# The Locational History of Scotland's District Lunatic Asylums, 1857-1913


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# Abstract

This thesis looks into the later 'Asylum Age' in Scotland, concentrating on the legislation and construction of Scotland's district lunatic asylums from the passing of the *Lunacy (Scotland) Act*, 1857 to the *Mental Deficiency and Lunacy (Scotland) Act*, 1913. Concentrating on the specific geographies of the asylums, what Foucault refers to as "the space reserved by society for insanity" (Foucault, 1965:251), the thesis weaves a new route between previous radical/critical and progressive/simplistic interpretations of the 'Asylum Age', by integrating a Foucauldian interpretation with non-representational theories around the engineering of affective atmospheres. This more nuanced approach, which concentrates on the 'affective power' of the institutions across different geographical scales (site and situation, grounds and buildings), recognises the ways in which Scotland's district asylums, constructed predominantly for pauper patients, were moulded and reshaped as the discourses around the treatment of insanity were developed. The moral, medical and hygienic dimensions to the discourses ultimately outlined the institutional geography, by having a profound influence on asylum location and layout. The ideal district 'blueprint' for asylum siting and design, as put forward by the Scottish Lunacy Commissioners, is uncovered and reconstructed by 'picking out' the macro and micro-geographies discussed in the annual reports of the General Board. The research then moves to uncover the system 'on the ground' as it was constructed in bricks-and-mortar by the various district boards. As asylum location and architecture was a relatively novel concern, questions of siting and design became more pertinent, and indeed central, in institutional planning during the decades after the mid-century lunacy reforms. Thus, despite periods of waning enthusiasm for the institution as a mechanism for 'curing' insanity, fitting the building to its purposes continually involved a variety of structural innovations, stylistic refinements and new ways of organising the external and internal spaces of the asylums.

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# Author’s Declaration

I declare that, except where explicit reference is made to the contribution of others, this thesis is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature .....

Printed Name

# Abbreviations

**A.R.** – Annual Report

**CAIS** - Centre for Archive and Information Services, University of Dundee

**D.B.** – District Board

**DP** – Discipline and Punish

**F.K.** – Fife and Kinross

**GGCA** – NHS Greater Glasgow and Clyde Archives

**GPI** – General paralysis of the insane

**GRA** – Glasgow Royal Asylum

**HM** - History of Madness

**LHSA** – Lothian Health Services Archives

**MC** – Madness and Civilisation

**M.P.** – Midlothian and Peebles

**M.B.** – Minute Book

**P.B.** – Patient Book

**PP** – Psychiatric Power

**REA** – Royal Edinburgh Asylum

**SCL** – Scottish Commissioners in Lunacy

**SLR** – Scottish Lunacy Report

# Chapter 1

# Introduction

### A DAY IN THE FIELD

> Merge onto the M8 (3.3 miles). At junction 12, take the A80 exit to Riddrie/Stepps (0.2 miles). Merge onto Gartloch Road. Destination will be on the right. (Google directions)

*A glimpse of twin towers through the trees. Feelings of anticipation, excitement and slight apprehension. A red sandstone cottage to the right that has the appearance of a gatehouse. A disused driveway. Behind a hedgerow to the left, stretches open country. We'd left the city behind us, although we'd only travelled eight miles. Again on the right, lining the road, a row of small terraced red sandstone cottages. Married attendants cottages? People standing at a bus stop. The hedgerow and trees lining the road grow taller, creating a green tunnel of leaves, the summer sun forms a mottled effect on the road. We reach the junction to 'Gartloch Village', and take a right. There's a postbox on the corner, pavements and streetlamps now line the road. Still the buildings are hidden, concealed, and this adds to our feelings of suspense. The top of a tower becomes visible again above the bank to the left, quickly followed by another. Eagerly stealing glimpses, we drive slowly forward, navigating the speed bumps on the road. We gasp as the full building, the administration block, comes into view. Commanding. Imposing. Derelict*.

It was 2011, and I was in the midst of a long archival stint for my PhD research on the district asylum system in Scotland. Research was, on paper, going well. I had been on jaunts to Edinburgh, Aberdeen, Falkirk and Dundee, and the archive collections were teeming with useful material: annual reports, minutes, maps and plans. But, I was finding it difficult to engage with the texts, and becoming tired of the travelling. The official documents, which comprised the majority of the archival material for the district asylums, seemed dry, dense and confusing. I needed a better sense of the asylum landscape: the views, scales and surroundings of the former institutions. It was for these reasons that one sunny afternoon David and I drove the fifteen minute journey from our flat in Glasgow to the site of the old Glasgow District Asylum. I had spent some time researching this institution, which had later become known as Gartloch Hospital, and I hoped that this little trip 'into the field' would help to illuminate the archive, perhaps reigniting excitement in my research.

*Continuing up the driveway, more of the site comes into view. I instantly recognise the single-story building to the right of the administration block as the hospital block. It has recently been converted into modern accommodation, contributing to the developer's vision of a new future for Gartloch. We continue round behind this building to park at some new build houses sitting directly behind the converted hospital block. The letters carved into the stone wall inform us that this small estate of around eight homes is called 'Sandilands'. "Robert Sandiland was one of two architects that designed the original asylum buildings, the other was John Thomson, son of renowned Scottish architect Alexander 'Greek' Thomson," I inform David. The initial jolt at seeing the site subsides, and is replaced by a keenness to explore. We start to wander.*

*Since closing in 1996, different parts of the site have fared better than others. Some of the buildings have been demolished (including, I note, the connecting corridors and nurses' accommodation). It quickly becomes apparent that the developers have concentrated on the west side of the site, as along with the hospital block, the three-story female accommodation block has also been converted into flats. The red sandstone has been blasted, small manicured gardens fill the spaces between buildings and road, and front doors have been painted red, some more recently than others. Cars lie parked in designated bays and wheelie bins sit on the pavement for collection. A community has returned to Gartloch, although one different[1] from the inhabitants for whom the buildings were originally designed.*

*But these neat, orderly, renovated spaces designed by developers and nurtured by residents, although separated by a tall wooden fence, feel dominated by the presence of the ruined buildings that sit directly adjacent. I recognise the male accommodation block, the administration block, the mortuary and the recreation block from plans, and point them out to David. All remain derelict, exposed to the elements and rapidly deteriorating. Walking up to the fence, we stand on tiptoes, struggling to peer over. Signs attempt to warn off trespassers: 'Dangerous building. Keep out'. Exposed tiles on the gable walls of the recreation block indicate where adjoining toilet blocks once stood. Most windows are boarded up, but I draw my breath as I spot the ceiling of the recreation hall through one which is uncovered. Although damaged, the vibrant colours and details are unmistakable, and offer a tantalising hint of its former glory. We continue to the front of the administration block. No windows are boarded, but the building is an empty shell. Fireplaces are suspended peculiarly where floors once lay. It is a narrow building, narrower than I had imagined. It casts long shadows on the road.*

*I turn to face the view, soaking up the landscape that thousands of patients, doctors and visitors would have looked out on daily. The rolling countryside stretches forward, fringed by a new housing estate; the continuing expansion of the new 'Gartloch Village' development. I imagine the bowling green, the cricket pitch. Behind the mature trees through which we had driven not long before, the Campsie hills lie clearly visible in the distance. Further to the east, the male accommodation block looms, broken glass still in the windows, faded yellow curtains pulled around in the light summer breeze. For the first*

[1] There may be cases, however, when the residents are not so far removed – asylum patients may have come from the immediate locality; some people living here now might have mental health problems. This point is

*time since arriving at the site, I feel spooked. Nestled between the three main ruins, I was surprised and quite shocked to find a block of converted accommodation. A small patch of inhabited accommodation set in a wider ecology of desertion. The situation of the buildings suggested that they had probably once been the workshops, placed for easy accessibility for the male patients. Perhaps the two buildings had once been connected via corridors, some evidence of which was visible on the external walls of the male block. The present day residents were enveloped, their windows on all sides framing the decaying buildings. Not for me, I thought.*

*Moving round to the front of the building, the more secluded side that would have been designated for patients, the buildings look out towards Bishop Loch. I ponder whether we are now facing south. David jokes that he didn't know he was meant to bring his compass. The loch is out of sight behind the trees. Tall, mature, oak, chestnut and elm giants offer indications of the past, clearly planted and planned to create a formal garden but long overgrown. Neglected. Following a rough path, we drift down past the haphazard metal construction fences, many of which lie flat, blown over, adding to the abandoned feel of this area. It feels like a deserted construction site. It is, I suppose, a deserted construction site; the economic downturn halting the progress of the 'Village' development. We continue on towards the trees, passing what appears to be an old boiler house. Red brick. Most likely a twentieth-century addition. A plaque on the door reads "Gartloch Hospital", offering another hint of a former existence. A dog barks. Someone shouts. I jump. We continue forward, commenting that we should have worn wellies. Gradually moving downhill, we glance back at the ruined buildings that now dominate the skyline. Attention, however, must remain on our feet. Uncovered manholes are dotted around, revealing a network of eroded pipes. Birch trees now surround us, a small forest, of sorts. Far enough. Time is passing, and we should leave. Strolling back to the car, I think about my research, and look forward with anticipation to my next trip to the archive.*

Engaging with the affective atmospheres of this ruined asylum, I was able to let my imagination dart back to the historic texts, making connections between the site where I had wandered and what I had painstakingly and meticulously detailed in notes from the historic record. Drawing energy from my site visit in effect re-engaged me with my research and brought life and meaning to the archive, and, conversely, taking my archival knowledge to future site visits gave me a deeper understanding of how these institutions ended up dotted around Scotland's landscape. The affective power of the trips to (re)ignite my interests was therefore an integral part of the research process, and as such more vignettes from further site visits will be flecked throughout this thesis.

## THE GROWTH OF THE ASYLUM AND THE INCREASING IMPORTANCE OF SPACE

The end of the eighteenth century in Britain, Europe and, to an extent, North America, saw a growing interest in 'madness', an increasing market for those 'trading in lunacy' and a greater public awareness about the treatment of the insane. Inquiries into and inspections of 'madhouses' had highlighted numerous cases of inhumanity, neglect, medical malfeasance, maltreatment and even murder, thus positioning lunacy reform at the centre of philanthropic attention (Scull *et al*, 1996). During the 1815-16 investigations in England and Wales, many asylum visitors recorded their shock (and repulsion) at discovering barely human-looking beings in dungeons, cells or lunatic huts where they were locked for weeks at a time, often chained or handcuffed, amid other lunatics and idiots (Donnelly, 1983). Alongside these revelations was the legacy of ideas from philosophers such as John Locke, who suggested in 1690 that insanity was caused by the mis-association of ideas, resulting in a move away from the belief that madness was a physical, organic disease that needed to be treated by physical methods, but rather should be seen as an emotional and rational disorder caused by errors in the patient's train of thought (Hickman, 2005; Digby, 1985). Gradually, individual superintendents and madhouse keepers shifted from the old methods of restraint:

> But, it may be demanded, what mode of treatment do you adopt in place of restraint? How do you guard against accidents? How do you provide for the safety of attendants? In short what is the substitute for coercion? The answer may be summed up in a few simple words, *viz.* – classification – watchfulness – vigilant and unceasing attendance by day and by night – kindness, occupation and attention to health, cleanliness and comfort and the total absence of every description of other occupation by the attendants. (Hill, 1839[2] in Bebbington, 1987:12)

Thus, with the growing recognition that insanity could be curable by reason being restored to the disordered mind, re-education was sought which centred on a more humane management of the insane, with some Georgian patients beginning to benefit from a 'moral treatment', characterised by both calmness and kindness, to build up self-esteem and self-restraint (Digby, 1985).

New model asylums such the York Retreat exhibited a "special 'ethos' of confinement" (Donnelly, 1983:31), distinguishing them dramatically from the chaos and inhumane treatment of the old madhouses, such as Bethlem, which the lunacy inquiries had so

[2] Robert Gardiner Hill (1811-78) was the superintendent of the Lincoln Asylum, England.

recently uncovered: "'Tranquillity' was the logical antipode to the pandemonium of Bedlam, and the tone judged suitable for the practices of a more sentimental charity than the insane had earlier received" (Donnelly, 1983:41). As Philo (1987:404) highlights:

> A vital point in this connection was that most contemporaries believed there to be some relationship between the so-called nineteenth-century 'march of civilization', as epitomized by the spreading urban-industrial landscape of gloomy tenements and smoky factory chimneys, and the production – indeed, according to most statistics, increased production – of insanity.

For varying reasons, alienists[3] such as Tuke in England, Pinel in France and Browne in Scotland made roughly contemporaneous calls for the spatial separation of the insane in purpose-built asylums removed from the urban environment. Patients were to benefit from the bucolic settings and humane treatments in such spaces that encapsulated 'moral', medical and hygienic dimensions. Moral treatment (also referred to as moral discipline or moral management) was developed in the late-eighteenth century and expanded throughout the nineteenth century, with the principles of the treatment centred upon humane patient welfare rather than mechanical controls, such as straightjackets and the swinging chair. There was an uneasy, shifting alliance with more overtly 'medical' (organic, somatic) treatments, an issue that will recur throughout this thesis. Moral treatment was instead to restore reason through the (re)creation of 'normal' life, engaging patients in, for example, recreation and occupation. Patients were expected to 'act' in the manner of the sane, with systems of rewards and punishments for behaviour, which, over time, would (it was hoped/believed) result in a return of their sanity and consequently a return to society. The design of the ideal asylum, both its physical structure and the siting of the building, was instrumental in advocating these moral, medical and hygienic dimensions, and central to realising its goal as supervisory machine and therapeutic tool.

Furthermore, new emphasis was placed on classification, which in the eighteenth century had largely been ignored, evident in John Howard's 1788 description of Bethlem:

> The patients communicate with one another from the top to the bottom of the house, so that there is no separation of the calm and the quiet from the noisy and the turbulent, except those who are chained in their cells. (in Scull, 1980:45)

[3] 'Alienist' was the contemporary term for a physician who specialised in mental illness. In the manner of historical accuracy, this term, and others such as 'madness', 'mad person', 'lunatic' and 'insanity' will be used throughout this thesis, as it was precisely the kind of vocabulary being applied at the time. To substitute terms like 'mental illness' or 'mental disease' would import to the past a specific medicalised understanding which is very much a modern invention. It would be misleading to transport this loaded vocabulary to the period of study (Philo, 2004).

Organised, ordered space and the grouping of patients was offered as a valuable alternative to enforce control and resocialisation (Scull, 1980). Thereby separation into different classes of madness was increasingly used as a key management device, with the asylum authorities exploiting it as a way of ensuring that patients exercised self-restraint. Misbehaviour resulted in demotion to a lower level, where social amenities were reduced. The importance of this method of controlling 'the mad' is indicated by the continual organisation of space to permit such classification. The environment was used in other ways too, for example by creating a home-like atmosphere for the asylum inhabitants. Furthermore, inmates were to be treated as individuals, rather than *en masse*, constantly stimulating their minds through employment and recreation but also sheltering them from the over – or wrong kinds of – stimulation offered by the emerging sites of urban-industrial activity. The site was also of tremendous importance, and it was gradually recognised that extensive rural grounds could be utilised for employment and recreation. It was, therefore, very much the *spaces* of the new asylums, consciously constructed by the professionals of the time, which were beginning to be enlisted, in countless ways, to assist in the treatment – which was at one and the same time a micro-management – of the insane.

## AN HISTORICAL GEOGRAPHY OF THE SCOTTISH DISTRICT ASYLUM SYSTEM

The slowly transforming 'Gartloch Village' complex around which we meandered on that warm summer's day has passed through a number of phases since it was built in the last decade of the nineteenth century. Moving back through the twentieth century, it has adopted various guises: Gartloch Hospital, Gartloch Asylum and, initially, Glasgow District Asylum. It is a late product of the so-called 'Asylum Age'[4] and is one of over thirty asylums that were built in Scotland during the late-eighteenth and early-twentieth century. Originally designated and designed specifically for the segregation of a particular population, its original purpose was abandoned in the mid-1990s and it is now in the gradual process of conversion. But, although (re)sparking my curiosity, this thesis is less concerned with the present buildings and their future use. Rather, the focus is on the processes by which these institutions came to be located in the landscape and why they were planned and constructed in particular ways. It concentrates on asylum development

[4] The 'Asylum Age' refers to the main asylum-building period in Britain, circa 1810-1900. Philo (2004) elects to end his 'Asylum Age' story circa the 1860s, in effect the point when the asylum system is all but fully instituted in England and Wales (and even seeing its first serious 'professional' critiques).

over the second half of the nineteenth century as the institutions responded to national discourses, local pressures and individual ideas. Ironically but unsurprisingly, the emotional responses that I experienced when visiting the site of the former Glasgow Asylum are disappointingly absent from the dry paper records left in the archives. The research, bound by the available records, is therefore principally an analysis of the state- and district-level responses to the ever-increasing number of Scottish pauper lunatics from the 1850s onwards. It is, more specifically, a geographical exploration of the Scottish response to the 'Asylum Age', particularly centring on the district[5] (public) asylums commissioned for predominantly pauper patients after the passing of the *Lunacy (Scotland) Act*, 1857.

Asylums possess fascinating geographies, with distinctive urban, regional, local, and environmental connections. The situation, grounds and lay-out of the former asylums were carefully chosen by a variety of people, such as entrepreneurs, 'mad-doctors', administrators and politicians, who were motivated by a desire to place people with particular diagnoses in a specific environment. As has been widely recognised by the likes of Foucault, Scull and Goffman, the "space[s] reserved by society for insanity" (Foucault, 1965:251) were located and designed for purposes of social control and custody, but more recent work has shown that this is a simplified and limited perspective on a complex and evolving structure that was extremely responsive to local and national politics, changing economic climates and significant social change (Walsh, 2005). Central to this thesis, therefore, and moving it forward from previous simplistic/celebratory or radical/critical interpretations of the 'Asylum Age', is the recognition that asylums, as multifaceted spaces, were engineered to embody a number of responses in the inhabitants through the (often subtle) manipulation of environments. Asylums were designed to control, to restore and to calm through careful planning and management. The internal and external spaces, engineered for what I am going to call 'affective power', were continually evolved and transformed, not simply as a coping mechanism in the face of ever-increasing patient numbers, but also predominantly with the fundamental aim of returning 'the mad' to reason in curable cases or creating a home-like, 'hospice' environment for non-curable patients. The alterations in the purposes and visions of these different spaces is a key facet in the arguments of this thesis, and one that will emerge slowly through the narrative across the chapters.

[5] There was a certain specificity to this term, with particular geographical connotations, in the Scottish context, which will be explored further in Chapter Six.

Although asylum histories and, more recently, asylum geographies, have received increasing academic attention, the district asylum system in Scotland has been relatively overlooked. This may perhaps be due to the late arrival of these institutions, which were still being constructed long after the high-point of the 'Asylum Age' in circa the 1850s to 1860s; arguably when the enthusiasm for and optimism about the asylum system was actually starting to wane. This thesis wishes to address this misbalance in two ways. Firstly, it aims to address the histories of the district asylum system from its inception and development after the passing of the 1857 Act until it was superseded by the *Mental Deficiency and Lunacy (Scotland) Act*, 1913. Secondly, this aim will be achieved through a detailed critical analysis of the asylum sites, grounds and buildings. The nuanced theoretical lens will weave together Foucauldian understandings of power and control with the recognition that the spaces of the asylums were being affectively engineered to manipulate the behaviour of the patients. This novel approach to researching the asylum will unfold in the following chapters:

**The 'Asylum Age' and the Scottish dimension – themes, theories and texts** (Chapter Two) overviews the historiography of work on histories of madness, asylums and psychiatry by contrasting, celebrating and condemning accounts within the literature, exemplified through a systematic excursion into the *History of Psychiatry* journal. It then moves on to an exploration of the specifically Scottish-facing literatures, noting the almost complete absence of attention to the district asylums (unlike their 'royal'[6] cousins). More briefly, it surveys inquiries into work on the geographies of madness, asylums and psychiatry. The crucial element of this chapter is the clarification that, ultimately, this thesis seeks to combine the sensibilities of the outlined literatures, but will, more conceptually, steer a line between 'extreme' positions in the parent historiography.

**Affective power** (Chapter Three) will then more formally position and elaborate the conceptual framings and theoretical underpinnings of the thesis. Echoing previous work on the histories and geographies of asylums, the chapter will begin with a brief outline of Foucault's well-known texts *Madness and Civilization* and *Discipline and Punish*. The main text to be utilised when developing the Foucauldian understanding of asylums is, however, the less prominent series of lectures titled *Psychiatric Power.* Adding to this critical-Foucauldian foundation, the thesis will be interlaced with other sets of ideas about

[6] The Scottish Commissioners in Lunacy commonly referred to the royal asylums as 'public' asylums. This term is somewhat misleading, as they were not state-organised but instead funded and maintained through private donations. In order to clearly differentiate them from the truly public institutions: the district asylums, I have continually referred to these institutions as 'royal asylums' rather than 'public asylums'.

'affect' and 'atmosphere'. This chapter will thereby unpack the notion of engineering affective atmospheres within space, through concentrating on explanations of affect in non- and more-than- representational literatures before moving to examine how these theories have been applied in studies of architectural geographies. Finally, the chapter will explore the difficulties of employing non-representational theories in historical inquiries where the main source of evidence is words, which are, by admission, representational. The chapter will conclude by offering ways in which this challenge can be navigated, namely through the recognition that this thesis will focus on uncovering the *potential* affective powers within the asylum spaces.

**Searching archives, researching asylums** (Chapter Four) begins by offering an exploration of the historical record and its place in understanding past events and layers of histories. Acknowledging that the archive is not a straightforward, apolitical space, but rather is embedded with its own power structures, the chapter details the myriad documentary sources consulted for the research in this thesis. It is recognised that, although there was no shortage of archive material (I attempted to scour the country for archival traces of every district asylums – and only in a few cases does very little remain), the sources retained for the district asylums very much concern the state and district level responses to insanity. The research is hence bound by its sources and is, unapologetically, a top-down approach to understanding the district asylum system. Finally, the discussion concludes by explaining how the sources have been interpreted more conceptually, in line with the theoretical underpinnings explored in the previous chapter.

**The stage for the coming of the district asylums** (Chapter Five) looks both back, to the earlier era of relatively limited Scottish lunacy provisions, and forward, anticipating the coming of the district asylum system, setting the scene for the spatially themed chapters that follow. Set on the eve of the 1857 legislation and with evidence from the mid-1850s 'Doomsday' inquiry and report, the chapter is used as a window into the 'pre-landscape' of lunacy provision as it stood before the far-reaching, legally-driven changes to come, which were to produce a new landscape upon which both district asylums and central inspection and direction were to be crucial. Identifying key actors that triggered investigation and detailing wretched conditions in which the Scottish insane were being accommodated, the chapter identifies the main catalysts for change and explores this pivotal moment in the history of lunacy provision in Scotland.

**The 'system' on the ground** (Chapter Six) is, in effect, a bridging chapter between pre- and post- 1857 'systems'. Focusing on the immediate aftermath of the 1857 Act, the chapter details the 1857 legislation and the consequences for lunacy numbers and provision in Scotland across the study period. Emphasis is largely on the district asylums, but includes a brief explanation of the alternative institutional accommodation over the period between the two main Acts, 1857 and 1913, in order to develop a full image of Scotland's institutional landscape. Before moving to the spatially themed chapters, there is a need to appreciate the overall chronology and spatial positioning of the 'system' (if indeed it could be called a 'system'), which was entwined with the stark rise in pauper lunacy numbers and the subsequent doubts as to whether the asylum was an effective tool in combatting insanity. The continually evolving and shifting discourses around the treatment of lunacy, as management responded to this increasing pressure, also deeply affected the 'system', suggesting issues to be brought forward into the remaining chapters of the thesis.

**Spatial themes:** The remainder of the thesis is divided into three thematic empirical chapters, moving progressively down in geographical scale. Each begins by outlining the 'blueprint' put forward by the post-1857 Scottish Lunacy Commissioners, detailing their vision for the ideal district asylum. All in turn then investigate the institutions as they appeared on the landscape in bricks-and-mortar, evaluating to what extent the Commissioners' vision was being made a reality. Weaving through the archival evidence, narratives are constructed that concentrate on the development of the system as it reacted to increasing patient numbers and changing discourses, all the time keeping in mind the theoretical underpinning of affective power. The first thematic chapter (Chapter Seven) concentrates on the **Sites and situations** of the district asylum buildings. Harking back to an arguably neglected part of the discipline of academic geography, namely regional/settlement geographies, this chapter surveys the locations chosen by the district boards for the construction of their asylums. Attention is devoted to physical geography – to landscape, aspect and soil type – as well as the distances from populations, trying to find a setting that closely matched the official guidelines. The second thematic chapter (Chapter Eight) surveys the **Grounds** of the district asylums, which were integral to the functioning and economic viability of the asylum, the therapeutic treatment and industrial work of individual patients, and the management of the population as a whole. This chapter, drawing on examples from across the district asylums, tracks the changing groundscape of the institutions as management responded to shifting opinions around supervision and altering discourses concerning treatment. Similarly, the final thematic chapter (Chapter

Nine) concentrates on the asylum **Buildings**, paying particular attention to the classification of patients and the engineering of (increasingly different) affective spaces. The shifting discourses introduced previously are explored further in this chapter, as they ultimately culminated in the splitting apart of the institution, transforming the layout of the buildings. Ironically, the 'moral' (geographical/spatial) dimensions of asylum design persisted, but chiefly for the chronic patients – not the 'acute' (curable) ones for whom such innovations had initially been instituted.

The final chapter (Chapter Ten) will conclude by summarising, re-staging the more conceptual dialogues and offering an innovative interpretation of the impact that the changing discourses had on the Scottish district asylum sites, grounds and buildings across the second half of the nineteenth and into the twentieth century. To close, the chapter will contemplate the future of these sites, buildings and grounds in a post 'Asylum Age', offering thoughts on future research agendas.

Figure 1.1 – Drifting curtains (own photograph, 2012)

Figure 1.2 – Hanging fire place (own photograph, 2012)

Figure 1.3 – Glasgow District Asylum showing conversion into Gartloch Village (own photograph, 2012)

Figure 1.4 – Ceiling detail (own photograph, 2012)

# Chapter 2

# The 'Asylum Age' and the Scottish dimension – themes, theories and texts

## INTRODUCTION

> With an intensely subjective subject matter, complex multidisciplinary origins, an insecure and shifting epistemological base, porous disciplinary boundaries, and a sectarian and dialectical dynamic of development, it has thus far proved impossible to produce anything like an enduring, comprehensive, authoritative history of psychiatry. (Porter and Micale, 1994:6)

The study of the history of madness, asylums and psychiatry is a vast and varied field, with wide-ranging, contradictory and controversial viewpoints from an array of scholars. The three foci – madness, asylums and psychiatry – intersect but are far from equivalent, with 'madness' taking this human phenomenon further back than its medical understanding, and 'psychiatry' referring to the medicalised subject which emerged in the late-nineteenth century.[7] Philo (2004) has recognised at least three different sets of writers who approach their research from, among others, pragmatist, idealist and materialist angles, thus holding different perspectives towards madness, asylums and psychiatry, and their history: namely, 'amateur' historians, 'professional' historians and other academic scholars (mostly sociologists). Indeed, Porter and Micale (1994:4) contend that, due to the diverse range of academic disciplines researching this field ("cultural and social theorists; sociologists; historians of science and medicine; social, cultural and intellectual historians [and more recently, geographers]; women's historians; and art and literary critics, as well as psychiatrists, neurologists, psychoanalysts, and clinical psychologists"), it can be better understood as the *histories* of madness, asylums and psychiatry. These diverse histories, influenced by various academic trends and influential theorists, have resulted in a number of phases, often as a result of provocations and subsequent reactions to previous/alternative ways of thinking, although it must be recognised that this has not been a straightforward temporal evolution with neat chronological 'periods'. As these phases and broad overviews

[7] As mentioned in Chapter One, there are dangers of talking about 'psychiatry' before the later-nineteenth century, although this is routinely done.

of the historiography have been explored by the likes of Scull (1989, 1991) Porter (1991a), Marx (1992) and Porter and Micale (1994), the following will give only a light-touch outline of the different positions taken towards the history of madness, asylums and psychiatry, exemplified through an excursion into the *History of Psychiatry* journal (HoP).[8] The chapter will then, crucially, move to concentrate on exploring the literature on histories of madness, asylums and psychiatry in Scotland in the late-eighteenth and nineteenth centuries. These literatures will also be used to provide context to the 'Asylum Age' in Scotland as well as emphasising the dearth of research into the district asylums in the second half of the nineteenth century. There will then be a brief indication of the history of the geographical work on madness, asylums and psychiatry, and details of the small contribution to this field from research conducted on Scotland. Ultimately, the chapter, and this thesis more generally, seeks to combine the foci/sensibilities of the broad histories *and* geographies of madness, asylums and psychiatry, but more conceptually steer a line between 'extreme' positions in the parent 'historiography', in effect, adopting Porter and Micale's 'post-ideological' position, but still retaining a critical-Foucauldian edge, interfaced with other sets of ideas about 'affect' and 'atmosphere' (to be explored in Chapter Three).

## HISTORIOGRAPHY OF MADNESS, ASYLUMS AND PSYCHIATRY

Early attempts to narrate the history of madness, asylums and psychiatry were written predominantly by psychiatrists themselves, often resulting in uncritical, 'Whiggish', progessivist accounts which generally moved "from cruelty and barbarism to organised, institutional humanitarianism, and from ignorance, religion and superstition to modern medical science" (Porter and Micale, 1994:6). Examples include Albert Deutsch's work on the situation in America (1937), Kathleen Jones and her work on England (1972), and D. K. Henderson's *The Evolution of Psychiatry in Scotland* (1964) (to be visited again below). Although cautious of stereotyping this early research, in general the studies lacked analytical rigour and failed to be properly comparative, with Grob noting that "their celebratory tone indicated a desire to demonstrate the march of progress in their speciality" (Grob, 1994:260). Although since surpassed by more critical analysts, this style of

[8] The history of madness, asylums and psychiatry does, of course, extend both back to ancient time, and forward to the present day, but due to length constraints, and relevance to this thesis, the majority of literature reviewed focuses on the eighteenth and nineteenth centuries. Furthermore, it is recognised that the review only considers texts from a European and American perspective, which must be kept in mind – this is not a review of the global history of psychiatry.

narrative is often still evident in the works of 'amateur' historians, most apparent in the centenary pamphlets of individual institutions. Some of these studies were, however, empirically thorough (see Hunter and Macalpine (1963) for example) and therefore do still repay attention, almost as 'primary' sources in themselves.

The 1960s saw the first wave of assaults on this optimistic yet ideological (masquerading as 'factual') interpretation of the history of madness, which was pushed due to the increasing contestation of psychiatry itself as a discipline. The early approach was critiqued for relying predominantly on secondary material, not positioning its account in wider social, economic or cultural contexts, and being extremely 'presentist' in nature. Turning the previous narratives on their heads, revisionists (often referred to as 'anti-psychiatrists',[9] although this term is itself problematic) such as Laing, Szasz, Foucault and Goffman[10] overthrew previous fundamental assumptions surrounding the progressivist nature of the history of madness, and ultimately questioned the conjecture that "more psychiatry means better psychiatry" (Porter and Micale, 1994:7). It must be explicitly underlined here that the work of Foucault will return as a key 'beacon' for this thesis, but in the following chapter.

The movement helped to widen the scope of investigation, bringing the field, for the first time, away from the antiquarians and into the realm of the scholarly researcher. Broadening the range of empirical evidence, approaching from a more objective[11] and systematic viewpoint, and introducing professional yet critical (often radical) academic rigour, radical sociologists and social historians, such as Rothman, Scull, Grob and Porter, drew on the new wave of revisionist theories to produce alternative histories of madness. Indeed:

> Whatever the excesses and inadequacies of the various revisionist accounts of lunacy reform … one must surely be grateful to them for liberating us from the narrowness and naïveté of a vision that reduced the whole process to a simplistic equation: humanitarianism + science + government inspection = the success of

[9] The anti-psychiatry movement developed as a differing set of reactions to the methods of (often controversial) treatment and the control of mentally ill persons, gathering most support/momentum in the 1960s and 1970s.

[10] Four key revolutionary texts were R. D. Laing (1960) *The Divided Self*, Erving Goffman (1961) *Asylums,* Thomas Szasz (1961) *The Myth of Mental Illness,* and Michel Foucault (1961) *Histoire de la Folie*.

[11] Many 'empiricist' historians (professional and amateur) object that the radical/revisionist historians have *not* been sufficiently 'objective', but rather themselves highly but not unacknowledgedly 'ideological'.

> what David Roberts terms 'the great nineteenth-century movement for a more human and intelligent treatment of the insane'. (Scull, 1989:34)[12]

The response to the 'progressivist' narratives is far from a unitary 'revisionist' school of thought (Scull, 1989:31), however, and Scull (1991) highlights that many of the differences reflect national boundaries, with scholars from France, Germany, England/Britain and America taking very different positions on the subject according to their conceptual and empirical groundings. Differences are also evident when looking at scholars who focus specifically on the establishment of the asylum system, with this part of the field being approached from the 'top down' (eg. Scull[13]) or the 'bottom up' (eg. Porter[14]),[15] although both still recognise the inherent social, political and economic *management* of insanity increasingly manifesting itself as the nineteenth century progressed. Scull, for example, whose analysis of the history of madness and its institutions draws from Polónyi's understanding of shifts in human transactions from 'reciprocity' to 'exchange', as well as links across to Marx, argues that the use of the asylum was a result of "historically specific and closely interrelated changes" (Scull, 1993:381), particularly connected to a change in society's moral consciousness.

Since the 1990s, there has arguably been a third 'wave' in the historiography of the history of madness, with Porter and Micale stating:

> … that the two main traditions of commentary [progressivist and critical/radical] about the history of psychiatry in the past half-century have been equally lacking in self-reflexivity and, for reasons that are not as dissimilar as members of either camp would care to acknowledge, both have been substantially politicised. (Porter and Micale, 1994:12)

As a response, the most recent turn is a much wider, more nuanced, reflective, and self-reflexive field of research, which Porter and Micale (1994:26) label the "post-ideological" age. Histories of madness, asylums and psychiatry now draw inspiration from an even wider range of academic disciplines, as well as giving increasing attention to, for example, the methodology and epistemology of the subject, thus creating even more varieties of researching and writing through these histories. This third wave is, though, not dismissive

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[12] Roberts (1960:62)

[13] See Scull, 1991, 2004

[14] See Porter, 1987

[15] Top-down approaches concentrate on the more formal, state-level responses to events, systems and so on, whereas bottom-up approaches focus on the more everyday perspectives. The terms will be re-visited and further explained below, and in Chapter Four.

of the previous interpretations, but rather borrows from both to expand more fully the possible subject-matters and their plausible interpretation, usually with a greater degree of self-awareness than possessed by the previous analysts. Furthermore, an increasing number of studies are being conducted at the local and detailed level (for example, tackling individual institutions and patient experiences), giving a more in-depth and empirically informed focus, although often with the purpose of refining or refuting some of the larger-scale revisionist claims (see Scull, 1991). There is a wish, therefore, to subject grander ('totalising') claims to the 'lens' of detailed empirical scrutiny, and, as Philo (2004:20) summarises, "there is now a large and incredibly rich mix of historical works examining temporal mutations in all elements of the mad-business from ancient times to the near-present".

## REVIEW OF THE *HISTORY OF PSYCHIATRY* JOURNAL

A window on this expanding and changing 'post-ideological' field is the *History of Psychiatry* journal (HoP), which was first published in March 1990 as a platform for research papers on mental illness and its histories with the aim of providing "a single forum for discussion, reviews and debates, and a stimulus to research and reinterpretation" (Berrios and Porter, 1990:1).[16] The establishment of the journal was arguably a response to the widening historiography, as its ethos was to bring together a range of historical research areas including: ideas about insanity and how these have changed over time, both within a cultural setting and as set out within psychiatry and psychological medicine; the mentally disordered and those assigned to caring for them; developments in psychiatric theory, practice and policy towards those suffering with mental illness within society; and, most pertinent to this thesis, the spaces where many of these activities have played out – the so-called asylums or psychiatric institutions. Ultimately enabling the exemplification of the Porter and Micale 'post-ideological' orientation to researching the history of madness, asylums and psychiatry, the close engagement with HoP that follows provides an outline sketch of some of these substantive issues tackled in the field post- circa 1990, which then track through the remainder of the thesis. Additionally, the following review introduces the sense of different world regions and countries having different 'psychiatric histories', which have been written through differing approaches, methods, substantive foci, and so

[16] Although advertising itself as a 'single forum for discussion', it is, of course, not the *only* forum for discussion, with articles on the history of psychiatry appearing in other books and journals. An analysis of this journal does, however, give a detailed snapshot of the field more widely. My in-depth review of the journal run ends at the end of 2012 when I began the final drafting of this thesis.

forth. This is an important clarification when considering the specifically Scottish history/historiography, which is explored in the final section of this chapter.

The research within the journal covers an extensive time period, from a handful of papers based in the 'ancient' times (before 500AD) to the majority of papers, which concentrate on the Modern era (1800 to the present day). Although the articles are global in reach, dividing the papers geographically, a relatively small number are based in Africa, the Americas, Asia and Australia, with the majority focusing on European histories of psychiatry, in particular, France, Germany and Britain. All geographical areas, scales and time periods support theoretical, empirical and clinical entries, thus encompassing a vast array of topics under the umbrella 'history of psychiatry'. Specific histories (accounts of 'national' developments) and historiographies (accounts of the scholarship researching such 'national' developments) have been investigated for a number of countries such as Belgium (Liegeois, 1991), Argentina (Balbo, 1991), Malta (Cassar, 1995), Australia (Kirby, 1999), Japan (Grenshiro, 2002), Norway (Kringlen, 2004), Brazil (Moreira-Almeida *et al*., 2005) and Italy (Kotowicz, 2008). The history of psychiatry in Britain is explored by Porter (1991a), but does not distinguish the developments in Scotland from the wider British landscape, despite specific temporal, spatial and legal differences occurring north of the border. At first glance it would appear that Scull (2011) does begin to differentiate and explore these variances in his paper entitled "Peculiarities of the Scots?", but rather than investigating the specifically Scottish responses to madness (which he does recognise), the paper instead offers an analysis of Scottish influences on the development of English psychiatry from 1700-1980. As such, to-date there is no in-depth, critically engaged exploration of the history of madness, asylums and psychiatry in Scotland, or indeed a specifically Scottish historiographical literature review. This deficit, and the papers included in the HoP journal that have a specifically Scottish focus, will be detailed later in this chapter.

Although the journal content can be roughly split between social history and more clinically-based themes – which include clinical cases on particular diseases, symptoms and their treatment, as well as articles on individual doctors and their connections to the understanding of particular diseases, institutions and the history of psychiatry more generally – the three-fold purpose when delving into every journal published (over 100 in total) for this chapter was uncovering all articles related to the social history of lunatic provision and providers in the nineteenth century, extracting a number of themes to introduce certain substantive and interpretational matters central to this thesis, in particular

the distinction between 'bottom up' (experiences, voices, resistance) foci and 'top down' (ideas, treatments, 'great men', institutions, regulation) foci, and finally finding every article written related to the history of madness, asylums and psychiatry in Scotland. This was primarily to address any gaps in my Scottish historiographical literature review, but also to highlight that research on Scotland's district asylums is limited. The brief review therefore provides an 'anatomy' of the kinds of studies conducted loosely under the sum of Porter and Micale's 'post-ideological age' to the historiography of madness, asylums and psychiatry.

Bottom-up approaches, taking inspiration from wider research on 'histories from below' (Thompson, 1963), give more 'everyday', patient perspective accounts of psychiatric history. Patient-written 'unofficial' records, such as diaries, letters, artwork and memoires, predominantly lead this interpretation of the history of psychiatry, but also include other sources such as folkloric collections (see Donoho, 2012). Although a much more sporadic source, these narratives, alongside more 'semi-official' sources, such as transcriptions of doctor-patient dialogues (Morrison, 2013) and asylum admission evidence from friends and family (Donoho, 2012), have been used to understand and recreate the lived experiences of mental (ill)health, institutional life, and so forth. Only a small number of papers in HoP take such an approach, which reflects the limited biographical sources available that give a 'voice' to the insane especially in particular time periods. Such papers in this vein which have appeared include: the use of photographs to explore 'the face of madness' in Romania (Buda, 2010); the diary excerpts, letters, memoirs and medical documents of a Russian psychiatrist-cum-patient, Victor Kandinsky (Lerner and Witztum, 2003); and the case of John Bunyan, a seventeenth-century religious reformer who was posthumously diagnosed as suffering from mental pathologies in the nineteenth century through the revelations in his autobiography, which consequently resulted in a translation of his idioms from religious to psychiatric language and understandings. Regarding patient encounters and asylums, research has been conducted into particular ethnic experiences such as Maoris' in New Zealand asylums (Barry and Coleborne, 2011), black Americans at St Elizabeth's Hospital in America from 1900-1941 (Ablard, 2003), and race and moral treatment on Robbin Island (Deacon, 1996).

More pertinent to this research, however, is that conducted on different asylums and the emergence and transformation of institutional care. These studies fall under the 'top-down' approach, drawing on more 'formal' records to reconstruct state-level and/or moral/medical responses and bureaucratic systems. Predominantly consisting of recorded,

administrative documents written and accumulated by the top tiers of management, the sources offer a more 'official' record[17] for psychiatric historians, who have utilised them to understand, for example, the systems developed to control insanity and to order the life of the institution (rather than institutional life, as above). Numerous papers within HoP exhibit a top-down approach to the history of madness, asylums and psychiatry. There have been analyses of overall inmate populations, as in the study of the Valencian asylum (Livianos-aldana *et al.*, 2001) or the aged population in Oxford who were admitted to the Warneford and Littlemore Asylum (Yorston and Haw, 2005). Articles on individual establishments include the County of Lancaster Asylum, Rainhill (Parker *et al.*, 1993), the Bath idiot and imbecile institution (Carpenter, 2000) and a brain hospital in Tokyo from 1926-45 (Suzuki, 2003), but the greatest emphasis is on developments in methods of managing the insane within asylums, including: farming in the metropolis (Murphy, 2001); beer rations (MacCrae, 2004); moral treatment (Simpson, 1999; Charland, 2007); physical restraint in the nineteenth century (Esther, 1997); and the open door policy of the twentieth century (Clarke, 1993). Only one paper looks specifically at the architectural construction of the asylum as a 'curative instrument', and is based on research into Norwegian institutions from 1820 to 1920. This article concentrates on four different asylum models (radial, pavilion, one-block and colony systems) which the author argues represent different aspect of contemporary psychiatry: "the instrument reflects certain aspects of the instrumentalist" (Skalevag, 2002:51), grounding them within the history of Norwegian psychiatry.

In a similar vein but outwith the HoP journal, attention should momentarily be drawn to Walsh's work on the development of the asylums system in Ireland (2012a, 2012b, 2008, 2005, 2004) as it in some ways parallels the research in this thesis. The district[18] asylum system in Ireland was, however, initiated much earlier than the system in Scotland, with twenty-two district asylums constructed between 1810 and 1870 (Walsh, 2005). In her chapter *Gendering the asylums: Ireland and Scotland, 1847 – 1877* (1999), Walsh offers a brief comparison between the experiences of male and female patients in Irish and Scottish asylums, arguing that the institutional systems within the two countries were markedly different. Walsh refers only to Scotland's royal asylums, however, and it might be argued that a fairer comparative study could be drawn between the *district* asylums in both systems (despite Scotland's system being initiated much later in the century) as these

[17] For discussions on using 'official' sources for geographical research, see Cloke *et al* (2004).

[18] Interestingly, the Irish system also referred to their institutions as 'district' asylums, unlike the English and Welsh equivalent, which were known as county asylums.

institutions were designed predominantly for the care, cure and/or control of pauper lunatics. Importantly, taking seriously the Irish and Scottish district asylum histories is to attend to the geographically most proximate exportation of the 'British' (English) 'colonial/imperial' project of imposing 'metropolitan' asylum/mad-doctoring models elsewhere.

Finally, there are twenty-six papers included in the HoP relating to the Scottish history of madness, asylums and psychiatry. These articles cover a wide breadth of topics, from the eighteenth through to the twentieth century, and include many of the main themes outlined above, namely: clinical perspectives, patients' voices, and a handful of papers that focus on specific institutions during particular time periods under certain superintendents. Interestingly, partly due to a large number of letters retained by the Royal Edinburgh Asylum (REA), and the sustained and detailed research by Beveridge and various collaborators, the main contributors to papers investigating the patient voice in HoP come out of Scotland (Barfoot and Beveridge, 1993; Beveridge, 1990, 1995a, 1995b; Beveridge, 1998; Beveridge and Williams, 2002; Beveridge and Watson, 2006), whereas the theme of institutional provision arises in a relatively small number of articles, with contributions from Anderson *et al.* (1997), Houston (2001a; 2001b) and Hutchison (2011). All of these contributions will be woven into the following section.

## SCOTTISH HISTORY AND HISTORIOGRAPHY OF MADNESS, ASYLUMS AND PSYCHIATRY

As recognised by Scull in one of his HoP papers, until relatively recently the majority of research on the history of madness, asylums and psychiatry was a predominantly Anglo-American affair, "largely neglecting the very different Scottish approaches to the containment and treatment of the mad" (Scull, 2011:403). Yet, although still relatively small, the historiography in Scotland has slowly been developing into "an exciting and sophisticated field of research" (Davis, 2008:17) over the last three decades, attracting contributions from a growing number of scholars. As has been outlined in the previous section, there have been contributions in HoP dedicated to the history of madness, asylums and psychiatry in Scotland, but this was not the only output for research in this field. The themes that emerge when looking more widely at the historiography of the history of madness, asylums and psychiatry in Scotland include: particular time periods such as the eighteenth century (Houston, 2000); particular asylums such as Gartnavel (Andrews and

Smith, 1993) and the REA (Thompson, 1984); particular 'diseases' such as syphilis (Davis, 2008); particular practices such as 'boarding-out' (Sturdy, 1996); particular forms of therapeutic treatment such as patient artwork (Park, 2007, 2010; Philo, 2006); particular patients such as the case studies on John Home and John Willis Mason (Barfoot and Beveridge, 1993); and particular regulatory bodies such as the Scottish Lunacy Commissioners (Andrews, 1998). The research can also be divided up geographically, with work being conducted on both the Edinburgh and Glasgow 'schools' during the nineteenth century, as well as a recent study of madness and its treatment in the Highlands and Islands (Donoho, 2012, see next section). Within these studies, a mass of varied archival sources – both published and unpublished – have been accessed and analysed, from clinical case notes to patient's letters and from official documentation to patient artwork.[19]

The following section gives an overview of the wider historiography of Scotland's history of madness, asylums and psychiatry, which can be added to the research summarised above. The review helps add to the picture of the wider field, by mapping out, for the first time, the detailed Scottish-focused research that was for so long neglected in the wider psychiatric story. It goes some way to understanding Scotland's place in the wider histories of madness, asylums and psychiatry, as well as emphasising the peculiarly Scottish developments in their treatment of the mentally ill. Furthermore, the review emphasises that there has been no detailed critical engagement with the network of district asylums that were constructed in the second half of the nineteenth century, thus providing legitimacy to the research that follows in the latter chapters of this thesis.

### *The 'Big Picture'*

The following section will discuss the 'big picture' treatments of the history of Scottish madness, asylums and psychiatry: those studies, from Henderson (1964), Rice (1981), Sturdy (1996) and Darragh (2011), with a synoptic quality, and a long time frame. This account will also outline some of the big empirical issues and shifts – in particular the

[19] Unpublished undergraduate dissertations available for consultation at the University of Glasgow should also be briefly mentioned as contributing to the overall field of the history of madness in Scotland. These include, but no doubt are not limited to, McLennan's (2004) study into the experience of insanity in late-nineteenth century Glasgow, which compares patient experiences of illness and treatment at GRA and Glasgow District Asylum, and Tod's (2000) dissertation on the emergence of shell-shock and its treatment and aftermath through an analysis of military records from Gartloch, from the period of time when it was converted into an emergency war hospital. I consulted both of these works but do not feel they substantively altered my overall interpretation of the Scottish 'historiography'.

relationship between the royal asylums and the district asylums, noting and to an extent explaining the relative absence of the latter from these 'big picture' narratives. Before moving to discuss the contributions to this theme, a brief introduction to the historical setting is necessary,[20] in order to situate the different scholarly research within its broader context.

As is widely recognised, the most substantial provision for the insane in the early part of nineteenth-century Scotland were charitable institutions, or 'royal asylums', with the situation staying this way until the *Lunacy (Scotland) Act*, 1857 (see Andrews, 1998 and Chapter Five for further details and other forms of provision). These institutions, situated close to main urban settlements, were broadly equivalent to the English 'charitable lunatic hospitals' of which the York 'Retreat' was one, as well as some English public asylums that contained, at least initially, a 'charitable' section.[21] Between 1782 and 1839, seven Scottish royal lunatic asylums were founded from the public purse and charitable donations despite there being no legislative requirement for such provisions until the 1857 Act. Rather, they grew out of new support in the late-eighteenth and early-nineteenth century for organised charity, and an attempt at rescuing the faltering poor relief system, which was also seen by many as unsuitable care for pauper lunatic patients. As a result of their financial dependence on the wider community and the crucial involvement of the urban middle classes both financially and practically, five of the Scottish royal asylums were named after the towns that helped to finance their erection, support and development: Montrose (1782), Aberdeen (1800), Edinburgh (1813), Glasgow (1814, but to be relocated to a site at Gartnavel (west Glasgow) in 1842) and Dundee (1820). Only two of the institutions, the Crichton Royal Asylum at Dumfries (1839) and the James Murray Royal Asylum at Perth (1827), were generously funded by individual benefactors: intriguingly, these were both in more rural situations.

Henderson's work titled *The Evolution of Psychiatry in Scotland* (1964) devotes a section towards these 'pioneering' institutions, of which he thought very highly, even going so far as to claim that "as a group they maintained a standard of excellence which has never been surpassed by similar types of hospital in any other country" (1964:42). He offers a short description of each of the royal asylums in his book, with some institutions being rated as

[20] This historical setting will be more fully investigated in Chapters Five and Six.

[21] The English charitable lunatic hospitals also initially appeared as predominantly *urban* phenomena, with the contradiction to the rule being the 'Retreat', which was situated in the countryside near York in the 1790s (see Philo 2004, Chapter Six).

