutions.[11] The Commissioners in Lunacy feared that the widespread construction of lunatic wards in workhouses would become 'surrogate' asylums.[12] Yet, when examining the increasing number of workhouse wards, it becomes clear that they were not a solution to the problem, and were not utilised as such.[13] Instead, it was another response in the 'tapestry of care'.[14] Reflecting the movement of people that was occurring in wider society, the great shift of asylum patients therefore became commonplace in the latter half of the nineteenth-century.

To address the gap, this chapter will explore the problem of overcrowding and how it was experienced at Garlands. The chapter will detail the problem in chronological order, to create an understanding of the ongoing, and unrelenting issue that the medical superintendents faced from the outset. Here, and in the rest of the thesis, the exploration of the circulatory nature of mental health provision offers a new area of research to extend the existing literature, which has tended to view the asylum as a static entity. Of course, the relative absence of sustained discussion of overcrowding in the historiography is to some extent explicable in terms of sources. No records exist which explicitly state the direct effect it had on the asylum populations of this period. Finding answers is a time-consuming process, one that has been carried out

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[10] D. J. Mellett, *The prerogative of asylumdom: social, cultural, and administrative aspects of the institutional treatment of the insane in nineteenth-century Britain* (New York: Garland, 1982), p. 154.
[11] D. Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteeth Century', *Social History of Medicine,* 10:1 (1997), pp. 137-55, quoted in Ellis, 'The Asylum, the Poor Law, and a Reassessment', p. 56.
[12] As early as 1865, 104 out of 688 workhouses in England and Wales had built separate lunatic wards, Mellett, *The prerogative of asylumdom,* p. 134 and p. 156.
[13] Anon., 'Workhouse Lunatic Wards', *Journal of Mental Science,* 47:197 (1901), pp. 358-9. For instance, the 'weak-minded' ward in Kendal Union Workhouse, remained at a steady capacity throughout this period. In 1851, the ward had 18 patients classed as 'weak-minded', and by 1871 the ward housed 16 residents, Ancestry.com, *1851 England Census* [database on-line], Class: *HO107*; Piece: *2442*; Folio: *295*; Page: *30*; GSU roll: *87125-87126*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8860&h=15308175&tid=&pid=&usePUB=true&_phsrc=SNv36&_phstart=successSource [accessed 29 August 2015]; Ancestry.com, *1871 England Census* [database on-line], Class: *RG10*; Piece: *5288*; Folio: *47*; Page: *42*; GSU roll: *848427*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7619&h=26579478&tid=&pid=&usePUB=true&_phsrc=SNv31&_phstart=successSource [accessed 29 August 2015].
[14] L. Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the insane in West Midlands workhouses, 1815-1860', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20. However, as will be seen later in the chapter, the problem of overcrowding came to be felt in some wards of the workhouses elsewhere in the two counties, as the issue continued to grow.

in this chapter, and in the rest of this thesis. The researcher must cross reference asylum case notes, admission and discharge registers with census material, workhouse admission documents (if they survive), and birth, marriage and death certificates – to name but a few - in order to fully understand the constant circulation of patients due to the over-burdening of asylums. As outlined in the introduction, this led to a compromise in care, which will be explored in detail in the next chapter. The two are closely interwoven, but the value in each examination will be clear in the new areas of research presented.

First, overcrowding will be explored from the opening of Garlands, to gain a sense of the rapid onset of the problem, and to highlight how patients were increasingly moved to deal with the growing issue. The second section will go further by examining the effect this transferal of care had on the patients themselves, through analysing specific examples from the sample. This will also add to the literature by setting out an explanation of the transitory nature of care in this period. The movement of a patient whilst in the middle of their recovery, could have a detrimental effect to their health. This exacerbated the problem further, as they were likely to be readmitted in a worse condition. Also important, is the negative effect overcrowding had on the staff, in particular the medical superintendents, which some were open about in articles they published in the wider medical arena. The third section will examine the unrelenting nature of overcrowding as the twentieth-century progressed. The focus in this section will be how the accommodation for pauper patients was continually stretched to capacity, whilst provision for fee paying out-county and private patients was increasingly safeguarded, as their monetary value became more important.[15] This, therefore, calls into question how concerned the Lunacy Commissioners were about the standard of treatment offered to pauper patients, when they continually ensured beds were available to patients who would yield profit. The final section will bring together all of the evidence and assess the effect overcrowding had on the Asylum. This discussion will contribute to the overall theme of the thesis, which will be explored in detail in chapter six. It will also bring together evidence of a neglected institution in the historiography. To begin the examination it is necessary to present the origins of overcrowding at Garlands.

[15] This contrasted to the treatment of private patients when they were first accepted in 1868, who would be the first to be forfeited to make room for pauper patients – see chapter two.

The Problem at Garlands, 1862-1883

Explained in the previous chapter, from the outset, Garlands received an influx of patients who had previously been in other institutions. Even before they arrived, Dr Kirkman predicted that the new institution would soon be overcrowded. In a letter published in the *Carlisle Patriot*, he stated: 'One hundred and fifty patients will be transferred directly from Dunston Lodge and Bensham Asylums, and I anticipate that the asylum will be filled very shortly after it is opened'.[16] This was no surprise, as the majority of asylums already constructed were experiencing overcrowding.[17] This section will document the growing number of admissions in Garlands in order to show the effects overcrowding had, particularly on the pauper patients. As early as 1863, the Committee of Visitors reported the strain being placed on Garlands: 'they are unable to provide sufficient accommodation therein for the number of lunatics who are chargeable to the two counties.'[18] Taking into account those residing in the care of relatives and in the workhouses, chargeable to the two counties, this was 460 in 1864.[19] The idealistic view of the authorities that all these cases would be properly cared for in the county asylums was grossly miscalculated. Providing Cumberland and Westmorland with such a relatively small institution in which to treat its insane population was only setting itself up for situations of severe pressure. Owing to overcrowding, admissions had to be constantly refused.[20] The average daily number of patients in Garlands swelled to 278 by the end of 1866.[21] The problem was so severe in 1865 that 22 patients had to be boarded out to Dunston Lodge, and two female patients were forced to sleep in a lavatory.[22] In 1864, plans were drawn up to increase the size of the Asylum to accommodate a further 105 patients.[23] This was not completed until

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[16] *Carlisle Patriot*, 31 December 1861. A total of 20 patients were transferred to Garlands from Bensham Asylum in January 1862. Thus, the majority were in Dunston Lodge prior to 1862, CACC, *Casebook 1862-1865*, THOS 8/4/38/1.
[17] Len Smith reinforces this, as he stated that by 1844, 'most of the asylums had more than doubled in size since their opening', Smith, *Cure, Comfort and Safe Custody*, p. 81.
[18] CACC, *Second Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1863*, THOS 8/1/3/1/1, p. 5.
[19] For 1864 225 resided in Garlands, 158 in workhouses, and 77 at home with relatives. Refer to Appendix 1.
[20] For instance in 1864 Clouston had to refuse 64 patients, CACC, *Fourth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1865*, THOS 8/1/3/1/3, p. 7.
[21] *Annual Report 1911*, Table a2 pullout, p. 19.
[22] CACC, *Fifth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1866*, THOS 8/1/3/1/4, p. 8.
[23] CACC, *Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1864*, THOS 8/1/3/1/2, p. 5.

1866, and in the interim several patients had to be refused admission and sent either to workhouses, or as seen above, to Dunston at a higher rate of maintenance.[24]

Despite the new block for 100 females opening in 1866, Garlands was full to capacity by December of that same year.[25] Sufficient alarm concerning the increasing rate of insanity meant that Clouston felt it necessary to state in 1867:

> the conclusion is made almost certain that insanity is not on the increase in the two counties, but that the numbers annually sent here have hitherto increased from merely temporary cases, the chief of these being the increased wish to send most cases here early the increased desire among a socially higher class to have their relatives sent here, and the tendency which prevails to send old persons labouring under temporary excitement with dotage here.[26]

He believed that overcrowding was becoming such a problem because people held the view that 'all mad people should...be sent to lunatic asylums, as they were the only places where there was any chance of proper treatment'.[27] As mentioned in the overview, the new asylum network had become known as the correct place to send anyone suffering with insanity. To facilitate only suitable cases being admitted, as set out in the 1870 Garlands rules and regulations, the importance of the recovery of 'recent and curable' patients was continually reinforced.[28] Patients suffering with more recent attacks of insanity were given priority. Medical superintendents were measured on their performance by recovery rates. The chronic insane were not likely to be cured and were not gladly received by asylum doctors. In this same year, Clouston noted that in Garlands 'there is an accumulating mass of chronic incurable cases'. Of the 250 patients admitted in 1862, 125 remained in 1870.[29] Thus, to prevent further pressure on

[24] In 1867 Clouston reported the exact figures of refusal; 64 patients in 1864, 76 in 1865, 80 in 1866, and 97 in 1867, CACC, *Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1867*, THOS 8/1/3/1/5, p. 11.
[25] *Annual Report 1866*, p. 13.
[26] *Annual Report 1867*, p. 15.
[27] T. S. Clouston, 'What Cases Should be Sent to Lunatic Asylums? And When?' *British Medical Journal*, 578:1 (1872), pp. 96-8.
[28] CACC, *General Rules for the Government of the Asylum at Garlands 1870*, THOS 8/1/1/3.
[29] CACC, *Ninth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1870*, THOS 8/1/3/1/8, p. 16.

resources, Clouston reinforced the need for patients to be sent to the asylum in the first instance of their illness to maximise the chance of recovery.

The introduction of the four shilling grant-in-aid facilitated this.[30] The practice of treating patients in the workhouse whilst judging their suitability for asylum provision, was condemned by superintendents, as it worsened the individual's condition. For example, as Clouston remarked in 1865: 'As usual many of the cases were far too long kept at home, or in workhouses, before being sent here…*early* treatment and *early* removal from the causes of the disease give by far the best chance of recovery.'[31] In addition, the treatment they suffered in the workhouse was not nearly adequate enough to bring about recovery, and the full implications of this will be explored in chapter four.[32] In 1864, Clouston outlined the following case that came from the workhouse: 'One woman…says that she was sent to a workhouse when she first became insane, and because she was sleepless and noisy the sane inmates beat her severely with sticks'.[33] However, in 1875, Dr Campbell refuted the grant as an explanation for the problem:

> It was feared that the imperial grant of 4s. per head for the maintenance of patients in Asylums would overcrowd Asylums, by inducing the admission of all the chronic cases in Workhouses. It has not had this effect in these counties. The admissions from Workhouses during 1875 were 9. The average number admitted for the last nine years was 7. Though above the average, it is not the highest number admitted, and it is considerably below the average of the years previous to 1867.[34]

Instead, he agreed with his predecessor, that the problem was due to the number of elderly cases being admitted with no hope of recovery. Campbell noted that: '81 patients are above 60 years of age…and of these 16 are between 70 and 80, and 5 are between 80 and 90'.[35]

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[30] Jones, *Mental Health*, p. 19.
[31] *Annual Report 1865*, p. 8.
[32] Anna Shepherd found similar cases of neglect, A. Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014), p. 27.
[33] *Annual Report 1864*, p. 9.
[34] CACC, *Fourteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1875*, THOS 8/1/3/1/13, p. 16.
[35] Ibid., THOS 8/1/3/1/13, p. 19. Later, in 1896, Campbell reiterated this, as he stated that due to 'increased longevity', the number of those admitted with 'senile insanity' had risen, J. A. Campbell, *Lunacy in Cumberland & Westmorland, with remarks: an address delivered at the opening of the Section*

By 1875, overcrowding had again become an urgent issue, which Campbell addressed in a dedicated a section of the annual report – see Figure 3.1 below.

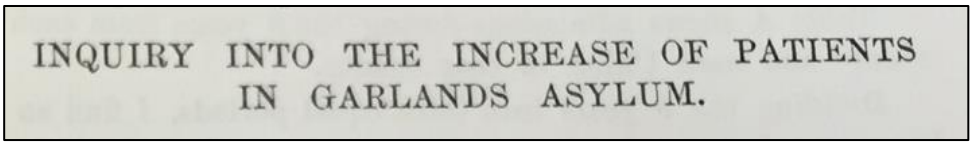
INQUIRY INTO THE INCREASE OF PATIENTS IN GARLANDS ASYLUM.

Fig. 3.1. 'Inquiry into the increase of patients in Garlands Asylum', 1875[36]

He noted that each year there had been an increase in admissions. The number of patients resident in Garlands at the close of 1862 was 196, and by 1875 this had risen to 419.[37] Although to begin with this was to be expected as there had never been an institution in the two counties to receive such cases; they anticipated that within the first decade at least that the numbers being admitted would have reduced. There had been a gross underestimation of the number of lunatics chargeable to the two counties who would be willing to receive treatment at Garlands. He also stated that over the previous four or five years, private patients had to be removed to the care of their friends,[38] 'much against their will…on account of the requirement of room for county patients', and that, 'such cases as were suitable have been sent to workhouses'. However, the Asylum still lacked sufficient room for its insane population, as eleven patients had to be sent to Morpeth Asylum, six to Macclesfield, and one to Fisherton House in Salisbury.[39] Thus, the situation of overcrowding had a direct effect on those patients who had to either be refused entry to Garlands, or who were existing patients and had to be transferred elsewhere. In the eleven cases described in 1875, this meant an upheaval in their current programme of recovery (detailed fully in chapter four), and being sent – in the case of the patient sent to Fisherton House – several hundred miles away from their friends and family, who remained an important source of support (explored in greater detail in chapter five). The doctors, in transferring patients in times of overcrowding, were not doing so with their best interests in mind. Instead,

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of Psychology at the Annual meeting of the British Medical Association, held in Carlisle, July, 1896 (Carlisle: Chas. Thurnam & Sons, 1896), p. 7.

[36] *Annual Report 1875*, p. 15.

[37] Ibid., Table III, p. 26.

[38] By this date, private patients had not been given separate wards. Only later in the century were their economic value prioritised over providing accommodation for paupers, which is explained fully later in the chapter.

[39] *Annual Report 1875*, pp. 11-12.

overstretched resources and no spare beds meant that asylums could no longer perform what they were set out to do: treat insane paupers.

In 1876, the pressure of overcrowding had not eased, with the number of patients standing at 422.[40] Twenty-two had to be boarded out to other asylums, costing fourteen shillings per head per week, as opposed to ten shillings and six pence if they were accommodated in Garlands.[41] The Lunacy Commissioners noted that these patients had cost a total of £300 per annum more than if they were in Garlands.[42] An additional reason, brought initially to the attention of the authorities in 1876, why Garlands, and a small number of other English county asylums, experienced overcrowding, was the influx of immigrant lunatics. The 1876 annual report stated particularly how Irish migrants were in part to blame for the problem of overcrowding: 'I firmly believe that if the [Irish] patients were as comfortably kept in the Irish District Asylums, as they are in the English County Asylums, the Asylums on the West Coast of England would not require such frequent enlargements'.[43] A high number had migrated to England to escape the Famine in the 1840s, and became employed in seasonal, low-skilled jobs, finding it hard to support themselves and their families. This caused a high level of mental disturbance and the migrant Irish contributed to the overcrowding of English asylums.[44] The full implications for Garlands with regard to the Irish immigrants, and their experience, will be explored in chapter six.

This burden was relieved in 1882 with the opening of a new block for the male patients, and a further extension in 1883 to accommodate 110 females.[45] However, incidents whilst building work was taking place in the asylum grounds, highlight the added element of risk when extra provision was granted. Instances of agency, and the ability of the attendants to keep watch of particularly determined patients, was tested

[40] *Annual Report 1911*, Table a2 pullout, p. 19.
[41] CACC, *Fifteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1876*, THOS 8/1/3/1/14, p. 13.
[42] CACC, *Seventeenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1878*, THOS 8/1/3/1/16, p. 8.
[43] *Annual Report 1876*, p. 12. For more on Irish Asylums see P. M. Prior, *Asylums, Mental Health Care and the Irish: 1800-2010* (Dublin: Irish Academic Press, 2012).
[44] D. M. MacRaild, *Culture, Conflict and Migration: The Irish in Victorian Cumbria* (Liverpool: Liverpool University Press, 1998).
[45] *Annual Report 1882*, p. 16; CACC, *Twenty-Second Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1883*, THOS 8/1/3/1/21, p. 15.

when their routine was disrupted.[46] Campbell noted in 1880 the increased burden on staff:

> the constantly crowded state of the Asylum, the amount of new work going on at different parts of it, and the inconvenience caused where the alterations impinge on the old Asylum, by impeding traffic and offering facilities for escapes and accidents, have all tended to increase the work and anxiety of the past year.[47]

Again in 1883, he reiterated: 'those unavoidable difficulties, with increased facilities for escapes and injury, have made the working of this division a matter of great care…' In this case, Campbell referred to two males who had both died after escaping from the asylum.[48] Instances of increased patient agency, and their implications on the ability of staff to deliver care, will be examined fully in the following chapter. The next section will explore the impact that continual overcrowding had on the pauper patients.

The Effect on the Pauper Patients, 1883-1902

By 1896 the widespread problem of overcrowding in asylums in England and Wales had attracted such attention that the Commissioners in Lunacy produced a special report in an attempt to explain the issue. In a similar vein to that of the article discussed briefly in the opening paragraph, the report linked the supposed increase of insanity to the 'growth and corresponding evils of large cities…necessity conspired to produce a larger and increasing ratio of incident and mental disorder in the population'. To demonstrate this, the report provided a detailed breakdown of the figures which suggested that the number of insane persons in England and Wales had increased dramatically since 1859. However, when compared to the increase of the whole

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[46] Preventing escape was the responsibility of the attendants, as those in charge of a patient at the time of escape were liable to cover the costs incurred to retrieve them, N. McCrae and P. Nolan, *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors* (London: Routledge, 2016), p. 79.
[47] CACC, *Nineteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1880*, THOS 8/1/3/1/18, p. 19. For more on patient protest, L. Smith, *Insanity, Race and Colonialism: Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838-1914* (London: Palgrave Macmillan, 2014), p. 177.
[48] One male 'J.H' escaped, was found after two days and taken to Brampton Workhouse, but soon died of exhaustion. The second, 'H.M', escaped and his body was found seven days later on a moor near Ingleton, Yorkshire. *Annual Report 1883*, pp. 13-16.

population, the rise had not been as alarming as it first seemed, as shown in table 3.1 below.

Year	Population	No. of Insane Persons	Percentage of Population
1859	19 686 701	36 762	0.18%
1869	22 223 299	53 177	0.24%
1879	25 371 489	69 885	0.28%
1889	28 447 014	84 340	0.3%
1896	30 731 092	96 446	0.31%

Table 3.1. The increase of insane persons in comparison to the increase in the whole population, 1859-1896.[49]

The Commissioners stated that this did not necessarily equate to an increase in the proportion of lunatics either. They explained that since 1859, there had been a shift in where people of unsound mind were being treated. This had occurred due to the opening of so many new county asylums, to which those already classed as insane had been admitted. They were noted as first admissions to the asylum, when in fact they had been under treatment in the workhouse for months or even years. Therefore, once the number of asylums grew and their provision widely advocated in the 1860s and 1870s, paupers that were transferred to the asylum resulted in the surge in the amount of 'new' cases of insanity that emerged in the statistics. Interestingly, the majority of asylum superintendents agreed with this, as out of 62, only ten stated that they believed that insanity had increased. The admission of the Lunacy Commissioners that there had been a large shift in the care of the insane is evidence that there was widespread circulation of pauper lunatics, particularly between the workhouse and the asylum. As stated, the significance of this transfer has been neglected from the existing literature, specifically in terms of the implications this had for paupers. Through this section, the effect this had on the pauper patients, and to some extent the staff, will be explored.

The much needed extensions to Garlands carried out in the early 1880s, relieved the burden of overcrowding, albeit temporarily, and all the insane persons chargeable to the two counties were accommodated within the asylum. In addition, any vacant beds

[49] House of Commons Papers, *Copy of the special report of the commissioners in lunacy to the Lord Chancellor on the alleged increase of insanity* (1897), http://parlipapers.proquest.com/parlipapers/docview/t70.d75.1897-074861?accountid=7420 [accessed 10 January 2017].

were utilised to receive private and out-county patients at a higher rate.[50] In 1884, 19 private patients were admitted, which provided extra income to fund future extensions and renovations.[51] In 1885, Campbell reported that these patients had raised £464 in that year alone. However, the private cases often stood a reduced chance of recovery than their pauper counterparts, as they sought to exhaust all means of home care, delaying early removal to the asylum, exacerbating their conditions (for full implications see chapter five). Therefore, although patients of the private class offered monetary benefits, they contributed greatly to the number of long-term, chronic cases which added to the growing admissions. In practice, the out-county patients would be the first to be transferred elsewhere, and the private patients were increasingly retained for their financial value to the Asylum until it was absolutely necessary for them to be removed. However, as will be seen below, this changed when they were given separate provision.

From 1883 until after the turn of the century there were no further extensions to Garlands; the capacity for pauper patients remained at around 620.[52]

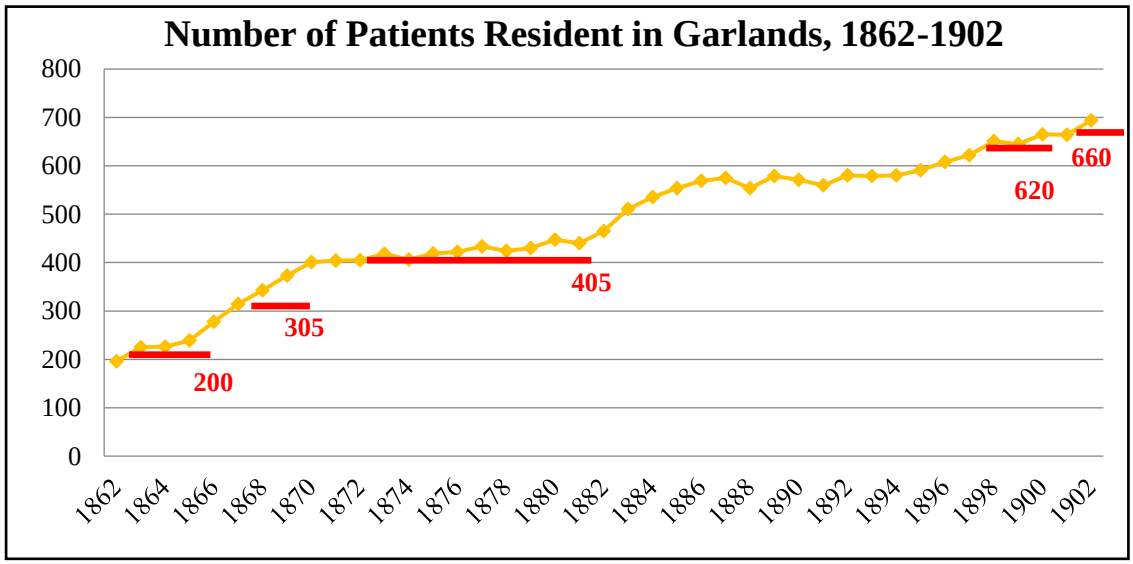

Fig. 3.2. The increase in the number of patients resident in Garlands, 1862-1902. The red lines indicate the patient capacity, and when this was exceeded.[53]

[50] As stated in chapter two, the provision for private patients belonging to Cumberland and Westmorland was desirable as there was no other accommodation in the two counties. However, throughout this period there is no evidence – in either the local newspapers or the Garlands Archive - to suggest that the asylum was under pressure from relatives wanting more private accommodation in Garlands. There are numerous advertisements in local newspapers stating that Garlands accepted private patients, and stated the cost, suggesting they were not inundated with applications once they accepted fee-paying admissions.
[51] CACC, *Twenty-Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1884*, THOS 8/1/3/1/22, pp. 5-6.
[52] The increase to 660 in 1900 was facilitated by extensions to accommodate private patients only.

Figure 3.2 shows the frequency of overcrowding. From the extension in 1883, Garlands remained close to full capacity until 1896 when this was exceeded, and continued to be, until 1902. This can be seen most prominently in the 1893 annual report, where the Committee of Visitors noted that there were 'increasing calls for asylum accommodation in this district', which had maximised the pressure upon the patient capacity. However, it was decided that the need for private beds was more important, and would prove to be more finically lucrative for the future of the Asylum. This was based on the fact that during the decade 1883-1893, income from private patients amounted to £5204, and the Lunacy Commissioners had hopes for increasing this.[54] To address the overcrowding issue, Cumberland House was added in 1896, which could accommodate twelve private patients, and Westmorland House opened in 1900 for a further 24 female private admissions.[55] This provision would have been a great benefit, as the fee-paying patients would not have to be sacrificed in times of overcrowding for the accommodation of paupers. Despite stretched resources in the pauper wards, provision for the private class would be safeguarded to protect the income they generated. This signalled a reversal of the policy to forfeit the private patients in times of overcrowding. As it was such an unrelenting problem, the Commissioners could see the disadvantage in continually refusing income from these patients, and decided to provide them with their own accommodation.[56]

This had negative implications for pauper patients, as they would be the ones who had to be moved to free up space for urgent admissions. When examining the sample, it is possible to see the effect overcrowding had on their treatment. As mentioned previously, patients regarded harmless to themselves or others were transferred to the care of the workhouse infirmary, or, if they were willing and able, to the care of their family. Dr William Farquharson, superintendent from 1898, noted in 1899 that: 'Great care is exercised in selecting suitable cases for the Workhouse'.[57]

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[53] *Annual Report 1911*, Table a2 pullout.
[54] CACC, *Thirty-Second Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1893*, THOS 8/1/3/1/31, p. 6.
[55] CACC, *Thirty-Fifth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1896*, THOS 8/1/3/1/34, p. 14; CACC, *Thirty-Ninth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1900*, THOS 8/1/3/1/38, p. 16.
[56] Denbigh Asylum had separate provision for private patients from its opening in 1848, for the monetary benefits, Michael, *Care and Treatment*, p. 55.
[57] CACC, *Thirty-Eighth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1899*, THOS 8/1/3/1/37, p. 13.

Patients from the sample that were discharged relieved to either the workhouse or to their relatives (12.5%), were the cases directly effected by the pressures of overcrowding.[58] For instance, Mary M was admitted for the first time to Garlands on 10 April 1883, aged 20, and was transferred from Fusehill Workhouse in Carlisle where she had resided since the age of thirteen. She was described on admission as: 'Weak minded and silly from birth', but had been in a manageable condition in the Workhouse, hence her residence there for so many years.[59] Mary's parents had died when she was young, leading to her committal to the Workhouse, and it was stated that she was allowed to grow up as a street waif. The worsening of her condition in the previous three months had led to her admission to Garlands, which was triggered by her disruptive behaviour: '[She] Got irritable, quick tempered, dangerous to others, tore her hair and clothes'. Mary's case notes stated that she was suffering from imbecility, and that she was imperfectly educated. She remained in Garlands for eleven years until July 1894 when she was discharged unrecovered back to Fusehill Workhouse.[60] Although not explicitly stated, Mary's removal was to free up room in Garlands to necessitate care for more 'urgent' cases which had an increased chance of recovery. However, after only four months, Mary was readmitted to Garlands due to her violent behaviour.[61] On her reception order, the matron at Fusehill gave the following statement indicating Mary's escalating condition:

> an inmate of Fusehill Workhouse, states that Mary M…took up a poker and struck violently at her…and that she had great difficulty in restraining her, and further that this was without provocation. She (Mary M) is often under the delusion that other people are plotting harm against her, and that she throws things violently at others without care.[62]

Thus, the transition of Mary's care from the Asylum to the Workhouse, although this is where she was originally cared for, had a detrimental effect in only four months, and she had to be brought back to Garlands. Removing patients that had been used to comparatively pleasant surroundings in the asylum clearly upset their routine and had

[58] 20 patients out of the main sample of 160.
[59] CACC, *Casebook 1880-1884,* THOS 8/4/38/8, admission no. 2395.
[60] CACC, *Casebook 1880-1884,* THOS 8/4/38/8, admission no. 2395.
[61] Smith noted how violence would be a trigger for removal from the workhouse to the asylum, as they posed risks to themselves, the staff and other inmates, Smith, 'A Sad Spectacle', p. 115.
[62] CACC, *Reception Orders 1894,* THOS 8/4/1/36.

the effect of causing further anguish.[63] In Mary's case it seems that the asylum doctors and Committee of Visitors learnt from their mistakes, as she was never transferred from the Asylum again, and remained in Garlands until her death in 1922.[64]

More widely, transferral usually meant a compromise in the level of care being received, which was recognised by the patients themselves, and was remarked upon by the Committee of Visitors in 1895; '[we have] been struck by the reluctance individual patients have expressed to leaving the Asylum [when] being transferred'.[65] In the asylum they had been in a safe, warm environment, had been fed with a nourishing, varied diet, and had been allowed respite from the pressures of outside life. Once transferred back to the family home or to the workhouse, the standard of care they had come to rely upon was dramatically altered. These circumstances often led to a further deterioration of a patient's condition, and ultimately to readmission. This was remarked upon in 1886 by Dr Campbell; 'the difference in diet scale is a principal cause of deterioration in mental state, physique, and habits when such cases are sent to workhouses'.[66] Thus, the superintendents themselves were aware of the consequences of transferring patients, but in situations of overcrowding, and with little help offered by the Lunacy Commissioners, they had no choice. The inferior treatment received in the workhouse was regarded adversely by the patient, and their friends and family. For instance, Mary Annie R from the sample, was admitted on 2 May 1883, aged 34. She was stated to have suffered from mania, which had lasted for six months, the duration of which she had spent in Haydock Lodge Asylum, in Lancashire. Mary was chargeable to Kendal Union. During her first bout of illness Garlands was over capacity, and she was instead sent to Haydock. Once pressure had been relieved by the extension of the female block in 1883, Mary was transferred to Garlands, where she remained for fourteen years. During this time she suffered from delusions and behaved in a childish manner. Overcrowding once again impacted her treatment, as on 6 May 1897, she was considered as a suitable case to be relieved to Milnthorpe Workhouse.[67] Realising the detrimental effect that this transition would have on Mary's health, her friends and family requested that she be returned to Garlands as a private patient, as they were willing to pay for her maintenance. The lower standard of care offered in the

[63] 35% of the patient sample removed to the workhouse were returned back to Garlands.
[64] CACC, *Female Casebook 1892-1895,* THOS 8/4/40/3, admission no. 4024.
[65] CACC, *Thirty-Fourth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1895*, THOS 8/1/3/1/33, p. 6.
[66] J. A. Campbell, 'On the Appetite in Insanity', *Journal of Mental Science,* 32:138 (1886), pp. 193-200.
[67] CACC, *Casebook 1880-1884*, THOS 8/4/38/8, p. 123.

Workhouse was clearly not an option for Mary's family, when she had been used to specialist care in Garlands for such a long time. Added to this was the fact that her family were of some means as they owned their own stationers shop in Kendal, therefore they were in a position to fund Mary's care.[68] She was readmitted to Garlands as a private patient on 10 May 1897, just four days after her removal, and she remained in the Asylum until her death in January 1924.[69] The refusal of her family to allow the authorities to transfer Mary's care is evidence of the continued role relatives played, despite them being incarcerated far away from the family home. This is also evidence that the family were not consulted when Mary's removal from Garlands was decided, as she was discharged from the Asylum for four days before being sent back and readmitted as a private patient. The continued role of the family will be explored fully in chapter five. For those without a support network of friends and relatives, pauper patients were frequently transferred back and forth between the asylum and the workhouse. The full implications of the effect on the treatment received, and the disruption this caused to moral treatment, will be examined in the next chapter.

Under immense pressure from the Commissioners in Lunacy to maintain high rates of recovery, when faced with overcrowding, it was the superintendents who bore the brunt of the criticisms directed towards the county asylums. As the head of these institutions, the superintendent was held personally responsible for any perceived failings. Along with this was the heavy workload placed upon their shoulders, and it was not just the attendants who had to work strenuous hours (further explanation of their role will be provided in the next chapter). Living in the grounds of their institutions meant that medical superintendents were on call 24 hours a day, and were expected to work regular twelve hour days, inspecting wards, filling out paper-work, and attending social functions of the psychiatric profession in the evenings. The role of asylum superintendent also offered no route for advancement.[70]

Medical superintendents faced further pressure as the size of their asylums grew to accommodate the number of admissions. The ties between patient and superintendent were severed as the reality of personally examining several hundred patients became

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[68] Ancestry.com, *1891 England Census* [database on-line], Class: *RG12*; Piece: *4333*; Folio: *95*; Page: 1, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=6598&h=15407855&tid=&pid=&usePUB=true&_phsrc=SNv39&_phstart=successSource [accessed 24 February 2016].
[69] CACC, *Female Casebook 1895-1899*, THOS 8/4/40/4, admission no. 2401.
[70] Shepherd, *Institutionalizing the Insane*, p. 42.

impossible to satisfy.[71] It is difficult to assess the indirect consequences of overcrowding without explicit evidence from the archives. In the Garlands annual reports, the medical superintendents were not forthcoming on the disadvantageous effects that overcrowding had on their ability to carry out their roles.[72] Instead, statements such as the following in 1882 were common to reassure the Lunacy Committee that they could still effectively manage their asylum:

> It is a good sign of the sanitary arrangements that in spite of the overcrowding which has existed for some years, the percentage of deaths from consumption should be lower than it was in the previous years.[73]

Doctors were not, however, immune from experiencing the adverse effects of overcrowding, and the wider pressures of producing favourable rates of recovery. Professionals such as medical superintendents were susceptible to stress which, in some circumstances, led to a compromise in their mental and physical health.[74] Dr Campbell wrote an article in the *Lancet* in 1897 detailing the risks which asylum doctors faced in carrying out their roles of responsibility, with particular regard to mental health:

> The public asylum service in Great Britain has many medical men engaged in its work and the risks asylum physicians run in their daily routine duties are little known, for asylum men scarcely care to talk of the evils that befal [sic] them in case force of example, notoriety or other causes which actuate the insane, should bring worse on their heads.[75]

One case from the sample which is indicative of the pressures placed upon the doctors in times of overcrowding, is that of Michael C, who between 1870 and 1888

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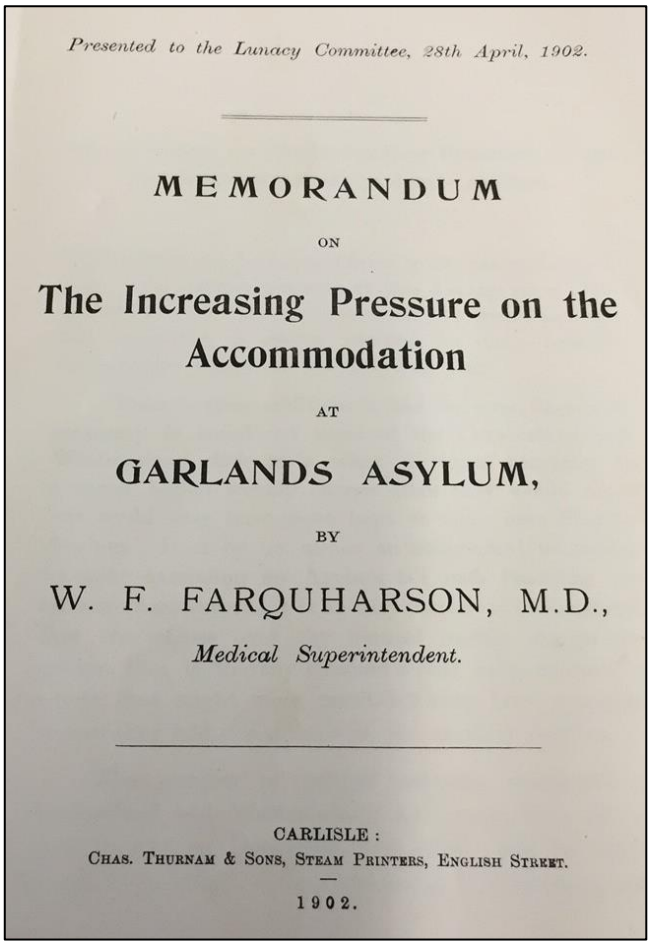
[71] A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Yale University Press, 1993), p. 172.
[72] As mentioned earlier in the chapter, superintendents were forthcoming about the growing numbers of admissions and the impact this had on transfers, but they were less willing to admit that it impeded their ability to carry out their role.
[73] *Annual Report 1882*, p. 24.
[74] A. Tomkins, 'Mad doctors? The significance of medical practitioners admitted as patients to the first English county asylums up to 1890', *History of Psychiatry*, 23:4 (2012), pp. 437-53.
[75] J. A. Campbell, 'The Hardships and Risks of the Medical Profession and those engaged in the Treatment of Bodily and Mental Diseases', *The Lancet*, 150:3877 (1897), p. 1619.

was admitted for treatment at Garlands on five separate occasions.[76] Ten years after his last bout of treatment, on what the local newspaper described as 'a terrible night in the workhouse', Michael beat a fellow inmate of Longtown Workhouse to death using the sticks he used to aid his mobility. This 'brutal murder'[77] was reported as an unprovoked attack, but Michael displayed symptoms of insanity shortly before the terrible incident, which led the magistrates to determine the verdict of guilty but insane for wilful murder,[78] incarcerating him in Broadmoor until his death in 1924.[79] In a newspaper report at the time of the trial, Dr Campbell examined and confirmed Michael's insanity at the time of the murder and during the last 25 years he had known him: 'On all these occasions [in Garlands] he was suffering…mania, was acutely violent, and in the early part of the attack was always dangerous to others.' He also stated that he was not of sound mind when he committed the fatal attack, and that he was in a confused state as recent events were a complete blank to him, as well as some of his former affairs.[80] Michael's case offers an insight into the indirect effects of overcrowding. On each occasion he was discharged stated to be recovered, but overcrowding would have actively exacerbated the pressure to 'cure' as many patients as possible in order to free up more beds. Therefore, patients that were discharged may not have fully returned to their normal state, leaving them susceptible to readmission and posing a possible danger to the surrounding community. As mentioned in the previous chapter, Clouston stated the difficulty in recognising when a patient had fully recovered their senses until they were back in their usual surroundings with their usual temptations.[81] What is apparent from the murder committed by Michael, is that the discharge of such vulnerable and volatile patients was given inadequate consideration in times of overcrowding. The monitoring of discharged patients was non-existent, therefore the onus on doctors in correctly identifying when a patient had recovered their normal

[76] 'The Longtown Workhouse Murder', *Carlisle Patriot,* 8 July 1898.
[77] *Carlisle Patriot*, 3 June 1898.
[78] Ancestry.com, *England & Wales, Criminal Lunacy Warrant and Entry Books, 1882-1898* [database on-line], Class: *HO 145*; Piece: *9*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=9162&h=1120&ssrc=pt&tid=89121375&pid=48582908186&usePUB=true [accessed 04 July 2018].
[79] Ancestry.com, *England & Wales, Civil Registration Death Index, 1916-2007* [database on-line], https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7579&h=15439652&ssrc=pt&tid=89121375&pid=48582908186&usePUB=true [accessed 04 July 2018].
[80] *Carlisle Patriot,* 8 July 1898; The National Archives (TNA), *Cumberland Summer Assizes, 1898*, ASSI/52/38.
[81] CACC, *Tenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1871*, THOS 8/1/3/1/9, p. 15.

mental health was hugely important. Of particular concern was the fact that Michael was continually referred to as dangerous and violent in his case notes, which seem to have also failed to have been taken in account. This section has explored how overcrowding affected the patients in the nineteenth-century, and how it could adversely affect the staff. Next, the chapter shall move onto examine how the situation intensified beyond the turn of the twentieth-century.

Intensification, 1902-1913



Presented to the Lunacy Committee, 28th April, 1902.

MEMORANDUM

ON

The Increasing Pressure on the Accommodation

AT

GARLANDS ASYLUM,

BY

W. F. FARQUHARSON, M.D.,

Medical Superintendent.

CARLISLE:
CHAS. THURNAM & SONS, STEAM PRINTERS, ENGLISH STREET.
1902.

Fig 3.3. 'The Increasing Pressure on the Accommodation at Garlands Asylum', 1902[82]

By 1902, the issue had reached such a pitch that Dr Farqharson wrote a ten page memorandum to the local Lunacy Committee detailing the problem of overcrowding at Garlands. Between 1883 and 1902 the number of daily average patients had risen from

[82] CACC, W. Farquharson, *Memorandum on Pressure on Accommodation at Garlands, 1902*, DHOD/11/102.

536 to 688. This had pushed the Asylum to bursting point and four temporary beds had to be put up on the male side to accommodate the extra patients. The need for space had forced Farquharson to remove some chronic cases to the workhouse, a move which, as discussed above, would have caused even more suffering. However, he ruled out transferring the private patients as they 'provide a legitimate profit to the two counties', which was quite the reverse attitude of previous superintendents who advocated the removal of those who paid for treatment. Farquharson requested permission to build an extension big enough to house 150 patients. He justified the size by stating that no new buildings will be required for at least fifteen years, and that any empty beds could be filled with out-county patients from other overcrowded asylums for profit. He went on further by explaining that the new extension would be solely for the 'most recent and curable cases of insanity'; because the large number of chronic patients were making it impossible to separate the curable from the incurable.[83] This would also have made it difficult for the attendants and himself to properly treat each patient as they would not have the necessary space.[84] By this stage, medical superintendents were in an irrevocable trap. Their asylums had become too big to effectively deliver curative methods of treatment, but they had to request extensions because there were ever more cases being admitted.

In the wider community, at the same time as Farquharson's memorandum, conversations were circulating in the local press concerning the need to build a separate institution to care for those suffering from imbecility, and deemed incurable.[85] Many believed this would resolve the issue of overcrowding in Garlands, and that it could be reserved for the treatment of recent cases of insanity, something which was constantly reiterated in the annual reports. As stated previously in the chapter, by this date, many counties already had more than one lunatic institution, therefore, the demand for another in Cumberland and Westmorland did not seem beyond the realm of possibility.

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[83] Ibid.

[84] Francis Scott stated at the 1877 select committee on the operation of lunacy law, it was 'totally impossible' for the asylum staff to do more than know the patients by name, evidence of Sir Francis Scott, S*elect Committee on the Operation of Lunacy Law,* 1877, p. 389, in Scull, *Most Solitary of Afflictions,* p. 285.

[85] Similar debates were common in all counties at this time. Michael found that the same was true for Denbigh when overcrowding was particularly unrelenting, Michael, *Care and Treatment,* p. 97.

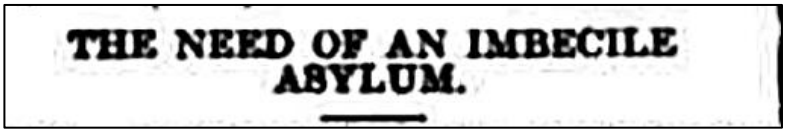
THE NEED OF AN IMBECILE ASYLUM.

Fig. 3.4. 'The Need of an Imbecile Asylum', 1902.[86]

Figure 3.4 is an example of one of many articles that appeared in local newspapers. The debate surrounding separate provision can be traced back to 1895, which had arisen out of the large number of imbeciles being transferred to workhouses. The high number of incurable insane in their wards had attracted attention, and led to the demand for a separate institution. One article detailed a meeting of the Whitehaven Board of Guardians, in which the 'inadequate accommodation' at Cockermouth Workhouse was brought to their attention. The reason was explicitly stated: 'There had been some imbeciles sent from Garlands and the small room at the workhouse was very much overcrowded'. The article even reported that it was 'disgraceful' that such unsuitable accommodation was provided.[87] This demonstrates that the overcrowding of Garlands had a much wider effect, as it fed into other institutions, and resulted in inadequate care being given.[88] An article printed in late 1902 put an end to the demands for a separate institution, as it declared the motion had been 'abandoned' due to the fact that only four Unions were prepared to discuss the matter.[89]

Farquharson highlighted in 1903 that the problem of overcrowding and the perceived increase of insanity was not unique to Garlands. He stated that in nearby West Riding, Yorkshire, the increase had been so marked in this period that the County Council were putting together a petition to present to the King, with the view to appointing a Royal Commission to investigate the causes of such an increase, and how best to deal with it. With the issue 'steadily becoming more serious' at Garlands, a temporary male dormitory was created in the rooms above the Asylum workshops. These helped to alleviate the pressure of overcrowding, which was now so severe that there were 64 extra patients than capacity would allow for.[90] However, as observed by

[86] 'The Need of an Imbecile Asylum', *The Maryport Advertiser,* 1 October 1902.
[87] 'The Imbecile Accommodation', *The West Cumberland Times,* 18 February 1899.
[88] This issue will be fully explored in chapter four.
[89] 'The Proposed Imbecile Home', *The West Cumberland Times,* 22 October 1902.
[90] CACC, *Forty-Second Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1903*, THOS 8/1/3/1/41, p. 9.

the Commissioners in Lunacy on their visit in 1904, the workshop below this temporary dormitory contained knives which were kept in open trays, rather than in locked drawers or boxes,[91] which posed a great risk to the patients and staff who were living and working in this area. In addition, Farquharson reported that the reason for the increase in the number of deaths from tuberculosis was: 'Probably the overcrowding of the Asylum, and the absence of proper means of segregating patients with tubercular disease, have contributed to the increased amount of this disease'.[92] The deaths attributable to tuberculosis amounted to 20.8%, whereas the average for other English asylums in 1904 was 17.5%.[93] Furthermore, the increase in patients was not met by an equal increase in staff to cope with the larger numbers, once again due to the lack of space to accommodate any additional resident attendants.[94] This stretched their curative capabilities to the absolute limit, resulting in palliative care rather than actively trying to cure the patients. The full implications of staff shortages will be examined in the next chapter.

