# Asylum for the mentally ill in historical perspective*

WILLIAM LL. PARRY-JONES, Professor of Child and Adolescent Psychiatry, Royal Hospital for Sick Children, Glasgow

At a time of increasing emphasis on community care for the mentally ill and of mounting concern about its adequacy, questions arise about the necessity for asylum and its optional provision. The term 'asylum' was first used in relation to institutions for the insane in the late 18th century and it became the 'in' word in 19th century lunacy terminology. It took over from 'madhouse', which a contemporary observer called "an opprobious epithet, only suited to the horrible ideas formerly deservedly associated with such places".[1] In turn, it was superseded officially by 'mental hospital' under the 1930 Mental Treatment Act, in an attempt to jettison the negative connotations of 'lunatic asylum', and to suggest a parallel curative function with general hospitals.

The proper understanding of present day psychiatry calls for analysis of its past development and, in this paper, an attempt is made to place the concept of asylum in its historical context. Asylum is bound up inextricably with mental hospital care and, consequently, the development of the institutional confinement of the mentally ill is reviewed, between the 17th and early 20th centuries. Since the heritage of the Victorian era remains so important, emphasis will be placed on the 19th century, which saw the heyday of the asylum system.

## *The development of institutional confinement*

The Poor Law Act of 1601 focused attention on the poor and the unemployed. Separate provision for the insane was not made and lunatics and idiots were left at liberty as long as they were not dangerous or socially disturbing. However, a change in social attitude towards lunatics took place in the 17th century, marking the beginning of the confinement of the insane with criminals, vagrants and the idle. This was reflected in the increasing use for this purpose of houses of correction and workhouses. An Act of 1714 permitted the restraint of "furiously mad and dangerous" lunatics, and a further Act of 1744 provided for their cure. In response, 'madhouses' began to spring up, catering for small numbers of both paupers and lunatics from the affluent classes, in the custody of lay and medical proprietors.[2] With the exception of the ancient Bethlem Hospital, these commercial ventures were the first specialised institutions for the insane. The early regimes were custodial and harsh and the first legal provisions for madhouse control, in 1774, were in response to public disquiet about brutal practices and wrongful detention. Madhouses, later called private asylums, continued as indispensable repositories for the insane until the late 19th century, by which time they were entirely a medical enterprise.

During the 18th century, the founding of hospitals or wards for insane patients by public subscription also became established practice, often in conjunction with general hospitals. For example, Bethel Hospital, Norwich, was founded in 1713; a ward for incurable lunatics at Guy's Hospital was opened in 1728 and lunatic hospitals were established in Manchester in 1766 and in York in 1777, the latter being the first to be called an asylum. The teaching of Dr William Battie at St Luke's Hospital, London, founded in 1751, exemplified the more optimistic approach towards insanity that was developing. In 1758, he observed, "madness is ..... as manageable as many other distempers, which are equally dreadful and obstinate, and yet are not looked upon as incurable; and that such unhappy objects ought by no means to be abandoned, much less shut up in loathsome prisons as criminals or nuisances to the society".[3] But these charitable hospitals provided little relief to the bulk of the insane, especially the poor. During the 19th century, their number expanded only slowly and they came to cater chiefly for members of the middle and upper classes.

By the close of the 18th century, workhouses, houses of correction and prisons contained a variety of lunatics and idiots, alongside the other inmates. Pauper madhouses of inferior quality had multiplied, attracting into the trade in lunacy unsuitable proprietors who exploited the situation to make a good living. The plight of the pauper insane was grave and their number so extensive that an Act of 1808 recommended the erection of rate-supported asylums. But building was slow until it became compulsory in 1845, a step that reflected an increasing degree of state intervention in the welfare of the insane. During the second half of the 19th century, a small number of

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idiot asylums were also established, beginning mainly as charitable institutions, and the Broadmoor Asylum for criminal lunatics was opened in 1863. Despite careful planning to meet the estimated demands, the county and borough asylums soon became overcrowded and it became increasingly apparent that they were not going to fulfil their early promise. Nevertheless, the 19th century was dominated by the rise of these public asylums, in which psychiatry grew into a major medical specialty.

## *Reasons for confinement and the place of asylum in changing patterns of care*

The exclusion and incarceration of the insane in the 17th century has been viewed by some historians as a politically expedient way of establishing social order and the protection of society. Undoubtedly, more humane concern for lunatics did not emerge until the next century, when madness came to be managed increasingly as a medical malady. Despite the cynical analysis by critics of psychiatry like Foucault,[4] Scull,[5] and Doerner[6] of the motives underlying medical involvement in lunacy reform, for the purposes of this paper, the process is accepted at its face value, without discussing the controversial claims that it represented professional imperialism and that psychiatry served as a force of social control. It is the case that in the 18th century, lunatics began to be admitted to institutions for their own care, protection and treatment, and insanity became viewed progressively as a curable disorder. In the new institutions, there was more on offer than safe refuge and the curative value of confinement itself was emphasised, coupled with the belief that separation from family and friends was necessary for recovery. At this stage, all patients were certified and the act of compulsory confinement, even for humane objectives, carried the potential for illegal or overlong detention, neglect and ill-treatment. Scandals and scares about asylum care followed one another rapidly from the 18th century right up to the present day, precipitating bursts of legislative intervention.