'better' than others. Aberdeen Royal Asylum is described as being "anything but luxurious" (1964:48) yet Perth Royal Asylum as being "built on a beautiful site … and was designed in an admirable manner" (1964:71). Although the original Glasgow Royal Asylum (GRA) was built in the heart of the city, when re-located west to the urban fringe of Gartnavel in the 1840s, Henderson (1964:63), not taking into consideration the contemporary want for salubrious, rural atmospheres and locations, proclaims that it was "not buried in the heart of the country as if it was something to be ashamed of". Henderson then turns his attention to notable reformers who influenced provisions for the insane, the poor and the sick in the nineteenth century across Britain: Dorothea Dix, Elizabeth Fry, Florence Nightingale and Octavia Hill,[22] before continuing to analyse the "preventative and research methods in psychiatry" (1964:95) as well as to give a synopsis of his own career. Although Henderson does recognise some of the features developed in the district asylums such as the open door policy and the increased use of observation wards, he does not give any detail of the district asylums, mentioning only one of them by name, the Roxburgh Asylum (1964:105-107). It can be deduced, therefore, that Henderson views the district asylums as the 'underdogs' to the royal asylums, not worthy of detailed attention. Moreover, he very much fits the stereotype of the 'progressivist' researcher as outlined above: he was the superintendent of Gartnavel Royal Hospital (as it was later known), and scripts a very positive analysis of the (predominantly royal) Scottish institutional system and its care towards the mentally ill.[23]

In contrast to Henderson's text, Rice's (1981) doctoral thesis engages with the more revisionist material on trend at the time. The research, titled *Madness and Industrial Society*, focuses on the origins and early growth of institutions for the insane in nineteenth-century Scotland (circa 1830-70), therefore only fringing into the district asylum period. Firstly, Rice outlines the social and economic history of Scotland, in order to ground his research within the broader context, particularly in relation to the processes of industrialisation. Part two of the thesis is committed to exploring insanity in Scotland, from both a statistical perspective, outlining the extent of the 'problem' mid-century, as well as gauging the state reaction and the national organisational developments, weighing them against the English response south of the border. Significantly, the emphasis of Rice's thesis is again on the royal asylums; and, although he does compare their provisions to the

[22] The influenced of Dix and Nightingale will be visited again later in this thesis: see Chapters Five and Nine.

[23] In practice, however, the younger Henderson was very much an 'outsider'/critic of the Scottish established lunacy system, see Morrison (forthcoming) for further details.

other institutions involved, namely private madhouses[24] and poorhouses, there is only brief mention of the district asylums despite his time period extending to 1870. Rather, Rice concentrates his case studies on both the GRA and the REA, as he believes that "nation-wide studies can often lose sight of important local initiatives which had a bearing on national developments" (Rice, 1981:10), itself a good geographically aware claim. Thus, part three of the thesis focuses on the implementations of care and treatment within these two establishments, emphasising his view that the distinction between the two terms 'care' and 'treatment' was all but artificial, stating: "a pleasant, therapeutic caring milieu was as much conducive to a 'cure' as positive, medicinal means of treatment" (Rice, 1981:9). This view leads him to an exploration of the environment in which the patient was treated in the two royals, and finally closes with an analysis of case notes from his two studies in order to uncover the theory and practice surrounding treatment within these institutions, with particular emphasis on specific class differences. At all times he questions the extent to which moral management was practised within the Scottish asylum, and concludes that, by the end of his study period, the Scottish legislation was failing, and that the institutions, echoing Scull's view, had become "mere depositories for the insane" (Rice, 1891:361). This is a conclusion with which I would partly agree, to be explored in Chapters Seven to Nine, but the will to provide 'moral' environments arguably remained, even for those left so 'deposited'.

A further study that concentrates on the 'big picture' of Scotland's particular/peculiar response to insanity in the nineteenth century is Sturdy's doctoral thesis on the pioneering policy of 'boarding-out'. Although the main impact of the *Lunacy (Scotland) Act*, 1857, was to compel the opening of the district asylums, it also saw the formal implementation of the boarding-out policy which involved harmless, chronic insane patients being housed in the community, rather than, increasingly, in the asylum. Sturdy's doctoral research looks into this Scottish alternative to institutionalisation between 1857 and 1913, and thus is in clear juxtaposition to this thesis, since it investigates the nature, growth and influence of boarding-out pauper and private patients within the same time period, as well as locating the Scottish practice in its broader context. Additionally, the thesis also includes an examination of the condition of the insane prior to the 1857 Act, including an assessment of all institutional accommodation (royal asylums, poorhouses and private madhouses), the

[24] The term 'madhouse' refers to the non-specialised/general houses of confinement (also known as licensed houses or private asylums). The houses were self-financed, and the proprietors regularly made monetary gains from the 'business', often without much regard for the inhabitants' wellbeing, particularly regarding poorer inmates (see Philo 2004, Chapter Five; also Parry-Jones, 1972).

existing accommodation for single patients, the role of Sheriffs and the parish within the system and the impact of the Royal Commission and their 1855 inquiry into the state of lunacy in Scotland. Furthermore, it traces the developments and modifications made to the system after the 1857 Act, looking at the nature and extent of supervision for boarded-out patients up to 1913. Sturdy constructs as complete a picture as possible of the persons embroiled within the boarding-out system, given the available sources, by analysing numerous aspects such as: the demographic characteristics of such patients and their carers; the mental conditions that were acceptable to be considered for non-institutional care; behavioural and clinical features; the experiences of the patients living in the community (as far as the sources made possible); the relative costs of both institutional and non-institutional systems; the degree to which boarding-out transformed the nature of asylums; the geographical extent of boarding-out; any criticisms of the system; and finally an assessment of the opinions of many groups (parish officials, commissioners, medical superintendents and so on) in triangulating contemporary views on this distinctively Scottish phenomenon.

The practice was controlled by the General Board of Lunacy, located in Edinburgh, but administered locally by parish officials. Although the 1857 Act effectively ordered all insane pauper patients to be admitted to a district asylum or other similar institution, if a district asylum was still to be constructed in a locality, exemption was given to persons certified as incurable and considered unable to benefit from life in an asylum. In these cases the lunatic could be kept in a private house, either with relatives in their own home, or with unrelated persons with up to three other lunatics. Boarded-out patients were still visited regularly by Deputy Commissioners of the Board (a requirement which was not covered by the Commissioners south of the border), and sanction for residence outside an asylum could be withdrawn at any time should the General Board see fit. Sturdy (1996:5) quotes Fraser, a supporter of boarding-out and a Deputy Commissioner for seventeen years, who proclaimed that:

> It is only in Scotland that those resident with their parents or natural guardians are subjected to the inspection and control of a central government board … the extent to which this method of provision has been developed among the pauper insane in this country is the feature in Scotch lunacy administration which has been deemed distinctive.

Yet, unlike practices such as moral management from the 1840s, which saw widespread support, not all asylum physicians in Scotland immediately embraced the system of

boarding-out. Sturdy recalls Doerner and Scull, who argue that this hesitation was due to strong beliefs in seclusion and specialist treatment in the purpose-built asylums being constructed across the country during the mid-nineteenth century, a period which Scull labels "the classic age of confinement" (Sturdy, 1996:7). But Sturdy claims that her research gives evidence that disputes Scull's tendency to include Scotland in his affirmation. Rather, as well as building district asylums from the mid-nineteenth century, the system of boarding-out was being encouraged and developed by lunacy officials alongside the establishment of the district asylum network. Sturdy argues that the roots of this system can be seen much earlier in the nineteenth century, during the development of moral treatment, where ideals of freedom and a more domestic system of care were developed. Even within the asylum, Sturdy highlights moves being made to transform the buildings, to draw them more in line with 'ordinary' dwellings in order to increase the liberty of the asylum patients. Further developments specifically underlined by Sturdy include the abolition of the airing court walls at the Argyll and Bute District Asylum and the open door system at Fife and Kinross District Asylum, which both resulted in a reduction in the number of escapes and a rise in recovery rates. Sturdy (1996:11) states that this evidence reflects:

> [a] gradual transformation in the treatment of the insane, and … the growing recognition that greater flexibility in lunacy provision was not incompatible with the implementation of safe and effective methods of care. (Sturdy, 1996:11)

Moreover, she argues that the growing numbers of insane people within Scotland during the course of the nineteenth century should also be taken into consideration, particularly during the second half of the century, where records show that between 1868 and the mid-1890s numbers rose by fifty per cent. Boarding-out was thus utilised as a method of relief for the overcrowded asylums, by caring for pauper lunatics not requiring hospital treatment, accommodating them instead in private houses that had been inspected as fit for such purpose. Many of the details examined here by Sturdy, such as the abolition of airing courts and boundary walls, the open door policy and the stark increase in the rise of pauper lunatics admitted to the asylum, will feature prominently in the later pages of this thesis, but with a markedly different emphasis, viewing the potential impact of such developments on institutionalised, rather than non-institutionalised, lunatics.

The latest overview of the overall asylum system has been provided by Darragh (2011), whose doctoral thesis is titled *Prison or Palace? Haven or Hell? An Architectural and Social Study of the Development of Public Lunatic Asylums in Scotland, 1781-1930*.

Submitted to a school of Art History, the research is predominantly an architectural analysis of the dates, plans and styles of each charitable and state funded institution built in Scotland during this time period, and therefore includes descriptions of the district asylums. Despite giving valuable empirical details (including plans and maps) of each institution, Darragh follows much the same celebratory, progressivist account as Henderson, and, again similar to Henderson and Rice, gives rather limited analysis to the later network of district asylums. Juxtaposed with Rice's conclusion, Darragh (2011:ii) labels the system a "therapeutic movement" which she believed "flourished" in Scotland. The uncritical angle that Darragh takes can further be seen in the statement: "at a time when few medical treatments were available, public asylum buildings created truly therapeutic environments, which allowed the mentally ill to live in relative peace and security" (Darragh, 2011:i). Moreover, the thesis has limited theoretical groundings, referring only to the "Moral Treatment regime", but engaging with none of the revisionist literature which recognises that this was not a straight forward "awakening of the Scottish people to the plight of the mentally ill" (Darragh, 2011:np).

It is evident that, although there are four summaries of the overall 'big picture' of the history of madness, asylums and psychiatry in Scotland, both Henderson's and Darragh's are relatively simple, progressivist studies, providing limited critical engagement with the more recent revisionist theories surrounding madness and its institutional provisions (understandable in the case of Henderson's text, published in 1964). Rice's thesis, again a product of its time, deeply engages with the revisionist literature, yet it provides limited analyses of the district asylum network. Sturdy's research, on the other hand, provides a useful analysis of the alternatives to institutional provision during the same study period as this thesis. Crucially, despite their general lack of (critical) engagement with the district asylums and the institutional provisions in the second half of the nineteenth century, these 'big picture' studies provide contextual understanding and rich empirical evidence that can be quarried for this thesis.

***Legal/Administrative procedures***

One of the only researchers centring on the 'long eighteenth century' in Scotland is Houston, who contributes across a number of different themes within his chosen time period, including institutional care for the insane and idiots (Houston, 2001, see below), the social context of insanity (Houston, 1999) and explanations for suicides in Scotland and northern England, (Houston, 2012), as well as concentrating much of his efforts on

unravelling the Scottish legal procedures for investigating the mental capacity of individuals (Houston, 2000, 2001a, 2001b). The main focus of Houston's 2000 book *Madness and Society in Eighteenth-Century Scotland* "is the process by which men and women became defined as mentally incapable" (Houston, 2000:3), which he labels the "prepatient phase", through to its transition into the "inpatient phase". Further to this, the study uses manuscript sources (civil court inquests) about mentally incapable people at the local level to uncover how a wide spectrum of Scottish society regarded insanity on a day-to-day basis. Houston (2000:8) clarifies that the book "is about the mental world of normal Scots seen through their understanding of mental problems, and about the way those perceptions mirror structure and change in social and cultural attitudes". Moreover, he recognises that "being insane is an individual affliction but it is also part of a societal process" (Houston, 2000:27), and it is this process which he seeks to uncover. Although falling the century before the construction of the district asylums, Houston's work provides important historical context to the nineteenth-century legislation.

Houston explicates the eighteenth-century legal procedure for classifying a person 'insane', which was largely done through 'brieves' and the civil court, where a judge would assess the evidence given by those who had knowledge of the insane 'subject' (the allegedly incapable person).[25] An inquest, conducted by fifteen men, was required to assess the capacities of the 'subject', which was based on both their own judgement and the testimony of witnesses, and was a process known as 'cognition'. Crucially, at this point in Scottish history, a jury was more likely to include a lawyer rather than a medical practitioner, and thus contained more legal than medical persons. Evidently, in the eighteenth century medical men were not regarded as essential in the legal process of determining mental incapacity, although this was to change over time, as they started to give evidence in greater numbers, collaborating with the legal professions.[26] This increasing central role of medical practitioners in defining insanity came from both a desire to use their knowledge on 'mental illness', as well as a conscious strategy by physicians and surgeons to boost their professional status (Houston, 2001a). Thus, it was only in the nineteenth century that doctors gained legal powers in determining insanity, moving the decision-making away from lawyers, relatives and friends. Finally, Houston also gives

[25] A 'brieve' of idiotry and furiosity was the name given to the call for an inquest into the mental capacity of an individual before a civil court, and were purchased from the Chancery. Brieves were predominantly raised by the insane person's next of kin, who would then put in a claim to be the heir of the 'subject'.

[26] This crucial shift is considered by Foucault in the opening chapter of his *Abnormal* (2003) lectures (delivered the year after *Psychiatric Power*). Donoho (2012) draws on this part of Foucault's corpus to shape her interpretation of the 'legal' process in insanity proceedings in the Highlands of Scotland (see below).

attention to understanding the differences in the country's poor-relief provision compared to the English system (Houston, 2001a), which will be explored further in Chapter Five.

Moving into the nineteenth century, Andrews (1998, 1999) provides a short though detailed insight into the reform of Scottish lunacy provision in the mid-nineteenth century, and the establishment of the General Board and the Scottish Lunacy Commissioners. His research discusses the difficulties and hesitancies encountered when trying to reform the previous system, and then gives detail on the members of the Board and their duties as implemented by the 1857 Act. Andrews (1999:201) recognises a "continuing and vigorous resistance to the asylum solution before (and after) 1857", and argues that it was only after the passing of the new lunacy legislation in 1857 that pivotal changes were made regarding lunatic asylum administration. Significantly, the 1857 Act, which resulted in the establishment of the General Board and the Scottish Commissioners in Lunacy (SCL) as well as the erection of compulsory district asylums, came twelve years after the decisive Lunacy Acts of 1845 south of the border. Andrews (1999:202) blames a "dislike of English interference and pride in traditions of voluntary charitable relief" for the delay in responding to the increasing inadequacies of the existing provisions. The 1855-57 inquiry into existing provisions had nonetheless uncovered: escalating costs of pauper maintenance in royal asylums; a growing awareness of an increase in pauper lunacy; and mounting opinion that current provisions for pauper lunatics were inappropriate and inadequate. Hence, the General Board was devoted to phasing out the old system of asylum provision in Scotland, slowly replacing the madhouses with larger-scale, public district asylums for pauper patients, which hypothetically set aside the royals for private patients only. This ambition was, for the most part, accomplished by the end of the century. Yet, Andrews points out that many local authorities were slow in providing accommodation for their pauper insane, with the Glasgow area not constructing any district asylums until the 1890s. This research, although brief, provides a valuable starting point for the context of this thesis, and the information covered by Andrews will be revisited and expanded in Chapters Five and Six.

***Institutions/Regions***

Work that focuses on specific institutions, which as shown above were starting to appear at the end the eighteenth century, includes specific contributions on the royal asylums – Dundee Royal Asylum (Walsh, 1999); the Glasgow Royal Asylum (GRA) (Andrews, 1999) and the Royal Edinburgh Asylum (REA) (Thompson, 1984; Beveridge, 1995a,

1995b; Andrews, 2012) – as well as focus on general and other forms of institutional care: in the eighteenth century (Beveridge, 1990; Houston, 2001a, 2001b); for 'idiots' and 'imbeciles' (Anderson *et al*., 1997); for mentally-impaired children (specifically the Baldovan Asylum near Dundee and the 'Scottish National Institution for the Education of Imbecile Children' in Larbert, Stirlingshire) (Hutchison, 2011): and for homosexuality in the twentieth century, with attention on the Jordanburn Nerve Hospital (Davidson, 2009). Additionally, there are a number of pamphlets commemorating the history of individual asylums in Scotland, most commonly published for their Centenary celebrations and hence following the simplistic/progressivist model. Specifically, the district asylums that have produced such accounts include Inverness (Whittet, 1964), Glasgow (Hutton, 1994), Lanark (Fitzpatrick, 1995) and Roxburgh (Miller, 2000). All generally include information on the opening of the institution, as well as detailing the superintendents and patient numbers, providing extracts from annual reports, and including photographs and notes on milestones in the institution's history. In effect they become more like primary sources, albeit to be handled with care, and as such have helped with empirical details in my thematic chapters (Seven to Nine). This array of institutional studies, although markedly thin in regards to the district asylums, adds to the large volume of research on English and Welsh institutions in the eighteenth and nineteenth centuries, as well as highlighting considerable differences between the Scottish system and the arrangements south of the border regarding both timing and type of provision.

Houston's contribution, chiming with his research interests as discussed above, focuses on the origins, development and extent of institutional care up to 1820, covering voluntary-subscription (royal) asylums and private madhouses. Additionally, he discusses the characteristics of these asylums, and patient experiences within them, specifically between different social classes. The study is used to give "a long-term perspective on the nineteenth-century heyday of the asylum" (Houston, 2001b:5), through a social history of the different types of institutions available from the end of the seventeenth century to circa 1820. The sources utilised in the study are largely original manuscripts, which, he argues, singles it out from previous progressivist literature that relied on printed secondary accounts, the advantage being that the former "bring us closer to the realities of identifying and caring for the mentally afflicted" (Houston, 2001b:7).

Beveridge (1990) also provides details of an eighteenth century institution in his examination of one particular patient, Edinburgh's poet laureate, Robert Ferguson. The main aim of the paper is the consultation of available records in order to examine the final

few months of Ferguson's incarceration/institutionalisation, offering an explanation for the cause of his early death in the Edinburgh City Bedlam, but it also provides great detail on institutional provision in Edinburgh during the eighteenth century. As there was no purpose-built asylum in Scotland at the time, in Edinburgh private lunatics would either be catered for in private madhouses or at home, whereas pauper lunatics were detained in the City Bedlam, located next to the charity workhouse and the house of correction, where their plight was described as "particularly woeful" (Beveridge, 1990:319). Beveridge relies on the accounts of visiting doctors in order to build up a picture of the conditions in which the inmates were retained, which involved damp, cold cells, mechanical restraints, and minimal ventilation. The discovery of the environment in which Ferguson was contained is widely recognised as a catalyst for the construction of the early royal asylums.

Moving on temporally from this research, Walsh focuses on the peculiarly Scottish phenomenon of charity and insanity in urban Scotland, locating the wider themes of the development of charitable institutions within a case study of the Dundee Royal Lunatic Asylum. Furthermore, she draws out the reasons behind the uniqueness of the Scottish system, enabling a picture to be constructed of the state of insanity provision at the close of the eighteenth century, presenting the three main distinguishing factors as being:

> The distinctive operation of the Scottish Poor Law, the overriding social and economic imperatives of the Scottish towns which founded institutions for the insane, and the importance of lay involvement in the establishment of the Scottish asylums. (Walsh, 1999:180)

She argues that, initially, provision for the insane within the royal asylums was "undoubtedly superior" (1999:192) to the service available in the private sector; meaning madhouses and the homes of individual 'private' persons where lunatics might be kept or boarded out. Yet, Walsh believes that directing all energy towards charitable institutions resulted in a narrower scale of provision for lunatics in Scotland overall, which became increasingly problematic as the numbers requiring accommodation expanded and the institutions ran into financial difficulty.[27] Despite these growing problems, Walsh stresses that there was continual opposition from the royal asylums to any proposed legislative change, arguing that this indicated something other than basic philanthropic needs were at stake. Rather, the development of those asylums was embedded within the economic and political agendas of the urban settlements:

[27] Why the numbers expanded in the nineteenth century, here and south of the border, is itself a controversial issue.

> [They] began with the aim of being more than simply a repository for the insane; [they] sought to facilitate the return of mentally – and morally – sound and productive members of society back into the community, to provide an economical form of care for the insane, and to retain local control over that provision. (Walsh, 1999:195)

Through her research, therefore, Walsh has determined that laypersons rather than physicians dominated the charitable institutions in the early part of the nineteenth century. In the early years of the Dundee asylum, only three of more than forty directors were medical men, with the majority being drawn from a range of powerful positions within the town's hierarchy, including the town council, the guildry and the church. This (im)balance, claims Walsh, had an effect on the type of care practised within the asylum, which leaned more towards moral rather than medical treatment:[28]

> The important role played by laymen in the establishment, organisation, financing, and also in many ways the ideological structuring, of the charitable asylums meant that their ideas and their opinions were central to the pattern of asylum development in Scotland. (Walsh, 1999:185).

As a result, Walsh recognised that asylums such as Dundee ventured to delay the employment of a resident medical superintendent for as long as possible. This delay was bolstered by the belief that such an obligation was only applicable in madhouses rather than asylums, as well as the financial burden that such a recruitment would place on the asylum's already limited budget. Furthermore, as the asylums were philanthropically funded, "constant vigilance was required in an effort not to upset public sensibilities" (Walsh, 1999:186). The asylums needed to portray the image of being 'value for money', which ultimately had an effect on how the institutions were run. Thus, argues Walsh, from the beginning, royal asylums had the aim of 'curing' inmates and returning them to society, rather than simply acting as a repository for lunatics: "the idea that infirmaries could heal, orphanages could reform and lunatic asylums could cure formed an essential part of the charitable appeal of these institutions" (Walsh, 1999:188).

Similar to Walsh, Andrews' (1999:200) research aims to "delineate some of the peculiar characteristics of the making of the asylum in Scotland", with particular focus on the Glasgow region, across a number of papers. Andrews specifically concentrates on how the divide in provisions between pauper and private patients had to be negotiated both at

[28] Intriguingly, the York 'Retreat' was founded on moral not medical treatment, but the English 'charitable lunatic hospitals', often being associated with a general infirmary, tended to be more medically inclined (see Philo, 2004, Chapter Six). The issues of 'moral' and 'medical' treatments (and their spatial implications) will feature in detail later on in this thesis.

different levels and between different parties. His study on the GRA (1999) highlights that, for this particular institution, increasing pressure on space throughout the century, together with an imbalance in numbers between private and pauper patients, meant they had to depart from their original ideals of separation of different classes until the 1880s, when the asylum decided to cater solely for private patients. Both the Murray Royal (Perth), Dundee Royal, and eventually the REA also went down this route, sending pauper lunatics to district asylums and lunatic wards of poorhouses. Andrews (1999:210) quotes the GRA's physician superintendent between 1874 and 1901, David Yellowlees, who explained the reasoning behind excluding pauper patients from his asylum:

> First, the policy was supported in terms of therapy: of expelling the most chronic cases from the asylum, who, it was adjudged, predominantly belonged to the pauper classes; and of permitting the earlier treatment of the acute insane, who, it was asserted, were being 'kept at home as long as possible … in order to avoid the expense of asylum treatment'. Second, it was advocated in terms of improving the asylum environment: reducing overcrowding and upgrading patient accommodation. Third, justification embraced a renegotiated, class-mediated economic that substantially reneged on earlier commitments to supporting the poor on the bounty of the rich.

The policy was also embraced for social reasons, as removal of the pauper patients would apparently raise the social 'tone' of the asylum. It was believed that obliterating all associations with the lowest classes would hopefully attract more private patients, as they would no longer have to worry about sharing accommodation with "socially repellent paupers" (Andrews, 1999:211), and it might benefit them psychologically from living in an environment filled solely with their own class. As a result, increasing numbers of private patients were admitted to Gartnavel, with numbers more than doubling between 1875-1900, from around 150 to over 400. Andrews (1999:212) labels this process as "a form of social cleansing", effectively supported by the establishment. This 'social cleansing' also involved the exclusion of both Roman Catholic patients (due to the majority being 'paupers') as well as criminals, with the royal asylum claiming the latter group were better placed in district asylums. The policy had a direct impact on the district asylums, as it further strengthened the hierarchy of Scottish asylums with the royal asylums now firmly 'on top'. This crucial point helps to contextualise further the focus on the district asylums, which were lower down this hierarchy and have, in consequence perhaps, attracted much less academic attention. Moreover, growing differences in rates between royal and district asylums were exacerbating the class divide by impacting on the types of patient sent to each institution. Yet, Andrews (1999:216) issues a caution:

> It would be a mistake to see the divisions between private and pauper patients at Victorian asylums like Gartnavel and even the subsequent off-loading of pauper patients to other asylums as something imposed entirely from above and wholly against the interests of parishes and paupers.

Segregation by class was called for not only by asylum officials but also by many patients and families, although these pleas came more from private rather than pauper inmates, and parishes, who would have found it cheaper to send their pauper charges to district asylums. By segregating the classes and prioritising the private patients, however, Andrews argues the authorities were mitigating the neglect of paupers. Although depicted as a return to the "benevolent function for which it was founded", the 'privatisation' of the GRA resulted in a departure from the ethos of the institution, set out in 1814, of providing "asylum to the wretched [insane] the wealthy and the poor" (Andrews, 1999:218).

Continuing with studies on the GRA, a collection of essays was published in 1993 titled '*Let there be Light Again'*, to mark the 150th anniversary of the institution (at its Gartnavel site). The book takes the history of the asylum from its inception through to the early-1990s, with contributions concentrating on: administration; religion; environment and architecture; medical officers, attendants and therapeutics; and the patient population, thereby giving a detailed picture of this changing asylum. Six of the seven contributors are current or former staff of the institution, with only one, Andrews, being a professional medical historian. The book, although drawing upon rich archival material, follows a celebratory account of the institution, claiming that, although it has been somewhat "under-rated" in the past, "there is much in its history which it can be proud of" (Andrews and Smith, 1993:np). It nonetheless also recognises that the institution has not had a straightforward, 'unproblematic' history, with difficulties mainly centring on the questions of how to care for the mentally ill.

Following Grob's premise that asylums were not homogenous (in reaction to Scull's 'museum of madness' assessment of asylums), but should instead be recognised as individual institutions with their own peculiarities and developments, Beveridge's (1995a, 1995b) HoP papers focus on the REA at the turn of the twentieth century, when it was under the charge of Thomas Clouston. Beveridge chose this asylum due to the wealth of archival material available and because, until the opening of the Edinburgh District Asylum, it admitted patients from across the social classes (unlike its English counterparts), giving a broad range of patients. The specific time period (1873-1908) was chosen to coincide with Clouston's superintendence, as he was a prominent alienist,

writing widely about mental disease and its classification as well as taking extensive clinical case notes. Clouston viewed the asylum as "a wonderful human laboratory in which the clinician could conduct empirical study and make observations" (Beveridge, 1995b:151) The aim of Beveridge's research is to provide detailed analysis of the social and clinical characteristics of the patients, comparing them with the medical and administrative settings of the REA and of nineteenth-century Edinburgh more generally. Finally, Beveridge compares the findings from the REA to research undertaken on other contemporary asylums, concluding that the majority of patients in the REA were single patients, with more women than men admitted, and that many suffered from organic diseases such as general paralysis and alcoholic insanity. Finally, Beveridge argues that a simplistic interpretation is avoided by recognising the wider contemporary social, economic, administrative and medical influences on the institution.

Andrews' (2012) paper titled "Death and the dead-house in Victorian asylums: necroscopy versus mourning at the Royal Edinburgh Asylum, c.1832-1901", again adds to the history of the REA, this time concentrating on the management and significance of post-mortem examinations and the "spatial ordering of patients' death, dissection and burial" (Andrews, 2012:6) at this specific institution. The paper considers how the mortuary and the procedure of dissection moved from the periphery to the centre of the institution (both spatially and metaphorically) as a result of the increasing medicalisation of madness into mental illness, which was pushed by both internal and external pressures, and is a theme relevant to internal asylum spaces in transition, to which I will return in Chapter Nine. This move is set against the wider social and familial issues of consent and funereal rituals, and uncovers a noteworthy resistance movement compiled of practitioners, relatives and the members of the general public, particularly regarding the non-consented use of patient's bodies for scientific post-mortems.

***'Great Men'***

Both the Universities of Glasgow and, in particular, Edinburgh, produced a number of prominent figures in the history of madness, asylums and psychiatry during the late-eighteenth to the early-twentieth century.[29] From Edinburgh, the following 'great men' have all been subject to research for their contribution to the discipline: Andrew Combe (Guthrie, 1964), W.A.F. Browne (Scull, 1991), Thomas Laycock (Barfoot, 1995), David

[29] Research has been conducted on other prominent later-twentieth century figures such as R. D. Laing (see, for example, Abrahamson, 2007; Miller, 2009; McGeachan, 2011).

Skae (Fish, 1978; Barfoot, 2009) and Thomas Clouston (Beveridge, 1991). In Glasgow, Andrews (1997) has concentrated on the lesser-studied 'Glasgow school of psychiatry', centring in particular on David Yellowlees. Andrews (Andrews, 1997:177) recognises that this school did not achieve the same level of prominence or impact as Edinburgh, and comments that "Glasgow alienists had no fundamental impact on methodology and theory in psychiatry during the nineteenth century, nor did they exert much influence on general approaches to the diagnoses and classification of mental diseases". Yet, in his paper, Andrews seeks to uncover the main developments in the Glasgow school during the nineteenth and early-twentieth centuries, evaluating its distinctiveness and influences, as well as assessing where and why it failed to achieve the same levels of success as the Edinburgh school. Some of these men, in particular Browne, were prominent characters in the development of the Scottish asylum system, and will feature again in the following chapters, yet the majority were physician superintendents to the royal asylums, with the superintendents to the district asylums still to be researched.

***Diseases***

Davis contributes by looking at Scottish aspects within historical accounts of a specific disease, general paralysis of the insane (GPI), which was linked to syphilis. The text discusses how GPI first emerged as a category during the early-nineteenth century, and was characterised by severe physical and mental problems, such as degenerative dementia and bodily paralysis. Far from a rare condition, twenty per cent of British male asylum admissions by the end of the nineteenth century received this diagnosis and, due to its chronic and ultimately fatal progressive nature, it took up a disproportionate amount of asylum resources. Davis' study concentrates on the period between 1880 and 1930, and to ensure archival depth and detailed analysis, she chooses a geographically localised investigation. Four asylums from central Scotland were chosen, two from the west and two from the east, as they appeared to be representative of the whole of the central region and also reflected well the range of institutional provision for the insane in Scotland during the time period. Two of the institutions, the REA and the GRA, have already been mentioned above, with Davis stating that they "were among the earliest and most prestigious of the Scottish asylums" (Davis, 2008:16). The other two asylums investigated were the Midlothian and Peebles District Asylum and the Barony Parochial Asylum, which means that Davis' research does touch upon one aspect of the district asylum story. These specific asylums are partly selected as a complete run of admission registers and case notes for the time period has been retained for each institution, "furnishing an exceptionally rich set of

insights into the social background and medical experiences of these patients" (Davis, 2008:16). Although she gives a factual outline of the Scottish institutional provision for the insane as contextual background to her study, Davis' main emphasis, and her archival inquiries, which focus on patient records, is dedicated to looking into the diagnosis, treatment and aetiology of GPI.

***Patient experiences***

As briefly stated above, and in line with the growing interest in 'the stories of the insane', a selection of authors have chosen to look at the history of madness, asylums and psychiatry in Scotland through the eyes of the patient, focusing their research on uncovering the often elusive patient perspective or 'patient voice' (Beveridge and Williams, 2002). This work has been conducted through a number of different sources and mediums, and across a lengthy time period, although all the studies are confined to examples from royal asylums. The written words of patients who find themselves within the institution is the focus of work by Beveridge (1998) in "Life in the Asylum: patients' letters from Morningside, 1873-1908". This research concentrates on over one thousand letters that were composed by patients resident in the REA between 1873 and 1908, when Thomas Clouston was physician-superintendent. Beveridge (1998:431) argues that, as these letters:

> … were composed while patients were still resident in the Asylum and in the midst of mental turmoil [,]… these accounts are less detached than retrospective compositions and convey much more vividly the daily experience of institutional life.

They provide a distinct insight into the life of the REA, albeit by this stage a predominantly private institution, taking lunatics 'of means' who were also likely to be well-educated and hence able to write (a point to bear in mind when considering the almost complete absence of equivalent letters in district asylum archives). Patients wrote letters for many reasons, including: to make sense of their institutionalisation; to voice their distress; to ask to be removed from the asylum; to denounce the institution and its staff; to condemn other inmates; or to show affection for them. The letters were written on an array of surfaces ranging from headed notepaper to toilet paper, and the length of the notes ranged from a few scrawled lines to pages of small, neat handwriting. The letters included details on the daily routine of the asylum, some negative, such as complaints about the early bedtime, the mundane walks around the garden and the asylum 'rules', which one patient felt were implemented to punish patients who spoke out about the asylum 'regime' (Beveridge, 1998:440), whereas others discussed the warmth that they felt for particular

attendants. Through analysing viewpoints such as these, but including several hundred patients, Beveridge has been able to construct an overall patient perspective on this particular asylum.

Conversely, other papers co-written by Beveridge have looked specifically at individual patient experiences within REA. One patient in particular was responsible for some of the letters in the Morningside collection, as well as an extensive collection of notebooks, scrapbooks, sketches, paintings, maps, charts, poems, entries in the Asylum magazine, the *Morningside Mirror*, and material about inventions that he claimed to have made. Barfoot and Beveridge (1993) have used these documents to construct a patient-orientated perspective on asylum life, entitled "'Our most notable inmate': John Willis Mason at the Royal Edinburgh Asylum, 1864-1901", an account of how this patient adapted to asylum life over thirty years. Again contributing to the theme of 'patient voice', Beveridge is joined by Watson (2006) to look at the story of Christian Watt, whose plight was uncovered after the publication in the 1980s of *The Christian Watt Papers*. Watt was a long-term inmate of the Aberdeen Royal Asylum, who, it was stated, became one of the 'characters' of the institution. Since the 1980s, her story has been told as both a play and a television documentary. Beveridge and Watson's paper explores the historical record to uncover Watt's story, which they are then able to compare with how Watt documented her own life. The final contribution to be included in the theme of patient voice and experience is a paper, again by Beveridge (1996b), entitled 'Metaphors of madness: Iain Crichton Smith's journey through the Inferno'. As can be gathered from the title, this is a different topic to the articles described previously, but does still recognise, in line with Porter (1987, 1991b), Peterson (1982) and Beveridge's other work outlined above, "that the 'stories of the insane' have much to tell us about the nature of madness and psychiatry" (Beveridge 1996:375).

A further entry into recovering patient experiences within the institution is through patient case notes. This source is analysed by Andrews (1998), who concentrates on how and why case notes were produced and used and their potential importance as a source for historians. Andrews pays specific attention to the case notes produced at the GRA, arguing that attention to the notes provides "the surest basis we have for understanding the changing nature of the experience of the insane in asylums since 1800" (Andrews, 1998:256), as well as for understanding discourses of treatment. Furthermore, Andrews recognises that the notes have the potential to uncover details about the inner environment of the asylum, the impact of visitors (public or official) on life in the asylum, "and the

whole spectrum of an institution's intramural and extramural relations" (Andrews, 1998:255-256). It is recognised, however, that the sources are not unproblematic, as there are always problems with their comprehensiveness and integrity, such as absences, biases and censorship, and so in order to be useful as a source there needs to be a strong sense of how they were constructed.

In a similar vein to the articles on the 'patient voice' by Beveridge *et al.*, recent work has also been conducted on patient art, from looking at its aesthetic qualities, to considering what it can reveal about its creator and their experiences of madness and institutionalisation. Contributions to this theme come from Beveridge and Williams (2002), Philo (2006)[30] and Park (2007, 2010), who aim to understand why this art was produced, with each addressing some of the following questions:

> Was it a means of coping with mental torment? Did it fulfil a cathartic function for the patient-artist? Did the asylum offer a unique environment for the creation of such work? And finally what was the attitude of asylum doctors to their patients' productions? Did they view them as further evidence of insanity, a visual demonstration of the madness within? Or did they discern some aesthetic qualities? (Beveridge and Williams, 2002: 20)

Interestingly, all of the artwork studied comes from patients who were resident in the Crichton Royal Asylum in Dumfries, because of the unusual regime here ran by the superintendent, W. A. F. Browne,[31] who also collected (and wrote anonymously about) 'mad art'. It is not thought that these artworks were produced as part of any species of art therapy, nor as a vehicle for allowing doctors to 'interpret' their patients' problems, albeit Browne does do a little of this in print (Beveridge and Williams, 2002).

Beveridge and Williams concentrate their research on the artwork of John Gilmour, who was resident in asylums in Trinidad, America, and Scotland, where he spent time in both the Gartnavel and Dumfries institutions at the beginning of the twentieth century. The archival records for this patient are incomplete, with only ten pictures surviving (all of which were drawn at Dumfries), although they are supported by other evidence such as

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[30] This historical-geographical paper investigates "the geographies *in* the ideas of one nineteenth-century psychological physician, Thomas Laycock" (Philo, 2006:891, original emphasis). This involves Philo exploring how Laycock understood madness through an 'imaginative historical geography', explaining a mad person's consciousness "as reversions to the mental worlds of other peoples living in other periods and places" (Philo, 2006:891). Philo explores Laycock's ideas around memory, as well as examining his responses to one anonymous artist-patient (identified as Blacklock, another artist-patient from Browne's collection), which Philo concludes, simultaneously lacked engagement as well as over-interpretation.

[31] Browne was a key figure in the history of madness asylums and psychiatry and his curative visions regarding the 'ideal' asylum will be detailed further in Chapter Five.

case notes, letters, a 'parable' and articles written in the *New Moon* (Dumfries Asylum's magazine). Beveridge and Williams (2002:44) conclude from these sources that "it is possible to gain an understanding of the persecuted world of John Gilmour". Gilmour's surviving pictures are all drawn in cartoon style and reveal that he viewed his treatment critically, but, as the drawings were not referenced in any medical notes, there is no way of knowing how they were viewed by staff or why they were kept. Furthermore, there is no way of knowing the audience, if any, at which Gilmour was aiming his sketches. What is clear is that the ten pictures disclose his opinion of both the asylum in which he was confined and the treatment that he was receiving. Beveridge and Williams go through each of the cartoons, describing them in detail and attempting to make some sense of their content. They deduce that Gilmour's cartoons cannot be classified as 'Outsider Art' drawn by so-called 'schizophrenic masters', which would usually convey strange and disturbing images portrayed in an unconventional manner. Rather, Gilmour's drawings are comprehensible, using traditional materials such as pen, ink, pencil and paint:

> Without doubt he was keen to communicate with others. His drawings tell a readily understandable tale, and he further emphasised his need to get his point across by including extensive textual explanations as an integral part of his pictures. (Beveridge and Williams, 2002:43)

It is through his work that viewers gain some empathy for the tormented world in which Gilmour lived. Perhaps, therefore, his work should be considered under the vague umbrella of 'Outsider Art', as they portray his experiences and grievances of institutional life, but the whole designation of this label is fraught with danger (see Parr, 2006).

Park (2010), an art historian, devotes her research to surveying Browne's entire surviving collection of patient art, and includes many copies of the images in her book. Opening with an exploration of Browne's life and the circumstances that positioned him as the first superintendent of the Crichton Royal Institution, Park then moves to detail the extra-ordinary collection of patient art retained by Browne, rediscovered by the Crichton archivist in 1983. Additionally, Park investigates the history of the Crichton Institution, as well as trying to identify as much information as possible about the individual patients responsible for the artwork. Park argues that, unlike other alienists during the first half of the nineteenth century who regarded art and painting as "a product of a rational and ordered mind" (Park, 2010:xv), Browne encouraged a range of cultural activities, including art, music and reading, which he believed to hold the power to alleviate, or even cure, the

disordered mind. Browne took these principles forwards into his position as one of the first Commissioners in Lunacy for Scotland after the 1857 Act.

### *The 'Scottish' review*

This extensive review of the historiography of madness, asylums and psychiatry in Scotland highlights the negligible primary research and evaluation to date of the Scottish district asylums, whether at the 'system' level (including the input of the Scottish Commissioners in Lunacy in shaping and inspecting the 'system') or indeed at the level of individual institutions. Furthermore, there is a relative overall absence of a more critical/revisionist perspective in the Scottish historiography, certainly from any scholars actually addressing the district asylums. There is, then, a sense that the district asylums are the 'poor relations' of the royals, both actually – a real pecking order existed, as in Andrews' observation – but also scholastically, in that the district asylums seem to have been regarded as relatively uninteresting, without much merit as sites for critical-scholarly examination, a situation which the research in this thesis hopefully shows is misguided. There is also an emerging sense of difference between the system and provisions in Scotland and England, respectively, with possible variations over boarding-out but also over how the new 'public' (district) asylums were created and regarded. There was also a different chronology, with Scotland creating a truly 'public' asylum system rather later than in England, hence at the tail-end of what is usually regarded as the golden 'Asylum Age'.

## THE GEOGRAPHIES OF MADNESS

In common with the field of the Scottish history of madness, research exploring the specific *geographies* within the history of madness have also been far less extensive, as well as being a relatively recent phenomenon. Philo (1997:73) stated that there is now "a small field of geographical studies exploring how space, place, environment and landscape are bound up in the worlds of people experiencing mental health problems". The research here can be divided into studies focusing on the geographies of mental ill-health meaning the spatial incidence of moral distress in its various guises and others specifically focusing on the geographies of mental health facilities past and present. Due to the focus of this thesis, attention in this brief review will be given to the small number of geographers who are interested in asylums (following the 1997 theme issue in *Health and Place*, essentially on 'asylum geographies'), rather than, for example, research which looks at the more

recent processes of deinstitutionalisation and post-asylum spaces (following the 2000 theme issue in *Health and Place*, essentially on 'post-asylum' geographies).

As well as reviewing the contributions to the sub-discipline of asylum geographies (Philo, 1997; Philo and Parr, 2000), Philo is perhaps the most sustained contributor to the field, with his research predominantly focusing on the historical geographies of what he terms the 'mad-business' in England and Wales, primarily through a Foucauldian lens. His research, which commenced in the mid-1980s, has been described as a "distinct departure by comparison to previous studies of the mad-business" (Andrews, 2004:xx), which has resulted in a more nuanced approach to the history of madness, achieved through attention to both 'aerial differentiation' and 'spatial relations' – calling for more attention to the geographical understandings and responses to madness across different spatial scales. This is achieved through detailed attention to the spaces "designed and designated" (Andrews, 2004:xx) for the insane from the medieval times to the 1860s.[32] Philo's work, and in particular his 2004 book, is a close analysis, using in-depth archival inquiries, into the external and internal spaces of madhouses, asylums and hospitals, which, Philo claims, "orients us informatively towards their peculiar and associated geometries and geologies; escorts us fastidiously around their locations and sites, and conducts us carefully into their landscapes and grounds" (Andrews, 2004:xx). The ideas explored in his work have inspired the small (yet expanding) field of 'mad geographies',[33] laying the groundwork for the following, and future, studies in different geographical locations and time periods.

Yet, splitting the sub-discipline of asylum geographies further, Philo and Parr (2000) recognise two distinct ways in which asylums have been researched by geographers: geographies *of* institutions and geographies *in* institutions. These two different research foci concentrate on different spatial scales, moving from macro- to micro- geographies. The first emphasises the specific locations of asylums in relation to other peoples, land-uses, towns and resources, and seeks to uncover the drive to develop an extensive network of socially and spatially separate institutional places. The latter is directed to the internal and external asylum spaces and how they are arranged and manipulated for social control and therapeutic purposes. Drawing from, and extending, the revisionists' theories outlined above, Philo and Parr (2000:514) state:

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[32] Philo's attention to Foucault will be reviewed further in Chapter Three.

[33] Most recently, 'mad geographers' contributed to the 'Asylum and Post-Asylum Spaces' conferences (2012 and 2013) held in Durham and Glasgow, and the 'Security and Insecurity: Experiences of Mental (Ill)health' sessions at the RGS-IBG (2012).

> [A]sylum studies tackling the geographies of and in institutions demonstrate that pre-planned locations and arrangements of space have commonly been taken as crucial to reforming the human subject: as key to the idea, purpose and practice of the institutions themselves.

Moving through these spatial scales, approaches centring on the macro-geographies, the intimate relationship between space, place, environment and landscape, the workings of power, and the state and societal responses to madness, have been researched by, among others: Philo (2004); Dear and Wolch (1987); Jones and Moon (1987); Radford and Park (1993); Park and Radford (1997); Alderman (1997); Melling and Turner (1999) and Smith *et al.* (2007). More micro-spatial geographical studies concentrating on the internal spatial arrangements of asylums, and the tensions that developed between the manipulation of space for either/both disciplinary or domestic means, have been researched by, for example, Philo (1989), Jenkins (1994), Park (1995) and Edginton (1997). Other research includes the use of internal and external asylum spaces for both medical and therapeutic activities such as work, exercise and recreation (Philo, 1994), the professional and social worlds and ideas of the asylum staff (Philo, 2006), and the patient-worlds which have been explored through both medical case notes (Park, 1995) and patient letters, which, taking inspiration from 'bottom up' approaches to history as outlined above, give a snapshot of asylum geographies 'from below' (Tuan, 1979; Park *et al.,* 1994; Parr and Philo, 1995; Gilbert *et al.*, 1996). Geographers have also given brief attention to the ultimate demise of asylums post-deinstitutionalisation (Cornish, 1997; Parr *et al.,* 2003; Kearns *et al*., 2012).

***The Scottish Geographies of Madness***

Given the relatively limited extent of the field of geographies of madness as outlined above, the contribution situated within Scotland is, unsurprisingly, even smaller, and has only emerged relatively recently. Although there has been no specifically geographical study into the overall system of institutional provision emerging from the late-eighteenth century, there have been Scottish-facing studies on particular geographical regions and their peculiar responses to madness (Donoho, 2012), particular institutions (Philo, 2007), and reflections on their closure (Parr *et al.*, 2003), and particular physicians and patients (Page, 2003; Philo, 2006). Furthermore, a number of undergraduate dissertations have looked at geographical aspects of specific institutions (Thomson, 1998; Cameron, 2000; Cunningham, 2000; Page, 2003; MacKinnon, 2006; Roberts, 2011; Farquharson, 2013) and particular processes such as deinstitutionalisation (Scanlon, 1998).

Donoho's thesis provides the most substantial entrée to date to understanding the historical geography of madness and institutional provision in Scotland, through her inquiry into the specific responses to the management and treatment of the mad in the Highlands and Islands region, from the Medieval to the late-Victorian period. The archival material consulted includes Medieval Celtic manuscripts, nineteenth-century folklore collections, Lunacy Commissioners' reports, Sheriff Court records and asylum case notes. Donoho turns to these sources in order to understand the social construction of madness in a geographically peripheral location, and how this develops over time through modernisation and as the region is incorporated into the national system of asylum legislation and provision after the *Lunacy (Scotland) Act*, 1857. The research is conducted using both a 'bottom up' and a 'top down' analysis, exploring the 'traditional' world of Highland madness through folklore as set against legislative state responses, while also explaining the interconnectivity of these binaries. In summary:

> It asks questions pertaining to how madness was recognised by Gaels, how such recognition changed over time, and how it reacts both to earlier 'folkloric' ideas and treatments, and later ones which appeared as a result of state intervention. (Donoho, 2012:13)

Through looking at early responses to perceived madness and abnormality in the region, Donoho is able to recognise how such behaviour was conceptualised, understood and dealt with prior to the period of institutional response, in order to construct a "'pre-modern' geography of lunacy" (Donoho, 2012:13). The research discusses how these early responses to madness were situated within the physical geography of the region, with cures often connected to supposed 'curative' locations such as specific lochs and wells. Prior to the nineteenth century, the responsibility of care for the mad and the abnormal was firmly placed in the community: friends, relatives and neighbours. Yet, as time progressed, these communities began to 'reject' certain behaviours, preferring instead to send such people away to asylums in the Lowlands. Donoho argues, "thus, the 'top-down' methods for managing the insane were embraced by the 'bottom', and the whole idea of 'top' and 'bottom' is hence inverted and made co-dependent" (Donoho, 2012:13).

Despite this increasing resort to institutionalisation, the Highlands and Islands were relatively late in receiving their own purpose-built institutions for their insane. Thus, Donoho devotes part of her thesis to understanding the alternative community and household responses to madness, which she recognises as embroiled within the deeply embedded Gaelic and folk culture. She states that it was not until the 1830s and 1840s,

when outside interest in the region increased both politically and economically, that formalised state provision was initially pursued. In tandem with this movement, Donoho recognises the shifting perceptions of madness, uncovering evidence that Highland dwellers were reconstructing their readings of insanity, wrapping it into their culture and beliefs, but also beginning to make use of both asylums and lunacy laws. Finally, the thesis moves to investigating the two district asylums that were built in the region after the 1857 Act, the Argyll and Bute District Asylum, opened in 1863, and the Inverness District Asylum, opened in 1864, and in so doing, provides details on these asylums highly relevant to my thesis. Donoho uncovers the official conversations around whether an asylum was necessary in this region, as well as discussions around the siting of the institutions once they had been approved. The first ten years of each institution are also considered, noting challenges that the asylums faced due to their geographical isolation, alongside an in-depth investigation of case notes to reconstruct something of the experiences of patients within the institutions.

The research conducted by Philo (2007) and Parr *et al.* (2003) also attends to one of these Highland institutions, the Inverness District Asylum, later known as Craig Dunain Hospital. Philo, through an historical-geographical inquiry, concentrates on three different geographies of the institution moving down the spatial scales. Firstly, attention is given to the region in which the asylum is situated, namely the Highlands of Scotland; secondly, the setting, pertaining to the local natural and human environment around and into the grounds of the institution; and thirdly, the buildings, concentrating on the structure and layout of the wards, corridors and interiors. Similar geographical themes, moving down the spatial scales, have been used in this thesis, particularly in Chapters Six to Nine. Philo draws on evidence from a variety of sources, from official archival documents as well as ex-patient and nurse testimonies, in order to reconstruct the three specific, yet inter-related institutional geographies, and in so doing uncovers both positive and negative images of the institution. Providing a closely related study to Philo's, Parr *et al.* examine the modern-day emotional geographies of the hospital, exploring, through archival enquiries and interviews, its value as a meaningful space for both staff and patients. Their research explores the geographies of the institution (real and imagined) and how they are perceived by people directly associated with the spaces of the hospital. They find that the internal and external spaces have both positive and negative connotations, often shaped by the distance, or nearness, of the individual to the institution.