Not until 1907 were two new hospital blocks completed, each able to accommodate 76 patients of each sex. Also constructed alongside the new blocks were separate accommodation for another resident medical officer; a new patient recreation hall; bedrooms, mess rooms and recreation rooms for attendants and nurses; a surgery room; an examination room; a pathological room, and a photography studio. Most importantly to alleviate the high percentage of deaths from tuberculosis, the new hospital blocks were 'provided with shut-off wards for tuberculosis cases', which had since 1906 accounted for 24% of deaths in the Asylum.[95] Following on from the previous chapter, which investigated the importance of the Dunston Lodge, it is clear from the records that the relationship between the establishments continued. Examining the ongoing transferral of patients between the two asylums in times of respective overcrowding, is a new area of exploration which has not been previously looked at in such detail by historians of the period. Instead, county lunatic institutions have been explored in an insular way, as a standalone establishment which was the product of its

[91] CACC, *Forty-Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1904*, THOS 8/1/3/1/42, p. 8.
[92] Ibid., THOS 8/1/3/1/42, p. 14.
[93] CACC, *Forty-Fourth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1905*, THOS 8/1/3/1/43, p. 15.
[94] *Annual Report 1904*, pp. 14-15.
[95] CACC, *Forty-Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1907*, THOS 8/1/3/1/45, p. 7, p. 9.

own fortunes. Despite the respite from overcrowding for the first time in ten years, Garlands accepted 55 patients (40 female and 15 male) from Gateshead Town Council, to be transferred from Dunston Lodge. Empty beds were not profitable to the Asylum authorities, and were, as can be seen, filled up with higher-paying patients when the space allowed. This agreement carried with it a number of stipulations, specifically in regard to the class of patient being transferred:

> The receiving Committee shall not be bound to receive into the said Asylum any lunatic affected with any contagious or infectious disease or malady or any lunatic who is paralysed or suicidal or habitually violent or destructive or dirty in habits and the patients received shall not include more than seven males and fifteen females who are epileptic or require continuous night supervision.[96]

The patients that were to be received into Garlands should afford no additional strain on their attendants and nurses, and warrant no special treatment. This provides a fascinating insight into the motivations of superintendents in choosing suitable cases to be transferred elsewhere. As well as having a say in who may be moved out of the Asylum, they also had stipulations for cases being brought in. This is a key element in addressing the gap in the literature concerning circulation, and one that will be explored fully in chapter six.

The agreement for treating the transferred patients was for a period of three years, and in 1910, due to Garlands still having available beds, was renewed. However, this was only on the understanding laid out in a letter dated 25 May 1910 from Farquharson to the Gateshead Committee:

> the Committee are prepared to enter into an agreement for a further period of three years from 30 Sept. 1910, provided 5 males and 5 females of the present number are removed from the Garlands Asylum on that date.

[96] CACC, *Memorandum of Agreement 1907,* THOS 8/1/8/5/36.

> Another 5 males on 30 Sept. 1911 and the remaining male patients on 30 Sept. 1912.[97]

This reduction in the number of patients is indicative that overcrowding had again become an issue, and that Garlands was having to forfeit some of its out-county patients. Despite the problem of being over capacity, the attendants, nurses and doctors of Garlands did not abandon the regime of moral treatment, as the Commissioners in Lunacy remarked in their annual report in 1910: 'No use of mechanical restraint or seclusion has been recorded since the last visit'.[98] The use of restraint will be explained in detail in the next chapter. The agreement with Gateshead remained in place until, in February 1913, Farquharson had to request the early removal of certain patients:

> I regret to inform you that there has been an influx of female patients to our asylum, and we are so overcrowded that we would very much obliged if you could make arrangements to transfer 10 of your female patients at an early date.[99]

Thus, overcrowding in Garlands had become such a problem that they could not fulfil the terms of the agreement. In fact, by 1913, the number of those resident in Garlands had reached 871, when its patient capacity stood at 871, including those kept in the hospital blocks. Therefore, the cycle of overcrowding was once again repeating itself, and the extension completed in 1907 for which Farquharson had promised would not be exceeded for fifteen years, had become inadequate. From this section, a sense of the desperation of the superintendent to secure adequate extensions to their asylum in times of increased pressure has been ascertained. It is clear that the nature of overcrowding had again come full circle, and that Garlands would require extending further to meet increasing admissions. This

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[97] CACC, *Correspondence between the Cumberland and Westmorland Asylum and Gateshead Town Council relating to overcrowding at the Garlands and the removal of patients,* THOS 8/4/82/13, Letter dated 25 May 1910.
[98] CACC, *Forty-Ninth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1910,* THOS 8/1/3/1/48, p. 8.
[99] CACC, *Correspondence between the Cumberland and Westmorland Asylum and Gateshead Town Council*, THOS 8/4/82/13, Letter dated 10 February 1913.

also demonstrated that the tide of lunacy failed to be stemmed, and that the therapeutic optimism of the county asylums were falling short.

Conclusion

From the exploration in this chapter, it is apparent that Garlands suffered severe overcrowding at a number of different stages throughout the period from its opening in 1862 to 1902 when Farquharson wrote his memorandum, and also in the years following, until the 1913 Mental Deficiency Act. As with most other county institutions at this time, for 23 of its initial 51 year period, it was over capacity. The numerous pleas of the successive medical superintendents for extensions to accommodate the growing number of admissions, have been presented chronologically to give a sense of the unrelenting pressure and burden that an increasing number of patients placed on them and their ability to carry out treatment. From its second year, the Garland's resources were continually stretched, with several building extensions only offering temporary respite. The consequence of such overcrowding was that not all cases of pauper insanity were able to be treated in a uniform manner.

This chapter has sought to address the identified gap of the pauper experience, as the stories of some of the patients that experienced the consequences of overcrowding at Garlands have been shared. Those who were at the forefront of the compromises in care made when in a situation of overcrowding are important, and must be recounted to provide a comprehensive understanding of the problem. Although only a small number of patient examples have been presented here, more will be examined in chapters four and six, which represent the issue that was so widely experienced in the sample, and the entire Asylum population. The disparate nature of care received by mentally unwell paupers in this period was solely in the hands of the relieving officers and the medical superintendents. Once it became apparent that the numbers of the insane far exceeded the capacity of the new county asylums, those suffering from chronic mental illness, and perceived by the authorities to be harmless, were transferred elsewhere to receive a substandard level of care, as compared to their counterparts deemed to be recent cases, and perceived as dangerous. This defeated the purpose with which the asylums were built to fulfil.

In this context, taking into account the research of this chapter, it is clear that mentally unwell paupers who were advocated asylum provision were circulated in an attempt to alleviate the issue, but instead were further damaged by the transitioning

nature of care in this era. The quote in the title of this chapter – 'the evils resulting from overcrowding' – summarizes the effect it had on the pauper patients, as rarely was the outcome positive. By examining those who experienced it at the lowest level, and using examples from the sample, this chapter has addressed two of the identified gaps in the historiography. Placing the pauper experience at the heart, as will be done throughout, the real impact of overcrowding and its role in circulation has been laid out. The next chapter will build upon what has been presented here and will go further to explore the moral treatment received by the patients. Specifically, the focus will be on how this was compromised by the constant shifting of patients in and out of Garlands, which was a result of overcrowding. It will also demonstrate how the burden on staff and resources effected the patient's treatment and experience. Thus, circulation had an impact on all areas of asylum life, most notably that on the patients.

Chapter Four: Moral Treatment

The better dietary and regular outdoor exercise strengthen the bodily health, and consequently lessen the mental irritability; the discipline of the house and the efforts of the attendants improve the habits and induce the patient to employ himself usefully; the means of amusement and recreation rouse whatever mental power still remains, and may even call up the long unfelt sense of conscious happiness and enjoyment of life.[1]

Overview

During the nineteenth-century, philanthropic efforts increasingly emerged in response to the need to support those who society did not; primarily, individuals burdened with poverty, illness, disability, and destitution. Private charities were created to provide social welfare on an individual basis. These were almost exclusively offered by the middle and upper-classes via a moral framework which reflected Victorian virtues.[2] This rhetoric was carried over to the new county asylums, as they strove to offer a departure from the supposed terrible conditions in the old madhouses.[3] As mentioned in the introductory chapter, the emergence of moral treatment reflected the increasing concern amongst policy-makers, and the wider public, for the welfare of the insane.[4] In reality, it was among a the small amount of treatment asylums could offer, as there was

[1] CACC, *Second Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1863*, THOS 8/1/3/1/1, p. 9.
[2] D. Owen, *English Philanthropy, 1660-1960* (London: Oxford University Press, 1965), p. 211. See also S. Lloyd, *Charity and Poverty in England, c.1680-1820: wild and visionary schemes* (Manchester: Manchester University Press, 2009).
[3] Although, Andrew Scull and Michel Foucault, among others, argue that asylums were constructed to control the deviant. See discussion in chapter one.
[4] 1815-1816 Parliamentary Enquiry was borne out of abuses uncovered at the York Asylum and Bethlem, A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Yale University Press, 1993), p. 115; A. Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (London: University of California Press, 2006), p. 115.

little understanding of mental illness, and no cure.[5] This chapter will explain fully the regime of care that was outlined in chapter two, and will assess the impact of moral treatment at Garlands.[6] The chapter will also build on the previous one, to explore in detail how treatment could be compromised, and will examine the implications this had for the patients, addressing the identified gap of the pauper experience.

With little understanding of the workings of the mind, medical superintendents focussed on treating the physical symptoms, and provided diversionary 'moral' therapy. Central to this was a rigid routine cemented through discipline to employ the patient's sane senses, to eradicate the depressed and disordered ones.[7] However, as has been outlined in the previous chapter, when the number of insane persons grew, asylum resources became strained; the 'crucial features of moral treatment' began to disappear, and it became impossible for doctors to deliver more than custodial care.[8] Superintendents who found it difficult to cope with an abundance of cases resorted to using drugs to restrain unruly individuals, and relied upon secluding excited patients in locked padded cells.[9] Failure to comply with moral treatment could result in prosecution, for staff members, under the various Lunacy Acts, as standards were rigidly inspected by the Commissioners.[10] As also seen in the previous chapter, overcrowding meant that patients deemed harmless were removed to workhouses to receive care,[11] which could negatively impact those under treatment.

Existing histories of asylums, include a description of the regime and how it was run under the ideals of moral treatment, but they have not considered in detail its

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[5] Medical treatments also employed in asylums, for more information see L. D. Smith, *"Cure, Comfort and Safe Custody": Public Lunatic Asylums in Early Nineteenth Century England* (London: Leicester University Press, 1999), pp. 187-226. The psychosomatic approach stated that mental and physical ailments were inextricably linked, E. Stainbrook, 'Psychosomatic Medicine in the Nineteenth Century', in J. D. Sutherland (ed.), *Evolution of Psychosomatic Concepts: Anorexia Nervosa: A Paradigm* (London: The Hogarth Press, 1965), p. 7.

[6] As outlined in chapter one, moral treatment referred to methods used to psychologically treat patients, see A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), chapter three, pp. 33-56.

[7] W. A. F. Browne, 'The Moral Treatment of the Insane; a lecture', *Journal of Mental Science,* 10:51 (1864), pp. 309-15.

[8] Scull, *Most Solitary of Afflictions,* p. 277, and p. 279.

[9] A. Scull, *Museums of Madness: The Social Organization of Insanity in nineteenth-century England* (London: Allen Lane, 1979), p. 203.

[10] For instance, Dr Maddock, proprietor of the West Malling Place Asylum, was fined 50*l* for not correctly recording instances of mechanical restraint, Commissioners in Lunacy, *Sixth Annual Report to the Lord Chancellor,* (1851), p. 19.

[11] D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001), p. 17; See also D. Hirst and P. Michael, 'Family, Community and the lunatic in mid-nineteenth century North Wales', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 65-85.

impact on the ordinary patients once this became compromised in times of increased overcrowding and circulation. For instance, in Pamela Michael's examination of Denbigh she outlined all the key aspects of moral treatment that were employed to attempt to facilitate the recovery of the patients, and that a 'therapeutic regime' was enveloped in all areas of the asylum.[12] She explained the incidence of mechanical restraint and seclusion due to overcrowding; 'as the hospital became more crowded, and the ratio to staff to patients worsened, there was increasing reliance on seclusion as a tactic in the management of difficult patients'.[13] Steven Cherry explained that a therapeutic regime, which centred on non-restraint, was adopted at Norfolk as early as the 1840s.[14] He described the diet, exercise, useful employment, and recreational activities offered, and highlighted the problems of overcrowding to the effectiveness of moral treatment through staff shortages, and that the behaviour of attendants in these circumstances was a cause for concern.[15] A gap, therefore, exists in bringing the pauper experience to the forefront, linking the ability of the asylum to carry out moral treatment when the movement of patients between institutions was particularly accelerated. Building on previous research, it is this area which the exploration of this chapter shall begin to fill, and will be presented fully in chapter six.

To begin with, the chapter will describe how moral treatment was delivered in Garlands, in much greater depth than was outlined in chapter two, using, predominantly, the annual reports and patient casebooks. This section, although confirming the perspectives of the existing literature, will give an insight into the delivery of care in an institution not previously researched. A sense of the large responsibility placed on the lay members of staff will be outlined. The second section will develop the crux of the argument to be presented in this chapter; that moral treatment was compromised in a number of situations. Using patient records as evidence, the ability of asylum staff to treat each individual will be examined. A sense of the pauper experience, in terms of treatment, can be understood through this chapter, which adds to the whole contribution to the gap addressed in the wider thesis. The effect which circulation, specifically, had on this, although outlined here, will be analysed in chapter six, to offer a rounded view of the factors involved in patient

[12] P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003), p. 69
[13] Ibid., p. 86.
[14] S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998* (Woodbridge: Boydell Press, 2003), p. 55.
[15] Ibid., p. 64.

transfer. The final section will provide an analysis of the effectiveness of moral treatment, particularly in an era of increased patient circulation, and the over-burdening of staff. The chapter shall begin by examining the moral methods employed at Garlands.

Moral Treatment at Garlands

The precedent for moral treatment at Garlands was set out in the first annual report by Dr Clouston, a passage of which has been provided at the beginning of this chapter. It was believed that, through usefully employing the patient during their stay in an asylum, their mind would be diverted from the thoughts which had impaired their judgement, causing the weakening of their mental health. The Garlands moral regime was further cemented in the 1870 rules and regulations, which stated that; 'the medical and moral treatment of the individual cases especially of the recent and curable cases be the first duty of the medical officers'.[16] Central to delivering this were the ordinary attendants and nurses. Demands of the role were high, and training was not a formal requirement.[17] In the final quarter of the nineteenth-century, this began to be addressed, as the *Handbook for the Instruction of Attendants on the insane* was issued to all lay asylum staff.[18] The book outlined that the core role of an attendant was to, 'supervise the patients without the aid of locked doors'. Among their many tasks would be; 'raising the patients, the serving of meals, the bathing of patients, and their supervision when at work or talking walking exercise'. The importance of following the routine was also reinforced in terms of its positive effects: 'The regular hours for rising, taking food, work, exercise, amusement, and retiring to bed, are beneficial not only to the bodily health, but also to the mental state in making the patient lead a regular life and educating him in good habits'.[19] This section will explore the facets of Garland's regime which the attendants and doctors had to ensure were available, and the effect this could have on the patients. Among its many facets, four aspects of treatment will

[16] CACC, *General Rules for the Government of the Asylum, 1870*, THOS 8/1/1/3.
[17] J. Walton, 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-1870', in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 166-97.
[18] Despite this, there was no training requirement for attendants and nurses until the 1930s. N. McCrae and P. Nolan, *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors* (London: Routledge, 2016).
[19] A. Campbell Clark, C. McIvor Campbell, A. R. Turnbull, and A. R. Urquhart, *Handbook for the Instruction of Attendants on the Insane* (London: Baillièrè, Tindall & Cox, 1885), pp. 48-50.

be examined: useful employment, recreational pursuits, diet, and religion.[20] Each of these will be considered in turn to assess their use in Garlands, an unrepresented institution in the historiography.

First, as outlined in chapter two, patients were employed in tasks to help the day-to-day upkeep of the institution.[21] Typically, males would carry out labouring activities such as, helping with the running of asylum farm land, fixing and making items used around the asylum. Women would be employed in the domestic, completing jobs such as laundry, housekeeping, and cooking.[22] More broadly, the occupation of the mind in tasks vital to the running of the asylum was believed to aid recovery,[23] and work became one of the main therapeutic tools in lunatic institutions.[24] Clouston stipulated that, 'regular work for both mind and body will do much to counteract the ill effects of the associations of the persons, places, and circumstances that were connected with the original outbreak of the malady.'[25]

The employment of patients became criteria on which asylums were assessed by the Commissioners in Lunacy. Their annual reports included how many patients they observed to be employed, and in which tasks. The more patients who were usefully occupied, the better the treatment offered by the institution, as they were demonstrating their ability to be productive members of society.[26] For instance, in 1866, the Commissioners noted that in Garlands: 'About 108 of the men work on the land or at trades, and in assisting the wards. Of the women, between 60 and 70 are regularly employed in the kitchen and laundry, or in needlework and household duties'.[27] Employment was also an important way of keeping finances afloat, as outlined in chapter one. Food which had been cultivated on asylum land, and furniture and textiles

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[20] Other aspects of moral treatment that have been researched include 'non-restraint' and the classification of patients. See Digby, *Madness, Morality and Medicine*, p. 82 and 135. Diet can also be considered to have been a medicinal treatment. See Smith, *Cure, Comfort and Safe Custody*, pp. 194-7.
[21] See L. Smith, '"A Powerful Agent in their recovery": Work as treatment in British West Indian lunatic asylums, 1860-1910', in W. Ernst (ed.) *Work, Psychiatry and Society, c. 1750-2015* (Manchester: Manchester University Press, 2016), pp. 142-162.
[22] A. Digby, 'Moral Treatment at the Retreat, 1796-1846', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II* (London: Tavistock Publications, 1985), pp. 52-72.
[23] J. Pettigrew, R. W. Reynolds, and S. Rose, *A Place in the Country: Three Counties Asylum 1860-1988* (Bedford: University of Hertfordshire Press, 1998), p. 62.
[24] See W. Ernst, '"Useful to both the patients as well as to the State": Patient work in colonial mental hospitals in South Asia, c. 1818-1948' in W. Ernst (ed.) *Work, Psychiatry and Society, c. 1750-2015* (Manchester: Manchester University Press, 2016), pp. 117-41.
[25] *Annual Report 1863*, pp. 11-12.
[26] Scull, *Most Solitary of Afflictions*, p. 288.
[27] CACC, *Fifth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1866*, THOS 8/1/3/1/4, p. 8.

that had been crafted by inmates were all valuable contributions that eased the economic pressure.[28] For instance, Clouston noted: 'all the carpenter work required in the house has been done by ourselves,'[29] and that 'one of the dormitories in the female division was entirely papered by the women themselves'.[30] Therefore, employment was useful in maintaining the 'efficiency of the Institution.'[31] The importance can be seen from the value placed on hiring specific attendants to assist with the various workshops provided in the Asylum. In 1882, Garlands employed, a full-time tailor, engineer, carpenter, joiner, baker, farm bailiff, gardener, and two general labourers.[32] This was in addition to the nurses and attendants who administered the general care of the patients. Thus, great value was placed financially to ensure that the patients were employed during their periods of treatment.

Secondly, recreational pursuits and leisure activities were encouraged, and were used as a supplement to employment.[33] Patients who could not, or were not, permitted to be usefully employed were provided with other distractions as a form of therapy. A 'library and an abundant supply of newspapers and periodical publications' were offered.[34] For women, craft materials such as knitting and needlework were also available.[35] The Asylum regularly invited a number of visitors to entertain the patients, these included choirs, drama groups, guest speakers and other performers such as ventriloquists. Each fortnight a dance would take place, and special concerts were held during holidays such as Christmas and Easter.[36] Patients were also taken on trips to the seaside, to change their surroundings for a few hours. For instance, in 1897 Dr Campbell stated that a grateful former patient donated £5 per year to the Asylum to facilitate a small number to visit Silloth for the day: '60 female patients were enabled to

[28] Wright, *Mental Disability in Victorian England*, p. 149.
[29] *Annual Report 1863*, p. 13.
[30] *Annual Report 1866*, p. 8.
[31] *Annual Report 1863*, p. 12.
[32] CACC, *Account of Weekly Wages Paid to Named Staff, 1882-1896*, THOS 8/2/7/6, p. 7. Similarly, Cherry noted that at Norfolk, tradesmen were employed to direct the patients in glazing, plumbing, upholstery, and smithery, Cherry, *Mental Health Care*, p. 66.
[33] Smith, *Cure, Comfort and Safe Custody*, p. 239.
[34] *Annual Report 1863*, p. 13.
[35] CACC, *General Rules for the Government of the Asylum, 1870*, THOS 8/1/1/3.
[36] *Annual Report 1863*, p. 13. Gladstone described how at the Western Counties Idiot Asylum, in 1880, on two evenings each week, there would be 'music and dancing', and there would be frequent 'visits by conjurers, pantomime performers and a Welsh male voice choir', D. Gladstone, 'The Changing Dynamic of Institutional Care: The Western Counties Idiot Asylum 1864-1914', in A. Digby and D. Wright (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London: Routledge, 1996), pp. 134-60.

have a pleasant outing, and enjoy the sea breeze'.[37] Leisure activities were not just another method in which to distract the patients from their maladies, they also provided a routine around which to organise their institutional lives. For one patient, Dr Farquharson described in 1906 his importance to the weekly activities, as during his 44 year stay in the Asylum, he had come to be relied upon in the various pursuits: 'He was one of the "characters" of Garlands; for many years he blew the organ in Church, said grace in the hall before and after meals, called out the dances at the weekly entertainments, and was a walking encyclopaedia of information'.[38] Thus, for some long-term patients, being given the opportunity to conduct such responsibility allowed them to adapt to institutional life. [39]

Thirdly, the importance of delivering a good diet to all patients was stressed, as proper nourishment was inscribed with curative properties.[40] Clouston believed that 'a good dinner has generally a far more soothing effect than any sedative'.[41] 'Bad and insufficient foods' were attributed to an individual's weakening health which could lead to insanity.[42] An above average dietary allowance was given to all patients, in comparison to that of working-class labourers on the outside, to combat the diminution of bodily power to aid the recovery of their mental wellbeing.[43] The Commissioners in Lunacy and Committee of Visitors regularly conducted inspections at mealtimes in particular, to comment on the standard of food offered and the effect it had on the patients.

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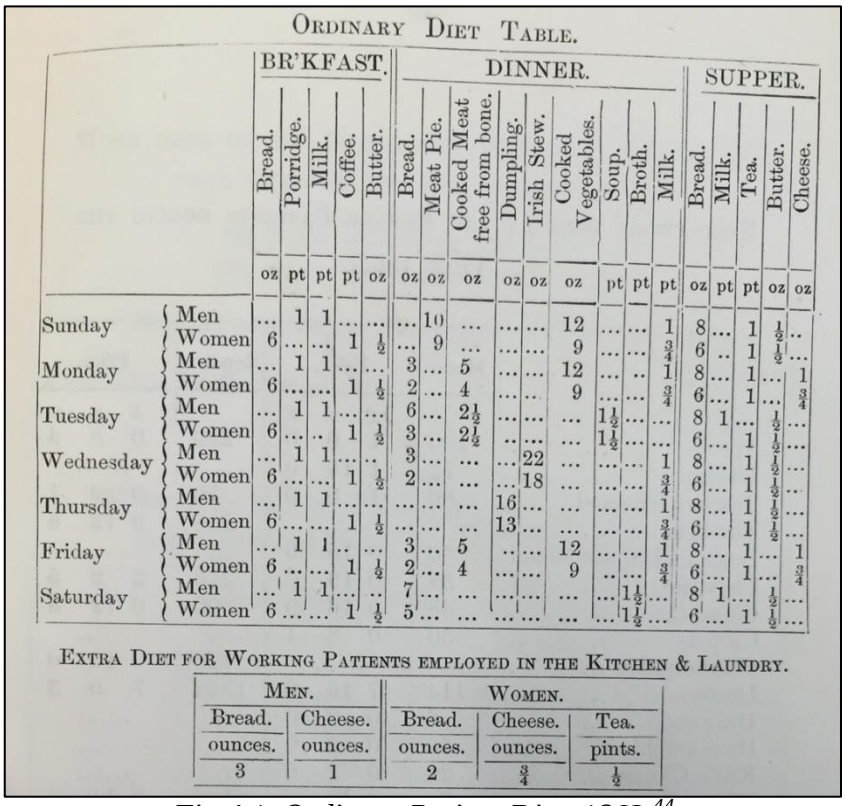
[37] CACC, *Thirty-Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1897*, THOS 8/1/3/1/35, pp. 10-15.
[38] CACC, *Forty-Fifth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1906*, THOS 8/1/3/1/44, pp. 13-14.
[39] Michael noted that for Denbigh, the annual ball became a high point in the institution's calendar, and regular dances such as these gave the most energetic patients the opportunity to channel their hyperactivity, Michael, *Care and Treatment*, pp. 72-3.
[40] I. Miller, 'Food, medicine and institutional life in the British Isles, c. 1790-1900', in C. Helstosky (ed.), *The Routledge History of Food* (London: Routledge, 2015), pp. 200-46.
[41] *Annual Report 1863*, quoted in C. Dobbing, 'An Undiscovered Victorian Institution of Care: A Short Introduction to the Cumberland and Westmorland Joint Lunatic Asylum', *Family and Community History*, 19:1 (2016), pp. 3-16.
[42] T. S. Clouston, *Clinical Lectures on Mental Diseases* (London: J & A Churchill, 1904), p. 483.
[43] CACC, *Ninth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1870*, THOS 8/1/3/1/8, p. 13. See also Cherry, *Mental Health Care*, pp. 76-7.



ORDINARY DIET TABLE.

		BR'KFAST.					DINNER.									SUPPER.				
		Bread.	Porridge.	Milk.	Coffee.	Butter.	Bread.	Meat Pie.	Cooked Meat free from bone.	Dumpling.	Irish Stew.	Cooked Vegetables.	Soup.	Broth.	Milk.	Bread.	Milk.	Tea.	Butter.	Cheese.
		oz	pt	pt	pt	oz	oz	oz	oz	oz	oz	oz	pt	pt	pt	oz	pt	pt	oz	oz
Sunday	Men	...	1	1	...	...	...	10	...	...	...	12	...	...	1	8	...	1	½	..
	Women	6	...	...	1	½	...	9	...	...	...	9	...	...	¾	6	..	1	½	...
Monday	Men	...	1	1	...	...	3	...	5	...	...	12	...	..	1	8	...	1	...	1
	Women	6	...	...	1	½	2	...	4	...	..	9	...	...	¾	6	...	1	...	¾
Tuesday	Men	...	1	1	...	...	6	...	2½	...	...	...	1½	...	...	8	1	...	½	...
	Women	6	...	..	1	½	3	...	2½	..	...	...	1½	...	...	6	...	1	½	...
Wednesday	Men	...	1	1	...	..	3	...	...	...	22	...	...	...	1	8	...	1	½	...
	Women	6	...	...	1	½	2	...	...	...	18	...	...	...	¾	6	...	1	½	..
Thursday	Men	...	1	1	...	...	...	...	...	16	...	...	...	...	1	8	...	1	½	...
	Women	6	...	...	1	½	...	...	...	13	...	...	...	...	¾	6	...	1	½	...
Friday	Men	...	1	1	..	...	3	...	5	..	...	12	...	...	1	8	...	1	...	1
	Women	6	...	...	1	½	2	...	4	...	...	9	..	...	¾	6	...	1	...	¾
Saturday	Men	...	1	1	...	..	7	...	...	...	...	...	...	1½	...	8	1	...	½	...
	Women	6	...	...	1	½	5	...	...	...	...	...	...	1½	...	6	...	1	½	...

EXTRA DIET FOR WORKING PATIENTS EMPLOYED IN THE KITCHEN & LAUNDRY.

MEN.		WOMEN.		
Bread.	Cheese.	Bread.	Cheese.	Tea.
ounces.	ounces.	ounces.	ounces.	pints.
3	1	2	¾	½

Fig 4.1. Ordinary Patient Diet, 1863.[44]

As seen in figure 4.1, the Asylum diet was varied, albeit in a rigid, weekly format.[45] Male patients received slightly more than the females, and some meals were different for each sex.[46] Meals were adapted depending on the time of the year, with meat pies being substituted for rhubarb and gooseberry ones in summer.[47] The printing of the diet in the annual reports demonstrates that this was an important aspect of Asylum life. For instance, the Commissioners would comment on visits: 'There were today 91 men and 82 women dining together in the hall, and the dinner of soup, with fresh meat and potatoes, which was well served and in good taste, seemed to meet with general approbation'.[48] Although alcohol was not allotted as part of the ordinary diet, as outlined in chapter two, in some cases beer was 'specially ordered at the discretion of

[44] *Annual Report 1863*, p. 33.
[45] Much like the workhouse diet, I. Miller, 'Feeding in the Workhouse: The Institutional and Ideological Functions of Food in Britain, ca. 1834-70', *Journal of British Studies,* 52:4 (2013), pp. 940-62.
[46] This was 'to take account of the perceived differing physical needs', Smith, *Cure, Comfort and Safe Custody*, p. 165.
[47] *Annual Report 1863*, p. 33.
[48] CACC, *Sixteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1877*, THOS 8/1/3/1/15, p. 9.

the superintendent in all cases where he deems it necessary'.[49] In the absence of an alternative treatment, those suffering from, for instance, feeble-mindedness, hysteria, or neuralgia, alcohol would be prescribed to improve patient's plight.[50] Alcohol was also allowed in times of national celebration. In 1897 all patients were granted a special provision of a pint of beer with their dinner to toast Queen Victoria's golden jubilee.[51] Garlands was one of the pioneers of the absence of alcohol, as widespread adoption of this policy did not occur until the 1880s.[52]

Finally, one additional element used to treat patients was religion.[53] Daily prayers and regular Sunday sermons were delivered in chapels purposely built in the asylum. The belief in a higher being promoted confidence within a patient to encourage self-restraint and to banish any destructive thoughts they may have.[54] Religious mania, as detailed in chapter two, was a cause of insanity, thus utilising religion to stabilise the mentally unbalanced could be beneficial. Clouston noted in 1863 the 'soothing and elevating effect' of religious services as they promoted 'the good order and discipline of the house'.[55] It was stated in the rules of the Asylum that one aspect of the chaplain's role was to 'administer consolation to persons the superintendent believes to be of benefit'.[56] The conduct of religious ceremonies and the percentage of patients that regularly attended were additional criteria on which asylums were assessed. Regular services had the additional benefit of communal activity.[57] Both sexes worshipped side by side, and it was one of the few opportunities for socialisation. The ability to behave well in an orderly manner, was commented on in a patient's case notes and was used to judge their recovery.[58] Different religions were also catered for. From 1886 Roman

[49] CACC, *Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1867*, THOS 8/1/3/1/5, p. 9.
[50] Z. Cope, *Past and Present Views of the Use of Alcohol* (London: Temperance Alliance, 1954), in N. McCrae, 'The Beer ration in Victorian Asylums', *History of Psychiatry*, 15:2 (2004), pp. 155-75.
[51] *Annual Report 1897*, p. 13.
[52] McCrae, 'The Beer ration', p. 168.
[53] L. J. Ray, 'Models of Madness in Victorian asylum Practice', *European Journal of Sociology*, 22:2 (1981), pp. 229-64. See also, Smith, *Cure, Comfort and Safe Custody*, p. 209.
[54] M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London: Routledge, 2001), p. 244.
[55] *Annual Report 1863*, p. 14.
[56] CACC, *Rules and regulations for the management of the Cumberland and Westmorland Asylum, Garlands, 1861*, THOS 8/1/1/1.
[57] Michael, *Care and Treatment*, p. 88.
[58] Cherry stated the 'spiritual comfort' derived from religious services, and that three-quarters of the patients at the Norfolk Asylum were expected to attend regularly, Cherry, *Mental Health Care*, p. 106.

Catholic services were carried out by a visiting Priest, to satisfy the growing number of patients of that particular faith, which will be examined in further depth in chapter six.[59]

When all the aspects of treatment were routinely employed, patients could respond well to the regime. For instance, Catherine B, from the sample seemed to forget her condition at the weekly dance. On 17 April 1885 it was reported in her case notes:

> Wanders about the ward moaning and groaning wretchedly. The only occasion in which she appears to forget her troubles is at the weekly dance, when she brightens up wonderfully. Laughs heartily and industriously goes round the hall... Labouring hard often to teach others the steps and educate her fellow patients who require it.

Suffering with mania, which had caused her to attempt to commit suicide before and during treatment, Catherine therefore benefitted greatly from the recreational pursuits offered. The weekly dances, however, were only a distraction, as she continued to suffer from suicidal thoughts, delusions and violent behaviour.[60] It was not just the attraction of different activities which encouraged the improvement in the conditions of the patients. Clouston reinforced the value attached to being in an institution free of locks and means of restraint. Simply being permitted, and trusted, to roam the grounds, was enough to soothe the most afflicted patients: 'They feel they are not prisoners…walks are much enjoyed by them'.[61] Thus, when it came to leaving Garlands patients were sometimes reluctant to return home, as Campbell noted in 1887; 'the disinclination many patients have shown to leave the asylum, shows that the efforts made to treat the inmates justly and kindly, and to render their life here pleasant and enjoyable, have been successful'.[62] To offer a contrasting view, the chapter will move on to examine what happened when treatment failed to be effectively employed, and how this impacted the patients.

The Compromise of Treatment

[59] *Annual Report 1887*, p. 8.
[60] CACC, *Female Casebook 1884-1888*, THOS 8/4/40/1, admission no. 2662.
[61] CACC, *Annual Report 1863*, THOS 8/1/3/1/1, p. 14.
[62] CACC, *Twenty-Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1887*, THOS 8/1/3/1/25, p. 20.

The aspects of treatment discussed in the previous section came to be compromised with the increased circulation of many of Garland's pauper patients. As outlined in the previous chapter, the growing pressure on the number of available beds, weakened the Asylum's ability to deliver a uniform standard of specialist care. Patients, who may have been cured following a continuous programme of recovery, were jeopardised and farmed out to other receptacles.[63] As seen in the previous chapter, this was recognised, and could be resisted by families. In addition to patient transfer, other factors have also been identified that could hinder the ability of staff to deliver a uniform standard of care. Six key areas have been identified which portray the compromise in the effectiveness of the moral regime.

First, following on from the discussion in the previous chapter, increasing patient admissions had the effect of weakening the asylum staff's resolve. Attendants and nurses were not required to be medically trained, and were among the lowest paid professions. In comparison to hospital nurses, who were highly regarded and better paid, in some quarters they were considered the 'scum of the earth', and they held little prospect for professional progression.[64] Long hours, low wages and a strict code of conduct, meant that high staff turnover was commonplace. Attendants were expected to work around twelve to fourteen hours a day, with only one day off a week.[65] Campbell admitted that the 'duties of attendants are arduous, anxious, trying to the temper, and frequently unpleasant'.[66] An increase in the number of patients was not always met by a greater number of staff to treat them. For instance, despite the extensions made only three years previous, in 1887 the attendant to patient ratio stood at one to 15.5 for the males, and one to fourteen for the females, which the Commissioners in Lunacy noted to be 'not numerically very strong'.[67] Although these numbers do not seem that different to the one to thirteen ratio in 1862 (as outlined in chapter two), the already heavily relied upon attendants, had even more vulnerable patients to deal with. The

[63] As seen in chapter two in the description of conditions at Kendal Workhouse in 1860. See also K. Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, c.1834-1900* (London: Bloomsbury, 2015).
[64] T. O. Wood, 'The Future of Asylum Nurses (Letter)', *The Asylum News,* 6:12 (1902), p. 127, quoted in N. Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890-1910', *Journal of Advanced Nursing,* 55:6 (2006), pp. 770-7.
[65] P. Nolan, *A History of Mental Health Nursing* (Cheltenham: Stanley Thomas Ltd, 1998), p. 49.
[66] CACC, *Seventeenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1878*, THOS 8/1/3/1/16, p. 15.
[67] *Annual Report 1887*, p. 8.

recommended ratio was given as one to ten, thus Garlands fell short of the standards set by the Commissioners.[68]

Considering the chronic tiredness, along with extremely challenging patients, it is unsurprising that instances of violence against patients occurred. The *Handbook for the Instruction of Attendants*, outlined clearly that: 'When it is necessary to use force, the Attendant should not…It is far better to summon assistance'.[69] Throughout the 1860s, increased efforts were made to stamp out attacks on patients, and attendants who were violent faced dismissal.[70] In 1865, Clouston sacked two attendants for their mismanagement. The first scolded a patient, and the second was 'dismissed for using a patient roughly'.[71] Not until the 1880s and 1890s was formal training introduced, but this was not a strict requirement.[72] In 1870, the Commissioners in Lunacy noted that on their annual visit to Garlands, several patients approached them complaining of the conduct of the attendants. One informed them that the attendants roughly treated those under their care; and another told them how 'he had been obliged to go into a filthy bath which had been used previously by two dirty patients, one of them with an ulcerated leg'.[73] Both complaints were dismissed on account of the attendants in question having already left employment of the Asylum. In another case, in 1880, the Lunacy Commissioners spoke with an epileptic patient who had been complaining that an attendant had twisted his arm. They reported; 'there was some truth in his statement…we think his [the attendant's] charge of the patients should be for some time closely supervised'.[74] Similarly, at Denbigh, the nurses, who were so heavily depended upon, suffered from a weakened morale and were more susceptible to losing their temper.[75] Thus, instances of violence towards the patients were not unheard of, which

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[68] CACC, *Forty-Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1907*, THOS 8/1/3/1/45, p. 14.
[69] Campbell Clark, et al., *Handbook*, p. 52.
[70] R. Hunter, 'The Rise and Fall of Mental Health Nursing', *The Lancet*, 267:6907 (1956), pp. 98-9, quoted in Nolan, *History of Mental Health*, p. 57.
[71] CACC, *Fourth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1865*, THOS 8/1/3/1/3, pp. 11-12.
[72] The first examination for the qualification of the Certificate of Proficiency in Nursing the Insane was sat in 1891, following two years of training, only 35 took part. Asylums put forward willing candidates. Nurses and Attendants were required to go to lectures in their own time, and to take on the expense of writing materials and text books. The qualification did not guarantee promotion, therefore properly trained staff were by no means the norm after the introduction of the Certificate. McCrae and Nolan, *The Story of Nursing*, pp. 71-2.
[73] *Annual Report 1870*, p. 9.
[74] CACC, *Nineteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1880*, THOS 8/1/3/1/18, p. 9.
[75] Michael found that one patient in 1901 showed the Committee of Visitors the extensive bruising across her chest she had suffered at the hands of the attendants, Michael, *Care and Treatment*, p. 102.

demonstrated the fragile resolve of the lay members of staff, and that the care could be compromised.

Second, staff negligence could have adverse effects on the care administered. Continually in the annual reports, there are accounts of injuries suffered by patients which could have been avoided through increased staffing and attention. For instance, as mentioned above, in 1865 a male paralytic patient was scalded by an attendant after being placed in a bath which was too hot. The burns induced an epileptic fit, from which he subsequently died. The attendant was struck off the Asylum books, and an inquest into the incident was held, which brought negative attention to Garlands from the Lunacy Commissioners, who asked serious questions of the standards of care being delivered. This instance of staff negligence occurred at a time when the Asylum was particularly overcrowded. The capacity of the institution stood at 200, but by the end of 1865, there were 239 resident. Thus, the increase in the number of patients put pressure on the attendants, which resulted in them compromising the standard of care being delivered, and, in this case, the result was fatal.[76] In 1890 the neglect of patients seemed to reach a high; four deaths, other than natural causes, were recorded. Two were suicides, one was an incident of a patient killing another, and the final case was an epileptic patient. The Commissioners in Lunacy reported that they were satisfied with the inquests of these incidents, but recommended that the procedure for observing suicidal patients be improved. As a result, Garlands employed two more attendants of each sex to prevent such tragic cases occurring.[77]

To demonstrate the how fatal staff negligence could be, on several occasions, suicidal patients succeeded in evading the attendant's gaze. Mary Ann W was admitted in May 1885 recorded as suffering with melancholia, and had been under treatment in Garlands five years previous. She was noted as harbouring suicidal thoughts, and was worried about the potential harm she may cause to herself or her children. It was noted that she expressed a desire to come to the Asylum, due to the fear of what she may do. Throughout her time in Garlands, Mary Ann was described as feeling restless, and attempted to injure herself on several occasions. For example in June 1885:

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[76] *Annual Report 1865*, p. 11. Similarly, the lack of night attendants specifically charged with observing the epileptic patients resulted in two deaths from suffocation in 1876, CACC, *Fifteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1876*, THOS 8/1/3/1/14, p. 9.
[77] CACC, *Twenty-Ninth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1890*, THOS 8/1/3/1/28, p. 9.

> while the attendant's back was turned she disappeared down the cellar stairs and, with a piece [of] tape, attempted to strangle herself. She was seen shortly after and no serious injury was observed, but she was noisy, listless, acutely depressed and struggled a great deal. Is sleeping close to attendant in observation dormitory.

When she showed signs of sufficient recovery, in December 1889, and her discharge was discussed, she became incredibly anxious: 'She said she did not yet feel sufficiently well and was anxious to be allowed to remain in the asylum a little longer'. It was this worry which preceded her suicide, which was detailed in the case notes:

> On Saturday and Sunday (14th and 15th December) she complained of headache and stayed in bed. Yesterday and this forenoon she went about her work as usual and was quite cheerful. She was seen and spoken to by Miss Fraser about 4 o'clock this afternoon and nothing peculiar in her manner was then noticed. A little before 6 pm this evening the medical officers were summoned to the coal cellar of the female infirmary where the dead body of this patient had just been discovered by an attendant. The body lay on its back on the coals, the arms laid across the body. A cut across the throat and liquid and clotted blood on the clothing and on the coals beside the body clearly indicated the cause of death. There was an ordinary attendant's table knife lying on the coals at the side of the body. The body was not cold, the muscles were flaccid. The cut is across the upper part of the throat, severing wind pipe and important vessels and death must have necessarily been rapid.