The York Retreat, a charitable asylum opened in 1796 for members of the Society of friends, exerted exceptional influence because of its development and practice of what was called moral, rather than medical, treatment.[7] It showed that lunatics could respond to the substitution of self-control for physical coercion and restraint and could be transformed into more rational beings. Removal from the environment causing insanity was an essential ingredient of this approach. A model was established for treating the insane in a comfortable, clean, family atmosphere, in the tranquil surroundings of a country house, where higher class families' desire for privacy and confidentiality could be met. In 1846, the Retreat was described as, "A place in which the unhappy might obtain a refuge—a quiet haven in which the shattered bark might find a means of reparation or of safety".[8] This was to remain the ethos of private asylums and charitable hospitals throughout the 19th century, and it became quite common practice for private asylums to be called 'retreats' and 'refuges'. The records of these asylums revealed that the majority provided a kindly, humane environment, but Scull has warned us that by removing the asylums' crudest features, moral treatment "made the reality of ..... imprisonment and control far more difficult to perceive".[9] Relief was undoubtedly given to families by removing the responsibility for caring for disturbed relatives, particularly those unable to look after themselves. In 1862, private asylums were empowered to receive voluntary boarders, so that early treatment could be facilitated. This option was taken up increasingly, but it was not extended to other types of asylum until 1890. By the end of the 19th century, the length of stay in hospitals and private asylums had increased significantly and their custodial functions had become relatively greater than the curative ones.

In the new public asylums, therapeutic optimism was initially high, fuelled by the ideals of humanitarian reform, moral treatment, the abolition of restraint and the prevailing belief in the curability of lunacy. The asylum itself was of central importance as the instrument of treatment and its design and management, incorporating regularity and discipline, were key parts of the therapeutic response to the patient's social disorder. Nevertheless, many patients broke down repeatedly, became chronic and continued to need creature care. In the overcrowded, sprawling asylums, limited financial and staffing resources meant that many chronic patients lacked individual attention and, by the end of the century, were being relegated to bleak, impoverished wards. As in the private asylums and charitable hospitals, confidence in the asylums' curative role declined when earlier treatment ran out of credibility. Gloomy hereditary and organic views of insanity began to prevail. Not suprisingly, treatments tended to be more concerned with managing and containing disturbed chronic patients than with actively curing their disorders. Asylums began to function increasingly as long-term repositories for the safe-keeping of lunatics, idiots, epileptics, paralytics and the elderly. By the 1870s, less than 8% of the total asylum population was thought to be curable. Moral treatment became reduced to benign custodialism, which continued virtually unchecked until the 1950s, when vigorous attempts began to be made to combat institutionalisation, using new psychotropic drugs, the 'revolving door' policy and by decanting patients into the community.

Retrospective denigration of the Victorian and Edwardian asylum system has been fashionable in recent years, on the ground, for example, that it symbolised resignation and despair and the failure of the biomedical approach to mental illness. The genuine therapeutic expectations of 19th century practitioners, however, should not be underestimated. Contemporary awareness of what was happening was acute and, in the 1850s and 60s, there was a wave of doubt about the efficacy and desirability of asylums. Attempts were made to disperse the chronic population using detached annexes, cottages in the grounds and boarding out with families. In this respect, the remarkable lunatic colony at Geel, in Belgium, provided a prototype for an alternative approach in the care of the chronic insane.[10] A consensus view emerged that many chronic patients could be housed outside the asylum, in accommodation that more closely resembled every day life, with less restriction of personal liberty. Placement in workhouses and the use of boarding-out continued on a widespread scale, but relatively unsupervised management amongst strangers in the community was never really acceptable. The Lunacy Comissioners felt that the inherent risks were too great, and fears of abuse had a paralysing effect, since asylum superintendents and their committees believed that only constant vigilance could prevent violations of duty and of humanity. There were some durable developments within the asylums themselves, with efforts directed towards approximating life in the wards to the domestic ideal. But the reply to the ever-mounting pressure for accommodation was phrased in bricks and mortar, symbolised by the construction of a number of huge, cheaply-built asylums for incurable inmates. The concept of the 'open-door' system gained ground, with use of parole and trial leave. The idea of prevention and mental hygiene emerged; but the problem of chronic incurable lunatics in asylums was not dealt with by reduced intake or dispersal, but by modified sequestration.