## CONCLUSIONS

This chapter has explored the historiography of the history of madness, asylums and psychiatry, and the ways in which it has evolved since the mid-twentieth century. It is widely recognised that there was previously two opposing broad-brush views in the historiography: a progressive/celebratory explanation of improving 'medico-psychiatric' inventions, which was then countered by the more critical/radical revisionist interpretations of asylums as 'police', oppression and control. More recently, however, there has been a move away from these arguably simplistic accounts towards a 'post-ideological', more nuanced and self-aware analysis, which has broadened the field of research. Due to the increasingly diverse range of contributors, theories and geographical and temporal foci, evident in the range of articles contributed to the HoP journal since its inception in the early 1990s, it has been suggested that this field should be recognised as multiple *histories* of madness, asylums and psychiatry.

Yet, despite this breadth of activity in the history of madness, asylums and psychiatry more generally, contributions to the geographies and Scottish histories, of madness, asylums and psychiatry have been somewhat meagre, and it is only relatively recently that both sub-fields are beginning to offer a small – although conceptually and empirically rich – contribution to the overall field. The insertion of specifically geographical perspectives within the history of Scottish psychiatry, asylums and madness nonetheless remains rather patchy, and, regarding an analysis of Scotland's district asylums, there has, to date, been very limited historical *or* geographical, attention. This thesis, adopting a 'post-ideological' framework for researching the historical geographies of madness, asylums and psychiatry is therefore an invaluable addition to the terrain of histories *and* geographies of madness, asylums and psychiatry in Scotland, concentrating on the arguably less-popular district asylums in the second half of the nineteenth and into the twentieth centuries. Moreover, the research adds to the wider literature by providing a nuanced, empirically rich yet theoretically engaged geographical interpretation through combining a Foucauldian understanding with the concept of 'affective atmospheres', to be explored in the next, more conceptual chapter.

# Chapter 3

# Affective Power

## INTRODUCTION

As was explored in the preceding chapter, there exists two contrasting views of the histories of madness, asylums and psychiatry. However, the approach adopted within this thesis can be construed as a middle-way between these two strands, with the theoretical lens through which asylums and lunacy are examined shifting to a much more nuanced, 'Foucauldian' approach to understanding the 'spatial relations' surrounding madness. Yet, taking this thesis beyond previous interpretations of Foucault and the asylum, it will particularly use his *Psychiatric Power* (PP) lectures as the core theoretical framing: to date little attention has been devoted to unpacking and using the ideas explored in PP. Again moving the understanding of the 'Asylum Age' forward, this thesis also draws on the notion of the engineering of affective atmospheres, which can in part be read from PP, but also bridges over to literature on affect and emotion. This chapter therefore begins by outlining the relevant elements of Foucault's *oeuvre*, with particular attention to the lesser-known PP, before turning to an exploration of non-representational theories and the notion of affect. This latter aspect is explored in relation to engineering specific atmospheres and architectural spaces that have the *potential* to affect the emotional responses of individuals and the ability to exert increased control over a population. The intention, therefore, is to merge together both Foucauldian and affective geographies in order to lay down a theoretical understanding for the construction of a network of state-funded district asylums in Scotland during the latter half of the nineteenth century.

## GEOGRAPHIES OF POWER: FOUCAULT AND THE ASYLUM

Michel Foucault (1926-1984) produced some of the most influential works in the humanities and social sciences in the twentieth century. Often reassessing and reversing taken-for-granted understandings of concepts, themes and processes, Foucault's writings caused upheaval and transformation in many historical understandings of the modern world: 'the Enlightenment', 'Reason', 'science', 'freedom', 'justice', and 'democracy'

(Garland, 1987). Taking history as his starting point, Foucault selected certain phenomena (such as madness, punishment and sexuality) with the aim of exploring the constitution of knowledge, power, governmentality and discipline, through what he termed 'discourses', that circled around such phenomena. Going beyond ways of simply thinking about and producing meaning, rather discourses for Foucault comprise and actually constitute the 'nature' of the body, institution, system: they are "organised bodies of knowledge" (Philo, 2010:163). Closely bound to knowledge is power, and Foucault is fascinated by how power is channelled through the use of discourse in order to shape individuals. This therefore goes beyond the purely theoretical description of power, with Foucault more interested in how power has been exercised in different time and spaces. The relationship between power, knowledge and discourses is an intimate, internal and entangled one in which each implies and inflects the other, all intricately connected through spatial networks and relations. Thus, Foucault's work is not a general attempt to reconstitute the past; instead, through looking at the creation of discourses, in particular the intersections of power and knowledge, which he believed created institutions of discipline such as prisons, schools, reformatories and asylums, each study outlines a problem and a consequent investigation. As Jones and Porter (1994:5) explain:

> Foucault's aim was to defamiliarize, to expose seemingly natural categories as constructs, articulated by words and discourse, and thus to underline the radical contingency of what superficially seems normal. Nothing in history could be taken for granted; all history was culturally fabricated; everything had therefore to be questioned.

The arguments in Foucault's work have had an immense impact across a wide range of intellectual fields, but it has not been short of criticism. Sharp *et al*. (2000:15) state that many conclude their reading of his texts with the sense "that power is nothing but a sticky pall of domination", present everywhere and always, manipulated by authority to enter into "every tiny pore of the social world". This creates an image of society being one vast Panopticon, with no one able to escape the 'normalising' gaze or, crucially, the feeling that they have to turn that gaze inwards, upon themselves. This very dominating notion of power, Sharp *et al*. continue, is very difficult to resist, due to its totalising embodiment of society. Objection has been raised to this envisioning of power as something that appears to have no limits, no obstacles and no outside. There is a fear that Foucault's account of power gives no room for resistance, individuality or freedom; that it creates an omnipresent "overall political philosophy of nihilism and despair" (Gordon, 1991:4).

This thesis explores the notion that, although power was deeply embedded in asylum discourses in the nineteenth century, of fundamental importance to Lunacy Commissioners, asylum superintendents and many others was the push to create landscapes, and to engineer spaces, which they believed would either ultimately restore reason in those suffering from curable forms of insanity, or produce a humane, home-like environment for incurable, long-stay patients. Only in the first instance can we really say that the power entrained in producing such landscapes and spaces was 'controlling' – seeking to produce sanity where previously there was insanity; to produce 'docile' productive subjects – but the point is that the power here is indeed far from a repressive form of power (as implied in a simplistic 'critical account' of asylums and lunacy) but rather is a 'productive' form of power, with Foucault himself moving away from a solely 'repressive' notion of power, as will be explored later in this chapter. It might be said that the second instance is about creating orderly asylum environments full of 'docile' patients, but performed through the subtle manipulation of space to create caring, 'hospice' type environments. Thus, the conceptual framing to this thesis incorporates a more nuanced Foucauldian approach, recognising the critiques outlined above.

### *Foucault and Geography*

Foucault's works are inherently geographical, it can be argued, revealing how power and knowledge were (and still are) unavoidably configured within different spaces. Despite criticism that discussions in Foucault's work using the specific language of spatiality[34] are "strangely muted" (Thrift, 2007:55), and that he does not give enough attention to "areal differentiation" (Philo, 2004:7), his reasonings are inherently spatialised. Elden (2001) has argued that Foucault's work can be read as more than a history of the present, but can also be viewed as a "mapping of the present":

> From architectural plans for asylums, hospitals and prisons; to the exclusion of the leper and the confinement of victims in the partitioned and quarantined plague town; from spatial distributions of knowledge to the position of geography as a discipline; to his suggestive comments on heterotopias, the spaces of libraries, or art and literature; analyses of town planning and urban health; and a whole host of other geographical issues, Foucault's work was always filled with implications and insights concerning spatiality. (Elden and Crampton, 2007:1)

[34] The term 'spatiality' means "of, relating to, involving, or having the nature of space" (The Free Dictionary), and is commonly used within the discipline of geography. It is a term, however, which some find problematic, especially out with a certain philosophically-turned geographical tradition. The term was the recent focus of a panel discussion at the Association of American Geographers conference (2010) by eminent academics (Merriman *et al.*, 2012)

Foucault's theories, which clearly encompass questions of space, place, environment and landscape (Philo, 2011), have been used, developed, applied and critiqued by a number of geographers, many of whom have constructed a specifically Foucauldian spatiality (Thrift, 2007): for example, as just a list of 'specimen' contributions: Driver (1985; 1995), Philo (1986; 1989; 1992; 2004; 2012; 2013), Pickles (1988; 2004) and Gregory (1994). These geographers have either analysed, critiqued and unpacked Foucault's works, or applied it as the theoretical foundation for understanding and developing their own research.[35]

In relation to the spatiality of madness, and as mentioned in the previous chapter, Philo has drawn extensively on the work of Foucault, most notably in his research on English and Welsh institutions from Medieval times to the 1860s (Philo, 2004). Philo (2004:8) argues:

> Foucault forces us, I suggest, to think of the myriad more subtle ways in which space has been mobilised and manipulated by many reformers, physicians, administrators and others in the struggle to treat madness, to calm it, to cure it, certainly to control it.

Philo (2004) critically engages with Foucault and particularly with the text *Madness and Civilization*, recognising that the history, and the historical geography, of madness can be interpreted through a specifically Foucauldian reading of social control (incorporating the aspects detailed in the above quote). Embracing Foucault's emphasis on 'spatial relations', Philo (2004:8) develops a more nuanced approach, incorporating the 'areal differentiation' of madness and its treatment in order to construct a "systematic Foucauldian historical geography of the mad-business in England and Wales from the Dark Ages to the 1860s".

***Foucault and Madness***

> Most scholars would date the eruption of detailed investigations into the workings of asylums from the publication of Foucault's tirade against the pretensions of modern science. (Melling, 1999:1)

The discussion in this section will be drawn from the following texts by Foucault: *Madness and Civilisation* (MC) (1965), *Discipline and Punish* (DP) (1977), *History of Madness* (HM) (2006) and *Psychiatric Power* (PP) (2008), all of which approach, in various ways, the themes to be addressed in this thesis: madness, power, knowledge, discipline, surveillance, and the asylum.

[35] Indeed, an edited book, published in 2007, summarises the relationship between Foucault and Geography, titled *Space, Knowledge and Power: Foucault and Geography* (Crampton and Elden, 2007).

Foucault's initial major work in this field, known in French as *Histoire de la Folie* (Foucault, 1961 [HF]), translated into English and heavily abridged as *Madness and Civilization* (Foucault, 1965 [MC]) and finally published as the full unabridged English version *History of Madness* in 2006 (Foucault, 2006 [HM]), is a complex examination of madness in Western society, an investigation into historically and geographically situated arrangements of mental institutions and discursive practices (Dreyfus and Rabinow, 1983)[36]. Although MC has been subject to deep criticism by historians such as Midelfort, who states that "many of its arguments fly in the face of empirical evidence, and that many of its broadest generalizations are oversimplifications" (in Gutting, 2003:50), and Scull, who takes the criticism even further by saying that MC rests "on the shakiest of scholarly foundations and riddled with errors of fact and interpretation" (Gutting, 2003:50), Philo (2013) notes that some of the responses to the text are based on the heavily abridged version, which arguably suffered from hefty editing. Furthermore, Philo thinks that the empirical evidence stands up much better than Midelfort, Scull and others claim, based on his own extensive forays into the English and Welsh empirical records.

The work signposts not the individual psychological experience, but rather the spatial relations of the various constructions of madness from the leprosaria of the Middle Ages to the workhouses and specialist asylums of later centuries. A binary opposition is identified between two different and opposing states of human being – 'Reason'[37] and 'Madness', moving on to speak of the 'Reason-Madness nexus' (Philo, 2004). Beaulieu and Fillion (2008:78) argue that the brief title of the unabridged English version, *History of Madness*, could be misleading, with the "unsuspecting reader" thinking that the book "is a history of a particular 'object' called madness", but rather the text "evokes something variously *called* madness, folly, insanity, precisely *not* as an object but as an Other to something else called Reason";[38] an 'other' differently constituted (discursively) by different societies in different times and places. It is this creation of madness that is Foucault's main concern,

[36] Philo (2013:1) explores the changing versions of this book as it becomes translated and shortened, which "in the process [loses] what can be cast as both its phenomenological undertones and a 'romanticism' about the truths supposedly revealed by madness".

[37] 'Reason', with a capitalized 'R', here understood as a highly important conceptualization of the supposedly fundamental qualities of possessing reason, being reasonable and acting reasonably: defining characteristics of 'civilised' humanity, apparently, as initially codified by the philosophers of Ancient Greece and subsequently refined through to the bold statements/presentations of the European Enlightenment *philosophers* of the 'long-eighteenth century'. The claim is that the specification of Reason always demanded a parallel specification of its 'other': Unreason, also announced with a capital 'U' in Foucault's texts. Unreason included what would become known as 'madness' but also a wider universe of seemingly unreasonable human thought, conduct and individuals. For further explanation, see Philo 2004, Chapter Two and Philo, 2012.

[38] Emphasis in the original quote. From here, all emphasis are in the original unless otherwise stated.

rather than the event of confinement for its own sake. This madness is viewed not as an ahistorical scientific given, but rather profoundly entrenched in and constructed by the economic, political, social, cultural, medical and intellectual configurations as they must have existed at the time (Philo, 2004). Thus, Foucault argues, madness was not created through behavioural or biological fact, but rather was the outcome of various socio-cultural practices, very much linked to the needs and demands of a given culture (McNay, 1994). Consequently, by viewing the construction of madness in this way, Foucault is able to highlight what he believes to be the 'true' nature of modern psychiatry, wherein modern notions of mental illness, and the construction of the asylum, have been unknowingly and subconsciously created out of the Classical (or 'Enlightenment') experience of Madness. This notion echoes other works by Foucault, which are framed as a "critical history of the present" (Foucault, 1977:31), to show how discourses were deployed historically but have then gone on to shape the situation in the present day, often in ways not immediately obvious.

Foucault (1965:*ix*) begins MC by returning to the period in history where madness was an "undifferentiated experience", thus implying that there was originally no division between 'Madness' and 'Reason'; neither singled out nor separated from the other. Rather, the text begins in the Middle Ages, with an account of the exclusion and incarceration of lepers in a network of lazar houses across Europe. These leprosariums were situated on the outskirts of major cities, separate from society, but close enough to be observed. During the Renaissance, however, the figure of the leper vanished from memory and the lazar houses emptied, with the segregated spaces refilled by new bodies causing social anxiety:

> Often in these same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals and 'deranged minds' would take the part played by the leper … With an altogether new meaning and in a very different culture, the forms would remain – essentially that a major form of a rigorous division which is social exclusion but spiritual reintegration. (Foucault, 1965:7)[39]

A result of these practices was the creation of a generalised 'Other' by Western Society. In Medieval times, this was the leper; in Early Modern times it was a collection of human

[39] The extent to which *exactly* the same spaces/structures were recolonised by the mad is actually very limited – the point is more that these ex-urban spaces, just outwith centres of population, were roughly equivalent. Historians object that evidence for such *direct* continuity is absent, hence they dismiss Foucault's overall reasoning; but, if Foucault's claim here is taken more 'symbolically', then it can absolutely be agreed that new 'deviant' populations moved into the same *kind* of sequestered and marginal spaces at a later date (becoming the 'new lepers')

'misfits': "the idle, the beggar, the criminal, the elderly, the sick, the lame, the spendthrift son, the unmarried mother and the lunatic" (Philo, 2004:37-38), who were all gathered together and deposited in 'houses of confinement'. Thus, a new type of social institution appeared, a consequence of the discourses which created the so called 'great confinement' of the seventeenth through to the eighteenth century. At this stage, the mad were combined and confined with other categories deemed responsible for economic and social problems: the unemployed, the poor, the criminal and the idle. This was a group which Foucault underlines as being "strangely mixed and confused" in our eyes, but that in the Classical age[40] would have been viewed as "a clearly articulated perception" (Foucault, 1965:45). It was a "police" response to "an economic crisis that affected the entire Western world: reduction of wages, unemployment, scarcity of coin" (Foucault, 1965:49), and, rather than expelling the vagabonds far from the city walls as was previously the response, they were now confined in houses close to the city boundaries.[41] A gesture of power and control, "the unemployed figure was no longer driven away or punished; he [*sic*][42] was taken in charge, at the expense of the nation but at the cost of his individual liberty" (Foucault, 1965:48). It was not long until this confined population was put to work, with advantage being taken of cheap labour by an increasingly industrialised and capitalist society. Foucault went on to stress: "It was in these places of doomed and despised idleness, in this space invented by a society which had derived an ethical transcendence from the law of work, that madness would appear and soon expand until it had annexed them" (Foucault, 1965:57). Here, he is saying that – notwithstanding the *will* to make these spaces full of labouring souls – in practice some could never work, and hence these spaces, particularly if populated by mad people, did indeed become regarded as problematic sites of idleness. Madness had been confined in the same spaces, expected to follow the same rules of governance that controlled this mixed population, but they singled themselves out "by their inability to work and to follow the rhythms of collective life" (Foucault, 1965:58). Due to their failure to operate in this "*other world*, encircled by the sacred powers of labour" (Foucault, 1965:58), and paralleling the rejection of the mad by the rest of this *other world* for fear of their own sanity, the mad were alienated, turned into a spectacle, now completely detached from reason and 'othered' from the general mass of unreason: "madness had become a

[40] The Classical age covers the time period from 1660 to the end of the nineteenth century, which, for Foucault, covers the period when many of the characteristics and structures of the modern world, such as institutions, were born .

[41] Quickly growing Early Modern cities soon swallowed these houses up, and in time they became city spaces, but ones feared for their physical and moral contaminants.

[42] From here *sic* will not be placed after such gendered terms, in either original (primary source) documents, or in Foucault's texts.

thing to look at: no longer a monster inside oneself, but an animal with strange mechanisms, a bestiality from which man had long since been suppressed" (Foucault, 1965:70).

Foucault tries to make sense of the social and cultural reasons for lumping all these people into a single category, but, as stated by Laing (1992:25), "gradually the mad came to be separated out from this scandalous crew". Foucault initially outlines a metaphorical image of many of the mad being loaded on to the "ships of fools", to highlight their position of being detached and outcast from society, sailing in search of their sanity, and in the process haunting the "imagination of the entire early Renaissance" (Foucault, 1965:9).[43] Thus, 'madness' began to be framed as a cultural figure of major concern, arguably becoming the foremost figure of unreason in literature, theatre and art where "the denunciation of madness (*la folie*) becomes the general form of criticism" (Foucault, 1965:13). It was through these images that madness acquired its place in the "hierarchy of vices" (Foucault, 1965:24), resulting in its spatial separation in society: "madness will no longer proceed from a point within the world to a point beyond, on its strange voyage; it will never again be that fugitive and absolute limit. Behold it moored now, made fast among things and men. Retained and maintained. No longer a ship but a hospital" (Foucault, 1965:35). Its wild otherness was now tamed and incarcerated, brought under the command of Reason.

Over time, and pushed by a changing political economy in Europe, a more scientific and humane method of confinement was developed, with the division and classification of the 'Other' (discussed further in DP). This coincided with the call for the release of the mad from their chains and cages, with the aim of restoring their mental (and physical) health. Foucault believes that this understanding is the mythic history of a progressive humanisation of the treatment of the insane, illustrated through the famous images of Pinel's freeing of the insane at Bicêtre and the 'liberation' of patients at the idyllic York Retreat,[44] to be 'released' from prisons ('general confinement') and taken to hospitals (asylums), the latter becoming a form of 'special confinement'. However, these images, asserts Foucault, hide "beneath the myths themselves … an operation, or rather a series of operations, which silently organised the world of the asylum, the methods of cure, and at the same time the concrete experience of madness" (Foucault, 1965:243). The mad were

[43] Again, historians became too hung up on whether these 'ships' were real, which essentially does not matter. They were pictured as 'real', a part of an emerging thought-system regarding what to do with the mad/unreasonable.

[44] The York Retreat, opened in the 1790s, with 'old' William Tuke at its helm.

now subjected to subtle control and coercion, still segregated from society, but now manipulated and managed through fear: "here fear is addressed to the invalid directly, not by instruments but in speech;[45] there is no question of limiting a liberty that rages beyond its bounds, but of marking out and glorifying a region of simple responsibility where any manifestation of madness will be linked to punishment" (Foucault, 1965:246). The patient had to learn not to manifest their madness, but to control their body, mind and actions. They had to take responsibility for their illness, and were taught to be/act 'sane' and feel guilt if they disturbed morality and society, which therefore did not amount to effecting a 'cure'. This was achieved through intricate institutional arrangements, a hierarchy of relations (with the patient at the bottom) and therapeutic interventions (Dreyfus and Rabinow, 1983) (developed further in PP). Thus, according to Foucault (1965:234), the liberation of the insane and the abolition of constraint were justifications hiding deep but nuanced forms of control:

> Tuke created an asylum where he substituted for the free terror of madness the stifling anguish of responsibility … Tuke now transferred the age-old terrors in which the insane had been trapped to the very heart of madness. The asylum no longer punished the madman's guilt, it is true; but it did more, it organised that guilt; it organised it for the madman as a consciousness of himself.

Once the patient had learnt 'self-restraint' and the internalisation of guilt, alongside realisation of their own madness, they would be on the path to regaining their sanity and restoring their reason (although this was not straightforwardly a 'cure' in the medical sense).

Order was maintained in the asylum not through overt repression, but through authority; reason now controlled madness through observation and language, and thus "the absence of constraint[46] in the nineteenth-century asylum is not unreason liberated, but madness long since mastered" (Foucault, 1965:252). Foucault believes that this mastery was asserted through a system of immediate punishment set within a *milieux* of religion, education and work. Treated as a child, with importance placed on the 'family model', the madperson was delivered "as a psychological subject, to the authority and prestige of the man of reason, who assumed for him the concrete figure of an adult, in other words, both domination and destination" (Foucault, 1965:253). Through these techniques, the mad

[45] But *not* a (proto-psychoanalytic) 'talking cure'; more a series of commands, injunctions and bribes.

[46] This refers specifically to the physical restraint of locks, chains and straitjackets.

person was to be subjected to values closely associated with normality, with these values being all the more effective due to being relatively invisible.

In both the Tuke's Retreat and Pinel's Bicêtre, the physician was to take on great significance, fostering "a new relation between insanity and medical thought" (Foucault, 1965:269). Through regulating the movement of bodies through the asylum door, as well as medicalising the internal space, the physician was to become the 'essential figure' in the institution (outlined further in PP). However, at this stage, the power was bestowed on the physician precisely *not* because of his scientific knowledge but because he was a 'wise man' (always a man), to help in the moral transformation and thus the 'cure' of the insane. Therefore, Tuke and Pinel brought 'medical' knowledge into the asylum, but:

> … they did not introduce science, but a personality, whose powers borrowed from science only their disguise, or at most their justification. These powers, by their nature, were of a moral and social order; they took root in the madman's minority status, in the insanity of his person, not of his mind. If the medical personage could isolate madness, it was not because he knew it, but because he mastered it. (Foucault, 1965:272)[47]

In fact Tuke did not really even bring in *medical* knowledge; he was very suspicious of the claims of 'medicine', and initially the Retreat only employed a visiting physician (mainly treating the obvious physical ailments of patients). Hence, there is an absurdity that Tuke is often claimed as effecting a crucial *medical* shift in the history of mental health care. Rather, the point is that Tuke, Pinel and others (some medical, others not) created a 'space' – the authorisation father-figure exerting soft-disciplinary control over child-like patients – that was subsequently inhabited by doctors, psychiatrists, psychoanalysists, and so forth.[48]

Foucault's analysis of the history of madness hence transcends the simple 'progressivist' history where conditions for the insane gradually improve. Rather, the narrative is inverted. Although environmental surroundings and their everyday plight improved, this was at the expense of an ever-deepening 'silence' about the content of their *real* madness (which was in effect denied, repressed, forced to speak in the language of medicine, psychiatry and then psychoanalysis, not its own language). The problematic deeper narrative of MC and HM is hence of the insane being increasingly moderated, controlled, silenced and mastered

[47] The charisma of the asylum superintendent as father figure is key. It is a 'resource' later colonised by psychiatric and (especially) psychoanalytic doctor-patient relations.

[48] The origins of the Freudian father-therapist are traced to here.

(Philo, 2013), with the spaces *between* madness and reason, and spaces actively created for the treatment of madness, being elemental to the narrative.

***Discipline and Punish***

The relationship between knowledge and power is expanded in DP, this time through an analysis of the alterations and developments in the European carceral system, from the sixteenth through to the nineteenth centuries, highlighting the changing relationships between methods of punishment and the human body. Similarly to HF/MC, this text is framed as a "critical history of the present" (Foucault, 1977:31), which illustrates how knowledge and power were mechanisms of control both historically within the prison, but also exuded in other institutional settings (hospitals, asylums, schools, etc). Therefore, this book is less a history of punishment (although written in a specifically historical narrative) and more a structural analysis of power, or even more specifically, discipline, by looking at changes in the systematic use of power and authority in society. Paralleling discussions about the body that were to emerge in PP, Foucault frames these power relations as a genealogical study: "the body – and everything that touches it: diet, climate, and soil – is the domain of the *Herkunft* [genealogy]" (Flynn 2003:35), themes which become more apparent in his later studies on 'biopower'. Yet, Foucault moves away from the more specifically Marxist understandings of 'power' as the property of particular classes or individuals who have power which they can use at their own will, and, more broadly, he distanced his account from 'repressive' notions of power. Foucault's power is a far more complex and verbose entity, as it refers to the various forms of domination and subordination that occur whenever and wherever social relations exist (Garland, 1987). In DP*,* this imposition of more abstract power relations can be seen through the practice of punishment on the body, moving from the dismembering of the body through public execution, to more 'modern' versions of power in the on-going development of the carceral system (Flynn, 1994), specifically through the careful control of the individual by the division of both space and time:

> The prison seizes the body of the inmate, exercising it, training it, organising its time and movement in order ultimately to transform the soul, the seat of the habits. It takes hold of the individual, manipulating him and moulding him in a behaviouristic mode, rather than just attempting to influence his moral thinking from the outside. (Garland, 1987:857)

The process was a movement from so-called 'sovereign power' to 'disciplinary power' (which was to be revisited again in PP):

> The high wall, no longer the wall that surrounds and protects, no longer the wall that stands for power and wealth, but the meticulously sealed wall,[49] uncrossable in either direction, closed in upon the now mysterious work of punishment, will become, near at hand, sometimes even at the very centre of the cities of the nineteenth century, the monotonous figure, at once material and symbolic, of the power to punish. (Foucault, 1977:116)

Yet, Foucault believed the true aim of the reform movement was not so much to establish a new right to punish based on more objective principles, but to set up a new 'economy' of the power to punish, a new strategy for the rearrangement of the power to punish, "down to the finest grain of the social body" (Foucault, 1977:80). The power to judge would move away from property relations, the "innumerable, discontinuous, [and] sometimes contradictory privileges" (Foucault, 1977:81) of sovereignty as occurred in the early modern period, towards the continuously distributed effects of public power, resulting in both political and economic savings. Not, therefore, the eighteenth-century thinker's dream of a 'theatre of punishment' (involving a diverse repertoire of suitable public punishments using signs and coded sets of representation), but rather a new 'politics of the body' controlled by a great system of institutions (Driver, 1985).

Despite the early reformer's vision of using punishment as a "procedure for requalifying individuals as … juridical subjects" (Foucault, 1977:31) remaining within a public setting – a kind of interim phase or option between the older 'sovereign power' and the newer 'disciplinary power' – it was the project for a prison institution that was brought forward through (Western) history as the accepted method of punishment. Similarly to claims in HF/MC, this method was viewed as a technique for the coercion of individuals, administrated by training the *body* (and thus gaining access to the soul/mind) through manipulating habits, behaviour and power within a presupposed institutional setting (Foucault, 1977:131). As Foucault describes it, "a question not of treating the body, *en masse*, 'wholesale', as if it were an indissociable unity, but of working it 'retail', individually … an infinitesimal power over the active body" (Foucault, 1977:137). Foucault frequently insists that this power is not to be viewed cynically, however, and it is for this reason that the central three sections of DP move away from the historical narrative of the birth of the prison towards a more structural framing of the diverse techniques and principles of disciplinary power. By 'freezing' the frame, Foucault picks out the various elements (and patterns between them) within an 'ensemble' of power, through the examination of various forms of institutional space arising in the nineteenth century (such

[49] And, increasingly, executions would be behind these walls, not public, spectacular occasions.

as schools, hospitals, youth reformatories and asylums), and explicitly dedicated to *creative* uses of control (Driver, 1995):

> Do not concentrate the study of the punitive mechanisms on their 'repressive' effects alone, on their 'punishment' aspects alone, but situate them in a whole series of their possible positive effects, even if these seem marginal at first sight. As a consequence, regard punishment as a complex social function. (Foucault, 1977:23, the first of the study's four 'general rules')

These other forms of corrective and educational establishments highlighted the more subtle application of the remedial and improving social ordering of space in the nineteenth century, circulating in and through what Foucault terms the 'disciplinary techniques'. These techniques, which can be understood as a more 'soft-disciplinary' approach to power (Beel, 2011), rely on the notion of 'docility', "[joining] the analysable body to the manipulable body" (Foucault, 1977:136), and thus creating 'docile bodies' (a chapter within DP) "which may be subjected, used, transformed and improved" (Foucault, 1977:136). The other institutions were explored to enable a diagram of these disciplinary techniques reduced to their ideal forms. This allowed logic and operating principles, and their relation to time and space, to be uncovered, rather than simply focusing on the history of a specific institution's development and use. For example, in the school setting, the educational space was allowed to function as a 'learning machine', but also as a machine for supervising, hierarchising and rewarding, creating both real, complex, functional, architectural and ideal spaces for the arrangements of characterisation and assessment. Foucault (1977:170) duly argues that 'docility' occurs through shaping practices, creating a normalising discourse, resulting in submissive, obedient, and useful individuals:

> Discipline makes individuals; it is the specific technique of a power that regards individuals both as objects and as instruments of its exercise. It is not a triumphant power, which because of its own excess can pride itself on it omnipotence; it is modest, suspicious power, which functions as a calculated, but permanent economy ... the success of disciplinary power derives no doubt from the use of simple instruments; hierarchical observation, normalising judgement and their combination in a procedure that is specific to it, the examination.

Along with surveillance, modern disciplinary society used the strategies of 'normalisation'[50] as one of its great instruments of power. The judges of normality come to include the social worker, the teacher and the doctor, everywhere assessing and diagnosing every individual in their care according to a normalising set of assumptions, extending, in

[50] This is a key theme of the *Abnormal* lectures that came the year after PP.

Foucault's words, the "carceral 'mechanisms' … intended to alleviate pain, to cure, to comfort – but which all tend, like the prison, to exercise a power of normalisation" (Foucault, 1977:308). As later suggested in PP, modern Western society came to behave not through overt repression but through a set of standards and values associated with normality, all initiated by a network of supposed beneficent and scientific forms of knowledge and environments (McNay, 1994). This notion of power echoes Foucault's previous quote (Foucault, 1977:23), which asks for power to be thought of not as a repressive force, but rather as a positive or 'productive' phenomenon.

Ultimately, there can be seen a gradual development of the techniques of surveillance and normalisation, which were considerably more complex and subtle than the early modern spectacular public displays of force. As has been widely documented, Foucault turns to Bentham's Panopticon[51] design from the late-1700s as being the ultimate architectural technique for surveillance and normalisation – the epitome of power-knowledge principles – which he believes fully embraced the above ideas for creating 'docile bodies' and developing 'disciplinary techniques' (see Figure 3.1). Not presented as a reflection of the reality of institutional life, its image is used more as a paradigm, a model, in which many of the disciplinary practices outlined previously could be concentrated. Foucault supposes Bentham to have envisaged a "simple idea in architecture" to achieve a "new mode of obtaining power of mind over mind" (Foucault, 1977:206). Of particular importance was his hope of creating an organisation of space that ensured the *possibility* of inmates being *continually* inspected, by creating the *illusion* of being continually inspected (Philo, 1989). The design ensured that surveillance relied only on architecture and geometry for control: a repressive yet simultaneously 'productive' system based on the principle of permanent perceived observation, giving all knowledge and power to the central authorities. The inmates were forced into controlling themselves, over time turning the external eye in the inspection tower inwards, replacing it with the internal eye of conscience (Sharp *et al*, 2000). Again similar to the methods of control outlined in HF/MC, this was a crucial shift from external material arrangements to internal 'psychological' processes, and in effect, was precisely a form of 'affective engineering' (see below):

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[51] Jeremy Bentham was an eighteenth-century English philosopher and social theorist. The idea for the Panopticon was delivered in a series of 'letters' written in 1787, titled: *Panopticon; or the inspection-house: containing the idea of a new principle of construction applicable to any sort of establishment, in which persons of any description are to be kept under inspection; and in particular to penitentiary-houses, prisons, houses of industry, work-houses, poor-houses, lazarettos, manufactories, hospitals, mad-houses, and schools: with a plan of management adapted to the principle: in a series of letters, written in the year 1878, from Crechieff in White Russia, to a friend in England.*

> Power no longer needs to unleash its sanctions, and instead its objects take it upon themselves to behave in the desired manner. Any remnant of physical repression is thus gradually replaced by a gentle but effective structure of domination. (Garland, 1987:860)

Foucault argues that this panoptic schema would spread throughout society's major institutions, and eventually throughout the whole social body, thanks to the mechanisms of 'panopticism'. Foucault's emphasis is very much on the disciplinary techniques themselves, rather than on the different ways in which they were actually diffused and resisted in later-eighteenth and nineteenth-century society (Driver, 1995), and he does not suppose 'panopticism' to be conceptually reducible to the workings of the Panopticon. Therefore, although Bentham's Panopticon *per se* gained little support amongst his contemporaries, its principles were embodied within other projects of moral regulation and the creation of docile bodies. It was this theoretical reflection on the relations of power within architecture, society and the body that Foucault elaborates in the latter section of DP:

> Foucault deploys the term 'panopticism' to capture not only the role of institutional plans and architectures, but also the nature of many other 'disciplinary techniques' (derived from the spheres of schooling, military training, accountancy, and so on), through which human subjects were converted into responsible 'docile bodies' whose labours would serve to 'strengthen social forces'. (Philo, 1989:264)

Foucault wants to show that those disciplinary techniques modelled on the Panopticon were evident not only within the prison, but also in other emergent institutional regimes, such as the school, the factory, the army, the hospital, the asylum and so forth, all forming part of the "carceral archipelago" (Foucault, 1977:297).

Consequently, this led the argument towards an account of the Mettray reformatory, a French agricultural colony for juvenile delinquents (see Figure 3.2). Foucault (1977:293) himself poses the crucial question; "Why Mettray?": "Because it is the disciplinary form at its most extreme, the model in which are concentrated all the coercive technologies of behaviour. In it were to be found 'cloister, prison, school, regiment'". Similarly to the Panopticon, Mettray was a model institution in a sense, but the fundamental difference was that, whereas the former was dismissed by many contemporaries as a speculative fantasy, the latter was an architectural reality, established as a working reformatory in France for more than fifty years. Contemporaries often described the colony as an exemplar of the principles of the reformatory discipline, a model that had a substantial influence upon social reformers, both inside and outside France. Indeed, a visit to Mettray was likened to a

pilgrimage to Mecca (Driver, 1995). For Foucault, the opening of Mettray marked a new era in the techniques of modern disciplinary power. It encompassed all of the disciplinary techniques explored throughout DP, culminating in Foucault's theories about power, knowledge, discipline, surveillance and the creation of 'docile bodies' in one specific institution.

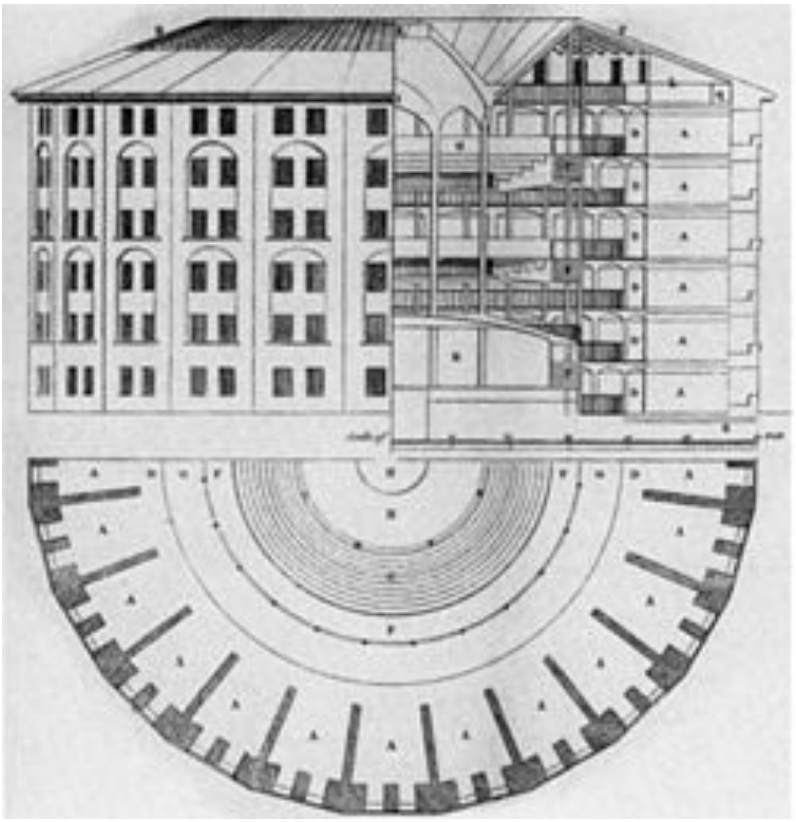

Figure 3.1 – Bentham's Panopticon (Bentham, 1843:172-173)

Figure 3.2 – Mettray agricultural colony (http://massthink.wordpress.com/page/5/). The individual buildings where each 'family' was house are clearly visible. Unlike Bentham's Panopticon, Mettray was designed with no high outer wall to contain the prisoners. Its emphasis was very much more along the moral line of reform rather than punishment, yet still enforcing discipline upon the inmates.

The colony was aimed at reforming delinquents, rather than just punishing crime, through a programme of moral and industrial training, designed primarily to instil a sense of self-discipline among the colonists. The main technique was the establishment of a 'family system', by which the boys were split up into separate 'families'. Each 'family' was placed under the charge of two 'elder brothers' and a family head. They were each given a distinctive colour and emblem, and occupied separate houses. Detailed progress reports were kept for each house, all being ranked according to the standard of their conduct in 'tables of honour' and displayed for all to see (Driver, 1995). This encouraged friendly competition between families, creating loyalty within each unit that consequently resulted in a form of decentralisation and mutual surveillance.

> By emulating the moral disciplines of family life, by exploiting the reformatory power of agricultural labour, and by designing the colony in the form of a 'well arranged village', the founders of Mettray hoped to turn the moral disciplines of nature itself into strategies of normalisation. (Driver, 1995:125)

These features: the 'villa'-like design, agricultural labour and rural setting, are all characteristics that will be revisited with reference to the Scottish district asylums.

The design and routines of Mettray could ostensibly not be further away from those of the Panopticon, yet the rationale was the same; discipline, exercise and constant surveillance – in Mettray by the 'forest of gazes' comprised of other inmates (Philo, 2012). Despite the very different architectural make-up and organisation of space in the two institutions, Foucault's principles of 'panopticism' were embodied in both. As Driver (1985:434) highlights, "the Panopticon was a particular mechanism, an abstract figure, and the disciplines on which it was based would appear in different guises in different contexts". Therefore, Mettray was used as one example, one guise, of how very similar methods and goals of 'panopticism' could be achieved through very different types of institution. But, Foucault goes on to develop, extend and critique the architecture of DP, and his understandings of disciplinary power, institutions, discourses and knowledge in his later work on psychiatric power, which is of inestimable importance to the theoretical underpinnings of this thesis.

***Psychiatric Power***

Following on from, and going beyond, the ideas developed in HF/MC and providing a segue into his later genealogies, particularly DP (which he had all but written *before* giving the PP lectures and was in fact based on materials from the two lecture series prior to PP),

PP was one year's component of the lecture series given by Foucault at the College de France from January 1971 until his death in 1984.[52] Foucault recognised the inadequacy of existing notions of power, and opens the PP lectures with dissatisfaction at his own conception of power, going on effectively to re-read themes from HF/MC through the lens of DP. This critique of his previous analysis of asylum power is twofold. Firstly, he states that the emphasis placed on the "perception of madness" (Foucault, 2006:13), rather than beginning from an apparatus of power itself (which he does in PP), was flawed; and secondly, the notions of violence, institutions and the family are dismissed as "rusty locks with which we cannot get very far" (Foucault, 2006:14) (although PP is *also* about 'institutions' and 'families', albeit through new(ish) levers). Despite a move towards more humane methods of treatment and control, Foucault asserts that violence still permeated the modern asylum. This notion of violence was embedded within power relations; all power was physical, allowing a connection to, and control over, the body. This can even be seen as a critique of certain claims in DP, which seem to imply an abrupt end to violence in new disciplinary forms of power. Rather, Foucault sees 'violence' continuing, in which regard he anticipates the later blurring of 'sovereign' and 'disciplinary power' (both effectively reworked by 'biopower') which occurs in the "*Society must be Defended*" lecture series (1975-76) onwards. Thus, arguably, Pinel's reforms outlined in HF/MC could not be labelled as humanism, as his whole practice was still infused with violence, "a meticulous, calculated power, the tactics and strategies of which are absolutely definite" (Foucault, 2006:14).

Continuing his critique, Foucault outlines his dissatisfaction at his previous notion of the institution; rather than concentrating on the regularity and rules of the institution, as was central in DP, focus should be centred instead on the *imbalances* of power within the asylum space.

> What is important … is not institutional regularities, but much more the practical dispositions of power, the characteristic networks, currents, relays, points of support, and differences of potential that characterise a form of power, which are … constitutive of, precisely, both the individual and the group. (Foucault, 2006:15)[53]

These power imbalances effectively distort the regularity of the institution and, consequently, according to Foucault, make it function. In other words, individuals, groups,

[52] Translated and published in 2006, this particular series was given between 7th November 1973 and 6th February 1974.

[53] Here, Foucault is very clearly deploying the vocabulary of DP.

communities and institutions appear as a result of these networks of power. The last of Foucault's discontents with his previous work was the notion of the family. In HF/MC, Foucault outlined that the control of mad people was through moral treatment, thus making them into 'children', to be treated kindly, respected and rewarded in return for good behaviour. The Tukean family model, outlined in HF/MC, and to an extent developed in DP through the Mettray example, becomes problematic for Foucault in PP, as it is a form of sovereign power, rooted in the specific 'sovereign' figure of the asylum father-figure, that he believed was diminishing by the late-1700s in Western Europe, being replaced with disciplinary power. In practice, though, this emphasis upon the medical superintendent remains (and indeed is centralised through PP), but arguably less in terms of the symbolic power wielded and more in terms of the everyday supervisory power over asylum space (Philo, 2007). The general emphasis within PP is therefore based around the question and construction of power in the asylum during the nineteenth century, and his analysis of its techniques and technologies. It looks at how the deployment of power, through its tactics and strategies, can result in assertions, negations, experiments, and theories; what Foucault refers to as a "game of truth" (Foucault, 2006:13).[54]

Expanding on the concept of power in the asylum, Foucault (2006:2) highlights that there was a need for a "certain degree of order, a degree [of] discipline, and regularity, reaching inside the body", which was necessary for two reasons. It was essential in the establishment of medical knowledge, with this discipline and order allowing exact observation, a condition of the medical gaze on the body, which was to become important with the development of an increasingly (re)medicalised understanding of madness.[55] Moreover, this disciplinary order was essential for permanent 'cure' (albeit in a limited sense of 'cure'), with the transformation from illness to health only possible "within this regulated distribution of power" (Foucault, 2006:3). Thus, building on the idea outlined in HF/MC regarding the significance of the physician, the disciplinary order which covers the entire space of the asylum becomes attached to a single authority, with unlimited control,[56] who holds power which is less sanctioned by medical knowledge (which is unsure, barely

[54] This is then a key notion through his later lecture series – he becomes increasingly concerned with how 'truth' is made and disputed.

[55] To an extent, there has been a 'medicalised' understanding of madness ever since Ancient times – and there were various attempts to create a nerves-based account of mental diseases in the 1700s (for example Batty at St. Luke's) – and seen thus, the 'moral' experiment of the Tukes and Pinel, and the great influence on national asylum policies for some of the nineteenth century, is arguably something of a 'blip'.

[56] This was not strictly true, of course, and medical superintendents *were* inspected (by, for example, the Lunacy Commissioners): arguably, Foucault overplays the control of the superintendent.

credible) and more by a prosaic everydayness of simply ruling over countless 'scenes' of disorder in the asylum. This relationship between the physician and the patient is outlined as "a play of two *wills* where the fundamentally unequal contexts and contours of the struggle involved almost always end up favouring the former over the latter" (Philo, 2007:151). Yet, Foucault recognises that this was not the only power exercised in the asylum, and, furthermore, perhaps contradictorily, that power cannot be attached to someone or some group. Similarly, as introduced above, it is not the regularity of the institutional space that makes it powerful. Rather, power works through practical dispositions; through "dispersion, relays, networks, reciprocal supports, differences of potential, discrepancies, etc." (Foucault, 2006:4). It is only within these systems of differences that power can function, and it is these systems that must be analysed. Set within a hierarchical structure of physicians, supervisors, servants and patients, they distort the general regulative system operating within the asylum. Each individual occupies a distinct place and role, creating tactical arrangements that consequently allow the power to be implemented. Additionally, these complex tactical arrangements operate through observation, "which ensures the objectivity and truth of psychiatric discourse" (Foucault, 2006:6). All of these arrangements play out in what Foucault refers to as a "battlefield", and have the sole purpose of bringing the mad person under control. The tactics in this battle were the subversion of the force of madness, through therapeutic action, both medical and moral, with the victory being the doctor's will over the patient's will.

Foucault outlines what he believes to be a profound shift in the type of power exercising its authority over the general population. As explained, in DP this is the unravelling and replacement of 'sovereign power' with what he terms 'disciplinary power', a move from a visible power attached to an individual (the monarch or father, for example) towards a discreet, distributed power, one which functions through networks "and the visibility of which is only found in the obedience and submission of those on whom it is silently exercised" (Foucault, 2006:22). Yet in PP, he starts to break with DP, seeing its limitations, with the slight contradiction being that the 'sovereign' (the asylum superintendent) still remains such a central focus.[57] 'Sovereign power', visible during a post-feudal, pre-industrial era, was often implemented through violence: dungeons, chains, shackles and blows. At the turn of the nineteenth century, sovereign power was clearly giving way to a "microphysics of disciplinary power" (Foucault, 2006:27), "a terrain of

[57] This is a hint at Foucault's later arguments about how 'sovereign' and 'disciplinary' power end up fusing, in 'biopower'.

orders, relays and transmissions permeating many different walks of life" (Philo, 2007:152). This disciplinary power has a direct hold on individual bodies, their actions, time, movements, strength and behaviour, with the ability to alter them through control of the mind. It also refers to a final, or optimum, state: "it looks forward to the future, towards the moment when it will keep going by itself and only a virtual supervision will be required, when discipline will have become habit" (Foucault, 2006:47), as at Mettray, which was without walls and the obvious omniscient 'eye'. This state is secured through the threat of punishment, miniscule punishment as well as a continuous punitive pressure. Thus, disciplinary power is not a punishment in response to damage or offence, but must influence and anticipate potential behaviour, spotting and stopping an action before it has even occurred, controlling the body, the action and the discourse (a key claim of the *Abnormal* lectures (1974-75)).

Similarly to DP, where Foucault recognises the Panopticon as being an important model of disciplinary power due to its ability to see everything and everyone all the time, and its ability to work by itself, the model is also explicitly mentioned on a few occasions in PP. In DP, Foucault emphasises that the person in charge of the disciplinary system is recognised as a function, hence the Panopticon could be operated by no one person in particular and as such is in direct contrast to the individualisation of sovereignty. But, there is a tension here with claims in PP, where at times the particular individual who runs the asylum seems still to matter (although there is sometimes also the sense of the asylum superintendent as simply an empty if decisive 'function'). Foucault recognises that Bentham refers to the model as a "mechanism", giving strength to the power that operates within the institutional space: "the Panopticon is a multiplier; it is an intensifier of power within a series of institutions. It involves giving the greatest intensity, the best distribution, and the most accurate focus to the force of power" (Foucault, 2006:79). Bentham recognises the capacity of the Panopticon model to give Herculean strength to *any* institution and the person who directs the power, as well as its potential to obtain the power of mind over mind. Foucault concurs that these intentions are both typical of the Panopticon mechanism and of the general disciplinary form, and adds that this Herculean strength, which ultimately is a physical force, impacts on the body, weighing down on the body, thus affecting the mind. Each of the bodies caught within this mechanism occupies a specific space; ideally, the power created by the mechanism, which is a complete power

over everyone, will only ever be directed at specific bodies, as a way to get at/into specific bodies.[58]

Having established the background to what he believes to be the formation of disciplinary power in the asylum, Foucault then moves on to discuss how the asylum works. He recognises the difficult, problematic, yet privileged relationship that it has with the family, and also the use of the asylum as a disciplinary system, a site for the creation of a certain kind of discourse of truth, whereby 'psychiatry' is produced *by* the asylum, far more than it produces the asylum.[59] Both of these concepts are entwined, mutually supportive of each other, "and will finally give rise to a psychiatric discourse which will present itself as a discourse of truth in which the family – family figures and family processes – is its fundamental object, target, and field of reference" (Foucault, 2006:94). Initially, though, the mad person is detached from the family field and thus family power, placed within the confines of the "State-medical field",[60] which combines "psychiatric knowledge and power with administrative investigation and power" (Foucault, 2006:96).[61] This move officially labels the mad person as mad. It must involve complete separation, as any contact with the family would be viewed as disruptive and dangerous. The transfer from family space to asylum space was believed to be crucial in curing the mad individual in the first half of the nineteenth century, as will be revisited in the later empirical chapters of this thesis. Fundamentally, it was the asylum space that was reckoned central to producing the cure:

> The architectural arrangement itself, the organization of space, the way individuals are distributed in this space, the way one looks or is looked at within it, all has therapeutic value in itself. In the psychiatry of this period the hospital is the curing machine. (Foucault, 2006:101)

It is here that Foucault moves to outlining the panoptic features in the asylum system, and it was these features that he believes held the assumed ability to cure (again, though, the restricted sense of 'cure'). By encompassing the panoptic mechanism, the asylum had the ability to exercise power, "for inducing, distributing, and applying power" (Foucault, 2006:102). The mad person, through the use of architecture and asylum staff, must always

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[58] As stated in the account of DP above, Foucault saw the Panopticon as an 'ideal type' example, rather than verbatim how it worked in reality.