This passage demonstrates that determined patients could use the regime to achieve their aim of self-destruction. The significance of the attendant's knife is evidence of the neglect which occurred. A known suicidal patient was given sufficient freedom to succeed in her suicide. An inquest was held into Mary Ann's death, but 'no blame could be attached to any of the asylum officials'.[78] The event was detailed in the Commissioners in Lunacy annual report, however,

[78] CACC, *Female Casebook 1884-1888*, THOS 8/4/40/1, admission no. 2687. This case has been researched in addition to the patient sample.

interestingly, they omitted the knowledge of the attendant's knife that was found next to the body. Instead they stated: '[She] had access to the scullery, and is thought to have abstracted a knife from here with which she cut her throat'.[79] Therefore, blaming Mary Ann completely, and detaching themselves from the need to impose sanctions on those who neglected her.[80]

The third aspect which emblematises the compromise of moral treatment, is the use of mechanical restraint, despite the abandonment of patient brutality.[81] The 1890 Lunacy Act stated that 'instruments and appliances' must only be used as a last resort when patients displayed intent of injuring themselves or others.[82] Poor staffing meant that encouraging self-restraint, was difficult to practice.[83] The Commissioners of Lunacy, in their annual inspections would note how many patients, and for how long, had been under restraint and seclusion, as ascertained from the institution's mechanical restraint registers.[84] For instance, in 1877 it was noted:

> Restraint has been employed with 4 men, in three cases for surgical reasons; and in the remaining one, on fourteen occasions by means of a "polka," with sleeves attached, on account of violence. Fifteen men and 12 women have been secluded on 61 and 22 occasions respectively, and all on account of violence or excitement. The longest continuous period for which any patient has been secluded was 94 hours, and that on account of acute delirious excitement from general paralysis.[85]

From the register, it is clear that restraint and seclusion were used as a method of controlling patients, but not for the majority of cases. Instead they were used to control single, unruly individuals, for sometimes months at a time. Typically, mechanical restraint was administered using the strait-jacket, or a similar device called

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[79] Commissioners in Lunacy, *Forty-fourth Annual Report to the Lord Chancellor,* (1890), p. 80.
[80] For more on patient suicides, see S. York, 'Alienists, Attendants and the Containment of Suicide in Public Lunatic Asylums', *Social History of Medicine,* 25:2 (2012), pp. 324-42.
[81] Anne Digby stated that restraint by mechanical means was resorted to at The Retreat when all other aspects of moral management had been unsuccessful, Digby, *Madness, Morality and Medicine*, p. 79.
[82] K. Jones, *Mental Health and Social Policy, 1845-1959* (London: Rouledge & Kegan Paul, 1960), p. 9.
[83] Walton, 'The Treatment of Pauper Lunatics', p. 181.
[84] W. Parry-Jones, *The Trade in Lunacy: a study of private madhouses in England in the eighteenth and nineteenth centuries* (London: Routledge Kegan and Paul, 1972), p. 19.
[85] *Annual Report 1877*, pp. 8-9.

the polka, which had detachable sleeves.[86] Patients would be restrained to prevent themselves posing a danger to their own life or that of others. Surgical reasons were commonly cited, as some were prone to removing bandages of injuries they had incurred during fits of excitement, or would scratch and interfere with wounds, making them worse.[87] Even at the York Retreat, methods of seclusion and restraint were employed as they were regarded as an essential part of 'the principle of fear' which encouraged patients to exert self-control.[88] Table 4.1 shows how many patients, and for how long, were secluded and restrained each year throughout the patient sample. The duration of seclusion and restraint, as can be seen in the table, was only used in a small number of patients, and varied greatly in each case. For instance, in 1892, only four patients were recorded as being restrained, all on separate occasions. These numbers are somewhat similar to those recorded at Denbigh, as in 1886 the Lunacy Commissioners noted how: 'Fifteen males have been secluded on various occasions for a total of 1853 hours, two of them accounting for 1400 for the total hours. Fourteen women have been secluded 16 times for 76 hours'.[89]

Year	Seclusion	Mechanical Restraint
1884	4 men & 11 women secluded for a total of 292 hours.	1 man & 4 females restrained by sleeved polka for a total of 550 hours.
1885	Not mentioned in report.	Not mentioned in report.
1886	Not mentioned in report.	Not mentioned in report.
1887	4 men secluded for 144 hours, and 7 women for 209 hours.	2 patients of each sex restrained by jacket for periods ranging from 24 hours to 17 days.
1888	10 men secluded for 121 hours.	3 men restrained on 52 occasions for 2225.75 hours.
1889	4 men secluded for 296 hours.	3 men restrained by polka, 2 of them also by sheets.
1890	3 men secluded for 118 hours, and 5 women for 58 hours.	2 men & 1 woman restrained for a total of 1844 hours.
1891	3 men secluded for 21 hours, and 8 women for 235.5 hours.	1 man restrained for 8 hours by sheets, and 1 woman by the jacket for 14.5 hours and by sleeves for 93 hours.

[86] Michael, *Care and Treatment*, p. 70.
[87] J. Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients and Practices* (London: Palgrave Macmillan, 2017), p. 46.
[88] Digby, *Madness, Morality and Medicine*, p. 78.
[89] Denbigh Record Office, *38th Annual Report*, HD/1/38, p. 11, quoted in Michael, *Care and Treatment*, p. 97.

1892	N/A*	N/A*
1893	5 men secluded for 160 hours, and 7 females for 173 hours.	1 woman restrained using bandage.
1894	14 patients secluded on 46 occasions for 483.5 hours.	No restraint used.
1895	2 men secluded on 7 occasions, and 9 women on 14 occasions; 449.5 hours in total.	1 woman and 1 man restrained.
1896	5 men secluded for 695 hours, and 8 women for 261 hours.	3 men restrained, 1 almost continually for 9 days.
1897	1 man secluded for 334 hours, and 5 women for 178.5 hours.	2 men restrained by the jacket for 637.5 hours.
1898	7 patients secluded on 53 occasions for 587 hours.	1 woman restrained by the jacket for a total of 1630 hours over 69 occasions.
1899	3 men and 7 women secluded on 49 occasions for 414 hours.	No restraint used.
1900	2 men secluded for a total of 19 hours.	No restraint used.
1901	No seclusion used.	No restraint used.
1902	No seclusion used.	No restraint used.
1903	No seclusion used.	No restraint used.

Table 4.1. Seclusion and Mechanical Restraint used, 1884-1903[90]

One example, Isabella R, was restrained using the polka for 69 consecutive days for 24 hours a day in 1898. Aged 42 at the time, and a resident of Garlands since 1885, Isabella's treatment was justified for surgical reasons: 'To keep her tearing off scabs off ulcers on [her] head'.[91] At this time, Garlands was under pressure from overcrowding, therefore Isabella's continual refusal to allow her head wounds to heal, would have taken its toll on the already overburdened attendants, and it was decided by the superintendent to restrain her arms for in excess of two months. As Isabella was the only patient recorded as being restrained for a whole year, it demonstrates that this was only resorted to when absolutely necessary.

When reading the Commissioners in Lunacy's inspection of these documents in the Garlands annual reports, it seems that they were not diligently filled out in all instances. In 1870 they remarked; 'three men in bed from sickness had the doors of their single rooms locked. These men were not considered to be in seclusion, but we

**Annual Report for 1892 has not survived.*

[90] CACC, *Annual Reports 1884-1903*, THOS 8/1/3/1/22-41.

[91] CACC, *Mechanical Restraint Register 1890-1946*, THOS 8/4/29/1; CACC, *Female Casebook 1884-1888*, THOS 8/4/40/1, admission no. 2676. Isabella R has been researched in addition to those in the patient sample.

think that whenever patients are locked up alone the fact ought to be recorded'.[92] Similarly, two years later, it was again noted how seclusion was not being indicated. They stated how one woman was ill in bed and was in a locked room, but was not recorded as secluded, and that; 'her case ought properly to be entered in the journal as one of seclusion'.[93] However, by the 1880s, the Garlands staff had begun adhering to the Commissioners instructions, as in 1882 it was reported that patients in locked rooms had been 'duly recorded in the medical journal'.[94] Chemical restraint also became common as the number of unruly patients was not met by an increase in staff. This was widely accepted by the Commissioners as a medical treatment to be undertaken on the judgement of asylum doctors.[95] In particular, Potassium Bromide was used to sedate and soothe excited and resistive patients. For instance, John F, from the sample, was admitted in April 1886 in an excited state, and could not be kept still. Throughout his stay at Garlands he continued to be restless, noisy and could be violent towards others. On 20 April 1886, Potassium Bromide was administered thrice daily, which continued until 1 May when he was noted to be 'much quieter and more subdued'.[96]

The fourth compromise of care was the employment of forcible methods of feeding. Getting patients to eat when they refused was a difficult and exhausting process. The brutal adoption of force-feeding, most commonly via the stomach pump, went against the principles of moral treatment. However, the practice was used frequently in asylums, [97] and was surrounded by debate, particularly in relation to the instruments employed.[98] Campbell published an article in 1878, 'Feeding versus Fasting', in which he noted that forcible feeding at Garlands was only resorted to in patients that had refused food for two consecutive days. For patients admitted in a state of severe emaciation, and who refused nourishment, this would be employed sooner. Since 1873, Campbell had had to use the stomach pump in 35 patients, with one notable case having to be fed continuously via this method for two years. In 1882, the

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[92] *Annual Report 1870*, p. 8.
[93] CACC, *Eleventh Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1872*, THOS 8/1/3/1/10, p. 9.
[94] CACC, *Twenty-First Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1882*, THOS 8/1/3/1/20, p. 9.
[95] P. Fennell, *Treatment without Consent: Law, Psychiatry and the treatment of mentally disordered people since 1845* (London: Routledge, 1996), p. 37.
[96] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 2795.
[97] In her examination of Denbigh, Michael found that liquid mixtures consisting of beef tea, milk, or brandy, were administered to the 5% of food refusing patients that were admitted, Michael, *Care and Treatment*, p. 93.
[98] Smith, *Cure, Comfort and Safe Custody*, p. 197.

Commissioners condemned the practice of force-feeding as they noted that coercing patients to eat using the feeding tube was 'open to grave objection; it should be altered, and no such coercion should be permitted except in the presence of the head attendant…or medical officer.'[99] Patients were often in a state of distress and fought against the staff pinning them down to administer food via the tube. For instance, from the sample, Jane K was admitted in January 1895 said to be suffering from melancholia, and refused all nourishment. To prevent her from becoming physically weak, she was fed via the stomach tube twice daily for a month, until she agreed to take food of her own accord. In her case notes, it was reported that she had 'fading finger marks on her arms probably caused by holding her when she was fed'.[100] The restraint of patients in this way signalled a return to the employment of physical force to coerce them into conforming, which called into question the effectiveness of moral treatment when faced with instances of resistance via self-starvation.

The fifth aspect, was instances of patient agency, some of which have already been seen in chapter three through escapes, and above with instances of suicide. As much as patients could respond well to the regime, when aspects of its programme of recovery failed to be delivered, they could also react adversely. An entry for a male, who had been present in Garlands since its opening, portrays the importance trips outside of the Asylum had: 'Today about 11 o'clock this patient feeling slighted at not being allowed to go the asylum annual picnic suddenly struck his hand through a pane of glass cutting it severely'.[101] The refusal to conform, and the lack of available staff to effectively deal with these cases, led to a compromise in the care received. For instance, Archibald P from the sample, was sent to work in the tailors shop in January 1890. However, his reluctance to engage resulted in him being sent to work outdoors, as 'he was lazy and disinclined to learn in the tailors shop'.[102] In Archibald's case it seems as though the useful employment was enforced upon him, despite his reluctance to engage with the tasks. When he became particularly excited and resistant, the doctors administered Potassium Bromide to sedate him, making him more compliant. However, once again Archibald refused to conform to being chemically restrained, further

[99] Commissioners in Lunacy, *Thirty-sixth Annual Report to Lord Chancellor,* (1882), p. 320.
[100] CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, p. 208.
[101] CACC, *Casebook 1862-1865*, THOS 8/4/38/1.
[102] CACC, *Male Casebook 1888-1891*, THOS 8/4/39/1, admission no. 3255.

compromising the efficacy of moral treatment.[103] Such patients were also subject to certain medical treatments, which in an era of 'moral' approaches to mental illness, seem somewhat misplaced. Blistering was a common medical treatement induced in patients suffering from particularly accelerated forms of mania and excitement, but could also be used in cases of melancholia, epilepsy and general paralysis.[104] A blistering fluid, most commonly used was liquor epispasticus, was applied to the front, top or back of the head to create blisters.[105] It was believed that by causing pain elsewhere on the body, the mental anguish causing a person's disruptive behaviour would be soothed.[106] One example was Maria S, admitted in March 1893. Maria was recorded to have suffered from mania, and was constantly excited, restless, shouting at the top of her voice, and was a disruptive influence in the wards, particularly at night. Six weeks after admission it was stated in her case notes: 'As she has been almost continuously noisy for a long time, the front part of her head was today shaved and painted with liq. Epispasticus'. Despite receiving the treatment on a regular basis, it was noted that it was having little effect. By 23 Sept 1893, the method had failed to soothe Maria, but doctors continued to administer it: 'Lately has been extremely noisy, frequently yelling at the pitch of her voice, using much profane language, gesticulating, and keeping the ward in an uproar. Back of the head was today shaved and blistered'. Her violent and disruptive behaviour remained throughout her time at Garlands, where she remained until her death in July 1908 from pneumonia.[107]

Finally, the consequence of an interruption in treatment can be seen most prominently through the number of patients that were readmitted on more than one occasion. As outlined in chapter two, and stated by Clouston, recovery was difficult to determine, and when superintendents were keen to free up beds (as seen in chapter three), patients who appeared well were discharged as recovered, and the cessation of treatment could lead to patients being readmitted. When examining the sample, 23% of males, and 30% of females were admitted on more than one occasion.[108] To minimise the risk of readmission, the practice of 'discharge on trial' was increasingly

[103] Entry dated 26 Aug. 1893 stated: 'is still somewhat excited, restless and incoherent, will not take the bromide'. CACC, *Male Casebook 1893-1897*, THOS 8/4/39/3, admission no. 3826.
[104] Smith, *Cure, Comfort and Safe Custody*, p. 202.
[105] J. K. Watson, *A Handbook for Nurses* (London: The Scientific Press Ltd, 1899), p. 402.
[106] Wallis, *Investigating the Body*, p. 48.
[107] CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, admission no. 3629 and 3745.
[108] This equates to 18 males and 24 females. See Appendix Three.

employed.[109] Patients who seemed to have fully regained their mental health were discharged for a number of weeks in order to ascertain if a relapse would be brought on by the outside world. However, this was not guaranteed, and many patients returned to the Asylum. For example, Hannah D was admitted for the first time to Garlands on 22 April 1891, and was recorded as suffering from melancholia. She was noted to have suicidal impulses and was issued with a cautionary ticket to be constantly watched to ensure she did not injure herself. It was due to these thoughts of harming herself that she wished to be sent to Garlands for her own safety. Hannah had prior to admission been unable to sleep properly and had lost her appetite. The treatment she received was that of rest and a nourishing diet. By December 1891 Campbell saw her fit for discharge, despite still being reported in the case books as quarrelsome and sulky. Hannah was readmitted in September 1894 in a somewhat worse condition than before. She suffered from several delusions, her health had weakened, and she was noted as having a strong hereditary predisposition to insanity, as her 'mother was weak minded, a paternal uncle committed suicide; cousin on father's side was [an] imbecile'. Hannah remained in Garlands until her death in February 1921.[110] The impact of her discharge and transferal back home worsened her condition to an extent that it became life-long. In 1898, Campbell wrote to the Brampton Poor Law Union and told them: 'There is no change in the condition of Hannah…and she is not likely to be fit for discharge for a long time'.[111] Which is a somewhat different view of her case than he adopted in 1891, when he discharged her after such a short period. This is evidence of the compromise in care inflicted upon patients that were increasingly circulated in and out of the institution. Readmissions such as this will be examined further in chapter six to fully assess the effect increased circulation had.

Patients could also be readmitted as a consequence of their prior removal to the workhouse. As discussed in the previous chapter, the practice of sending them to receive an inferior level of care, was an unfair system whereby those most likely to resist the moral regime were the ones retained in times of overcrowding. It was the quiet, conforming patients that were circulated in the wider 'tapestry' of responses to

[109] CACC, *Tenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1871*, THOS 8/1/3/1/9, p. 15.
[110] CACC, *Female Casebook 1888-1892*, THOS 8/4/40/2, admission no. 3479, and also CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, admission no. 3992.
[111] CACC, *Brampton Poor Law Union General Ledger, 1895-1899*, SPUB 2/14, Letter dated 14 July 1898 from Dr Campbell to Brampton Poor Law Union.

relieve pressure,[112] and who experienced the substandard care in workhouses, detailed in chapter two, which was often a detriment to their mental health. Workhouse infirmaries were, for the most part, staffed by pauper inmates with no medical training. Lunacy Commissioners inspected these wards, but their powers to effect change were limited. The prevailing issues of overcrowding, understaffing and underfunding, effected the Poor Law Unions too. This led to large scale neglect of those suffering with mental illness, as they were frequently ignored, and accidents were common. The result was a level of care that was far below the expected standard, and much lower than that provided in asylums.[113]

One example from the sample is Edward E, who was admitted to Garlands on three separate occasions. Due to the constraints of overcrowding, each time he was discharged unrecovered to Whitehaven Workhouse. Throughout each of his treatments he was described as quiet and unobtrusive, and was regularly employed without protestation. Edward fully conformed to the facets of moral treatment during the twelve years he was said to have been labouring under insanity, whilst also suffering with persistent delusions that he was being persecuted regularly by electricity and his body was filled with the fumes.[114] On each occasion he was returned to Garlands from the Workhouse, his condition had worsened. When he was first admitted to the Asylum in 1896 he was not described as dangerous to others, whereas on his readmission in 1906, he was noted as having attacked fellow inmates, and was described as dangerous.[115] Therefore, the interruption of asylum treatment, had worsened Edward's condition and had transformed him from being a dull and depressed individual, into a violent one. On his final bout of treatment in Garlands, Edward's health deteriorated rapidly, and after only four months he died of chronic Bright's disease on 28 June 1908.[116] The adverse effect circulation had on the patients was increasingly noticed as overcrowding ceased to relent into the twentieth-century, as was seen in chapter three. Farquharson noted in 1903 that:

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[112] L. Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the insane in West Midlands workhouses, 1815-1860', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20.
[113] Price, *Medical Negligence,* p. 127.
[114] CACC, *Male Casebook 1893-1897*, THOS 8/4/39/3, admission no. 4306.
[115] CACC, *Male Casebook 1903-1906*, THOS 8/4/39/6, admission no. 5819.
[116] CACC, *Male Casebook 1906-1909*, THOS 8/4/39/7, admission no. 6199.

> it is becoming increasingly difficult to draft chronic harmless cases from the Asylum to the various workhouses; though giving no trouble in the Asylum, many of these cases seem before long to become unmanageable in the Workhouses, and they are quickly returned.[117]

The evidence gathered in this section has suggested that patient care could be compromised in a variety of situations. In particular, the disruption of the regime of care inflicted by patient transfer could be detrimental. Although examples have been given above, in the context of the wider sample, the full implications of circulation on moral treatment will be addressed in chapter six, particularly for those who were removed to workhouse wards. With this in mind, it is necessary to provide an evaluation of the evidence presented in the above sections to determine the wider meaning of these findings.

Conclusion

Throughout this chapter, using several patient examples, the some facets of moral treatment have been explored, both in terms of how they were utilised, and what happened when they were unsuccessful. It is clear that the regime did work for patients willing to live by its ideals, and they could respond well to it. However, as explored in the section above, once moral treatment could not be delivered in the full capacity, it failed to have a curative effect, and could worsen a patient's condition. This exploration goes further than existing literature, as an understanding of the pressurised and volatile environment in which attendants were expected to deliver the aspects of moral management has been offered.

The information presented in the first section provides no real new avenues of research in terms of how moral treatment was practically employed in county asylums. However, it does portray its use in a pauper institution which has been left absent from the historiography. On a small scale, examples have been provided of how pauper patients could respond well, and the practicalities of administering moral treatment at a time when increased responsibility was placed upon the ordinary attendants and nurses. Offered in the second section is evidence of patients who refused to abide by the aspects of treatment, and how the asylum failed to effectively deal with these patients.

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[117] CACC, *Forty-Second Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1903*, THOS 8/1/3/1/41, p. 18.

Thus, moral management of large county asylums would only work when patients were willing to cooperate; when they were not, restraint had to be resorted to.[118] Overcrowding of asylums, and their subsequent enlargements, led to an increasing compromise in the standard of care being administered. This also reduced the effectiveness of moral treatment, and as explained above, the problems highlighted in the previous chapter are inextricably linked to the discussion here, and the one offered in chapter six.

Pauper patients, and their experience of asylum care, have been placed at the heart of this analysis throughout. Relevant examples have been provided in this chapter to portray how moral treatment could affect them, both positively and negatively. The regime could only work when applied uniformly, and also if patients were willing to abide by its constraints. When either of these failed to occur, adverse reactions were felt, which hindered the ability of moral treatment to be a success. The increased movement of patients impeded the regime further, which is highlighted prominently by the high incidence of readmissions. Moral treatment failed to take into account what would happen when patients were discharged, or were transferred elsewhere.[119] The realities and struggles of ordinary, working-class lives were enough to cause patients to relapse, as the kindness, warmth, accommodation and diet, offered in the asylum was often of a much higher standard than the pauper patients were used to. Through the research presented in this chapter, and in more detail in subsequent chapters, the experience of pauper patients has been offered in terms of the compromise in their care which occurred in a variety of different situations. Subsequent chapters will examine the implications circulation had for the patients, in terms of the compromise of asylum care. The thesis will now explore the role played by the relatives of asylum patients, and how their involvement affected those admitted to Garlands in the period of study.

[118] For more on the physical implications of these treatments on the patients see, Wallis, *Investigating the Body*.
[119] For more on negligent care received in the workhouse see, Price, *Medical Negligence.*

Chapter Five: The Role of the Family[1]

A mistaken kindness on the part of their relatives allows them to exhaust all the questionable benefits of home treatment often without recourse to special knowledge of the disease, and only when home treatment is found worse than unavailing is the patient sent to an asylum.[2]

Overview

When examining the working-classes who formed the majority of patients admitted to Garlands, the role of the family in their lives cannot be ignored.[3] As stated by Leonore Davidoff, it was not only immediate relatives who formed this network of support; the use of communal lands and co-operation over vital amenities resulted in others from the wider community becoming a part of family decisions.[4] The shift which occurred in the nineteenth-century, due to the growth of the asylum network, theoretically removed the onus on families to deliver care to mentally ill relatives. Following on from the exploration begun in chapter one, the role of relatives will be examined once a family member was admitted to an asylum. Previous literature has focussed on an earlier time period, before county institutions became the dominant receptacle of care, or have been limited to recounting the experience of the middle and upper-classes. This chapter shall address several of the core identified gaps, as it will use examples of pauper patients

[1] Some material from this chapter has been used in C. Dobbing (Forthcoming), 'The Family and Insanity: The Experience of the Garlands Lunatic Asylum, 1862-1910', in C. Beardmore, C. Dobbing and S. King (eds), *Family Life in Britain, 1650-1910* (London: Palgrave Macmillan, 2019).
[2] CACC, *Twenty-Fourth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1885*, THOS 8/1/3/1/23, p. 12.
[3] J. Benson, *The Working Class in Britain, 1850-1939* (London: Longman, 1989), p. 95.
[4] L. Davidoff, 'The Family in Britain', in F. M. L. Thompson (ed.), *The Cambridge Social History of Britain, 1750-1950, Volume 2: People and Their Environment* (Cambridge: Cambridge University Press, 2008), pp. 71-130.

from a geographically absent institution in order to explain how families remained important actors in the care delivered in asylums to their relatives.

Research into the role of the family in asylums constructed after 1845 has largely been confined to their involvement in the admission and discharge process.[5] The majority of literature which delves deeper into the family's role in treatment, has focused predominantly on the experience of private patients, or children.[6] Akihito Suzuki considered the family's role in caring for an insane relative, at home with the support of physicians who practiced in the domestic sphere. The family exercised a certain influence over their relatives as they controlled the purse strings. [7] In dealing with a higher class of patient than is being dealt with in this thesis, Suzuki omits the experience of a whole institutionalised population. David Wright's examination of Earlswood provides some insight into the family relationships which existed around the framework of asylum committal and the care of dependent juvenile idiots.[8] However, this institution was only for children aged between eight and eighteen who had not previously been in receipt of poor relief.[9] While the research of Richard Adair, Joseph Melling and Bill Forsythe into the Devon Asylum has focussed on pauper patients, and

[5] David Wright stated that: 'Investigation into familial care of the insane in Victorian England lies in neglected land', D. Wright, 'Familial Care of "Idiot" Children in Victorian England', in P. Hordon and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions and the provision of welfare since antiquity* (London: Routledge, 1998), pp. 176-97. For work concerning admission and discharge: E. Clark, 'Lessons from the Past: Family involvement in patient admission and discharge, Beechworth Lunatic Asylum, 1900-1912', *International Journal of Mental Health Nursing*, 27:1 (2018), pp. 320-28; D. Wright, 'The discharge of pauper lunatics from county asylums in mid-Victorian England: The case of Buckinghamshire, 1853-1872', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 93-112; J. K. Walton, 'Casting Out and Bringing Back in Victorian England: pauper lunatics, 1840-70', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II* (London: Tavistock Publications, 1985), pp. 132-46; C. Smith, 'Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics', *Family and Community History*, 9:2 (2006), pp. 109-24.

[6] For private patients: C. Mackenzie, 'Social Factors in the admission, discharge, and continuing stay of patients at Ticehurst Asylum, 1845-1917', in Bynum, Porter and Shepherd (eds), *Anatomy of Madness Vol. II*, pp. 147-74; for children, S. J. Taylor, *Child Insanity in England, 1845-1907* (London: Palgrave Macmillan, 2017).

[7] A. Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (London: University of California Press, 2006), chapter four.

[8] See D. Wright, 'Family Strategies and institutional confinement of "idiot" children in Victorian England', *Journal of Family History*, 23:2 (1998), pp. 190-208.

[9] The data collection methods used in this chapter are similar to those used by Wright. Using the name and addresses of the next of kin on reception orders to the Asylum, these have been linked to information provided by census data to create a wider picture of a patient's family background. Wright, 'Family Strategies', p. 192.

examined the nature of family structure and insanity, they omit any observations on the relationship families had with their relatives once confined in an asylum.[10]

Despite a growing interest in recounting history from below, mainly due to a lack of existing primary material, little has been documented on family involvement in the asylum *treatment* process, particularly regarding paupers.[11] Cathy Smith has provided an insight into the role of the family of asylum patients.[12] Using cross-referenced information, similar to the method of this thesis, from casebooks and census material, she has built a picture of the larger familial context in which a relative was admitted to a lunatic institution. However, where her research differs is that she examined family letters to the Northampton Asylum's finance committee concerning the lower-middle and working classes who were not deemed poor enough to be admitted as paupers. Thus her focus is on privately admitted patients, and is based on a small number of cases, which makes it difficult to fully understand this relationship.[13] In addition, the respective research of Len Smith and Louise Wannell into the letters written by families to asylum superintendents, do offer a glimpse of the ongoing involvement of families, but the full extent of their relationship with the patient is lacking, as the focus is instead on the conversations between families and doctors.[14] Therefore, a considerable gap exists in recounting the involvement of families in the treatment of a mentally ill relative whilst in an asylum.

This will be addressed, partly, in the examination of letters written by patients that demonstrate the familial bonds. In addition, secondary accounts of an individual's family circumstances will be considered in tandem with other material. For researchers examining the pauper experience, letters written by the patients provide an important insight into the level of contact maintained with family members once incarcerated in a county asylum. The problem lies in the scarcity of these records, as the few letters which were kept, were prevalently ones which indicated the nature of a person's

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[10] See R. Adair, J. Melling and B. Forsythe, 'Migration, Family Structure and Pauper Lunacy in Victorian England, admissions to the Devon County Pauper Lunatic Asylum, 1845-1900', *Continuity and Change*, 12:3 (1997), pp. 373-401.
[11] For instance, see A. Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014), p. 89.
[12] Smith, 'Family, Community and the Victorian Asylum'.
[13] C. Smith, 'Living with Insanity: Narratives of poverty, pauperism and sickness in asylum records 1840-76', in A. Gestrich, E. Hurren and S. King (eds), *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938* (London: Continuum, 2012), pp. 117-41.
[14] L. Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910' *Social History of Medicine*, 20:2 (2007) pp. 297-313; L. Smith, '"Your Very Thankful Inmate": Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine*, 21:2 (2008), pp. 237-252.

condition, either through the expression of delusions from the patient themselves, or from the relatives providing further examples of symptoms displayed before admission, adding to the accuracy of diagnosis.[15] These letters can be found attached to the case records, which are bound in huge volumes, although only for a very small number of patients.[16] Previous literature has neglected these letters, and the importance of them remains absent in the current understanding of the pauper experience.

First, this chapter will offer an exploration of the precise involvement of families, with regard to the committal, treatment, and discharge of their relatives. This will fill the identified gap by recounting history from below and providing the pauper experience of insanity. The lack of primary material written by patients leaves the historian with a certain area of guesswork and critique regarding the assessment of second-hand accounts of a patient's insanity. Instead, the researcher has had to view their comments through the hand of the medical men, as their testimonies were recounted into casebooks by superintendents. Testimonies provided by families which were recorded on these documents will be key in this section, as they give an added dimension in explaining a patient's background and circumstances. Second, how family ties were maintained once a family member was admitted will be considered. Letter writing and frequent visits were encouraged, and the merit of this for the patients will be examined. The survival of a visitation book will be particularly useful in demonstrating the continued support families provided to patients.

The third section will focus on how the family could be attributed to the cause of an individual's insanity. The hereditary nature of mental illness will be considered, using instances of family members who were present in the asylum at the same time, or whose relatives had been previous residents. Through patient examples, this section will go further than previous research and highlight the conditions which could be linked to relatives. Fourth, this chapter will explore the notion that the asylum was built to emulate the structure of a middle-class family home. This familial context was important to those patients admitted without a support network of kin. Lacking from the historiography is an explanation of the domesticity instilled in the county asylum network, and particularly its effect on the patients, therefore this section offers an

[15] Shepherd, *Institutionalizing the Insane*, p. 41.
[16] For the period researched in the thesis, letters attached to 38 patients have been found attached to case notes, out of thousands of admissions.

entirely new area of exploration.[17] In the final section, all the evidence discussed will be analysed to explain the role the family played in the lives of pauper lunatics admitted to Garlands, offering a new contribution to the literature. To begin, it is necessary to document the precise involvement of the family at the admission and discharge stages of the process, to build upon what is already understood.

The Family's Role

Despite the increasing insistence throughout the nineteenth-century that county asylums were the best places to treat the mentally ill, the family remained the primary care givers until their condition began to deteriorate. Admission to the asylum signified a point in the family cycle where all resources had been exhausted.[18] The trigger point seems to have coincided with life events, for instance, the death of the main family care giver may have prompted relatives unable to cope to turn to the authorities for assistance.[19] Periods of change, for example, old age, adolescence, childbirth and menopause, were all times in which some required help.[20] Adair, Melling and Forsythe argued that lunatics belonging to larger families were increasingly likely to be admitted to an asylum. Thus, families would admit mentally ill relatives for their own good.[21] Steven Cherry echoed this, as he asserted that admission signalled a proactive resort to address their relative's illness.[22] In this section patient examples will be examined to deduce the importance of the family in the process of asylum committal, treatment, and

[17] Jane Hamlett does offer an explanation of the domesticity of Victorian asylums, but these were private, fee-paying establishments, not pauper asylums, J. Hamlett, *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* (Hampshire: Palgrave Macmillan, 2015).

[18] J. Melling and B. Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London: Routledge, 2006), p. 99. See also L. Smith, *Insanity, Race and Colonialism: Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838-1914* (London: Palgrave Macmillan, 2014), p. 16; Taylor, *Child Insanity*.

[19] R. Adair, B. Forsythe and J. Melling, 'Families, Communities and the Legal Regulation of Lunacy in Victorian England: Assessments of Crime, Violence and Welfare in Admissions to the Devon Asylum, 1845-1914', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: the history of care in the community 1750-2000* (London: Athlone Press, 1999), pp. 153-80. Michael and Hirst found many patients admitted to the Denbigh were done so after the breakdown of a long-standing care arrangement in the family, D. Hirst and P. Michael, 'Family, Community and the lunatic in mid-nineteenth century North Wales', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 66-85.

[20] M. Anderson, *Family Structure in Nineteenth Century Lancashire* (Cambridge: Cambridge University Press, 1971), p. 136.

[21] Adair, Melling and Forsythe, 'Migration, Family Structure and Pauper Lunacy', p. 385. Cathy Smith correctly places the family at the heart of the committal process, as most came directly from their homes by the signatures of their relatives. Smith, 'Family, Community and the Victorian Asylum', p. 110.

[22] S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998* (Woodbridge: Boydell Press, 2003), p. 15.

discharge.[23] This exploration differs from previous research as the individual histories will be examined in much more detail to reinforce the primary role of the family.

As mentioned in chapter one, the casebooks provide a great amount of medical and biographical detail about each individual, including their close relatives.[24] The next of kin would typically be, for married persons, their spouse; for the unmarried it would be their parents, and for the widowed it would be their children.[25] On admission, case notes recorded how long patients had been suffering with their condition, which could range from a few days, to a number of weeks, months or even years. In the first instance of mental affliction the patient was not 'readily surrendered',[26] it was only when it became clear that domestic care would not suffice that the family sought committal to the asylum.[27] For instance, Anastasia D, aged 24, was admitted to Garlands on 28 August 1895.[28] She was recorded as having suffered from mania for 'over 6 months' prior to admission, and had resided at home under the care of her parents in Alrecdon near Whitehaven, along with nine of her siblings – one of eleven children altogether. Her father and older brothers were iron ore miners.[29] It was noted that hereditary tendencies towards insanity were present in the family, as Anastasia's paternal grandmother was in an asylum several years previous, and her elder sister, Elizabeth H, had been in Garlands for two years. The size of the family and the presence of so many older siblings at home accounts for the domestic treatment prior to

[23] Similar histories, such as Michael's work on Denbigh, have also used patient samples from which to draw out the role of relatives in the committal process. Michael examined around 2000 cases, and although this is much larger, it was for a longer period, 1875-1937. Michael, *Care and Treatment*, p. xii. Whereas, the 160 patients researched in this thesis are from a much smaller period, 1884-1903. In addition, several other cases have been researched from the Garlands records, and are indicated accordingly.

[24] M. Levine-Clark, 'Dysfunctional Domesticity: Female insanity and Family relationships among the West Riding Poor in the mid-nineteenth century', *Journal of Family History,* 25:3 (2000), pp. 341-61; See C. Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Basingstoke: Palgrave Macmillan, 2010), p. 67; J. Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the nineteenth century', *Social History of Medicine,* 11:2 (1998), pp. 255-81.

[25] D. Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteeth Century', *Social History of Medicine,* 10:1 (1997), pp. 137-55. In the absence of relatives, the relieving officer of the Poor Law Union the patient belonged to was recorded as the next of kin.

[26] D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001), quoted in Smith, 'Living with Insanity', p. 119.

[27] One the other hand, it has also been argued, for instance by Cathy Smith, that families readily surrendered relatives to unburden themselves from an unproductive member – as seen in chapter one. Smith, 'Living with Insanity'.

[28] CACC, *Female Casebook 1892-1895,* THOS 8/4/40/3, admission no. 4159.

[29] Ancestry.com, *1891 England Census* [database on-line], Class: *RG12*; Piece: *4312*; Folio: *65*; Page: *26*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=6598&h=11542833&ssrc=pt&tid=88900993&pid=48578300646&usePUB=true [accessed 13 April 2016].

admission. The trigger for her removal was a 'severe fit', suffered a week before which had caused a deterioration in her condition. She was noted as hearing voices, having delusions that she was married, that she was fourteen years of age, and could be very violent at times. Thus, the family saw it fit that Anastasia should be committed to Garlands, as domestic care delivered by relatives was not enough to bring about her recovery. However, neither was asylum provision, as she died in Garlands in February 1903.[30]

Medical superintendents were conflicted between reinforcing the need for early admission, as seen in the quote at the head of this chapter, and stating the importance of the family offering the primary instance of care. Facing a growing number of patients, Clouston wrote the following in 1871, encouraging relatives to exhaust all possible means of care before resorting to admission:

> It is as much the duty of the relatives and medical attendant of a patient suddenly seized with insanity, to try every means for his recovery at home, as it is for them to lose no time in sending him to an asylum after every reasonable chance of cure at home has passed away. The time during which it is proper for patients to be treated at home must depend much on the nature of the case and on the circumstances of the patient. In one case two days maybe too long, in another two weeks may be too short.[31]

However, in the same report, he noted one case which demonstrated family care could be detrimental:

> One young woman was sent here in a deplorable state of filth and neglect, who had been for years allowed to remain in a state of nudity in her father's house, occupying the same sitting apartment as the rest of the family, scorching herself at the fire, looked after chiefly by a brother, nearly grown up; and all this in the middle of a town of considerable size.[32]

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[30] CACC, *Female Casebook 1892-1895,* THOS 8/4/40/3, admission no. 4159.
[31] CACC, *Ninth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1870*, THOS 8/1/3/1/8, p. 13.
[32] CACC, *Tenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1871*, THOS 8/1/3/1/9, p. 14.

Therefore, the ability of families to treat relatives at home could have drastically different consequences, as not all units had the same capabilities to deliver the correct standard of care. Table 5.1 demonstrates how long the patient sample was kept at home before being admitted to Garlands. Patients who were transferred from the workhouse or other institutions have been omitted.

Length of time treated at home prior to admission	Male	Female
Less than 1 week	10 (17%)	5 (8%)
1 week-1 month	22 (37%)	22 (36%)
1-3 months	11 (18%)	12 (20%)
3-12 months	13 (22%)	16 (26%)
Over 1 year	2 (3%)	6 (10%)
Unknown/not stated	2 (3%)	0
Total	60	61

Table 5.1. Length of stay of patients at home prior to admission.[33]

It is clear that the male patients were admitted at an earlier point in their condition. The majority, 54%, were admitted in the first month. This is because men were the main wage earners, and at the first sign of illness, families would be increasingly willing to seek help from the asylum to bring about a recovery as soon as possible.[34] Similarly, women were the primary carers, and would be treated at home in order to continue their domestic duties for as long as was feasible. From this research, it is evident that the family were important in instigating asylum admission, and were much more likely to do so for male relatives, due to their economic value to the domestic unit.

The reception order, as explained in chapter one, was the document required to admit an individual to an asylum. Interestingly, these forms provided equal space for the evidence of insanity to be relayed by the medical practitioners and the lay observations of family members.[35] The 'indications of insanity' were transferred to a

[33] Information for the table has been drawn from the casebooks. CACC, *Casebooks 1884-1888*, THOS 8/4/38/9; CACC, *Male Casebooks 1888-1906*, THOS 8/4/39/1-6; CACC, *Female Casebooks 1884-1906*, THOS 8/4/40/1-6. For a comparison of statistics see P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London: Leicester University Press, 1999), Appendix 2, Table 5, p. 270.

[34] Nancy Tomes stated that the apparent remedial benefits of asylum treatment was the main reason why families were prepared to admit their relatives to an institution, N. Tomes, *A Generous Confidence: Thomas Story Kirkbride and the art of asylum-keeping, 1840-1883* (Cambridge: Cambridge University Press, 1984), chapter 4, quoted in Wright, 'Family Strategies', p. 197.

[35] Wright, *Mental Disability in Victorian England*, p. 48. Suzuki asserts that this proves lay narrative enjoyed preference over medical observation, as those who knew the patient's character best were those

patient's case notes to act as a comparator to their behaviour as they underwent the recovery process, which provides an insight into how insanity was identified and responded to in the late Victorian era.[36] For example, Martha W stated of her daughter Sarah on admission: 'She is beyond control. She can't sleep at nights. She is going about all day without any evident cause or object'.[37] Fathers or other close male relatives signed the reception orders as the next of kin, but it was predominantly female caregivers such as mothers and sisters that relayed the statements of insanity to medical practitioners.[38] The individual signing the reception order was typically the arbiter of committal, and the occupation of the next of kin gives information of the profile of one member of the family, which provides clues to a patient's background and class.[39] These documents have been utilised widely in the historiography for the fascinating insights they provide into experiences of insanity. The exploration here extends this knowledge by cross-referencing with a large number of other documents for each patient, in order to build a comprehensive understanding of the pauper experience.

As evidenced from reception orders, violence and erratic behaviour were often catalysts for admission, as they were considered irrational, due to the financial and emotional implications they posed on the family.[40] The acts committed by patients towards their relatives can be demonstrated through four examples.[41] First, Edward W was admitted 2 July 1875 said to be suffering from mania caused by 'ill health'. It was noted that he was dangerous as he had attacked his brother and sister. As well as this, Edward had used threatening language and had broken several windows. This unruly and destructive behaviour, which had happened for five weeks prior to admission, posed a threat to his relatives and their home. Respite in Garlands was enough to bring about Edward's sufficient recovery, as he was discharged after four months treatment.[42]

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closely acquainted with them, thus rendering the examination of the doctor as inferior, Suzuki, *Madness at Home*, pp. 41-2. See also Taylor, *Child Insanity*, p. 40.

[36] Wright, *Mental Disability in Victorian England,* p. 53.

[37] CACC, *Reception Orders 1896*, THOS 8/4/1/38.

[38] Wright, *Mental Disability in Victorian England,* p. 63. Wright suggests that this was because women were disproportionately the ones responsible for the care of mentally unsound relatives, Wright, 'Familial Care', p. 182.

[39] Wright, 'Getting Out', p. 147.

[40] M. Finanne, 'Asylums, Families and the State', *History Workshop Journal,* 20:1 (1985), pp. 134-48; J. Busfield, *Men, Women, and Madness: Understanding gender and mental disorder* (Basingstoke: Macmillan, 1996), p. 121.This has also been explored by Wright, who argued that 'confinement was predicated upon the desires of families to care for and control dependent and violent relatives', Wright, 'Getting Out', p. 137.

[41] These were among other circumstances and events that led to committal.

[42] CACC, *Casebook 1875-1877*, THOS 8/4/38/5, admission no. 1456. This case has been researched in addition to the core sample.

Second, Patrick M, admitted in November 1896, threatened several times to kill his sister by cutting her throat. His behaviour worsened and the event which triggered his committal occurred the evening before. He attempted to break the window of her house and said he would 'finish' off both his sister and her husband.[43] Third, in 1899 prior to her committal to the asylum, Annie C 'attempted to strangle her sister whilst in bed'.[44] Finally, Elizabeth P, admitted in 1893, attempted to throw her daughter in the river Caldew in Carlisle.[45] The display of threatening behaviour to their own family evidently represented a point of no return for many relatives. Table 5.2 shows the symptom identified by families which indicated insanity, given on the reception order. These statistics provide valuable information as to the characteristics which signified insanity by the working-classes of the latter half of the nineteenth-century. As can be seen, these were; violence, or the threat of violence; suicide attempts, or the threat of suicide; delusions; domestic trouble or upheaval, including pregnancy; weakness of health, and excessive drinking.[46]

Behaviour	**Males**	**Females**	**Total**
Violence or threat of violence	30	28	58
Suicide Attempts	19	22	41
Delusions	40	36	76
Domestic trouble or upheaval	1	12	13
Weakness of health	1	11	12
Excessive drinking	12	5	17

Table 5.2. Indications of insanity by relatives as recorded on reception orders[47]

Therefore, an instigation of transfer was seen as a necessity to effectively treat their relatives.

During treatment, family members remained in contact with the Asylum and played a continual role in their care.[48] Information was passed on via letters from relatives to doctors throughout the period of hospitalization, providing much more detail than was given by the admission documents.[49] This relationship was important as doctors would have an increased chance of identifying the supposed cause and

[43] CACC, *Reception Orders 1896*, THOS 8/4/1/38.
[44] CACC, *Female Casebook 1899-1902*, THOS 8/4/40/5, admission no. 4782.
[45] CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, admission no. 3737.
[46] For a comparison, see Walton, 'Casting Out', table 7.1, p. 141.
[47] CACC, *Reception Orders 1884-1903*, THOS 8/4/1/26-45.
[48] See Smith, 'Your Very Thankful Inmate'.
[49] Coleborne, *Madness in the Family*, p. 56.

condition.[50] For example, when Isabella F was admitted to Garlands, her husband, Matthew, continued to provide with doctors background information about her history of mental illness. In a letter sent on 16 June 1865, three weeks after her committal, he described in great detail Isabella's past afflictions:

> …five years since my wife had a child but three weeks before she was confined…she was very nervous for about three months always thinking that she was going insane…She soon got over the attack and for near four years I never saw the past symptoms of weakness. About two years since she began to show signs of insanity amagining [sic] that every person who came in our house were coming to do her some mischief, coming to take her to gaol, or some such thing…she began to recover…ten months since she had two children. During pregnancy she got very weak, so much so that…she had no milk for them nor did it come…she has become regularly weaker, taking no delight in the family whatsoever.

This demonstrates that Matthew wanted the doctors to understand the full detail of her past episodes. Also, as he began the letter, 'in answer to your letter of yesterday', it can be assumed that the doctors requested further information from Matthew regarding Isabella's history.[51] Another example was found attached to the case notes of Ann S, admitted in January 1866 from Cockermouth recorded as suffering from mania. The letter was addressed to Clouston, and was also written by her husband, John. He detailed Ann's violent convulsions she suffered after the birth of her three children, the last of which was born in 1863, thus attributing her condition to pregnancy and the trauma of three successive births. At the end of one of his letters, John included a note to the infirmary of the Asylum indicating what he believed to be the cause of his wife's condition:

> P.S: Infirmary
> The want of outdoor exercise. The want of attention at last confinement, and finally the use of tobacco.

[50] Ibid.
[51] CACC, *Casebook 1865-1867*, THOS 8/4/38/2, letter attached to case notes, admission no. 398. This case has been researched in addition to the core sample.