For the middle and upper classes, confinement had a different face. In private asylums and charitable hospitals, there were higher standards of accommodation, limited overcrowding and better classification of patients. The environment and atmosphere striven for were evocative of substantial country houses, prosperous middle-class homes or comfortable guest houses, retaining a family atmosphere. Although the emulation of a domestic family model was undertaken in all types of institution, it was most effective in small private asylums, where the intimacy and tranquillity of a family home was easier to create. Asylum for lunatics in such 'homes' was appealing to their families, despite the fact that the domestic environment was simulated and stood at variance with the locked doors and concealed window bars. The strength of the appeal reflected the view that the outside world was hostile, harsh and immoral.

## *Comments*

Unlike refugees from oppressive political regimes, who seek asylum actively, the mentally ill have always had asylum imposed on them by social and medical pressures, backed invariably, until relatively recent times, by the force of law. Further, the explicit provision of asylum, without the primary objective of treatment and possible cure, has not been customary, although in practice this often became the case. One is left to consider, therefore, whether care provided in lunatic institutions of all kinds has ever incorporated asylum in the pure sense, or whether, even in the context of moral treatment, the term was simply a euphemism for confinement, repression and control. The possibility of elective asylum as part of voluntary treatment only became fully permissable under the Mental Treatment Act of 1930 and was greatly expanded in the Mental Health Act of 1959. As far as certified patients were concerned, the possibility has to be considered that even a refuge with restrictions may have been preferable to the world outside. In this respect, the history of confinement may not have been devoid of what can be termed passive asylum. At best, institutional asylum, in any type of 19th century establishment, offered an ordered way of life which excluded selectively factors that made life outside alien, rejecting and intolerable. At worst, it provided food, clothing, protection from physical maltreatment, some social contact and health care. Whatever the social, political and economic reasons for the rise of the asylum, and whatever assumptions are made about the causes of what is called mental illness, historical research on clinical records indicates that there has been an enduring body of mentally disordered people having basic needs for care, protection and shelter, who have proved resistant to the treatment of the day and whose behaviour was not tolerated in their contemporary society. Whilst an element of asylum entered into even short admissions, its main beneficiaries were the chronically mentally ill, suffering mainly from psychoses, the elderly confused, and the mentally handicapped, who were homeless, friendless and who could not be contained within their families.

There has always been a price to pay for asylum, in terms of the loss of personal choice and autonomy. Public asylums became so organised and regimented that systems of care, designed to be protective and nurturing, easily became patronising and enfeebling. Inmates could be treated like children "under a perpetual personal guardianship". Although passive asylum was provided most effectively in small private asylums and charitable hospitals, where the personal dignity and special needs of individuals were more

readily provided, there remained all the adverse effects of imposed dependency and subjugation to patriarchal authority and control in a simulated family. For a proportion of inmates, however, a strong case can be made that the quality and predictability of this form of microcosmic life, whether in utilitarian refractory wards or genteel parlours, is likely to have been comparatively more desirable than unprotected existence outside, in a workhouse or in single confinement. The indiscriminate provision of asylum was a common factor in institutions of all kinds and it is impossible to quantify those persons who were subjected unnecessarily to its effects.

## Concluding remarks

The history of asylum and asylums is not an uneventful progression from irrationality and neglect to informed concern, humanity and effective treatment. Far from it; generally there is a clear sequence of neglect, reform and further indifference. The current renaissance of community care and the increased impetus for de-institutionalisation need to be seen in historical perspective. They reflect a move towards greater acceptance of the mentally ill in society; the replacement of the long-standing belief in the therapeutic role of the mental hospital by focus on the individual and the family; changes in the political and economic acceptability of state welfare policies and continuing misconceptions and mistrust about what goes on in mental hospitals. In this context, the telling words of a distinguished asylum superintendent, writing in 1860, are particularly apt:

> "The tide of public opinion has set strongly against asylums; soon, however, it will be slack water, and then a few outrages will probably turn the prejudices of the fickle public against the liberty of mad folk. A few striking examples either way are sufficient to turn the direction of public opinion."[11]

In the haste to develop new models of care, it is essential to retain a balanced view of institutional asylum, from the 19th century to the present, and those with the responsibility for planning services should not overlook its contribution in terms of basic survival needs, social activities, occupation, health care, continuous support and relief for the family and friends. In this respect, those concerned with the planning of mental health services should beware the danger of the ideological presentation of facts about its adverse effects and the beneficial nature of the community. Publically funded services outside hospital for less severe mental health problems have expanded but, for the chronically mentally ill who are as yet only ill-served in the community, the reinvention of the asylum is already waiting in the wings.[12] There is a 'cycle of fashion' in such things.

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