[59] This reverses a certain discursive/representational 'determinism' in HF/MC.

[60] This anticipates Foucault's later attention to the *state*, which is rather absent in earlier writings.

[61] This intriguing reference to the state both anticipates Foucault's later interest in the role of the state in biopower (biopolitics) and also speaks to the empirical fact of the nineteenth century witnessing the state (the public sector) becoming *the* prime provider of asylum 'care' (although many asylums did remain non-state institutions: eg. Scotland's 'royal' asylums).

be watched, always be seen, through being open to permanent inspection and uninterrupted observation.

By the later-nineteenth century, the regime increasingly incorporated specifically *medical* organisational patient classifications, but again Foucault (2006:181) recognises this as "quite simply the extension of the asylum regime, the regime of discipline". As such, it was not implemented to ensure the development of nosographies or etiologies of mental diseases, or, similarly, the classification of patients within the asylum spaces, which was not, at this time, divided along types of illness; rather it was between the curable and incurable; the restless and calm; the obedient and disruptive; those who were fit to work and those who were idle: "this is the distribution that effectively measured out the intra-asylum space, and not the nosographic frameworks being constructed in theoretical treatises" (Foucault, 2006:180). This again reveals that 'psychiatry' as (medical) knowledge was a pseudo-science (with scant bearing 'on the ground'). Any medication that was distributed, Foucault recognises as a part of the disciplinary regime.

For power to function successfully, the asylum had to be completely cut off from society but also mirror everyday life as much as possible, in order to replace madness with non-madness, which explains the need for the constant desire to create a 'home-like' environment or atmosphere. The goal was creating a convincing (affectively engineered) 'reality' with which to counter the mad person's erroneous impressions. Psychiatric power was, therefore, a regime; a mastery that brought madness under complete control. This direction aimed to authorise the power exercised within the asylum as being the power of reality: "thus you find both the principle that the asylum must function as a closed milieu, absolutely independent of pressures like those exerted by the family – an absolute power therefore – and, at the same time, the principle that this asylum, in itself, entirely cut off, must be the reproduction of reality itself" (Foucault, 2006:175). Within the asylum space, the doctor is able to manipulate reality in order to bring 'truth' to the erroneous judgement of the mad. Thus, the psychiatrist becomes the master of reality, raising a bigger issue about what kind of 'reality' is created by an asylum scene. He must give reality the force to be able to take over the madness, making it disappear by entirely penetrating it: "the psychiatrist is someone who – and this is what defines his task – must ensure that reality has the supplement of power necessary for it to impose itself on madness and, conversely, he is someone who must remove from madness its power to avoid reality" (Foucault, 2006:132). Psychiatry and the psychiatrist become powerful because they claim to know the truth, the scientific truth, of madness (at least, they create the impression of knowing

such a 'truth', but really this is a cipher, an empty space), and also because they have mastered the power of the asylum space. Therefore, psychiatric power's fundamental function "is to be an effective agent of reality, a sort of intensifier of reality to madness" (Foucault, 2006:143).

So obviously the doctor's purpose in the asylum was not specifically for his medical, psychiatric knowledge, but rather it was purely the physical presence of a medical person within the asylum that was important, the incorporation of the asylum space and the psychiatrist's body: "the asylum is the psychiatrist's body, extended to the point that his power is exerted as if every part of the asylum is a part of his own body, controlled by his own nerves" (Foucault, 2006:181). It was through this method – the asylum space functioning as the psychiatrist's body – that the asylum space held the potential to cure. Foucault sees a number of crucial ways in which this transpires. Firstly, the first person or 'body' the new patient encounters, "which is, in a way, the reality through which all the other elements of reality will have to pass" should be the psychiatrist. The patient was thus exposed to the reality of the psychiatrist's body, which would in turn be pressed on the patient as reality. Secondly, through the manipulation of the asylum architecture, it was crucial that the psychiatrist's body appeared to be omnipresent:

> At any moment he must be able to see and make a complete survey of the establishment, patients and personnel; he must see everything and everything must be reported to him: what he does not see himself, he must be informed about by supervisors completely subservient to him, so that he is always present, at every moment, in the asylum. The entire asylum space is covered with his eyes, ears, and actions. (Foucault, 2006:182)

This was achieved through the complete co-operation of the asylum staff, who would operate as an extension of the psychiatrist's body, operating as "the cogs of the machine, the hands, at any rate the instruments, directly under the psychiatrist's control" (Foucault, 2006:182). A game was played, therefore, "between the mad person's subjected body and the psychiatrist's institutionalised body" (Foucault, 2006:189). This game was the microphysics of asylum power, of psychiatric power.

To achieve this, an imbalance of power must be created between the doctor and the patient, with the patient accepting his/her subordination, and the relegation of his/her madness, to the doctor. Some see this occurring through the doctor marking his power through violence or the demand for esteem, or through the doctor's personal qualities (his prestige, presence and aggressiveness, for example), whereas others "see the fundamental imbalance of

power as sufficiently assured by the asylum system itself, its system of surveillance, internal hierarchy, and the arrangement of the buildings, the asylum walls themselves, carrying and defining the network and gradient of power" (Foucault, 2006:148). Foucault suggests it is the latter, the internal mechanisms of the asylum rather than the individual doctor, that are the most effective in therapeutic treatment. The doctor directs his regime through the hospital and thus directs the individual, which, again, is why this is not exactly the personality-driven violence of older 'sovereign power'. Foucault (2006:152) states that "the asylum was thought to be therapeutic because it obliged people to submit to regulation, to a use of time, it forced them to obey orders, to line up, to submit to work". Yet, the doctor is central to the functioning of the asylum, and therefore "the asylum is a curing apparatus in which the doctor's action is part and parcel of the institution, the regulations, and the buildings" (Foucault, 2006:164).[62] It is the combined effect of all the staff and the arrangement of the buildings which act as a single force, a 'total environment', performing different functions but coming together as a collective effort.

Therefore, throughout PP, Foucault outlines how the asylum and the psychiatrist were able to gain power over the patient. The asylum especially was crucial in restoring regular behaviour. It helped discover the truth of the madness by "excluding everything in the patient's milieu that may conceal it, muddle it, give it aberrant forms, as well as sustain it and stimulate it" (Foucault, 2006:339); and it also confronts madness such that, "within it [the asylum], madness, the disturbed will and perverted passion, must come up against a sound will and orthodox passions" (Foucault, 2006:339). This healthy will belonged to the doctor, and, if conducted properly, through the use of the disciplinary and medical regime, the fight in the "battlefield" of the asylum space should result in victory for the healthy will and the surrender of the disturbed will. Within the asylum space, then, there was "a process of opposition, struggle and domination" (Foucault, 2006:339). This process was clearly a question of power: "mastering the madman's power; neutralizing external powers that may be exerted on him; establishing a power of therapy and training" (Foucault, 2006:344). The institutional site was a mechanism for these power relations, and conversely, the power relations conditioned how the asylum institution functioned.

Through HF/MC, DP and PP, Foucault demonstrates the development of the Western system of disciplinary power, and by exploring the texts in order, his shifting

[62] There is tension here, as the medical superintendent matters, then he does not, then he does again, which highlights an instability in Foucault's *own* account. But, the hesitant, developmental character of Foucault's lectures must always be remembered – they reveal his thoughts 'in process' (see Philo, 2012).

interpretations and developments of thoughts are revealed. He concludes by stating the changes he has uncovered and unravelled:

> … at the centre of the city … there is, not the 'centre of power', not a network of forces, but a multiple network of diverse elements – walls, space, institutions, rules, discourse; that the model of the carceral city is not, therefore, the body of the king, with the powers that emanate from it, nor the contractual meeting of wills from which a body that was both individual and collective was born, but a strategic distribution of elements of different natures and levels (Foucault, 1977:307).

Arguably, Foucault leaves open the possibility for considering different 'elements' to his more geometrical[63] vision in PP [via DP]: which is then the clarion call for considering more substantive-environmental features enrolled in this new psychiatric power. Foucault emphasises that power took on many forms, demonstrating that discipline and power had undergone a fundamental historical transformation; a move away from the repressive power of the sovereign, to the more generalised surveillance of society as a whole. Yet, in the case of the asylum, Foucault still retained some significance for the role of the psychiatrist as sovereign figure, whose power was now effected through intricate power relations between individuals. The management of the inhabitants of the asylum was attempted through both direct forms of institutional power, and more subtle disciplinary techniques, including through engineering both institutional architecture and affective atmospheres: designing spaces capable of manipulating, controlling and 'curing' patients' behaviours, but also creating caring, 'home-like' environments and seemingly 'real' settings for their residence. This was achieved through careful site selection, planning of the architectural arrangements of the asylum buildings, and the attempt to create particular curative/caring environments and atmospheres in and around the institutions. There was, therefore, a need to create not just a 'geometry' but also an 'environment' – of internal and even external places, sites, objects, assemblages – conducive to this goal, through engineering affective spaces within the institution.

## GEOGRAPHIES AND AFFECT: NON-REPRESENTATIONAL THEORY AND THE ASYLUM

A criticism of the work of Foucault explored above, according to Thrift, is that, although the practices which Foucault investigates "comes charged with affect, sometimes of the most extreme kind" (Thrift, 2007:54), affect is not overtly discussed within his works.

[63] Meaning here a detailed attention to the precise 'geometry' of asylum spatial arrangements.

Thrift draws upon a number of reasons to explain this omission, citing emphasis on both power and discourse (as shown above), but argues that affect and emotion can also be read from his texts. Thus, moving the exploration of the work of Foucault forward, this chapter will now turn to the concept of affect, and the notion that those responsible for founding, shaping and managing the asylums (from at least the eighteenth-century onwards) aimed to control and manipulate the behaviour and emotions of the patients through engineering affective atmospheres within and around the institutional spaces.

Recently, there has been a turn in geography and across the social sciences towards the study of affect (see Pile, 2010; Thien, 2005; Thrift, 2004). This expanding affective turn[64] has occurred as a response to an apparent absence of emotions within academic research and practice; an attempt to comprehend how the world is negotiated by feelings, forces and drives. This takes "geographical knowledges … beyond their more usual visual, textual and linguistic domains", towards understanding emotions "as ways of knowing, being and doing in the broadest sense" (Anderson and Smith, 2001:8). The study of affect is connected to emotions, with ontological distinctions commonly drawn between the two terms. The latter refers to the emotions that individual humans feel, perceiving in a perhaps corporeally bio-physical sense (a 'sinking feeling', a 'light head') but certainly as an altered state-of-being in the world (happy, sad, elated, depressed, angry, resigned), which arguably becomes cognitive and can usually be self-consciously identified, named and talked about (even if the words inadequately represent the sensations and perceptions). More complexly, affect denotes the prior force that impels the emotions or, more generally, impels a response in an 'other' thing; usually conceived of a human having an emotional response, but it could be an animal instinctively running away or even a paper turning yellow (Lorimer, 2008; Wetherall, 2012), a response, according to Pile (2010), regarded as non/pre-cognitive on the part of the responding thing. Affect is the 'material' connection – that which moves, travels, resonates, chimes across from one 'thing' or body to 'another', travelling between entities or bodies – which can encompass "things, people, ideas, sensations, relations, activities, ambitions, institutions, and any other number of other things, including other affects" (Sedgwick, 1993:19, in Thrift, 2004:61). Thus, affect can be defined as a material 'force' impelling changes, responses, re-actions and emotions,[65]

[64] The study of affect largely sits within an umbrella of work known as non-representational theory, although emotional, psychoanalytic, feminist and some other sub-areas of geography who speak of 'affect' do not necessarily fit so easily under the 'non-representational' heading.

[65] Non-Representational theorists like to talk about 'affect' almost as 'stuff' hovering/vibrating in the 'atmosphere'; humans may register it in some way (may have an emotional response), but there is almost the

and is consequently concerned not with the singular body,[66] but with the relations between bodies (Pile, 2010). The definitions of, and connections between, affect and emotion have been outlined and contested by a number of geographers, for example Pile (2010), who argues that there are important conceptual differences which should be respected, while Bondi and Davidson (2011:595) reply: "emotions, feelings and affects present us with messy matters to work with; they are tough to 'see', hard to hold, even trickier to 'write up'. But this is the nature of the beasts". Recognising these disagreements, for this thesis the crucial point is the appreciation that these affects/emotions can be consciously and politically manipulated (Sharp, 2009), particularly by those in positions of power, through the specific engineering of bodies, space and atmospheres, which can be produced in such a way so as to create certain performances, or the potential for a desired performance, within those spaces: "the presumption that the powerful can manipulate the non-cognitive" (Pile, 2010:14).

New research on affect within the social sciences approaches the term from different directions. For many, their interest is topic-based, "infusing social analysis with what could be called psychosocial 'texture'" (Wetherall, 2012:2), which results in a focus on embodiment; how people are moved, what attracts them, feelings and memories. For others, the affective turn is more extreme, "a more extensive ontological and epistemological upheaval, marking a moment of paradigm change" (Wetherall, 2012:2-3). For Pile (2010), affect is indeed non/pre-cognitive, interpersonal (or even transpersonal) and inexpressible (thus non-representational), while Anderson (2006:735) defines it as "a transpersonal *capacity* which a body has to be affected (through an affection) and to affect (as the result of modifications)". The affective turn in geographical research predominantly lies within this theoretical shift, following the philosophies of, among others, Spinoza, Deleuze and Massumi (or as Pile (2010:8) summarises "Brian Massumi's reading of Gilles Deleuze's reading of Spinoza's account of affect"). This marks a significant turn away from critical theory based on discourse and disembodied language and text, to "more vitalist, 'post human' and process-based perspectives" (Wetherall, 2012:3). Geographies of affect, according to Thien (2005), are interested in researching this 'how' of affect, with focus on the *potential* of the virtual, following Massumi, who argues that "affects are

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sense of the 'affect' (or, rather, a distributed ecology of affects) hanging there in the ether, irrespective of a human presence.

[66] The argument that emotional geographies are concerned solely with the individual are disputed by Bondi and Davidson (2011:596) who state that "emotional geographies made the case for studying emotion precisely because of its potential for offering important insights into relationships between and among people and environments".

virtual synesthetic perspectives anchored in (functionally limited by) the actually existing, particular things that embody them" (Massumi 2002:35-36, in Thrift, 2004:63). Thrift in particular has written considerably on the theory of affect, perhaps most noticeably his 2004 essay on the spatial politics of affect. Of crucial relevance to this thesis, he believes affect to be:

> … more and more likely to be *actively engineered* with the result that it is becoming something more akin to the networks of pipes and cables that are of such importance in providing the basic mechanics and root textures of urban life … a set of constantly performing relays and junctions that are laying down all manner of new emotional histories and geographies. (Thrift, 2004:58, emphasis added)

In his paper, he considers four approaches to affect "that work with a notion of broad tendencies and lines of force: emotion as motion both literally and figurally" (Thrift, 2004:60). These four approaches, which are all connected to varying degrees, are each framed as 'inhuman' or 'transhuman'. Instead of being outlined as the idea of human individuals coming together in community, rather "individuals are generally understood as effects of the events to which their body parts (broadly understood) respond and in which they participate" (Thrift, 2004:60). Furthermore, affect here is conceived as a form of thinking, "often indirect and non-reflective, it is true, but thinking all the same" (Thrift, 2004:60). Two of these approaches are relevant to this thesis.[67] The first approach emerges from a phenomenological understanding, which conceives affect as an assemblage of embodied practices. The primary concern in this approach tackles two problems of the study of emotions in the past, that of decontextualisation and representation, by developing

[67] The two others encompass notions of 'drive' and 'Darwinianism'. The first involves recognising that an individual's physiological drive ("sexuality, libido, desire" (Thrift, 2004:61)), due to their emotions, is the foundation of human motivation and identity, and is connected to a Freudian psychoanalytic understanding. Thrift (2004:61) argues that thinking in terms of affect (happiness, sadness, etcetera), rather than drive, is less restrictive as it "can range across all kinds of aims … can continually redefine the aim under consideration, can have greater freedom with respect to time than drives … and can focus on many different kinds of object". Yet, Tomkins argues this affect is not only compliant to the individual's drive system, but rather, in many instances, "the apparent urgency of the drive system results from its co-assembly with appropriate affects which act as necessary amplifiers" (Thrift, 2004:61). The final of Thrift's translations of affect he labels Darwinian, as, for Darwin, "expressions of emotion were universal and are the product of evolution" (Thrift, 2004:63). Ekman understood Darwin's work to be important in three ways, as: firstly, it attempted to answer the question of why particular facial expressions are associated with particular emotions; secondly, it was collated from a wide range of samples of both a peculiar quantity and quality; and thirdly, it claimed a "strong line of emotional descent running from animals to humans, born out of the evolution of affective expression as a means of preparing the organism for action" (Thrift, 2004:64). Darwin's study failed to include any communicative part of emotion, and thus it has been expanded upon by neo-Darwinians, who argue that there are five emotions that cross all cultures – anger, fear, sadness, disgust and enjoyment – with each producing the same common facial expressions. These facial expressions, it is argued, "are involuntary signs of internal physiological changes and not just a part of the back-and-forth of the communicative repertoire" (Thrift, 2004:64). Yet, unlike instincts, these emotions are influenced by cultural and social experience, which in turn effect when, and which, particular emotion will be displayed.

"descriptions of how emotions occur in everyday life, understood as the richly expressive/aesthetic feeling-cum-behaviour of continual becoming that is provided chiefly by bodily states and processes" (Thrift, 2004:60). As the cause of emotions very often come from somewhere outside the body, context is essential in the creation of affect. Furthermore, as emotions are, for the most part, non-representational, they are "formal evidence of what, in one's relations with others, speech cannot conceal" (Katz, 1999:323, in Thrift, 2004:60). In other words, they go beyond, thus cannot be grasped, by talk; they are embodied, often invisible, yet can surface through reactions such as laughing, crying or blushing. As Thrift explains, "in other (than) words, emotions form a rich moral array through which and with which the world is thought and which can sense different things even though they cannot always be named" (Thrift, 2004:60).

The second version of affect, often connected to Spinoza and Deleuze, is naturalistic and centres on "adding capacities though interaction in a world which is constantly becoming" (Thrift, 2004:61). DeLanda (2002:62) describes this in another way: "an individual may be characterised by a fixed number of definite properties (extensive and qualitative) and yet possess an indefinite number of capacities to affect and be affected by other individuals". Thus, a person's complex psychology is continually adjusted by the endless experiences that occur between individuals and other unlimited things. The types of adjustments that happen are down to the various possible and different relations between individuals who are at the same time implicated in/with other complex bodies. Spinoza argues, using the terms emotion or affect, that the result of these entangled encounters on affect is "the modifications of the body by which the power of action of the body is increased or diminished, aided or restrained" (Spinoza, in Thrift, 2004:62). Hence affect is released – certainly to become something localisable in emotions or other detectable changes – through encounters (usually of the human with something else). In other words, affect is the result of an encounter, either positive or negative, which results in "an increase or decrease in the ability of the body and mind alike to act" (Thrift, 2004:62). For Spinoza, emotions are attached to actions and encounters rather than responses and situations, thus becoming strongly attached to 'nature'; believing that "things are never separable from their relations with the world" (Thrift, 2004:62). It is this translation of affect that has been used recently in human geography, particularly inspired by Deleuze, but there is hesitancy: "we really have no idea either what affects human bodies or minds might be capable of in a given encounter ahead of time, or, indeed, more generally, what worlds human beings might be capable of building" (Thrift, 2004:62-63). Affect, therefore, as stated previously

when looking at the work of Massumi, is "always emergent" (Thrift, 2004:63). Furthermore, what is also present here is Thrift's consistently optimistic sense of what wonderful, creative things humans may be 'affected' to accomplish.

To summarise Thrift's notions of affect, it is evident that each is based, although with subtle differences, on a sense of the 'push' of the world:

> In the case of embodied knowledge, that push is provided by the expressive armoury of the human body. In the case of affect theory it is provided by biologically differentiated positive and negative affects rather than the drives of Freudian theory. In the world of Spinoza and Deleuze, affect is the capacity of interaction that is akin to a natural force of emergence. In the neo-Darwinian universe, affect is a deep-seated physiological change written involuntarily on the face. (Thrift, 2004:64)

It is clear that approaching studies with an awareness of these different concepts of affect allows researchers to "read the little, the messy and the jerry-rigged as a part of politics and not just incidental to it" (Thrift, 2004:75). Consequently, this approach allows researchers to "trace the insidious ways through which power works on and produces bodies" (Dawney, 2011:600), as well as having great importance in allowing the world to be comprehended as externalities, where individuals, concepts and materialities develop as a result of material practices, objects, institutions and so on. In other words, "different sets of things, their configuration, their assemblage and spacing; their energy, have different capacities to do different things" (Bissell, 2010:83), with Tolia-Kelly (2006:2) arguing that it is essential to recognise the "power geometry" of these capacities to affect or be affected. Clearly, then, there are possible connections between Foucault and affect, despite the apparent absence of specific recognition lent to affect appearing within the former's texts. Furthermore, contrary to Pile's assertion that affects "cannot be grasped, made known or represented" (2010:9), it is argued that those in positions of authority (in this instance Commissioners, politicians, superintendents and architects) *do* have the necessary capacity consciously to manipulate, engineer and control affectual spaces, in order to influence the behavioural and emotional responses of people inhabiting those spaces. Moreover, although Pile (2010:15) argues that affect cannot be shown or understood (in the present):

> It is not clear, since affect is supposedly non-cognitive, how it is that the powerful – and non-representational theory – can actually have this ability to know the unknowable, let alone to engineer that which cannot be grasped. If, on the other hand, it is argued that the powerful are actually manipulating the pre-cognitive or

> cognitive, then what role is affect playing? Maybe, instead, affects resist the manipulations of the powerful. We simply do not know.

It is possible, as will be explored below and developed in subsequent chapters, to uncover the *potential* of affect, or the desire to create affective spaces, and the will of the powerful to manipulate such spaces, through historical records. Although contemporary actors may not "know the unknowable", it is possible to observe their discussions, actions and motivations, and uncover their *will* to manipulate, yet still recognising that this will cannot always be traced through to exposing the emotional responses to such engineered affects on the ground, thus remaining *potential*.

### *Affect and Atmospheres*

As stated above, Anderson believes that the notion of affect is best understood as "the transpersonal or prepersonal intensities that emerge as bodies affect one another" (Anderson, 2009:78), and that in everyday speech this notion is summed up by the term 'atmosphere'. He argues that this term navigates differences between peoples, things and spaces; therefore, for example, "it is possible to talk of: a morning atmosphere, the atmosphere of a room before a meeting, the atmosphere of a city" (Anderson, 2009:78) and so on. Indeed, he ponders that perhaps atmospheres envelope all things, with everything being able to be described as atmospheric. Taking Thrift's third understanding of affect, Deleuze's notion that "affects are becomings" (Deleuze and Guattari, 1994:164 in Anderson, 2009:78), Anderson believes that the capacities "take on the dynamic, kinetic, qualities of the atmos" (Anderson, 2009:78). Affects go beyond emotions, feelings, or affections, thus surpassing rational explanation: "atmospheres may interrupt, perturb and haunt fixed persons, places or things … [they are] perpetually forming and deforming, appearing and disappearing, as bodies enter into relation with one another" (Anderson, 2009:78-79) and with other things (Thrift's overall 'ecology of place'). So, atmospheres, in this sense, could take on "dynamic qualities of feelings such as 'calming', 'relaxing', 'comforting', 'tense', 'heavy', or 'light' that animate or dampen the background sense of life" (Stern, 1998:54, in Anderson, 2009:78). These feelings, although perhaps unclear and difficult to define, have potential affective qualities on/for the individual.

Anderson expands on the connection between affect and atmospheres by turning to the work of phenomenologist Dufrenne (1973), who takes the concept of 'aesthetic experience' to understand 'affective atmospheres', where he differentiates between objects that have aesthetic qualities and other types of objects. Aesthetic objects can be described

as a "coalescence of sensuous elements" which have an "irresistible and magnificent presence" (Dufrenne, 1973:13,86), although it is hard to specify which objects have 'aesthetic' qualities and which do not. This presence, Dufrenne argues, creates the settings that result in representation, with atmosphere being the term used "for how the 'expressed world' overflows the representational content of the aesthetic object as '[a] certain quality which words cannot translate but which communicates itself in arousing a feeling'" (Anderson, 2009:79). Through atmosphere, therefore, a represented object will express, and take on, a certain meaning. Consequently, atmosphere is an assertive quality that objects or beings have; yet it is a quality that does not specifically belong to them, but is rather embodied within them and can flow, resonate and emanate from them, thus producing a certain feeling, ambience or affect. Although the definition of atmosphere is purposefully vague, what is clear according to Anderson (2009:79) is that it has a singular affective quality, and that "through this affective quality, the aesthetic object creates an intensive space-time". The atmosphere of an aesthetic object, rather than re-presenting objective or lived space-time, emanates the space-time of an 'expressed world'. This is not self-enclosed, as the atmosphere prompts emotions within the individual, which, argues Dufrenne, 'completes' the aesthetic object and 'surpasses' it (Dufrenne, 1973:581). Thus, "the singular aesthetic quality of an aesthetic object is 'open' to being 'apprehended' through feelings or emotions" (Anderson, 2009:79). Taking this understanding, Anderson views atmospheres as being unfinished "because of their constitutive openness to being taken up in experience" (Anderson, 2009:79). They need a 'perceiving' individual to be completed, yet they also radiate from the aesthetic object:

> Atmospheres are, on this account, always in the process of emerging and transforming. They are always being taken up and reworked in lived experiences – becoming part of feelings and emotions that may themselves become elements with other atmospheres. (Anderson, 2009:79)

The concept of atmosphere is interpreted slightly differently by Bohme, who focuses on the spatialities of atmospheres, relating more to the material roots of the word: "*atmos* to indicate a tendency for qualities of feeling to fill spaces like a gas, and *sphere* to indicate a particular form of spatial organization based on the circle" (Anderson, 2009:80). By this definition, it can be understood how atmosphere can surround people, things and environments:

> Thus one speaks of the serene atmosphere of a spring morning or the homely atmosphere of a garden. On entering a room one can feel oneself enveloped by a friendly atmosphere or caught up in a tense atmosphere. (Bohme, 1993:113-114)

Their characteristic spatial form is dispersion within a sphere, having the ability both to envelope and/or to radiate from, an individual or object. Research on the connections between affect and atmosphere include work by McCormack (2008a; 2008b, 2010), in particular his paper on engineering affective atmospheres and the 1897 Andrée expedition. This work looks at both "atmosphere in a meteorological sense *and* as an event generative" (McCormack, 2008a:413) in the context of the 1897 attempt to reach the North Pole in a hydrogen balloon. It is the second understanding of atmosphere that is useful here; 'affective atmosphere', which McCormack outlines as "something distributed yet palpable, a quality of environmental immersion that registers in and through sensing bodies while also remaining diffuse, in the air, ethereal" (McCormack, 2008a:413). As put forward by Deleuze and Guattari, multiple types of bodies, which affect each other on a daily basis, produce various atmospheres, which can be potentially shaped:

> Practices as diverse as interior design, interrogation, landscape gardening, architecture, and set design all aim to know how atmospheres are circumvented and circulate. By creating and arranging light, sounds, symbols, texts and much more, atmospheres are 'enhanced', 'transformed', 'intensified', 'shaped', and otherwise intervened on. (Anderson 2009:80)

Therefore, it becomes clear that it is possible to engineer affective atmospheres through attention to, among other things: light, colour, sound, shape, temperature, arrangement, texture, objects and people. Different feelings, emotions and moods[68] are suggested and enabled by, for example, designing an apartment to have a specific outlook, arranging the layout of a room or choosing specific aesthetic objects to create a certain feeling within a space. Bodies can be affected in an almost unlimited number of ways (Kraftl and Adey, 2008), but engineering spaces and atmospheres through architectural, landscape and interior design is a way of stabilising and controlling affect "to generate the possibility of precircumscribed situations, and to engender certain forms of practice" (Kraftl and Adey, 2008:228). One of these aspects that embraces the engineering of affect is therapeutic space, which can be defined as "spaces emergent through the enactment of practices that explicitly attempt to facilitate a kind of transformation in awareness, thinking, feeling and relating" (McCormack, 2003:491), with a specific sense of engineering therapeutic atmospheres. Indeed, as Kraftl and Adey state, "for architects and their buildings to be taken seriously, buildings must be imbued with the power to make a difference to their

[68] Another useful, if quietly in-specific, term, also with certain connotations for mental health/well-being: what 'mood' are you in?

inhabitants" (Kraftl and Adey, 2008:213); for example, to feel 'home-like' even if they are not a home (Kraftl, 2010).[69]

Kraftl and Adey's research considers this manipulation and engineering of architectural space, looking at both the creation and limitation of affect within certain buildings. Their emphasis goes beyond generic kinds of architectural affect (such as "homeliness", "comfort", or "peacefulness"), instead focusing "on the definite, desired affects that – through design – should be properties of the buildings, if the designs are effective" (Kraftl and Adey, 2008:215). They recognise the performative connection between a building and an individual: architectural designs are "imbued with styles of bodily doing, because of the push that the particular relationship between a body and that building could bring about: an affect" (Kraftl and Adey, 2008:217); a quote likely influenced by the Thrift (2004) paper and with the notion of "the push". Following Thrift, and harking back to arguments outlined previously in this chapter, they recognise that designing particular affects into, and out of, a building is a 'political' decision and, "though affective response can clearly never be guaranteed, the fact is that this is no longer a random process either. It is a form of landscape engineering that is gradually pulling itself into existence, producing new forms of power as it goes" (Thrift, 2004:68). By this reckoning, individuals' behaviour and emotions can be controlled by the manipulation of affective spaces within particular institutions. Yet, Kraftl and Adey (2008:219) caution that, "there is not (and could never be) a neat or complete correspondence between the design of affect and its experience; the creation, evocation, and experience of affect is just not like that", as it is never certain how an individual will respond. As a result, spaces can only ever be engineered and designed to be *potentially* affective: there will always be 'gaps' between the engineers' interior and how a building's dwellers experience, receive and respond to the affective atmospheres being engineered. Kraftl and Adey (2008:228) conclude by opening up the invitation for more studies to focus on the non-representational aspects of the built form:

> There is a need to explore the importance of a variety of architectural designs, forms, and inhabitations that try to embrace, manipulate, entrain, channel, push, pull, and create different capacities and collectivities for dwelling, and for affect production.

[69] See also Moran (2013) for discussions on affect and prison architecture.

## ARCHITECTURAL GEOGRAPHIES

Finally, here, picking up on this attention to architecture and buildings, it can be recognised how architectural studies within geography have engaged with the way buildings are produced, as well as with how they are consumed. Prompted by the cultural turn in the discipline of human geography more generally (Cook *et al.*, 2000), architectural geography studies have moved from a more regional focus on landscape, people and vernacular architecture (ie. the so-called 'Berkeley School: see Kraftl, 2010), to recent work, such as Jacobs' (2006) research on 'big things' such as skyscrapers, which goes beyond the materiality of the building by turning attention to both the "meaning and politics of representation" (Jacobs, 2006:2), yet still retaining a deep interest in the building's physical structure, form, style and construction:

> In this model of a geography of architecture, the building and how it is made does not simply operate as the evidentiary field for a story about the cultural typology of settlement patterns. Rather, the objective is to investigate the processes by which certain things cohere to produce 'building', 'architecture', 'housing'. In this sense, these studies effectively broach the question of how a building comes to have 'presence', how it is stitched into place by fragmented multi-scaled and multi-sited networks of association. (Jacobs, 2006:3)

Furthermore, it must be recognised that buildings, in their many forms, play a significant part in the daily lives of the majority of individuals: "they embody the literal act of place-making" (Kraftl, 2010:403). Thus, geographers such as Lees (2001) and Llewellyn (2004) argue that a critical geography of architecture should go beyond representation, because "both as a practice and a product architecture is performative in the sense that it involves ongoing social practices through which space is continually shaped and inhabited" (Lees, 2001:53).

Additionally, there are of course embedded power relations within, and attached to, buildings. This claim follows Lefebvre, who explores the notion that "space is not merely produced for simple consumption, but [rather] spaces can be adapted, manipulated, appropriated, and produced by a range of individuals" (Llewellyn, 2004:229). Developing this point further, Lees, like Kraftl and Adey, believes that not enough is said by geographers on the non-representational and affective aspects of architecture, and that more attention should be directed towards the "embodied engagement with the lived building" (Lees, 2001:52), since the inhabitation of the building is just as important as its physical form and architectural type. Practical engagement with the "situated and everyday

practices through which built environments are used" (Lees, 2001:56) is essential in understanding the occupancy of the specific spaces and places of a building. This leads to considering the individual consumption of architecture, asking questions about what the architecture *does* to its inhabitants (or what it is *trying* to do) rather than what it *means,* as well as questions about how people 'dwell' in buildings, streets and other structures:

> No longer just a passive stage for the rehearsal and re-presentation of predetermined social scripts, space becomes alive and integral, inextricably connected to and mutually constitutive of the meanings and cultural politics being worked out within it. (Lees, 2001:72)

Thus, architecture can be read as representing or symbolising, for example, systems, histories and intentions (Kraftl, 2010). Rather than just blank canvases waiting to be used, Lees (2001:56) claims that an ethnographic methodology "provides one way to explore how built environments produce *and* are produced by the social practices performed within them", allowing the researcher to go beyond the symbolic built form and start answering questions about the embodied, performative and indeed affective aspects of architectural spaces. However, she also cautions that such an approach should not ignore the meaning of buildings, but instead should address them from a different angle, "as an active and engaged process of understanding rather than as a product to be read off retrospectively from its social and historical context" (Lees, 2001:56).

This orientation becomes difficult from an historical perspective, as understanding what a building was designed to *do* to its inhabitants in the past, through the engineering of affective atmospheres as outlined above, requires an interpretation of the available archive material. Often allowing no proper recovery of the actual everyday practices of individuals within the spaces concerned, the archive can be used to understand how past architects and planners have calculated and designed affective *blueprints*, incorporating the means *potentially* to affect the building's inhabitants (a further illustration that affects are always becoming and emergent). Drawing from Jacobs' work on 'big things' concerning the *making* of buildings, archival analysis can, to some extent, uncover "the ways in which certain architectural forms come to be in certain places" (Jacobs, 2006:3), and, extending this idea, how they were designed to be used.

Llewellyn's research on Kensal House, London, in the 1930s is an example of how architectural plans and notes can be read to uncover the desired way of living put forward by the planners:

> The kitchen was purposely designed to be small with the intention that 'if it were made really workable without being cramped … then it could be used for work only and meals be taken in the living-room'. This was a decision made on the *assumption* that a larger living room was more desirable than a larger kitchen, and that the kitchen would be used in a scientifically managed way. (Llewellyn, 2004:233, emphasis added)

Llewellyn (2004:233) also states that the planners "worked elements into the architectural plan that would encourage the inhabitants to work together as a community", thereby attempting to shape and affect the daily lives and geographies of the occupants. Through an examination of the archival documents, the building no longer appears as a final 'fixed' entity, but rather there is scope to "interrogate the conjoined technologies (pipes, bricks, cabling), practices (construction, inhabitation, even demolition) and regulations (laws, building codes, health and safety legislations) that ensure they stand up over time" (Kraftl, 2010:407-408). This directly chimes with Thrift's (2004:58) notion of "networks of pipes and cables" discussed previously in this chapter.

It can be seen, then, that an insight into the production and creation of affect within architectural spaces can be read from archival sources. Furthermore, the asylum very much fits within Jacobs' category of 'big things', or 'big architecture'; developed as a very particular response to dealing with a certain population. Affectual language, or *potential* affectual language, can be gleaned from the archive, giving an insight into architectural decisions and how individuals were manipulated to react (emotionally and physically) in desired ways when they were brought together in certain designed spaces. Affectual geographies within an historical geographical study have been explored in work by McCormack (2005, 2010) and Llewellyn (2004), yet the connection between Foucault and affect, approached through an historical-geographical perspective, is a novel yet inviting approach to researching asylum geographies. Moving back to Foucault, and in particular PP, it can be understood how those in positions of power were able to use affective techniques and engineering as a mechanism to control how bodies acted in response to their (socially and politically constructed) environments. Nineteenth-century authorities used and manipulated asylum spaces to affect institutional inhabitants, creating, they hoped, a curative machine through architectural arrangements. They organised the space, and the distribution of individuals within this space, to have therapeutic value, with the institution, rather than medical treatment (brought in later), being the remedial apparatus. Thus, engineered spaces should not be configured as solely repressive devices, for they have the power to affect but also be affected (McCormack, 2005) as they come in contact

with other bodies and other affects. Although unable, in many instances, to uncover the bodily and emotional responses to the affective atmospheres and power relations created, reconstructing the *blueprint* and the desired *potential* outcome written in historical documents becomes a useful tool in constructing the methods of power deployed in an historical context.

# Chapter 4

# Searching Archives, Researching Asylums

## INTRODUCTION

Despite a number of landscapes dotted around Scotland which testify to a previous institutional past, no matter how hard you look at them, or spend time 'in' them, there will always be stories that the landscape will not tell, or cannot reveal: "today's tangible, visible scene reveals nothing[70] of the process by which this transformation took place" (Hanlon, 2001:15). Thus, the historical record becomes key in understanding the layers of history, negotiations and occupations that have occurred since a specific site became associated with a particular purpose. Holdsworth (1997:55) concedes that archival work "provides a useful additional lens for viewing what does remain and what does survive, illuminating earlier phases of place making and of economic and social restructuring". To understand the landscapes and networks of lunacy provision being constructed in the nineteenth century, my research 'field' was inevitably going to be chiefly the archive, with my evidence mainly textually source-bound. Yet, as has been widely recognised, the archive is not an unproblematic space in which one spends time 'doing geography' (Withers, 2002). Documents are subjective, representing a particular viewpoint of their authors, and hence the history (and geography) of a source – and the meaning and motives enmeshed therein – must first be established before it can be usefully deployed in a geographical study. Furthermore, it is important to recognise and triangulate the historical dynamics written across a number of texts, so as not to form a linear, single narrative. The following chapter will briefly explore the concept of the archive, incorporating recent discussions about archives by historical geographers, before outlining the sources that I consulted and their various locations. Finally, the chapter will move to discuss more conceptually how I have interpreted the sources, in line with the theoretical underpinnings explored in the previous chapter.

[70] This is debatable, see discussion to follow.

## THE ARCHIVE

For the historical researcher, under whose umbrella the historical geographer falls, the archive is a crucial bank of knowledge: the main source of empirical data collection. These archives assume many guises, across different scales, temporalities, places and spaces, and with collections accumulating for a plethora of reasons. Recent debates attempting to contextualise and deconstruct the archive have nonetheless recognised that they are not always straightforward repositories of 'stuff' (Steedman, 1998), but rather sites of both authority and meaning, "related to issues of representation and power in society" (Kurtz, 2001:26). Additionally, many researchers, amongst whom there is particular input from historical geographers, have opened up the very definition of what constitutes an 'archive', taking it beyond the more traditional confines of, for example, the document and the text.[71] Furthermore, recent literature has re-addressed the connections between the historical geographer and their research methods; and, as Moore (2009:2) asserts, "it seems the archive looms large in [their] imagination". Within the historical geography community, some focus (particularly in recent years) has been given to the extraction of information from the archive, with concerns raised regarding "(un)availability of sources, or the negotiation of absent, powerful or powerless voices in the archive" (Moore, 2009:2). Yet, Lorimer (2010) laments the fact that, traditionally, overviews of research methods and methodologies in historical geography have been patchy. Due to similarities between the commentaries of historical researchers and historical geographers, the explorations of archives that follows will integrate both, yet with recognition that, crucially, the sources used by historical geographers were not themselves constructed and collated for specifically geographical purposes, which throws up different questions during the search and analysis process:

> Among historical geographers there is a more widespread acceptance of the need to critically interrogate the historicity of the archive as cited repository, and a space of knowledge. The very idea of the archive – its origins, scope, layout, composition, content and treatment – has been stirred up and shaken, and in the process, the status of the information it holds, been rendered more provisional, indeterminate and contestable. (Lorimer, 2010:253)

Thus, as outlined by Lorimer, all archives and their contents need to be catechised in a number of ways; their purpose, whose interests they serve (if anyone's) and, ultimately, the angle(s) they provide on a research topic (Hoggart *et al*, 2002). As such, there needs to be a

[71] See, for example, Patchett, 2010.

'knowledge of space' as well as recognising the "space of knowledge" as demarcated above.

It is generally recognised that the origins of British (and many global) archives are connected to the state formation process and thus the growth of disciplinary power and knowledge control from the eighteenth century (Burke, 2000; Featherstone, 2006), including imperial expansion and administration in the nineteenth century. This encompassed the development of methods to record and analyse the growing population, alongside sites and institutions that used this knowledge to discipline and normalise individuals:

> People's characteristics were observed, recorded and stored in the files. Each individual was distinguished from others by his or her case history. The individual was formed as a category of knowledge through the accumulated case records (the file) which documented individual life histories within a particular institutional nexus such as a prison, hospital or more generally through governmental welfare or security agencies. (Featherstone, 2006:591-592)

Coupled with these growing records about individuals, the creation of archive spaces was felt to legitimise the formation of the nation-state, which was deemed central for national memory and collective identity. Inevitably over time, this push to record and collect resulted in the accumulation of archivable material, and thus, particularly with the move towards digital technologies, life is increasingly "lived in the shadow of the archive" (Featherstone, 2006:591). Similarly for Derrida, in his (in)famous *Archive Fever* (1996), the archive is a place and reflection of social and institutional authority, and on this account archives are never 'raw', they are 'sites of action' – movements of knowledge, material and people in and out of topological sites and nomological spaces (Withers, 2002).

Yet, for Foucault, there is a more abstract quality to the archive. He argues they are more than "the sum of all the texts that a culture has kept upon its person as documents attesting to its own past, or as evidence of a continuing identity" (Foucault, 1972:145). More precisely, the archive has an abstract role as "the system that governs the appearance of statements as unique events" (Foucault, 1972:145). They are bracketed together in distinct figures, composed together in agreement with multiple relations, maintained or blurred in accordance with specific regularities, not simply an endless amorphous mass (Foucault, 1972). As an archive forms/takes shape, to an extent it conditions what 'statements' (materials) can be lodged in that archive (this can easily be seen happening as the Scottish

Lunacy Commissioners reports develop a pattern, logic and order repeated year in, year out). Thus, the archive can be viewed as a site of interpretation, political action and knowledge-making, much like the laboratory of the natural scientist (Osborne, 1999). A number of historical geographers critically engage with these power and partiality issues (see Duncan, 1999; Kurtz, 2001; Hanlon, 2001), and in particular Ogborn (2003) argues that the creation and survival of the archive is connected to the social and political contexts in which it is constructed and maintained, with this revealing much about the information that is produced, used and valued.

Also of importance is the recognition that archives themselves have a spatial history, and are not static objects. Collections can be "destroyed, stolen, purchased and relocated" (Featherstone, 2006:592). This is particularly pertinent when the archive has less value to the state (for example, subaltern archives) or, conversely, when more powerful groups/countries have the ability to acquire and reproduce collections, which, for example, often occurred with the materials of the imperial colonies. It must be acknowledged that decisions need to be made at a number of levels (by the state, archivists, librarians) as to what should be kept, how it should be stored, and what the public can access (see Lorimer, 2010). Furthermore, collections within the archives can be manipulated and controlled to produce particular authoritative histories. As Steedman (1998:67) asserts, there should be no surprise at the emptiness of the archive, that archives are incomplete, with certain documents, even certain social groups, excluded: "in its quiet folders and bundles is the neatest demonstration of how state power has operated, through ledgers and lists and indictments, and through what is missing from them"; and hence the real salience of these 'presences' and 'absences'. There has also been recognition by a number of historical geographers concerning the power structure, preservation and partiality of archives. For Kurtz, it is not simply a process of 'archive creation', or 'collection and storage', but a social and political practice that directly affects the material itself (Kurtz, 2001). Till (2001) focuses on the absences and silences in the archive, acknowledging both temporal and institutional boundaries, while Gagen (2007) reflects on the partiality and negotiations of different 'voices' in the archive. Thus, taking these thoughts into consideration, caution should be exerted when reconstructing memory and history from archived documents:

> It is impossible to approach the data in a way which it … can be 'made to speak' neutrally, objectively and once and for all. The archivist, librarian and professional researcher create the maps and record the journeys into the archive that produce the images we have of the possibilities of the materials. (Featherstone, 2006:593)

Unearthing relevant documents within archival collections can often be down to chance and time, particularly when faced with many boxes labelled 'miscellaneous'. Thus, the archive, whether it be state, local or personal, is always imbued with the *potential* for discovery, reliant on documents firstly being deposited within a collection, and secondly, on them being extracted from the collection for the purpose of research.

For some, however, the archive is *not* best understood as a direct manifestation of state power. For example, in Withers's (2002:305) experience, the archive can also encompass a "haphazard accumulation of 'stuff' rather than of pre-ordained governmental scrutiny". Crucially, therefore, there is what Featherstone (2006:594) describes as a "counter-image" to the archive as an organised state entity, yet crucially archives still retain their own, if somewhat different, meanings, problems and power relations. There are many alternatives: archives can be unorganised or only loosely catalogued – often vast repositories containing "material whose status is as yet indeterminate and stands between rubbish, junk and [(in)]significance, material which has not been read and researched" (Featherstone, 2006:594). They can be fragmented, broken and incomplete, or more 'informal', such as an individual's personal collection(s). Their contents can be imaginative, creative or even accidental, a result of hoarding and impulsive stockpiling. The state of archival (dis)order very much depends on which archive, when it was created, who it was collected by, for, and so forth, and often chaos and order can co-exist (see Lorimer and Philo, 2009). Historical geographers have, in recent years, increasingly turned to these more alternative, local or sometimes 'messy' archives for their research. For example, DeSilvey (2006) has taken inspiration from the absences, silences and incompleteness of the archives, approaching the gaps not as hurdles but rather as opportunities. Often these more unconventional, 'haphazard' archives are framed and used as alternative memories and different cultural identities. Some researchers are widening the notion of the archive, taking it beyond its traditional spatial surrounds (see Benjamin, 2000; DeLyser *et al*, 2004; Burton, 2005; Edensor, 2005b; Cresswell, 2012).[72] For Benjamin (2000), the city is an archive, with detail drawn from across the different streetscapes; building architecture, street signs, bill board adverts and music posters. This idea can be extended to other landscapes more widely (Lorimer, 2010), which, as stated previously, often hint to former pasts, allowing their previous uses to be 'read' much like fragmented texts. Importantly, when the definition is widened, Withers (2002:305) acknowledges that "we must not lose

[72] Intriguingly here the distinction between 'field' and 'archive' can be see to collapse, but in a different direction to that set out in the introduction where the 'field' is narrowed to the (asylum) 'archive'. Instead here the 'archive' is effectively exploded to include the 'field' (as in material traces of old asylums).

sight of differences in and between archives and of how such differences may affect our 'styles of reasoning'". Yet, despite these differences, in type, scale, location, (perceived) value, and so on, there is inevitably a power in both the 'presences' and, conversely, the 'absences', of *all* archives.

Additionally, Steedman (1998:72) highlights that the historical researcher in the archive is "always the *unintended* reader of the book", which, although throwing up potential ethical considerations, adds to the allure of the historical document. Osborne (1999:54) asks whether there is an ethic to the archive, concluding that "the person who speaks from the archive is the person who mediates between the secrets or obscurities of the archive and some or other kind of public".[73] Thus, although there is no formal ethical procedure, there is a certain 'ethics of responsibility' for the historical researcher. To make sense of the fragments, the words written for other eyes, the researcher must draw on their own knowledges and their own imagination, and ultimately come to their own conclusions, yet doing so with a degree of sensitivity. Often it is the potential of discovery and use of imagination needed when delving into the archive that is the charm for historical researchers, who are drawn to uncovering and (re)discovering new documents and/or piecing together new discourses of historical knowledge. This notion is best summarised by Lorimer (2010:257), who states:

> While the body is ever present on site, thoughts are restless and nomadic. The great multitude of ideas that spring out from archival materials have a rich inner life, journeying hither and thither. Oftentimes, and without any great act of will, researchers call on their geographical imagination to picture, to populate and to personalise the pasts to which they are dedicating such time, effort and thought. In the mind's eye, unknown aspects of subjects' identities are coloured in, the outlines of unseen faces are etched, landscapes settled, and key scenes set and staged so that events might dramatically unfold. The urgent workings of the mind take the researcher on travels, perhaps even offering the co-ordinates for them to lead a second life. In this respect, it might be said that archival method is boosted by a vivid imagination and an ability to inhabit imaginary, or parallel worlds.

This quote explores the 'journeying' in the mind between archive (as you sit there) and a world beyond, which speaks exactly to how I have used the field/site visits to energise my archival encounters, and *vice versa*, as introduced in Chapter One and discussed below. The meanings to be extracted from the vast and various archival repositories, collated for many purposes, are boundless, intrinsically linked to the researcher's understandings and

[73] For further discussion regarding historical research and ethical considerations, see Moore's (2009) discussions on the historical geography of abortion.

imagination, their motives and their drives, as well as their initial inspirations and attractions towards the project/research: "the researchers' own past significantly shapes their historico-geographical interpretation" (Baker 1997:238).

My own personal motivation for undertaking this research is a long-standing fascination with ruins, and how they came to be positioned in the landscape. Growing up in Scotland, as a family we would often, by foot or by sail, explore abandoned buildings, from castles to cottages, mulling over their past lives, questioning why they were constructed, but also why they were abandoned. My interest in asylums was born at high school, as when a pupil acted 'daft' cries of "you belong in Craig Dunain" would often ring out, consequently building a mystical air around the institution. I recall being particularly stirred when I saw a bus with 'Craig Dunain'[74] as its destination in Inverness, and interested in the news of the hospital's closure in 1999, and the extensive fire damage in 2004. Therefore, after completing my degree in geography (specialising in historical geography) at undergraduate level, and on discovering that no detailed research had been conducted into Scotland's district asylums, I felt compelled to combine my interest in asylums and in buildings and ruins more generally with my growing expertise in archival inquiry to undertake the following research into Scotland's district asylum network.