If such would cause this sad affect – I know of nothing else.[52]

These cases provide valuable evidence of the lived pauper experience of insanity. Although the letters from Clouston in reply have not survived, a sense of the relationship between asylum doctors and families can be ascertained, as they relied on each other for information pertaining to the welfare of the patient. This reasserts the importance of the lay observations of mental illness, and that they were regarded as valuable as the opinions of the medical professionals.

The family could also play a significant role in a patient's discharge. Friends and relatives could request a patient be sent home at any time. Clouston remarked that the practice of removal at Garlands was, 'always followed here in suitable cases, and where the custodians seemed suitable…the person who removes a patient is required to sign the obligation…to take care of the patient'.[53] Hilary Marland noted that for women this was more marked as families were keen to get their wives and mothers back to their childcare duties and domestic chores.[54] However, the same could be said for males as they would be required to regain their role as breadwinner as soon as possible. Discharge may have been inspired by a family that experimented with asylum treatment, expecting the quick recovery of their relative, and when this failed to materialise, they sought removal losing faith in the institutional alternative to domestic care.[55] Increasingly, as the county asylums became overcrowded (explored in chapter three), release was more frequently granted as it signified a success doctors, in terms of cure, and helped resolve the burden of an over-capacity institution.[56] For example, Maria S (the patient from the previous chapter who experienced blistering), was first admitted on 2 June 1892, aged 34, said to be suffering from mania caused by insanity of lactation. She had given birth to nine children in fifteen years and the last had been born just five months prior to her committal.[57] Her husband William, an engine fitter,

[52] CACC, *Casebook 1865-1868*, THOS 8/4/38/2, letter attached to case notes, admission no. 421. This case has been researched in addition to the core sample.
[53] CACC, *Annual Report 1871*, THOS 8/1/3/1/9, p. 16.
[54] H. Marland, 'Getting away with murder?: Puerperal Insanity, Infanticide and the Defence Plea', in M. Jackson (ed.), *Infanticide: Historical Perspectives on child murder and concealment, 1550-2000* (London: Athlone Press, 2002), pp. 168-92.
[55] M. E. Kelm, 'Women, Families and the Provincial Hospital for the Insane, British Colombia, 1905-1915', *Journal of Family History,* 19:2 (1994), pp. 177-93. Kelm also noted that families that were happy with asylum care would be willing to readmit them. However, this exploration was not carried out in the context of provision in England, as presented here.
[56] Cherry, *Mental Health Care*, p. 47.
[57] CACC, *Female Casebook 1888-1892,* THOS 8/4/40/2, admission no. 3629.

was left to look after nine children aged between fourteen years and five months whilst Maria resided in Garlands.[58] Although inevitably aided by the older siblings, it would have been difficult for the family to cope in the absence of their mother. Whilst in Garlands, Maria held several delusions, such as; a 'Mrs Hamilton mesmerised her and put a bag of money down her chimney', and that 'her children had been cut to pieces'. She was also very restless, excited, violent, and incoherent in her speech. After nine months in the Asylum, despite showing little improvement and still displaying signs of mania, she was discharged against the wishes of the superintendent on 13 March 1893 by her husband as he was 'very anxious to try her at home'. However, Maria was readmitted only two days after her removal, due to the fact that 'after reaching home she became extremely excited and noisy'. Evidently suffering from a more serious disease than her family first assumed, readmission was necessary to ensure Maria received the correct care. She remained in Garlands until her death on 26 July 1908.[59]

A Similar case is Elizabeth W,[60] admitted on 1 October 1862, who was noted to have experienced delusions that her husband was conspiring to poison her, and was being unfaithful. Her daughter-in-law, Mary Ann, stated that Elizabeth had been behaving oddly for seven weeks, and had attempted to drown herself in the river. Mary stated that the allegations could not be true, as 'she could not have a kinder husband'. Despite her condition, Elizabeth's husband David removed her from Garlands after only 24 days treatment, against the wishes of the medical superintendent.[61] On examination of the 1861 census, an indication of why David wanted her removed can be found. They had seven children to take care of, the youngest of whom was nine.[62] Interestingly, the following note had been recorded by Dr Kirkman in Elizabeth's case book entry after her discharge:

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[58] Ancestry, *1891 England Census*, Class: *RG12*; Piece: *4310*; Folio: *124*; Page: *29*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=6598&h=10163960&ssrc=pt&tid=90465381&pid=75012386592&usePUB=true [accessed 21 September 2016].
[59] CACC, *Female Casebook 1888-1892*, THOS 8/4/40/2, admission no. 3629; CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, admission no. 3745.
[60] This Elizabeth W is different to those presented in chapter two.
[61] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 224.
[62] Ancestry.com, *1861 England Census* [database on-line], Class: *RG 9*; Piece: *3914*; Folio: *59*; Page: *4*; GSU roll: *543206*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8767&h=13173535&ssrc=pt&tid=150776668&pid=402001055178&usePUB=true [accessed 23 April 2018].

> I learnt a few days ago after this woman's discharge from Mr P…that she was as bad as ever and he expected would soon have to come back – also from another source…that the husband said before she had been half an hour in the house he would have given £5 to have had her back in here again.

Elizabeth was readmitted on 28 December 1862, and remained for three months.[63] In 1869, Clouston commented on the occurrence of patients being removed from the asylum by their relatives; '12 cases [out of 57 discharges that year] were discharged unrecovered…They were chiefly removed by their relatives, who had signed the statutory obligation to take charge of them and keep them from doing harm to themselves or others'.[64] In these circumstances, the family were the instigators of circulation. Demanding the discharge of a relative, and taking charge of their care, may have put them at risk of deteriorating further, and in the cases of Maria and Elizabeth, having to be readmitted. Life once out of the Asylum was not straight forward, as remarked in the annual reports: 'It is often very hard for a man to earn his livelihood after being a patient in an asylum'.[65] Thus, in some cases, the family would have to continue to financially support a patient even after discharge, until they were able to unburden the stigma of insanity and find work.

For those suffering from long-term conditions, and whose families were the sole carers, the Asylum could provide a place of temporary respite in times when their condition became particularly unmanageable and disruptive.[66] One example is Jacob C, admitted to Garlands on 16 July 1886 stated as suffering from mania. Jacob, aged 58 from Carlisle, was afflicted with insanity caused by intemperance. Prior to this admission he had been cared for at home by his wife, Ann, for six months. This was Jacob's fourth attack of mania, and had been in Garlands on three previous occasions; the first in 1872 for six months; second in 1876 for eleven months, and the third in 1886 for three months.[67] Jacob was a publican of the Guardsman's Inn in the centre of

[63] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 224. This case has been researched in addition to the core sample.
[64] CACC, *Eighth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1869*, THOS 8/1/3/1/7, p. 12.
[65] *Annual Report 1871*, p. 16.
[66] Wright, 'Getting Out', p. 144.
[67] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 2845.

Carlisle, and was clearly unable to avoid temptation of alcohol.[68] In total, he was admitted seven times between 1872 and 1894, the last being a three month stay shortly before his death at the end of 1894. His alcoholism caused him to suffer delusions of vision, as he believed he saw faces in the wall and that the devil troubled him at night. The indication of insanity was relayed to the relieving officer by Ann, and she was also stated as his next of kin. She described in Jacob's 1887 reception order the behaviour which led her to commit him to the Asylum; 'he wanders about all day, and comes home generally very dirty and without his shoes and stockings…this morning a man fetched him home having found him in a midden [compost] heap…he has torn up his clothes…and has set fire to articles of value'.[69] Thus, her husband's destructive and unmanageable behaviour had become too much for Ann to cope with. The added worry that he had wandered off into the community and had to be returned by a stranger would also have been a great concern as his insanity was visible to the surrounding neighbourhood which had a deep stigma attached. On all his visits to the Asylum, with one exception, he was discharged recovered. It is therefore reasonable to assume that Jacob, and his family, utilised Garlands as a temporary place of care to allow him to reinstate his sobriety. This would have provided his wife and seven children with respite from his behaviour so they could effectively run their Inn, reassured by the knowledge that Jacob was safe. In his final five years alive he even lost his sight in one eye due to excessive drinking. This is a prime example of how the care of the insane during the latter half of the nineteenth-century was not static. Jacob was circulated several times from the family home to the Asylum from 1872 until his death in 1894.[70] The key instigator of this movement were his relatives, who in the first instance of insanity, were the primary providers of his care. Only when Jacob became particularly uncontrollable did his family resort to committal. In addition to these examples, full exploration of how families drove circulation will be carried out in chapter six.

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[68] Ancestry.com, *1881 England Census* [database on-line], *Class: RG11; Piece: 5154; Folio: 11; Page: 17; GSU roll: 1342243*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7572&h=2220357&ssrc=pt&tid=100983283&pid=290006049778&usePUB=true [accessed 06 June 2016].
[69] CACC, *Reception Orders 1887*, THOS 8/4/1/29.
[70] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 2959; CACC, *Male Casebook 1893-1897*, THOS 8/4/39/3, admission no. 3911.

Although asylum provision became widespread in the period after 1845, domestic care remained an important option.[71] In 1859, 5920 insane people resided at home with families or friends. Poor Law medical officers were required to record lunatics residing at home in the care of relatives, and had to visit them each quarter.[72] From 1871, census returns required households to declare if any family member suffered from a mental condition by entering either 'lunatic', 'imbecile', or 'idiot' into the final column.[73] These returns give an indication of the numbers outside institutional care in this period, but it does not detail precisely how they were kept and treated. In the Garlands records, an enumeration list has survived detailing the lunatics residing with friends or relatives in East Ward Union, Westmorland in 1875. The list details eight individuals, seven of whom were labelled 'idiot from birth', and one as suffering from chronic mania. For instance, Mary W, aged 50 from Brough, was living under the care of her mother, Ann S aged 69.[74] Ann had remarried after Mary's father Robert had died. In the 1861 census, Mary was listed with the surname of her step-father John, along with Ann's children she had with John, suggesting that she had fully integrated into her new family.[75] Mary was listed as living with her mother until the 1881 census where she then lived with her sister Isabella and husband George, following her mother's death in 1880.[76] From the 1871 census onwards, Mary was listed as an 'idiot', and no occupation was ever given for her.[77] Thus, Mary, due to her life-long mental disability, posed a financial strain on the domestic unit. In the event of her mother's

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[71] S. Barrett, 'Kinship, poor relief and the welfare process in early modern England', in S. King and A. Tomkins (eds), *The Poor Law in England 1700-1850: An Economy of Makeshifts* (Manchester: Manchester University Press, 2013), pp. 199-227.
[72] Bartlett, *Poor Law of Lunacy*, p. 48.
[73] Wright, *Mental Disability in Victorian England*, p. 47.
[74] CACC, *Quarterly list of lunatic paupers not in any asylum 1875*, THOS 8/4/82/9. These eight cases have been researched in addition to the core sample.
[75] Ancestry, *1861 England Census*, Class: *RG 9*; Piece: *3958*; Folio: *57*; Page: *17*; GSU roll: *543213*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8767&h=13305380&tid=58865364&pid=38039207456&hid=71565064517&usePUB=true&_phsrc=SNv47&_phstart=default&usePUBJs=true [accessed 13 April 2016].
[76] FreeBMD. *England & Wales, Civil Registration Death Index, 1837-1915* [database on-line], https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8914&h=29757112&ssrc=pt&tid=58865364&pid=38039206013&usePUB=true [accessed 13 April 2016]; Ancestry, *1881 England Census*, Class: *RG11*; Piece: *5200*; Folio: *53*; Page: *13*; GSU roll: *1342254*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7572&h=22971082&ssrc=pt&tid=58865364&pid=38039211719&usePUB=true [accessed 13 April 2016].
[77] Ancestry.com, *1871 England Census [database on-line]*, Class: *RG10*; Piece: *5270*; Folio: *52*; Page: *13*; GSU roll: *847454*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7619&h=28862180&ssrc=pt&tid=58865364&pid=38039211719&usePUB=true [accessed 13 April 2016]; Ancestry, *1881 England Census.*

death the responsibility for her care transferred to her eldest sibling, Isabella, suggesting that they were comfortable with treating Mary domestically.[78]

Figure 5.1 shows where the certified insane population of Cumberland and Westmorland were maintained at five year intervals between 1875 and 1900. It is clear that the asylum was the primary receptacle, and that the numbers resident increased, as discussed in chapter three. However, what is interesting to note is that the care given by relatives in the domestic setting remained relatively constant. Andrew Scull's observation that the family's response to insanity was increasingly abandoned during the nineteenth-century as the asylum system expanded, does not have purchase, in the context of this area.[79]

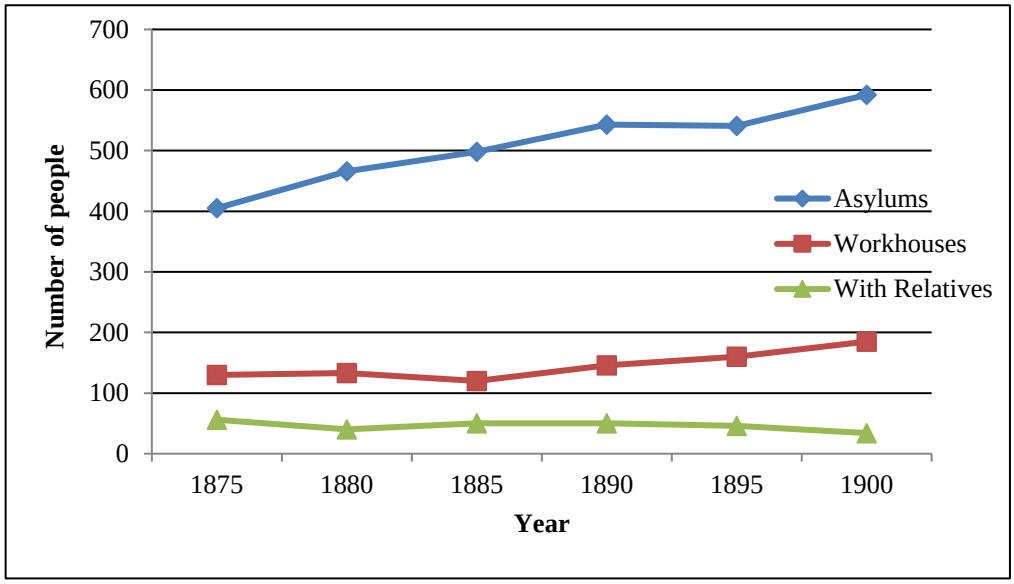

Fig. 5.1. Where those certified as insane were maintained in Cumberland and Westmorland, 1875-1900.[80]

Thus, the family remained caregivers of insanity, and should not be discounted when considering mental health provision throughout the period. The next section will utilise additional archival material to fully examine how relatives remained in contact with

[78] Wright noted, in his research of Earlswood, that once parents were no longer able to care for children deemed 'idiots from birth', the responsibility passed onto the eldest sibling, the life-cycle of the family evolved, Wright, *Mental Disability in Victorian England,* p. 59.
[79] A. Scull, *Museums of Madness: The Social Organization of Insanity in nineteenth-century England* (London: Allen Lane, 1979), p. 26.
[80] Information for the graph was obtained from the Annual Reports of the Commissioners in Lunacy. For full statistics please see Appendix 1.

patients once confined. This will create a wider understanding of the pauper experience, addressing the identified gap.

Contact with Relatives Once Confined

Maintaining familial relationships whilst a relative was confined in an asylum was seen as incredibly beneficial to a patient's condition. Family and friends remained important sources of emotional and practical support, as well as offering a link to a world that was temporarily off limits.[81] In 1886, Dr Campbell reinforced this:

> I am more and more convinced, as my experience extends, of the value of visits from relatives in many cases of insanity. To be left without the sight of a relative or friend, without a cheering word from home, in an asylum among strangers, is enough to make a desponding patient more desponding, a patient tending to dementia more ready to lose interest in all mundane matters. I strongly advise frequent visits to such cases, as I believe they will benefit by them'.[82]

Previous research into the role of families once patients were incarcerated is sporadic, and tends to focus specifically on the experience of those who belonged to the middle and upper-classes. Historians have been correct in identifying the importance of the maintenance of family ties whilst in the asylum, but few have provided evidence. The problem lies in the scarcity of the records. Letters were censored by the medical superintendent, and those which survive were kept as an indication of a patient's insanity or because they were deemed too offensive to be sent. Only a small number survive for each county institution, as they were considered of sufficient interest to be placed in the patient's case notes. Of these, a high percentage were addressed to the asylum doctors, with the minority being addressed to their family.[83] References to family and the visitation of relatives can be drawn from a small number of entries in the patient case notes. Whilst researching a Parisian voluntary institution for the middle to upper classes, Patricia Prestwich found notes in the casebooks from doctors who noted

[81] G. Mooney and J. Reinarz, 'Hospital and Asylum Visiting in Historical Perspective: Themes and Issues', in G. Mooney and J. Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Rodopi, 2009), pp. 7-30.
[82] CACC, *Twenty-Fifth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1886*, THOS 8/1/3/1/24, p. 15.
[83] Andrews, 'Case Notes', p. 270.

phrases such as 'much visited', to indicate the continued family relationships whilst under treatment.[84]

In the Garlands records, a patient's friend's book for 1900-1904 has survived. This register details the visits of family and friends, and records the name of the patient, the visitor, their address, and, crucially, their relation to the patient. This provides a rare insight into the frequency and type of asylum visits. From a sample of the first 100 entries of each year of the patient's friends book, it can be ascertained that the largest proportion of visitors were siblings of the patients (26.3%). Spousal relationships followed, as husbands and wives of patients accounted for 24.9% of visitors. Lastly, mothers and fathers visiting their mentally ill children made up 14.8% of visitors.[85] These findings reassert Suzuki's claim that spousal relationships remained stronger than parental ones. What his research did not account for, however, was the maintenance of strong sibling relationships when a family member was committed to an asylum. As mentioned in the section above, this could have been because siblings took on the responsibility of a mentally ill relative from their parents as they grew older. For parents, the care of an insane child became increasingly difficult as they aged because their income declined, and responsibility inevitably passed onto the siblings.[86]

The position of a county asylum was an important consideration when constructing such an institution, as touched upon in chapter two, the proximity to the most inhabitants was a main concern.[87] Contemporary commentators were of the view that the appearance of an institution solely for the care of pauper lunatics, in an area which previously did not have such a place, caused the attitudes of the surrounding communities to become more receptive.[88] As can be seen from Figure 5.2, Garlands was not central to the two counties. Rather, for most inhabitants of Westmorland, the Lancaster Asylum, situated below Morecambe Bay just off the bottom of the map, would be closer. Proximity to the asylum was often a factor which drove families to

[84] P. E. Prestwich, 'Family Strategies and Medical Power: "Voluntary" Committal in a Parisian Asylum, 1876-1914', *Journal of Social History,* 27:4 (1994), pp. 799-818.
[85] Full table of statistics can be found in Appendix 2; CACC, *Patient's Friends Book 1900-1904*, THOS 8/4/24/1. The patients in this book have been researched in addition to the core sample.
[86] A. Suzuki, 'The Household and the Care of Lunatics in Eighteenth Century London', in P. Hordon and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions and the provision of welfare since antiquity* (London: Routledge, 1998), pp. 153-75.
[87] *Further Report of the Commissioners in Lunacy,* Parliamentary Papers 1847-1848 XXXII, p. 323, quoted in C. Philo, 'Journey to asylum: a medical-geographical idea in historical context', *Journal of Historical Geography*, 21:2 (1995), p. 156.
[88] Wright, 'Getting Out', p. 153.

retain insane relatives in domestic care.[89] This was reflected in the annual report of 1869, as Clouston noted: 'Distance from the asylum certainly operates as a cause for not sending patients at once'.[90] In 1850, Edward Jarvis asserted the distance decay model and used this as an explanation for the higher tendency for those closer to an asylum to commit their relatives, as opposed to those who resided some distance away.[91]

Fig. 5.2. Map of Cumberland and Westmorland, 1880.[92] *Red dot indicates the position of the Garlands Asylum in relation to the counties of Cumberland (pink) and Westmorland (beige).*

[89] Hirst and Michael, 'Family, Community and the lunatic', p. 84.
[90] *Annual Report 1869*, p. 11.
[91] J. M. Hunter and G. W. Shannon, 'Jarvis Revisited: Distance Decay in Service Areas of Mid-Nineteenth Century Asylums', *Professional Geographer,* 37:3 (1985), pp. 299-300, quoted in J. Melling and R. Turner, 'The Road to the Asylum: Institutions, Distance and the Administration of Pauper Lunacy in Devon, 1845-1914', *Journal of Social Geography,* 25:3 (1999), pp. 298-332.
[92] CACC*, Jackson's Postal Address Directory Map, 1880.*

Considering again the first 100 entries for each year of the patient's friends book, it is clear that the majority of visitors did not travel far to visit their relatives. An overwhelming majority, 57%, travelled less than five miles to the asylum as they lived in Carlisle itself. Secondly, 35% travelled less than 40 miles, coming from Cumberland. Less common were visitors travelling from Westmorland, 3%, who came an average distance of 60-70 miles. Finally, visitors travelling from outside of the two counties accounted for 5%. The distances varied greatly from 18 miles (Annan, Dumfries) to 268 miles (Newmarket, Suffolk).[93] Only on rare occasions were visitors recorded as travelling over 200 miles to reacquaint with their relatives. One example is John S who travelled 309 miles from Salisbury, Wiltshire, to visit his father on 4 January 1904.[94] His father, also called John, had been admitted to Garlands on 9 November 1903 reported to be suffering from mania caused by two strokes within the previous 18 months.[95] John lived in Carlisle with his wife and five youngest children. John, his second eldest son, worked as a soldier, and at the time of his father's admission he was stationed in Salisbury at Bulford training camp.[96] Thus, the large distance travelled represented the importance of maintaining family ties whilst confined in an asylum. John (senior) was visited by various members of his family on 16 occasions from his admission in November 1903, until his death on 24 August 1904. This further reinforces the notion that family visits were important to those in lunatic institutions. However, in John's case, asylum treatment failed to have any remedial affects, as repeated epileptic fits, due to the strokes he suffered, weakened his health and eventually killed him.[97]

In addition to visits, friends and relatives were encouraged to write frequent letters to patients, to maintain their ties to the outside world. This form of socialization was believed to have a great remedial quality,[98] especially for those with relatives unable to travel the distance to visit in person. [99] As mentioned, only a small number of

[93] CACC, *Patient's Friends Book 1900-1904*, THOS 8/4/24/1.
[94] Ibid.
[95] CACC, *Male Casebook 1903-1906*, THOS 8/4/39/6, admission no. 5458.
[96] Ancestry.com, *1901 England Census* [database on-line], Class: *RG13*; Piece: *3444*; Folio: *92*; Page: *7*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7814&h=20559243&ssrc=pt&tid=90189402&pid=76009427645&usePUB=true [accessed 20 April 2016].
[97] CACC, *Patient's Friends Book 1900-1904*, THOS 8/4/24/1; CACC, *Male Casebook 1903-1906*, THOS 8/4/39/6, admission no. 5458. This case has been researched in addition to the core sample.
[98] Marland, 'Getting away with murder?'.
[99] Kelm has noted how, for women in particular, familial contact speeded up the process of recovery and gave them an outlet through which to vent their frustrations and possibly quicken their release, Kelm,

these letters survive, but four examples have been chosen which highlight the emotions involved in maintaining contact with loved ones whilst in the Asylum.[100] First, James N was admitted to Garlands in October 1899 as a 'stray lunatic' wandering at large.[101] He was found in Carlisle, and was believed to have escaped from a Scottish asylum only a few days before. James was listed as single and nothing was known about him or his relatives. However, in the letter attached to his case notes, he addressed it 'dear flower', and expressed how sorry he was for not being in touch as he had been detained in Carlisle. James went onto to invite his unnamed recipient to come and visit, as it had been five months since they had last met. The fondness for his 'flower' is clear in the tone of the letter, but so too is James' illness, as he signed the letter 'professor Nevan', when he was listed as a labourer.[102] Thus, despite the sentimental tone, the letter was kept as a symbol of James' delusions and confused state, but despite this this, the importance of seeing his 'flower' is clear.

Second, Joseph D was admitted in January 1897noted as suffering from melancholia. Similar to that of James, Joseph's letter was also sentimental, and he expressed clear emotion at being detached from his family. However, it seems that his relative did not reciprocate his feelings as he was pleading with 'George' to come and visit him. He had contact with other family members as he stated that he had written to his father who had told him that another male relative, 'Timothy', was coming to see Joseph the following week, and he wondered why George could not accompany him on his visit to Garlands. Joseph goes on to tell George about how he is getting on in the Asylum and that he had recently been suffering from rheumatism. He signed the letter 'your affectionate brother', thus showing how he still cared for George, despite his lack of communication.[103] Third, a series of letters found in the Male Casebook 1893-1897, unattached to a particular patient, but signed with the name Fred, provide a first-hand insight into how important family contact could be. In one undated letter to his 'dearest

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'Women, Families and the Provincial Hospital', p. 180. Simialrly, Wannell argued that relatives did play a role in asylum treatment, Wannell, 'Patients' Relatives and Psychiatric Doctors', p. 297.

[100] Letters within asylum records are difficult for researchers to locate. Often, they have not been kept in separate files, or at all. Instead, they have been attached to some patients, but not to others. For instance, David Scrimgeour used letters in his examination of 158 pauper patients of the West Riding Lunatic Asylum, but had to be cross-referenced with other material to be fully understood, D. Scrimgeour, *Proper People: Early Asylum Life in the Words of Those Who Were There* (York: York Publishing Services Ltd, 2015).

[101] *Carlisle Journal,* 24 October 1899.

[102] CACC, *Male Casebook 1897-1900,* Letter attached to patient case record, admission no. 4800. This case has been researched in addition to the core sample.

[103] Ibid., admission no. 4356. This case has been researched in addition to the core sample.

mother', Fred writes how he hoped she would not fail to turn up at the next visit as it would be a 'bitter disappointment to him'.[104] Finally, a letter from Grainger N, dated 4 December 1901, three years after his admission, also written to his mother, stated how he was glad to have a son's feeling towards his mother, and signed the letter, 'with best wishes from your affectionate son'.[105] These letters written by pauper patients provide a fascinating insight into the importance of maintaining familial relationships when undergoing treatment. The desperate language portrays the significance of visitation and of hearing from them via written correspondence. The historiography is dominated by examinations of the letters and diaries of the wealthier classes.[106] Thus, these letters represent a new source of primary material which contributes to filling the identified gap, and establishing the pauper lunatic experience within a neglected institution in the historiography. From the evidence presented in this section, it is clear that the family remained an important source of contact throughout a patient's committal, which was actively encouraged. The next section will begin by examining the hereditary traits which gave patients a relationship with the institution even before they were admitted.

The Family as a Cause of Insanity

The notion of insanity as being hereditary was borne out of the contemporary idea that poverty bred unacceptable behaviours, and that children brought up in this environment would suffer the sins of their parents.[107] As mentioned in chapter two, a hereditary predisposition to insanity was increasingly cited as a cause of a patient's malady, particularly towards the end of the end of the nineteenth-century, as the eugenics movement and degeneracy theorists gained momentum.[108] It is important to state that hereditary predisposition was given on a patient's case notes in addition to the identified cause, under the heading 'hereditary history', and the identified form.

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[104] CACC, *Male Casebook. 1893-1897*, THOS 8/4/39/3. This case has been researched in addition to the core sample.
[105] CACC, *Male Casebook. 1897-1900*, THOS 8/4/39/4, admission no. 4653.
[106] Demonstrating the availability of the higher-class patient letters is the extensive archive of the York Retreat, which comprises of 40 boxes of patient correspondence (1800-1965), now digitized. *The Retreat Archive*, RET/6/19, https://search.wellcomelibrary.org/iii/encore/record/C__Rb2496244__Syork%20retreat%20letters__P0%2C3__Orightresult__X1;jsessionid=D58D0C118730DA4D0B61870E80F0765A?lang=eng&suite=cobalt [accessed 03 August 2018].
[107] A. Rebok Rosenthal, 'Insanity, Family and Community in Late-Victorian Britain', in A. Borsay and P. Dale (eds), *Disabled Children: Contested Caring, 1850-1979* (London: Pickering & Chatto, 2012), pp. 29-42.
[108] L. Hide, *Gender and Class in English Asylums, 1890-1914* (Hampshire: Palgrave Macmillan, 2014), p. 20 See also Taylor, *Child Insanity.*

Therefore, it was an attributing factor to the cause of insanity, and it's importance in diagnosis is reinforced by its presence in the casebook.[109] In Mary-Ellen Kelm's research, hereditary predisposition became the most common cause to be diagnosed by superintendents who were delivering unsatisfactory cure rates.[110] Clouston echoed the popular opinion through the following passage:

> The facts of nature compel the physician to see that purely mental and moral qualities and mental defects are transmissible from parent to child, and prepare him for the great part that…[hereditary] plays in psychological development and in mental disease. It has not yet been proved statistically whether a man's features or the acuteness of his moral sense are most apt to be transmitted to his children or grandchildren, but I am strongly of opinion that the latter will be found to be equally so with the former.[111]

Although it was not scientifically proven that mental illness was passed on through generations of the same family, psychiatrists believed this was the case regardless. The tendency of major psychiatric illnesses to cluster in certain family trees was proof enough of the predisposition of individuals to insanity.[112] On admission, doctors would thoroughly probe into a patient's family history to ascertain if insanity was a hereditary trait. This was frequently noted in the casebooks, under the heading of 'hereditary history', by phrases such as; 'mother insane'; 'father committed suicide'; 'paternal grandmother treated at Garlands', and more remote and indistinct comments such as, 'maternal aunt peculiar in mind'. One obscure example for Edward M, admitted 25 July 1888 aged 70, even cited his hereditary predisposition as; 'all his friends known of are eccentrics and fond of whiskey'.[113] Presumably this was an attempt to explain the cause of his intemperance through the belief that vice and degenerative habits could easily

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[109] For instance, on the case notes for James S, the cause of insanity was given as alcoholism, the form as mania, and it was noted under 'hereditary history', that his brother was also in Garlands, CACC, *Male Casebook 1900-1903*, THOS 8/4/39/5, admission no. 5435.
[110] S. E. D. Shortt, *Victorian Lunacy: Richard M Bucke and the Practice of Late Nineteenth Century Psychiatry* (Cambridge: Cambridge University Press, 1986), in Kelm, 'Women, Families and the Provincial Hospital', p. 180. Similarly, Marland notes that with regard to female mental conditions – puerperal insanity, menopausal mania, insanity of lactation, or a malady induced by pregnancy – asylum doctors tended to explain these through hereditary factors, Marland, 'Getting away with murder?'.
[111] T. S. Clouston, *Clinical Lectures on Mental Diseases* (London: J & A Churchill, 1904), p. 2.
[112] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), p. 28.
[113] CACC, *Male Casebook 1888-1891*, THOS 8/4/39/1, admission no. 5094. 'Friends' in here is taken to refer to the contemporary use, as it could denote relatives rather than friends in a modern sense.

spread. Particularly from the 1860s, the defective heredity explanation gained prominence among psychiatrists in causing vulnerability to madness.[114]

Clouston commented on the large number of cases in Garlands attributable to hereditary factors.[115] In 1872, on analysing the previous five years admissions, he noted that 42% of cases had a marked 'family taint'.[116] Clouston regarded the identification of a patient's family history to be extremely valuable to diagnosis and treatment:

> For its proper medical treatment nothing is more important sometimes than such a history of any case, as well as a correct account of the antecedents and family history; yet this information it is often impossible to get satisfactorily. It is always desirable for a relative or someone previously acquainted with the patient, and who also knows the symptoms he has laboured under since the commencement of his illness, to accompany the relieving officer to the Asylum…nothing, certainly, pleases and satisfies the relatives of a patient more than seeing the interest and trouble implied in asking a series of minute questions relating to the disorder, and recording the answers. To myself the sort of answers I am able to get to those questions makes all the difference between treating the case with one's eyes shut or with them open.[117]

Just under one third of the patient sample were noted as suffering from a hereditary predisposition, with one eighth specifically having one or more relatives who were previously treated at Garlands.[118] One example, Thomas F, admitted 28 November 1887, displayed signs of intemperance which were mirrored in his father's admission 19 years earlier.[119] His father, John, had been admitted in 1869 suffering from

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[114] A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Yale University Press, 1993), p. 238.
[115] Similarly, Cherry found that in the absence of any obvious cause of insanity, the Norfolk Asylum began increasingly to denote a 'hereditary predisposition' in patient diagnosis, Cherry, *Mental Health Care*, p. 89, p. 43.
[116] CACC, *Eleventh Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1872*, THOS 8/1/3/1/10, p. 19.
[117] Ibid., p. 13.
[118] This closely reflects the findings of Dr Farquharson in an 1898 article. Based on all the admissions until that date, he found that 30.7% of patients had a hereditary predisposition to insanity, W. F. Farquharson, 'Heredity in Relation to Mental Disease', *Journal of Mental Science*, 44:186 (1898), pp. 538-554.
[119] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 3000. Superintendent of the West Riding Asylum during the 1850s and 1860s, James Crichton-Browne, believed that intemperance of a

melancholia due to intemperate habits.[120] Thomas fell into the same drunken habits, exhibiting violent bouts and marked delusions, for example: 'That a warrant has been out for him and that police were watching him'.[121] For Thomas, poverty was cited as a cause of his insanity, which leads to the assumption that in the absence of his father's economic earning capacity, the family home was affected by destitution. The Asylum acted as a place for the intemperate of society to 'dry out',[122] but in the case of Thomas and John once the drying out period was over their insanity continued to affect them, and they both saw out their final days in Garlands, John died in 1895 and Thomas in 1929. As will be explored in the next section, the Asylum offered those from poorer backgrounds a higher standard of living than they were used to, and were probably ever likely to achieve. Thomas and John certainly benefitted from this as they lived to the age of 68 and 67, respectively.[123]

The presence of multiple members of the same family being confined in a lunatic institution together was not a rare occurrence. As Campbell noted, in 1887:

> At present there are in this asylum three brothers, two uncles and nephews, three sisters whose mother died here, two mothers and daughters, and numerous more relatives. I have known as many as four of one family here at the same time.[124]

When examining the patients from the sample who had relatives in Garlands, attempting to compare their cases to pinpoint any similarities is difficult, due to the relative infancy of psychiatry, and the lack of solid scientific knowledge which accounted for an individual's insanity. For instance, John K was admitted 13 January 1900 recorded as suffering from religious mania. The cause of his condition was given as 'probably hereditary predisposition' as two of his first cousins, Edward K and

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parent would 'transmit to his children a heritage of disease', J. Crichton-Browne, 'Psychical Diseases of Early Life', *Journal of Mental Science,* 6:33 (1860), p. 290, quoted in Rebok Rosenthal, 'Insanity, Family and Community', p. 34.

[120] CACC, *Casebook 1865-1870*, THOS 8/4/38/2, admission no. 727.

[121] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 3000.

[122] Smith, 'Family, Community and the Victorian Asylum', p. 120.

[123] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 3000; CACC, *Casebook 1882-1884*, THOS 8/4/38/8, admission no. 2364.

[124] CACC, *Twenty-Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1887*, THOS 8/1/3/1/25, p. 10.

Jonathan K, were also in the Asylum at the same time.[125] When comparing the case notes to his cousins there seems to be few similarities between their conditions. All three men were stated to be suffering from some form of mania, with Edward's condition given as 'epileptic mania', and Jonathan's as 'mania'. Additionally, they all showed violent tendencies both before admission and during their stay.[126] Notably, the suicide attempt, which led to committal, was reported in the local newspaper: 'Edward K…27 years of age…made an attempt to cut his throat with a table knife, but fortunately only succeeded in inflicting a slight scratch…'[127] Edward and Jonathan were brothers and were admitted to Garlands in 1897 and 1899, respectively. Both suffered from long-term mental illness, as they both remained until their death in 1944 and 1943, respectively. By contrast, John was only in Garlands for seven months, and it was recorded that he suffered from 'religious mania' due to over-studying. It is clear that Jonathan and Edward's form of insanity were similar; given that they were brothers the hereditary link would be stronger. However, the form of insanity experienced by John was much different and evidently easier to cure. After his discharge John continued living with his adopted father Thomas and gained employment as a pit shaft hand in a nearby mine.[128] Therefore, the presence of a hereditary predisposition was unfounded. This is evidence of the tenuous nature of heredity as an explanation for mental illness, as it was misunderstood.

As well as indirectly causing a relative's mental illness through hereditary predisposition, families could be the direct cause.[129] Medical superintendents held strong views about the negative consequence of the family home for those inclined to insanity through hereditary ties.[130] Suzuki referred to 'domestic disagreement, dispute and cruelty' as causing insanity,[131] and Marland asserted that family were often the key to a patient's misfortune as for many the familial setting was 'a dreadful place to be'.[132]

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[125] CACC, *Male Casebook 1897-1900,* THOS 8/4/39/4, admission no. 4839.
[126] Ibid., admission nos. 4830 (John), 4373 (Edward), 4776 (Jonathan).
[127] 'A Violent Lunatic at Cockermouth', *The West Cumberland Times,* 20 February 1897.
[128] Thomas was John's uncle, who had adopted him after the death of his parents when he was young. Ancestry, *1901 England Census*.
[129] Smith found that family behaviour could steer vulnerable members toward the asylum, Smith, *Insanity, Race and Colonialism*, p. 16.
[130] Kelm, 'Women, Families and the Provincial Hospital', p. 180. Shorter highlighted that isolation from the detrimental environment, could have positive effects as the patient's attentions would be diverted from the previously unhealthy habits, Shorter, *A History of Psychiatry,* p. 13.
[131] A. Suzuki, 'Framing Psychiatric Subjectivity: Doctor, Patient and record-keeping at Bethlem in the Nineteenth-Century', in Melling and Forsythe (eds), *Insanity, Institutions and Society,* pp. 115-36
[132] H. Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave-Macmillan, 2004), p. 158.

Exploration of family involvement in the onset of mental illness in the historiography has been piecemeal, as relatives, could be, but were not always, specifically attributed to triggering an individual's condition. Mistreatment prior to admission is often clearly stated in the records, but identifying them as the instigator of illness can be difficult to determine, as other factors were also stated. Doctors became increasingly frustrated by the cases brought to them who had worsened due to cruel treatment whilst under the care of their families.[133] This was highlighted in the 1885 annual report by Campbell, in which he blamed a patient's family for failing to send a mentally ill relative in the first phase of the illness: 'the excusable desire of trying to keep hid the presence of such a dire disease as insanity often produce sad results'.[134] For instance, Isabella Y was admitted in November 1896 given to be suffering from mania. The case notes stated: 'Her husband is said to have locked her up in a room and not to have let her outside for years'. Her physical state indicated that she had been kept indoors for some time, as she was described as pale, emaciated, filthy, and in a generally poor condition. However, although mistreatment was indicated, and it is clear that concealment did not benefit her condition, it was not given as the cause of Isabella's illness. Instead, this was 'unknown', and the family were not attributed to the onset of her mania.[135]

Using the sample, record linkage has been carried out to provide a more comprehensive picture of the family role in mental affliction. Although some overlaps exist with the examples outlined in chapter two, here the exploration will focus on how the family could be the direct cause of insanity, rather than the conditions themselves. Four areas have been identified that demonstrate how relatives of patients, from an unrepresented institution in the historiography, could adversely impact an individual's mental health, triggering asylum care. First, the stigma attached to becoming an unwed mother could drive expectant women to the point of insanity, as a result of strong social expectations.[136] Clouston noted that in Garlands, 'puerperal insanity is much more frequent among the mothers of illegitimate children than other women'.[137] This was because 'the shame and mental distress' brought on insanity,[138] as they anguished at the

[133] Ibid., p. 148.
[134] *Annual Report 1885*, p. 13.
[135] CACC, *Female Casebook 1895-1899*, THOS 8/4/40/4, admission no. 4334.
[136] Deborah Cohen noted illegitimacy as carrying with it a 'powerful' stigma, D. Cohen, *Family Secrets: Living with Shame from the Victorians to the Present Day* (London: Viking, 2013), p. 113. See also Levine-Clark, 'Dysfunctional Domesticity', p. 348.
[137] CACC, *Fourth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1865*, THOS 8/1/3/1/3, p. 8.
[138] T Clouston, *Clinical Lectures*, p. 551.

prospect of being labelled 'immoral' and cast out from society. For instance, Grace L was admitted on 1 April 1898 stated as suffering from puerperal mania. This was reported in the case notes as the result of her giving birth to an illegitimate child eleven days previous, which caused her to have epileptic fits. Before and during confinement Grace attempted to commit suicide, and continually searched for items to harm herself with. She was noted as stating just after her arrival that 'she has been a wicked woman'.[139] Giving birth to an illegitimate child drew attention from Poor Law Guardians, and was reason enough to warrant a stay in the workhouse.[140] In Grace's case, she was sent to Garlands from Cockermouth Workhouse, where she most likely gave birth to her child. Her violent behaviour and refusal to eat caused her transferal to receive specialist care. Grace remained in Garlands for just under a year, and she was discharged as recovered on 7 March 1899.[141] She married a year later and never returned, reinforcing the notion that puerperal insanity, although attributed to her baby, was a highly curable condition.[142]

Second, domestic disturbances could cause a loss in mental faculties. For example, Dinah L was admitted in June 1899 said to be suffering from melancholia caused by 'domestic trouble.' This was stated to be caused by 'unpleasantness at home'. Four days before her admission, for reasons unstated in her records, she left her house, and was found wandering barefoot in a friends garden by a neighbour.[143] At the time, Dinah was living with her husband Thomas, and several of their ten children. Her last child, Edith, had been born in 1892 when she was 45.[144] It was stated that she had been feeling melancholic and had frequently felt suicidal for the seven years since Edith's birth. The exact trigger for Dinah leaving home, which led to her admission, was not definitively stated, but she was described as having two black eyes and several bruises on all of her limbs. Along with the description of 'unpleasantness at home', it can be assumed that Dinah suffered some form of domestic abuse from either her

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[139] CACC, *Female Casebook 1895-1899*, THOS 8/4/40/4, admission no. 4555.
[140] Busfield, *Men, Women and Madness*, p. 127.
[141] CACC, *Female Casebook 1895-1899*, THOS 8/4/40/4, admission no. 4555.
[142] FreeBMD. *England & Wales, Civil Registration Marriage Index, 1837-1915* [database on-line], https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8913&h=17828991&ssrc=pt&tid=88443294&pid=38563464328&usePUB=true [accessed 07 July 2016].
[143] CACC, *Female Casebook 1895-1899*, THOS 8/4/40/4, admission no. 4743.
[144] Ancestry, *1891 England Census*, Class: RG12; Piece: 4333; Folio: 13; Page: 19, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=6598&h=16149622&ssrc=pt&tid=101582453&pid=170009787730&usePUB=true [accessed 23 June 2016].

husband or her children. Whatever the case, it is clear from her record that she was anxious to leave her home, and in July 1899 she was described as saying 'she is very happy in the asylum…and has no desire to leave'. She had been married for 29 years, and since 1871 had given birth to eleven children, of whom ten survived. Therefore it is reasonable to assume that the demands of what was clearly a hectic domestic life had taken their toll on Dinah. After receiving treatment in the asylum for some months, Dinah's health improved and her suicidal thoughts subsided enough for her want to return home to her family. She was discharged as recovered on 19 October 1899,[145] and remained living with her husband in Kendal until her death in 1911, never returning to Garlands with any further problems.[146] The respite offered to her during those months in 1899 was enough to return her to her usual physical and mental health which had become so weak due to her domestic situation.

Third, emotional unrest concerning relationships, or potential relationships, could cause insanity, as seen in chapter two in the case of Elizabeth Q.[147] An additional example is Ellen W, admitted 31 March 1890, stated to be suffering from mania caused by 'disappointment in love'. She had taken a house under the impression she was going to be married, but her family stated this was not to be, and curiously no further details of Ellen's prospective husband are given. Her family stated on admission that they suspected she was pregnant, and that this was the root cause of her malady.[148] Delusions of paranoia regarding rumours being circulated within the neighbourhood about an individual were not uncommon among those suffering from conditions caused by domestic disturbances.[149] Thus, Ellen was possibly driven insane by the thought of having a child out of wedlock with a man who had deserted her. Also, the reason that the name of the man who had left her was not supplied could have been due to the feeling of shame of leaving Ellen with an illegitimate child. After four months treatment, she was discharged as recovered back to the family home. However, she was

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[145] CACC, *Female Casebook 1895-1899*, THOS 8/4/40/4, admission no. 4743.
[146] Ancestry.com, *1911 England Census* [database on-line], Class: *RG14*; Piece: *31635*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=2352&h=31672488&ssrc=pt&tid=101582453&pid=170009787730&usePUB=true [accessed 23 June 2016]; FreeBMD. *England & Wales, Civil Registration Death Index, 1837-1915* [database on-line], https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8914&h=20979002&ssrc=pt&tid=101582453&pid=170009787730&usePUB=true [accessed 23 June 2016].
[147] E. Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago Press, 1987), p. 30.
[148] CACC, *Female Casebook 1888-1892*, THOS 8/4/40/2, admission no. 3337.
[149] Levine-Clark, 'Dysfunctional Domesticity', p. 349.

readmitted on 15 October 1890. The symptoms of her condition were this time given as: 'she cannot by any persuasion be induced some to leave her home. Has an absent, distrustful look'; also that she was afraid of the dark and was not fit for work. Faced with an unproductive member, Ellen's family were forced to readmit her for further treatment, as they could no longer carry the emotional and financial burden of her illness. She remained in Garlands for three years, until her death in September 1893, aged 26, from exhaustion.[150] Therefore, the disappointment of her affections was enough to trigger a considerable mental breakdown, which prolonged until her death three years later, demonstrating that spousal relationships could bring about insanity.