As already alluded, historical geographers have talked about and used the archive in a number of ways, with recent discussions opening up the idea of alternative collections and spaces. Of relevance to this research, it must be recognised that historians of psychiatry have also explored the archive to gather evidence for their own studies. Yet, researchers here have not always turned to the archive for evidence. In the mid-twentieth century, Hunter and MacAlpine (1963:viii) stated that there was a surprising lack of studies on the history of psychiatry that drew explicitly from primary data, and those that did exist were somewhat limited in scope. They worried that this limited research created an 'unrealistic picture', with researchers relying on secondary accounts which had resulted in "repetitive error, inaccuracy, false emphasis and misrepresentation which reliance on 'quotes from quotes' notoriously entails". They put this failing partly down to difficulties in accessing the original documents, but also to "a lack of appreciation of the past" within the discipline (broadly speaking, psychiatric history), which they believed was detrimental to the current practice of psychiatry as it results in the opinion "that what is present is good and what is bad [is] past" (Hunter and MacAlpine, 1963:viii). Thus, with an awareness that the past

[74] See Parr *et al*. (2003) for contemporary discussion around Craig Dunain Asylum.

and original documents needed to be (re)visited, they published a book of original texts[75] which, although in no way exhaustive, includes excerpts from contemporary texts that relate in some way to the practice and history of psychiatry over a three hundred year period (1525-1860), a reference work that has inevitably become a major tool, and inspiration, for future researchers. As explored in Chapter Two, since the time when this volume was published, there has been a growth in history of psychiatry research which utilises the archive, with studies varying from 'bottom-up' to 'top-down' approaches depending on the nature of the sources and the angle of interpretation.

The research in this thesis, due to source availability, falls into the more 'top-down' category, as it is based principally on 'official' sources, in part because other sources really are almost entirely absent. Historical inquiries are reliant on documents being kept: firstly by contemporary agents, and secondly in collections and by archivists. In this case, the collections that have reached the archive, and that now represent the district asylum records, are almost solely 'official records', with this fact, therefore, reflected in the research design of this thesis. This is probably more true for the district (pauper) asylums than for the royal asylums, which in the second half of the nineteenth century admitted predominantly fee-paying patients who, as outlined in Chapter Two, were more disposed to keep diaries, write letters and otherwise create the kinds of written sources that can be the bread and butter of 'bottom up' histories. Consequently, the research for this thesis was very much driven by, and moulded around, the availability of certain (more 'official') documents within the archive, but, although the research was limited, to an extent, by its sources, it was also, conversely, enabled by these sources and shaped by their content.

## SOURCES

It has been commented that "to practice empathetic historical geographies, we must be willing to dig" (Till, 2001:70), and so I dug, in a lot of different locations, archive spaces and time periods. The following section will outline the anatomy of the overall archival field which I consulted in my attempt to uncover and (re)construct the locational histories of the Scottish district asylum system, with its complex scalar political wranglings between institutions, local authorities (parochial boards and district boards) and the central body responsible for regulating Scottish lunacy reform after 1857 – the Scottish General Board.

[75] The book includes medical sources as well as ones which draw on the field of psychiatry more widely, including: writings of divines, philosophers, philanthropists, lawyers, men of letters, self-accounts of patients, Parliamentary acts, and reports documenting society's interest in psychiatry.

As has been outlined above, the archive takes many forms, is stored and maintained for many reasons and in numerous locations, and can be in various states of (in)completeness. I experienced many of these arrangements of archive and challenges to 'data collection' during my extensive archival outings, which included visiting the 'places' outlined in Table 4.1.

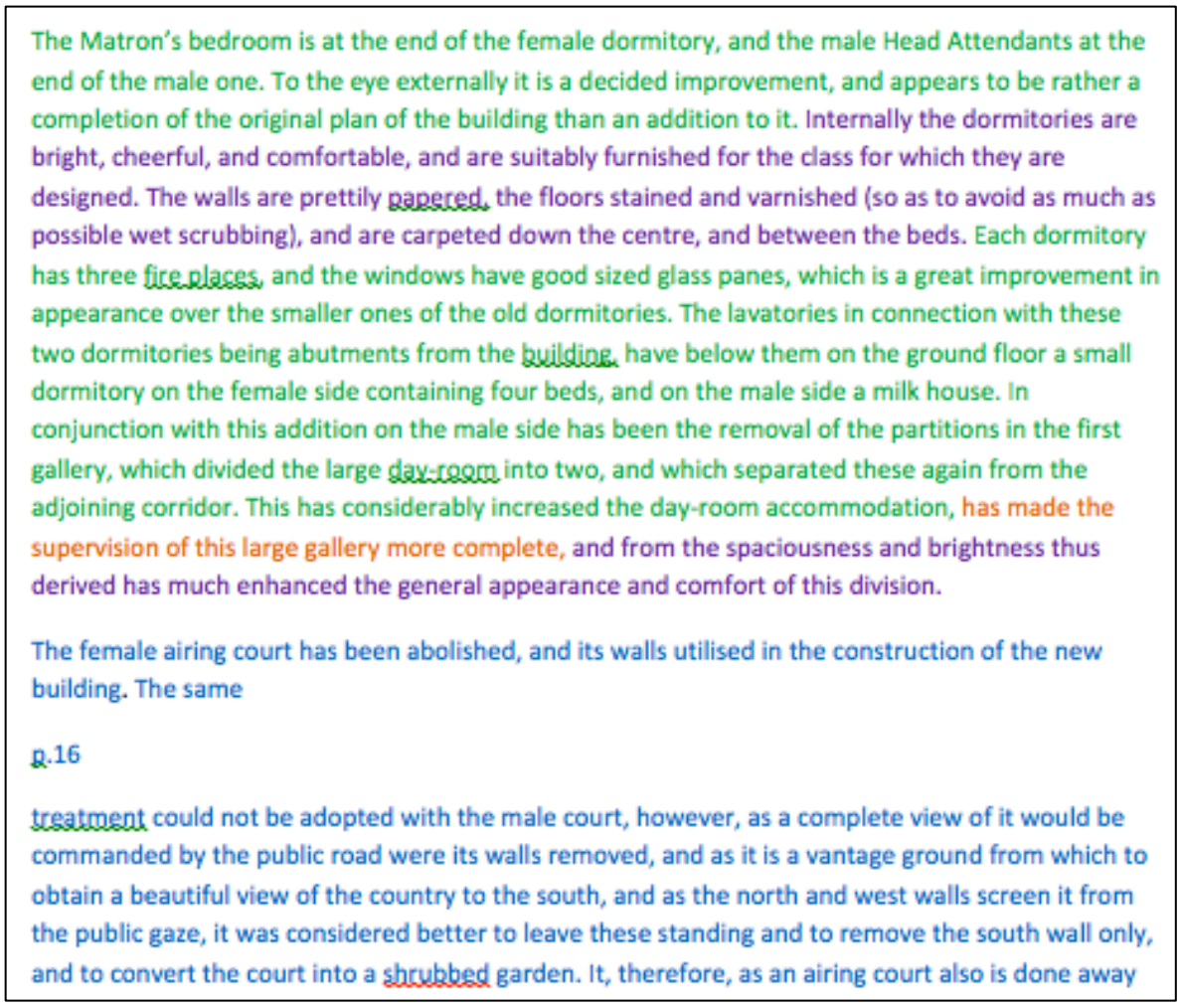
Tying back to claims made above, the sources consulted fall very much into the bracket of 'traditional' historical records, mostly the 'official' state response to what they deemed a problem population. The background discussions, the 'chatter', the deliberations, the disagreements and the negotiations were either not recorded or have not survived. Furthermore, despite the asylum system directly impacting the patients, their experiences, stories and emotions are eerily absent from the collections consulted. It is with this in mind that I would like to take space to acknowledge the 'missing voices' that have not been retained in the official records, but whose lives were, for better or worse, directly affected by the institutions that were constructed and the system that was created to manage this particular sector of society.

| Archive | Location | Authority |
|---|---|---|
| **Parliamentary Papers** | Online | General Board |
| **National Archive for Scotland** | Edinburgh | General Board |
| **Mitchell Library** | Glasgow | Miscellaneous |
| **Royal College of Physicians** | Edinburgh | Miscellaneous |
| **Lothian Health Services Archives** | Edinburgh | District Board |
| **NHS Greater Glasgow and Clyde Archive** | Glasgow | District Board |
| **NHS Grampian Archives** | Aberdeen | District Board |
| **Highland Archives Centre** | Inverness | District Board |
| **Centre for Archive and Information Services** | Dundee | District Board |
| **Ayrshire Archives** | Ayr | District Board |
| **Falkirk Community Trust** | Falkirk | District Board |

Table 4.1 – Archive collections consulted, their location, and the tier of lunacy administration they included

While systematically working through all of the documents in the various archives relating to the district asylums in Scotland, I collected my data by 'picking out' information that the numerous authors of the sources included on all aspects of the geography of the individual asylums and on the construction of the national system which was being rolled out across the country. This 'evidence'; the quotes, vignettes and examples, were typed out and compiled in a number of electronic documents (one for each district asylum record, and one for each report from the General Board), effectively constructing my own archive through 'geographical entitation' (Cloke *et al*, 2003). I then revisited these files of

geographical information, further interpreting the evidence and assigning it into themes which would match my main empirical chapters (site, grounds and buildings), in effect via a thematic 'geographical coding up' (see Figure 4.1). [76]


The Matron's bedroom is at the end of the female dormitory, and the male Head Attendants at the end of the male one. To the eye externally it is a decided improvement, and appears to be rather a completion of the original plan of the building than an addition to it. Internally the dormitories are bright, cheerful, and comfortable, and are suitably furnished for the class for which they are designed. The walls are prettily papered, the floors stained and varnished (so as to avoid as much as possible wet scrubbing), and are carpeted down the centre, and between the beds. Each dormitory has three fire places, and the windows have good sized glass panes, which is a great improvement in appearance over the smaller ones of the old dormitories. The lavatories in connection with these two dormitories being abutments from the building, have below them on the ground floor a small dormitory on the female side containing four beds, and on the male side a milk house. In conjunction with this addition on the male side has been the removal of the partitions in the first gallery, which divided the large day-room into two, and which separated these again from the adjoining corridor. This has considerably increased the day-room accommodation, has made the supervision of this large gallery more complete, and from the spaciousness and brightness thus derived has much enhanced the general appearance and comfort of this division.

The female airing court has been abolished, and its walls utilised in the construction of the new building. The same

p.16

treatment could not be adopted with the male court, however, as a complete view of it would be commanded by the public road were its walls removed, and as it is a vantage ground from which to obtain a beautiful view of the country to the south, and as the north and west walls screen it from the public gaze, it was considered better to leave these standing and to remove the south wall only, and to convert the court into a shrubbed garden. It, therefore, as an airing court also is done away

Figure 4.1 – Screenshot of personal notes, showing example of coding. This example is from the Ayr Asylum District Board Annual Report. Green refers to 'buildings', purple to 'affect', orange to 'supervision/discipline/power', and blue to grounds.

### *National Archives*

The material available for the top tier of administration in the Scottish district asylum system is far from being a fragmentary, piecemeal archive, but rather constitutes as near to a complete 'official record' as I could have hoped. This collection includes: the Commissioners' mid-1850s inquiry into lunacy in Scotland; the unpublished, hand-written minutes; official published annual reports of the General Board, which run from 1857 to 1913; and the Acts and Bills passed through parliament relating to the management of lunatics and the construction of asylums. Andrews (1998) does still provide a word of warning: the records available regarding the Scottish Lunacy Commissioners' work,

[76] See Cloke *et al* (2003) for discussions around the processes of 'sifting and sorting' data.

particularly the published reports, obviously constitute very much the 'official version' of the Commissioners' activities, with the sources being strongly biased towards a self-justifying view. The cases publicised in the annual reports were selected largely to validate the Commissioners' own peculiar prejudices, strategies and ethos in dealing with the mentally disordered. Yet, having said this, they do also represent the crystallisation of a large body of factual information concerning the Boards' work, much of it (seemingly) presented fairly and objectively, and open to careful historical analysis.

The initial, crucially important, document was the *Report into the State of Scottish Lunacy, Lunacy Law and Lunatic Asylums*[77] – the written conclusions of the 1855-57 inquiry conducted by the Royal Commissioners.[78] This document, which contains over 800 pages of material, was an essential starting point into understanding the conditions prior to the *Lunacy (Scotland) Act*, 1857, and the incentives and motivations for reform.[79] It included:

1. An abstract of the existing law of Scotland on the subject of lunacy, both as regards the custody and treatment of the persons of lunatics, and the care and management of their property.

2. A statement of the numbers of lunatics at present in Scotland, and of the manner in which they are distributed.

3. A description of the nature and extent of the accommodation provided for the insane, whether in public asylums, or private establishments recognised by law; together with an account of the condition of these establishments, and of the treatment of the lunatics confined in them.

4. An account of the condition of lunatics not confined in any of these establishments, in so far as we have been able to ascertain the same.

5. An exposition of the mode in which the law has been, and is practically administered, having special reference to the question, how far any abuses that may be found to exist, are owing to the defective administration of the present law, or may require new legislative enactments for their effectual remedy.

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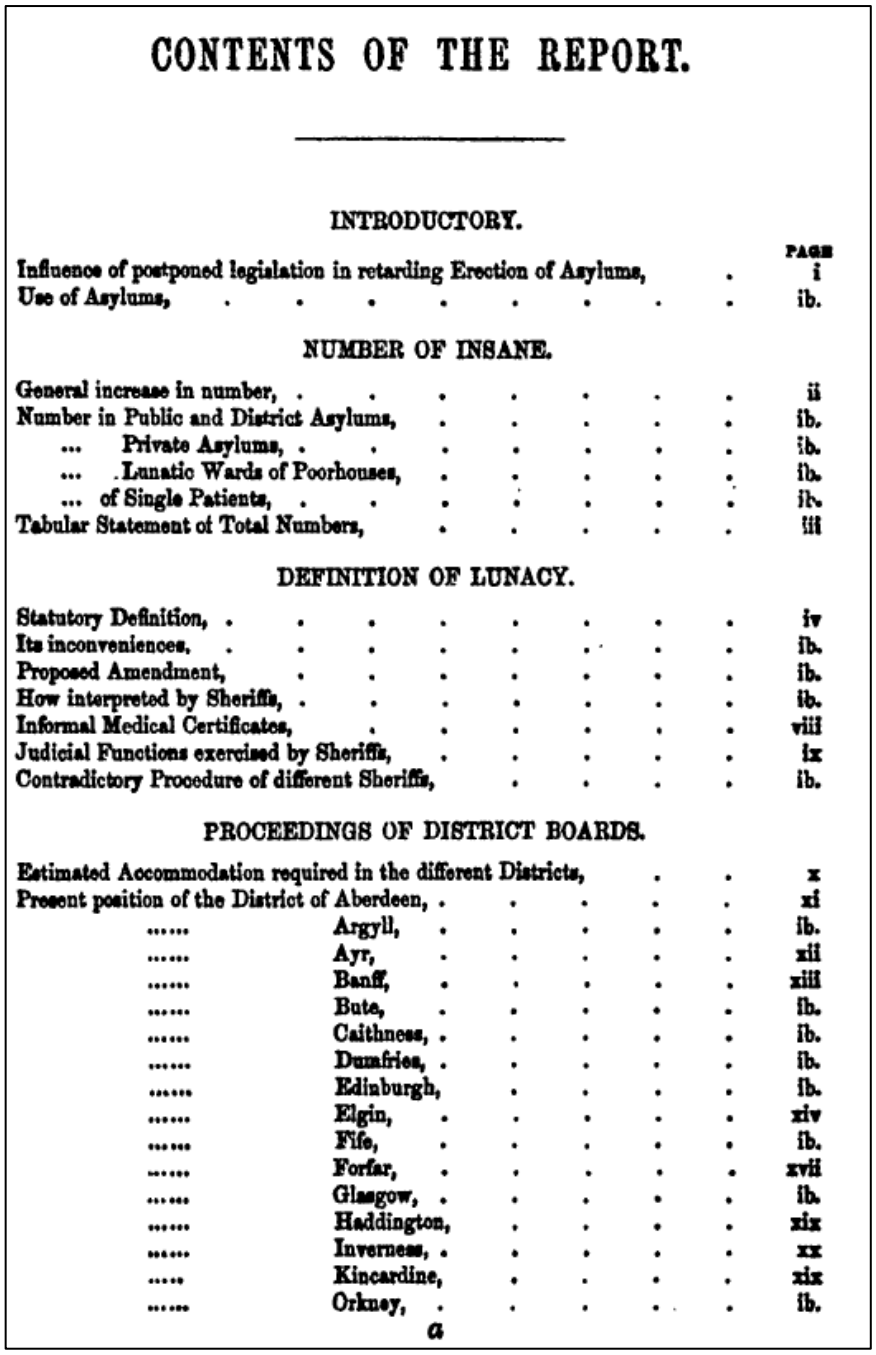
[77] The full title of this document is the Report by Her Majesty's Commissioners appointed to enquire into the State of Lunatic Asylums in Scotland and the Exisitng Law in Reference to Lunatics and Lunatic Asylums in that Part of the United Kingdom with an Appendix.

[78] Information such as who the Royal Commissioners were and how they were appointed will be elaborated in Chapters Five and Six.

[79] In England, the Metropolitan Commissioners in Lunacy, appointed after the original Madhouses Act of 1774 became just the Commissioners in Lunacy after 1845, following their own 'Doomsday" inquiry of 1844. See Philo 2004, Chapter Seven, for further details on the system south of the border.

6. A brief resumption of the leading particulars which seem to call for legislative interference; and of the principles on which it appears to us that such remedial legislation ought to be based. (SLR, 1857:2-3)

This report provided the backbone of information for Chapter Five below, which offers detailed analysis of the geographical elements of its content. To complement the report, I also accessed the commentary leading up to the 1857 Act on the Hansard webpage, which records the parliamentary proceedings. The Bill is available on the Parliamentary Papers webpage, and the Act itself is held in the University of Glasgow Library.



CONTENTS OF THE REPORT.

INTRODUCTORY.



NUMBER OF INSANE.



DEFINITION OF LUNACY.



PROCEEDINGS OF DISTRICT BOARDS.



a

Figure 4.2 – Contents page of the Third Annual Report of the General Board of Commissioners in Lunacy for Scotland (SCL, 1861). This is page one of four contents pages for this report. The *Proceedings of District Boards* was of particular use when analysing the reports.

The majority of information regarding the General Board, and the development of the overall system of district asylums, was garnered from the Annual Reports of the General Board of Commissioners in Lunacy for Scotland (SCL), which was commenced after the 1857 Act. These reports are available online on the House of Commons Parliamentary Papers website, and constitute a complete collection from 1858 to 1914.[80] I consulted all of the reports, taking the information right up to the *Mental Deficiency and Lunacy (Scotland) Act*, 1913,[81] thus giving a full overview of the period governed by the 1857 Act. Each of these reports is made up of between 250-350 pages, and thus a vast volume of material was processed across the fifty-six years (see Figure 4.2). While the general contents for each report varied slightly, depending on the specific agenda for each year, the standard format includes the following sections:

- Introductory remarks
    - General and exceptional comments about lunacy and the system as a whole for the preceding year.
- Proceedings of District Boards
    - Information regarding the district boards, and the royal and district asylum provision in each district (see below for more information).
- Expenditure for Pauper Lunatics
    - Information about the costs of accommodating lunatics in public, private and district asylums, as well as poorhouses and private houses, and the average daily expenditure for each pauper lunatic in each County, and comparisons between Counties.
- Condition of Single Patients
    - Single patients were those 'boarded-out' in the community, who were still subject to bi-annual inspections by the General Board. This sections included details such as number of applications for exemption from removal to asylums, tabular statements of numbers and distribution of non-institutionalised pauper lunatics, and illustrative cases.
- Conditions of Patients in Establishments
    - This section included information on pauper patients in all institutions: public, private, parochial and district asylums and lunatic wards of poorhouses, such as increases in patients, efforts to diminish numbers in asylums, the current rates of maintenance for pauper patients. It also included information on numbers of attendants such as their remuneration and average period of service and the condition of the different institutions, including suggestions for improvements, compliments on aspects which worked particularly well, and criticism for various deficiencies.
- Dangerous/Criminal Lunatics
    - Information on number of lunatics who were labelled 'dangerous', and had been detained for their own, and the publics, safety, as well as details on where they were to be confined.
- Alien Lunatics

[80] The first report was published in the January after the 1857 Act was passed, and the final report in the January after the 1913 Act was passed.

[81] The *Mental Deficiency and Lunacy (Scotland) Act*, 1913 saw legal and administrative changes in the care and treatment of lunatics, and the General Board of Lunacy was replaced with the Board of Control.

- This referred to the removal of lunatics to their own country for institutionalisation, with most of the cases referring to English and Irish lunatics.

The section that produced the biggest volume of information for use in this research was the *Proceedings of District Boards,* which occurred in every report. This section gave an insight into where the royal and district asylums were situated in Scotland, and the General Board's opinions on both the extent and standard of provision of asylums in the different districts. The appendix of the reports also gave a systematic account of the condition of the individual asylums, which were extracted from the entries made in the patients' book of all the institutions by the visiting Commissioners during their bi-annual inspections.

Special attention should be drawn here to the First Annual Report of the General Board, Appendix C, entitled 'Suggestions and Instructions issued by the Board in reference to (1.) Site, (2.) Construction and Arrangement of Buildings, (3.) Plans, of Lunatic Asylums' (Figure 7.1), which provides the first evidence for what can be cast as the Commissioners' 'blueprint' for their ideal district asylum. It is these subtitles that have loosely been copied for the headings of the later empirical chapters (Seven to Nine) in this thesis, as they link well to my own interests in geographical scale and clearly show the Commissioners' undoubted geographical concerns.

Finally at the national level, the handwritten unpublished minute books, located in the National Archive for Scotland (West Register House), allowed a degree of insight into the inner mechanisms of the General Board. Each entry was circa three pages long, entered at two-week intervals. They cover practical details about the running of the Board, and, although not going into great detail, they do help in working out how the system was organised and managed. Issues of concern are raised, often brought to the attention of the Board through letters from different districts or specific asylums. These letters were seemingly read to meetings of the Board, whose members commented on what action should be taken, requesting the Secretary to reply in writing to those concerned. Frustratingly, the details of these letters and the Board's replies were not retained in the collection. Comments in the early minute books relate to the larger geographical task of ensuring that districts and counties were divided in the most suitable manner, as well as ensuring that all the poorhouses and private madhouses were licensed through communications with Parochial Boards. As the minutes progressed, the comments moved towards individual asylums and their keepers or managers. A result of the bi-annual inspection of asylums was the constant stream of recommendations for improving both the layout and the management of institutions. When it came to discussing the erection of new

district asylums, there is evidence that the Commissioners referred to an architect (usually Mr Moffat, the consulting architect) before then circulating suggestions and instructions to the district boards. Similarly, when a new site for the erection of a district asylum had been proposed, the Board had to reply to confirm or reject the proposal. Unfortunately, limited detail is written as to why certain sites were rejected or accepted, although often it was due to a good, or lack of, adequate water supply. There are also hints of the process by which plans for new asylums were discussed and deliberated. Overall, no great detail is divulged in the minute books, yet they can most effectively be used to 'flesh out' the official annual reports.

***Local Archives***

In order to achieve more depth to the research pertaining to the local, day-to-day workings of the asylum system, as far as possible[82] the records of the different district boards and their asylums were consulted (see Appendix A for full list). These collections are predominantly located in the archive closest to the asylum site, which in the majority of cases was the local health board archives. This meant spending a significant amount of time travelling to various archives across the country, and experiencing a number of different archive spaces and archivists, all of whom were exceptionally knowledgeable and helpful in answering my queries and providing me with my requested documents. I found this part of my research the most rewarding and interesting, particularly as these are documents that very few (if any other) people have spent time reading. Furthermore, every search room was distinctive, each with its own charm that I quickly learned to appreciate, fully immersing myself in, and taking inspiration from, the different working environments (see Figures 4.4 and 4.5).

Figure 4.4 – Contrasting environments. Left: Royal College of Physicians Search Room; Right: LHSA Search Room.

[82] See later section regarding the 'lost' archive.

Figure 4.5 – Consulting the Glasgow District Asylum plans in the Mitchell Library, Glasgow (personal photograph by David, 2012).

The extent of the records relating to each of the districts varied greatly, and thus different volumes and types of information were gleaned from each archive. The majority of the collections could best be described as patchy and incomplete, offering only glimpses into the internal workings and decisions of the different district boards and their asylums. Again, the records very much constitute the 'official account', with the majority of the documents being published annual reports, although a few unpublished documents have also been kept, such as visitor's books and minute books.

| District Asylum | Archive | Location of Records Office |
|---|---|---|
| **Aberdeen** | NHS Grampian Archives | Aberdeen |
| **Ayr** | Ayrshire Archives and Dundee Archives | Ayr/Dundee |
| **Banff** | NHS Grampian Archives | Aberdeen |
| **Barony** | NHS Greater Glasgow and Clyde Archives | Glasgow |
| **Edinburgh** | Lothian Health Services Archives | Edinburgh |
| **Elgin** | NHS Grampian Archives | Aberdeen |
| **Glasgow** | NHS Greater Glasgow and Clyde Archives | Glasgow |
| **Govan** | NHS Greater Glasgow and Clyde Archives | Glasgow |
| **Haddington** | Lothian Health Services Archives | Edinburgh |
| **Inverness** | Highland Archives Services | Inverness |
| **Peebles and Midlothian** | Lothian Health Services Archives | Edinburgh |
| **Perth** | Centre for Archive and Information Services | Dundee |
| **Roxburgh** | Lothian Health Services Archives | Edinburgh |
| **Stirling** | Falkirk Community Trust | Falkirk |

Table 4.2 – The location of each district asylum archive consulted[83]

[83] Although there were twenty-one lunacy districts, there are only fourteen archives listed here. There are a number of explanations for this. Firstly, due to time constraints, I did not consult the archive collections of the Argyll and Bute, the Fife and Kinross, or the Renfrew Asylums, relying in these cases solely on the SCL records. Secondly, not all districts built district asylums, some, such as Shetland, Orkney and Caithness, reached agreements with bigger districts and therefore never built their own asylums. Thirdly, some of the districts took on parochial or royal asylums as their district asylums, and, as these were not built specifically as purpose-built *district* asylums, I omitted them from my research. Finally, the records for one district asylum (Lanark) have not been retained, see below for further details.

Examples of the documents consulted include: annual reports, minutes, visitor's books, maps, plans, newspaper articles and photographs. An inventory of all the different documents consulted in each archive has been appended (Appendix A). Due to constraints on time, there were instances when I needed to make decisions as to how much of the documents I would consult, particularly with some of the earlier district asylums, whose records reached into the later decades of the nineteenth century. I did ensure that I consulted all available material from around the opening of the asylum, which held the majority of discussions regarding siting and building construction, but if the documents were far removed from the asylum opening date, I was more selective with my research, safe in the knowledge that I was still getting a clear overview of the whole asylum period through the annual reports of the General Board.

***The 'Lost' Archive***

One of the district archives proved to be elusive, despite my incessant searches. It would appear that administration for Hartwood Hospital, which had been opened in 1895 as the Lanark District Asylum, located near the town of Shotts, fell geographically and administratively between the two large health boards that covered the Scottish 'Central Belt'.[84] Thus, when the hospital closed its doors in 1998, its records were not passed to either the NHS Greater Glasgow and Clyde Archives or the Lothian Health Services Archives. After a number of enquiring emails, I was put in touch with an ex-senior nurse of the hospital, Tony, who had used the records in 1995 to write the centenary history pamphlet for the hospital. At the time, the records were kept in boxes in the attic of Hartwood, but it was suggested that they had been transferred to Wishaw or Hairmyres General Hospital. Eventually, it was confirmed that the records from Hartwood had indeed made their way to Hairmyers Hospital and, with Tony as my guide, I spent a morning in their general store room, sifting through shelf after shelf of the old records, which had in no way been 'archived'; a very dusty process (Figure 4.6). As time passed, it became clear that the only records which had been retained were the patient records and case books. Tony lamented that he had carefully saved a number of the original maps and plans from the skip when the hospital was being cleared, and had put these, along with the annual reports and minutes, which he had consulted when writing the centenary pamphlet, into a box, specifically requesting that it be saved, stored and archived. It may be that this act of separating these records from the case books sealed their fate. Both myself and Tony were

[84] This is a common term used to describe the area of highest population density within Scotland, although it is not geographical central in the country. It incorporates the main urban areas of Glasgow and Edinburgh.

disappointed, for different reasons, that these records were still 'missing', and, although I have Tony's detailed pamphlet for reference, and references to Hartwood from the General Board reports, it is unfortunate that the original records could not be consulted for this thesis.

Figure 4.6 – Uncatalogued Lanark Asylum patient records (own photograph, 2012)

***Miscellaneous Archives***

To help triangulate a fuller view, I made two visits to archives to check collections for any 'other' material regarding the district asylum system. The first was the Royal College of Physicians in Edinburgh, where I found five box files containing loose hand written sheets mostly of reports on madhouses within specific counties, compiled by the County Sheriffs. These provided a useful addition to understanding the condition of lunacy provision prior to the 1857 Act, and add to the picture described at great length by the Commissioners in the 1857 Report. Secondly, I spent time scouring the drawers of the Mitchell Library filing system searching for any information regarding the Glasgow asylums, coming across minutes of combined meetings of the Barony, City and Govan Combination Parochial Boards as to the proposed division of the Lanark lunacy district, as well as some reports in newspapers. Regarding newspapers more generally, I also did a thorough search of the British Newspapers online catalogue. This pursuit proved fruitful, as I came across a large number of articles directly relating to various individual district asylums, as well as commentary on the system as a whole. These were included in newspapers such as the *Dundee Courier*, the *Aberdeen Journal* and the *Glasgow Herald*, and covered an array of subjects such as reports of meetings of district boards, details of newly opened asylums, extracts from the reports of the General Board and advertisements for architects and tradesmen.

Other archives of sorts, including ones that are particularly 'unofficial', have accumulated due to the activities of a number of service-users and so-called 'urban explorers'. During

my research I had contact with one group, '*Oor Mad History'*, who are a service-led community history project, established "to record, preserve and celebrate the history of the mental health service user movement in the Lothians in Scotland" (https://www.facebook.com/OorMadHistory/info). This group has therefore collated a degree of information on the recent histories of the services in this area, predominantly as more recent oral histories. A more alternative record has been deposited online by urban explorers, who have, since deinstitutionalisation and the closure of the majority of mental health units across the country, started exploring, documenting and photographing the demise of the former institutions (see Figure 4.7). I used this online source to get a sense of what the buildings and their interiors, described in such detail in the archived documents, actually looked like, but also to understand this new stage of the buildings, their informal occupations and invasion by nature, echoing Edensor's (2005a) research on industrial ruins.

Figure 4.7 – Screenshots from 28dayslater.co.uk (urban explorers blog) showing the recreation hall of the Gartloch Hospital (vis. Glasgow Asylum) (right) and glass linking corridors at Hartwood Hospital (vis. Lanark Asylum) (left).

### *Landscape as Archive*

> Equipped now with maps, note book, stout boots and a stout heart the historical geographer is ready to pursue his [*sic*] investigations o'er fell, field and fen, down macadamed road, up cobbled street with eyes open and mind alert to see and appreciate the visible landscape as the present phase of an ever-changing pattern

> indissolubly linked to its past and irrevocably the foundation of its future. (J. B. Mitchell, in Domosh, 1997:225)

Taking inspiration from the likes of Benjamin, DeLyser, Cresswell, and Lorimer, and as a way of breathing some meaning and life back into the documents consulted in the archives, over the research period I visited a number of the sites of the former institutions. As Domosh (1997:225) puts it, "I wanted the past made visible". Perhaps contrary to urban explorers, my purpose when visiting the sites of the district asylums was primarily to get a 'feel' for the wider place, and to grasp some sort of understanding of the scale, the landscape and the location of these sites, capturing images of the spaces which have been planned and described in specific detail in the pages of the archive. Although the asylum buildings are now in various states of (dis)repair, often ruined, renovated or bulldozed completely, I was still able to get a grasp of the views and surroundings that thousands of people (patients, doctors and staff) would have lived in and looked upon daily (Figure 4.8). This aspect of the thesis – an interest in asylum 'afterlives' – is an underlying concern/motif of the project, with particular salience for the concluding chapter.

Figure 4.8 – Gartloch Hospital (vis. Glasgow Asylum) (own photograph, 2011)

## ANALYTICAL PROCESS – INTERPRETING THE ARCHIVE

The analytical process used in interpreting the data was very fluid, rather than a more structured version of coding or discourse analysis, although borrowing from these methods, as outlined below. As stated previously, the archives were approached to extract any information that pertained to the specific geographies of the asylums both as an overall 'spatial system' and in terms of individual institutional locations and lay-outs. This resulted in a personal archive of electronic files, each containing tens of thousands of words extracted from each of the documents consulted. The second step was to retrace these 'geographical' documents to 'pick out' the evidence for the empirical chapters. The themes were loosely scalar, taking inspiration from the three headings in the appendix of the first report of the General Board: site and situation, grounds and layout, buildings and positioning.[85] The information unearthed was then analysed in a number of ways, not focusing on the specific meanings of the words themselves, but rather on the text as *machinery*, trying to expose both the affective implications and constructions of power sedimented within the documents, as well as recovering the overall system as it developed during the time period. Explained thus, it should be clear how the conceptual themes threaded through Chapter Three above have been the prime ordering/sensitising devices for my methodology. This outcome was achieved primarily through a Foucauldian approach to discourse analysis, as well as close attention to the moments when the text hinted that its authors were concerned with the creation of affective atmospheres. Importantly, it must be remembered that the documents now stored in the archives were originally created to be functional: they 'did' things, they made things happen, they 'authored' changes in the asylum system from mid-nineteenth-century Scotland forward. As McGeachan and Philo (2014:3) put it:

> Words are both crucially *reflective* of the goings-on in the human world, but also unavoidably *generative* of that world in all kinds of ways. Words can shape, wound, fracture and direct how lives, and the material landscape housing these lives, are planned, enacted, altered and obliterated.

The likes of the Scottish Commissioners in Lunacy, or at least the district-level 'managers' (doctors, architects, engineers), effectively produced these 'real' asylum geographies from these texts, and hence the close analysis of the written documents, uncovering the energy and animation within the languages deployed, and the discourses circulating within them

[85] The thematic chapter titles were loosely taken from these headings, although amended slightly to: Sites and Situations; Grounds; and Buildings.

through theoretically-informed lenses, is fundamental in understanding and reconstructing the geographies of the district asylum system.

Fairclough, who writes at length on the use of critical discourse analysis and incorporating a Foucauldian slant, understands the method as more than the close reading of text, but rather involving a dissection of the text in order to comprehend broader societal structures, practices and relationships:

> Text analysis is an essential part of discourse analysis, but discourse analysis is not merely the linguistic analysis of text. I see discourse as 'oscillating' between a focus on specific texts and a focus on what I call the 'order of discourse', the relatively durable social structuring of language which is itself an element of a relatively durable structuring and networking of social practices. (Fairclough, 2003:3)

Thus, a post-structuralist Foucauldian discourse analysis method looks beyond discourse as text, focusing specifically on "the social consequences of difference through power in tandem with the construction of identity" (Aitken and Craine, 2005:264). In Foucauldian terms, "discourses are not simply reflections or (mis)representations of 'reality', rather they create their own 'regimes of truth' – the acceptable formulation of problems and solutions to those problems" (Lees, 2004:102-103). Hence, discourses are not purely communicative exchanges, but rather are abstract mechanisms that incorporate sets of social practices, principles and beliefs that are interconnected. Furthermore, Aitken and Craine (2005) argue that it is possible to speak of a specifically geographical discourse; allowing the special language of Geography as a discipline with its own concepts and vocabularies pertaining to space, place, landscape, including spatial relations, uneven development and the power of places to be brought into contact with other discourses from outwith the discipline (such as those of lunacy reformers).

By approaching the text with certain questions, mostly attending to mechanisms of power, one can begin to recognise how language is used to construct the various structures that shape society. It is a mediating agent that classifies, subjectifies and objectifies (Dittmer, 2010). A discursive structure can be uncovered and established through the language, because of the systematicity of the ideas, opinions, concepts, ways of thinking and behaving which is created within specific contexts (Mills, 1997). Thus, there is a cyclical nature to the production of all texts and how they are formed through discourse. A text may produce or maintain a discourse, but as a result of its construction the agents accountable are entangled within the wider discourses that are responsible for its

production, which resultantly shapes the 'next' text. This relationship is important, as it shows that agents cannot act, and texts cannot be produced, in a vacuum, since both are embedded within the wider functionings of society, as well as texts 'making' these wider functionings happen. Despite text being, more-often-than-not, the dominant evidence in an historical study, it is important to recognise the interplay between the document and other actors, recognising the context of the wider network of related events and actions, and the conditions in which the text has been constructed, and subsequently, the power of the text to influence discourse. An example is drawn from the records of the Ayr Asylum, which shows how the words in a report reveal power relations to be inscribed into asylum spaces:

> In conjunction with this addition on the male side has been the removal of the partitions in the first gallery, which divided the large day-room into two, and which separated these again from the adjoining corridor. This has considerably increased the day-room accommodation, [and] *has made the supervision of this large gallery more complete*. (Ayr D.A., A.R., 1880:15, emphasis added)

Here, the text reveals that the alteration of the internal space of the asylum resulted in the easier supervision of the patients. Following the arguments of PP, it can be assumed that this allowed the extension of the superintendent's body/will over the patients' body/will through enabling the asylum staff to better monitor the behaviours of the inhabitants, thus gaining power over the patients.

The documents were also scoured for any reference to the engineering of affective atmospheres, and moments when it was evident that the various authorities were trying to manipulate the emotional responses of the patients to the institutional spaces. As outlined in Chapter Three, the study of affect generally falls under the umbrella of non-representational theory, which in its description criticises the emphasis on words. Thus, using the archive, the written word, to uncover the potential creation of environments designed to affect individuals could be seen as problematic. I needed to establish how to think through affect when all I had was words (and not even the patients' words). Despite this perceived drawback, it became evident that the very language used in the documents lent itself to being viewed through an affective lens, as a close reading of the text allowed such affective language to emerge. Take, for example, this vignette from the Glasgow Asylum:

> The various sections have been furnished in a way best fitted to secure the efficient care and treatment of the patients. In the day-rooms sofas and various kinds of easy chairs have been liberally provided, and these will not only afford comfortable seats for patients who are aged and infirm, but will also conduce, generally, to good

> conduct and contentment. Pleasant and comfortable surroundings have a marked influence in diminishing irritability and restlessness, and in contributing to the happiness of the patients. It was noticed, with approval, that there was a piano in many of the day rooms. Pictures, plants, and other objects of decoration have been freely supplied, and the aspect of the wards was throughout one of cheerfulness and brightness. (SCL Report re-printed in the *Free Press*, 1904:np)

Here, it can be read that it was assumed that the improved quality of the furniture and surroundings would have a direct affect on the behaviour of the patients. Creating more cheerful surroundings would, it was hoped, not only produce more docile, and thus more manageable, patients, but also impact on the patient's emotional wellbeing.

Importantly, and as suggested previously, the texts consulted were predominantly written to be functional, to shape 'things' and make 'things' happen (McGeachan and Philo, 2014). The authorities responsible for the creation of the institutions were aware that attention to specific details, such as internal décor and decorations, could alter the perceived atmosphere of these spaces and thus could *potentially* affect the patient's non-cognitive responses to these spaces. Additionally, the engineering of affective spaces enhanced the ability to control individuals, manipulating their behaviour to respond in certain ways, thereby enhancing the effectiveness of supervision and management. Suggestions and commands were therefore written into their documents, which were often then acted upon by the district boards and the asylum superintendents. Despite not having an insight into the actual responses (through written observation or patient's personal reaction), the recognition of this detail of institutional design is a significant component in understanding the overall system of asylum provision that was being engineered and constructed during the research time period.

# Chapter 5

# The stage for the coming of the district asylums

## INTRODUCTION

Beginning on the 'eve' of the 1857 legislation, the following chapter outlines the pivotal inquiries that had far-reaching consequences for lunacy provisions in Scotland over the second half of the nineteenth century. The 1855-57 Scottish Lunacy Inquiry and Report (SLR), which was conducted by Her Majesty's Commissioners,[86] attended to both the state of lunatic asylums and the existing law pertaining to lunatics and lunatic asylums in mid-nineteenth-century Scotland. Importantly, it looked both back, to the earlier era of relatively limited Scottish lunacy provisions, and forward, anticipating and planning the coming of the district asylum system. It can therefore be used as a window into the 'pre-landscape' of lunacy provision as it stood before the far-reaching, legally-driven changes to come, which were to produce a new 'landscape' upon which both district asylums and central inspection/direction were to be crucial.

The Report recognised the existence of four categories of lunatic accommodation that were being used to manage the insane: poorhouses, boarding-out, private 'madhouses' and royal asylums (see Figure 5.3, 5.4 and 5.5). These categories will be used to construct a picture of the geographies of lunacy provision prior to the 1857 Act, alongside other primary and secondary evidence such as information on pre-1845 poor relief and its alteration post-1845. The old and new Poor Laws of Scotland had a particular effect on pauper lunatics because they placed a duty on parochial boards to provide authorised asylum accommodation (Darragh, 2011), although this duty was apparently not properly implemented or enforced, as the Report discovered.

[86] The Commission was made up of two English Commissioners, William George Campbell, who had been a member of the English Lunacy Board since its establishment in 1845 (but was originally from Argyll, Scotland), and Samuel Gaskell, who was the first resident Medical Superintendent to become a Commissioner. Gaskell had been in charge of the Lancashire County Asylum at Lancaster, and was advisor on asylum design and management to the English Commissioners. Dr James Coxe was also appointed, and was the Scottish representative on the Board (Darragh, 2011).

As will become evident, the Royal Commissioners[87] focused a lot of their attention on the specific geographies of the different institutions, the importance of which is twofold: firstly, it gives an insight into what they perceived to be unacceptable geographical arrangements, and thus secondly, led on to recommendations, and praise for, elements they thought should be more greatly implemented into future asylum buildings – the initial hints of an asylum blueprint which was to be encouraged by the later Scottish Lunacy Commissioners (SCL) in the designs and settings of the new district asylum system (see Chapters Six-Nine). Geographical information is flecked throughout this chapter, as it was throughout the Report, but the geographical themes, and how the later SCL developed their locational reasoning over the remainder of the century, will be elaborated in greater depth in later chapters.

Credit for the investigations and reform has often been given to American social reformer Dorothea Lynde Dix (1802-87),[88] who was a chief instigator in championing for an inquiry, and her contribution will be detailed below. Change, however, had been set in motion even earlier in the century by visionists such as Samuel Tuke, writer of *Description of the Retreat: An Institution near York for Insane Persons of the Society of Friends* (1813), Johan G. Spurzheim, writer of *Observations on the Deranged Manifestation of the Mind, or Insanity* (1817), Sir Andrew Halliday, writer of *A General View of the Present State of Lunatics and Lunatic Asylums in Great Britain and Ireland* (1828) and, in Scotland, Dr W. A. F. Browne, writer of *What asylums Were, Are, and Ought to Be* (1837), which all set new standards in asylum expectations (see Scull, 1991).[89] In Browne's (1805-1885) words, he sought to use his book to launch "a crusade" (Browne, 1837:99) and it arguably comprises the single most influential study by a medical writer on the topic of insanity (Donnelly, 1983).

Attempting to establish supporters amongst the politically influential, Browne (1837:1) aimed "to condense, in a plain, practical, and still popular form, the results of observation

[87] It is important to note that the Commissioners responsible for this Report were not quite the same as those who become the Scottish Lunacy Commissioners, who will be discussed in later chapters. This distinction is important, as the recommendations discussed in Chapters Five and Six were coming from two different, if related, bodies. In order to differentiate between the two groups in this chapter, those responsible for the inquiry and Report will be initially referred to as the Royal Commissioners and henceforth the Commissioners, with the group responsible for the lunacy provision after the 1857 Act referred to as the Scottish Lunacy Commissioners, whereas in Chapter Six onwards, the latter will be referred to simply as the Commissioners (SCL).

[88] For more detailed information on Dix, see Thompson (1984); Brown (1998); Darragh (2011).

[89] The parliamentary debates highlighted that a Bill had been attempted in 1848, put forward by Lord Rutherford, which they believed, if passed, would have remedied the complaints that were brought to light by the 1855 inquiry.

in the treatment of insanity, for the specific and avowed purpose of demanding from the public an amelioration of the condition of the insane" . Through depicting the worst scenes of torture and inhumanity, and the unjustness and intolerances within the old madhouses, in the section on *What Asylums Were*, he repeatedly illustrated stories "designed at once to titillate and to repel" (Scull *et al*., 1996:106), with the aim of raising "the cry for improvement … where hitherto the silence of indifference has reigned" (Browne, 1837:1-2). By the time Browne published his book in 1837, alternative methods of care and treatment had started to become evident, and were described in his fourth chapter, *What Asylums Are*. Yet, despite "great improvements … proceeded partly from selfish motives, partly from the prevalence of sounder views of the nature and treatment of mental disease, and chiefly… from the dread of Parliamentary investigations, and the surveillance and remonstrances of the medical commissioners", Browne (1837:134-135) claimed that "we have not altogether escaped from the evils characteristic of what asylums were". Predictably, he was not content with the advancements made, announcing that although "the promised land was in sight; it was not reached" (Browne, 1837:139). He concluded this chapter by announcing that for moral treatment to be effective, "it would become necessary that all asylums should be public and under the control of government" (Browne, 1837:174), believing that private asylums detained patients for as long as possible for economic gain, whereas public asylums aimed to dismiss patients as soon as possible.

In the final chapter, *What Asylums Ought to Be*, Browne drew out the characteristics of his utopian asylum. His vision was resolutely geographical, built on the curative potentials of the therapeutic landscape, the moral qualities of the superintendents and the need for educated, kind and gentle keepers, which all promised to rehabilitate the majority of patients to both sanity and society. Markedly contrasted with the traditional madhouses, whose "great objects were – confine, conceal" (Browne, 1837:101), if properly managed, the asylum could be "beautiful and self-operating" (Browne, 1837:203), relying on what Browne (1837:177) believed to be the secret of the new system and of moral treatment – "kindness and occupation":

> There must exist a benevolent kindness which shall be so deep and expansive as to feel sympathy for the lunatic, not merely because he is an alien to his kind, because he is visited with the heaviest and hardest affliction which humanity can bear and live; but will feel an interest in those unreal and artificial and self-created miseries with which the distracted spirit is oppressed … There must be a benevolence which will be prepared to make the lunatic a companion and a friend … (Browne, 1837:179)

Browne's concluding paragraphs described "an asylum as it ought to be" (Browne, 1837:229) to an imaginary visitor, obviously pushing to sell the vision to his audience through stark, vivid contrasts between past and current asylum conditions. Madness could be brought under control without the use of whips, chains or corporal chastisement, but rather with the comforts of domesticity, "extensive and swelling grounds and gardens", galleries, workshops and music rooms, enjoyment, with all around "a hive of industry" (Browne, 1837:229). Inmates would be encouraged to read, play music, attend church or the market, and walk, ride and drive in the country depending on the severity of their malady: a utopia where, "in short, all are so busy as to overlook, or all are so contented as to forget their misery" (Browne, 1837:231). Browne (1837:231) closed optimistically by declaring "such is a faithful picture of what may be seen in many institutions, and of what might be seen in all, were asylums conducted as they ought to be".

*What Asylums Were, Are and Ought to Be,* was to receive great scrutiny from the medical press, bringing Browne national and international attention and propelling him to the forefront of the newly amalgamating profession of alienism. The book firstly secured Browne the position of physician-superintendent at the new Crichton Royal Asylum, followed in 1857 by his appointment as one of the first two Scottish Lunacy Commissioners, where he was able to strive to implement many of the pronouncements made in his book. In 1865 Browne's stature was further recognised by his election as president of the Medico-Psychological Association of Great Britain and Ireland for 1865–6, and he was awarded honorary degrees from the University of Heidelberg and the University of Wisconsin (Henderson, 1964; Hunter and MacAlpine, 1963). The book's powerful propaganda in support of the new therapeutic, moral regime was arguably a significant contributor to advancing reforms in the treatment of lunatics, and was viewed almost as a manifesto, a crystallisation of what Browne and other revisionists proceeded to work towards, and was a text purchased and highly regarded by a great number of asylum superintendents (Andrews, 1998). For example, in the United States of America, the founding members of the Association of Medical Superintendents of American Institutions for the Insane directed their asylums to be constructed and run under Browne's principles (Geller and Morrissey, 2004).

Attention will now turn to Dorothea Dix, who had dedicated her time to teaching, moral improvement and social reform in her twenties and thirties, eventually became connected to a number of Quaker philanthropists, particularly spending time with Sir William Rathbone at Greenbank, near Liverpool, and with Samuel Tuke of the York Retreat. This

sparked her interest in the care and treatment of the insane, and in her later life she devoted her time to establishing asylums and influencing legislation, particularly in America (Darragh, 2011). Using information from visits to other asylums in North America, England and Ireland, Dix visited all of the royal asylums and private madhouses in Scotland, uncovering numerous cases of horrific abuse and avoidance of responsibility, particularly respecting pauper lunatics in private madhouses, which mirrored strongly the earlier findings in England by the English Lunacy Commission.[90] Reform did not come easily, however, with Dix encountering hesitancy and resistance from the majority of Scottish politicians, due to their tradition of being suspicious of interventions in Scottish affairs. Dix was particularly disheartened by Browne's response to her investigation, as he referred to her as 'The American Invader' and an 'interfering busybody' (Robinson, 1989). Andrews (1998) points out that it took outside intervention to promote the inquiry, a fact that highlights the contemporary level of resistance in Scotland towards separate central control of lunacy provision, and towards any change to the new Scottish Poor Law passed in 1845. The Board of Supervision[91] was of the belief that it was adequately managing the relief of lunatics in Scotland, and officials feared that any change might result in importing the English system of poor relief north of the border, a system which they felt promoted idleness and dependency due to being too dependent on indoor relief in the form of the 'workhouse'. There was, conversely, a view that the English (and Welsh) New Poor Law was *too* harsh – too hostile to outdoor relief, which included boarding-out arrangements, and would demand wholesale building of 'workhouses', whereas the Scottish system depended less on institutions (poorhouses) and more on myriad other outdoor relief arrangements. Yet, through bringing to light the dire conditions, Dix's mission was the final incentive for instigating change, and thus the building of the district asylum system. Her perseverance and campaigning gradually succeeded in converting enough politicians to agree to a Commission of inquiry and investigation. Indeed, the parliamentary debates time and again praise her "philanthropic mission" (Ellice, 1857:np). It was these differing socio-economic views of poor relief and nationalistic concerns that help explain the twelve-year lag between the English and Scottish Lunacy Acts.

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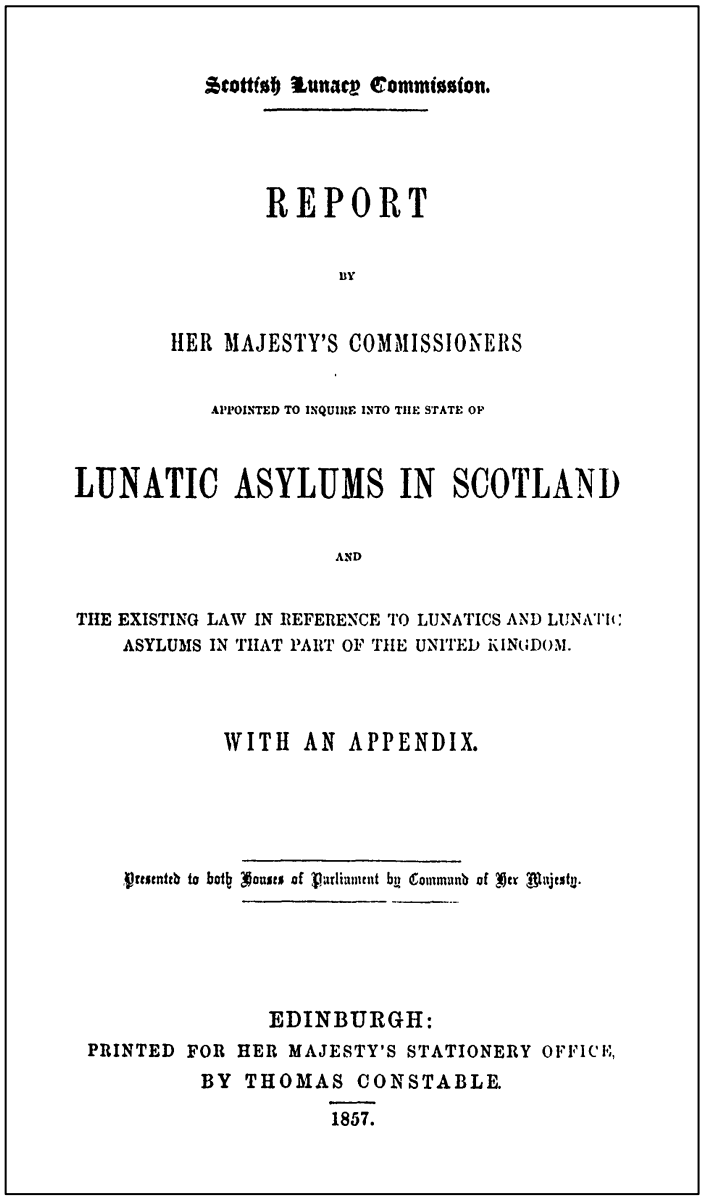
[90] See Philo 2004, Chapter Seven for geographical reading of the equivalent from 1844.

[91] The Board of Supervision was the central authority for poor relief in Scotland. It was established as part of the *Poor Law (Scotland) Act*, 1845, was based in Edinburgh and its membership comprised the Lord Provost of Edinburgh, the Lord Provost of Glasgow, The Solicitor General of Scotland, the Sheriffs Depute of the counties of Perth, Renfrew, Ross and Cromarty, and three other persons appointed by the Crown. It was responsible for the administration of the poor laws and the general relief of paupers across the country.

## SCOTTISH LUNACY COMMISSION REPORT, 1857

The inquiry, and subsequent report (over 800 pages in length and detailed in Chapter Four), was presented to both Houses of Parliament, by command of Her Majesty, and consequently resulted in the *Lunacy (Scotland) Act*, 1857: *An Act for the Regulation of the Care and Treatment of Lunatics, and for the Provision, Maintenance, and Regulation of Lunatic Asylums in Scotland* (Figure 5.1).[92]



Scottish Lunacy Commission.

REPORT

BY

HER MAJESTY'S COMMISSIONERS

APPOINTED TO INQUIRE INTO THE STATE OF

LUNATIC ASYLUMS IN SCOTLAND

AND

THE EXISTING LAW IN REFERENCE TO LUNATICS AND LUNATIC ASYLUMS IN THAT PART OF THE UNITED KINGDOM.

WITH AN APPENDIX.

Presented to both Houses of Parliament by Command of Her Majesty.

EDINBURGH:
PRINTED FOR HER MAJESTY'S STATIONERY OFFICE,
BY THOMAS CONSTABLE.
1857.

Figure 5.1 – The front page of the Scottish Lunacy Commission Report (SLR, 1857).

The Report covered a vast number of topics regarding lunacy in Scotland, past, present and future, including: an account of the laws pertaining to the subject of lunacy; both the treatment and custody of lunatics, and the care and management of their property

[92] Sturdy (1996) also covers much of this data in her thesis, but with more emphasis on the fortunes of single patients and the boarding-out system.

(including any abuses or defective administration of the law); numbers of insane resident in both formal and informal accommodation; location, size, situation and layout of existing institutions (public and private), including information on diet, restraint and seclusion, attendants and religious services; and single patients not confined in establishments. The information was gathered by the Commissioners through both visiting the various institutions and addressing different public authorities for information: for example, the Board of Supervision for Relief of the Poor, Parochial Inspectors, the General Board of Prisons, secretaries and superintendents of royal asylums, and many proprietors of private asylums. Through their investigation, it become clear that all persons of insane mind resident within Scotland should be included in the inquiry, whether in asylums or not, thus ensuring a complete overview, a 'Doomsday survey', of the situation and provisions in Scotland at the time.

Previous attempts to survey and enumerate the insane were not standardised and therefore unreliable (see Darragh, 2011:53). So, in order to determine the numbers of insane in Scotland, the Commissioners decided to divide them into four classes: firstly, those resident in royal asylums or lunatic wards of poorhouses; secondly, those resident in houses officially known to the Sheriff; thirdly, those irregularly detained in poorhouses under the sanction of the Board of Supervision but not under warrant of the Sheriff; and fourthly, all those residing with relatives or strangers, or living alone in houses not officially recognised by the Sheriff and only partially known to the Board of Supervision. The importance of finding out the numbers of insane not officially known to the Sheriffs grew as it became clear that a great number were in this position, particularly within the northern parishes (see Donoho, 2012). Three options for gaining this information were taken into consideration: appealing to the clergy, medical practitioners, or the rural police. The Commissioners decided on the latter as, particularly in the Highland districts, there were problems with a lack of information. The Established Church and the Free Church did not possess the desired information and the medical men, who due to their low numbers in this region were often the parochial surgeons, were potentially placed in a difficult position with the parochial boards if they were to disclose their information. Thus:

> For the above reasons, we made application to the superintendents of the constabulary force in the different counties, as best able to afford the required information; and we requested them to instruct the constables under their charge, to make returns of all the insane and fatuous persons resident within the districts traversed by them, according to a schedule sent by us for the purpose, under the following heads: – County – Parish – Name of Lunatic or Fatuous Person – Age of

> Lunatic or Fatuous Person – With whom Resident – Where Resident – How long Fatuous or Lunatic – Whether or not in receipt of Parochial Relief – Whether or not ever in Confinement in an Asylum – Remarks. (SLR, 1857:33)

In areas with no organised police, particularly Orkney and Shetland, the ministers and sheriff-officers were asked for the information. The combined returns, the first enumeration of the insane in Scotland, as well as a detailed map which, perhaps surprisingly, prefaced the Report and shows the location of Scotland's public and private establishments (see Figure 5.2), allowed a picture to be constructed of the distribution of the insane, in which establishments they were situated, if any, and the geographical spread across Scotland as a whole.[93] The total number of the insane in Scotland, as gleaned from the inquiries, was as follows:

| **Insane in Scotland** | |
|---|---|
| Under special protection of the law (eg. royal asylums, lunatic wards of poorhouses) | 3328 |
| In poorhouses, but not under Sheriff's warrant | 253 |
| With relations or strangers, or living alone | 3798 |
| In unlicensed establishments (eg. private 'madhouses') | 24 |
| **Total** | **7403** |

Table 5.1 – Numbers of insane and where they resided as uncovered in the 1855-57 inquiry

From the inquiry, the Commissioners came to the conclusion that the difference in environment between cities and rural places had a significant impact on people's mental health. Many of those residing in cities had the greatest mental activity but suffered from great physical deterioration due to continuous labour, residence in "unwholesome dwellings" and intemperance, thus amounting to "a prolific source of insanity among the crowded population in our towns" (SLR, 1857:39). Conversely, in rural locations, it was perceived that the environment caused the mind to "stagnate", with a large number of cases of insanity due to "congenital causes", attributed to intermarriage, which resulted in a large proportion of "idiots and imbeciles" (SLR, 1857:39). Indeed:

> The preponderance of this cause of mental disease in remote counties, distinctly appears, on comparing the proportions of congenital cases occurring in them, with

[93] The surprise/pleasure of the geographer finding a map at the outset of this Report was great, and the inclusion is seemingly unique in nineteenth-century lunacy reports and related documentation, certainly in Britain.

those found in southern counties, where the mental powers have been more called into action, and intermarriage is less frequent.[94] (SLR, 1857:39)

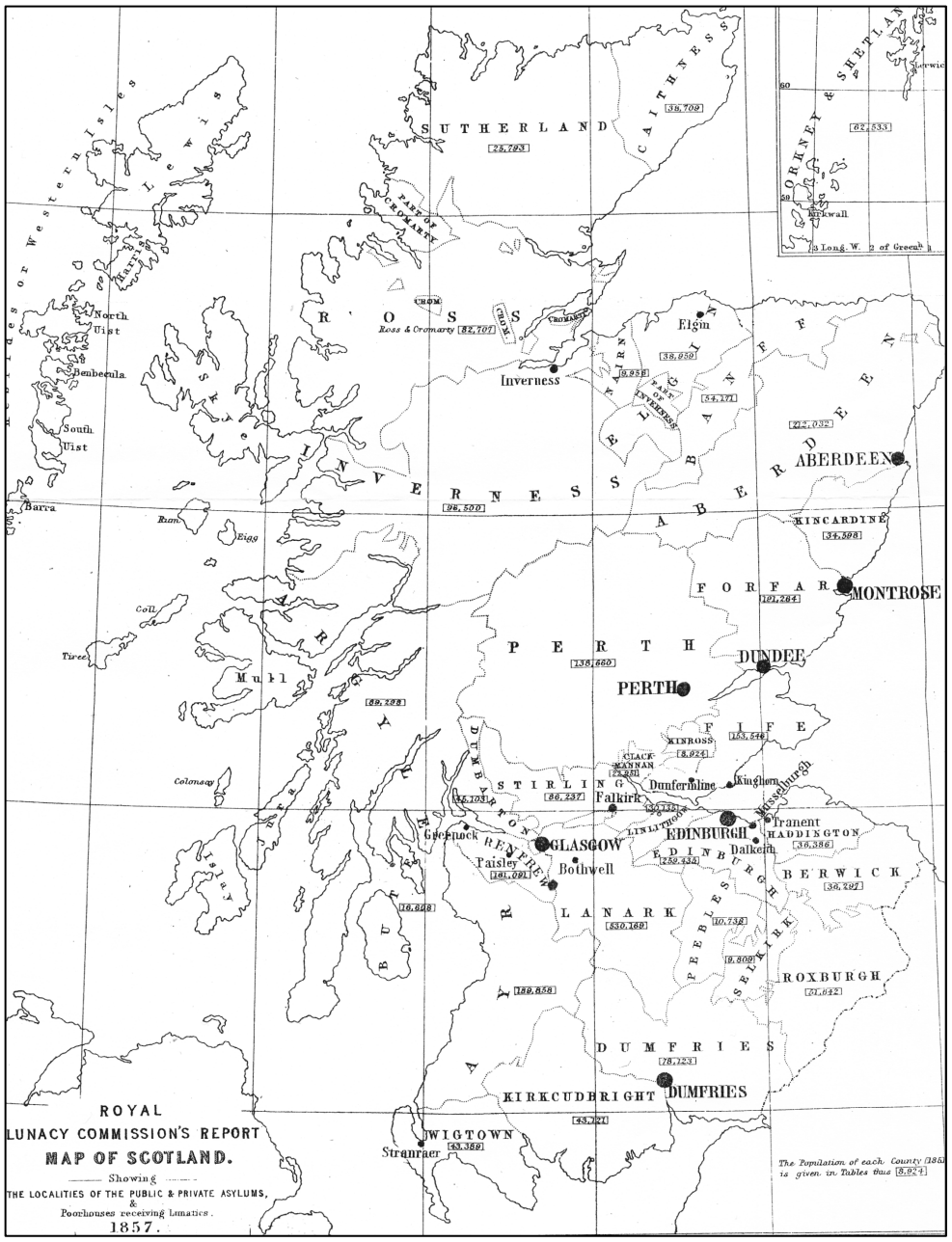


Figure 5.2 – Map of Scotland from the Scottish Lunacy Commission Report, showing locations of royal asylums (SLR, 1857:np)

The Commissioners used this evidence to argue that, although they had no way of determining whether insanity in Scotland was on the increase, as this was the first comprehensive inquiry into the numbers of insane within the country, it did provide grounds to believe that "civilisation, which leads to an improved condition of the people, is not productive of insanity" (SLR, 1957:40). The Commissioners were nonetheless acutely aware of the drawbacks in the statistics. The rate of pauper lunatics varied greatly across

[94] This hints at the sense of what 'in-breeding' does to society.

the country, being higher in some remote, thinly populated counties than in other more heavily populated areas; yet, they stated, it was unclear whether this variation was due to the level of pauperism or the level of lunacy. There were further difficulties with determining the actual distribution of the insane, as the numbers were erroneously amplified in the counties containing royal asylums, causing an immigration of patients, and conversely were diminished to an equivalent extent in others.

| Royal asylums | Asylums with no royal charter | Poorhouses with separate lunatic wards | Poorhouses without separate wards for the insane | Prisons |
|---|---|---|---|---|
| Aberdeen | Elgin[95] | Abbey (Paisley) | Ayr | Perth |
| Dumfries | | Aberdeen | Dalkeith Combination | |
| Dundee | | Barony (Glasgow) | Dumfries | |
| Edinburgh | | Dunfermline | Easter Ross Combination | |
| Glasgow | | Edinburgh | Govan (Glasgow) | |
| Montrose | | Falkirk | Inverness | |
| Perth | | Glasgow | Jedburgh Combination | |
| | | Greenock | Kelso Combination | |
| | | Leith (South) | Kircaldy Combination | |
| | | Old Machar (Aberdeen) | Kirkpatrick-Fleming Combination | |
| | | Paisley | St Cuthbert's (Edinburgh) | |
| | | Rhinns of Galloway Combination | | |

Table 5.2 – Institutions receiving no financial gain (SLR, 1857:50-52)

Despite these difficulties, the information gathered was used to determine what type of accommodation was available in each of the districts, and the numbers residing in each institution. Furthermore, through their own investigations, the Commissioners were able to ascertain the extent of accommodation provided for the insane, both in public institutions and private establishments. The institutions that made no financial profit are outlined in Table 5.2. Overall in 1855, there were 2,868 lunatics in these establishments: 659 private (paying) patients and 2,180 receiving parochial relief.

[95] Elgin Asylum was opened in 1835 as a small pauper institution, being reclassified as the district asylum for Elgin after the *Lunacy (Scotland) Act*, 1857.

Private houses, or 'madhouses', those in which the proprietor made pecuniary gains from their establishment, consisted almost exclusively of licensed[96] houses, of which there were twenty-three in Scotland, spread across the counties of Aberdeen, Ayr, Edinburgh (nine in Musselburgh alone), Haddington, Lanark and Renfrew (see Table 5.3). Although only 657 of the insane dwelt in these houses, the Commissioners reported that most were incredibly overcrowded, and that the accommodation was indeed more than fully occupied. There were probably also a small number of unlicensed madhouses, but due to the nature of these institutions, they were not included in the inquiry.

| Private Establishments ('Madhouses') | |
|---|---|
| **Aberdeen** | Middlefield, Old Machar |
| **Ayr** | Ryefield House, Dalry |
| **Edinburgh**[97] | Eastfield, near Joppa |
| | Eastport House, Musselburgh |
| | Hallcross House, Musselburgh |
| | Hawkfield, South Leith |
| | Lilybank, Musselburgh |
| | Market Street, Musselburgh |
| | Market Street, Musselburgh |
| | Millholme House, Musselburgh |
| | Newbigging House, Musselburgh |
| | Newbigging, Musselburgh |
| | Pennywell House, Grange Loan, Edinburgh |
| | Saughtonhall, Slateford |
| | Senbank House, Musselburgh |
| | Shepherd House, Inveresk |
| **Haddington** | Lunatic Asylum, Tranent |
| **Lanark** | Langdale House, Bothwell |
| | Garngad House, Glasgow |
| | Springbank Retreat for Insane Ladies, Glasgow |
| | Blackfauld Private Lunatic Asylum, Rutherglen |
| **Renfrew** | Hillend, Greenock |

Table 5.3 – List of licensed houses (SLR, 1857:53)

The remainder of the chapter will give further details on the four categories of provision that the Lunacy Commissioners uncovered through their inquiry, from non-specialist to

[96] Licensed by the Sheriff to receive lunatics.

[97] There was a surprising preponderance of madhouses in Musselburgh, likely due to the ease of which a license could be obtained in this town.

specialist: poorhouses, boarding-out, licensed 'madhouses', and royal asylums, as well as wider information on the system of poor relief pre- and post-1845.[98] In order to gain an understanding of poor relief in Scotland, which had peculiar differences to the arrangements in England and Wales due to Scotland retaining judicial powers after the 1707 Act of Union, the following section will also give a summary of the system prior to the *Lunacy (Scotland) Act*, 1857.

## CARE FOR PAUPERS AND PAUPER LUNATICS PRIOR TO 1857

Prior to the 1857 Act, a person deemed to be of insane mind was entrusted to the care of their relatives (more regarding the management of their property than the care and treatment of the person),[99] except in two cases: firstly, when the lunatic was regarded to be a danger to the public; and secondly, when they were dependent on parochial funds for support. The responsibility for seclusion of the former lay with the Procurator-Fiscal, and in the latter case they were under the charge of the Parochial Inspector who should alert the relevant local parochial board. Thus, pauper lunacy provision and care prior to the 1857 Act was embedded within the structure of poor relief which had developed for general paupers through both the old and new Poor Law legislation.[100]

Throughout the seventeenth and eighteenth centuries, provision for Scottish paupers was difficult in both rural and town locations. In the country, the problem was exacerbated by seasonal labour causing periods of unemployment across the population, meaning many people were struggling to fund themselves let alone provide help for others.[101] As such, before the establishment of general poor relief, there were many vagrant beggars who travelled the country in search of basic sustenance. In towns and cities, the problem was arguably worse, but there were also more options to acquire some form of relief, perhaps

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[98] The report also included information on insane received into prisons and schools of idiots, but this information lies outwith the scope of this thesis.

[99] For detailed information on the process by which a person becomes legally classified as insane prior to 1857, see Houston (2000).

[100] The system of support and relief for paupers in Scotland caused major problems across the centuries. Consequently, it went through various stages, developments and parliamentary acts (the first passed in 1424) in its aim to provide an appropriate level of care for the poor of the country. Most acts in the fifteenth and sixteenth centuries were concerned with the problem of beggars and vagabonds, and it was not until after the Reformation that the parishes became responsible for the relief of the poor. This was implemented through both kirk sessions and heritors (local landowners), with relief funds raised through voluntary contributions from these two groups and taxes. Only individuals who were deemed destitute and disabled (for example, the old, blind, orphaned and sick) were entitled to regular parochial relief.

[101] There was particular hesitancy and difficulty when dealing with those willing to work but unable to find employment, and particularly for those capable but indisposed to work.

from an incorporation/friendly society[102] or, after the Reformation, from the kirk session, which, particularly post-1649 and the formation of the Great Session, had a duty to provide funds for the poor. Conditions and diet within poorhouses were extremely basic, with space and time highly regulated, resulting in public aversion to such establishments, partly due to the assumption, despite authorities claiming otherwise, that those housed there were incarcerated. As a consequence, by 1837 poorhouses only existed in Edinburgh (Figure 5.3), Paisley and Glasgow (Ferguson, 1948).

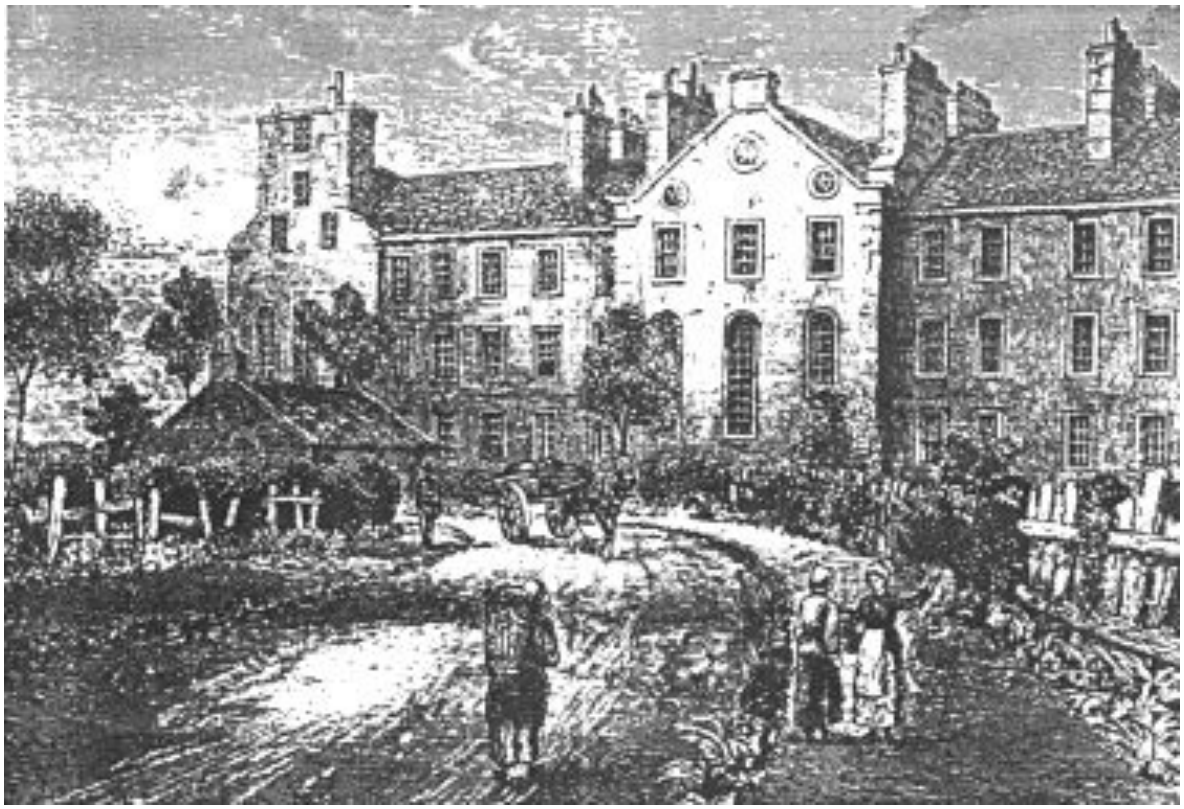

Figure 5.3 – Edinburgh charity poorhouse, 1820 (The Workhouse). This institution was funded by public subscription, and was opened in 1743. By 1777-8, it could accommodate 484 adults and 180 children.

By the end of the eighteenth century, the Church was struggling to meet the demands of providing respite for paupers and begging was once more a severe problem. At this stage, only ninety-two of the 878 parishes in Scotland (mainly urban) used legal assessments for raising funds from the heritors (landowners) for the relief of the poor,[103] with the majority, 786, relying on the old voluntary system (Ferguson, 1948). However due to economic pressure, the practice of assessment was steadily to increase, initially mainly within towns and cities, despite reluctance from the Church. Legal assessment was a system that was

[102] By 1826 there were over 85,000 "free" members in seventy friendly societies in Scotland (Ferguson, 1948).

[103] Legal assessment was the system of raising funds for poor relief from the landowners and property owners in the parish. There were four different ways of doing this, with the individual boards choosing which was most appropriate for their parish.

governed, in the burghs at least, by the magistrates, thus showing a move towards a more secular administration system. Within rural districts, however, assessments for gathering funds were virtually unknown, particularly in the north, where relief was still predominantly through voluntary kirk collections even into the first decades of the nineteenth century. In short, there was great geographical difference between the methods and amounts of relief across the country, which was to come to a head in the 1840s.

It was clear that those who proffered money, the well-off Scots, "were prepared to pay towards the maintenance of the poor and the insane only provided that their giving was voluntary and its destination clear" (Houston, 2001b:8). Thus, there were differences in opinion between social reformers, rate-payers and the Church as to how to approach the rapidly growing numbers of unemployed poor, many of who were strong, able-bodied poor, out of work due to depressions in trade. Adding to these problems, towns and cities were rapidly growing due to increased migration of labour, helped by expanding rail and road networks. Consequently, more and more parishes were pushed to impose assessments for poor relief despite what many perceived to be drawbacks. These included the arguments that:

> … an organised system of relief would take away the earnings of the industrious to support the idle and dissolute, make no distinction between poverty resulting from misfortune and that from vice, destroy the ties of relationship, and lessen both the sympathy of the wealthy and the mutual aid of the poor. (Ferguson, 1948:193)

Despite opposition, the pressures for changing the Scottish poor relief system could not be ignored. A Government inquiry was held in 1844, which looked:

> … into the Practical Operation of the Laws which provide for the Relief of the Poor in Scotland; and whether any and what Alterations, Amendments, or Improvements, may be beneficially made in the said Laws, or in the Manner of administrating them, and how the same may be best carried into effect. (Report from Her Majesty's Commissioners for Inquiring into the Administration and Practical Operation of the Poor Laws in Scotland, 1844:np)

The inquiry found, unsurprisingly, that, despite broadly varying conditions across the country, overall the standard of support was deemed low. As previously stated, at this stage there were only thirteen poorhouses, and thus the predominant system of support was outdoor relief, with allowances extremely small (see Young, 1994). The Poor Law Commissioners looked into a number of areas where poor relief was provided, including medical situations, which, particularly in rural locations, were provided almost exclusively

by private charities. Regarding the provisions for the insane, the Poor Law Commissioners recognised the great improvements made in some institutions, but they found that overall accommodation for pauper lunatics was insufficient (a situation echoed by the Lunacy Commissioners a decade later).[104] Despite the clergy's strong opposition, the Poor Law Commissioners were to put forward the recommendation of legal assessment for the poor, which was to be included in the *Poor Law Amendment (Scotland) Act*, 1845 (to become known as the new Poor Law).

The new Poor Law stipulated that, if a person was classified as a pauper lunatic, the relevant parochial board was responsible for providing the insane with accommodation in an asylum or other legally certified establishment within fourteen days of their condition being highlighted. Inspectors of the poor were then responsible for reporting all such cases to the Board of Supervision in Edinburgh. As Sheriffs were not responsible for non-pauper lunatics, there was uncertainty in the Act as to what extent pauper lunatics were under the law of the Sheriff, or whether their care was fully transferred to the Board of Supervision. This uncertainty arose particularly when it was found that a pauper lunatic did not need to be confined in an asylum/madhouse, but rather could be placed with a stranger (see later section on boarding-out). In these cases, the Board of Supervision had no right to house lunatics in such places, unless the house was fully licensed by the Sheriff. The vagueness of the legislation often resulted in harmful and unlawful situations, many of which were described in the 1857 Report.

***Poorhouses***

Poorhouses were provided for the accommodation of paupers eligible for relief: the friendless poor, orphans and those who were unable to take care of themselves and their affairs, thereby including lunatics. In the early years this was not a formal incarceration, as inmates could leave at their own will, and, furthermore, although encouraged, work was not compulsory. As stated previously, when the 1845 new Poor Law Act was passed, there were thirteen poorhouses in Scotland, and by the close of the nineteenth century, this number had risen to sixty-six,[105] being kept relatively low due to the high expense of building and running such institutions. In comparison, 550 union workhouses were

[104] The evidence for the Poor Law inquiry (Scotland) was collated into five parts, containing minutes of evidence from all the counties in Scotland. It is available on the Parliamentary Papers website, along with the annual reports of the Board of Supervision for the Relief of the Poor in Scotland.

[105] Not all poorhouses had designated lunatic wards. At the passing of the *Lunacy (Scotland) Act*, 1857, only twelve of the poorhouses had attached lunatic wards (see Chapter Six).

constructed in England between 1835 and the 1870s-1880s (Philo, 2004).[106] After 1845, parishes of over 5,000 inhabitants were prompted to construct poorhouses by the Board of Supervision, some then being built as combination poorhouses with smaller parishes able to buy bed space as required. Over time, as both pauper and poorhouse numbers increased, more difficulties and complaints surfaced regarding their administration and regulation. One step taken to alleviate problems, particularly in relation to spurious claims for relief, was the implementation of rules and discipline, with the aim of creating an environment "more irksome than labour" (Ferguson, 1948:214).

As stated previously, overall conditions within the poorhouses were kept extremely basic, cheerless and impersonal. Inmates were deprived of their liberty, were exercised in small, narrow yards enclosed by high walls, were fed subsistence levels of food, and had to wear a uniform. As a result, there was controversy as to whether the poorhouse and the new Poor Law were adequate systems of relief for the destitute poor. Some, such as the Earl of Stair, argued that the poorhouses provided security and comfort for those eligible and could also be fostered as a place of industry and education, which in time would both check begging and reduce the poor rates (Ferguson, 1948). Alternatively, even the Board of Supervision argued that in some situations they could inflict a great hardship on the pauper with no benefit to the community (Ferguson, 1948), and that in such cases, outdoor relief should be provided. Other condemnations of the new Poor Law included the following from Dr Littlejohn, Medical Officer of Health of Edinburgh, who reported in 1861 that "the pittances that are given to paupers, through the proverbial economy of Boards, representing the ratepayers of our City, are only intended to allow a life being maintained at a legal flicker and by no means at a steady flame" (in Ferguson, 1948:219). By 1862, the death rate among inmates was twenty-three per cent, with nine in every hundred dying within the first year of entry (Ferguson, 1948). Obviously this had a particularly detrimental effect on the physical and mental wellbeing of pauper lunatics, who often found themselves effectively incarcerated in these houses.

The new Poor Law Act indeed requested that all parochial boards remove their "insane and fatuous"[107] paupers to an asylum or licensed house. Due to limited accommodation and the cost of removal to official institutions, however, many were kept at home:

[106] For more detail on the great phase of workhouse building south of the border, see Driver (1993).
[107] 'Fatuous' "adverts to persons who, from weakness or facility of mind, are unfit to take charge of their own affairs" (SLR, 1857:24). 'Fatuous' patients were classed with the insane, and were therefore eligible for

> From the time of the inception of the Board of Supervision in 1845 up to the middle of 1848, the number of cases of lunatic and "fatuous" paupers not in asylums investigated by the Board was 2,003, and removal to an asylum was required in only thirty-eight of these. (Ferguson, 1948:207)

Although there were moderately low numbers of poorhouses in Scotland, all appear to have received insane or fatuous paupers, mostly with the warrant of a Sheriff,[108] in order to avoid the costs associated with residence in public asylums or licensed houses. As it was mainly the decision of the Sheriff, sometimes in connection with the Board of Supervision,[109] as to what kind of cases should be received into the poorhouse, the practice differed across the counties. Accommodation was varied, as in some houses lunatics were mixed with general paupers, whereas in others separate wards had been provided. The different kinds of accommodation received different types of lunatic, with the "merely harmless imbecile" (SLR, 1857:128) tending to be housed in the mixed institutions. Recent cases were generally admitted to the separate lunatic wards, which had an asylum-type feel, but rarely possessed the "advantages of an hospital for the treatment of insanity" (SLR, 1857:128). Between the establishment of the new Poor Law in 1845, and the time of the lunacy inquiry, the numbers of poorhouses, and lunatics lodged in poorhouses, had risen quite markedly. This, along with the complications and inconsistencies over who was in charge of the insane in these establishments, meant the condition of the insane in the different poorhouses was becoming of great importance, particularly as only two (the Glasgow City, and Barony parish poorhouses) had a resident medical man.

The Scottish Lunacy Commissioners later stated in their first report:

> The treatment of the insane, is a question which should not be considered from the sole point of view of economy. It must be tested by the standards of humanity and medical science; and, from the results thus obtained, we are called on to determine whether the insane in poorhouses receive the treatment which is best calculated to alleviate their heavy affliction, and restore them to health. On these principles we proceed to examine it. (SCL, 1859:134)

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asylum or mad-house accommodation. Importantly, it was a different definition to 'weak-mindedness', whose persons were housed in poorhouses.

[108] The Edinburgh City poorhouse and St Cuthbert's workhouse were found to be receiving insane and fatuous paupers without a Sheriff's warrant, and in some cases even without a medical certificate. The Sheriff had never visited either institution, leaving the responsibility with the parochial authorities. The reason that they had not applied for a license was apparently both to avoid paying fees and to avoid inspection and interference from the Sheriff.

[109] The Commissioners objected to the Board of Supervision being involved in this decision, believing that it belonged entirely to the jurisdiction of the Sheriff.

The Report highlighted many anxieties, including geographical concerns, about the standard, location and construction of poorhouse accommodation, examining both external and internal spaces. Through their inquiry, poorhouses were found to be generally situated in a locality convenient to the parish. Older poorhouses such as Edinburgh City and Paisley Burgh were positioned within the town, and thus were enclosed by buildings, meaning that the purchase of additional land was restricted. Although the newer houses often occupied "pleasant sites in the suburbs of towns" (SLR, 1857:134), they did not possess adequate grounds. Consequently, there was limited opportunity for outdoor exercise, as there was usually only one extremely small airing court for each sex, which had walls so high that they shut out any view of the surrounding countryside. The Report illustrated this deficiency by providing measurements from a few poorhouses, such as Falkirk, whose airing courts were each about 20 yards long, 10 yards broad and surrounded by walls 18 feet high:

> These examples will suffice to show that the means of exercise provided for the patients are of the most inadequate description, being much inferior even to those of the licensed houses. As many of the poorhouses possess no land, except the site of the house and airing-courts, the patients in them have no opportunities of going into more extensive grounds. (SLR, 1857:144)

This lack of external space meant that, even if there was a wish to provide such facilities, there was insufficient land to afford occupation to the patients. Only two houses had enough land to allow outdoor occupation (Barony parish poorhouse (30 acres) and Abbey parish poorhouse (18 acres)). Similarly, there was no means of amusement, no bowling-greens or any other form of outdoor recreation, due to the limited outdoor space.

The internal spaces of the houses were found generally to consist of large, barely furnished dormitories and day-rooms, and several were found to be overcrowded. When separate lunatic wards were provided, they were usually "small and ill-contrived" (SLR, 1857:135), and did not allow appropriate classification of patients. It was a common occurrence to find no separate sick-room or infirmary. It was found that all houses had rooms that could be used for the seclusion of noisy cases, but they were regularly located so close to rooms occupied by quiet patients "that one refractory case disturbs the tranquillity of the whole ward" (SLR, 1857:143). The chief problem with the set-up was that the poorhouses were designed to be as unattractive to ordinary paupers as possible, to reduce the numbers claiming admission. This was said to have a detrimental effect on the health and treatment of the lunatic inmates. Often, attention was not paid to details such as a "cheerful prospect"

from the windows, which were frequently "darkened with paint, [and] generally look into small airing-courts, which are enclosed by high walls" (SLR, 1857:136). Within the rooms, the only furniture provided was limited to backless benches, which were deemed unsuitable for sick and feeble patients. The methods of ventilating the poorhouses varied greatly, from simple windows and open fireplaces, to more complex systems involving a warming apparatus, with varying degrees of success. In the Barony poorhouse, which used an apparatus which worked through suction, the patients complained that, when the windows were closed, there was a "closeness and oppression" (SCL, 1859:140) to the air. When they were opened, however, the current often flowed back in to the room.

Due to the low attendant-to-patient ratio, the proper treatment of patients could not be guaranteed. Methods of mechanical restraint, such as the strait-waistcoat and leather muffs, were found in all bar one poorhouse (Burgh parish poorhouse, Paisley), with the instruments on the whole left with, and used at the discretion of, the attendants. In the houses that received only fatuous and incurable inmates, these attendants were ordinary pauper inmates only occasionally given payment for their duties. In houses with separate wards that received recent cases, there was, on the whole, one male and one female paid attendant, who were helped by the general paupers.

As a consequence of these inadequate arrangements within the majority of poorhouses, the Commissioners decided to condemn the use of poorhouses for accommodating insane patients. They believed that the direct management by parochial boards of the insane poor was not conducive to administering the sort of care and attention which they felt was necessary for their wellbeing. Thus, they sought to discourage parochial boards from undertaking the practice of connecting insane wards to poorhouses, as they felt it tended "not only to check progress, but to produce positive retrogression in the treatment of the insane" (SLR, 1857:149).

***Boarding-out***

The boarding-out of pauper and private lunatics was a pioneering phenomenon in Scotland, made legal through the *Lunacy (Scotland) Act*, 1857 (see Sturdy, 1996), but the practice of housing harmless, chronic insane patients in the community as an alternative to institutionalisation had evolved long before legislation. Written into earlier lunacy statutes, it was a policy initially developed due its combination of allowing privacy as well as official supervision, and was originally intended for the upper classes of society. Houses that lodged one non-related insane patient were required to report to the Sheriff, but, due to

slack administration, this rarely occurred, with the Commissioners uncovering a mix of private and pauper, registered and non-registered boarders, in total numbering 3,798 persons.

As a consequence of the new Poor Law Act of 1845, large numbers of insane paupers were placed in the care of strangers, but in the majority of cases the law requiring lunatics to be registered or reported with the Sheriff was wholly disregarded. Thus:

> Of the large number of insane who are resident with private individuals, whether relatives or strangers, the Sheriff takes no cognisance whatever, except in those comparatively few cases, which are specially reported to him. (SLR, 1857:152)

Despite the new Poor Law statute directing all pauper lunatics to be removed to an asylum or licensed house within 14 days of their insanity becoming known, this often did not happen, due to the expense and inconvenience of providing institutional care, or the Inspector of Poor not reporting the case of insanity to the Board of Supervision.[110] The number of boarded-out pauper lunatics in Scotland according to the Inspectors of Poor was 1,363, but the constabulary force found it to be higher, at 1,998 (and even then, it was believed, some still escaped enumeration). Hence, particularly due to the high numbers not under inspection, investigating boarded-out pauper lunatics and their treatment became one of the most important tasks of the Commissioners' inquiry. During their investigations, they found "'deplorable' instances of what was to be regarded to be neglect, cruelty and insanitary living conditions" (Sturdy and Parry-Jones, 1999:87) within the population of single patients, many of whom should have been removed to an asylum. Particularly in rural locations, where transfer to asylums was expensive, "the welfare or recovery of the patients is, as a general rule, very little considered when deciding on the manner of their disposal" (SLR, 1857:176), with many cases continually boarded-out when they should have been in asylum care. To highlight their plight, the Commissioners outlined a few cases, including J.T., aged 43, suffering from mania, and residing at Helmsdale:

> This patient has been insane for 14 years. She has delusions, and fancies her husband has murdered her. She is never out, and scarcely ever leaves her bed, which is in the room in which the family take their meals. She becomes violent at times, and is then managed with difficulty, especially in the absence of her husband. She has an allowance of 1s a week from the parish of Kildonan. (SLR, 1857:177)

[110] It was in this situation that the Commissioners made use of the constabulary, who they asked to note all insane and fatuous who were receiving parochial relief.

The Commissioners discovered, much like the situation with the licensed houses discussed below, that the living conditions of single patients in the western counties was markedly below the same class in the eastern counties. Houses were dirtier, patients were worse dressed and more "debased", which they attributed "to the large influx of Irish into the western districts" (SLR, 1857:180), a 'racist' deduction in effect.

Overall, it was felt that countless numbers of single patients would greatly benefit from removal to an asylum. It could have possibly relieved their mental situation, as well as the pressure on relatives; and, even if their insanity had continued, it was believed that they would derive both benefit and enjoyment from outdoor exercise. On the other hand, the Commissioners were aware that a great number of this class, mainly the idiotic, weak-minded or fatuous paupers, most of who had been this way since birth, would not benefit from removal to an asylum or poorhouse. In these instances, the Commissioners' role was to inquire as to whether their general needs were appropriately met.[111] Through investigating the conditions of the insane and fatuous not in asylums, the Commissioners stated: "it is obvious that an appalling amount of misery prevails throughout Scotland in this respect" (SLR, 1857:196).

***Licensed 'Mad' Houses***

The 1857 Report outlined a very critical, disparaging picture of the numerous private licensed houses ('madhouses') within Scotland.[112] There was no standardisation of these houses and limited control over the proprietors, resulting in discrepencies in the kinds and level of accommodation provided. Houses providing for the upper classes of society were often found to be run by educated people, well-suited to the management of such an establishment (although no specific qualification was required), but the majority of pauper institutions were run by proprietors wholly unfit for the proper care and treatment of the inmates. Licenses were distributed to people who had no knowledge of the nature or treatment of insanity, nor the funds to supply a satisfactory service to the inmates.[113] Clearly, there was more emphasis on the 'trade in lunacy' (Parry-Jones, 1972), housing patients for economic gains rather than for curative purposes. When compared to the royal

[111] For further research regarding the system of boarding-out, particularly after the *Lunacy (Scotland) Act*, 1857, see Sturdy and Parry-Jones (1999), Sturdy (1996) and Donoho (2012).

[112] For information on the geographies of English and Welsh 'madhouses', see Philo 2004, Chapter Five.

[113] In Musselburgh, the Commissioners found proprietors who had previously been: a victual dealer, an (unsuccessful) baker, a gardener, and a women who ran both a public-house and a madhouse, and was waiting to see which would be more profitable (SLR, 1857).

asylum's accommodation and treatment, the Commissioners drew the conclusion that the rates charged in the licensed houses, particularly the larger institutions, "leave a considerable margin as profit to the proprietor" (SLR, 1857:103). For the sum of money paid in many of the establishments, moreover, the Commissioners supposed that the patients had a right to expect a better standard of accommodation.

Figure 5.4 – Drawing of Mr Drury's Private Asylum (SCRAN). Garngad House was opened in 1823 as one of the only purpose built private madhouses. It was located on Garngad Hill, to the north of Glasgow Cathedral in a residential area. It is thought that this sketch is the only illustration remaining of the institution.

The majority of the licensed houses were situated in and around Edinburgh and Glasgow, with a high number located in Musselburgh, arguably due to the ease at which licenses could be obtained in Midlothian (SLR, 1857). In the years leading up to the Report, there was a considerable increase in the number of houses, both due to cheaper rates and the lack of space for pauper patients in royal asylums. There was a huge variation in the size of the houses, with most receiving a mix of private and pauper patients. None of the institutions (with the exception of Saughtonhall) were purpose-built. Indeed:

> In one or two of the better class, such as Saughtonhall and Whitehouse, great expense has been incurred by the proprietors in providing suitable accommodation for the patients; but generally a private house has been rented, or bought, and afterwards altered and enlarged, to fit it (in most cases imperfectly) for its new destination. The sole aim, especially in the houses where the patients are principally paupers, has evidently been to accommodate the greatest possible number, at the smallest outlay. (SLR, 1857:101)

To ensure minimum expenditure, the majority of the 'madhouses' were of the most basic standard. Outhouses never planned for human occupation had, on occasion, been used for accommodation. The Report highlighted that large, over-crowded, comfortless dormitories were common, and frequently there was no proper separation of the sexes, "who were

placed in adjacent apartments, approached by the same stair or passage, who use the same airing-courts, and are not even provided with separate water-closets" (SLR, 1857:101). Often, due to the lack of dayrooms, inmates had no option but to reside in their over-crowded sleeping-rooms during the day when not occupying the airing-courts. In further efforts to economise, the Commissioners reported a general lack of furniture "and in several instances an almost total absence of everything that is not absolutely necessary" (SLR, 1857:101), meaning that patients had to sit on their beds or squat on the floor to eat their food as no seats or tables were provided. When dayrooms were provided, they were bare and comfortless. There was certainly no attempt at trying to create a home-like environment, and when dayrooms were provided, they were bare and comfortless. Moreover, due to poor ventilation, crowded dormitories, and a large number of patients with "dirty habits", the atmosphere of the rooms could become "very offensive and deleterious" (SLR, 1857:106), particularly as they were often occupied for at least thirteen hours a day.

Few or no spaces were dedicated to the treatment of the sick, feeble and aged inmates, and "they are kept in bed, and ultimately die in the dormitories, in the midst of the other patients" (SLR, 1857:102). In some cases it was reported that after death, the body was taken by cart to the nearest cemetery and buried without any religious service. In the very few institutions that had single-rooms for the separation of epileptic, noisy or refractory patients, the space was far too small and very poorly ventilated. Consequently, due to the poor spatial arrangements found in the vast majority of licensed houses, the Commissioners observed "that mechanical coercion[114] is applied and continued in these houses to a considerable and much greater extent" (SLR, 1857:103). To highlight the situation, the Report gave examples of what the Commissioners took as the worst cases uncovered. They found two men at the Hillend asylum, near Greenock, both of whom had been in decent employment and paid a sum that should have given them comfortable accommodation, but were found sharing a small bedroom with a third patient, and for months they "had slept together, entirely naked, in a miserable trough-bed, upon a small quantity of loose straw" (SLR, 1857:105). This habit of occupying rooms with more patients than they were calculated to accommodate was a regular occurrence, and in one case, at Hallcross, arguably contributed to one patient killing the other.

[114] Mechanical restraint refers to controlling the movement of the lunatic through the use of, for example, straitjackets, muffs, manacles and handcuffs. The aim was to stop the patient escaping, or to stop them attacking attendants or other patients, or self-harming.

As with the internal spaces of the licensed houses, the external spaces differed considerably at each institution. A very small number possessed airing courts of a fair size, but generally "they are small, gloomy, surrounded by high walls, and without any view" (SLR, 1857:111). There was no evidence of planning regarding the prospects of the enclosures, emphasised by another example from Hillend. Here, the patients exercised in four small courts located at the rear of the house, surrounded by high walls, whereas if they had been placed on the opposite side of the house "the inmates would have had the advantage of a cheerful view of the Clyde and distant mountain scenery" (SLR, 1857:112). A further consequence of the limited external space was the lack of opportunity for occupation, recreation and amusement. It was reported that in many houses, the grounds for 60-90 patients rarely exceeded one acre.

The Commissioners concluded that the great difference between the licensed houses and the royal asylums arose because the former were driven by economic gain for the proprietor, while the latter were motivated chiefly by providing for the welfare and benefit of the patient. This was reportedly subsistence living of the lowest order, with minimal money spent on furniture, food, clothing, bedding and attendants. Furthermore, to save even greater expense, clothing was found to be removed to save money on washing, wear and tear, and during the winter the patients often spent the whole day in bed to save money on candlelight. The geographies of the institutions were criticised as the spaces and activities recognised as promoting both recovery and cheerful living conditions, for example outdoor grounds, recreation rooms, exercise and occupation, were virtually non-existent. The Commissioners were clearly pushing an agenda by highlighting the worst cases of abuse.[115] Due to the evidence uncovered by the investigation, they stated that, although there may be a small number of exceptions (of which only limited information was divulged), the majority of the licensed houses should be "fundamentally reformed" (SLR, 1857:128), and ultimately eradicated as a source of accommodation for pauper patients.

***Royal Asylums***

By the time of the Commissioners' inquiry, seven asylums, later to be known as 'royal' asylums when they all received royal charter, had been built in Scotland (see Table 5.4). It

[115] For an arguably more balanced assessment of English private madhouses, see Parry-Jones (1972).

is crucial to recognise that these were *not* truly 'public' asylums[116] with an arms-length relationship to the state, but rather were funded by philanthropic donations from a range of sources: "medical, civic, mercantile and lay" (Rice, 1981:246)[117], although they were considered 'public' institutions in law.

| Royal Asylum | Opened |
|---|---|
| **Montrose** | 1781 |
| **Aberdeen** | 1800 |
| **Edinburgh** | 1809 |
| **Dundee** | 1812 |
| **Murray, Perth** | 1827 |
| **Crichton, Dumfries** | 1834 |
| **Glasgow** | 1814, relocated 1842 |

Table 5.4 – Royal asylums and the year they opened.

The asylums were in a sense unique to Scotland, with the equivalent in England and Wales being the so-called 'charitable lunatic hospitals', but these tended to be smaller and did not possess royal charter (Rice, 1981), although one exception was Bethlem, which was huge and did have a 'royal' charter. Once opened, the 'royals' were funded by subscriptions and fees from paying patients, and, despite the royal charter securing their legal status as institutions for the treatment of lunatics, they did not fall under government control. They received, and had demarcated spaces, for all social classes of patients, with the fees of the upper classes defraying the costs of poorer patients. Moreover, unlike the previous provisions, the new asylums marked out different 'types' of lunatic: the furious, the idiot and the melancholic were now separated within and between buildings. As Houston (2001b:19) notes, "by 1820 the keynote had become not lumping or distinguishing but specialising". Within royal asylums, patients were also split up into the following three categories: private patients whose family paid for their whole maintenance; pauper patients whose fee was paid by their parish; and *gratis* patients who benefitted from civic or asylum funds.

The Commissioners noted that the existence of royal asylums for the insane in Scotland was proof that there was interest in helping "this most destitute portion of the community" (SLR, 1857:59), particularly as there was no legislation forcing their erection and no

[116] The REA was the only exception, as it was funded with public donations rather than private capital. It was, however, still not a 'public' (state-run) facility.