Finally, bereavement was cited in the case notes, as the loss of loved ones could lead to madness and despair.[151] Michael MacDonald describes the suffering of the surviving relative as an indicator of the intense emotional bonds prevalent within the family.[152] This was the case for Ellen H, admitted to Garlands on 12 April 1886 aged 41 from Carlisle. The cause of her mania was given as 'loss of child and conduct of husband', she was however also stated to be suffering from the 'insanity of pregnancy'.[153] At the time of admission, Ellen had given birth to three children, of whom only two were alive, aged fifteen and eight. Her second oldest, Margaret, had died in 1883 aged eight.[154] The grief of her loss was given as the reason for her change in disposition over the previous three years. One year before her admission, it was stated that her husband, William, who was a drunk, went away with another woman. However, Ellen's marriage cannot have completely broken down, as she was stated to be in the fourth or fifth month of pregnancy, carrying William's child when she came to Garlands. Similar to the examples of Grace and Ellen W above, the case may have been that combined with the loss of Margaret, the infidelity of her husband, and the situation she now faced, bringing up William's three children alone, became too much for Ellen to handle. Thus the grief she felt over her bereavement was the first of many events beyond her control, inflicted by those closest to her, led to the breakdown of her mental

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[150] CACC, *Reception Orders 1890*, THOS 8/4/1/32; CACC, *Female Casebook 1888-1892*, THOS 8/4/40/2, admission no. 3410.
[151] Coleborne, *Madness in the Family*, p. 66.
[152] M. MacDonald, *Madness, Anxiety and Healing in Seventeenth-century England* (Cambridge: Cambridge University Press, 1981), p. 77.
[153] CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, admission no. 3872.
[154] Ancestry.com, *1881 England Census*, Class: RG11; Piece: 5183; Folio: 62; Page: 29; GSU roll: 1342250, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7572&h=2358084&ssrc=pt&tid=102990984&pid=300024643105&usePUB=true [accessed 07 September 2016].

health. Ellen gave birth in Garlands in September 1886; after only 18 days the baby was taken away and handed over to William. Ellen died in Garlands in April 1888, and in October of that year William remarried Mary Jane, whom was most likely the woman he left Ellen for.[155] The examples offered in this section represent an insight into an area of the literature which has been left relatively unexplored. The involvement of relatives in the cause of an individual's insanity is one which requires further examination, and this chapter has provided the platform for this research, by presenting cases from an unrepresented institution in the literature. Next, the chapter shall move on to look at how the asylum came to be modelled on the structure and ideals of the family home, as it offered those that were institutionalised a domestic environment in which to promote and conduct recovery.

The Asylum Emulating the Family Home

During the nineteenth-century, as the number of institutions grew, so too did the number of those residing in them away from the family home. In consequence, these establishments,[156] came to emulate the structure of the domestic household, not just physically, but also in terms of the familial environments they aimed to reflect. Among these were the county asylums.[157] Specific research into their domesticity has been confined to the experience of establishments for middle and upper-class patients, although some useful overviews of pauper institutions have been provided. In her book, *At Home in the Institution*, Jane Hamlett dedicates one chapter to the experience of four public asylums in the South East of England.[158] She provides some examples from the records of these institutions to reinforce the idea of domestication in the asylum network. Her account focuses on the moral treatment of patients, and examples of how the asylum offered a familial context while its patients were temporarily, or permanently, displaced from their own, remain absent. To redress this gap in the historiography, this section will examine the experience at Garlands to expand this neglected area of knowledge within the pauper institution.

Closely associated with moral treatment, the domestication of asylums was commonplace as the county network expanded after 1845. Browne identified a shift, in

[155] CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, admission no. 3872. This case has been researched in addition to the core sample.
[156] For example workhouses, children's homes, lodging houses, military barracks, to name a few.
[157] Hamlett, *At Home in the Institution*, p. 1.
[158] Ibid., Chapter 1.

which asylums transformed from the 'gloomy madhouse', to establishments that resembled the homes from which the patients came from, because they 'love and have been accustomed to these dwellings'.[159] In this family template, there would be a masculine 'head' modelled on the patriarchal dominance of a father, with dependents attached to this head emulating the wife/mother, and children.[160] Anne Digby also found in her research through the York Retreat case books that the 'patients were seen as dependents who needed to be looked after like young children'.[161] The mixture of kindness and discipline emulated that which is necessary for preserving order in the family home.[162] As mentioned in the previous chapter, underpinning the domestic structure were the tasks given to the patients to keep them usefully employed. Roles were assigned, gender dependent, to help the day-to-day running of the asylum. Everyone had a vested interest in the upkeep of the house, just as members of a family would to ensure the survival of their domestic unit. Thus reaffirming the importance of the family structure in the asylum regime, and establishing a degree of trust between the staff and patients, which mirrored that of relatives. However, patients could also form familial relationships with each other. In the case notes of Joseph B, admitted in June 1862 suffering with dementia, it was reported that: 'ordered about by fellow patient who takes a fatherly interest in him, at times makes him say his prayers'.[163]

The furnishing of the Asylum was modelled on the home, and the importance of domestic decoration was continually referred to in the Lunacy Commissioners annual reports.[164] They promoted the idea that the Asylum should offer a better standard of living than the pauper patients were used to, to encourage them to want to better themselves and their surroundings once they were discharged. For example, in 1904, they remarked of Garlands:

> Some of the day-rooms were dull, and much in need of brightening by lighter decoration, and by the provision of a more liberal supply of

[159] W. A. F. Browne, 'The Moral Treatment of the Insane; a lecture', *Journal of Mental Science*, 10:51 (1864), pp. 309-15.
[160] Davidoff, 'The Family in Britain', p. 71.
[161] A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), p. 59.
[162] N. Bingham, *Observations on the Religious Delusions of Insane Persons* (London: Hatchard, 1841), p. 105, quoted in Showalter, *The Female Malady*, p. 28.
[163] CACC, *Casebook 1862-1865*, THOS 8/4/38/1, admission no. 188. This case has been researched in addition to the core sample.
[164] Hamlett, *At Home in the Institution*, p. 19.

> ornaments and other objects calculated to attract the attention and arouse the interest of patients, especially those of the less favourable class.[165]

This was also commented on in the Asylum annual reports. The upkeep of the décor was referred to by Campbell in 1894: 'The wards have been kept clean, bright, and well decorated with flowers, and the airing courts while the weather allowed of it, were lovely with well-trimmed grass, and beds of tastefully assorted flowers'.[166] He reinforced the importance of 'aesthetic painting and papering, and true harmony of colours in the decorations', as well as 'unlocked doors' to increase the liberty of the patients displaying symptoms of recovery. However, he also reiterated that the primary function of the Asylum was a place of care, and that a preoccupation with the furnishing of the asylum must be avoided.[167] Thus, the domesticity of the pauper lunatic asylum provided a familiar setting in which to conduct patient therapy. This could be successful, as one patient, Hugh L, who was admitted in December 1882, following a period of removal to Wadsley Asylum due to overcrowding, returned to Garlands and was reported to have: 'Refused all food until he was placed in the same ward and in the same chair as he occupied when here previously'.[168] Hugh had been transferred two years previous, but still craved the familial environment of Garlands. It was noted on his first night back in the Asylum, he 'did not sleep well last night, because it was not his own bed he said'.[169]

Interestingly, it was the disruption of the familial setting which led families to admit their relatives to the asylum initially.[170] Removal of a disruptive member reinstated the domestic order, whilst bringing disorder to the asylum. Patients who damaged homely furnishings during bouts of violence, associated with several mental disorders, were seen as attacking the structure of the Asylum.[171] An example is Sarah F,

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[165] CACC, *Forty-Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1904,* THOS 8/1/3/1/42, p. 8.
[166] CACC, *Thirty-Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1894*, THOS 8/1/3/1/32, p. 14.
[167] J. A. Campbell, 'Four Years' Treatment of Insanity at Garland's Asylum, With Remarks', *The Lancet*, 121:3108 (1883), pp. 497-8.
[168] See Table 6.2 in chapter six for full implications of this transfer.
[169] CACC, *Casebook 1882-1884*, THOS 8/4/38/8, admission no. 2334. This case has been researched in addition to the core sample.
[170] Marland, *Dangerous Motherhood*, p. 65. Suzuki has also noted that families were concerned over their mentally defective relative's mismanagement of property, Suzuki, *Madness at Home*, p. 120.
[171] Similarly, in his study of London workhouses, David Green recognised that window breaking was a sign of rebellion against the institutional regime, D. Green, 'Pauper Protests: Power and Resistance in

who throughout her treatment in Garlands during the 1890s was continually described as destructive and violent. Admitted in 1893, Sarah was said to have suffered from mania and experienced delusions that people were conspiring against her. This made her extremely restless and anxious, which was reflected in her violent behaviour. She frequently struck out at fellow patients and destroyed articles in the Asylum. In September 1893 it was stated that she was 'very destructive to her clothes and plants'; and in June 1894 that she, 'often strikes and interferes with other patients, breaks glass and is very unruly'. However, it was noted on occasion that Sarah could respond well to the moral regime, as in April 1894 it was stated that she was more settled and had begun to work in the laundry, where she 'does fairly well'. This interchangeable behaviour continued throughout Sarah's treatment, and she remained in Garlands until her death in May 1911.[172] The fact she could adhere to the Asylum regime indicates that when she did not feel able to conform, rebellion through the destruction of furnishings was a form of agency in which to express her opposition. Thus, the domestication of the Asylum, in some cases, did not offer comfort to all.

The emulation the domestic environment offered a familial context to those who lacked a supportive network of relatives. The family must not be viewed solely as a willing participant in the support of a mentally unsound member, as has been seen above through the ways in which relatives could cause insanity, as they could react negatively when their domestic framework was threatened. Relatives who failed to conform to constraints of family life could be cast aside and left for the Poor Law Guardians to care for.[173] The disruption of the family as carers, also occurred as a result of industrialization. Migration from rural areas to the expanding towns and cities separated families from their extended members on which they had relied on for support and sustenance in times of ill health. Long hours demanded by jobs in factories and mills made it increasingly difficult to find the time to care for dependant relatives, leading to the demand of publicly funded provision.[174] This will be explored further in the next chapter, in the context of the patients admitted to Garlands that were Irish

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Early Nineteenth-Century London Workhouses', *Social History*, 31:2 (2006), pp. 137-59, quoted in Hamlett, *At Home in the Institution*, p. 31.

[172] CACC, *Female Casebook 1892-1895*, THOS 8/4/40/3, admission no. 3817.

[173] Digby, *Madness, Morality and Medicine*, p. 57.

[174] G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), p. x; see also M. Hanly, 'The Economy of Makeshifts and the role of the Poor Law: A Game of Chance?' in S. King and A. Tomkins (eds), *The Poor Law in England 1700-1850: An Economy of Makeshifts* (Manchester: Manchester University Press, 2013), pp. 79-99.

immigrants, some of who left their families behind. Little has been written, since John Walton's research, about the pauper lunatics who were the victims of family breakdowns, particularly within the Asylum context.[175] One example drawn from the Garlands records is Sarah M, who demonstrated a reliance on the institutional framework for familial support, and became ingrained in the 'tapestry of care'.[176] Admitted to Garlands in May 1890, Sarah was transferred directly to the Asylum from Brampton Workhouse.[177] She had been living with her mother, Mary, until her death in 1884; and her father was absent from the family home.[178] On Sarah's admission record, her father was described as having 'a violent temper', and it can be assumed that this is why he did not reside with Sarah and her mother. After Mary's death, Sarah was unable to settle to work, 'wandered about the roads', and was unable to look after herself. The trigger for her removal to Garlands was her unmanageable behaviour in the Union house, her refusal to eat, and her constant protestations that her food had been poisoned. After five years in Garlands, Sarah was discharged unrecovered back to Brampton Workhouse, which, as has been explored in chapter three, was a frequent occurrence in periods of overcrowding.[179] Sarah had two brothers and a sister living at the time of her first committal to Garlands. Thus, as she had ended up in the care of the local workhouse, it is clear that they were either unable, or unwilling, to support their sibling. Sarah was transferred back to Garlands for the second time from Brampton Workhouse on 23 July 1897. What is interesting from her second admission is that her reception order lists her as having 'no known relatives';[180] therefore this confirms that her siblings distanced themselves from Sarah and her unruly behaviour, possibly because the stigma of an insane relative was a source of intense shame.[181] From Sarah's case record, what is more interesting is that she came to prefer life in Garlands: 'has no

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[175] See Walton, 'Casting Out'. Also touched upon in the context of child insanity by Taylor, Taylor, *Child Insanity*.
[176] See L. Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the insane in West Midlands workhouses, 1815-1860', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20.
[177] CACC, *Reception Orders 1890*, THOS 8/4/1/32.
[178] Ancestry, *1881 England Census*, Class: RG11; Piece: 5150; Folio: 71; Page: 2; GSU roll: 1342242, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7572&h=2207430&ssrc=pt&tid=102929455&pid=410022244609&usePUB=true [accessed 08 August 2016]; FreeBMD, *England & Wales, Civil Registration Death Index, 1837-1915*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=8914&h=22593013&ssrc=pt&tid=102929455&pid=410022244609&usePUB=true [accessed 08 August 2016].
[179] CACC, *Female Casebook 1888-1892*, THOS 8/4/40/2, admission no. 3359.
[180] CACC, *Reception Orders 1897*, THOS 8/4/1/39.
[181] Suzuki, *Madness at Home*, p. 121.

interest in her former life, contented and happy to be here'. Sarah never returned to living outside an institution, as she died in Garlands in 1930, aged 67.[182] In Sarah's case, and in that of many others, in the absence of a willing family network of support, the Asylum offered a domestic setting which she relied upon for the majority of her life. This will be explored in great depth in chapter six, particularly for the implications this had on the Roman Catholic patients in the sample who had migrated to England, leaving their families behind.

Conclusion

This chapter has provided several new areas of research which are absent from the historiography. In terms of family involvement in asylum treatment, the secondary literature is heavily concentrated on the admission and discharge process. Some have gone further and researched aspects of family involvement, such as Suzuki, Marland and others. However, due to the sparse nature of records, little is understood of family involvement whilst a mentally ill relative was present in an asylum. This chapter has gone some way to redress this, and through the examples drawn from the Garlands patients, a more comprehensive understanding of the family's role in this process has been ascertained. Historians have been correct in their assertions that the family remained at the centre of the asylum committal, despite the rapid expansion of the county network, but they have not gone far enough to fully explore this role to give a true understanding of the pauper experience in this period. Thus, one of the identified gaps set out in chapter one, has been addressed. This also begins to explain how the family contributed to patient circulation, which will be examined in detail in chapter six.

From the evidence gathered in this chapter, the implications of the historiography have been confirmed, as it is clear that the domestic unit remained important. The family relinquished ultimate control and were the ones who transformed their relatives into patients of the asylum system. Without their instigation, committal to an insane institution would not have taken place in the majority of cases. Similarly, the decision to discharge a pauper patient once they showed signs of recovery, was a joint one, mutually agreed by the asylum doctors and relatives that they were fit enough to be returned home. However, this process could have been unsupported by doctors;

[182] CACC, *Female Casebook 1895-1899*, THOS 8/4/40/4, admission no. 4452.

but the final decision lay with those closely bonded with the patient, giving them ultimate power. Thus, although the family home was no longer the 'correct' place to treat a mentally unsound member, they remained in control before and after the period of treatment had taken place. Where this examination has gone further is through the exploration of an absent institution from the historiography.

The letters found within the Garlands case records have provided important examples of the maintenance of contact between the relatives and asylum doctors in charge of their care. This relationship is one of which little is known, but this chapter has gone some way to assert its importance for both parties. The majority of the existing literature has focussed on the wealthier classes who left behind more records which provide evidence of this. Similarly, the maintenance of family bonds whilst an individual was a patient in an asylum, is an area in which little has been researched in terms of the pauper class. The patient's friend's book examined in this chapter provides an important source from which information has been drawn regarding the visits of relatives who were resident in the county institutions in this period. A greater understanding has been ascertained of those which remained in closest contact, in terms of the type of relationship they had with the patient, and how far they were willing to travel to maintain the familial bond. Thus, through the analysis of these documents, the value in the evidence presented in this chapter is reinforced, as a deeper understanding the pauper experience is understood.

Although not explicitly referred to in the existing literature, the instance of the family themselves triggering a person's insanity has been limited to examining the inherited predisposition to mental illness, and the onset of mental unrest caused by pregnancy and childbirth. The hereditary traits of insanity seem to have been exaggerated to form an explanation of a patient's malady in the absence of proper knowledge of the inner workings of the mind. The examples offered in this chapter detailing how relatives could be directly attributable, provide a new direction in the existing research of the role of the family in times of mental illness. Additionally, this chapter examined the structure of the Asylum as emulating that of the family home. Previously, this has only been remarked upon by historians of institutions that catered for higher classes of patient. Absent is the experience of the pauper institution in modelling itself on the familial context. Although unable to provide the high level of furnishings of the private asylums financed by paying patients, the uniform nature of asylum life was structured around the family unit, providing a sense of normality in

times of mental abnormality. The patriarchal role taken on by the medical superintendent, could offer those without such stringent discipline, an environment in which their behaviours would return to normal. Also, for those whose home life was particularly disordered and had worsened their mental state, the asylum provided a place of safety and a familial context which they otherwise lacked, and so desired in order to return to their ordinary state of health. This has further addressed the gap of the pauper experience, which has been so evident throughout the examination of the existing literature.

On reflection of the historiography, it is apparent that an in-depth analysis of the family's role in the experience of pauper lunatics is a somewhat neglected area. Studies such as the one conducted in this chapter, offer a valuable exploration of the involvement of relatives in the provision of treatment for mentally ill paupers. The evidence from the various sections all provide additional elements which build on the existing research. Further scope for analysis of this area is evident, as only a small number of cases have been explored. What is required in future is a more rounded view of the family in the asylum process, rather than being confined to their involvement in admission and discharge. Additionally, the family must not be viewed as a willing entity looking out for the best interests of their relatives. Families, particularly those of the pauper class, were financially stretched to capacity, and unburdening an unproductive member to the asylum could have been a necessary decision. Therefore, in future examinations of family involvement, simple, idealistic views of the domestic unit cannot occur, as each one was different, with individual sets of circumstances to understand before reaching any conclusions about their decisions, specifically in terms of asylum provision for their mentally ill relatives.

Chapter Six: Circulation[1]

Periodically sending out chronic harmless cases to the Workhouses in the two counties, meets with only partial success; a considerable proportion of these cases sooner or later come back to the Asylum (about 25 per cent during the last ten years).[2]

Overview

The exploration of the previous chapters have all encountered the same gap in the existing research, albeit following a number of different themes. Chapter two suggested that patient transfer was present from the inception of the county lunatic institutions, and that initial populations underwent a process of circulation before beginning treatment. Chapter three found that historians have assessed the impact that overcrowding had on the asylum, but not on the patients.[3] Similarly, as put forward in chapter four, when others have examined the moral regime employed in asylums, it has been highlighted that once patients had to be transferred due to overcrowding, this care was compromised; but, again, no detailed exploration has occurred on the effect this had on the lowest-classes. Chapter five outlined the involvement of families in asylum care, and but their impact on patient transfer remains absent. Considering the universal transfer of care, it is surprising that the effect circulation had on the patients has not been examined previously. There are mentions of transfers to and from the workhouse,

[1] The main points of this chapter have been summarized in C. Dobbing, 'The Circulation of Pauper Lunatics and the Transitory Nature of Mental Health Provision in Late Nineteenth Century Cumberland and Westmorland', *Local Population Studies*, 99 (2017), pp. 56-65.
[2] CACC, *Fortieth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1901*, THOS 8/1/3/1/39, p. 14, quoted in Dobbing, 'The Circulation', p. 63.
[3] For instance, Peter Bartlett presented this shift in terms of the impact felt by the workhouses once asylums became overcrowded, and described the patients as numbers, rather than individuals. P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London: Leicester University Press, 1999), p. 54.

and from the family home, but this has not been viewed in terms of the effect it had on the pauper lunatics themselves.

The high incidence of transfer of the insane, mirrored the wider movement of people that took place throughout the nineteenth-century.[4] Migration to Britain, particularly from Ireland, due to innovations in transportation, facilitated the economic boom of the industrial revolution.[5] Movement within Britain was also widespread, as people relocated from rural areas to the growing towns and cities in search of greater opportunities.[6] This transfer was reflected in the institutions which were increasingly constructed throughout the period. Among these were the county lunatic asylums built after legislation in 1808 and 1845. Patients were, for various reasons, some of which have been outlined throughout earlier chapters, moved in and out of the asylum. Previous research has identified that mental health provision in this period was delivered in a number of places, but has failed to present the asylum as part of such an interconnected network of responses. Len Smith has correctly identified the 'tapestry of care',[7] and Catherine Cox, Hilary Marland and Sarah York have highlighted the 'patient exchanges' that went on between the institutions that made up the vast system of mental health provision.[8] However, existing secondary works concerning asylums are somewhat insular in their consideration of the care provided to treat the pauper classes. They do mention the discharge of cases to and from the workhouse, thus giving a hint of circulation, but only as a consequence of overcrowding, as explored in chapter three.[9] For instance, Pamela Michael mentions that at Denbigh, due to the pressure on

[4] For instance see: A. Redford, *Labour Migration in England, 1800-1850* (Manchester: Manchester University Press, 1964); C. G. Pooley and I. Whyte (eds), *Migrants, Emigrants and Immigrants: A Social History of Migration* (London: Routledge, 1991); C. Pooley and J. Turnbull, *Migration and Mobility in Britain Since the 18th Century* (London: Routledge, 1998); D. Baines, *Migration in a mature economy: emigration and internal migration in England and Wales 1861-1900* (Cambridge, 1985).
[5] D. M. MacRaild, *Irish Migrants in Modern Britain, 1750-1922* (London: MacMillan, 1988), p. 42.
[6] R. J. Morris and R. Rodger, 'An Introduction to British Urban History, 1820-1914', in R. J. Morris and R. Rodger (eds), *The Victorian City: A Reader in British Urban History, 1820-1914* (London: Longman, 1993), pp. 1-39.
[7] L. Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the insane in West Midlands workhouses, 1815-1860', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20.
[8] C. Cox, H. Marland and S. York, 'Itineries and Experiences of Insanity: Irish Migration and the Management of Mental Illness in Nineteenth-Century Lancashire', in C. Cox and H. Marland (eds), *Migration, Health and Ethnicity in the Modern World* (Basingstoke: Palgrave Macmillan, 2013), pp. 36-60.
[9] See Barlett, *Poor Law of Lunacy;* R. Adair, J. Melling and B. Forsythe, 'A Danger to the Public? Disposing of Pauper Lunatics in late-Victorian and Edwardian England: Plympton St. Mary Union and the Devon County Asylum, 1867-1914', *Medical History*, 42:1 (1998), pp. 1-25; K. Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, c.1834-1900* (London:

accommodation, in 1876, 28 chronic and imbecile patients had to be discharged unrecovered to the workhouse to receive treatment.[10] Similarly, Steven Cherry remarked how the practice of discharging patients 'unrecovered' to the workhouse or family home was often in vain when the patients were readmitted back to the asylum, indicating the failure of the method.[11] No comprehensive study has been undertaken which encapsulates the effect that the shift of patients to and from different establishments had on their treatment and overall wellbeing. This gap forms the first aspect this chapter shall address, via a detailed analysis of the impact of circulation, through recounting the pauper experience, and the reasons it occurred.

This chapter will address an additional gap in the literature, as outlined in chapter one, and shall examine the experience of Roman Catholic patients. Historians have documented widely the mass emigration in the second half of the nineteenth-century of the Irish to Britain, in part due to the Famine, in search of work and a better standard of living.[12] The effect of such upheaval and struggle once in Britain led this highly mobile population to become entrenched in the Poor Law system, often for life. Those who circulated themselves the most prior to asylum admission, became the hardest to remove once incarcerated due to the inherent chronic nature of their conditions. Insanity among the Irish migrants who moved to Britain and its colonies has been widely documented in recent years, and it is through these works which circulation has been hinted at the most.[13] However, historians have tended to focus on the Irish experience as a direct impact of the Famine on the areas which felt it most, for instance in Liverpool and Lancashire,[14] and further afield in America and the British colonies.[15] Absent from this area of the historiography is the experience of Irish pauper lunatics in areas not as widely documented as having a large immigrant population in

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Bloomsbury, 2015), p. 127; A. Shepherd, *Institutionalising the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014), p. 69.

[10] P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003), p. 85.

[11] S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998* (Woodbridge: Boydell Press, 2003), p. 80.

[12] See F. Neal, *Black '47: Britain and the Famine Irish* (Basingstoke: Palgrave Macmillan, 2002); D. Fitzpatrick, *Irish Emigration 1801-1921* (Dublin: Social History Society of Ireland, 1984); R. Swift and S. Gilley (eds), *The Irish in Britain 1815-1939* (London: Pinter, 1989).

[13] For instance, see C. Coleborne and A. McCarthy, *Migration, Ethnicity and Mental Health: International Perspectives, 1840-2010* (London: Routledge, 2012); M. Harper (ed.), *Migration and Mental Health: Past and Present* (London: Palgrave Macmillan, 2016).

[14] C. Cox and H. Marland, '"A Burden on the County": Madness, Institutions of Confinement and the Irish Patient in Victorian Lancashire', *Social History of Medicine*, 28:2 (2015), pp. 263-87.

[15] See J. W. Fox, 'Irish Immigrants, Pauperism, and Insanity in 1854 Massachusetts', *Social Science History*, 15:3 (1991), pp. 315-36; Coleborne and McCarthy, *Migration, Ethnicity and Mental Health.*

the decades following the Famine. For instance, Cumberland attracted a great number of migrants from Northern Ireland from the 1860s onwards.[16] This wave of relatively late migration resulted in a number of Irish paupers being admitted to Garlands and the county's workhouses, both in times of prosperity and hardship. The full implications of this in terms of circulation, and why this came to be such an issue will be explained in depth in the second part of this chapter.

To address the highlighted gaps, this chapter follows two strands. The first section will expand on the knowledge gathered previously in the thesis. It shall begin by examining how circulation began, building upon the outline of chapter two. The first cohort of patients, who were transferred to Garlands in January 1862, will be assessed in detail to evaluate the impact the initial transfer had on their conditions. Next, following on from the examination of chapter three, the effect overcrowding had on accelerating the movement of pauper lunatics in and out of the Asylum will be examined. In-depth analysis of the sample will be undertaken to fully assess the patient experience. Then, to fully explore the compromise of moral treatment, as laid down in chapter four, the chapter shall look closer at the issue of adverse care when patients were transferred elsewhere. Finally, going deeper than the research presented in chapter five, this section will explore how families could facilitate circulation, and the factors which came into their consideration to admit relatives to the Asylum on multiple occasions. The second section of the chapter will be an examination of the reasons why Irish lunatics were treated with such contempt as they were difficult to circulate. As will be seen through a sample of Roman Catholic patients, the great majority remained in Garlands until their death; with only a small minority being discharged recovered. The final section of this chapter will aim to bring the two strands together, and assess the impact that circulation had on their various conditions, and how this effected the wider system of asylum provision, widening the understanding of the pauper lunatic experience. In addition, the exploration of the immigrant Irish patients will be a valuable contribution to this neglected area of the literature. To begin with, it is necessary to assess the reasons why circulation became commonplace and the effect it had on Garland's lowest-class of patient in the latter half of the nineteenth-century.

[16] Cumberland's Irish born population in this period was around 5% of the total population. D. M. MacRaild, *Culture, Conflict and Migration: The Irish in Victorian Cumbria* (Liverpool: Liverpool Univeristy Press, 1998), p. 27 and p. 38.

Impact of Circulation[17]

On examination of the sample, 45% were circulated in or out of Garlands at some point.[18] It is clear that the impact of this shift is important to understand the patient experience. As mentioned in chapters one and three, the workhouse remained a vital part of the committal process throughout the period of study.[19] The movement of patients between the two institutions has been a key focus of this thesis, which is evident from the sample data, as 38% of them were either transferred from or to the workhouse at some stage of their illness, despite the sample all being admitted after the introduction of the four shilling grant. The practice of sending the long-term sufferers of insanity for treatment in the workhouse was acknowledged as being detrimental in the 1902 annual report:

> Most of the cases in Garlands that at present come under that category have already at some time had a trial in the workhouse, whence after a varying interval they have been brought back to us. We are thus afforded convincing proof that these chronic dements require treatment such as they are unable to receive elsewhere than in the Asylum, however harmless they may appear to be while properly housed and under the supervision of adequate staff.[20]

This section will fully explain the impact of circulation, following on from what has been outlined in the previous four chapters.

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[17] The research gathered in this section offers additional primary material to that collated for the core sample of this thesis. Extensive research has been conducted to ensure the gap in the literature concerning the circulation of patients is fully addressed. Patient samples in addition to those already analysed and collected have been further researched in detail to fully evaluate the effect circulation had on these patients at different stages of their institutional lives.

[18] This amounted to 72 patients out of the 160 sampled. Circulation in this analysis, and throughout the thesis, has been interpreted as those who were either removed from the Asylum as relieved to receive care elsewhere, and also includes those who were admitted to the Asylum on more than one occasion. See Appendix 3. Cox, Marland and York interpreted their 'patient exchanges' as those who were admitted to Lancashire's asylum's from other institutions, C. Cox, H. Marland, and S. York, 'Emaciated, Exhausted, and Excited: The Bodies and Minds of the Irish in late Nineteenth-Century Lancashire Asylums', *Journal of Social History*, 46:2 (2012), pp. 500-24.

[19] In his research of the Leicester Asylum, Bartlett found that between 1861 and 1865 27% of pauper admissions were transferred directly from workhouses, P. Bartlett, 'The Asylum and the Poor law: The Productive Alliance', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 48-67.

[20] CACC, *Forty-First Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1902*, THOS 8/1/3/1/40, p. 16.

First, to extend the research presented in chapter two, Table 6.1 shows in detail where and when Garland's first admissions were transferred from. Although the patients in this table only represent 144 cases, this formed the majority of admissions for 1862, as the total resident on 31 December of that year was 196.[21] Therefore, 73% of the first admissions underwent a process of transfer from other institutions. Cherry briefly recounts how often the first pauper patients admitted to the Norfolk Asylum were already institutionalised and that some came in a feeble state from the nearby Bethel Hospital.[22] However, he does not indicate the scale of the transferral of patients from other establishments, nor does he consider the effect this movement had on the patient's welfare.

Date	Male	Female
2 January 1862	15 (Dunston Lodge)	2 (Dunston Lodge)
3 January 1862	18 (Dunston Lodge)	
4 January 1862	1 (Dunston Lodge)	
6 January 1862	20 (13 Dunston Lodge, 7 Bensham Asylum)	3 (Dunston Lodge)
7 January 1862		20 (13 Bensham Asylum, 7 Dunston Lodge)
8 January 1862	1 (Barnard Castle Workhouse)	20 (Dunston Lodge)
9 January 1862		17 (Dunston Lodge)
10 January 1862	22 (Dunston Lodge)	3 (Dunston Lodge)
24 January 1862		1 (West Ward Workhouse)
27 January 1862		1 (Cockermouth Workhouse)

Table 6.1. Origins of the patients admitted to Garlands in January 1862.[23]

In part, this circulation can be judged to be advantageous to the patients, as they were now resident in an institution closer to their families,[24] who remained an important source of support throughout treatment, reinforced in the previous chapter. However, the overwhelming majority (74%) died in the Asylum, as they suffered from long-term,

[21] CACC, *Fiftieth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1911*, THOS 8/1/3/1/49, Table a2 pullout, p. 19.
[22] Cherry, *Mental Health Care*, p. 40.
[23] CACC, *Casebook 1862-1865*, THOS 8/4/38/1. The 144 patients in this table have been researched in addition to the core sample.
[24] The importance of proximity to an institution, in terms of the implications on a patient's health was reinforced by Dr Wilkinson, as laid out in chapter 2.

chronic conditions. For 16% of these patients, they underwent another process of transfer, and left the Asylum unrecovered. The smallest proportion of the initial admissions (10%) were discharged recovered from Garlands. Of those who were either discharged as relieved or recovered, almost a third were readmitted to Garlands at a later date, with half of the returned patients remaining in the Asylum until their death.[25]

The great disparity in the death rate of these first cases of insanity from the average death rate of the patients admitted into the county asylums during this period – around 10% - can be explained by the nature of their conditions.[26] The necessity of sending patients, at a higher cost to receive treatment a great distance from their relatives, in the first instance to Dunston Lodge, or Bensham, signalled that each of these patients suffered from a serious mental illness. For those who died in Garlands, this did not occur suddenly due to the upheaval of being transferred. Rather, the standard of care, delivered in a new specialist institution, meant that they survived much longer, with 40% of these patients dying before the end of 1872; 30% before the end of 1882, and 21% remaining in Garlands up until the end of 1892. There were even ten patients who remained in the Asylum beyond 1892, with the final one dying in December 1915. The consequence of this was that 106[27] of the initial 200 patient capacity was immediately expended on chronic cases. Once the accommodation had been exceeded, at the end of 1863, the increased circulation of patients began to occur, and it was these patients who were affected adversely.

Second, expanding on the information presented in chapter three, although superintendents reinforced the need for early removal to asylums, patients continued to be siphoned out to workhouses and to other lunatic institutions to receive care.[28] Asylum doctors knew that once subjected to adverse levels of care, as has been demonstrated through the conditions of Kendal and Cockermouth Workhouses in chapters two and three respectively, patients stood an increased chance of being readmitted.[29] It was the long-term sufferers of mental illness who were most likely to be

[25] See Appendix 4a and 4b for full statistics.
[26] CACC, *Third Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1864*, THOS 8/1/3/1/2, p. 11.
[27] 106 was the number of the original 144 admissions that remained on 31 December 1862.
[28] E. D. Myers, 'Workhouse or Asylum: the Nineteenth Century Battle for the Care of the Pauper Insane', *Psychiatric Bulletin,* 22:9 (1998), p. 575-7.
[29] Price asserted that workhouse inmates would often be the ones working as nurses in lunatic wards, which 'created a general standard of care that was far below the expected level for the time.' Price, *Medical Negligence,* p. 127.

transferred, as was demonstrated in the case of Edward E in chapter four.[30] On analysis of the group of patients within the sample who were circulated, it is evident that these were the ones with chronic conditions. Two-thirds remained in the Asylum suffering in the long-term, with 38% of these dying in Garlands, and 29% being relieved to the care of other institutions.[31] As stated in the 1902 report, it was the chronic cases that were considered first for transferal: 'so that vacant accommodation might be kept here for the reception of acute cases'.[32] Thus, the patients who posed the biggest burden on the Asylum's resources, were the ones forfeited in times of overcrowding, with the reasoning that the transferal of care would not impact their progress as they stood little chance of recovery.

To again extend the analysis of chapter three, Table 6.2 below details a group of patients who returned to Garlands 1882 and 1883, when extensions to the Asylum had been completed. They were readmitted from other Asylums, not workhouses, where they had been sent due to overcrowding. Whilst unburdening themselves of certain long-term patients, the superintendents did so at an increased cost, as seen in chapter three. This was never a permanent solution to overcrowding, but it did result in the increased movement of these particular cases.

Date admitted & where from	Name	Marital Status	How they left Garlands
24 Oct. 1882, Durham Asylum	James K	Single	Died 14 March 1918
24 Oct. 1882, Durham Asylum	John L	Single	Died 24 Oct. 1884
24 Oct. 1882, Durham Asylum	William B	Single	Died 11 Dec. 1888
3 Nov. 1882, Wadsley Asylum	William S	Single	Died 2 May 1884
3 Nov. 1882, Wadsley Asylum	Joseph P	Single	Died 1 April 1905
3 Nov. 1882, Wadsley Asylum	George M	Single	Died 18 June 1888
3 Nov. 1882, Wadsley	Daniel S	Single	Died 9 Dec. 1922

[30] Cox and Marland, 'A Burden on the County', p. 272. Michael also found that workhouses and asylums would incur patient exchanges, whereby the unruly ones were returned to the asylum, in exchange for accepting manageable cases into their wards, P. Michael, 'Class, Gender and Insanity in Nineteenth-Century Wales', in J. Andrews and A. Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), pp. 95-122.
[31] See Appendix 3 for full statistics.
[32] *Annual Report 1902*, p. 16.

Asylum			
8 Dec. 1882, Wadsley Asylum	Hugh L	Single	Died 26 Jan. 1888
8 Dec. 1882, Wadsley Asylum	John J	Single	Died 29 Dec. 1917
8 Dec. 1882, Wadsley Asylum	John L	Single	Died 19 March 1914
15 Jan. 1883, Lancaster Asylum	Thomas S	Single	Relieved 28 July 1883 - escaped
16 Jan. 1883, Macclesfield Asylum	David B	Single	Died 20 June 1929
16 Jan. 1883, Macclesfield Asylum	Gibson G	Single	26 Oct. 1892 (relieved)
16 Jan. 1883, Macclesfield Asylum	Lancelot B	Single	Died 4 Feb. 1901
16 Jan. 1883, Macclesfield Asylum	James C	Married	Died 11 Sept. 1902
23 Jan. 1883, Macclesfield Asylum	John F	Married	Died 14 Oct. 1895
23 Jan. 1883, Macclesfield Asylum	Michael F	Single	Died 27 Dec. 1895
23 Jan. 1883, Macclesfield Asylum	Henry K	Single	Sent to Broadmoor 15 March 1890
23 Nov. 1883, not stated.	Agnes G	Married	Relieved 29 July 1897
23 Nov. 1883, not stated.	Ellen M	Widow	Relieved 9 May 1893
30 Nov. 1883, Morpeth Asylum	Margaret B	Single	Recovered 1 Jan. 1885
30 Nov. 1883, Morpeth Asylum	Elizabeth J	Single	Died 16 Sept. 1884
30 Nov. 1883, Morpeth Asylum	Susannah R	Married	Died 29 Oct. 1902
30 Nov. 1883, Morpeth Asylum	Isabella P	Single	Died 29 Nov. 1887
30 Nov. 1883, Morpeth Asylum	Margaret C	Single	Died 24 March 1887
30 Nov. 1883, Morpeth Asylum	Mary S	Single	Died 24 May 1902

Table 6.2. Patients admitted to Garlands in 1882 and 1883 from other Institutions[33]

Table 6.2 shows that 26 patients[34] were readmitted from other institutions in just over twelve months. The majority (77%) died in the Asylum, reinforcing the evidence that

[33] CACC, *Casebook 1882-1884*, THOS 8/38/4/8.

[34] Although the sample is small in comparison to the research of similar topics, the case notes have been thoroughly cross referenced with other data, such as census material, admission and discharge documents, to fully ascertain the background from which these patients came, and to assess the full

chronic sufferers were the ones transferred. It is also interesting to note that 81% of these cases were unmarried, which highlights an important additional consideration for the doctors when choosing suitable cases to be boarded out. The input of a patient's family has been explored in chapter five, and it is clear that the relatives of a pauper lunatic remained an important voice in where individuals received treatment, as was also seen in the case of Mary Annie R in chapter three. Therefore, the increased circulation, in particular to other asylums, brought about by overcrowded conditions, occurred disproportionately in single, chronic sufferers of insanity, a consideration that does not feature in the historiography.

Additionally, when the space permitted, Garlands also received patients from other asylums who were themselves suffering from overcrowding.[35] One example is Mary C, who was admitted to Garlands in May 1900 diagnosed with epileptic mania. The county asylum she should have been transferred to from the Crumpsall Union Workhouse was Prestwich, but due to overcrowding they had to board her out at a higher rate to Garlands.[36] Her dangerous outbursts after frequent epileptic fits, meant that she needed to be detained in an asylum under the correct supervision.[37] Pressure due to overcrowding meant that Prestwich had to find her alternative provision, which resulted in her being transferred 116 miles away from her husband and seven children to receive suitable treatment.[38] Mary remained in Garlands for two years until the space allowed for her treatment in the correct institution, and she was transferred to Prestwich Asylum on 11 March 1902.[39] She remained institutionalised until her death in 1915,

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impact of such movement. Large studies of several asylums, such as that of Len Smith in *Cure, Comfort and Safe Custody*, pinpoint noteworthy cases. Here, the comparatively small sample instead uses a group of patients that indicate the circulation between different institutions, and are therefore worthy of closer scrutiny to add to the understanding of the motivations for moving groups of patients, and the circumstances surrounding this.

[35] For instance, on the reception order of James A, admitted in May 1900 from Lancaster Asylum, it specifically stated that his transfer was due to 'a deficiency of room in the asylum for the County of Lancaster', CACC, *Reception Orders 1900*, THOS 8/4/1/42. This case has been researched in addition to the sample.

[36] Prestwich County Asylum opened in 1851 to house 350 patients, but by 1903 had expanded to accommodate 3135, as it began to admit more patients from across Lancashire due to population increase, Taylor, *Child Insanity*, p. 9.

[37] CACC, *Reception Orders 1900*, THOS 8/4/1/42.

[38] Ancestry.com, *1901 England Census* [database on-line], Class: *RG13*; Piece: *3748*; Folio: *30*; Page: *2*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7814&h=23576150&ssrc=pt&tid=112209362&pid=220097679231&usePUB=true [accessed 29 May 2017].

[39] CACC, *Female Casebook 1899-1902*, THOS 8/40/4/5, p. 71.

never returning to the care of her family.[40] The distance to an asylum from the family home as an issue will also be discussed later in this section.

Third, to further explore the discussion began in chapter four, the impact circulation had on the compromise of care will be examined in greater detail. Following the principles of moral treatment that have been set out in chapter four, it seemed somewhat hypocritical to surrender some patients for lower standards of care in other establishments, when the negative effect on patients was well known. One article stated in 1901 that: 'Workhouse lunatic wards have achieved an unenviable notoriety of late'.[41] The quote at the beginning of this chapter was taken from a statement made by Dr Farquharson in 1901, in which he acknowledged the detriment experienced when circulating certain patients:

> The plan that has hitherto been adopted for keeping vacancies for fresh cases, viz., by periodically sending out chronic harmless cases to the Workhouses in the two counties, meets with only partial success; a considerable proportion of these cases sooner or later come back to the Asylum (about 25 per cent during the last ten years). The mere fact that cases that do well and give no trouble as long as they are in the Asylum, apparently become unmanageable when sent to the Workhouse, shows that skilled supervision and appropriate management are necessary to keep such cases quiescent.

He praised the care delivered in asylums in such a way that suggested that the treatment received in the workhouse was inferior. Later in the passage he also described the practice of workhouse transferal in times of overcrowding as being 'of doubtful expediency'.[42] To give an indication of the detrimental effect this had on patients who were transferred, on analysing the patient sample, specifically those who were discharged as relieved, 35% returned from workhouses to the Asylum. It is interesting that Farquharson framed the statistics

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[40] Ancestry.com, *UK, Lunacy Patients Admission Registers, 1846-1912* [database on-line], Class: *MH 94*; Piece: *39*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=9051&h=479451&ssrc=pt&tid=112209362&pid=220097679230&usePUB=true [accessed 29 May 2017].

[41] Anon., 'Workhouse Lunatic Wards', *Journal of Mental Science*, 47:197 (1901), pp. 358-9. This has also been seen in both chapters two and three for Kendal and Cockermouth Workhouses.

[42] *Annual Report 1901*, pp. 14-15.

in such a way that he focused on the quarter of workhouse transfers that returned to Garlands. He could have explained that 75% did not come back, and praise the practice as being successful. This highlights a personal motivation of the superintendent, as he argued that the worsening condition of 25% was not good enough, and utilised this to obtain funding for further extensions to the Asylum.

An example is Ann E, admitted to Garlands in September 1900, aged 55. She was noted as having a congenital condition, and as always being weak minded. She had been suffering from her condition for two years, with it gradually worsening to the point that she had experienced delusions that several men were to marry her. Due to a lack of violence and excitement, Ann was seen fit to be transferred elsewhere, and was discharged relieved to Penrith Workhouse less than eight weeks after admission. Her delusions remained prominent, and her condition was still given as mentally enfeebled, but due to the severe pressure from overcrowding the Asylum was experiencing at that time, cases such as Ann where considered fit for workhouse treatment, as seen in chapters three and four.[43] Six months later, after a deterioration in her condition, Ann was readmitted to Garlands in May 1901. A Workhouse attendant said that she was continually soliciting him for an immoral purpose; the matron stated that her behaviour had become violent and uncontrollable, and a fellow inmate reported that the other women could not sleep as she got up shouting at imaginary persons.[44] Thus, due to the disruption caused to the staff and inmates, Ann was circulated to once again receive treatment in Garlands. However, similar to her first admission, Garlands was still greatly overcrowded, and in predicting her eventual removal to the Workhouse again, her friends and family removed Ann from the Asylum to take care of her at home less than a month after admission.[45] Had Ann not had such a supportive network of relatives, her circulation between the Workhouse and Asylum may have been much more frequent.

Finally, the decision to admit a mentally ill relative to an institution for specialist treatment is an area which is difficult for historians to fully understand, as explored in detail in the previous chapter. It is clear is that relatives were, for the most part, the ones who instigated initial contact with the Poor Law relieving officer.[46]

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[43] CACC, *Female Casebook 1899-1902*, THOS 8/4/40/5, admission no. 4941; CACC, *Certificates re pauper lunatics, 1893-1934*, SPUP/189.
[44] CACC, *Reception Orders 1901*, THOS 8/4/1/43.
[45] CACC, *Female Casebook 1899-1902*, THOS 8/4/40/5, admission no. 5042
[46] Bartlett, *Poor Law of Lunacy*, p. 48.

Farquharson touched upon the stigma surrounding asylum committal, but stated that by 1901 it seemed to be less of an issue:

> The mentally afflicted are frequently kept as long as possible at home – largely from mistaken ideas of kindness, and to avoid what is wrongly considered the disgrace of being sent to an Asylum, and it is only as a last resort that Asylum treatment is consented to. That the Asylum is being recognised more and more as a hospital for the treatment of disease is fortunate, and anything that tends to enlighten the public on this question is to be commended.[47]

With this in mind, the difficult decision to admit a relative was made several times by the families of some of the patient sample. Of those who were circulated, 46% of females and 35% of males were admitted on *several* occasions by their families.[48] The reasons surrounding committal of an insane relative have been explored extensively in the previous chapter. The focus here will be on the reasons why families sought institutional help on more than one occasion, which increased the incidence of patient transfer.

One example is Julia G, who was admitted to Garlands on four separate occasions by her husband, John. Each time, Julia was discharged as recovered after receiving treatment for an average of three months. Her first admission in May 1876 was due to her display of violent behaviour and the presence of delusions. Julia believed that the Devil was troubling her, and she experienced numerous nonsensical delusions about pigs and cows. The root cause of her mental illness was given as the tumour she had on her breast. For her family, the presence of such uncharacteristic behaviour, alongside the fact she was suffering from a physical wound, would have worried them greatly. At the time of this admission, her husband was left to care for their three children, of whom the youngest was just two years old.[49] She left Garlands

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[47] *Annual Report 1901*, p. 12.
[48] Of the 37 female and 34 male patients circulated, 17 female and 12 males circulated by their families. Several is taken to mean admission on more than one occasion. See Appendix 3.
[49] Ancestry.com, *1881 England Census* [database on-line], Class: *RG11*; Piece: *5143*; Folio: *96*; Page: *21*; GSU roll: *1342241*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=7572&h=2186235&ssrc=pt&tid=112214273&pid=370096431504&usePUB=true [accessed 29 May 2017].

as recovered three months later, and her next bout of illness did not occur until 1889.[50] On this occasion, she was admitted at a much earlier stage of her illness. Previously, she had been suffering from mania for a month prior to admission, but on the second visit, she was admitted after just three days. As stated in chapter three, early removal to the Asylum was a crucial factor in a patient's chance of recovery. Once Julia's family began to recognise the signs of mental illness, they would have been able to put into place the process of committal at a much earlier stage. Besides this was the fact that they would have been more willing to seek the help of the Asylum, as they had seen how effective it had been before. Julia was discharged as recovered two months later,[51] but was soon readmitted in May 1892, after threatening suicide, using violence and obscene language. Although on admission she was noted as being rough in conduct and unwilling to partake in any tasks, after only a couple of weeks the Asylum seemed to have a calming effect on her and she was discharged recovered on 5 July 1892.[52] However, Julia was readmitted for the final time only ten days later, with her case notes stating that: 'Since discharge, has been very noisy, excited, and constantly talking nonsense'. From this it is clear that the decision to transfer Julia home in July 1892 was the wrong one, and it was necessary for her husband to readmit her to Garlands. Thus, the circulation back to the domestic environment was enough to induce another bout of insanity. Julia's family therefore had no choice in moving her once again to the Asylum, as her condition had worsened to such a degree that she felt suicidal, as she stated that she wished to be shot. She died in Garlands in September 1893 having suffered a stroke.[53]

The distance a patient's family resided from the Asylum has been explored in chapter five, in terms of the impact this had on the frequency of visits they made. To extend this, the distance relatives lived from the institution, and the role this played when families decided to admit members on several occasions, will be analysed, offering a departure from the research of the secondary literature.[54] By examining the

[50] CACC, *Casebook 1875-1877*, THOS 8/4/38/5, admission no. 1554.
[51] CACC, *Female Casebook 1888-1892*, THOS 8/4/40/2, admission no. 3165.
[52] Ibid., admission no. 3621.
[53] Ibid., admission no. 3648.
[54] Joseph Melling and Bill Forsythe have looked at how distance from the asylum impacted the likelihood of families to admit relatives, but not in terms of the decision to admit them on several occasions, J. Melling and B. Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London: Routledge, 2006), pp. 75-98. See also the discussion in chapter five about the distance-decay model and C. Philo, 'Journey to asylum: a medical-geographical idea in historical context', *Journal of Historical Geography,* 21:2 (1995), pp. 148-68.

home address of those who were admitted on more than one occasion by their relatives, a sense of the importance of being in close proximity to the institution in which their family members were incarcerated can be ascertained.[55] These have been divided into those who resided 0-5 miles from Garlands, within Carlisle; those who lived in Cumberland (5-50 miles to travel), and those from Westmorland, and Bootle (although in Cumberland, was a greater distance away – refer to Figure 5.2), 50-80 miles from the institution.

Sample circulated by family (total 29)	**Carlisle (0-5 miles)**	**Cumberland (5-50 miles)**	**Westmorland & Bootle (50-80 miles)**
Male (total 12)	5 (42%)	5 (42%)	2 (16%)
Female (total 17)	7 (41%)	8 (47%)	2 (12%)

Table 6.3. Distance to the Asylum travelled by patients from sample circulated by family[56]

Table 6.3 demonstrates that the overwhelming majority of the sample who were admitted on several occasions by their relatives, were transferred from Cumberland, or within Carlisle. Maintaining close familial ties whilst a member was receiving treatment in an asylum, was an important aspect of recovery reasserted by the medical superintendents. This is confirmed in the above example of Julia, who resided in Penrith, only 20 miles from Garlands. Therefore the above figures are unsurprising given the fact that families would be motivated by being able to keep in regular contact with the mentally unwell relatives whom they committed.[57]

[55] The addresses have been obtained from the reception orders, CACC, *Reception Orders 1884-1903*, THOS 8/4/1/26-45.

[56] This sample has been drawn from the patients in the main sample who were admitted by their relatives – 12 male and 17 female. Similar to the sample in table 6.2, the number examined here can be justified by the extent to which each patient has been researched. From the wider patient sample, consisting of 160, each one has been extensively mapped through numerous documents to follow their lives in and out of the asylum. This has increased the accuracy of the findings, and has gone into much more detail than the large samples conducted by similar researchers - such as David Wright who used a sample of 2053 patients in D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001), p. 8, and Anne Digby who used 2011 patients in A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), p. 171. As is demonstrated through the research of these authors, similar work within the area tends to use large data sets and present more generalised findings, rather than detailed patient case histories.

[57] Similarly, at Denbigh, Michael has found that transferring patients from the county asylum to either the workhouse or to another institution further afield; 'proved costly, and was isolating for the patients if they lost contact with relatives who might have visited', Michael, *Care and Treatment*, p. 100.

One example who seems to go against this tendency was William D, who was admitted several times by his family, from Millom, in the Bootle Poor Law Union, 70 miles from Garlands. William had three attacks of insanity; on two occasions he was admitted to receive treatment, and for another he was treated at Lancaster Asylum. William's first committal to Garlands occurred in June 1886, thirteen years after his six month stay in Lancaster. He was admitted by his sister, Mary Ann, after having attempted suicide by cutting his throat with a razor. On admission, William was described as being a 'hard-working, respectable, temperate man', who had become insane due to a loss of work. He was stated as suffering from epileptic mania, and has wandering about aimlessly refusing to converse with others. His sister was troubled by his disappointment, and when this caused William to attempt to take his own life, the barrier of distance to the Asylum did not seem to matter, as she believed he required urgent, specialist treatment. William was discharged as recovered back home to his sister in December 1887.[58] In November 1889, his condition once again reached crisis point. After a severe epileptic fit ten days before admission, which knocked him unconscious, his behaviour became erratic and he began suffering from delusions, that on previous occasions he had not experienced. He failed to recognise any of his friends, he believed he was going to be blown up and was going to be hanged. Campbell stated that his manner and conduct were completely altered from when he was discharged as sane two years previous, thus there had been a severe deterioration in William's condition. On this occasion, he remained for 18 months until June 1891 when it was stated in his case notes that: 'For some time this patient has been doing well, being quite civil and obedient. He is cheerful and anxious to be out earning his own livelihood'.[59] He was once again discharged as recovered back to the care of his sister. From this example, one of the many factors that surrounded the decision to commit a relative on more than one occasion has been ascertained: the display of suicidal and out of character behaviour. The fact that after all three bouts of treatment William was discharged as recovered, and showed a willingness to return to his normal life, is testimony that his sister's decision to send him the great distance to receive treatment was the correct one. Thus, in certain circumstances, the willingness to bring about

[58] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 2820; CACC, *Reception Orders 1886*, THOS 8/4/1/28.
[59] CACC, *Male Casebook 1888-1891*, THOS 8/4/39/1, admission no. 3278.

recovery in a family member, greatly outweighed the disadvantage in being cut off from them whilst they were incarcerated.[60]

The research presented in this section has followed the path laid by previous chapters, and has expanded the analysis of each one to fully consider the implications of circulation. This has added to the understanding of the pauper experience, which, as indicated throughout, is lacking somewhat in the literature. Although Smith has identified the varied institutional response in the 'tapestry of care', the analysis here has gone further and extended was is already understood.[61] This section has assessed the impact transfer had on the patients, through detailed statistical evaluation, and by detailing some case histories. The chapter shall now consider the Roman Catholic patient experience, as they were a marginal group that were regarded differently to those of English origin. This offers an additional area of new research which will add value to the historiography. The importance of both sections in this chapter, is that the research presented is from an unrepresented institution in the literature.

Roman Catholic patients and the issues they posed to circulation[62]

Neglected in the historiography of asylum admissions is an exploration of the migrants who settled in counties like Cumberland and Westmorland. These settlers were in better circumstances than those first-wave, destitute, Irish paupers that fled the Famine in the late 1840s.[63] Donald MacRaild has carried out extensive research into the influx of migrants, particularly from Northern Irish counties, to Cumberland in the decades following the Famine. He found that migrants were attracted by the industries of West Cumberland, which offered labouring opportunities in shipbuilding and mining. Facilitating this was the geographical closeness and relatively cheap crossing offered by Northern Irish steamship companies.[64] However, absent from his study are the

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[60] An additional case who had to be transferred a relatively large distance to receive treatment was Harriet W, also from Millom. However, in Harriet's case four bouts of asylum treatment in (three in Garlands and one in Lancaster) between 1890 and 1903, could not restore her to former health, and she died in Garlands in 1916, CACC, *Female Casebook 1903-1906*, THOS 8/4/40/6, admission no. 5419.
[61] Smith, 'A Sad Spectacle', pp. 103-120.
[62] The research gathered in this section is in addition to that collated for the core sample of this thesis. Extensive research has been conducted to ensure the gap in the literature concerning Roman Catholic patients has been fully addressed. Patient case notes have been cross-referenced with census material, birth, death and marriage certificates in order to gain a comprehensive understanding of the pressures and support surrounding this vulnerable class of patient.
[63] For works on Irish Migration to Britain see: MacRaild, *Irish Migrants*; Fitzpatrick, *Irish Emigration*; Swift and Gilley (eds), *Irish in Britain*.
[64] MacRaild, *Culture*, pp. 27-8. See also B. Gainer, *The Alien Invasion: The Origins of the Aliens Act of 1905* (London: Heinemann, 1972), p. 2.

problems faced by medical superintendents when this class of patient were admitted to the Asylum, and the prejudice received by pauper inmates. Anti-Irish sentiment was widespread long before the Famine, therefore by the mid to late nineteenth-century sectarian violence and riots were a common feature in many parts of Britain. The chronic nature of a large majority of Irish cases of insanity added to the existing problem of overcrowding, as they came to depend on asylum care for the rest of their lives, further limiting the doctors' ability to effect cure on as many of their patients as possible. With this in mind, the Irish lunatics came to be a burden on asylum provision (as briefly touched upon in chapter three), as they could not be discharged permanently from the system. Relieving them to the workhouse was only a temporary measure, as in most instances they were transferred back due to the display of violent and unruly behaviour.

It must be highlighted that the burden of the Irish migrants was not confined to this area. Cox and Marland have researched the impact of Irish paupers on the Lancashire Poor Law system, and in particular that of Liverpool. By the 1870s, around half of the population of the city's Asylum, Rainhill, were Irish, attracting significant attention from rate payers and local unions.[65] Similar to Campbell at Garlands, Rainhill's superintendent, Dr Lawes, closely tracked the admission of Irish lunatics and the problems this caused on the availability of accommodation in the institution. Due to the sheer scale of Irish admissions, and the great costs involved in repatriation to the country of origin, Removal and Settlement legislation failed to be implemented in the majority of cases.[66] The cost of maintaining these paupers was recouped from the county, but remained a serious area of contention as, despite new legislation being implemented in 1846 and 1865, the Irish were regarded as unworthy of relief, and the amount spent on their maintenance in various institutions was regularly publicised in the local and national press, and government reports. This section will build upon the discussion in the previous one to ascertain the impact, specifically, that Irish lunatics had on the transferral of care in Garlands. To address the gap in the literature, this section offers an additional new area of exploration when researching the county lunatic asylums of this era, which no other historian has carried out in such detail.

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[65] Designating Whittingham Asylum solely for Roman Catholic patients when it opened in 1872 was debated, B. Melling, 'Building a Lunatic Asylum: "A Question of Beer, Milk and the Irish"', in T. Knowles and S. Trowbridge (eds), *Insanity and the Asylum in the Nineteenth Century* (London: Pickering & Chatto, 2015), pp. 57-70.
[66] Cox and Marland, 'A Burden on the County', pp. 269-270.

As set out in chapter one, the patient sample from which the majority of primary data has been drawn throughout this thesis, has been gathered with circulation and the Irish patients in mind. One hundred and sixty patients have been chosen at random, admitted in the years 1884-1903, half of whom were of Irish birth or descent, and who were classed as Irish by doctors. It is important to note that for the patients in the latter part of our sample, some were born in Cumberland and were second generation Irish immigrants. However, they were regarded with the same racial prejudice and ill-feeling due to their Irish descent, and continued to be classed as Irish in the Asylum case books. The years of the sample have been chosen, as in each annual report the exact number of each nationality of the patients in Garlands were recorded, seen in Figure 6.1 below. This data has been analysed and cross referenced with census material, birth, death and marriage records, and where applicable other institutional records such as workhouse registers. Although the Irish presented here are a small percentage of the total patient population (the lowest being 4% in 1898 to the highest of 14% in 1885), the importance in closely studying this marginal group that was continually referred to adversely in annual Asylum reports and newspaper articles, is that they remain absent from such detailed research.[67]

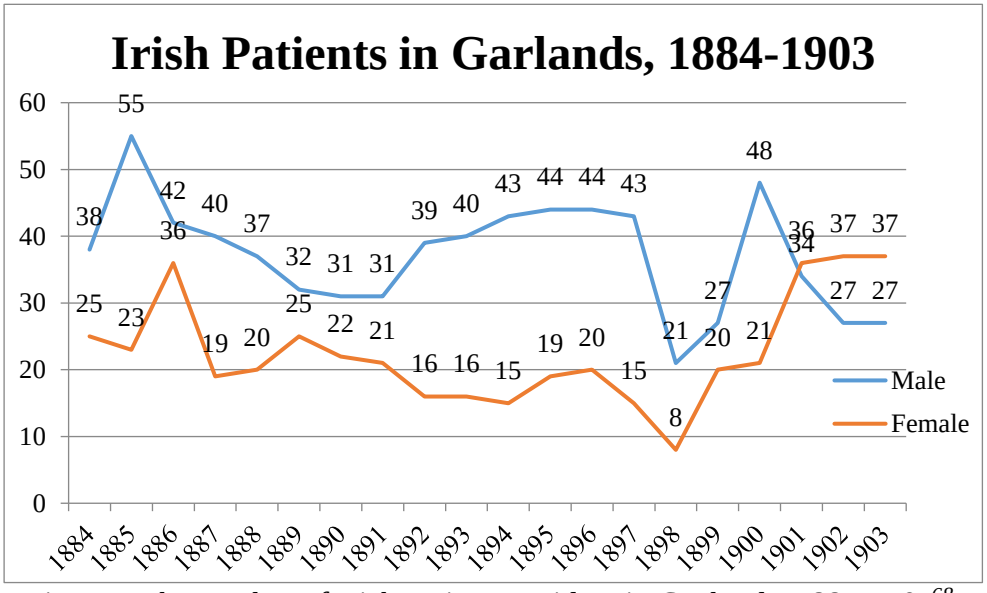

Fig. 6.1. The number of Irish patients resident in Garlands, 1884-1903[68]

[67] CACC, *Annual Reports 1884-1903*, THOS 8/1/3/1/22-41. Cox, Marland and York found that 46.3% of those resident in Rainhill Asylum in 1871 were Irish, Liverpool Record Office (LRO), *Annual Report Rainhill Asylum, 1871*, M614 RAI/40/2/2, Tables XIII and XV, quoted in Cox, Marland and York, 'Emaciated, Exhausted and Excited', p. 508.
[68] CACC, *Annual Reports 1884-1903*, THOS 8/1/3/1/22-41.

Figure 6.1 demonstrates that the male presence in Garlands was, for the majority of the period, greater than that of the female. This may have been due to the type of migrants coming to the county from Ireland seeking better employment opportunities. As stated by David Fitzpatrick, family groups were less likely to make up the majority of migrants to Britain, and were more likely to be 'unaccompanied men'.[69] This is further evidenced by the Unions in which the male Catholic patients settled in Cumberland and Westmorland, indicating the areas in which they were employed and had attracted them in the first instance to the area.

Poor Law Union	Number of Patients
Bootle	2 (5%)
Brampton	1 (2.5%)
Carlisle	10 (25%)
Cockermouth	4 (10%)
Kendal	3 (7.5%)
Penrith	2 (5%)
West Ward	1 (2.5%)
Whitehaven	14 (35%)
Wigton	2 (5%)
Other	1 (2.5%)

Table 6.4. Residency of the male Roman Catholic patients from the sample.[70]

The high proportion of this sample that came from the Whitehaven Poor law Union, provides clear evidence that the migration to this area of Irish persons was heavily concentrated on the coastal towns of Cumberland engaged in the mining and shipbuilding industries.[71] Alongside this, 33% gave their profession as either a coal or iron miner on admission, compared with just 5% of those born in Cumberland and Westmorland. In addition, the second highest proportion came from Carlisle, which, considering the expanding industry in the city is unsurprising, as Irish immigrants would have been attracted by the increased job opportunities in the factories and

[69] Fitzpatrick, *Irish Emigration*, p. 7.
[70] Information has been drawn from the male casebooks spanning the years of the sample, CACC, *Male Casebooks 1888-1906*, THOS 8/4/39/1-6.
[71] Campbell further stated this in an 1896 address: 'The Irish [are employed] in the coal and iron districts in the west', J. A. Campbell, *Lunacy in Cumberland & Westmorland, with remarks: an address delivered at the opening of the Section of Psychology at the Annual meeting of the British Medical Association, held in Carlisle, July, 1896* (Carlisle: Chas. Thurnam & Sons, 1896), p. 14.

workshops.[72] One example of a single male who came to England in search of employment, was Daniel S, admitted to Garlands for the first time in February 1879. He came to Cumberland in search of employment in his early twenties from Castlewellan, a small village in County Down, Northern Ireland. Daniel was initially admitted at the age of 26 suffering from 'insanity of masturbation'. He was described as a railway labourer who had settled in Cockermouth Union, and who was single with no listed relatives. Daniel, like many other Roman Catholic patients examined, remained institutionalised for the majority of his life; and also like many of the other patients in the sample, he was circulated between different receptacles of care. His first stint of treatment at Garlands ended with his transfer, unimproved, to Wadsley Asylum in York in September 1880.[73] Daniel remained there until he was brought back in November 1882, when Garlands had completed its extension of the male ward, and could now accommodate him and several other patients who had been transferred there (see Table 6.2 in previous section). From 1882 Daniel remained in Garlands until his death in December 1922, aged 69.[74] The susceptibility of Irish migrants to mental illness, has been the focus of recent research.[75] The nature of their circumstances when arriving in Britain often meant they were more likely to become unwell. The dependency upon the local economy led to their vulnerability to trade depression and ensuing poverty.[76] Campbell commented in 1896 on the causes of insanity for these migrants:

> the Irishman who comes to this country and secures employment at high wages, away from his home, his mother, his sweetheart, his respected priest and confessor, is placed in a position he has not been educated up to; he succumbs to the unwonted luxuries and excesses.[77]

Whether in Daniel's case his condition was due to the absence of family support in the upheaval, increased wages, or the struggle to find work, unfortunately the Asylum records do not shed any light on this.

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[72] M. E. Shepherd, *From Hellgill to Bridge End: Aspects of Economic and Social Change in the Upper Eden Valley, 1840-95* (Hatfield: University of Hertfordshire Press, 2003), p. 283.
[73] CACC, *Casebook 1877-1880*, THOS 8/4/38/6, admission no. 1869.
[74] CACC, *Casebook 1882-1884*, THOS 8/38/4/8, admission no. 2324.
[75] Similar to Cox, Marland and York, who found that a large proportion of Irish migrants to Lancashire seemed susceptible to insanity and ended up in the county's asylums. Cox, Marland and York, 'Itineries and Experiences', p. 36.
[76] Cox, Marland and York, 'Emaciated, Exhausted and Excited', p. 505.
[77] Campbell, *Lunacy in Cumberland*, p. 14.

The admission of Irish patients to Garlands was first acknowledged publicly as a problem in 1876, as mentioned in chapter three. However, as stated above, the anti-Irish sentiment existed in Britain long before the Asylum was constructed. The Lancashire Asylums had recognised, and spoken out against, the issue of Irish paupers silting up English institutions as early as 1854.[78] The arrival of large numbers of Famine-stricken, destitute, people added to the anti-Irish sentiment, and fuelled the problem of overcrowding. Their maintenance in publicly funded institutions further exacerbated the ill-feeling. With no right to settlement in England, the charges for their asylum treatment could not be recuperated from the Union of residence, thus incurring great costs. Removal laws were implemented increasingly less and less during this period, as it often cost more to move Irish paupers back to Ireland to receive care, and more often than not they found their way back to England.[79] Considering the problem of Irish paupers on the Union rates in Lancashire in the years immediately following the Famine, it can be seen as inevitable that the issue reached Cumberland and Westmorland in the 1870. The problem had therefore failed to be addressed, and had simply spread elsewhere. Anti-Irish sentiment that had been building since the act of union in 1801 came to a head in Cumberland in the 1870s. As occurred in several other Northern towns and cities during this period, violent protests against Fenianism began to increasingly erupt in the Cumbrian coastal towns where Irish migrants were most heavily concentrated. From 1871, prominent Protestant spokesman, William Murphy, began delivering lectures up and down the country about the large wave of Catholic migrants settling in Britain, in an attempt to stir up anti-Irish feelings.[80] The Murphy riots of April 1871 in Whitehaven attracted widespread attention at the anti-Catholicism which had risen up from the working-classes in the area. Murphy engaged his fellow supporters among the Orange Order in Whitehaven, and presented a number of lectures. As to be expected, he was met with animosity and the proceedings soon descended into violence on 27 April. Newspaper reports stated that a gathering of 300 Catholics marched through the town in protestation of the lecture. Twelve men were arrested for

[78] Cox, Marland and York, 'Itineries and Experiences', p. 41.
[79] MacRaild, *Irish Migrants*, p. 62. For instance, in 1860 there were six adults and four children removed from Cumberland, and no removals from Westmorland, Ancestry.com. *Ireland, Poor Law Union Removals From England, 1859-1860* [database on-line], https://search.ancestry.com/cgi-bin/sse.dll?_phsrc=SNv58&_phstart=successSource&usePUBJs=true&indiv=1&db=irelandpoorlaw&gskw=cumberland&new=1&rank=1&uidh=243&redir=false&gss=angs-d&pcat=36&fh=2&h=12&recoff=&ml_rpos=3 [accessed 11 February 2018].
[80] MacRaild, *Culture*, p. 18.

conducting a 'riot at Whitehaven', but were all released on bail.[81] The significance of this event for this thesis is twofold: One of the twelve men arrested was Patrick D, who later was admitted to Garlands in 1881, and is present in the Roman Catholic sample; and second, a Catholic patient was admitted to Garlands in May 1871 reportedly suffering with mania caused by his involvement in the Murphy Riots. The presence of such anti-Irish sentiment is evidence of the predisposing ill-feeling which the Roman Catholic patients were met with when being admitted to Garlands. The views of the superintendent reflected that of the surrounding community, and with the additional burden on the Poor Law rates, it is no surprise that these patients were met with such racial distaste.

By 1883, for the implications they had on Garlands, it was clear that the Irish 'problem' was one that had to be addressed. Attached in one of the casebooks survives a list, made on 8 March 1883, of the Roman Catholic patients present in Garlands on that date, which is made up of 31 males, and 29 females.[82] The significance of the list, it can be judged, was due to the increasing pressure upon the Asylum accommodation at this time. As mentioned in chapter three, overcrowding came to a head in 1881, when the Asylum capacity stood at 405, and the number of patient's resident was 440. After completion of extensions, one in 1882 for males, and one in 1883 for females, increasing the patient capacity to 620, the superintendent was in a position to reflect as to why the problem had got so bad in the first place. Thus, the list of Roman Catholic patients, could have been Campbell taking stock of the large number of Irish present in the Asylum, and to highlight the burden they placed upon the staff and the county rates. The patients in this particular sample were predominantly long-term chronic cases, which accounts for the low number of recoveries when compared to the previous sample, and the overall recovery rates of the Asylum.

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[81] S. Duffy, 'The Murphy Riots', http://cleatormoor.blogspot.co.uk/2011/08/murphy-riots.html [accessed 24 May 2017]. Seven men in total were charged with 'riot, and wounding, occasioning bodily harm', and were imprisoned for either three or twelve months, Ancestry.com. *England & Wales, Criminal Registers, 1791-1892* [database on-line], Class: *HO 27*; Piece: *158*; Page: *95*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=1590&h=493331&tid=&pid=&usePUB=true&_phsrc=SNv60&_phstart=successSource [accessed 24 May 2017].

[82] List found in CACC, *Casebook 1880-1882*, THOS 8/4/38/7. These patients have been researched in addition to the sample, and have been cross-referenced with census material to ascertain that they were either Irish or of Irish descent. These have then been compared to the figures for 1884 for the amount of Irish patients resident in the Asylum to ascertain that those deemed 'Irish' were of Catholic faith.

	Recovered	Relieved	Died
Female	4 (14%)	12 (41%)	13 (45%)
Male*	2 (7%)	3 (11%)	23 (82%)

Table 6.5. How the Roman Catholics of 1883 left the Asylum.[83]

From this sample it can be ascertained that, on the whole, the Irish lunatics made up a large proportion of the long-term cases that came to silt up the institution. As noted in chapter two, the average recovery rate for Asylum patients was 40%, and from the Table 6.5 it can be seen that the Roman Catholic patients recovery rates (male and female combined) was just over 10%. From the high number of patients that remained until their death, it is clear why the Asylum doctors felt that the Irish patients inflicted such a heavy burden. Although offering only palliative, rather than curative care, Garlands came to be depended on by many paupers of Irish descent, regardless of how they were thought of by the staff and wider lunacy authorities. Additionally, when looking at the numbers of those removed to other institutions, the ability of the Asylum doctors to circulate the Irish patients, in particular the females, was indicative that they were the ones which required its provision the most, as they failed to recover to the same extent as the English patients.

The prominence of the Roman Catholic Church and its influence in institutions throughout this period has also been a point of discussion among historians, but its specific impact in the Asylum remains absent. The New Poor Law 1834 stated that adults within its institutions were free to follow their own religions.[84] Poor Law establishments during this period were under increasing pressure from 'dissenting' sects to provide alternatives to the Church of England chaplain.[85] The Catholic Church wanted to retain its influence over inmates by emphasising regular worship and presiding over the teaching of children.[86] Due to the growing number of patients of Catholic faith resident in Garlands throughout the 1880s, particularly from 1886, the local Lunacy Committee were under increased pressure to provide religious services to

* Three of the males in the 1883 sample have unknown outcomes due to the records not been filled in for their discharge.

[83] Information for Roman Catholic patients drawn from the following case books, CACC, *Casebook 1862-1884*, THOS 8/4/38/1-8.

[84] A. D. Gilbert, *Religion and Society in Industrial England: Church, Chapel and Social Change* (London: Longman, 1976), in R. Talbot, 'North South Divide of the Poor in the Staffordshire Potteries' (Unpublished PhD Thesis, University of Leicester, 2017), p. 125.

[85] M. A Crowther, *The Workhouse System 1834-1929* (London: Batsford Academic and Educational Ltd, 1981), pp. 129-30.

[86] Talbot, 'North South Divide', p. 134.

cater to their ecclesiastical preferences.[87] Catholic priests were granted access to the Asylum to attend to individual patients, particularly on their deathbeds. It was not until 1887 that Mass was held, at the recommendation of the Committee, however, this only occurred occasionally when the Priest was available,[88] much less than was offered to Anglican patients.[89] Although this indicates that the Irish patients began to become accepted in the institution, it does not suggest that the ill-feeling towards them, on the part of the medical superintendent, had dampened, rather, it is more plausible that the influence of the Catholic Church would have been one that the authorities could not have ignored any longer.

In 1889, Campbell again felt the need to publicise the presence of the problem of the Irish patients. This time he expressed the issue in monetary terms, whilst also offering a typical derogatory stereotype of these patients which were echoed in the casebooks:

> …up to the end of 1889…£15,761 has been expended here on Irish…patients who had no settlement in England…the Irish lunatic is more noisy, dirty, troublesome, and quarrelsome than the English or Scotch, he is more treacherous, and owing to this, more dangerous, and the more miserable his previous outside surroundings were the more critical and complaining is he about the food, clothing and bedding in the asylum…[90]

It is questionable how true Campbell's statement is with regard to the settlement of the Irish patients. By this date, several amendments had been made to the Poor Law regarding removal, most notably in 1865 which changed the period of settlement in a particular Union from five years to just one.[91] Thus, an Irish immigrant who remained in the same Poor Law Union for a year or more was entitled to relief, which calls into question Campbell's statement. As presented above, the majority of both samples of

[87] CACC, *Lunacy Committee Minute Book, 1882-1894*, CC/1/24/4.
[88] CACC, *Twenty-Sixth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1887*, THOS 8/1/3/1/25, p. 8. By 1890 Mass was held regularly, but only once every three weeks.
[89] Church of England services were performed twice on a Sunday, and patients were encouraged to participate in prayers each morning. CACC, *Eighteenth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1879*, THOS 8/1/3/1/17, p. 10.
[90] CACC, *Twenty-Eighth Annual Report of the Cumberland and Westmorland Lunatic Asylum, 1889*, THOS 8/1/3/1/27, p. 17.
[91] M. E. Rose, 'Settlement, Removal and the New Poor Law', in D. Fraser (ed.), *The New Poor Law in the Nineteenth Century* (London: Macmillan, 1976), pp. 25-44.

Irish patients had been resident in Cumberland and Westmorland for some time previous to their move from Ireland. On the 1891 census, 582 pauper lunatics are listed as residing in Garlands on the evening of enumeration, but only 18 (3%) of these were noted as being born in Ireland.[92] It is therefore clear that the prejudice suffered by the Roman Catholic patients in Garlands was a result of their heritage, and not due to their place of birth. The stereotypical 'Paddy' was a Victorian construct, which labelled Irish migrants as drunks, violent, predisposed to habits of vice, and altogether racially inferior.[93]

The stereotype attached to Irish lunatics is a continual feature of the patient records throughout this period.[94] Their physical characteristics were often referred to casebooks in terms of their nationality, phrases such as, 'a quick tongued jerky little Irishwoman of low class'.[95] For instance, Ann D, was described in June 1886, whilst under treatment; 'in many respects [is] a characteristic Irishwoman'. On admission Ann was reported as being violent, suicidal, refused to eat, and was in delicate health.[96] One of the facets of the distaste and hatred aimed towards the Irish immigrants was the view that they were apt to resort easily to violence.[97] In the case of many mental illnesses, violent outbursts were a common symptom, therefore in circumstances of ill health, the Irish stereotype remained at the forefront of English perceptions of such patients. Even in situations where patients did not seem to conform to their stereotype, it was still remarked upon in the casebooks. For instance, Thomas F, who was examined previously in chapter five, was admitted in November 1887, said to have been suffering from mania caused by poverty. Given his strong ancestral tendency to insanity, the Asylum doctors will have held preconceived notions of Thomas and his character. On 1 Dec. 1887 it was noted that he was, 'quiet at nights and well conducted during the day for a man of his class', going against their presumptions of how he would behave, and

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[92] Ancestry.com. *1891 England Census* [database on-line], Class: *RG12*; Piece: *4287*; Folio: *130*; Page: *11*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=6598&h=24522141&tid=&pid=&usePUB=true&_phsrc=SNv62&_phstart=successSource [accessed 24 November 2016]. The patients on the 1891 census have been researched in addition to the core sample.

[93] MacRaild, *Irish Migrants*, p. 160.

[94] Campbell also addressed the issue in an 1896 public address: 'Most of the troublesome patients are Irish…Ireland sends us the worst specimens…a very unstable and unreliable addition to the county stock', Campbell, *Lunacy in Cumberland*, p. 15.

[95]Found in the records of Seacliff Hospital, New Zealand: Archives New Zealand, Dunedin Regional Office, Seacliff Hospital Medical Casebook, DAHI/D264/19956/52, case 3377 (1900), quoted in A. McCarthy, *Migration, Ethnicity, and Madness: New Zealand, 1860-1910* (Liverpool: Liverpool University Press, 2015), p. 180.

[96] CACC, *Female Casebook 1884-1888*, THOS 8/4/40/1, admission no. 2803.

[97] MacRaild, *Irish Migrants*, p. 162.

surprising as on admission he had been violent and abusive towards his closest relatives – rather more 'normal' for a man of his class.[98] Anti-Irish sentiment is common in the case notes of such patients, as they were closely associated with degeneration and were regarded as being difficult to manage, as can be seen from Campbell's passage in the 1889 annual report above.[99]

Owing to the continual burden they placed upon the Asylum resources, some Irish patients show evidence of marked circulation in comparison to the majority that remained in Garlands until their death. This was an attempt to transfer problematic cases that the Asylum was unwilling to deal with, but only occurred in those that were easily moved, for instance those with no family in the area. Superintendents would remove them to other institutions, saving on staff labour, and saving on the Union rates. An example is Jane R, who was admitted to Garlands in December 1889 stated as suffering from mania. She was listed as a hawker who resided in a lodging house in Kendal, and was single with no known relatives. On admission Jane was described as a 'pale and rather sour' woman, who had several delusions, one of which was that she was royalty. She remained in Garlands for five months, during which time her delusions never abated. Jane was discharged unimproved in April 1890 and transferred to Rainhill Asylum, Lancashire.[100] There, Jane remained until October 1901 when she was removed unimproved to Derby County Asylum. Her institutional transfer continued, as after under eleven months residence, she was again removed unimproved to Winwick Asylum, Warrington in September 1902. The final trace in the UK Lunacy Register of Jane is her removal from Winwick in December 1911 to Monmouth Asylum in South Wales.[101] This accelerated circulation was fairly rare, but is evidence of how patients could be moved great distances in situations of overcrowding, it an attempt for the Poor Law Unions to unburden themselves with mentally unwell paupers. This case also highlights the neglected research of patients who experienced such frequent transfer between lunatic asylums.

In addition, Hugh L, who was examined in chapter five, was similarly transferred between different institutions owing to his behaviour, who was also listed as

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[98] CACC, *Casebook 1884-1888*, THOS 8/4/38/9, admission no. 3000.
[99] Cox, Marland and York, 'Itineries and Experiences', p. 51.
[100] CACC, *Female Casebook 1888-1892*, THOS 8/4/40/2, admission no. 3283.
[101] Ancestry, *UK, Lunacy Patients Admission Registers, 1846-1912*, Class: *MH 94*; Piece: *46*, https://search.ancestry.com/cgi-bin/sse.dll?indiv=1&dbid=9051&h=17408&ssrc=pt&tid=115282501&pid=370139838519&usePUB=true [accessed 11 September 2017].

being single with no known relatives. On admission to Garlands in December 1866, he was brought from Dunston Lodge, where he had been for the previous six months, and was described as having 'a sinister expression of face and a most typical Irish look.'[102] Hugh remained in Garlands until September 1880, when he was transferred, due to overcrowding, to Wadsley Asylum, and was not returned until December 1882 (see Table 6.2). On readmission, Hugh was described as suffering from chronic mania and being 'very peculiar in his ways'. He remained in Garlands until his death in January 1888, and became one of the hundreds of Irish immigrants that became life-long receivers of institutional care in Garlands.[103] Until the end of the period under examination in this thesis, the issue of Irish patients remained constant, and the problem of transferral continued to blight the conscience of the superintendent. From the evidence presented in this chapter, it is apparent that the increased circulation of the long-term cases of insanity, regardless of nationality, was a feature of everyday life in Garlands, and one which has proved important in increasing the knowledge of the workings of such institutions.

Conclusion

This chapter is the culmination of the research presented in the previous five of the thesis. Throughout, it has been identified that the movement of patients in and out of the asylum is an important aspect of the historiography that remains absent. Understanding the comprehensive network of actors and forces which impacted the lives of the lowest class of patient is vital to fully assessing the effectiveness of the mental health provision delivered in this period. Two strands have been explored in detail to assess the impact of circulation on the patients themselves, and both have presented new findings.

First, the transfer of care and its effects has been considered. The circulation of paupers has been dealt with in each of the preceding chapters, which have sought to address the issue in terms of each of their respective themes. This has been expanded on, in order to gain a greater understanding of the wide ranging impact that circulation had on all aspects of asylum life. The examination of chapter two made clear that this circulation was present from the inception of the Asylum, and here it was been proved that it continued to occur throughout the years it was in operation. From the research

[102] CACC, *Casebook 1865-1870*, THOS 8/4/38/2, admission no. 489.
[103] CACC, *Casebook 1882-1884*, THOS 8/4/38/8, admission no. 2334.

presented in chapter three, the most prominent reason for the frequent transferal of patients was due to the pressures of overcrowding. The impact of this, as examined closely in chapter four, was the compromise of moral treatment, which ultimately led to a worsening of a patient's condition, once they had been removed to the workhouse, or another asylum, for instance. Whilst considering the detriment that circulation had on an individual's health, the research presented in chapter five is illuminating. The exact triggers behind admitting a mentally unwell relative to an asylum remain unexplained, largely due to the lack of primary material from the lower classes. However, the admission documents for patients who were admitted by their families on several occasions, yields some answers behind the necessity in removing an unwell member to an asylum, despite the effect the change of environment, and the partial severance of ties, may have had on their overall wellbeing. This portrays a 'for the greater good' attitude that families possessed when deciding to inflict the upheaval of asylum committal on a loved one. This decision is significant in terms of the research presented here, as it has shown that circulation was willingly encouraged by family members who acted, for the most part, in the best interest of their mentally ill relatives. The first section, therefore, followed the main themes presented in the literature and has gone further by assessing the impact circulation had in each area.

Second, this chapter has presented circulation in terms of the migrant experience in Britain in the late nineteenth-century, particularly of those who came from Ireland. What has been left largely absent is the experience of those who found themselves committed to the various lunatic institutions of the period. Research of has been confined to those who were admitted to the asylums of Lancashire.[104] Although this area was one in which Irish migrants were heavily concentrated, it only provides one geographical area of focus, thus limiting the understanding of the treatment of this class of patient. In addition, the movement of these patients, whilst in the asylum has not been explored in any detail. The second section addressed this imbalance, as it presented two different samples of Irish patients that were admitted to Garlands and assessed their experience. The racial prejudice felt by this group meant that they were easily marginalised and regularly treated with contempt. By building on the research of the existing literature, that confirms the discrimination in English asylums, this chapter has found that the patients of Irish descent suffered disproportionately from chronic

[104] As researched by Cox, Marland and York.

mental conditions, resulting in their increased circulation. Overwhelmingly, these patients remained institutionalised for life, making them undoubtedly worthy of study to ascertain the reasons behind this, and the issues faced by the Poor Law authorities in maintaining them.

With all this in mind, it is clear that the movement of pauper patients was an important consideration in the practicalities of asylum administration, and is a topic which is merely hinted at in the historiography, and has been left unexplored. Each of the aspects mentioned briefly above, that have been presented in previous chapters, are new areas of research, which reinforce the importance of the analysis provided throughout the thesis. Placing the pauper patients at the centre of this research has been key to fully determining the effect that circulation had on the people who experienced it first-hand. This is important in order to create a comprehensive understanding of these institutions as part of a wider network of Poor law initiatives. Additionally, the experience of Irish migrants has also created a wider view of the pauper experience in terms of prejudice and racial stereotypes that existed within the mental health care system, and wider society. Such novel analysis provides scope for further research into the experience of other migrants in other areas, that also suffered mental health breakdowns in the country of settlement, and the possible problems they may have faced because of this movement. Without question, other English asylums at this time would have been facing similar issues with marginal groups they considered to be unworthy of such treatment. For instance, large swathes of Jewish, Eastern European and American immigrants came to Britain in this period.[105] Areas in which these groups were highly concentrated must have felt some degree of them being treated as 'the other' in Poor Law institutions such as county asylums.[106] Further research into these groups and their experience of mental health provision is worthy of future analysis as an important comparison to the one of the Irish community in Garlands. Following the same sentiment, the focus on the movement of insane pauper patients could be reciprocated in other institutions to determine whether the effect that circulation had

[105] See L. Tabili, *Global Migrants, Local Culture: Natives and Newcomers in Provincial England, 1841-1939* (Basingstoke: Palgrave Macmillan, 2011). For work on the Jewish experience at Colney Hatch see C. Reeves, 'Insanity and Nervous Diseases amongst Jewish immigrants to the East End of London, 1880-1920' (Unpublished PhD Thesis, University College London, 2001).
[106] British newspapers from the period are littered with articles on the problem of immigrant insanity and non-settlement. For instance, 'German Lunatics in England', *Sheffield Independent,* 20 April 1880, p. 3.

was the same, or if patients were circulated for the same reasons as was felt in Garlands.[107]

[107] Preliminary research has found that in Lancashire patients could be transferred between its four county asylums as a change of environment to aid recovery, rather than due to overcrowding or the unruly behaviour of patients.

Chapter Seven: Conclusion

State of the Art

From the outset of the thesis, it has been apparent that the existing historiography of mental health, and the institutions in which it was treated, is crowded. There are a number of fundamental texts which have provided initial framing of the subject, and have given detailed analysis of the history of madness and the development of psychiatry in the county asylum network constructed in the later nineteenth-century.[1] Following that of Andrew Scull and others, Len Smith has carried out extensive research on the early country asylum network. He found that, despite legislation, many counties experienced delays in opening their public asylums, for various reasons.[2] This provided an impetus for the value of studying each individual asylum, as respective institutions had a number of factors contributing to the timing of their opening. More widely, Smith's examination into the institution as both a curative and therapeutic environment has paved the way for others to build upon such research.