[117] There is a small body of extant scholarship on these establishments, as I discuss in Chapter Two, unlike on the other 'spaces' mentioned here, and particularly unlike on the district asylums.

prompts by central authority for their improvement and advancement. Overall, the Commissioners were impressed that the directors of the extant royal asylums:

> [h]ave not only shown themselves willing at all times to advance the condition of the institutions under their charge; but they have at once abandoned sites and buildings [as in Glasgow] which experience had proved to be objectionable; and have also taken means to provide additional accommodation so as to meet the increasing wants of the community. (SLR, 1857:61)[118]

The Commissioners dedicated a considerable amount of discussion to the merits of suitable locality, site, size and construction to the patient, integrating both an assessment of the current royal asylum buildings with their vision for the future architecture, arrangements and locations of the ideal asylum blueprint, in anticipation of the planned national district asylum system (see Chapter Six). The Commissioners believed that the asylum locality, more than just a place to discard undesirable people, could exercise "a positive though indirect influence upon the condition of the patients" (SLR, 1857:62). Furthermore, they stated that "the important influence exercised upon the inmates of asylums, by the nature of the sites upon which they are built, can hardly be over-estimated" (SLR, 1857:64). They agreed that of the seven royal asylums only Montrose was not situated on a well selected site. Ideally the site should be elevated, southerly facing and with good views. It should be distant enough from a town to secure privacy and uninterrupted exercise beyond the limit of the asylum grounds, but close enough so as to ensure that officials and servants were not shut off from general society, and also to allow the more trustworthy patients to benefit from "an occasional visit to the public amusements of a city" (SLR, 1857:64).[119]

Moreover, the size of the asylum was also perceived as having an influence on the health of the patients. It was preferable for asylums to be of moderate size, as both the building and the patients could be managed much more efficiently and effectively than in larger establishments. Additionally, it was understood that smaller local institutions better serviced the wants of the different communities, as patients could be more easily transferred to them. Furthermore, the Commissioners "had reason to believe" that smaller asylums were preferred by patients "where their individuality is more recognised, and where they have a more home-like feeling" (SLR, 1857:65).

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[118] This is an important point, as it shows locational dynamic was already associated with these institutions. The closest equivalent in England and Wales were the charitable lunatic hospitals, which, discussed in Philo 2004, Chapter Six, also displayed a number of crucial locational moves prior to the mid-nineteenth century (or (controversial) non-moves, in the case of Bethlem and St Luke's).

[119] These geographical themes will be elaborated at greater length in later chapters, particularly how the Commissioners developed their locational reasoning over the remainder of the century.

Figure 5.5 – Early nineteenth-century sketch of the Edinburgh Asylum (East House), Morningside, Edinburgh (SCRAN).

The correct internal layout of the asylum added to the ease with which patients could be managed. The Commissioners considered this matter while discussing the construction of the asylum buildings. They observed that both the Perth Asylum and the Crichton Institution at Dumfries, constructed on a similar plan, had a central staircase, "with a curiously contrived double wall", with galleries radiating from this staircase which could be inspected through "glazed apertures over the door" (SLR, 1857:65), which hints at a panoptic arrangement. Furthermore, at Perth, Dumfries and Edinburgh, there were open spaces, like external galleries, enclosed on the outside by strong wire, which seemed to have been designed to allow the patients to benefit from air and exercise during adverse weather. The Commissioners felt that "the arrangement is costly, and presents a very objectionable and cage-like experience, both from within and without" (SLR, 1857:65). For these reasons, and also because they seemingly did not serve a good purpose for either the management or treatment of patients, the Commissioners advised against inspection staircases and extensive external galleries in any new asylums to be constructed. Rather, they recommended the erection of more 'simple', 'ordinary' buildings for paupers, with emphasis on their domestic arrangement and aspect. Giving over all the building's internal space to sleeping accommodation and dayrooms with access to the open air would, the Commissioners argued, have the double benefit of bringing down the cost of the construction of the buildings and providing a greater level of comfort to the patients.

The Commissioners took evidence from Dr Rainy's inspection of the GRA, who noted that the Paisley paupers resident in this asylum had made a plea to be returned to Paisley, as they 'felt lost' in the royal institution:

> There is little doubt that to be near home, and to be surrounded with homely objects, in dwellings having a domestic character, and affording opportunities for ordinary daily occupation in household work, by arrangements familiar to them at home, are grateful to the feelings of poor patients, who, generally, prefer an inferior description of accommodation of this kind to the spacious galleries provided in some of the public asylums. (SLR, 1857:66)

The Commissioners were of the belief that a plainer, domestic building would help foster a more contented frame of mind and thus help restore sanity. These debatably trivial arrangements, with their very clear *affective* interventions, were identified as holding the key to helping patients: "by recalling past impressions, awakening deadened sympathies, and reviving former habits and customs", and consequently having the effect of "arresting the aberration of a diseased mind, and of restoring it to healthy action" (SLR, 1857:66). If the building was home to both private and pauper patients, the architecture should be designed in such a way as to ensure that patients were placed in apartments according to their social class, so they could mix with similar associates as those they had known before lunacy took hold, again aiding in their management and recovery (as well as for economic reasons: accommodation for pauper lunatics could be more cheaply provided).

The Report detailed that in the older royal asylums (specifically Aberdeen, Perth and Dundee), the airing courts had been subdivided into numerous smaller spaces to allow the separation of classes and sexes. The division was by extremely high walls, which shut out the view of the surrounding countryside. To combat the lack of view, mounds were erected in some airing courts allowing patients to look over the enclosure walls, revealing a belief that views could be beneficial in a therapeutic sense, but this action had the negative impact of further reducing the already very small space. Moreover:

> A minute separation of the inmates into classes, both as respects position in life, as well as the nature of the malady, become necessary; and, consequently, the patients are subdivided into a large number of communities, each having their respective apartments, and airing-grounds. By the adoption of such arrangements, liberty within doors is diminished, the facilities of egress into the open air are impeded, and the space appropriated for exercise is considerably curtailed. (SLR, 1857:96)

These faults in the use and construction of the buildings were cited as causing lengthened periods of seclusion, resulting from over-crowding and lack of areas to exercise. If these

deficiencies were corrected, the Commissioners envisaged that the use of arrangements such as seclusion rooms and seclusion yards could be dispensed with altogether.

Furthermore, it was now acknowledged that occupation, particularly in the form of outdoor labour, was "of the greatest consequence to the wellbeing of the insane" (SLR, 1857:87). Thus, it was of great importance for every asylum to have a sufficient quantity of land to allow constant employment, particularly for the male patients. From the Report, it was concluded that the royal asylums had insufficient amounts of land for the "cheerful and varied agricultural employment" (SLR, 1857:87) of the patients, although the Commissioners did state that land outside of the walled airing courts available for the use of patients was generally neatly laid out, contained good gravel walks, with extensive views and was of benefit to the more orderly patients. Caution was advised that the employment of the patients should be predominantly for curative rather than economic purposes; a nod towards concerns (especially in England and Wales) about some asylums *over*-exploiting patient labour.

Again exhibiting both a physical and 'affective' argument, the need for extensive grounds to exercise was based on the theory that the inmates, unlike those suffering from physical disease, still harboured:

> a positive restless craving for muscular exercise; and hence nothing tends so much to promote the tranquillity of an asylum, and to diminish the necessity for the use of mechanical restraint and seclusion as the expenditure of this augmented nervous power by exercise and labour in the open air. (SLR, 1857:88)

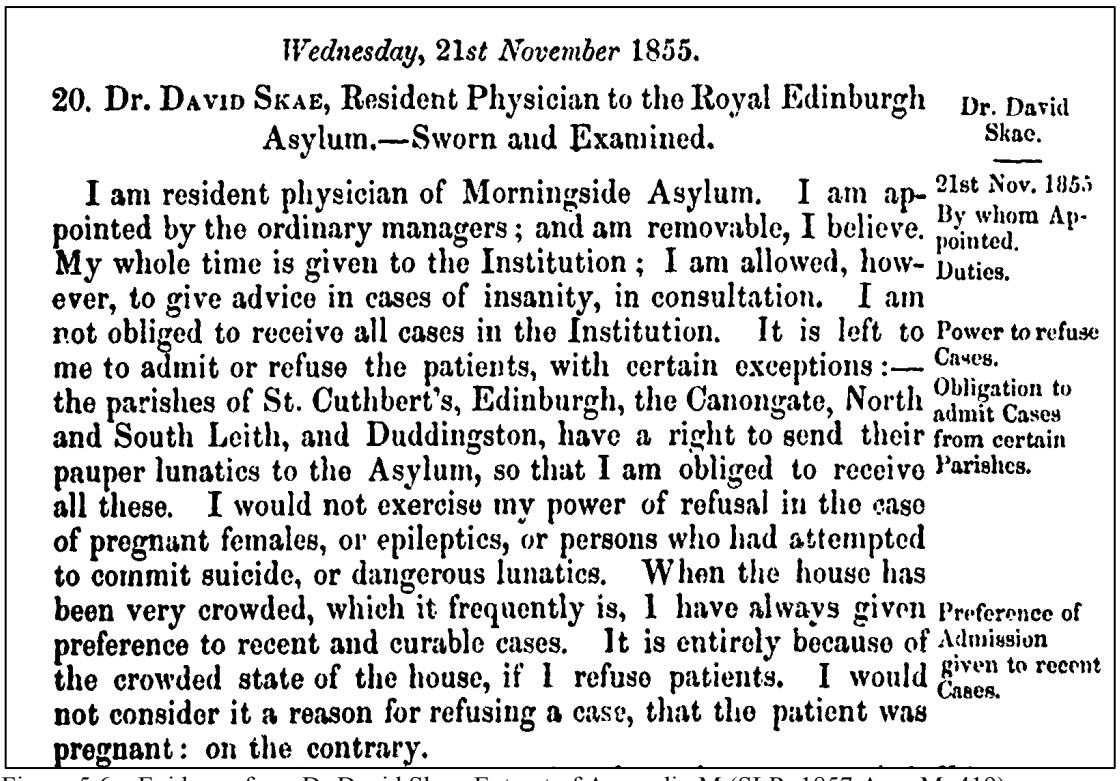
For a similar reason, recreation and amusement were also to be provided, with most of the asylums complying by providing excursions, picnics, concerts, lectures, evening parties and dances. Although some concerns had undoubtedly shifted over time as treatment of the insane was modified and developed, it was clear throughout the Report that the Commissioners were, on the whole, pleased with the condition of the royal asylums, exclaiming them to be in a "highly satisfactory state" (SLR, 1857:94). They summarised:

> The chartered [royal] asylums are situated in elevated, salubrious localities. Separate rooms are provided in them for day and night accommodation. They are spacious, generally well-furnished, well-warmed, and lighted by gas. Suitable arrangements are made for the sick and infirm ... The more orderly patients take exercise in cheerful grounds, and also beyond the premises. Workshops and means of out-door occupation are provided. (SLR, 1857:127)

To an extent, then, the royal asylums, along with knowledge of good practice elsewhere (for example in England and Europe more widely), were indeed the model for the district asylums to come.

## FURTHER DETAILS AND EVIDENCE FROM THE REPORT

Extensive details about the inquiry conducted by the Commissioners were given in the appendices of the Report. Appendix B included systematic descriptions of every asylum in the country, specifying the object, origin, history, date of opening, quantity and appropriation of land, and the amount and description of accommodation for patients. Also included was an account of the condition of each asylum and its patients when visited by the Commissioners during the inquiry. A similar format was followed in Appendix C and D, which focused on private institutions and poorhouses respectively. The information in these sections was not quite as detailed as in Appendix B, but all could be used to provide an extensive illustration of each institution providing accommodation for the insane in mid-nineteenth-century Scotland.



*Wednesday*, 21*st November* 1855.

20. Dr. DAVID SKAE, Resident Physician to the Royal Edinburgh Asylum.—Sworn and Examined.

Dr. David Skae.

21st Nov. 1855

By whom Appointed.

I am resident physician of Morningside Asylum. I am appointed by the ordinary managers; and am removable, I believe.

Duties.

My whole time is given to the Institution; I am allowed, however, to give advice in cases of insanity, in consultation.

Power to refuse Cases.

I am not obliged to receive all cases in the Institution. It is left to me to admit or refuse the patients, with certain exceptions:—

Obligation to admit Cases from certain Parishes.

the parishes of St. Cuthbert's, Edinburgh, the Canongate, North and South Leith, and Duddingston, have a right to send their pauper lunatics to the Asylum, so that I am obliged to receive all these. I would not exercise my power of refusal in the case of pregnant females, or epileptics, or persons who had attempted to commit suicide, or dangerous lunatics.

Preference of Admission given to recent Cases.

When the house has been very crowded, which it frequently is, I have always given preference to recent and curable cases. It is entirely because of the crowded state of the house, if I refuse patients. I would not consider it a reason for refusing a case, that the patient was pregnant: on the contrary.

Figure 5.6 – Evidence from Dr David Skae, Extract of Appendix M (SLR, 1857:App. M, 419).

The final relevant inclusion was Appendix M, which provided accounts from the individuals who supplied evidence to the Commissioners during their 1855 inquiry,[120] offering insights into the numerous problems of the system in place up until 1857 (although, unsurprisingly, no patients and no women were consulted). Furthermore, this section also uncovered a number of differences in opinions regarding the correct treatment and management of the insane in Scotland at this time. A selected number of examples of issues that were raised by these individuals are outlined below, with numerous more available (see Figure 5.6).

Difficulties with the old 'system', insofar that it could even be labelled a 'system', were recorded by many. For example, the surgeon who visited a number of private asylums in Musselburgh felt that, even if he thought arrangements to be insufficient, he had no power to enforce his recommendations, noting that if he was to find a number of faults then he would simply be dismissed by the proprietors. This problem was also noted by the Sheriff of Lanarkshire, who stated: "in the case of directions given for improving the ventilation, or the drainage, or for additional security, it is very difficult to say what powers we have; they are undefined" (SLR, 1857:App. M, 369). Furthermore, the statements made regarding the accommodation were often vague, suggesting inadequate inspection:

> I think the sexes in all the houses are properly separated; they occupy separate apartments; they are separate, generally speaking. Nothing has arisen, so far as I am aware, in consequence of the mixture of the sexes, that was objectionable, except in one case, but that was with a keeper. (SLR, 1857:App. M, 285)

Thus, regarding licensed houses, it was argued that there should be more independence between proprietors and medical inspectors so as to ensure fair assessment of the institutions, detectable here too is the dynamic leading to legislation requiring the *inspection* of such establishments by authorities with real power to demand improvements/revoke licenses.

Another issue with the system was that, due to no uniformity, Sheriffs in one county were unaware of the standards of asylums in other areas. There was also no standardisation regarding the warranting of individual patients, with a different system occurring in each

[120] These people included surgeons, physicians from various asylums (Dr D. Skae of Edinburgh, Dr W. A. F. Browne of Dumfries, Dr A. McIntosh of Glasgow), proprietors of private asylums, the secretary to the General Board of Prisons in Scotland, Sheriffs from various counties, the secretary to the Board of Supervision for the Relief of the Poor in Scotland, Inspectors of Poor, a Fellow of the Faculty of Physicians and Surgeons in Glasgow, a Fellow of the Royal College of Physicians in Edinburgh, and the Professor of Medical Jurisprudence in the University of Glasgow. For full list see my Appendix B.

district. The Sheriff of Lanarkshire nonetheless believed that the inspections by the Sheriffs of the asylums in their district should continue even if a national system was implemented, as he did not think it possible that any individual could investigate properly the large number of patients in each region alone. This was also the opinion of the Sheriff of Dumbarton and Bute:

> I should certainly be inclined to have a General Board, with medical officers, and proper inspectors. There should be a certain proportion of lawyers at the Board. I would have district asylums, and district inspectors; and I would have these district asylums inspected by the district inspectors, along with the Sheriff, because I think it is desirable that his connection with them should be continued. (SLR, 1857:App. M, 455)

On the other hand, the Sheriff of Edinburgh believed that authority should be administered through a General Board rather than through individual magistrates so as to ensure uniformity:

> I certainly would much rather see the whole of these houses placed under some general superintendence, with an inspector who should be totally disassociated from all counties or parishes, and be in fact nearly parallel to the prison inspector – a central authority – a board to superintend, and a government officer to inspect. (SLR, 1857:App. M, 408)

This example gives an insight into the varying opinions about the difficulties of the old system and the different views as to how a new national system could be operated, as well as different views on the 'geography' of inspection and control.

Probably pushed by the Commissioners' questions, a number of individuals discussed the need for a national system of district asylums. The Sheriff of Lanarkshire described them as being "a most excellent thing" (SLR, 1857:App. M, 379), and thought that it was very important they be supplied in Aberdeen, Inverness and Dumfries. Dr Malcolm felt that the lack of district asylums in the north and west of the country must increase the number of lunatics in this area, "as there are no means of effecting a cure" (SLR, 1857: App. M, 392). Caution was expressed by Dr R. Renton that one asylum per district would still not provide enough accommodation to overcome the severe overcrowding found in many of the current institutions, anticipating how asylums seem to fuel demand for their services.

There were differing views as to the types of asylum that were best suited to treating the insane. On the one hand, opposing the Commissioners' ideal of medium-sized asylums, the Sheriff of Lanarkshire and Dr Renton felt that patients would be treated better in large,

properly regulated asylums, as secure attendance could be provided more easily. This was also the view of Dr R. Christonson, who argued that larger asylums were beneficial as greater occupation could be provided for the inmates, and also experienced officers would be more likely to be attracted to employment at larger establishments:

> I do not see the point in limiting the size of asylums, if there is a sufficient number of good officers to manage them. You might suppose an asylum too extensive for the effective superintendence of one person; but from what I have seen, I think an intelligent superintendent might very easily take charge of an asylum, even as large as to contain 500 or 700 patients. (SLR, 1857:App. M, 487-488)

On the contrary, the following individuals were more inclined towards the Commissioners' stance of medium sized institutions. Dr A. McIntosh believed that the smaller the asylum, the better the attendance upon patients, with the Sheriff of Renfrewshire adding that there would likely be less chance of abuse in smaller, public institutions. Dr W. A. F. Browne, consistent with his view since his 1837 text, recorded that he would prefer "small asylums and numerous" (SLR, 1857:App. M, 502), claiming that he struggled to attend effectively to the 350 patients accommodated in his asylum. He continued:

> With reference to the influence of size on the success of treatment, small asylums invariably send out a greater number of cures; and with regard to moral influence, it is quite obvious that the aggregation of a mass of unhealthy minds must in itself prove detrimental, and obstructive to recovery. (SLR, 1857:App. M, 503)

The Sheriff of Edinburgh felt that the current royal asylums were "perhaps going to extremes in their mode of treatment" and that there was not enough use of architecture to classify and separate patients, meaning that "a man's chances of getting better are as much prevented as promoted by his daily associates" (SLR, 1857:App. M, 408). Dr Rainy also believed that there should be clear classification in new public asylums, as many patients "dislike being in a crowd" (SLR, 1857:App. M, 443). Dr Browne was of similar opinion that larger galleries led to difficulties in classification, and that currently, "with regard to the construction of asylums, I think the buildings are generally too massive. I think they might be much more economically built" (SLR, 1857:App. M, 521).

Evidently there were many views regarding the situation of lunacy and lunacy provision on the cusp of reform. These opinions anticipate on-going terrains and debates about the district asylum system, which evolve over the rest of the century and beyond, and will be returned to repeatedly throughout the remaining pages of this thesis. Often they were very

clear statements about and feelings for the required *geography* of the asylum, and highlight different views of the ideal asylum.

## MOVING FORWARDS FROM THE 1855 INQUIRY

Through their final reflections upon the findings of the 1855 inquiry, the Commissioners were able to remark on what they believed to be the nature of insanity and, consequently, the best means for its successful treatment. It was thought that all symptoms of insanity were due to "perverted action of the brain", which led to impaired judgement, non-appreciation of "the phenomena of the external world" (SLR, 1857:237) and a deprived understanding of the mind. Consequently, this was believed to have a negative effect on both the moral nature and self-control of the sufferer, leading to a reliance on outside assistance and guidance to ensure adequate welfare. The asylum was to provide the solution:

> It thus becomes a moral obligation on those who recognise the workings of disease in the conduct of the patient, to place him under control, which is most beneficially and effectually exercised by persons fitted, by education and experience, to undertake such delicate and responsible duties. The patient is accordingly sent to an asylum, where, by judicious mental discipline, and attention to the improvement of his bodily functions, his recovery becomes extremely probable, if the treatment be undertaken at an early period of the malady. (SLR, 1857:238)

> On the one hand, all means calculated to expend superfluous energy by exercise and occupation, should be provided; and, on the other, all necessary agents should be supplied to soothe the irritable, cheer the depressed, and encourage the helpless. (SLR, 1857:239)

Through utilising the space provided by the asylum, engaging the attention of the patients, and through their 'affective' visions, the Commissioners believed that "morbid trains of thought" (SLR, 1857:239) could be dispelled, and that the patients could (re)discover their powers of self-control. It was considered essential, however, that the proposed asylums be constructed and organised following these principles, to ensure beneficial results.

Again resonating with statements penned previously in the Report, the Commissioners reiterated the fact that the number of patients admitted to an asylum diminished when the distance to the asylum increased, as well as their opinion that larger asylums were detrimental to the welfare of the patients. Thus, they suggested that future asylums built in Scotland should be of a moderate size, economically constructed and conveniently located,

claiming that "in a well-conducted house, where the nervous energy of the patients is expended in exercise and judicious occupations, there is no necessity for the special and expensive arrangements that characterise the older establishments" (SLR, 1857:240). The 1857 publication of the Report marked a turning point in ideals, moving away, in theory at least, from the old, grand designs of the royal asylums. It also hinted at a more 'parsimonious' system/geography, in part reflecting the poorer occupants of the planned district asylums.

The results of the 1855 inquiry, and the interrogation of individuals by the Commissioners, determined the extant situation in Scotland; that there was no national provision for the insane; the shocking state of the majority of private asylums; and the dependence on public benevolence resulting in uneven geographical supply. All of this was "most unsatisfactory, and … it does not afford sufficient protection to the lunatic" (SLR, 1857:254). Thus, the Commissioners called for urgent change, concluding that the existing laws relating to the insane in Scotland should be abolished and replaced by "a new and comprehensive code framed to meet the many pressing wants of the community" (SLR, 1857:255). They envisaged this new policy to include the erection of new district asylums for pauper lunatics; the implementation and tightening of regulations surrounding, among others, licensed houses and lunatics residing at home; clarifying the duties and powers of sheriffs; and the formation of local boards for the management of the individual asylums within their districts, which should act in union with the proposed General Board of Lunacy for Scotland.

***Parliamentary Debate/Legislation***

Mr Ellice, St Andrews,[121] brought the Report to the attention of the House of Commons on 29th May 1857, stating that it was "one of the most horrifying documents he had ever seen" (Ellice, 1857:np) and began by asking "what steps the Government intend to take for immediately securing to Pauper Lunatics in Scotland proper protection and maintenance?". He continued to summarise the report, which brought to the attention of the House both the neglect of duties and the law regarding lunatics and lunacy provision in Scotland. Throughout the debate, there was controversy over who to blame for the mistreatment and inattention towards "the most helpless class of the whole family of human beings" (Ellice, 1857:np). Criticism was directed towards the Board of Supervision, Inspectors, proprietors

[121]Ellice was the (Liberal) Member of Parliament for St Andrews, elected in 1837. In the 1840s and 1850s, his principal interest was in the reform of the Scottish poor law, and he was a strong critic of the 1845 Act (Spain, 2004).

and Sheriffs in turn, who, it was stated, had "more regard for the pockets of the rate-payers than for the condition of the pauper lunatics" (Ellice, 1957:np), although there was disagreement as to whether the law (new Poor Law) or the administration lay at the route of the debacle. As the debate progressed, the tone shifted, with a call to look forward towards a solution, rather than bicker over who was answerable. Additionally, attention was drawn to the point that "no country in proportion to its population … had done so much voluntarily for this class of sufferers as Scotland" (Baxter, 1857:np), and that, although criticism could be made because there was no national system for the insane poor in place, the philanthropic attempts to relieve some of the burden should not be overlooked. Baxter duly proposed that it was a continuation of the large royal asylums that would remedy the situation outlined in the report, rather than implementing a new national system.

There was evident controversy around ways to move forward. Calls varied from a centralised board (with some wanting this to be an extension of the duties of the English Lunacy Board, while others wanting a new Scottish Board based in Edinburgh), to no integrated specific lunacy board but rather increased power of inspection by the Board of Supervision and therefore continuance under the legislation of the new Poor Law. The majority believed that a central authority was needed to "set the machinery in motion" (Grey, 1857:np). The Lord Advocate[122] finally stated that "the habits and condition of the lower orders in Scotland were matters which must be taken into consideration, and it was vain to think of importing from the south ideas and opinions which were entirely foreign to Scotland" (1857:np). This shows a strong sense of Scotland wanting to devise a 'Scottish' solution, and overall the House was unified in their belief that immediate and permanent protection was desperately needed for the Scottish insane, specifically pauper lunatics.

The subsequent Act, prepared by the Lord Advocate and Sir George Grey,[123] called for The Regulation of the Care and Treatment of Lunatics, and for the Provision, Maintenance, and Regulation of Lunatic Asylums in Scotland. It outlined the objects of the legislation to include the creation of a General Board of Commissioners in Lunacy for Scotland, which was to be made up of three Commissioners (two paid, one unpaid) who would have an

[122] At this time, the Lord Advocate was James W. Moncrieff.

[123] At this time, Grey worked for the Home Office as home secretary (although he had previously held various posts in Parliament, including working for the Colonial Office). Despite the above quote about the need for central authority, Grey had a reputation for being skeptical of central government efforts to seize responsibilities that he believed should remain the obligation of local government (Smith, 1984). As home secretary, his main responsibility was penal policy, and he was a strong advocate of the 'separate' system of prison discipline, which he believed would encourage moral improvements.

office in Edinburgh, meeting there for two General Meetings a year, as well as any necessary special meetings. The Board could appoint more Commissioners if they thought their duties necessary. It was specifically stated that the Commissioners would not derive any profit (except their salary), with paid Commissioners devoting all their time to their duties. Regarding the construction of district asylums, the Board was to assess the requirements of the district (including population and existing accommodation), before then determining what, if any, district asylum provisions should be constructed. As will be discussed in subsequent chapters, the costing, planning and design of the district asylums was the responsibility of the district boards:

> The [General] Board shall, as soon may be, make investigations into the population and necessities, as regards accommodation for the pauper lunatics, of the several districts hereby established, and into the accommodation for the care of such pauper lunatics (if any) already existing for such districts; and upon consideration of the result of such investigation it shall be lawful for the Board to determine, either that the existing accommodation for the district, with or without additional accommodation, is sufficient, or that a district asylum for pauper lunatics shall be provided for the district; and the Board shall communicate the result of such investigation to the district board of such district, and may require the district board to order plans of the district asylum to be prepared together with specifications and estimates of the probable expense of erecting and completing the same, or of altering or enlarging and adapting any existing asylum, house, or accommodation to the purposes of a district asylum under this Act, and to report the same, and also their opinion of an eligible site for such district asylum, where a new one is to be provided, to the Board. (The Scots Statutes Revised, Volume IV, 1900:175)

The Board was also to outline *The General Rules for the Inspection and Visitation of Public, Private and District Asylums, as well as all Single Patients*. When on official visits, the Commissioners were to examine whether any coercion or physical restraint had been used, the general health of the community, the efficiency of the staff, and the management and condition of each institution including: its state of repair, heating, ventilation, cleanliness, supply of water, diet, occupation etc. This set-up survived relatively unchanged until superseded by the General Board of Control in 1913 following the *Mental Deficiency and Lunacy (Scotland) Act* of that year.

## CONCLUSIONS

This Chapter comes full circle to conclude on the ‘eve’ of the passing of the 1857 Act and the founding of the district asylum system. It has been shown that a plethora of catalysts

resulted in state-led investigations that condemned the current conditions of lunacy provision in Scotland. The inquiry was prompted by general dissidence: for example towards the treatment of lunatics under the new Poor Law; from individual visionaries, such as Browne and his aspiration to strive towards his utopian asylum concept; as well as Dix's abhorrence at current conditions for the insane, and her determination to instigate an investigation. The Report, which was the most in-depth enumeration ever of lunacy and lunacy provisions in Scotland, found that official oversight "remained at best variable and at worst simply inadequate" (Andrews, 1998:3), and condemned the majority of accommodation in which the Scottish insane resided. The Commissioners were concerned that pauper lunatics were being lodged in places that were not designed to be curative and therefore did not embody environments that would have a positive mental affect on patient behaviour, whether that be in poorhouses alongside the general pauper population or exploited for monetary gains in unregulated private 'madhouses'. The Commissioners resolved that overall the accommodation was generally found to be comfortless, poorly ventilated, overcrowded and did not permit the classification of different types of maladies. The royal asylums, on the other hand, offered evidence that pauper lunatics could be housed in accommodation that put the welfare and treatment of the patient to the fore. Through the implementation of government control, this system could be emulated for pauper lunatics through the construction of a state-run district asylum system. The Commissioners claimed that the distance of the more urban-centric royal asylums from many paupers' homes was considered "a great evil" (SLR, 1857:211), and as such it was understood that, if asylums were in easy reach, the expense of transferring patients would be limited and lunatics would be institutionalised far faster.

As has been explored in this Chapter, all these various ingredients – contemporary visions of power, 'affectivity', geography (at different scales), and expert and popular views – were duly coded into the legislation and had a central bearing on the practical suggestions and applications developed in the immediate years after the Act. Ultimately, the platform had been created for the roll-out of district asylums across Scotland. Chapter Six will go on to unpack the Act and investigate its implications for those who fell under its jurisdiction, as well as the impact of the legislation on Scotland's changing asylum landscape.

# Chapter 6

# The system on the ground

## INTRODUCTION

> A new Institution of much importance has lately been imposed upon the counties and Burghs of Scotland, by Acts of Parliament, compelling the erection of Asylums for the cure and care of Pauper Lunatics. (Wemyss, 1867:np)

An *Act for the Regulation of the Care and Treatment of Lunatics, and for the Provision, Maintenance, and Regulation of Lunatic Asylums, in Scotland* (Statute 20 & 21. Vict. cap. 71)[124] passed through Parliament and received Royal Assent on the 25th August 1857. After the Short Titles Act, 1896, it was to become known, and remembered, as the *Lunacy (Scotland) Act*, 1857. As shown in Chapter Five, the 1857 Act was passed due to a mounting dissatisfaction with the care and treatment of the insane in Scotland, and as a direct response to the conditions uncovered by the 1855-57 inquiry and subsequent report, and as such, the primary objectives of the Statute were:

> To provide for the building of district asylums for the reception of pauper lunatics, and to insure the proper care and treatment of lunatics generally, whether placed in asylums, or left in private houses under the care of relatives or strangers. (SCL, 1859:i)

By the time that the *Mental Deficiency and Lunacy (Scotland) Act* was passed in 1913, the goal of providing each district with its own purpose-built district asylum for the reception of pauper lunatics had been achieved.[125]

In order to help reach this goal, the Act sanctioned the establishment of a more practicable administrative system by creating a Board to be known as the General Board of Commissioners in Lunacy for Scotland (henceforth the General Board) and a district board for each district. The General Board, which, as outlined in Chapter Five, was to constitute three persons – one unpaid Commissioner, who was to undertake the role of chairperson,

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[124] The Act transferred the powers and duties of the Secretary of State (except in the case of criminal lunatics and insane prisoners) to the Secretary for Scotland, 48 & 49 Vict. c. 61, s. 5.

[125] Although the General Board claimed this achievement, in actual fact some of the smaller districts did not build their own asylum, but instead reached agreements with larger districts to receive their lunatics.

and two paid Commissioners, all appointed by Her Majesty[126] – had overall responsibility for all lunacy provisions, institutional or otherwise (royal, district and (later) parochial asylums, as well as licensed houses, poorhouses and single patients[127]). The district boards, responsible for the management, control, development and supervision of their own asylums and lunatics, were answerable to the General Board. The first meeting of the General Board was held in Edinburgh on the 4th November 1857,[128] with the provisions of the Act coming into full operation on the 1st January 1858. Rather than three Commissioners, the inaugural Board was comprised of five members: the Chairman, William Elliot-Murray-Kynynmound, Viscount Melgund, third Earl of Minto;[129] two non-medical men, Mr George Moir[130] and Mr George Young (afterwards Lord Young);[131] and two medical physicians, Mr James Coxe[132] and Mr W.A.F. Browne[133]. The secretary was

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[126] The Oath of the Commissioners, to be taken by every Commissioner at the outset of his duty, was as follows: "I, A.B., do swear, that I will discreetly, impartially, and faithfully execute all the trusts and powers committed to me by virtue of the *Lunacy (Scotland) Act*, 1857; and that I will keep secret all such matters as shall come to my knowledge in the execution of my office, except when required to divulge the same by legal authority, or so far as I shall feel myself called upon to do so for the better execution of the duty imposed upon me by the said Act. So help me God" (*The Scots Statutes Revised Volume IV*, 1900:167)

[127] In Scotland the inspection duties extended to every parish where a lunatic was kept, whereas in England and Ireland, the Act did not cover the inspection of single patients.

[128] Hereafter, the Board was to hold two general meetings per annum, the first on the first Wednesday in March, and the second on the first Wednesday in November. The Board could arrange to convene at other dates and in other locations as they saw fit.

[129] Elliot-Murray-Kynynmound (known as Earl Minto) (1814-1891) was a Liberal Member of Parliament. Between 1847 and 1852 he was MP for Greenock. He unsuccessfully contested Glasgow in the 1852 general election but from 1857 to 1859 was MP for Clackmannanshire and Kinross-shire, standing down after 1859 (Craig, 1989). He was made a Knight of the Thistle in 1870. He was briefly replaced by Mr Forbes Mackenzie, and on Mackenzie's death, Sir John Don Wauchope became chairman of the General Board.

[130] Moir succeeded Sir A.C. Gibson-Maitland, Bart.[130] before the first report of the Board was written. Moir (1800-1870) hailed from Aberdeen and attended Marischal College, later moving to Edinburgh to work in a lawyers office. Developing an interest in writing and languages, he was appointed as Regius Professor of Rhetoric at the University of Edinburgh, a position he held until 1840 when he resigned to become Sheriff of Ross until 1858. At the time of his appointment to the General Board, he had just become Sheriff of Stirling. In 1864 he took up the position of professor of Scots law, again at Edinburgh (Hillyard, 2004).

[131] Young (1819-1907), originally from Dumfries, obtained his law degree from the University of Edinburgh, excelling in his class. He was admitted to the Scottish bar in December 1840 and was described as being "one of the most brilliant and successful court pleaders of his day" (Millar, 2004:np). He became Sheriff of Inverness in 1853, and Sheriff of Haddington and Berwickshire from 1860 to 1862, when he was then appointed Solicitor-General for Scotland. He was later elected Lord Advocate for Scotland, and was responsible for the *Public Health (Scotland) Act*, 1871 and the *Education (Scotland) Act*, 1872 (Millar, 2004).

[132] Coxe (1811-1878) was the nephew of George Combe, author of the *Constitution of Man*, and leading figure in the science of phrenology, and Andrew Combe, a physician who wrote widely on physiology, digestion and infancy. Due to his father's untimely death, Coxe and his brothers were brought up by his uncles, and he was undoubtedly influenced by their visions, achievements and careers. Coxe studied medicine at the University of Edinburgh and went on to practice medicine in the city until he was appointed one of the Royal Commissioners in the 1855-57 inquiry. It was Coxe who wrote the subsequent Report (see Chapter Five). He was then given one of the two paid positions on the General Board and was knighted in 1863 (*The Scotsman*, 1878:9).

[133] Browne (1805-1885) received his medical training at the University of Edinburgh, and shortly after was elected a fellow of the Royal Medical Society and held the post of Senior President from 1827 to 1828. It was

Mr William Forbes. At a later date, two medical Deputy Commissioners were appointed, Mr A. W. Cockburn and Mr Arthur Mitchell[134]. The Board was responsible for the bi-annual inspection of every lunatic in Scotland, [135] as well as the production of the Scottish Lunacy Commissioners' annual reports. This ensured improved regulation in official visitations of the various asylums, and allowed familiarity "with the persons, peculiarities, and special requirements of the lunatics residing in them" (SCL, 1866:253).

The chapter that now follows explores the rolling out of the 1857 Act across the country, and the effect that it had on Scottish lunatic numbers and the development of institutional provisions. The focus will predominantly be on district asylums but will also briefly explain the alternative institutional accommodation over the period between the two main Acts, 1857 and 1913. Crucially, it provides a broad background to later chapters, which focus in greater depth on the geographical themes that emerged when looking at the overall system. Following Philo and Parr (2000:514):

> Institutional geographies are practically and conceptually shaped in many different ways. This means that we do not have to be discussing just one visible institution anchored in a single location, situation or site, a big blocky building with grounds and rooms, but rather can be concentrating on a spidery network of dispersed intentions, knowledges, resources and powers.

Through this approach, and analysing the overall network of district asylums established in Scotland, a clearer picture becomes visible as to the methods and means deployed by the various stakeholders in managing and treating the insane. Initially responses were firmly situated within a moral approach, but, as the decades progressed, increasing patient numbers, declining optimism around current practices in their ability to 'cure' the insane, and the growing belief that insanity should be recognised as a medical phenomenon all

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during these years that he developed an interest in insanity. After graduating, he travelled across Europe in the company of a person suffering from insanity, together visiting a number of asylums and taking specific interest in their arrangements and modes of treatment. He was in direct contact with the French alienists Esquirol at Charenton and Parist at Salpêtrière. An advocate of phrenology, and close friends with George and Andrew Combe, he was elected Vice-President of the Edinburgh Phrenological Society from 1830 to 1832. With help from the Combes, he secured the position of Physician Superintendent at Montrose Royal Asylum in 1834, where he implemented the treatments learnt in Europe. After the publication of his set of lectures *What Asylums Were, Are, and Ought to Be* in 1837 (see Chapter Five), he was offered the post of Physician Superintendent at the newly opened Crichton Royal Institution in Dumfries. Browne was elected as one of two paid medical Commissioners for the General Board in 1857, a post held for nineteen years (Scull, 2004; 2006).

[134] Mitchell (1826-1909), born in Elgin, received his medical training in Paris, Berlin and Vienna, before finally receiving his MD from the University of Aberdeen in 1850. Mitchell was promoted from Deputy to full Commissioner in May 1870, holding this post until his retirement in September 1895. He was a strong advocate of the boarding-out system, which he promoted in his book *The Insane in Private Dwellings* (1864) (Millar, 2004).

[135] In England, Asylums and patients were inspected only once a year.

resulted in a move towards the treatment of insanity or, as the terms shifted, mental illness, through medical means. This had a profound influence on the specific geographies of the different institutions, and ultimately resulted in a more segregated approach to asylum design by the last years of the nineteenth century through a separation of hospital (for the treatment of mental disease) and asylum (a 'home' for incurable long-stay patients) sections on individual district asylum sites. Through concentrating on the Commissioners' vision for the ideal asylum, and looking at the district institutions that were built as a direct result of the Act, it was clear that the Scottish lunacy administrators and physicians were treating the insane, and designing their establishments, in alignment with contemporary discourses surrounding madness, but were nonetheless altering their visions as the century progressed. Moreover, the rapidity here with which views changed – and the asylum solution in its moral conception fell into doubt – is remarkable, but so too is the extent to which the older asylum (geography) 'blueprint' still endured as a kind of default, even as the basis and logic for its continuation was seemingly eroded.

## MODES OF CONFINEMENT AND PAUPER LUNATIC NUMBERS, 1857-1913

As detailed in Chapter Five, there were a number of institutions in which pauper lunatics were accommodated, and were therefore to be inspected and monitored by the General Board. The alternative provisions were predominantly used prior to district asylums opening, but were also resorted to after the construction of district asylums, for the care of harmless, incurable lunatics or when the district asylum accommodation became overcrowded. Although not the focus of this thesis, the following section will briefly summarise these other establishments, so as to give a complete overview of all institutions available for accommodating lunatics during the period of study in order to clarify claims made below that will touch on these 'spaces',[136] before moving on to outline the changing numbers of the insane in Scotland between 1857 and 1913 (see also Appendix C).

*Lunatic Wards of Poorhouses*: Driven by the findings of the 1855-57 inquiry, the Lunacy Commissioners initially wanted to eradicate lunatic wards of poorhouses. But, realising that this would result in a severe lack of accommodation and acknowledging that many of the parochial boards had followed their recommendations for the development of these

[136] There were, of course, also a number of pauper lunatics retained in the royal asylums, particularly in the districts where initially the royal asylums were providing adequate accommodation, such as Aberdeen, Edinburgh and Glasgow. This situation changed, however, when these districts built their own district asylums at the end of the nineteenth and into the twentieth century (to be discussed below).

institutions, improving their conditions to a great extent in a number of cases, they advocated the passing of the *Lunacy Amendment Act*, 1862 (25 & 26 Vict. c. 54). This Act allowed permanent licenses to be granted to many lunatic wards of poorhouses for the reception of harmless and chronic cases only. Initially, however, the General Board was still "firmly convinced that it is only by the provision of full asylum accommodation that many existing evils can be efficiently met" (SCL, 1859:xxix), and so they continued to push for full asylum provision. In 1857 there were twelve lunatic wards of poorhouses operating in Scotland, containing around 400 patients. By the final report, only five of these initial institutions were still open, though others had received licenses along the way, with the number in 1913 being fourteen, reportedly accommodating between 800 and 900 patients.

*Parochial Asylums*: Parochial Asylums were first mentioned in the Sixth Annual Report, and were outlined as follows: "Under the name of Parochial Asylums we have comprehended all lunatic wards of poorhouses which admit patients for curative treatment; and we shall in future restrict the terms of lunatic wards of poorhouses to those establishments which receive only patients who are considered harmless and not amenable to curative treatment" (SCL, 1864:xlv). There were six such asylums in 1863,[137] with a total population of around 486, but by 1913, there was only one, belonging to the Parish of Greenock. A number of the others had been rebranded as district asylums and incorporated into the administration of the respective district boards, notably the Barony Parochial Asylum, which was amalgamated into the Glasgow District Board in 1898, and the Paisley Parochial Asylum, which became the district asylum for the Paisley District Board when the Board was established in 1909.

*Private asylums*: In 1858 there were eighteen private asylums containing 219 private and 526 pauper patients. Again due to the findings of the 1855-57 inquiry, the Board had resolved under the conditions of the 1857 Act that these institutions would only be licensed for the reception of pauper patients until the district asylums were open for their reception. This was achieved by the time the twentieth report was published (1878), which proudly stated "there are now no pauper patients in any Private Asylum in Scotland" (SCL, 1914:lxxxvii). By 1913, there were only two private asylums open in the whole of the country, both receiving private patients only.

[137] These belonged to the following Parishes: One in Falkirk, two in Glasgow (Barony and City), one in Greenock, and two in Paisley (Abbey and Burgh).

### *Lunacy Numbers, 1857-1913*

The total number of insane in Scotland resident in an institution recorded in the First Annual Report of the General Board, excluding private single patients, as their number could not be correctly measured is shown in Table 6.1. As the figures show, the number of pauper lunatics uncovered by the Commissioners during their investigation was 4,737,[138] which was almost 6 per cent of the overall pauper population in Scotland of that year. At this time there were nearly four times more persons registered as pauper rather than as private insane, and as shown visually by Figure 6.1, the majority of these pauper lunatics were situated in either royal asylums, or private dwellings, with smaller numbers housed in private asylums or poorhouses.

| Institution | Male | Female | Private | Pauper | Total |
|---|---|---|---|---|---|
| **Royal Asylums** | 1226 | 1154 | 786 | 1594 | 2380 |
| **Private Asylums** | 330 | 415 | 219 | 526 | 745 |
| **Poorhouses** | 352 | 487 | 6 | 833 | 839 |
| **Private Dwellings** | 810 | 974 | -- | 1784 | 1784 |
| Total | 2718 | 3030 | 1011 | 4737 | 5748 |

Table 6.1 – Distribution of insane in each type of accommodation, 1858 (SCL, 1859).

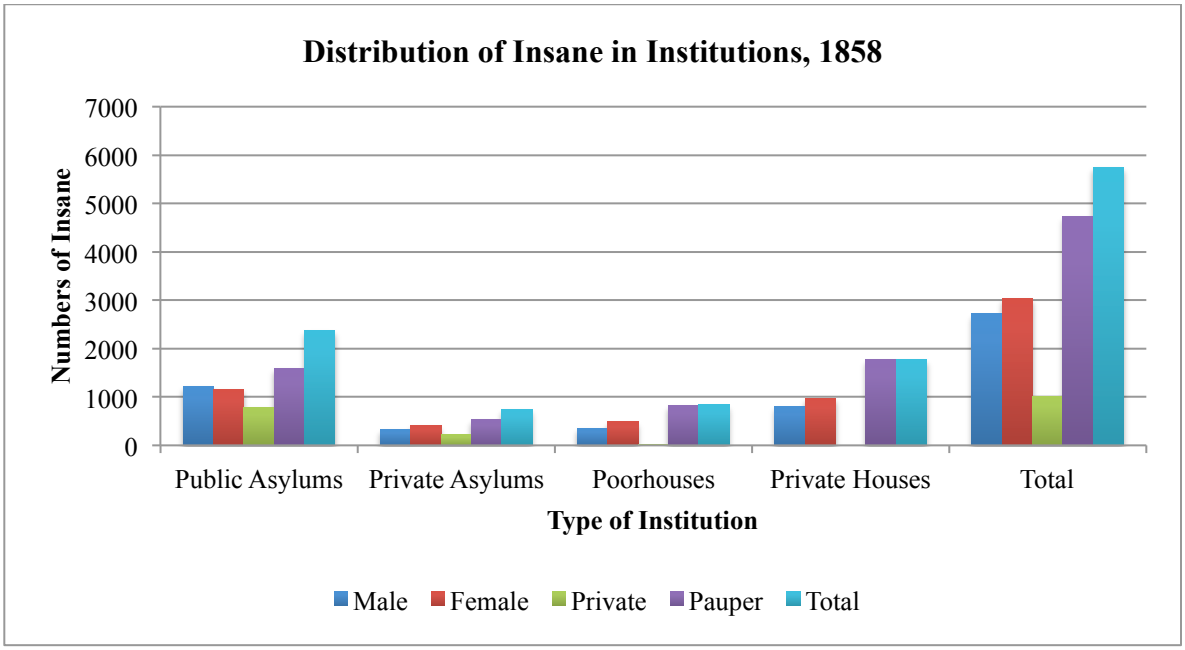


Figure 6.1 – Distribution of insane each type of accommodation, 1858 (SCL, 1859).

What these figures do not reveal, was that the Commissioners discovered great discrepancies in the proportions across Scotland, which they argued were dependent:

> (1) on differences in the constitution of the inhabitants, (2) on differences in their education and mental culture, (3) on different degrees of social intercourse, and in

[138] The number of pauper lunatics returned by the Royal Commissioners during the 1855 inquiry was only 3,904, but it appears they omitted a large number of pauper lunatics.

> the amount and nature of their occupations, and (4) on differences in the pecuniary position. (SCL, 1868:xii)

The discrepancies were so great, however, that they found it difficult to conclude which circumstances caused pauper lunacy to be more prevalent: a manufacturing or agricultural population, or in people of a Saxon or Celtic race. They supposed there to be, as a general rule, "a greater degree of mental activity among an urban and manufacturing population, than among one which is chiefly agricultural, and to this fact may possibly be ascribed the more frequent *occurrence* of insanity among the former" (SCL, 1868:xii). The Commissioners stated that, taking the country as a whole, it must be recognised that it was typically the lower classes of the population where insanity prevailed, drawn from the fact there were more pauper lunatics recorded. They argued that this was due to their low display of mental activities, with the urban and manufacturing environment having an increased impact on the levels of insanity compared to rural agricultural communities as a result of "overcrowding, impure air, exhausting labour, insufficient diet, abuse of stimulants, and contagious diseases" (SCL, 1868:xii). That said, high numbers of pauper patients were later sent to the rurally situated asylums in both Argyllshire and Perthshire, despite the overall population of both districts being in decline. It was generally assumed that such districts, which had a poor and sparse population, would have placed the majority of their patients in private dwellings, but, due to the poor standard of such dwellings and the small allowance available from the parochial boards to substitute home treatment, numbers sent to asylums were nonetheless accumulating.

By the concluding year of the General Board, the insane were distributed as follows:

| Institution | Male | Female | Private | Pauper | Total |
|---|---|---|---|---|---|
| **Royal Asylums** | 1774 | 2006 | 1964 | 1816 | 3789 |
| **District Asylums** | 5553 | 5253 | 319 | 10487 | 10806 |
| **Private Asylums** | 29 | 42 | 71 | 0 | 71 |
| **Parochial Asylums** | 126 | 100 | 0 | 226 | 226 |
| **Lunatic Wards of Poorhouses** | 441 | 415 | 0 | 856 | 856 |
| **Private Dwellings** | 1289 | 1654 | 110 | 2833 | 2943 |
| Total | 9212 | 9470 | 2464 | 16218 | 18632 |

Table 6.2 – Distribution of insane in each type of accommodation, 1913 (SCL, 1914).

The figures in Table 6.2, and visually in Figure 6.2, show that, as well as a massive rise in the overall number of pauper lunatics since the first report in 1859, by 1913 the majority of pauper patients were, unsurprisingly, distributed around the district asylums. Although one fifth of the pauper patients were accommodated in royal asylums, which would have included patients from counties such as Orkney and Caithness, who had agreements with the REA and Montrose Royal Asylum, the main energy of the General Board was focused

on providing state-run district asylum accommodation for pauper patients, ideally through the expansion of the district asylum network.