The existing literature is heavily focussed upon the establishments famous for pioneering treatments, as researchers have attempted to find the first to utilise each of the facets of asylum care. Most prominent is Anne Digby's *Madness, Morality and Medicine,* which outlines the main elements of the asylum regime; useful employment, nourishing diet, regular exercise, religion, and non-restraint.[3] The evolution throughout the nineteenth-century of the provision of mental health care is evidenced, particularly by Digby, via the advance from the abuses uncovered by the 1815 Parliamentary enquiry, to the widespread adoption of moral treatment from 1845.[4] Almost all

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[1] For instance see A. Scull *Museums of Madness: The Social Organization of Insanity in nineteenth-century England* (London: Allen Lane, 1979); K. Jones, *Mental Health and Social Policy, 1845-1959* (London: Rouledge & Kegan Paul, 1960); R. Porter, *Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Cambridge: Harvard University Press, 1987); P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London: Leicester University Press, 1999).

[2] L. D. Smith, *"Cure, Comfort and Safe Custody": Public Lunatic Asylums in Early Nineteenth Century England* (London: Leicester University Press, 1999), p. 284.

[3] A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), and also see L. Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910' *Social History of Medicine*, 20:2 (2007) pp. 297-313.

[4] The impetus for this advance has been the focus of many works within the historiography. Beginning with Digby, *Madness, Morality and Medicine,* also see R. Hunter and I. Macalpine, *Psychiatry for the*

institutional histories of lunatic asylums allude to the problem of overcrowding experienced throughout the county network later in the century, and offer several reasons for this. The role of the workhouse in alleviating the burden of increasing admissions to asylums, has been explored in the historiography, which has reinforced its importance in the provision for the mentally ill in this period.[5] With this in mind, Smith memorably identified a 'tapestry of care' that emerged as a result of the large number of different establishments that were constructed to deal with insanity.[6] This contribution has paved the way for the examination of this thesis, as the varied responses to insanity require further research in tandem with the asylum, in order to fully assess the movement between different receptacles of care.

A growing area of focus in the wider literature is the role played by the relatives of pauper lunatics admitted to county institutions. As the asylum network expanded, the main caregivers of mentally ill paupers shifted from the domestic setting, to the new county establishments. After 1845, when families became more willing to transfer the care of relatives to the asylum, the role played by those closest to the patients began to be understood. Several prominent works have focussed on the family's role in admitting and discharging relatives, which provide valuable insights into the complex factors involved in institutionalising pauper lunatics.[7]

Despite the accumulated influence and scope of work in this area, some important gaps remain, and were identified in chapter one. Firstly, as mentioned, the focus for institutional histories has been on those where 'pioneers' and influential individuals in the development of the wider psychiatric profession honed their skills. This has resulted in a geographical imbalance in the focus of asylum studies of England and Wales after 1845. The historiography is heavily skewed towards those which fall within the English heartlands. The examination of Northern institutions does not extend

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poor: 1851 Colney Hatch Asylum – Friern Hospital 1973: A Medical and Social History (London: Dawsons of Pall Mall, 1974), pp. 13-14.

[5] See P. Bartlett, 'The Asylum and the Poor law: The Productive Alliance', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 48-67; P. Bartlett, 'The Asylum, The Workhouse, and the voice of the insane poor in nineteenth century England' *International Journal of Law and Psychiatry,* 21:4 (1998), pp. 421-32, quoted in S. King, 'Poverty, Medicine, and the Workhouse in the eighteenth and nineteenth centuries: An afterward', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 228-51; R. Hodgkinson, 'Provision for Pauper Lunatics 1834-1871', *Medical History,* 10:2 (1966), pp. 138-54.

[6] L. Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the insane in West Midlands workhouses, 1815-1860', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20.

[7] D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001).

beyond Yorkshire and Lancashire. Both counties have attracted significant scholarly attention, due to their large populations and the numerous asylums that were constructed to serve them. The York Retreat has been the subject of many studies, due to its role in the birth of moral treatment, and the county institutions of that area have also been widely examined.[8] The public asylums of Lancashire have also attracted a wide range of academic attention, John Walton, for instance, examined the correlation between economic growth in the area and rising levels of pauper insanity.[9] More recently, Lancashire has been the focus of a project looking at the mental health of immigrants. Catherine Cox, Hilary Marland and Sarah York have utilised the Lancashire Asylum records to assess the experience of Irish immigrants who found themselves admitted to the wards of the county institutions.[10] The counties north of Lancashire and Yorkshire remain understudied. That is not to say they are not worthy of any in-depth research, rather, they have gone unnoticed by historians who have focussed upon areas of notoriety, large populations, and of pioneers in the emerging field of mental health care.

Secondly, in much of the existing literature, the asylum is presented as an institution which offered static treatment. After legislation enacted in 1845, county asylums were recognised as the correct place to treat insanity, and quickly became over-capacity.[11] The focus of asylum histories has centred on recounting what happened when patients were admitted, how they were treated whilst there and how they left.[12] The factors that may have contributed to their committal and where they went after discharge are mentioned briefly in the historiography of these institutions, but the significance to the pauper experience of insanity has not been analysed in any detail. In almost all the county asylums in England and Wales, overcrowding was a serious issue at some stage. The solution was to continually provide extensions, and to transfer patients to other institutions that offered treatment. Steven Cherry and Pamela

[8] Most notably by Rob Ellis, see R. Ellis, 'The Asylum, The Poor Law and the Growth of County Asylums in nineteenth century Yorkshire', *Northern History,* 45:2 (2008), pp. 279-293.
[9] J. K. Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50', *Journal of Social History,* 13:1 (1979), pp. 1-22.
[10] C. Cox, H. Marland, and S. York, 'Emaciated, Exhausted, and Excited: The Bodies and Minds of the Irish in late Nineteenth-Century Lancashire Asylums', *Journal of Social History,* 46:2 (2012), pp. 500-24.
[11] A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Yale University Press, 1993), p. 363.
[12] For instance, S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998* (Woodbridge: Boydell Press, 2003), and P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003).

Michael both mention that overcrowding was alleviated by sending out patients to workhouse wards. However, this shift is not emphasised, or explained. When considering the universal movement of the insane, it becomes abundantly clear that the treatment of mental illness was not conducted in the asylum alone. The workhouse remained important in wider 'tapestry of care', but the mapping of the experience of those who moved through the different receptacles of care, for various reasons, remains threadbare.[13]

Thirdly, although the bulk of the historiography on madness has focussed on the county asylums, the experience of patients remains thin.[14] Traditionally, little work has been carried out on patients, and as a result their voices remained hidden. Since Roy Porter's call for researchers to conduct 'history from below', increasing numbers of studies have examined the receptacles built solely for the lowest classes in recent years. To address this, those such as Cherry and Michael have utilised large data sets of admissions of patients to their respective asylums. However, the pauper experience is confined to a few biographical lines of a small number of the patients from these large databases, and does not provide any significant information of the wider understanding of insanity. Deeper analysis has been conducted by historians, for instance Akihito Suzuki, but has been confined to the upper and middle classes who were treated in concealed environments away from the public institution.[15] Thus, middling and labouring patients who experienced mental health care in the county asylums have been abstracted from the literature. Surprisingly little research has been presented that focuses on the patient voice, except that of Louise Wannell, mainly due to the scarcity of records.[16]

Finally, when evaluating the historiography of mental health provision in the period of study as a whole, it is clear that, apart from distinguishing asylum populations by their class, marginal groups such as immigrants within these institutions have only been partly considered, and not in significant detail. Children have been the subject of recent studies, and as a distinct group, are becoming more widely understood in the

[13] Smith, 'A Sad Spectacle', p. 103.
[14] Recent work such as that of Anna Shepherd and Jennifer Wallis, investigates the patients in relation to how/where they were kept, and their bodily treatment, respectively, however, the pauper experience through their own words remains largely absent. A. Shepherd, *Institutionalising the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014); J. Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients and Practices* (London: Palgrave Macmillan, 2017).
[15] See A. Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (London: University of California Press, 2006).
[16] Wannell, 'Patients' Relatives and Psychiatric Doctors'.

context of asylum treatment.[17] However, the research of immigrant populations, who experienced institutionalisation within the asylum system differently, has only been briefly examined. For instance, Cox, Marland and York have focussed on the patient exchange of Irish immigrants in the four Lancashire Asylums.[18] This has only occurred on a small scale, and only examined those fleeing Ireland in the years during, and immediately following, the Famine. What remains to be done is an in-depth analysis of minority groups who were within the patient populations that have already been widely documented, but whose treatment was considerably different.

Contribution

The thesis has attempted to explore and contribute to the filling of these gaps through a detailed analysis of the development of patient experiences in Garlands Asylum. This is the first study of the institution and those who were treated within its walls. Firstly, utilising the experience of such a northerly institution has created a more comprehensive view of the operation of county asylums in this era. For instance, the need to build a lunatic institution was not so readily felt in counties that were so sparsely populated, as compared to those situated further south, and in more densely inhabited areas.[19] The comparatively late opening to that of other counties put Garlands at an immediate disadvantage, as when it did eventually open its doors, demand was so high that it was over capacity by the end of its second year. The value of researching a geographically neglected lunatic institution is that the significance of such an Asylum, can be understood most prominently through the effect it had on patients who had previously been without access to specialist care. The availability of surviving records has been incredibly important in analysing the impact of the Garlands Asylum on patient conditions, their family relationships, and on the doctors' ability to facilitate recovery. An important consideration has been the availability of care, once the staff and resources became particularly strained. Instances of patient resistance and agency increased as attendants struggled to effectively carry out the regime of treatment in the face of growing admissions. The extensive patient records that have been kept, not just

[17] For instance Steven Taylor has begun to do this more recently, S. J. Taylor, *Child Insanity in England, 1845-1907* (London: Palgrave Macmillan, 2017).
[18] Cox, Marland and York, 'Emaciated, Exhausted and Excited'.
[19] Cumberland and Westmorland were the last English counties to provide their own Asylum. By this date, most had at least one institution. C. Philo, *A Geographical History of Institutional Provision of the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter: Edwin Meller Press, 2004), Table 7.2, p. 542.

the casebooks, but also admission, discharge, death, post-mortem, and restraint registers – to name only a few – along with the vast array of administrative information and reports, have contributed greatly to the comprehensive view obtained of this neglected institution, and have led to the definitive conclusions of this thesis.

Second, through utilising these records, the core gap of circulation has been addressed, and offers the mainstay of the contribution of the thesis. The bulk of this analysis has been presented in the previous chapter. The continued reluctance of the counties of Cumberland and Westmorland to provide their own Asylum, led to a backlog of insane paupers being housed in Dunston Lodge, workhouses, and other asylums. This facilitated the first major transfer of patients in January 1862. Circulation at Garlands was thus present from the outset. Detailed examination of the main patient sample, along with a large amount of other records in the collection, has been conducted in order to ascertain the impact such constant movement of asylum populations had on the patients themselves, and, to some extent on the relatives and staff. Almost immediately the main facilitator of the frequent shift was pinpointed as the recurring issue of overcrowding. This has been identified as being a crucial issue for almost all county asylums of the period. The constant over-stretching of resources at Garlands, therefore, was nothing new, but presenting it in terms of the effect it had on the patients themselves, using statistics and through individual cases, has provided a new area of analysis. Central to addressing this gap has been the examination of each patient's history. Although a small, core sample has been researched in comparison to previous work, the in-depth of analysis of these patients have added greatly to the understanding of the pauper experience. In addition to this, many more cases have been explored and evaluated throughout the entire thesis, taking the actual number of patients examined to over 400. Mapping the lives of those who came through the Asylum doors adds value to what is already understood of lunatic institutions, as the factors acting upon each patient often had an effect on their conditions and how they left. For instance, an unmarried patient who had little or no relatives was increasingly likely to be circulated to another asylum some distance from Garlands in times of overcrowding.

Third, to address the absence of pauper experience within the historiography, the research has emphasised the stories of individual cases. History from below has been important in bringing the patient experience to the forefront of this thesis, and is vital in understanding the effect the frequent movement of Asylum inmates had on

those who felt it first-hand.[20] Although a smaller sample has been utilised than in other comparable studies, the detail to which each patient has been explored, and cross-referenced in various documents, is on a much deeper scale.[21] Examining each case in such a way creates a comprehensive picture of their individual experience of insanity in the period of study, and when brought together a greater understanding of the circulatory nature of mental health provision has been obtained. For instance, when choosing suitable patients to be transferred to the workhouse to continue receiving care, it was often the chronic cases that posed the least risk to harming themselves or others, who were removed. The consequence of this was that the patients who were quiet and gave no trouble whilst in the Asylum, reacted adversely to the lower standard of care in the workhouse and often became noisy, irritable, and sometimes violent. Therefore circulation compromised the moral regime of care offered to pauper patients, and through close examination of their case notes, it is clear that this could be detrimental to their conditions.

Whilst undertaking the in-depth study of each patient, the role their relatives played in this process has become increasingly clear. In recent years the family as instigators of asylum admission has become the focus of many studies,[22] but the absence of available documents to provide such information has hindered any large scale analysis. The survival of pauper letters, and the register of visits from relatives in the Garlands records, has been vital in providing a starting point for the evidence of the role played by families. Also important were the indications of insanity provided by family members on a patient's reception order on admission. The findings of chapter five offer new areas of research with regard to family involvement in the asylum process. The most important of these was the reasons why families made the decision to admit their relatives on more than one occasion to Garlands, making them the instigators of circulation. As families were the closest to those afflicted with mental illness, they knew when their health had deteriorated to the point when they would have to seek the assistance of the relieving officer. This willingness to do the best for their

[20] R. Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14:2 (1985), pp. 175-98.
[21] For instance, for Michael's 2000 cases only 'a small fraction of the individual case histories' were mentioned, Michael, *Care and Treatment*, p. 7
[22] For instance C. Smith, 'Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics', *Family and Community History*, 9:2 (2006), pp. 109-24; Wright, *Mental Disability in Victorian England*, pp. 46-8; L. Smith, '"Your Very Thankful Inmate": Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine*, 21:2 (2008), pp. 237-252.

loved one was prioritised over what the individual themselves would have liked to have happened. Quite the opposite was also found to be true. The absence of willing family members to take care of mentally ill relatives could also have increased the circulation of patients. For example, patients who were classed as imbeciles or idiots, who were manageable at home, could have been looked after by their families. However, in lieu of willing relatives to take on such a financial burden, the responsibility for care fell to the Poor Law authorities, and they would be passed between the workhouse and the asylum for the rest of their lives.

Finally, from the research gathered, it was clear that certain groups experienced circulation more than others. The Roman Catholic patients admitted to Garlands were examined using the same level of analysis as the Protestants. This exploration has ascertained an understanding that was greatly lacking in the historiography. The only research of the Roman Catholic faith that has been conducted is of those who were admitted to the Lancashire Asylums in the years immediately following the Famine. This thesis has found that this particular group experienced discrimination which resulted in their accelerated movement through the institutions of the Poor Law system. Patients who came to Garlands who were of Irish birth, or were descended from Irish immigrants that had settled in the area, were more likely to experience circulation at some point in their institutional lives, and disproportionately suffered with higher rates of long-term mental illness. This posed a continuous problem for doctors, as the financial burden of these patients was felt most heavily. Along with this was the prejudice felt towards the Roman Catholic patients, as it was believed they were undeserving of such care, funded by local Poor Law Unions.

Novelty

When bringing together all the new areas of research, the way in which the historiography is viewed alters. First, the exploration of a Northern, rural asylum has highlighted the need for the literature to reflect the geographical diversity of English institutions. The value of previous works remain important as every asylum had its own set of circumstances and individual actors that influenced the way in which it was run. Each asylum also had different populations from which its patients were drawn, resulting in an individual set of admissions equally worthy of study. Therefore, the research carried out here reinforces the need for historians of lunatic institutions to now consider the experience of patients from previously un-researched locations. In

addition, the historiography concerning these institutions has failed to analyse the impact of patient agency on the ability to deliver moral therapy. The evidence offered in chapter four requires further extension to fully evaluate the responses to resistance, and how this effected those under treatment.

Second, the existing literature concerning lunatic asylums, hints at the fact that patients were increasingly moved in and out of these establishments – for instance Smith correctly identified a 'tapestry of care'.[23] However, the reasons why, and the effects of the transition, have been left absent. The research presented in this thesis confirms and extends the analysis of Smith and others. As a result, the understanding of the asylum, and of mental health provision, has altered so that the lunatic institution is considered to be a fluid entity, which formed only one part in a larger system of care. In light of the research conducted here, the asylum is viewed as a temporary solution, as patients showing the slightest sign of recovery or of becoming more complicit, were quickly considered fit for discharge or removal to the workhouse to free up space for more urgent cases. When viewing the asylum in this way, the patient experience is understood as transient, and uncertain, as there were several possible outcomes for individuals classified as suffering from similar conditions. Considering the patient experience in this way does not mean that all institutional histories are incorrect and should be disregarded. Instead, the understanding has been widened. In viewing the pauper lunatic experience as transient, future research concerning the county institutions built after 1845 will be much more inclusive of the other establishments that played a key role in mental health provision in this period.

Third, now that the thesis has demonstrated that overcrowding was the main facilitator of circulation, the historiography can be extended with regard to this area. All institutional work on asylums explain the problem of overcrowding, and what happened to alleviate the issue, as argued above. In light of this thesis, the focus shifts to the effect this had on the patients themselves. Centring on the pauper experience, the measures put in place to deal with overcrowding provides another dimension to the operation of nineteenth century asylums. An additional consideration here is the actors who facilitated the movement of patients in situations of overcrowding. The continual reluctance of the relevant authorities to finance extensions large enough to accommodate all paupers classified insane, overlaps with the issue of local government

[23] Smith, 'A Sad Spectacle', p. 103. This has also been reinforced by Taylor, who stated that the asylum must be understood as part of a larger system of care, Taylor, *Child Insanity*.

finance in the late Victorian era, and works concerning the Poor Law and the financing of its institutions. The pieces that connect the facets of circulation together are key to understanding the reasons why certain patients were moved out of the asylum, and others were not. The role of, and relationships between, the Lunacy Commissioners, Committee of Visitors, medical superintendents and Poor Law Officers in this process, therefore, requires further exploration in light of the analysis provided in this thesis.

Finally, by focussing on groups such as the Roman Catholics, it is clear that not all pauper lunatics experienced treatment within an asylum in a uniform way. Patients have previously been explored according to their class in the literature. This understanding has been challenged, as this thesis has explained how those of the same class experienced insanity differently. This exploration crosses over in several areas with existing works on the treatment of the Irish in wider Victorian society, and adds to the debate surrounding the consideration of 'aliens' in the period before the 1905 Act. Closely allied to this is the notion of religion, and the difference in treatment of sects other than the Church of England. Groups who were placed on the fringe of institutional life, for reasons of religion or ethnicity, require further in depth study, in both lunatic asylums, and the wider Poor Law system.[24] The reasons for their movement, or stagnation, would offer a valuable comparison to the frequent transfer of pauper patients in the county asylum system.

The study presented in this thesis has not only set out the above stated new areas of research concerning the treatment of pauper lunatics, but has also brought to light a number of key areas worthy of future study, and has provided a system of in depth, cross-referencing of records through which it can be conducted. Circulation can now be considered in relation to each of the county asylums, whether previously researched or not, and a new area of understanding lies waiting to be expanded. The author will develop the methods utilised in this thesis to consider the wider movement of paupers through the various institutional responses to poverty, illness and disability. Viewing these groups in such a way would offer a contrast to the pauper lunatic experience, so that researchers can examine the reasons why such groups were circulated more, or less, frequently in and out of specific institutions. Particular focus shall be on Poor Law

[24] A study into the experience of Jewish Patients has been conducted by Smith, which provides a good starting point for further research, L. D. Smith, 'Insanity and Ethnicity: Jews in the Mid-Victorian Lunatic Asylum', *Jewish Culture and History*, 1:1 (1998), pp. 27-40. See also, C. Reeves, 'Insanity and Nervous Diseases amongst Jewish immigrants to the East End of London, 1880-1920' (Unpublished PhD Thesis, University College London, 2001); R. Littlewood and M. Lipsedge, *Aliens and Alienists: Ethnic Minorities and Psychiatry*, 3rd edn (London: Routledge, 2001).

Unions that remain unused by researchers, in order to add an additional novelty to the area.

Appendices

Appendix 1 – Where the insane chargeable to Cumberland and Westmorland were maintained, 1864-1903[1]

Year	Asylums	Workhouses	With Relatives	Total
1864	225	158	77	460
1870	401	143	86	630
1873	359	231	141	731
1874	388	243	142	773
1875	405	252	130	787
1876	441	260	133	834
1877	448	279	129	856
1878	458	287	138	883
1879	457	286	143	886
1880	466	292	133	891
1881	487	299	135	921
1882	485	298	134	917
1883	489	310	130	929
1884	513	316	120	949
1885	498	300	120	918
1886	501	290	114	905
1887	508	304	120	932
1888	530	328	143	1001
1889	523	322	147	992
1890	543	327	146	1016
1891	545	336	148	1029
1892	523	346	145	1014
1893	544	346	161	1051
1894	537	338	170	1045
1895	541	323	160	1024
1896	553	336	172	1061
1897	566	340	171	1077
1898	582	341	166	1089
1899	599	378	179	1156
1900	592	381	185	1158
1901	597	373	176	1146
1902	602	388	174	1164
1903	632	405	171	1208

[1] Data for this table has been drawn from the Commissioners in Lunacy Annual Reports for each year. Statistics for 1865-1869, and 1871-2 are absent due to no information given in these reports. These are the patients who were chargeable to Cumberland and Westmorland. Differing levels present in Garlands than those listed in the tables as residing in Asylums, account for cases in Garlands who were accepted from other counties. Commissioners in Lunacy, *Annual Reports to the Lord Chancellor* (1864-1903).

Appendix 2 – Relationship of Patient's Visitors, 1900-1904[2]

	Spousal		Sibling		Parental	
	Wife	**Husband**	**Brother**	**Sister**	**Mother**	**Father**
1900	14	8	10	19	11	3
1901	8	10	10	21	7	6
1902	18	11	4	24	7	6
1903	11	14	5	20	19	1
1904	13	16	10	7	9	4
Total	123		130		73	

[2] The relationship of visitors to the first 100 patients named 1900-1904 in the Patient's Friends book. Other relations that visited: Aunt, uncle, niece, nephew, daughter-in-law, son-in-law, sister-in-law, brother-in-law, stepmother, granddaughter, cousin, and friend, CACC, *Patient's Friends Book 1900-1904*, THOS 8/4/24/1.

Appendix 3 – Patients from the sample who underwent circulation[3]

Females

Name	Details of Circulation	Final Outcome
Coelia Ann M	Three times in Garlands.	Died in Garlands
Ellen W	Twice in Garlands.	Died in Garlands
Hannah D	Twice in Garlands.	Died in Garlands
Harriet W	Three times in Garlands, once in Lancaster Asylum.	Died in Garlands
Helen W	Twice in Garlands.	Died in Garlands
Julia G	Four times in Garlands.	Died in Garlands
Maria S	Twice in Garlands, removed by husband first time.	Died in Garlands
Mary M	Moved between Workhouse and Garlands twice.	Died in Garlands
Mary W	Twice in Garlands.	Died in Garlands
Agnes O	Twice in Garlands, relieved then brought back.	Died in Garlands
Bridget D	Once in garlands, came from Workhouse.	Died in Garlands
Catherine C	Twice in Garlands, came from Workhouse.	Died in Garlands
Elizabeth F	First attack in Ayr Asylum.	Died in Garlands
Isabella G	Came from Fusehill Hospital.	Died in Garlands
Isabella O	Came from Fusehill Workhouse.	Died in Garlands
Jane K	Twice in Garlands, came from Workhouse.	Died in Garlands
Rosanna M	Came from Fusehill Workhouse	Died in Garlands
Margaret J	In Garlands several times.	Died in Garlands
Sarah Mc	Moved between Workhouse and Garlands several times.	Died in Garlands
Sarah Mu	Twice in Garlands.	Died in Garlands
Annie C	Twice in Garlands.	Died in Garlands
Annie H	Came from Cockermouth Workhouse.	Died in Garlands
Sarah Ann P	Came from Kendal Workhouse.	Relieved
Mary C	Came from Manchester Workhouse.	Relieved
Jane R	Transferred to several institutions after Garlands.	Relieved
Mary Elizabeth D	Once in Garlands.	Relieved
Ann E	From Penrith workhouse. Twice in	Relieved

[3] Information for both these tables has been drawn from the various casebooks and reception orders for the period of study, and the UK Lunacy Patient Register. CACC, *Casebook 1884-1888*, THOS 8/4/38/9; CACC, *Female Casebooks 1884-1906*, THOS 8/4/40/1-6; CACC, *Male Casebooks 1888-1906*, THOS 8/4/39/1-6; CACC, *Reception Orders 1862-1913*, THOS 8/4/1/4-55; Ancestry.com, *UK, Lunacy Patients Admission Registers, 1846-1912* [database on-line].

	Garlands.	
Sarah W	Mistaken transfer from Morpeth Asylum.	Relieved
Sarah H	Twice in Garlands.	Recovered
Barbee L	Twice in Garlands. Came from Milnthorpe workhouse.	Recovered
Ann D	Twice in Garlands.	Recovered
Ruth A	Twice in Garlands.	Recovered
Sarah Ann W	Was in Stafford Asylum and twice in Prestwich Asylum.	Recovered
Sarah B	In Garlands three times.	Recovered
Sarah F	Twice in Garlands.	Recovered
Martha J	Twice in Garlands.	Recovered
Margaret Jane H	Three times in Garlands.	Recovered
Grace L	Transferred from Cockermouth Workhouse.	Recovered

Males

Name	Details of Circulation	Final Outcome
Caleb H	Came from Cumberland Infirmary.	Died in Garlands
Edward E	Transferred several times from Garlands to Workhouse.	Died in Garlands
Henry S	Came from East Ward Workhouse.	Died in Garlands
John George W	In Garlands twice.	Died in Garlands
John M	Came from Newcastle Workhouse.	Died in Garlands
Robert B	In Garlands three times.	Died in Garlands
Robert Walter K	Came from Netley Hospital.	Died in Garlands
Thomas S	Several times in Garlands and Penrith Workhouse.	Died in Garlands
William S	Came from Taunton Military Prison.	Died in Garlands
Edward M	Came from Wigton Workhouse.	Died in Garlands
George M	Came from Fusehill Hospital.	Died in Garlands
Gerald F	Came from Cumberland Infirmary.	Died in Garlands
John M	In Garlands three times.	Died in Garlands
Matthew G	In Garlands twice, discharged to Workhouse and brought back.	Died in Garlands
Michael H	Came from Kendal Workhouse.	Died in Garlands
William N	Came from Gateshead, in Garlands twice.	Died in Garlands
John G	Discharged to Workhouse.	Relieved
John W	Relieved.	Relieved
Felix D	Relieved.	Relieved
Michael O	Relieved.	Relieved
Robert H	In Garlands twice.	Recovered

William D	In Garlands three times, previously in Lancaster Asylum.	Recovered
Hugh Q	Came from Brampton Workhouse, in two other asylums prior.	Recovered
James S	In Garlands twice.	Recovered
John F	In Garlands twice.	Recovered
John N	In Garlands twice.	Recovered
Michael C	In Garlands several times. Died in Broadmoor.	Recovered
Patrick James B	In Garlands twice.	Recovered
Patrick M	In Garlands twice. Came from Workhouse.	Recovered
Thomas D	Came from Kendal Workhouse.	Recovered
Thomas K	Came from Wigton Workhouse.	Recovered
Archibald P	In Garlands twice.	Recovered
Isaac S	In Garlands twice.	Recovered
Jacob C	In Garlands seven times, recovered each time.	Recovered

Appendix 4a – How the patients admitted in January 1862 left the Asylum[4]

	Number
Died	**109**
Recovered	**15**
Relieved	**23**
Total	**147**

Appendix 4b – Patients admitted in January 1862, who were discharged recovered or relieved, returned to the Asylum and/or subsequently died

Those who were…	Readmitted	Readmitted and Died in Garlands
Recovered	3	2
Relieved	3	4

[4] Data for both these tables has been obtained from CACC, *Casebook 1862-1865*, THOS 8/4/38/1; Ancestry.com, *UK, Lunacy Patients Admission Registers, 1846-1912* [database on-line].

Appendix 5 – Methodology and Sample Representation

Method

In the absence of a catalogued database of patients, the core sample used in this thesis had to be constructed using the casebooks. The comparative studies in the literature have used catalogued admission registers to select a sample of patients to analyse. For instance, Pamela Michael used this to select ten percent of patients admitted between 1875 and 1914, which amounted to 578 patients.[5]

The years that the sample spans – 1884-1903 – was guided by the annual reports and the fact that for each of these years the superintendents recorded the nationality of patients present in the asylum on 31 December. For each year an equal amount of male and female patients were chosen, ensuring that there was an equal amount from the Protestant and Catholic faiths. Apart from Cox, Marland and York's research on the Irish patients admitted to the Lancashire asylums in the years immediately following the famine, studies focussing on the experience of Irish Catholics were absent for other English Asylums – with existing ones largely focussing on those who immigrated to the colonies and elsewhere overseas. As the sample was constructed with circulation in mind, half of the sample was dedicated to focussing on the Irish experience of frequent transfer. Although this does alter the representation of the sample, as only 4-14% of the asylum population between these years was Catholic, it is with the intention of focusing in on the experience of a marginal group.

Using these filters, two Protestant males, two catholic males, two protestant females and 2 catholic females for each year. To select the patients at random I had the casebooks in front of me, and for each year opened randomly to a page and chose that patient. The fact the patient admissions weren't catalogued made it easier for me to do this, as I had no prior knowledge of the patients in each volume. All the chosen cases were then photographed, and from there were cross-referenced with other records, and more information was gathered about each one.

Sample Representation

Representation of the analysed sample is an issue for researchers of asylums, as it is impossible to know the exact makeup of an asylum population at a given time due to the constant flow on patients in and out of the institution. For instance, I could not construct a sample that was representative of the exact distribution of the ages of patients for the years studied, as the information is not there. In the annual reports, ages are given for those that were admitted that year, but not of the patients present in the asylum on a given day.

The constant movement of patients in and out makes it difficult to know the exact characteristics of those in an asylum. Therefore the sample had to be chosen at random, as the exact characteristics of the general population cannot be fully known – no definite catalogue. I can gather certain information from the general statements given in annual reports like – 8% of cases admitted suffered from puerperal mania for the first decade of operation – ascertain the frequency of conditions. Similarly, when occupations given for patients admitted, you can gain a sense that having a schoolmaster admitted was fairly rare, but having agricultural labourer, more common. As a result, the patient sample could not be gathered as a representation of the wider asylum population as these statistics are impossible to gather.

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[5] P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003), p. 89.

The patient cases presented throughout the thesis have been analysed as a part of the entire sample in terms of the ways in which they came to the asylum, how they left, and how many times they returned. Where other information has been commented on about each case, for instance in chapter four when blistering was discussed for Maria S, the representativeness of these other characteristics have not been analysed as it detracts from the focus on patient circulation. The information pertaining to the sample and patient transfer has been provided throughout in the text, in footnotes or in the tables of the appendix.

Bibliography

Archival Material

Asylum Records

CACC, *Casebooks 1862-1888*, THOS 8/4/38/1-9.
CACC, *Male Casebooks 1888-1906*, THOS 8/4/39/1-6.
CACC, *Female Casebooks 1884-1906*, THOS 8/4/40/1-6.
CACC, *Reception Orders 1862-1913*, THOS 8/4/1/4-55.
CACC, *Rules and regulations for the management of the Cumberland and Westmorland Asylum, Garlands, 1861*, THOS 8/1/1/1.
CACC, *General Rules for the Government of the Asylum at Garlands, 1870*, THOS 8/1/1/3.
CACC, *Annual Reports of the Cumberland and Westmorland Lunatic Asylum, 1863-1913*, THOS 8/1/3/1/1-51.
CACC, *Mechanical Restraint Register 1890-1946*, THOS 8/4/29/1.
CACC, *Quarterly list of lunatic paupers not in any asylum 1875*, THOS 8/4/82/9.
CACC, *Patient's Friends Book 1900-1904*, THOS 8/4/24/1.
CACC, *Register of post mortems carried out on named patients 1863-1907*, THOS 8/4/36/1-6.
CACC, *Registers of Admission, Discharge and Death – 1862-1907*, THOS 8/4/83/1.
CACC, W. Farquharson, *Memorandum on Pressure on Accommodation at Garlands*, 1902, DHOD/11/102.
CACC, *Correspondence between the Cumberland and Westmorland Asylum and Gateshead Town Council relating to overcrowding at the Garlands and the removal of patients*, THOS 8/4/82/13.
CACC, *Quarterly account of salaries and wages paid to named staff, 1861-1906*, THOS 8/2/7/1-2.
CACC, *Account of Weekly Wages Paid to Named Staff, 1882-1896*, THOS 8/2/7/6.

Poor Law Records

CACW, *Bootle Poor Law Union*, SPUBO.
CACC, *Brampton Poor Law Union*, SPUB.
CACC, *Carlisle Poor Law Union*, SPUCA.
CACW, *Cockermouth Poor Law Union*, SPUCO.
CACK, *East Ward Poor Law Union*, WSPUE.
CACK, *Kendal Poor Law Union*, WSPUK.
CACC, *Penrith Poor Law Union*, SPUP.
CACK, *West Ward Poor Law Union*, WSPUW.
CACW, *Whitehaven Poor Law Union*, SPUW.

Other Records

CACC, *Lunacy Committee Minute Books 1846-1912*, C/C/1/24/1-6.
CACC, *Jackson's Postal Address Directory Map, 1880.*

TNA, *Four letters relating to the Carlisle Lunatic Asylum, 13 May 1846-27 Feb. 1847*, HO 45/1437.
TNA, *An Agreement between the counties of Westmoreland and Cumberland to unite in the creation of a new joint lunatic asylum, 3 Aug. 1852-20 Aug. 1852*, HO 45/4097.
TNA, *Cumberland Summer Assizes, 1898*, ASSI/52/38.

Cambridge University Library, Anon., *Report of the Cumberland Lunatic Asylum at Dunston Lodge, Gateshead-on-Tyne* (Edinburgh: Neill & Co., 1847).

Carlisle Central Library Local History Reference Section, G. R. Wyld, *A History of the Garlands Estate and Garlands Hospital, Carlisle, Cumberland, 1757-1914* (n.pub, 1972).

Acts of Parliament

48 George III c. 96, An Act for the Better Care and Maintenance of Lunatics, Being Paupers or Criminals in England, 1808.

8 & 9 Victoria c. 100, An Act for the Regulation of the Care and Treatment of Lunatics, 1845.

8 & 9 Victoria c. 126, An Act to Amend the Laws for the Provision and Regulation of Lunatics Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England, 1845.

25 & 26 Victoria c. 111, Lunatics Law Amendment Act, 1862.

53 Victoria c. 5, Lunacy (Consolidation) Act, 1890.

Government Reports

Commissioners in Lunacy, *Annual Reports to the Lord Chancellor* (1847-1910).

House of Commons Papers, *Copy of the special report of the commissioners in lunacy to the Lord Chancellor on the alleged increase of insanity* (1897), http://parlipapers.proquest.com/parlipapers/docview/t70.d75.1897-074861?accountid=7420 [accessed 10 January 2017].

Primary Literature

Anon., 'Proposed County Asylum for Northumberland and Cumberland', *Asylum Journal,* 1 (1854), pp. 61-2.

Anon., 'Overcrowded London', *The Review of Reviews,* 19 (1899), p. 496.

Anon., 'Workhouse Lunatic Wards', *Journal of Mental Science,* 47:197 (1901), pp. 358-9.

Anon., 'Complimentary', *Journal of Mental Science,* 56:233 (1910), pp. 375-8.

Browne, W. A. F., 'The Moral Treatment of the Insane; a lecture', *Journal of Mental Science,* 10:51 (1864), pp. 309-15.

Bucknill, J. and Tuke, D. H., *A Manual of Psychological Medicine: Containing the History, Nosology, Description, Statistics, Diagnosis, Pathology, and Treatment of Insanity. With an Appendix of Cases* (London: Blanchard and Lea, 1858).

Campbell, J. A., 'Four Years' Treatment of Insanity at Garland's Asylum, With Remarks', *The Lancet,* 121:3108 (1883), pp. 497-8.

Campbell, J. A., 'On the Appetite in Insanity', *Journal of Mental Science,* 32:138 (1886), pp. 193-200.

Campbell, J. A., *Lunacy in Cumberland & Westmorland, with remarks: an address delivered at the opening of the Section of Psychology at the Annual meeting of the British Medical Association, held in Carlisle, July, 1896* (Carlisle: Chas. Thurnam & Sons, 1896).

Campbell, J. A., 'The Hardships and Risks of the Medical Profession and those engaged in the Treatment of Bodily and Mental Disease', *The Lancet,* 150:3877 (1897), p. 1619.

Campbell Clark, A., McIvor Campbell, C., Turnbull, A. R., and Urquhart, A. R., *Handbook for the Instruction of Attendants on the Insane* (London: Baillièrè, Tindall & Cox, 1885).

Clouston, T. S., 'The Medical Treatment of Insanity', *Journal of Mental Science,* 16:73 (1870), pp. 24-30.

Clouston, T. S., 'What Cases Should be Sent to Lunatic Asylums? And When?' *British Medical Journal,* 578:1 (1872), pp. 96-8.

Clouston, T. S., *Clinical Lectures on Mental Diseases* (London: J & A Churchill, 1904).

Clouston, T., 'The Fifth Norman Kerr Memorial Lecture. Some of the Psychological and Clinical Aspects of Alcohol', *The British Journal of Inebriety,* 11:3 (1914), pp. 105-31.

Conolly, J., *Treatment of the Insane Without Mechanical Restraints* (London: Smith, Elder & Co., 1856).

Conolly, J., *The Construction and Government of Lunatic Asylums* (London: Dawsons of Pall Mall, 1968).

Conolly, J., *Treatment of the Insane Without Mechanical Restraints. With an Introduction by Richard Hunter and Ida Macalpine* (London: Dawsons, 1973).

Curwen, J. F., *Kirkbie-Kendall: Fragments Collected Relating to its Ancient Streets and Yards; Church and Castle; Houses and Inns* (Kendal: T. Wilson, 1900).

Falconer, W., *A Dissertation on the Influence of the Passions Upon the Disorders of the Body* (London: Dill, 1788).

Farquharson, W. F., 'Heredity in Relation to Mental Disease', *Journal of Mental Science,* 44:186 (1898), pp. 538-554.

Lidbetter, R. M (ed.), *A Temperance Handbook for Boys and Girls: Text-book for the annual competitive examinations of the Cumberland Band of Hope Union* (Carlisle: W. Etchells & Son, 1912).

Maudsley, H., 'The Alleged Increase of Insanity', *Journal of Mental Science,* 25:101 (1877), pp. 45-54.

Oliver, R., *Suggestions as to the Expediency of Erecting a Public Asylum for the Insane, Belonging to the Counties of Cumberland and Westmorland, in a Letter to Edward William Hasell Esq.* (Carlisle: James Steel, 1842). https://archive.org/details/b22387171 [accessed 27 May 2018].

Philips, C. P., *The Law Concerning Lunatics, Idiots and Persons of Unsound mind* (London: James Wildy, 1858).

Robertson, C. L., 'A Further Note on the Alleged Increase of Lunacy', *Journal of Mental Science,* 16:76 (1871), pp. 473-97.

Rutherford Macphail, S., 'Clinical Observations on the Blood of the Insane', *Journal of Mental Science,* 30:131 (1884), pp. 378-89.

Tuke, D. H., *Chapters in the History of the Insane in the British Isles* (London: Kegan Paul, Trench & Co., 1882).

Tuke, S., *Description of the Retreat: an institution near York for insane persons of the Society of Friends: containing an account of its origin and progress, modes of treatment, and a statement of cases* (York: W. Alexander, 1813).

Wilkinson, J. E., *Reply to the Statements contained in a pamphlet and letter by Dr Oliver, Carlisle, on the Expediency of Erecting A Public Asylum for the Insane, Belonging to the Counties of Cumberland and Westmorland* (Newcastle Upon Tyne: T & J Hodgson, 1842), https://archive.org/details/39002086345437.med.yale.edu [accessed 27 May 2018].

Watson, J. K., *A Handbook for Nurses* (London: The Scientific Press Ltd, 1899).

Contemporary Newspapers and Journals

Carlisle Journal.
Carlisle Patriot.
Cumberland Pacquet.
Lakes Chronicle and Reporter.

The Maryport Advertiser.
The Times.
West Cumberland Pacquet.
The West Cumberland Times.
Westmorland Gazette.

Asylum Journal.
British Medical Journal.
The British Journal of Inebriety.
British Journal of Psychiatry.
Journal of Mental Science.
The Lancet.

Ancestry Sources

Ancestry.com, *1851 England Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005.

Ancestry.com, *1861 England Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005.

Ancestry.com, *1871 England Census [database on-line]*, Provo, UT, USA: Ancestry.com Operations Inc, 2004.

Ancestry.com, *1881 England Census [database on-line]*, Provo, UT, USA: Ancestry.com Operations Inc, 2004.

Ancestry.com, *1891 England Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005.

Ancestry.com, *1901 England Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2005.

Ancestry.com, *1911 England Census* [database on-line]. Provo, UT, USA: Ancestry.com Operations, Inc., 2011.

Ancestry.com, *England & Wales, Civil Registration Birth Index, 1837-1915* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2006.

Ancestry.com, *England & Wales, Civil Registration Marriage Index, 1837-1915* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2006.

Ancestry.com, *England & Wales, Civil Registration Death Index, 1837-1915* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc, 2006.

Ancestry.com, *UK, Lunacy Patients Admission Registers, 1846-1912* [database on-line]. Provo, UT, USA: Ancestry.com Operations, Inc., 2014.

Ancestry.com, *UK and Ireland, Masters and Mates Certificates, 1850-1927* [database on-line]. Provo, UT, USA: Ancestry.com Operations, Inc., 2012.

Ancestry.com, *England & Wales, National Probate Calendar (Index of Wills and Administrations), 1858-1966, 1973-1995* [database on-line]. Provo, UT, USA: Ancestry.com Operations, Inc., 2010.

Ancestry.com, *Ireland, Poor Law Union Removals From England, 1859-1860* [database on-line]. Lehi, UT, USA: Ancestry.com Operations, Inc., 2017.

Ancestry.com, *England & Wales, Criminal Lunacy Warrant and Entry Books, 1882-1898* [database on-line]. Provo, UT, USA: Ancestry.com Operations, Inc., 2014.

Ancestry.com, *England & Wales, Civil Registration Death Index, 1916-2007* [database on-line]. Provo, UT, USA: Ancestry.com Operations Inc., 2007.

Secondary Sources

Abel-Smith, B., *A History of the Nursing Profession* (London: Heinemann, 1960).

Adair, R., Melling. J., and Forsythe, B., 'The New Poor Law and the County Pauper Lunatic Asylum – The Devon Experience 1834-1884', *Social History of Medicine,* 9:2 (1996), pp. 335-55.

Adair, R., Melling. J., and Forsythe, B., 'Migration, Family Structure and Pauper Lunacy in Victorian England, admissions to the Devon County Pauper Lunatic Asylum, 1845-1900', *Continuity and Change,* 12:3 (1997), pp. 373-401.

Adair, R., Melling, J., and Forsythe, B., 'A Danger to the Public? Disposing of Pauper Lunatics in late-Victorian and Edwardian England: Plympton St. Mary Union and the Devon County Asylum, 1867-1914', *Medical History,* 42:1 (1998), pp. 1-25.

Adair, A., Forsythe, B., and Melling, J., 'Families, Communities and the Legal Regulation of Lunacy in Victorian England: Assessments of Crime, Violence and Welfare in Admissions to the Devon Asylum, 1845-1914', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 153-80.

Adair, A., Forsythe, B., and Melling, J., 'Politics of Lunacy: Central State Regulation and the Devon Pauper Lunatic Asylum, 1845-1914', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 68-92.

Anderson, M., *Family Structure in Nineteenth Century Lancashire* (Cambridge: Cambridge University Press, 1971).

Andrews, J., 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the nineteenth century', *Social History of Medicine,* 11:2 (1998), pp. 255-81.

Andrews, J., ‘The Boundaries of her Majesty’s Pleasure: Discharging child-murderers from Broadmoor and Perth Criminal Lunatic Department, c. 1860-1920’, in M. Jackson (ed.), *Infanticide: Historical Perspectives on Child Murder and Its Concealment, 1550-2000* (London: Athlone, 2002), pp. 216-48.

Andrews, J., ‘Cause or Symptom? Contentions Surrounding Religious Melancholy and Mental Medicine in Late-Georgian Britain’, *Studies in the Literary Imagination,* 44:2 (2011), pp. 63-91.

Andrews, J., ‘History of Medicine: Health, Medicine and Disease in the Eighteenth Century’, *Journal for Eighteenth Century Studies,* 34:4 (2011), pp. 503-15.

Baines, D., *Migration in a mature economy: emigration and internal migration in England and Wales 1861-1900* (Cambridge: Cambridge University Press, 1985).

Barrett, S., ‘Kinship, poor relief and the welfare process in early modern England’, in S. King and A. Tomkins (eds), *The Poor Law in England 1700-1850: An Economy of Makeshifts* (Manchester: Manchester University Press, 2013), pp. 199-227.

Bartlett, P., ‘The Asylum, The Workhouse, and the voice of the insane poor in nineteenth century England’, *International Journal of Law and Psychiatry,* 21:4 (1998), pp. 421-32.

Bartlett, P., *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London: Leicester University Press, 1999).

Bartlett, P., ‘The Asylum and the Poor law: The Productive Alliance’, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 48-67.

Bartlett, P., and Wright, D., ‘Community Care and its antecedents’, in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 1-18.

Bashford, A., ‘Insanity and Immigration Restriction’, in C. Cox, and H. Marland (eds), *Migration, Health and Ethnicity in the Modern World* (London: Palgrave Macmillan, 2013), pp. 14-35.

Bennett, D., ‘The Drive Towards the Community’, in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 193-208.

Benson, J., *The Working Class in Britain, 1850-1939* (London: Longman, 1989).

Berrios, G. E., and Freeman, H (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991).

Beveridge, A., ‘Thomas Clouston and the Edinburgh School of Psychiatry’, in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 359-388.

Bhavsar, V., and Bhugra, D., ‘Bethlem’s Irish: Migration and distress in nineteenth-century London’, *History of Psychiatry,* 20:2 (2009), pp. 184-98.

Bingham, R. K., *Kendal: A Social History* (Milnthorpe: Cicerone Press, 1995).

Borsay, A., *Disability and Social Policy in Britain since 1750: a history of exclusion* (Basingstoke: Palgrave Macmillan, 2005).

Bradley, K., *Poverty, Philanthropy and the State: Charities and the working class in London, 1918-79* (Manchester: Manchester University Press).

Brimblecombe, N., ‘Asylum Nursing as a Career in the United Kingdom, 1890-1910’, *Journal of Advanced Nursing,* 55:6 (2006), pp. 770-77.

Brooks, G., ‘The Building of the Cumberland and Westmorland Joint Lunatic Asylum’, *Transactions of the Cumberland and Westmorland Antiquarian and Archaeological Society,* 4 (2004), pp. 229-244.

Busfield, J., *Men, Women, and Madness: Understanding gender and mental disorder* (Basingstoke: Macmillan, 1996).

Bynum, W. F., ‘Rationales for therapy in British Psychiatry, 1789-1835’, in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 35-57.

Bynum, W. F., Porter, R., and Shepherd, M., ‘Introduction’, in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III* (London: Tavistock Publications, 1988), pp. 1-12.

Cashman, B., *A Proper House: Bedford Lunatic Asylum (1812-1860)* (Bedford: North Bedfordshire Health Authority, 1992).

Chaney, S., ‘”No ‘Sane’ Person Would Have Any Idea”: Patients’ Involvement in Late Nineteenth-century British Psychiatry’, *Medical History,* 60:1 (2016), pp. 37-53.

Cherry, S., *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew’s Hospital c. 1810-1998* (Woodbridge: Boydell Press, 2003).

Clark, E., ‘Lessons from the Past: Family involvement in patient admission and discharge, Beechworth Lunatic Asylum, 1900-1912’, *International Journal of Mental Health Nursing,* 27:1 (2018), pp. 320-28.

Clark, M. J., ‘The Rejection of Psychological Approaches to Mental Disorder in late nineteenth century British psychiatry’, in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 271-312.

Cochrane, D., '"Humane, economical, and medically wise": the LCC as administrators of Victorian lunacy policy', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III* (London: Tavistock Publications, 1988), pp. 247-72.

Cohen, D., *Family Secrets: Living with Shame from the Victorians to the Present Day* (London: Viking, 2013).

Coleborne, C., 'Challenging Institutional Hegemony: Family Visitors to Hospitals for the Insane in Australia and New Zealand, 1880s-1910s', in G. Mooney and J. Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Rodopi, 2009), pp. 289-308.

Coleborne, C., *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Basingstoke: Palgrave Macmillan, 2010).

Coleborne, C., and McCarthy, A (eds), *Migration, Ethnicity and Mental Health: International Perspectives, 1840-2010* (London: Routledge, 2012).

Cox, C., and Marland, H (eds), *Migration, Health and Ethnicity in the Modern World* (London: Palgrave Macmillan, 2013).

Cox, C., and Marland, H., '"A Burden on the County": Madness, Institutions of Confinement and the Irish Patient in Victorian Lancashire', *Social History of Medicine,* 28:2 (2015), pp. 263-87.

Cox, C., Marland, H., and York, S., 'Emaciated, Exhausted, and Excited: The Bodies and Minds of the Irish in late Nineteenth-Century Lancashire Asylums', *Journal of Social History,* 46:2 (2012), pp. 500-24.

Cox, C., Marland, H., and York, S., 'Itineries and Experiences of Insanity: Irish Migration and the Management of Mental Illness in Nineteenth-Century Lancashire', in C. Cox and H. Marland (eds), *Migration, Health and Ethnicity in the Modern World* (Basingstoke: Palgrave Macmillan, 2013), pp. 36-60.

Crowther, M. A., *The Workhouse System 1834-1929* (London: Batsford Academic and Educational Ltd, 1981).

Davidoff, L., 'The Family in Britain', in F. M. L. Thompson (ed.), *The Cambridge Social History of Britain, 1750-1950, Volume 2: People and Their Environment* (Cambridge: Cambridge University Press, 2008), pp. 71-130.

Davidoff, L., Doolittle, M., Fink, J., and Holden, K., *The Family Story: Blood, Contract and Intimacy, 1830-1960* (London: Longman, 1999).

Day, K., and Jancar, J., 'Mental handicap and the Royal Medico-Psychological Association: a historical association, 1841-1991', in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 268-78.

De Young, M., *The Encyclopaedia of Asylum Therapeutics, 1750-1950s* (Jefferson: McFarland & Co., 2015).

Digby, A., 'The Rural Poor Law', in D. Fraser (ed.), *The New Poor Law in the Nineteenth Century* (London: Macmillan, 1976), pp. 149-70.

Digby, A., 'Changes in the Asylum: The Case of York, 1777-1815', *The Economic History Review,* 36:2 (1983), pp. 218-39.

Digby, A., 'The Changing Profile of a Nineteenth Century Asylum: The York Retreat', *Psychological Medicine,* 14:4 (1984), pp. 739-48.

Digby, A., *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985).

Digby, A., 'Moral Treatment at the Retreat, 1796-1846', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II* (London: Tavistock Publications, 1985), pp. 52-72.

Digby, A., *Making a medical living: Doctors and Patients in the English market for medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994).

Digby, A., 'Contexts and Perspectives', in A. Digby and D. Wright (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London: Routledge, 1996), pp. 1-21.

Dobbing, C., 'An Undiscovered Victorian Institution of Care: A Short Introduction to the Cumberland and Westmorland Joint Lunatic Asylum', *Family and Community History,* 19:1 (2016), pp. 3-16.

Dobbing, C., 'The circulation of pauper lunatics and the transitory nature of mental health provision in late nineteenth century Cumberland and Westmorland', *Local Population Studies,* 99 (2017), pp. 56-65.

Dobbing, C. (Forthcoming), 'The Family and Insanity: The Experience of the Garlands Lunatic Asylum, 1862-1910', in C. Beardmore, C. Dobbing and S. King (eds), *Family Life in Britain, 1650-1910* (London: Palgrave Macmillan, 2019).

Driver, F., *Power and Pauperism: The Workhouse System 1834-1884* (Cambridge: Cambridge University Press, 1993).

Ellis, R., 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century', *Social History of Medicine,* 19:1 (2006), pp. 55-71.

Ellis, R., 'The Asylum, The Poor Law and the Growth of County Asylums in nineteenth century Yorkshire', *Northern History,* 45:2 (2008), pp. 279-293.

Ernst, W., '"Useful to both the patients as well as to the State": Patient work in colonial mental hospitals in South Asia, c. 1818-1948' in W. Ernst (ed.) *Work, psychiatry and society, c. 1750-2015* (Manchester: Manchester University Press, 2016), pp. 117-41.

Fennell, P., *Treatment without Consent: Law, Psychiatry and the treatment of mentally disordered people since 1845* (London: Routledge, 1996).

Finanne, M., 'Asylums, Families and the State', *History Workshop Journal,* 20:1 (1985), pp. 134-48.

Finnane, M., 'The Ruly and the Unruly: Isolation and inclusion in the management of the insane', in C. Strange and A. Bashford (eds), *Isolation: Places and Practices of exclusion* (London: Routledge, 2003), pp. 89-103.

Fitzpatrick, D., *Irish Emigration 1801-1921* (Dublin: Social History Society of Ireland, 1984).

Fitzpatrick, D., 'A Curious Middle Place: the Irish in Britain, 1871-1921', in R. Swift and S. Gilley (eds), *The Irish in Britain 1815-1939* (London: Pinter, 1989), pp. 10-59.

Foucault, M., *Discipline and Punish: The Birth of the Prison* (New York: Vintage Books, 1979).

Foucault, M., *Madness and Civilisation: A History of Insanity in the Age of Reason* (London: Routledge, 2001).

Foucault, M., *History of Madness* (Abingdon: Routledge, 2006).

Fox, J. W., 'Irish Immigrants, Pauperism, and Insanity in 1854 Massachusetts', *Social Science History,* 15:3 (1991), pp. 315-36.

Gainer, B., *The Alien Invasion: The Origins of the Aliens Act of 1905* (London: Heinemann, 1972).

Gilley, S., 'English Attitudes to the Irish in England, 1789-1900', in C. Holmes (ed.), *Immigrants and Minorities in British Society* (London: George Allen & Unwin, 1978), pp. 81-110.

Gingell, K., 'The Forgotten Children: Children Admitted to a County Asylum between 1854-1900', *The Psychiatrist,* 25:11 (2001), pp. 432-4.

Gladstone, D., 'The Changing Dynamic of Institutional Care: The Western Counties Idiot Asylum 1864-1914', in A. Digby and D. Wright (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London: Routledge, 1996), pp. 134-60.

Goffman, E., *Asylums: Essays on the Social Situation of Mental Patients and other inmates* (London: Aldine Transaction, 2007).

Goodman, N., ‘Poverty, Old Age and Gender in Nineteenth Century England: The Case of Hertfordshire’, *Continuity and Change,* 20:3 (2005), pp. 351-384.

Greenslade, L., Madden, M., and Pearson, M., ‘From Visible to Invisible: The “problem” of the health in Irish people in Britain’, in L. Marks and M. Warboys (eds), *Migrants, Minorities and Health: Historical and Contemporary Studies* (London: Routledge, 1997), pp. 147-78.

Guyatt, M., ‘A Semblance of Home: Mental Asylum interiors, 1880-1914’, in S. McKellar and P. Sparkle (eds), *Interior Design and Identity* (Manchester: Manchester University Press, 2004), pp. 48-71.

Hamlett, J., *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* (Hampshire: Palgrave Macmillan, 2015).

Hanly, M., ‘The economy of makeshifts and the role of the poor law: a game of chance?’, in S. King and A. Tomkins (eds), *The Poor in England 1700-1850: An economy of makeshifts* (Manchester: Manchester University Press, 2003), pp. 76-99.

Hare, E., ‘Was Insanity on the Increase?’, *British Journal of Psychiatry,* 142:5 (1983), pp. 439-55.

Harper, M (ed.), *Migration and Mental Health: Past and Present* (London: Palgrave Macmillan, 2016).

Hervey, N., ‘A slavish bowing down: the Lunacy Commission and the psychiatric profession’, in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II* (London: Tavistock Publications, 1985), pp. 98-131.

Hide, L., *Gender and Class in English Asylums, 1890-1914* (Hampshire: Palgrave Macmillan, 2014).

Higgs, M., *Life in the Victorian and Edwardian Workhouse* (Stroud: Tempus Publishing, 2007).

Hilton, J. A., ‘The Cumbrian Catholics’, *Northern History,* 16:1 (1980), pp. 40-58.

Hodgkinson, R., ‘Provision for Pauper Lunatics 1834-1871’, *Medical History,* 10:2 (1966), pp. 138-54.

Hodgkinson, R. G., *The Origins of the National Health Service: The Medical Services of the New Poor Law, 1834-1871* (London: Wellcome Historical Medical Library, 1967).

Hollen Lees, L., ‘The Survival of the Unfit: Welfare Policies and Family maintenance in Nineteenth Century London’, in P. Mandler (ed.), *The Uses of Charity: The Poor on Relief in the Nineteenth Century Metropolis* (Philadelphia: University of Pennsylvania Press, 1990), pp. 68-91.

Hughes, F., ‘Was Lunacy and Idiocy a rural or an urban condition? A comparison of two county asylum services 1845-1900’, *The Local Historian,* 44:4 (2014), pp. 301-11.

Hunter, J. M., and Shannon, G. W., ‘Jarvis Revisited: Distance Decay in Service Areas of Mid-Nineteenth Century Asylums’, *Professional Geographer,* 37:3 (1985), pp. 296-302.

Hunter, R., and Macalpine, I., *Psychiatry for the poor: 1851 Colney Hatch Asylum – Friern Hospital 1973: A Medical and Social History* (London: Dawsons of Pall Mall, 1974).

Hurren, E., *Protesting about Pauperism: Poverty, Politics and Poor Relief in late-Victorian England, 1870-1900* (London: Royal Historical Society, 2007).

Hurren, E. T., ‘“Abnormalities and Deformities”: the dissection and internment of the insane poor’, *History of Psychiatry,* 23:1 (2012), pp. 65-77.

Hurren, E., ‘Belonging, Settlement and the New Poor Law in England and Wales 1870s-1900s’, in S. King and A. Winter (eds), *Migration, Settlement and Belonging in Europe, 1500-1930s: Comparative Perspectives* (Oxford: Berghahn Books, 2013), pp. 127-52.

Ignatieff, M., ‘Total Institutions and Working Classes: A Review Essay’, *History Workshop Journal,* 15:1 (1983), pp. 167-73.

Jackson, M., ‘Institutional Provision for the feeble-minded in Edwardian England: Sandlebridge and the scientific morality of permanent cure’, in D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency*: *historical perspectives on people with learning disabilities* (London: Routledge, 1996), pp. 161-83.

Jackson, M., *The Borderland of Imbecility: Medicine, Society and the fabrication of the feeble mind in late Victorian and Edwardian England* (Manchester: Manchester University Press, 2000).

Jacyna, L. S., ‘Somatic theories of mind and the interests of medicine in Britain, 1850-1879’, *Medical History,* 26:3 (1982), pp. 233-58.

Jansson, A., ‘Mood Disorders and the Brain: Depression, Melancholia, and the Historiography of Psychiatry’, *Medical History,* 55:3 (2011), pp. 393-9.

Jones, D. M., ‘The Custody and care of the mentally ill in Lancashire – historical perspectives and sources’, in J. V. Pickstone (ed.), *Health, Disease and Medicine in Lancashire 1750-1950* (Manchester: Manchester University Press, 1980), pp. 66-86.

Jones, D. W., ‘Moral Insanity and psychological disorder: the hybrid roots of psychiatry’, *History of Psychiatry,* 28:3 (2017), pp. 263-79.

Jones, K., *Lunacy Law and Conscience, 1744-1845: The Social History of the Care of the Insane* (London: Routledge & Kegan Paul, 1955).

Jones, K., *Mental Health and Social Policy, 1845-1959* (London: Rouledge & Kegan Paul, 1960).

Jones, K., 'The Culture of the mental hospital', in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 17-28.

Jones, K., 'Law and Mental Health: Sticks or Carrots?', in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 89-101.

Jones, K., *Asylums and After: a revised history of the mental health services from the early 18th century to the 1990s* (London: Athlone Press, 1993).

Kelm, M. E., 'Women, Families and the Provincial Hospital for the Insane, British Colombia, 1905-1915', *Journal of Family History*, 19:2 (1994), pp. 177-93.

Kidd, A. J., *State, Society and the Poor in the Nineteenth Century* (Basingstoke: Macmillan, 1999).

King, S., and Tomkins, A (eds), *The Poor in England 1700-1850. An Economy of Makeshifts* (Manchester: Manchester University Press, 2003).

King, S., 'Poverty, Medicine, and the Workhouse in the eighteenth and nineteenth centuries: An afterward', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 228-51.

King, S., 'Poor Relief, Settlement and Belonging in England, 1780s to 1840s', in S. King and A. Winter (eds), *Migration, Settlement and Belonging in Europe, 1500-1930s: Comparative Perspectives* (Oxford: Berghahn Books, 2013), pp. 81-101.

Levine-Clark, M., 'Dysfunctional Domesticity: Female insanity and Family relationships among the West Riding Poor in the mid-nineteenth century', *Journal of Family History*, 25:3 (2000), pp. 341-61.

Lewis, J., 'Family Provision of Health and Welfare in the Mixed Economy of Care in the late Nineteenth and Twentieth Centuries', *Social History of Medicine*, 8:1 (1995), pp. 1-16.

Littlewood, R., and Lipsedge, M., *Aliens and Alienists: Ethnic Minorities and Psychiatry*, 3rd edn (London: Routledge, 2001).

Lloyd, S., *Charity and Poverty in England, c.1680-1820: wild and visionary schemes* (Manchester: Manchester University Press, 2009).

Lockley, D., *Such Tender Years: Leicestershire's Young Asylum Patients* (Harbourne: Anchor Print Group, 2013).

Lyons, M., '"Ordinary Writings" or How the "Illiterate" Speak to Historians', in M. Lyons (ed.), *Ordinary Writings, Personal Narratives: Writing Practices in 19th and Early 20th-century Europe* (Oxford: Peter Lang, 2007), pp. 13-32.

MacDonald, M., *Madness, Anxiety and Healing in Seventeenth-century England* (Cambridge: Cambridge University Press, 1981).

Mackenzie, C., 'Social Factors in the admission, discharge and continuing stay of patients at Ticehurst Asylum, 1845-1917', in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II* (London: Tavistock Publications, 1985), pp. 147-74.

MacKenzie, C., *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792-1917* (London: Routledge, 1993).

MacRaild, D. M., *Irish Migrants in Modern Britain, 1750-1922* (London: MacMillan, 1988).

MacRaild, D. M., *Culture, Conflict and Migration: The Irish in Victorian Cumbria* (Liverpool: Liverpool Univeristy Press, 1998).

Malcolm, E., '"A Most Miserable looking object": The Irish in English Asylums, 1850-1901. Migration, Poverty and Prejudice', in P. M. Prior (ed.), *Asylums, Mental Health Care and the Irish: Historical Studies, 1800-2012* (Dublin: Irish Academic Press, 2012), pp. 121-32.

Mandler, P., 'Poverty and charity in the nineteenth century Metropolis: An introduction', in P. Mandler (ed.), *The Uses of Charity: The Poor on Relief in the Nineteenth Century Metropolis* (Philadelphia: University of Pennsylvania Press, 1990), pp. 1-37.

Marland, H., 'At Home with Puerperal Mania: the Domestic Treatment of the insanity of childbirth in the nineteenth Century', in P. Bartlett and D. Wright (eds), in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 45-65.

Marland, H., '"Destined to a Perfect Recovery": The confinement of puerperal insanity in the nineteenth century', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 137-56.

Marland, H., 'Getting away with murder?: Puerperal Insanity, Infanticide and the Defence Plea', in M. Jackson (ed.), *Infanticide: Historical Perspectives on child murder and concealment, 1550-2000* (London: Athlone Press, 2002), pp. 168-92.

Marland, H., *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave-Macmillan, 2004).

Marland, H., 'Under the Shadow of Maternity: birth, death and puerperal insanity in Victorian Britain', *History of Psychiatry,* 23:1 (2012), pp. 78-90.

McCandless, P., ‘Liberty and Lunacy: The Victorians and Wrongful Confinement’, in A. Scull (ed.), *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 339-62.

McCarthy, A., ‘Transnational Ties to Home: Irish Migrants in New Zealand Asylums, 1860-1926’, in P. M. Prior (ed.), *Asylums, Mental Health Care and the Irish: Historical Studies, 1800-2012* (Dublin: Irish Academic Press, 2012), pp. 149-66.

McCarthy, A., *Migration, Ethnicity, and Madness: New Zealand, 1860-1910* (Liverpool: Liverpool University Press, 2015).

McCarthy, A., Coleborne, C., O’Connor, M., and Knewstubb, E., ‘Lives in the Asylum Record, 1864 to 1910: Utilising Large Data Collection for Histories of Psychiatry and Mental Health’, *Medical History,* 61:3 (2017), pp. 358-79.

McCrae, N., ‘The Beer ration in Victorian Asylums’, *History of Psychiatry,* 15:2 (2004), pp. 155-75.

McCrae, N., and Nolan, P., *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors* (London: Routledge, 2016).

Mellett, D. J., ‘Bureaucracy and mental illness: The Commissioners in Lunacy 1845-90’, *Medical History,* 25:3 (1981), pp. 221-50.

Mellett, D. J., *The prerogative of asylumdom: social, cultural, and administrative aspects of the institutional treatment of the insane in nineteenth-century Britain* (New York: Garland, 1982).

Melling, B., ‘Building a Lunatic Asylum: “A question of beer, milk and the Irish”’, in T. Knowles and S. Trowbridge (eds), *Insanity and the Lunatic Asylum in the Nineteenth Century* (London: Pickering & Chatto, 2015), pp. 57-70.

Melling, J., ‘Accommodating Madness: New Research in the social history of insanity and institutions’, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 1-30.

Melling. J. and Forsythe. B., *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London: Routledge, 2006).

Melling, J., and Turner, R., ‘The Road to the Asylum: Institutions, Distance and the Administration of Pauper Lunacy in Devon, 1845-1914’, *Journal of Social Geography,* 25:3 (1999), pp. 298-332.

Michael, P., *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003).

Michael, P., ‘Class, Gender and Insanity in Nineteenth-Century Wales’, in J. Andrews and A. Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Gender*

and Class in the History of British and Irish Psychiatry (Amsterdam: Rodopi, 2004), pp. 95-122.

Hirst, D., and Michael, P., 'Family, Community and the lunatic in mid-nineteenth century North Wales', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 66-85.

Michael, P., and Hirst, D., 'Recording the many faces of death at the Denbigh Asylum, 1848-1938', *History of Psychiatry,* 23:1 (2011), pp. 40-51.

Miller, E., 'Variations in the official prevalence and disposal of the insane in England under the poor law, 1850-1900', *History of Psychiatry,* 18:1 (2007), pp. 25-38.

Miller, I., 'Feeding in the Workhouse: The Institutional and Ideological Functions of Food in Britain, ca. 1834-70', *Journal of British Studies,* 52:4 (2013), pp. 940-62.

Miller, I., 'Food, medicine and institutional life in the British Isles, c. 1790-1900', in C. Helstosky (ed.), *The Routledge History of Food* (London: Routledge, 2015), pp. 200-46.

Mooney, G., 'Diagnostic Spaces: Workhouse, Hospital, and Home in Mid-Victorian London', *Social Science History,* 33:3 (2009), pp. 357-90.

Mooney, G., and Reinarz, J., 'Hospital and Asylum Visiting in Historical Perspective: Themes and Issues', in G. Mooney and J. Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Rodopi, 2009), pp. 7-30.

Moorat, D., *Life in Brampton with 63 Public Houses* (Studley: Brewin Books Ltd, 2007).

Moran, J., Wright, D., and Savelli, M., 'The Lunatic Fringe: Families, Madness, and Institutional Confinement in Victorian Ontario', in N. Christie and M. Gauvreau (eds), *Mapping the Margins: The Family and Social Discipline in Canada, 1700-1975* (London: McGill-Queens University Press, 2004), pp. 277-304.

Morris, R. J., and Rodger, R., 'An Introduction to British Urban History, 1820-1914', in R. J. Morris and R. Rodger (eds), *The Victorian City: A Reader in British Urban History, 1820-1914* (London: Longman, 1993), pp. 1-39.

Murphy, E., 'The administration of insanity in England 1800 to 1870', in R. Porter and D. Wright (eds), *The Confinement of the Insane: International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003), pp. 334-49.

Myers, E. D., 'Workhouse or Asylum: the Nineteenth Century Battle for the Care of the Pauper Insane', *Psychiatric Bulletin,* 22:9 (1998), p. 575-7.

Neal, F., *Black '47: Britain and the Famine Irish* (Basingstoke: Palgrave Macmillan, 2002).

Neal, F., ‘English-Irish Conflict in Rural England: The case of the Irish migrant’, in P. M. Prior (ed.), *Asylums, Mental Health Care and the Irish: Historical Studies, 1800-2012* (Dublin: Irish Academic Press, 2012), pp. 47-62.

Negrine, A., ‘Practitioners and Paupers: Medicine at the Leicester Union Workhouse’, in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 192-211.

Nolan, P., *A History of Mental Health Nursing* (Cheltenham: Stanley Thomas Ltd, 1998).

Ó Gráda, C., ‘British Agriculture, 1860-1914’, in R. Floud and D. McCloskey (eds), *The Economic History of Britain Since 1700, Volume 2: 1860-1939* (Cambridge: Cambridge University Press, 1994), pp. 145-72.

Ossa-Richardson, A., ‘Possession or Insanity? Two Views from the Victorian Lunatic Asylum’, *Journal of the History of Ideas,* 74:4 (2013), pp. 553-75.

Owen, D., *English Philanthropy, 1660-1960* (London: Oxford University Press, 1965).

Parry-Jones, W., *The Trade in Lunacy: a study of private madhouses in England in the eighteenth and nineteenth centuries* (London: Routledge Kegan and Paul, 1972).

Pettigrew, J., Reynolds, R. W., and Rose, S., *A Place in the Country: Three Counties Asylum 1860-1988* (Bedford: University of Hertfordshire Press, 1998).

Philo, C., ‘Thoughts, words, and “creative locational acts”’, in F. W. Boal and D. N. Livingstone (eds), *The Behavourial Environment: Essays in Reflection, Application, and Re-evaluation* (London: Routledge, 1989), pp. 205-34.

Philo, C., ‘Journey to asylum: a medical-geographical idea in historical context’, *Journal of Historical Geography,* 21:2 (1995), pp. 148-68.

Philo, C., *A Geographical History of Institutional Provision of the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter: Edwin Meller Press, 2004).

Pooley, C., and Turnbull, J., *Migration and Mobility in Britain Since the 18th Century* (London: Routledge, 1998).

Pooley, C. G., and Whyte, I (eds), *Migrants, Emigrants and Immigrants: A Social History of Migration* (London: Routledge, 1991).

Porter, R., ‘The Patient’s View: Doing Medical History from Below’, *Theory and Society,* 14:2 (1985), pp. 175-98.

Porter, R., *A Social History of Madness: Stories of the Insane* (London: Weidenfeld & Nicolson, 1987).

Porter, R., *Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Cambridge: Harvard University Press, 1987).

Porter, R., 'The gift relation: philanthropy and provincial hospitals in eighteenth century England', in L. Granshaw and R. Porter (eds), *The Hospital in History* (London: Routledge, 1989), pp. 149-78.

Porter, R., 'Madness and its institutions', in A. Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), pp. 277-301.

Potts, P., 'Medicine, Morals and Mental Deficiency: The Contribution of Doctors to the development of special education in England', *Oxford Review of Education,* 9:3 (1983), pp. 181-96.

Prestwich, P. E., 'Family Strategies and Medical Power: "Voluntary" Committal in a Parisian Asylum, 1876-1914', *Journal of Social History,* 27:4 (1994), pp. 799-818.

Price, K., *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, c.1834-1900* (London: Bloomsbury, 2015).

Prior, P. M., *Asylums, Mental Health Care and the Irish: 1800-2010* (Dublin: Irish Academic Press, 2012).

Pritchard, D. G., *Education and the Handicapped 1760-1960* (London: Routledge & Kegan Paul, 1963).

Ray, L. J., 'Models of Madness in Victorian asylum Practice', *European Journal of Sociology,* 22:2 (1981), pp. 229-64.

Rebok Rosenthal, A., 'Insanity, Family and Community in Late-Victorian Britain', in A. Borsay and P. Dale (eds), *Disabled Children: Contested Caring, 1850-1979* (London: Pickering & Chatto, 2012), pp. 29-42.

Redford, A., *Labour Migration in England, 1800-1850* (Manchester: Manchester University Press, 1964).

Reeves, C., 'Everyday Life for Jewish Patients in Colney Hatch', *Shemot,* 19:3 (2011), pp. 31-3.

Reinarz, J., 'Investigating the "deserving" poor: charity and the voluntary hospitals in nineteenth-century Birmingham', in A. Borsay and P. Shapely (eds), *Medicine, Charity and Mutual Aid: the consumption of health and welfare in Britain, c.1550-1950* (Aldershot: Ashgate, 2007), pp. 111-34.

Reinarz, J., and Ritch, A., 'Exploring Medical care in the nineteenth-century provincial workhouse: A view from Birmingham', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 140-63.

Rollin, H. R., 'Psychiatry in Britain one hundred years ago', *British Journal of Psychiatry,* 183:4 (2003), pp. 292-8.

Rose, M. E., ‘Settlement, Removal and the New Poor Law’, in D. Fraser (ed.), *The New Poor Law in the Nineteenth Century* (London: Macmillan, 1976), pp. 25-44.

Ross, E., ‘Hungry Children: Housewives and London Charity, 1870-1918’, in P. Mandler (ed.), *The Uses of Charity: The Poor on Relief in the Nineteenth Century Metropolis* (Philadelphia: University of Pennsylvania Press, 1990), pp. 161-96.

Rushton, P., ‘Lunatics and Idiots: Mental Disability, the Community and the Poor Law in North-East England, 1600-1800’, *Medical History,* 32:1 (1988), pp. 34-50.

Russell, R., ‘The Lunacy Profession and its staff in the second half of the nineteenth century, with special reference to the West Riding Lunatic Asylum’, in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III* (London: Tavistock Publications, 1988), pp. 297-315.

Scrimgeour, D., *Proper People: Early Asylum Life in the Words of Those Who Were There* (York: York Publishing Services Ltd, 2015).

Scull, A. T., ‘From Madness to Mental Illness: Medical Men as Moral entrepreneurs’, *European Journal of Sociology,* 16:2 (1975), pp. 218-61.

Scull, A., *Museums of Madness: The Social Organization of Insanity in nineteenth-century England* (London: Allen Lane, 1979).

Scull, A., ‘The Social History of Psychiatry in the Victorian Era’, in A. Scull (ed.), *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 5-32.

Scull, A., ‘Moral Treatment Reconsidered: Some Sociological Comments on an episode in the history of British Psychiatry’, in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 105-18.

Scull, A., ‘The Domestication of Madness’, *Medical History,* 27:3 (1983), pp. 233-48.

Scull, A., ‘John Conolly: A Victorian Psychiatric Career’, in A. Scull (ed.), *Social Order/Mental Disorder: Anglo-American psychiatry in historical perspective* (London: Routledge, 1989), pp. 165-98.

Scull, A (ed.), *The Asylum as Utopia: W. A. F. Browne and the mid-nineteenth century consolidation of psychiatry* (London: Routledge, 1991).

Scull, A., ‘Psychiatry and Social Control in the nineteenth and twentieth centuries’, *History of Psychiatry,* 2:6 (1991), pp. 149-69.

Scull, A., *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Yale University Press, 1993).

Scull, A., ‘The Peculiarities of the Scots? Scottish Influences on the Development of English Psychiatry, 1700-1980’, *History of Psychiatry*, 22:4 (2011), pp. 403-16.

Scull, A., ‘A Culture of Complaint: Psychiatry and its Critics’, in J. Reinarz and R. Wynter (eds), *Complaints, Controversies and Grievances in Medicine: Historical and Social Science Perspectives* (London: Routledge, 2015), pp. 37-55.

Scull, A., MacKenzie, C., and Hervey, N., *Masters of Bedlam: The Transformation of the Mad-doctoring Trade* (Princeton: Princeton University Press, 1996).

Sheldon, N., ‘“Something in the place of the Home”: Children in Institutional care 1850-1918’, in N. Goose and K. Honeyman (eds), *Childhood and Child Labour in Industrial England: Diversity and Agency, 1750-1914* (Farnham: Routledge, 2013), pp. 255-76.

Shepherd, A. C., ‘Mental Health care and charity for the middling sort: Holloway Sanatorium 1885-1900’, in A. Borsay and P. Shapely (eds), *Medicine, Charity and Mutual Aid: the consumption of health and welfare in Britain, c.1550-1950* (Aldershot: Ashgate, 2007), pp. 163-82.

Shepherd, A., *Institutionalising the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014).

Shepherd, M. E., *From Hellgill to Bridge End: Aspects of Economic and Social Change in the Upper Eden Valley, 1840-95* (Hatfield: University of Hertfordshire Press, 2003).

Shorter, E., *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

Shortt, S. E. D., *Victorian Lunacy: Richard M Bucke and the Practice of late nineteenth-century psychiatry* (Cambridge: Cambridge University Press, 1986).

Showalter, E., ‘Victorian Women and Insanity’, in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 313-336.

Showalter, E., *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago Press, 1987).

Skultans, V., *Madness and Morals: Ideas on the Nineteenth Century* (London: Routledge & Kegan Paul, 1975).

Skultans, V., *English Madness: Ideas on Insanity, 1580-1890* (London: Routledge, 1979).

Smith, C., ‘Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics’, *Family and Community History*, 9:2 (2006), pp. 109-24.

Smith, C., ‘Parismony, Power and Prescriptive Legislation: The Politics of Pauper Lunacy in Northamptonshire, 1845-1876’, *Bulletin of the History of Medicine,* 81:2 (2007), pp. 359-85.

Smith, C., ‘“Visitation by God”: rationalising death in the Victorian asylum’, *History of Psychiatry,* 23:1 (2012), pp. 104-16.

Smith, C., ‘Living with Insanity: Narratives of poverty, pauperism and sickness in asylum records 1840-76’, in A. Gestrich, E. Hurren and S. King (eds), *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938,* (London: Continuum, 2012), pp. 117-41.

Smith, L. D., ‘To Cure those afflicted with the disease of insanity: Thomas Bakewell and Spring Vale Asylum’, *History of Psychiatry,* 4:13 (1993), pp. 107-27.

Smith, L. D., ‘Insanity and Ethnicity: Jews in the Mid-Victorian Lunatic Asylum’, *Jewish Culture and History,* 1:1 (1998), pp. 27-40.

Smith, L. D., *“Cure, Comfort and Safe Custody”: Public Lunatic Asylums in Early Nineteenth Century England* (London: Leicester University Press, 1999).

Smith, L. D., ‘The County Asylum in the Mixed Economy of Care, 1808-1845’, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 33-47.

Smith, L., ‘“Your Very Thankful Inmate”: Discovering the Patients of an Early County Lunatic Asylum’, *Social History of Medicine,* 21:2 (2008), pp. 237-252.

Smith, L., ‘“The Keeper Himself Must be Kept”: Visitation and the Lunatic Asylum in England, 1750-1850’, in G. Mooney and J. Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Rodopi, 2009), pp. 199-222.

Smith, L., ‘“A Sad Spectacle of Hopeless Mental Degradation”: The Management of the insane in West Midlands workhouses, 1815-1860’, in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse* (New York: University of Rochester Press, 2013), pp. 103-20.

Smith, L., *Insanity, Race and Colonialism: Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838-1914* (London: Palgrave Macmillan, 2014).

Smith, L., ‘“A Powerful Agent in their recovery”: Work as treatment in British West Indian lunatic asylums, 1860-1910’, in W. Ernst (ed.) *Work, psychiatry and society, c. 1750-2015* (Manchester: Manchester University Press, 2016), pp. 142-162.

Smith, L., ‘Lunatic Asylum in the Workhouse: St Peter’s Hospital, Bristol, 1698-1861’, *Medical History,* 61:2 (2017), pp. 225-45.

Smith, R., *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981).

Smith, R., ‘Legal Frameworks for psychiatry’, in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 137-51.

Stainbrook, E., ‘Psychosomatic Medicine in the Nineteenth Century’, in J. D. Sutherland (ed.), *Evolution of Psychosomatic Concepts: Anorexia Nervosa: A Paradigm* (London: The Hogarth Press, 1965), pp. 6-35.

Sturdy, H., and Parry-Jones, W., ‘Boarding-out Insane Patients: The Significance of the Scottish System’, in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 86-114.

Suzuki, A., ‘Lunacy in Seventeenth- and Eighteenth-century England: analysis of Quarter sessions records’, *History of Psychiatry,* 2:8 (1991), pp. 429-36.

Suzuki, A., ‘The Politics and Ideology of Non-Restraint: The Case of Hanwell Asylum’, *Medical History,* 39:1 (1995), pp. 1-17.

Suzuki, A., ‘The Household and the Care of Lunatics in Eighteenth Century London’, in P. Hordon and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions and the provision of welfare since antiquity* (London: Routledge, 1998), pp. 153-75.

Suzuki, A., ‘Framing Psychiatric Subjectivity: Doctor, Patient and record-keeping at Bethlem in the Nineteenth-Century’, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 115-36.

Suzuki, A., ‘Enclosing and disclosing lunatics within the family walls: domestic psychiatric regime and the public sphere in early nineteenth century England’, in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 115-31.

Suzuki, A., *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (London: University of California Press, 2006).

Swift, R., and Gilley, S (eds), *The Irish in Britain 1815-1939* (London: Pinter, 1989).

Szasz, T. S. (ed.), *The Age of Madness: the history of involuntary mental hospitalization presented in selected texts* (London: Routledge & Kegan Paul, 1975).

Tabili, L., *Global Migrants, Local Culture: Natives and Newcomers in Provincial England, 1841-1939* (Basingstoke: Palgrave Macmillan, 2011).

Tanner, T., ‘Care, Nurturance and Morality: The role of Visitors and the Victorian London Children’s Hospital’, in G. Mooney and J. Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (New York: Rodopi, 2009), pp. 81-110.

Taylor, S., '"All his ways are those of an idiot": The Admission, treatment of and social reaction to two "idiot" children of the Northampton Pauper Lunatic Asylum, 1877-1883', *Family and Community History,* 15:1 (2012), pp. 34-43.

Taylor, S., 'Insanity, Philanthropy and Emigration: Dealing with Insane Children in late-nineteenth century North-West England', *History of Psychiatry,* 25:2 (2014), pp. 224-36.

Taylor, S. J., *Child Insanity in England, 1845-1907* (London: Palgrave Macmillan, 2017).

Thompson, R. N., 'The Working of the Poor Law Amendment Act in Cumbria, 1836-1871', *Northern History,* 15:1 (1979), pp. 117-37.

Tomes, N. J., 'A Generous Confidence: Thomas Story Kirkbride's Philosophy of Asylum Construction and Management', in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 121-43.

Tomes, N., *A Generous Confidence: Thomas Story Kirkbride and the art of asylum-keeping, 1840-1883* (Cambridge: Cambridge University Press, 1984).

Tomkins, A., 'Mad doctors? The significance of medical practitioners admitted as patients to the first English county asylums up to 1890', *History of Psychiatry,* 23:4 (2012), pp. 437-53.

Towill, S., *Georgian and Victorian Carlisle: Life Society and Industry* (Preston: Carnegie Publishing Ltd, 1996).

Turner, T., '"Not worth powder and shot": the public profile of the Medico-Psychological Association, c.1851-1914', in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 3-16.

Wallis, J., *Investigating the Body in the Victorian Asylum: Doctors, Patients and Practices* (London: Palgrave Macmillan, 2017).

O. Walsh, 'Lunatic and Criminal Alliances in the nineteenth-century Ireland', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 132-52.

Walton, J. K., 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50', *Journal of Social History,* 13:1 (1979), pp. 1-22.

Walton, J., 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-1870', in A. Scull (ed.), *Madhouses, Mad-doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), pp. 166-97.

Walton, J. K., ‘Casting Out and Bringing Back in Victorian England: pauper lunatics, 1840-70’, in W. F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II* (London: Tavistock Publications, 1985), pp. 132-46.

Wannell, L., ‘Patients’ Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910’, *Social History of Medicine*, 20:2 (2007) pp. 297-313.

Wardle, C. J., ‘Historical influences on services for children and adolescents before 1900’, in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841-1991* (London: Royal College of Psychiatrists, 1991), pp. 279-93.

White, A., *A History of Kendal* (Lancaster: Carnegie, 2013).

Williams, K., *From Pauperism to Poverty* (London: Routledge & Kegan Paul, 1981).

Wright, D., ‘“Childlike in his innocence”: Lay attitudes to “idiots” and “imbeciles” in Victorian England’, in D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency*: *historical perspectives on people with learning disabilities* (London: Routledge, 1996), pp. 118-33.

Wright, D., ‘Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century’, *Social History of Medicine,* 10:1 (1997), pp. 137-55.

Wright, D., ‘The Certification of Insanity in nineteenth-century England and Wales’, *History of Psychiatry*, 9:35 (1998), pp. 267-90.

Wright, D., ‘Family Strategies and institutional confinement of “idiot” children in Victorian England’, *Journal of Family History*, 23:2 (1998), pp. 190-208.

Wright, D., ‘Familial Care of “Idiot” Children in Victorian England’, in P. Hordon and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions and the provision of welfare since antiquity* (London: Routledge, 1998), pp. 176-97.

Wright, D., ‘Community Care and its antecedents’, in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999), pp. 1-18.

Wright, D., ‘The discharge of pauper lunatics from county asylums in mid-Victorian England: The case of Buckinghamshire, 1853-1872’, in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 93-112.

Wright, D., ‘Learning Disability and the New Poor Law in England, 1834-1867’, *Disability and Society*, 15:5 (2000), pp. 731-45.

Wright, D., *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001).

Wright, D. and Themeles, T., 'Migration. Madness, and the Celtic Fringe: A Comparison of Irish and Scottish Admissions to Four Canadian Mental Hospitals, c.1841-91', in C. Coleborne and A. McCarthy (eds), *Migration, Ethnicity and Mental Health: International Perspectives, 1840-2010* (London: Routledge, 2012), pp. 39-54.

Wynter, R., '"Good in all Respects": Appearance and dress at the Staffordshire County Lunatic Asylum, 1818-54', *History of Psychiatry,* 22:1 (2011), pp. 40-57.

Wynter, R. and Smith, L., 'Introduction: historical contexts to communicating mental health', *Medical Humanities,* 43:2 (2017), pp. 73-80.

York, S., 'Alienists, Attendants and the Containment of Suicide in Public Lunatic Asylums', *Social History of Medicine,* 25:2 (2012), pp. 324-42.

Yorstin, G., and Haw, C., 'Old and mad in Victorian Oxford: a study of patients aged 60 and over admitted to the Warneford and Littlemore asylums in the nineteenth century', *History of Psychiatry,* 16:4 (2005), pp. 395-421.

Internet Sources

Beveridge. A., 'Clouston, Sir Thomas Smith (1840–1915), Asylum Physician' *Oxford Dictionary of National Biography* 8 October 2009 http://www.oxforddnb.com.ezproxy3.lib.le.ac.uk/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-38634 [accessed 2 March 2018].

Davidson, J. A., 'Dunston, Gateshead, Tyne and Wear: Lunatic Asylum', 9 Feb. 2014 http://dutsfc.wordpress.com/2014/02/09/lunatic-asylum/ [accessed 26 Feb. 2014].

The Retreat Archive, RET/6/19, https://search.wellcomelibrary.org/iii/encore/record/C__Rb2496244__Syork%20retreat%20letters__P0%2C3__Orightresult__X1;jsessionid=D58D0C118730DA4D0B61870E80F0765A?lang=eng&suite=cobalt [accessed 03 August 2018].

Unpublished Material

Ayers, C., 'Community, Culture and Conflict: The Irish in Carlisle, 1800-1851' (Unpublished BA Dissertation, University of Sunderland, 1995).

Negrine, A., 'Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union, 1867-1914' (Unpublished PhD Thesis, University of Leicester, 2009).

Perry, A. J. L., 'The implementation of New Poor Law in the Kendal Union 1836-1847' (Unpublished BA Dissertation, University of Lancaster, 1986).

Reeves, C., 'Insanity and Nervous Diseases amongst Jewish immigrants to the East End of London, 1880-1920' (Unpublished PhD Thesis, University College London, 2001).

Talbot, R., ‘North South Divide of the Poor in the Staffordshire Potteries’ (Unpublished PhD Thesis, University of Leicester, 2017).