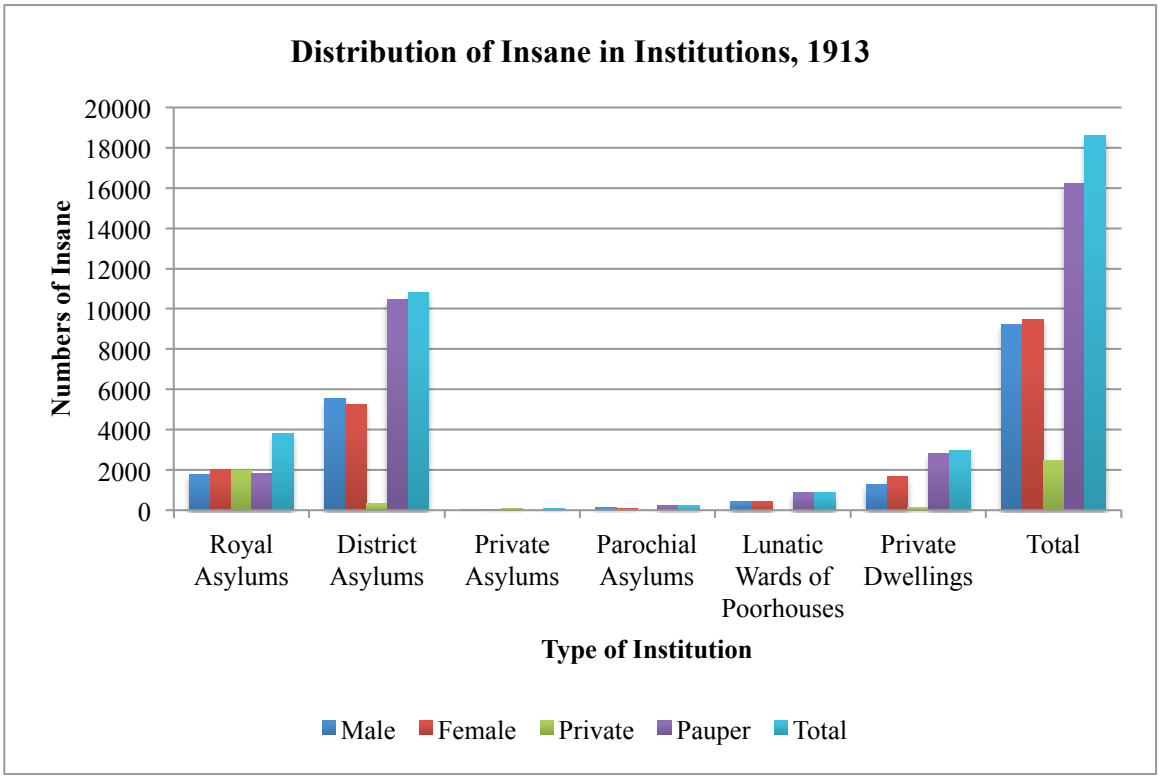


Figure 6.2 - Distribution of insane in each type of accommodation, 1913 (SCL, 1914)

As well as the concerted effort to provide each district with its own institution, which ultimately increased the pauper patient numbers as patients were moved out of private dwellings, the accumulation of this class in asylums was also exaggerated due to families taking advantage of the parish contributions towards maintenance costs, and an increasing willingness more generally for the poorer classes to accept pauper relief. The Commissioners recognised the increases as being due to the following:

1. The erection of new asylums for pauper lunatics – especially affecting localities in which no asylum accommodation for pauper lunatics previously existed.

2. The readier means of access to asylums due to increased facilities for travelling.

3. The gradual dying out among the public of feelings of dislike and suspicion towards asylums, a change which has resulted from an increasing recognition on the part of the community of the humane and enlightened methods of modern treatment, and of the protection, comforts, medical treatment, and curative influences generally which modern asylums afford.

4. The greater readiness among the poorer classes to send relatives to asylums as pauper lunatics, which is due in part to the cause just mentioned, but also in part to a strengthened conviction of the difference which exists between the

acceptance of parochial relief in cases of insanity and its acceptance under other conditions.

5. The growing unwillingness of the poorer classes to submit to all that is involved in keeping an insane relative at home – the discomfort which usually results from the presence of an insane person in a small house, the expense of supporting a member of the family who is unable either to earn wages or to do housework, and the diminution of the earnings of the healthy which the care of an insane relative often involves.

6. The greater willingness of parochial authorities to recognise claims to parochial relief on the ground of insanity.

7. The stimulus, both to the readiness to seek relief and to the willingness to afford it, which has resulted from the giving of a State Grant-in-aid towards the cost of maintenance of pauper lunatics [see below].

8. The widening of medical and public opinion as to the degree of mental unsoundness which may be certified to be lunacy. (SCL, 1892:lvii)

Unlike private patients, who were often removed from institutions after a much shorter period of time to save the family money (either once the hope of recovery was passed or the patient had become more manageable), the pauper patient was more likely to be left in the asylum. As such, the total number of private lunatics enumerated in 1858 and 1913 less than tripled, whereas the pauper lunatic population rose from 4,737 to 16,218; a near four-fold increase.[139] Through their institutionalisation, the pauper family and the inspector of poor were "relieved of all trouble and responsibility in connection with the case" (SCL, 1870:v). Only thirteen years after the passing of the 1857 Act, the General Board warned that the consequences of these factors "were every day assuming an aspect of greater gravity" (SCL, 1870:v), as the growth of pauper patient numbers fast outgrew the provision of accommodation.

The increase for financial reasons was further exacerbated by the implementation of the so-called 'State Grant-in-aid', first available in the year 1874-75, which subsidised part of the maintenance cost using 'imperial'[140] funds (SCL, 1875). It was estimated that by 1881, 969 patients had been admitted as a result of the grant, and as such, extra accommodation had to be constructed that would otherwise not have been needed (SCL, 1881). Indeed, the Commissioners reported that an extra £70,000 to £100,000 had to be spent on constructing

[139] This could, of course, also be due to pauper patients moving from private houses to district asylums.

[140] The nature/source of these funds is not clear, although it can be assumed that it was some sort of government funding.

additional buildings to house patients that were funded by the grant (see Chapter Nine). Further impacting the lunacy numbers, during the research period there was a shift in both medical and public opinions towards madness, and hence the type of lunacy that should be subjected to asylum care and treatment, which increased numbers as the definition of lunacy was widened and more people were labelled 'mad'. The Commissioners warned that this increase:

> … [i]n some of its effects may be injurious to the country by unnecessarily increasing the burden which lunacy lays on it, and injurious also to some of those persons who exhibit the milder forms of mental unsoundness by subjecting them to discipline and restraints which they do not require, and which take away from the happiness they are capable of enjoying. (SCL, 1875:xiv)

This is an argument that gradually appeared as the years progressed, and to which the Commissioners and superintendents responded through continual alteration and extension of district asylum spaces. This matter will be explored at length in the thematic chapters.

***Changing Provisions***

The following discussion goes on to detail the different and changing accommodation distribution of both private and pauper lunatics during the duration of the study period. This is shown in Table 6.3 and Figure 6.3, emphasising the rise in 'public' asylum provision and the parallel fall in 'private' asylum facilities. There was likely a (spatial) competition between public and private sectors – with expert opinion tending to regard the latter as a problem because it could not be properly regulated (and hence was open to abuse) (see Philo, 2004, Chapter 5).[141] There was, therefore, effectively a 'war' waged on the private sector, with the explicit initial aim of the General Board to transfer all pauper patients into public institutions. Thus, between 1857 and 1913, the numbers in royal and district asylums increased by 12,204 persons, whereas the private asylums saw a decrease of 674 persons, with only 71 patients accommodated in private institutions by the close of the period, none of which were pauper lunatics. The General Board commented on this movement:

> The gradual shifting of the mass of lunacy or mental unsoundness in the community from private to public support has been attended with some good and with some evil results. It has extended the benefits of asylum care and treatment to

[141] Down south, it is very clear that the English Commissioners agitated for public provisions to be made in localities currently 'served' by big private madhouses (notably ones taking in, and often clearly failing, large numbers of pauper lunatics).

> many persons who needed such treatment and who could not otherwise have obtained it; and by bringing many imbeciles in private dwellings in poor and outlying districts under official inspection, it has ameliorated their condition in various ways. On the other hand, there are grounds for thinking that the shifting of the burden of lunacy to public bodies has been accompanied by a weakening of the sense of family obligations towards the insane. The belief appears to have become more general that a claim to freedom from the duties of kinship so far as regards pecuniary sacrifice and personal trouble has been established whenever the person in regard to whom their exercise is called for is certified to be of unsound mind. (SCL, 1892:lx)

The tone here echoes what also occurred down south: some restatement of certain advantages of a 'private' system, which could have been connected to ideological underpinnings too: a recognition that the Victorian/Edwardian state was becoming too large, too paternalist, and so forth.

Inevitably, the growing number of district asylums, particularly initially, resulted in the steady decrease in those housed in private dwellings and private asylums. The numbers of pauper patients in private asylums decreased to none over the study period, but, as can be seen in Figure 6.3, the number of patients boarded-out to private dwellings was to rise slowly as overall patient numbers grew (see Sturdy, 1996). The latter system was encouraged as a small way of managing the fast-growing numbers of asylum patients, and the increased resort to boarding-out may have been encouraged to check the convention of families using the institutions as a convenient place for inconvenient people (Scull, 1980), instead trying to (re)instate family responsibility for their insane relatives (combating the concerns outlined in the above quote). Furthermore, there was an early realisation that, "contrary to the expectations that were previously entertained, the erection of asylums exercises no influence in checking the growth of insanity" (SCL, 1869:xv). It was eventually recognised that if, after two or three years of asylum treatment the patient had not recovered, their chances of doing so were extremely small, meaning that the vast majority of patients in the asylums would never be 'cured'. It was thereby realised that many harmless and incurable patients could be more suitably accommodated in private dwellings rather than detained in the asylum.[142] For these reasons, there was a slower rate of admittance of pauper patients in royal and district asylums in the period between 1880 and 1895, as shown in Figure 6.3. Although, having said this, there were no new district

[142] In 1871 there was a suggestion made by the General Board that, after two or three years, if the patient was to be kept in the asylum, some of the cost of their maintenance should be met by their relatives, but there is no evidence that this policy was ever implemented.

asylums erected during this period, which inevitably decelerated the admissions into institutions.

| Years | In Royal and District Asylums | In Private Asylums | In Parochial Asylums, Lunatic Wards of Poorhouses with Unrestricted Licence | In Lunatic Wards of Poorhouses with Restricted Licences | In Private Dwellings | Total Number of Registered Lunatics |
|---|---|---|---|---|---|---|
| **1858**[143] | 2380 | 745 | 840 | | 1804 | 5769 |
| **1859** | 2496 | 821 | 797 | | 1901 | 6015 |
| **1860** | 2632 | 852 | 866 | | 1868 | 6218 |
| **Average of 5 years, 1861-1865** | 2880 | 883 | 879 | | 1712 | 6354 |
| **Average of 5 years, 1866-1870** | 3824 | 69 | 459 | 569 | 1553 | 6975 |
| **Average of 5 years, 1871-1875** | 4697 | 320 | 657 | 588 | 1525 | 7787 |
| **Average of 5 years, 1876-1880** | 5459 | 192 | 1072[144] | 647 | 1508 | 8878 |
| **Average of 5 years 1881-1885** | 6168 | 155 | 1380 | 723 | 1811 | 10237 |
| **Average of 5 years 1886-1890** | 6530 | 146 | 1471 | 865 | 2370 | 11382 |
| **Average of 5 years 1891-1895** | 7512 | 156 | 1590 | 871 | 2654 | 12783 |
| **Average of 5 years 1896-1900** | 9597 | 136 | 117 | 886 | 2802 | 14498 |
| **Average of 5 years 1901-1905** | 11625 | 126 | 525 | 1082 | 2788 | 16146 |
| **Average of 5 years 1906-1910** | 13072 | 100 | 488 | 811 | 2920 | 17391 |
| **1911** | 13939 | 90 | 202[145] | 834 | 2994 | 18059 |
| **1912** | 14250 | 85 | 206 | 861 | 3017 | 18419 |
| **1913** | 14380 | 82 | 228 | 841 | 3021 | 18552 |
| **1914** | 14586 | 71 | 226 | 856 | 2943 | 18682 |

Table 6.3 – The different modes in which lunatics, both private and pauper, have been provided for, 1858-1914 (not including Lunatic Department of General Prisons or Training Schools) (SCL, 1900, 1914)

The overall rise in patients admitted to institutions in the later-1890s was due to the breaking up of the original Glasgow district into five smaller districts, which were each provided with their own district asylum between 1895 and 1910, and the overall decrease of patients in parochial asylums was due to the Barony and Paisley Parochial Asylums being reclassified as district asylums. After 1898 Barony came under the control of the Glasgow District Board, to be known as the Glasgow District Asylum, Woodilee, and Paisley became the district asylum for the newly formed Paisley Board.

[143] The numbers given in the final report for the first year do not match the figures given by the General Board in the first report. This is an error by the Commissioners, and it is unclear how it occurred.

[144] Barony Parochial Asylum was constructed in 1875, hence the start of the spike. The big drop after 1895 reflects a reclassification of this institution as a district asylum, under the management of the Glasgow District Board.

[145] The drop in numbers here reflects the reclassification of Paisley Parochial Asylum to Paisley District Asylum.

The remainder of this chapter will now look in greater detail at the roll-out of the system of district asylum provision across the country throughout the second half of the nineteenth century and into the twentieth century. The first stage of district asylum building was to fill out the geographical gaps by providing accommodation in districts lacking any institutional provision of any kind, and the latter stage was a move to provide district asylums in the districts which were already provided with royal asylums, in the process updating and progressing the designs and grounds of the earlier institutions (see Chapters Seven-Nine).

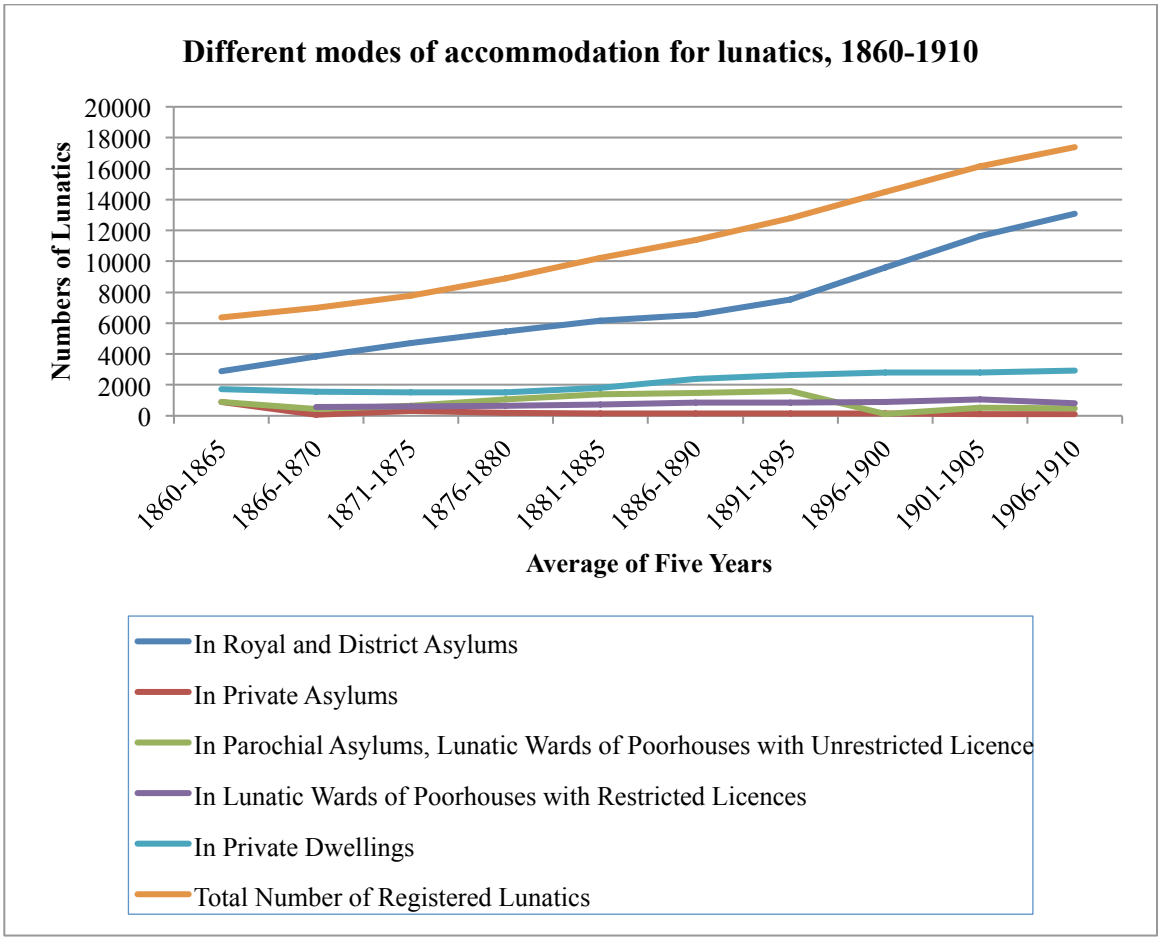


Figure 6.3 – Different modes of accommodation for lunatics, 1860-1910 (SCL, 1900, 1914)

## THE DEVELOPMENT OF THE DISTRICT ASYLUM NETWORK, 1857-1913

At the outset, the Commissioners believed that the establishment of a network of district asylums across the country was "capable of rendering to humanity far greater services than they [royal asylums] have yet achieved", with their object being "the cure of the insane and the diminution of insanity" (SCL,1859:iv). There was recognition of obvious geographical 'gaps' in asylum provision across the country (see Figure 6.4), with the *Builder* writing in 1860:

> … striking a line from Aberdeen to Glasgow through Perth, there was in 1857 absolutely no provision in the northern and north-western counties, except a few cells in the basement of the infirmary at Inverness, and a pauper institution at Elgin. (*Builder*, 1860:4, in Darragh, 2011:87)

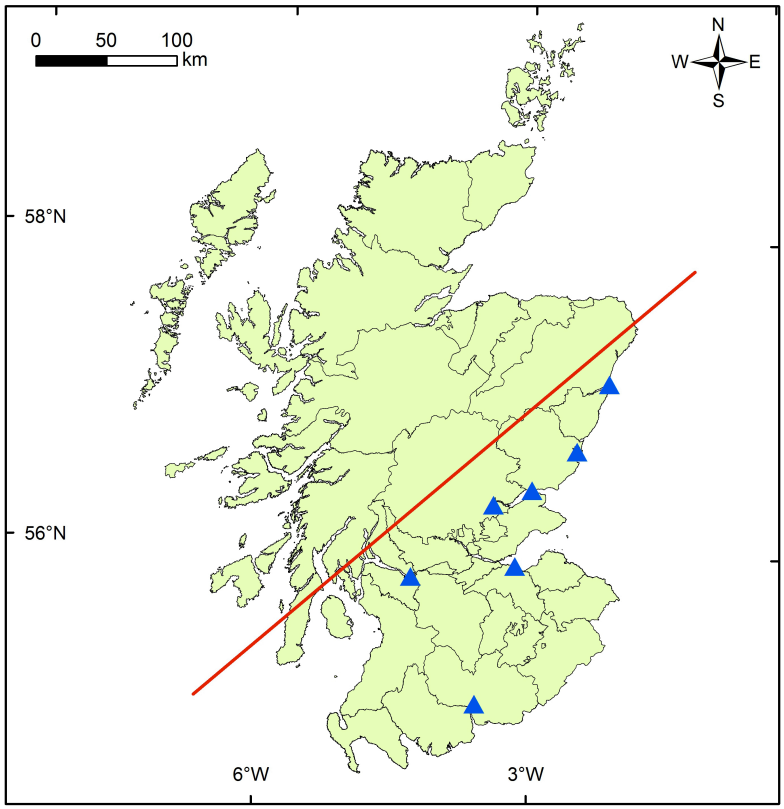


Figure 6.4 – Location of royal asylums, showing lack of provision to the north and north-west of the country (see also Figure 5.2).

Drawing from the material uncovered by the 1855-57 inquiry and their own inspections, the General Board was able to draw some conclusions as to the 'existing accommodation' in each of the districts (this latter term will be discussed below). From the evidence, they supposed that districts "tolerably provided for" (SCL, 1859:xii) in 1859, which unsurprisingly included Forfar, Edinburgh and Lanark (all with royal asylums), had on average 84.11 per cent of the recognised lunatic population in asylums or poorhouses, leaving only 15.89 per cent at home. On the other hand, the districts of Caithness, Ross and Cromarty, Sutherland, and Inverness, none of which had royal asylums, were considered severely underprovided, with only 27.64 per cent residing in asylums. This example illustrates the statement outlined earlier from the *Builder,* and shows great geographical difference in institutional provision, with the northern districts, at this stage, lacking any asylum provision. This correlates with Jarvis's Law[146], which was a "law of nearness and

[146] Edward Jarvis (1803-1884) was a North American physician interested in the influence of distance on the utilisation of lunatic asylums (See Philo, 1997). In 1850, he published a paper in the *Boston Medical and Surgical Journal* entitled "The influence of distance from, and proximity to, an insane hospital, on its use by

distance", suggesting that the closer a lunatic lives to an asylum, the more likely relatives/parochial officers were to send their lunatic charges to the asylum (Philo, 1995). The Commissioners observed "that easy access to asylums greatly influences the distribution of pauper lunatics"; and, perfectly fitting with Jarvis's Law of distance-decay, the Commissioners continued by adding:

> It may be accepted as an axiom, that the number of patients sent to asylums diminishes in a ratio corresponding to the distance, and that the number of those which remain at home increases in a similar degree. (SCL, 1860:ix)

Following this Law, they trusted that, "when asylums are provided within easy reach of the patients' homes, many of the objections at present entertained in regard to them will be neutralised, and the consent of relatives to removal be more easily obtained" (SCL, 1859:xxix). This again confirms their belief that proper care and early treatment was best provided in custom built, ideally situated district asylums.

Consequently, one of the first tasks was to divide the country into 'districts' in seeking to establish a more even geographical spread of institutional provisions. Scotland was comprised of thirty-three counties at this time, and the lunacy districts were to consist of varying combinations of these counties (see Figure 6.5). Many of the counties in Scotland were too small in geographical size and population to have their own board and construct their own asylum, and hence the difference between 'county' asylums in England and Wales and 'district' asylums in Scotland. Initially, it was proposed to split the country into eight districts, comprised of the following counties:

| Districts | Comprised of which Counties |
|---|---|
| **Edinburgh** | Edinburgh, Haddington, Berwick, Linlithgow, Roxburgh, Selkirk, Peebles, Orkney |
| **Inverness** | Sutherland, Ross and Cromarty, Inverness, Elgin, Nairn |
| **Aberdeen** | Caithness, Banff, Aberdeen Kincardine, Shetland |
| **Perth** | Forfar, Perth, Fife, Clackmannan, Kinross |
| **Dumfries** | Dumfries, Kirkcurdbright, Wigton |
| **Glasgow** | Lanark |
| **Stirling** | Argyll, Bute, Dumbarton, Stirling |
| **Renfrew** | Renfrew, Ayr |

Table 6.4 – Initial proposed lunacy districts (SCL, 1859)[147]

any people". The paper described "the perceived phenomena of diminishing numbers of admissions from areas of increasing physical distance to asylums located in Massachusetts and other Eastern American states" (Smith *et al*, 2007:2364). Furthermore, Jarvis tended to see issues such as mental sickness in an environmental and social light, thus believing prevention was based around sanitation, education and religious instruction (Philo, 1995).

[147] There are parallels here with the initial proposals in 1807 to create large 'catchments' for the English asylums (based on amalgamations of counties) (see Philo 2004, Chapter Seven).

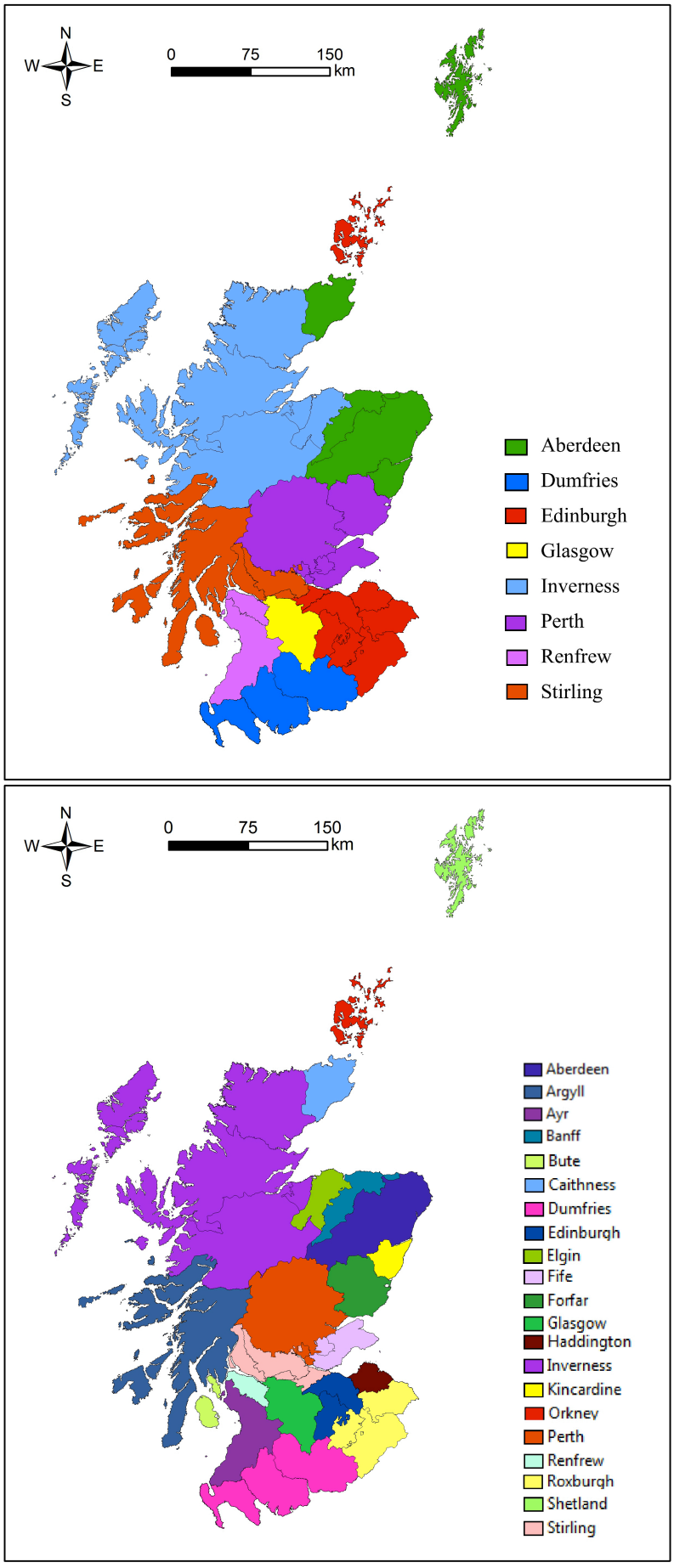


Figure 6.5 – Maps showing eight and twenty-one lunacy districts, or proposed initially and then revised.

Many of the counties disagreed with these combinations, however, and requested separation under Section 110 of the Act, which "gave the power to … any county to sever itself from the district of which it forms part, and to erect itself into a separate district" (SCL, 1859:v), thus forcing the General Board to combine and divide the counties further. Consequently, the initial districts were completely remodelled:

> … partly by the larger counties erecting themselves into separate districts; partly by the aggregation of smaller counties into new combinations; and partly by the involuntary isolation of counties through the secession of those to which they were originally united, and their subsequent rejection by other counties with which they proposed to unite. (SCL, 1859:v)

Therefore, at this stage the districts were constructed as follows:

| District | Comprised of which Counties |
|---|---|
| **Aberdeen** | Aberdeenshire |
| **Argyll** | Argyllshire |
| **Ayr** | Ayrshire |
| **Banff** | Banffshire |
| **Bute** | Buteshire |
| **Caithness** | Caithness-shire |
| **Dumfries** | Dumfries, Kirkcudbright, Wigton |
| **Edinburgh** | Edinburgh and Peebles |
| **Elgin** | Elginshire |
| **Fife** | Fife and Kinross |
| **Forfar** | Forfarshire |
| **Glasgow** | Lanarkshire |
| **Haddington** | Haddington |
| **Inverness** | Inverness, Nairn, Ross and Cromarty, Sutherland |
| **Kincardine** | Kincradineshire |
| **Orkney** | Orkney |
| **Perth** | Perthshire |
| **Renfrew** | Renfrewshire |
| **Roxburgh** | Roxburgh, Berwick, Selkirk |
| **Shetland** | Shetland |
| **Stirling** | Clackmannan, Dumbarton, Linlithgow, Stirling |

Table 6.5 – Confirmed lunacy districts (SCL, 1859)

As is evident, these districts were still unequal in terms of extent, wealth and population. This was particularly stark in the case of districts that had become isolated from larger counties, such as Caithness, Orkney and Shetland. Many were considered too small to provide their own efficient separate asylums, and therefore had the difficult task of trying to negotiate amalgamation with larger districts or draw up contracts with other asylums. The Commissioners remarked that further alterations were possible, but, as they were powerless to force districts to combine, they believed that the union of isolated districts

was, at this stage, unlikely. The districts were not altered again until after the passing of the *Lunacy Districts (Scotland) Act*, 1887[148], discussed below.

***'Existing Accommodation'***

With the formation of the districts in place, the next task for the General Board was to decide whether there was sufficient existing accommodation in each of the districts or if new accommodation was needed. The Commissioners assumed, from the general tone of the Act, that pauper lunatics in need of institutional accommodation should be placed in either a district or a royal asylum. Therefore, if a district did not possess a royal asylum, a district asylum should be constructed under the provisions of the Act. The definition of 'existing accommodation' nonetheless posed great difficulties for the Commissioners due to the wording of Section 59 of the Act, which brought into question whether the General Board had to recognise and even adopt as adequate provision private asylums and, even more seriously in the eyes of the Commissioners, lunatic wards of poorhouses, both of which had, on the whole, been damned by the 1855-57 Report as suitable venues for the care and treatment of lunatics (as discussed in Chapter Five). Consequently, a short Amendment Act was passed in 1858[149] which clarified the wording, overcoming the uncertainty around the term, and granting temporary five-year licenses to registered lunatic wards of poorhouses in order to house pauper patients legally until the district asylums were constructed. This left 'existing accommodation' to be royal and private asylums; but, due to private asylums only being licensed temporarily until district asylums were provided, the term was realistically only applicable to royal asylums.[150] Yet, in response to the success of the 1858 Amendment Act, it was followed by a further Amendment Act in 1862[151] which authorised the Board to give permanent licenses to lunatic wards of poorhouses "for the reception and detention of pauper lunatics who were not dangerous and who did not require curative treatment" (SCL, 1914:lxxxvi). This follow-up Act in 1862 potentially marked a key shift: a realism in the face of mounting numbers of (harmless) chronic lunatics; but it might also be a signal of emerging doubts about the efficacy of the asylum solution.

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[148] *Lunacy Districts (Scotland) Act*, 1887 (50 & 51 Vict. c. 39)

[149] *Lunatics (Scotland) Act*, 1858 (21 & 22 Vict. c. 89)

[150] Only two institutions objected to the Amendment: the Edinburgh City poorhouse, on the grounds that it represented the old City Bedlam, which was the public asylum before the erection of the REA, and the Barony parish, Glasgow, which claimed that lunatic wards of poorhouses fell under the statutory definition of public asylum. Both of these claims were dismissed by the General Board, and thus both institutions were deemed to be receiving patients illegally.

[151] *Lunacy (Scotland) Act*, 1862 (25 & 26 Vict. c. 54)

Section 59 also stated that, if there was already an asylum established in a district at the time the Act was passed, as in the case of the districts with royal asylums, the district boards should draw up a contract with that institution for the reception and maintenance of the pauper lunatics of that district before proceeding to found a district asylum. This provision is crucial in understanding the relationship between district and royal asylums. Perth was the only district which failed to draw up a contract for the reception of its pauper patients in its royal asylum and, consequently, it was among one of the first districts to build its own district asylum. It is therefore a rare early example of spatial overlap between a royal and a district asylum within the same district. This overlap did not take place in the other districts with royal asylums until the end of the nineteenth century.

***The Early District Asylums (1860-1874)***

Despite the passing of the 1857 Act, and the publication of the aforementioned *Suggestions and Instructions,* the Commissioners were disappointed with the progress in the year directly following the Act. They reported that several of the boards had taken no steps at all towards establishing a district asylum, with only three or four making satisfactory progress. Many of the boards initially delayed the decisions while they waited to see what alterations might be made regarding 'existing accommodation' during that year's Session of Parliament. Yet, given the realisation that "no amount of legislation will remove the necessity for providing asylums" (SCL, 1861:x) and prompted by the 1858 and 1862 Amendment Acts clarifying the definition of 'existing accommodation', several of the boards began to take positive steps towards the erection of asylums. The General Board commented:

> We cannot doubt the propriety of this course, as we are satisfied that its adoption will exercise a beneficial influence, not only on the patients who are placed in these institutions, but also on those whom it may be considered right to leave in their homes. (SCL, 1861:i)

Although in hindsight, and perhaps with a rose-tinted reflection on the early development and success of the district asylum system, the Commissioners indicated in 1913 that "in those counties more remote from any asylum accommodation special efforts seem to have been made to provide asylums *with as little delay as possible*" (1914:lxxxvii, emphasis added). Hence Argyll and Inverness were the first to provide asylums – in part reflecting prior efforts to open a public institution in the north, the Northern Counties Asylum, to

overcome the near total absence of institutional provisions (See Philo, 2007 and Donoho, 2012).[152]

| District Asylum[153] | Year Opened |
|---|---|
| **Argyll (later to become Argyll and Bute)** | 1863 |
| **Inverness** | 1864 |
| **Perth** | 1864 |
| **Banff** | 1865 |
| **Ayr** | 1866 |
| **Haddington** | 1866 |
| **Stirling** | 1866 |
| **Fife and Kinross** | 1866 |
| **Roxburgh** | 1869 |
| **Peebles and Midlothian** | 1874 |

Table 6.6 – Date of the openings of the early district asylums.

The main asylum-building period, which included the construction of the majority of district asylums, occurred in the first twenty years after 1857. The first asylums to be opened were located in the districts where there was no existing provision, thus attempting to 'fill in' the geographical 'gaps', and thereby expanding the network of institutions more evenly across the country. As is shown in Table 6.6, the first of the asylums which may be considered as having been built as a direct response to the 1857 Act was opened in 1863 (Argyll), and the last of the original group – numbering ten in total – in 1874 (Peebles and Midlothian).

But, as is evident from Figure 6.6, there was still a large proportion of the country unprovided with accommodation. This was particularly stark in the Highlands, which relied on the two main institutions in Inverness and Argyll, meaning that many rurally situated pauper lunatics were either kept at home or had to travel long distances to reach their closest district asylum. Furthermore, due to the continually increasing numbers of lunatics, by 1874 the Fife, Argyll and Elgin asylums had all been enlarged, and the extension of the Perth, Inverness and Stirling district asylums was being contemplated by the respective boards (see Chapter Nine). Despite these difficulties, by 1878 the General Board had succeeded in ensuring that all pauper lunatics who were in confinement were now housed in public, not private, asylums, meaning that "it is no longer in the interest of any private individual, either to make a profit out of the low rate of board paid for them, or to prolong their detention unnecessarily", and also that:

[152] This venture had failed due to a lack of funds.

[153] Elgin Pauper Asylum was recognised as the asylum for the district of Elgin in 1864, though the original building was opened in 1835.

> This change in the way of providing for those of the pauper lunatics of Scotland who are held to require the restraints and appliances of asylums for their safe keeping and proper care, represents the complete accomplishment of one of the chief objects in view when the lunacy laws were amended in 1857. (SCL, 1878:iv)

The Commissioners heralded this achievement, claiming that it had not been so thoroughly accomplished in any other country. Indeed, south of the border, a stubborn group of private provisions remained (see Philo, 2004, Chapter Five).

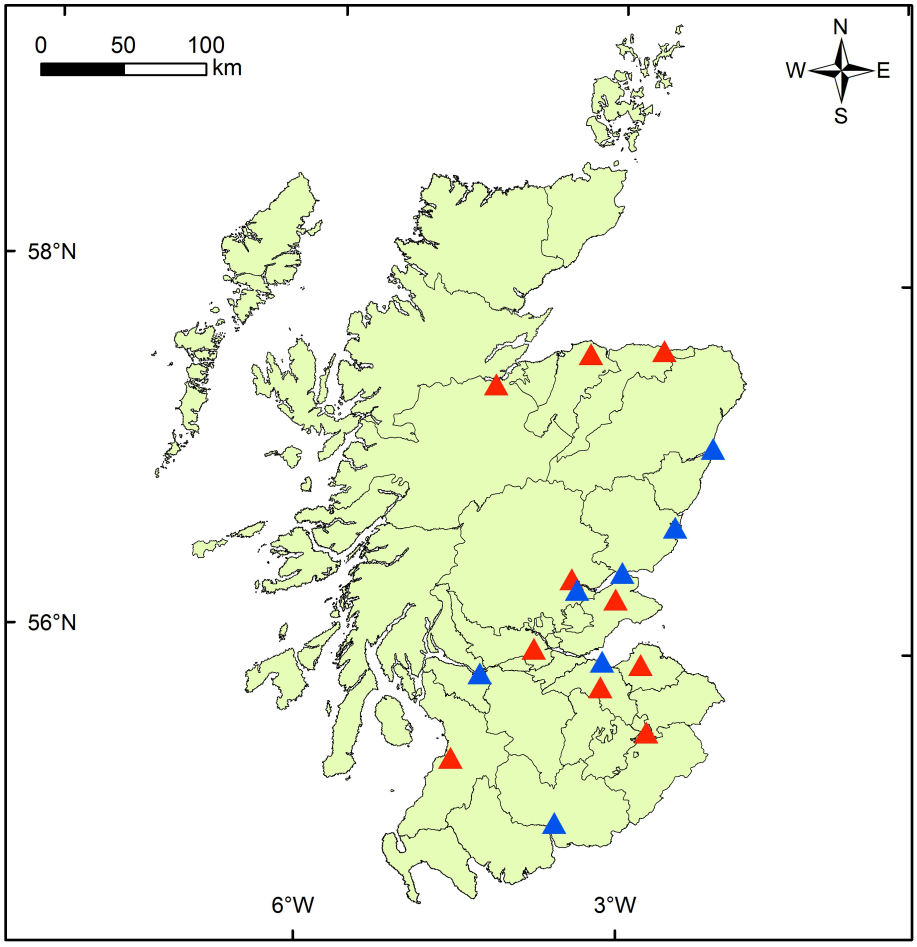



Figure 6.6 – Location of asylums. Royal asylums (built pre-1857), blue; and early district asylums (built 1863-1874), red.

As will be explored in greater detail in subsequent chapters, the Commissioners were intent on creating an environment far removed from the old 'madhouse', yet still wanting to provide a certain level of flexibility and license when it came to the overall design and layout of the different district asylums, with the needs of each district to be met in customised, purpose-built institutions. It was not their wish for every new asylum to be the same. Throughout the reports of the General Board, there was abundant evidence showing the Commissioners' willingness to support the district asylums and district boards in developing their own institutions in ways beneficial to the local insane, adjusting their

recommendations as provisions developed through the century. They stated in the twentieth report:

> It is a satisfactory feature of the Scotch lunacy laws and of their administration, that no hindrance to progress is offered through the existence of any uniformity or inflexibility in the standard of what is proper. (SCL, 1878:xxxi)

The General Board believed that this variety encouraged the superintendents and administrators of the different district asylums and boards to explore differing ways of managing the insane through drawing from, and improving upon, their own experiences. They argued that, had this flexibility not existed and instead a "strict uniformity" imposed on the different districts, they would probably not have witnessed "those beneficial changes in the structural arrangements of asylums and in the modes of managing their inmates" (SCL, 1914:lxxxviii) which they believed to have transpired over the years after the 1857 Act. Indeed:

> So long as the aim is good, so long as the purpose is benevolent and honest, the intelligence of such Superintendents as preside over Scotch Asylums may with safety be trusted not to purpose the introduction of changes which have not a reasonable prospect of attaining their end. If in some instances failure appears to us probable, or even if new modes of treatment are occasionally adopted which seem to us in a wrong direction, it is practically found sufficient that we state our views and doubts, and thus secure a careful reconsideration of the matter. (SCL, 1914:lxxxviii)

This attitude, which was clearly not a heavy-handed regulationist ethos, prevailed throughout the fifty-six years of the General Board's control, and many changes were made without realising the far-reaching consequences that they would exert on lunacy provision. It was the Commissioners' understanding that the flexible system which they had fostered allowed space for the positive, energetic and zealous manner of the administrators gradually to develop the treatment, cares and custody of the insane, improving their conditions:

> … by removing repressive measures in treatment, by encouraging healthy and interesting occupations, by endeavouring to make asylum life more like ordinary life, and, by means of general hygienic measures, ameliorating the condition of those patients in whose case recovery was hopeless. (SCL, 1914:lxxxviii)

During the early period of district asylum construction, the discourses surrounding treatment were very much *moral*-focused, with a clear spatial solution, evident in the Commissioners' Seventh Report:

> The general principles on which the treatment of the patients in Scotch asylums is conducted, are in a great degree purely hygienic. Little reliance appears to be placed on any specific action of drugs, and the use of counter irritation is sparingly resorted to. The leaning of medical superintendents seems to be to avoid active interference, whether by physical or moral agents; and to trust for success more to the removal of the patient from the sources of mental irritation and the causes of bodily disease, and to placing him in circumstances where his bodily wants will be properly supplied, and where he will be trained in the exercise of self control. (SCL, 1865:xxxviii)[154]

Just five years later, though, the General Board stated,

> Palliative measures are however within our reach, and for their attainment the first step is undoubtedly to qualify medical practitioners to form an accurate and independent judgement on the nature and treatment of insanity. (SCL, 1870:xliv)

The Commissioners were conscious that the district asylums built in the years in the first phase of district asylum construction after the 1857 Act had arguably taken on the character of boarding-houses, with the patients' welfare "far more dependent on comfortable meals and beds, and on adequate exercise, occupation, and recreation, than on any special medical treatment" (SCL, 1870:xlvi). The General Board recognised the great advances that had been made in the care of the insane by moving away from mechanical restraint towards occupation, exercise and recreation-based treatments, but in 1871 they stated that they had "reached a stage at which it behoves us to inquire whether the constant expansion of the asylum system is not detrimental to further progress in the rational treatment of inanity" (SCL, 1871:xliii). A sense began to prevail that increasing number of patients was damaging to the power and methods of moral treatment. For this reason (and also the practical reason that every district was now provided with some form of public institution), the building of new district asylums was halted for over twenty years (though with many existing asylums undergoing considerable expansion to manage the increasing numbers during this time: see Chapter Nine).

By the later years of the nineteenth century, influenced by "great and important scientific advances" in the Commissioners' "knowledge of the etiology and pathology of mental diseases", and the understanding that "every malady to which man is subjected is caused by a disorder of his bodily functions, and insanity is no exception to this rule" (SCL, 1870:xliv), discourses increasingly shifted towards a *medical* understanding of the insane. As such, when new district asylum construction was started again in the 1890s, the

[154] Though these latter elements could be configured as the use of 'moral means'.

direction was focused much more towards the medical treatment of disease, with the explicit focus on the moral now receding. Although important to recognise in this chapter, the changes implemented and the consequences of shifting discourses of treatment from asylum sites, grounds and buildings, will be explored in more depth in Chapters Seven-Nine.

### *The Late District Asylums (1890-1900)*

As stated previously, during the early period no district asylum had been constructed in a district that already had a royal asylum, with the exception of Perth. After the last of the early district asylums was opened, the Commissioners were grateful for this arrangement, as it saved some of the district boards the expense of erecting their own district asylums. But, due to the demand on the existing accommodation, particularly within these districts, further district asylums were constructed in the last decade of the nineteenth century and the beginning of the twentieth century (see Table 6.7).

| District Asylum | Opened |
|---|---|
| **Lanark** | 1895 |
| **Govan** | 1895 |
| **Glasgow** | 1896 |
| **Dundee**[155] | 1882 |
| **Aberdeen** | 1904 |
| **Edinburgh** | 1906[156] |
| **Paisley**[157] | 1876 |
| **Renfrew** | 1909 |

Table 6.7 – Dates of the opening of the late district asylums

The construction of these institutions was prompted by the great overcrowding in the existing accommodation, which also impelled the passing of the *Lunacy Districts (Scotland) Act*, 1887. In the years immediately prior to this Act, the parochial boards of Govan, Barony, Lanark and City gathered to propose an alternative plan to the one suggested by the Commissioners, as Barony and Govan had already provided accommodation in the form of parochial asylums, paid for by the ratepayers of these parishes. The alternative schemes were proposed:

> First – That the City Parochial Board should provide themselves with proper lunatic accommodation, as the Barony and Govan Parishes have done, and in these circumstances it is believed there would be no need for the proposed action of the District Lunacy Board.

[155] Formerly a royal asylum, acquired by the Dundee District Board in 1903.

[156] First patients transferred from the REA in 1904, but officially opened in 1906.

[157] Formerly a parochial asylum, became Paisley District Asylum in 1909 (see earlier in this chapter).

> Second – That the City Parochial Board would combine with the Barony Board for Asylum purposes, in which case the Woodilee Asylum [Barony Parochial Asylum] might be extended at a moderate cost so as to furnish sufficient accommodation for the lunatic paupers of both parishes.
>
> Third – That the City, Barony, and Govan Boards should all three combine for Asylum purposes, and make arrangements for having their first class, or curable patients treated in Woodilee (which could be extended if necessary for that purpose), and their second class, or harmless but incurable patients treated in the present City and Govan Parochial Asylums. It is believed that this scheme would provide for a much more efficient treatment of the insane poor than at present exists.
>
> The meeting is further of opinion, that in the event of either one or other of these alternative schemes being adopted the three Parochial Boards should join together in requesting the General Board of Lunacy to separate them from the Lunacy District of Lanarkshire, as provided for by Sect 49 of the Act 20 and 21 Vict., cap. 71. (Minutes from Conference Meeting of Representatives of the Barony, City, and Govan Combination Parochial Boards , 1878:6)

Despite this opposition from the parochial boards, and the Commissioners outlining a similar proposal in their Tenth Report, the Act was passed which granted the General Board the authority to divide and alter the lunacy districts, a power previosuly lost after the passing of the *Prisons (Scotland) Act*, 1877[158], which repealed Section 50 of the 1857 Lunacy Act.

Immediately after the 1887 Act was in place, various 'representative bodies' from the Glasgow district applied for its division into five new districts, to consist of the Barony Parish, the City of Glasgow Parish, the Govan Combination, the Renfrew Parish and the remaining county of Lanark after the separation of the four other parishes. Except for Barony, which was already provided with asylum accommodation by the Barony Parochial Asylum, all of the new district boards constructed district asylums, each in line with the up-to-date discourses around lunacy, which were reflected in the siting, grounds and architectural designs of the building, to be explored in the remaining chapters (see Figure 6.7).

[158] *Prisons (Scotland) Act*,1877 (40 & 41 Vict. c. 53).

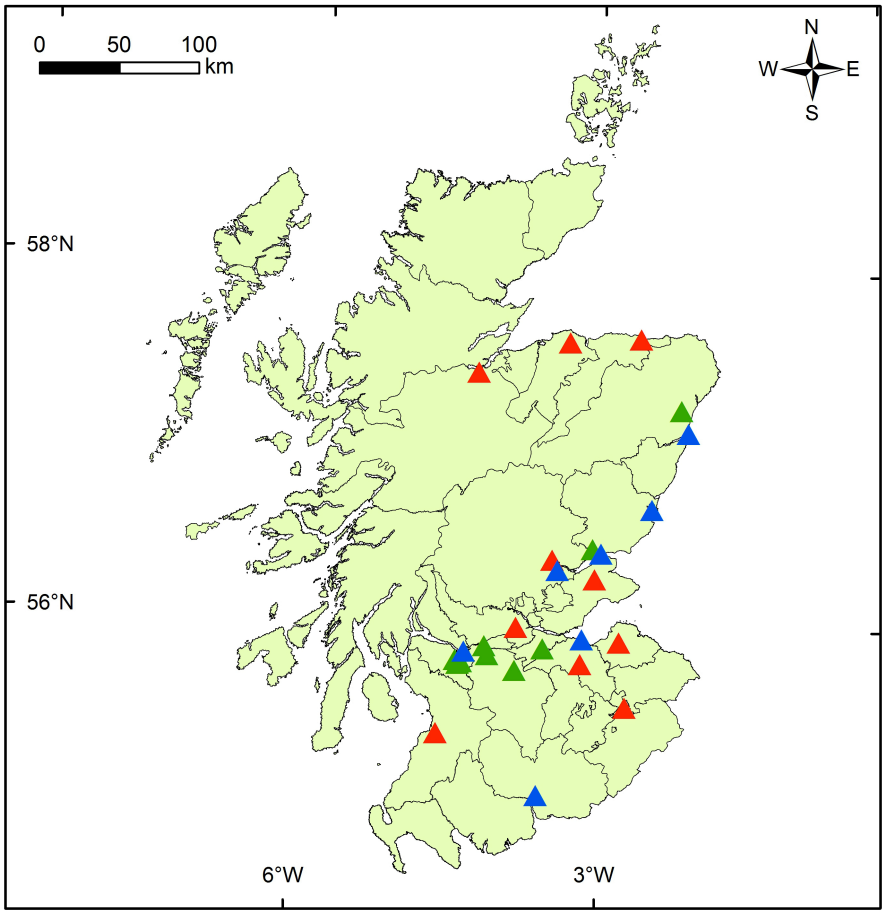


Figure 6.7 – Locations of asylums. Royal asylums (built pre-1857), blue; early district asylums (built 1863-1874), red; and late district asylums (built 1895-1913), green.

The construction of these asylums effectively produced a 'ring' of asylums around Glasgow, which created a new city geography of madness provision (see Figure 6.8). There was, however, marked variety displayed between the different asylums, which expressed different leanings, ideologies and experiments, despite being proximate to one another in a relatively small region (see Chapters Seven-Nine). The later phase here can be characterised as an *urban* phase (akin to the in-filling of 'borough asylums' south of the border), as additionally, new district asylums were also constructed outside the other main urban settlements of Aberdeen and Edinburgh. This was a consequence of increasing urbanisation and reflecting the population distribution across the overall country, as well as a response to pressures from the royal asylums, which increasingly wished for their institutions to provide accommodation for private patients only. Towards the close of the nineteenth century the attention, therefore, was again returned to the urban centres (as it had with the construction of the royal asylums), arguably leading to some re-creation of institutional unevenness between the Highlands and Lowlands that had to an extent been ironed out in the earlier phase of district asylum openings.

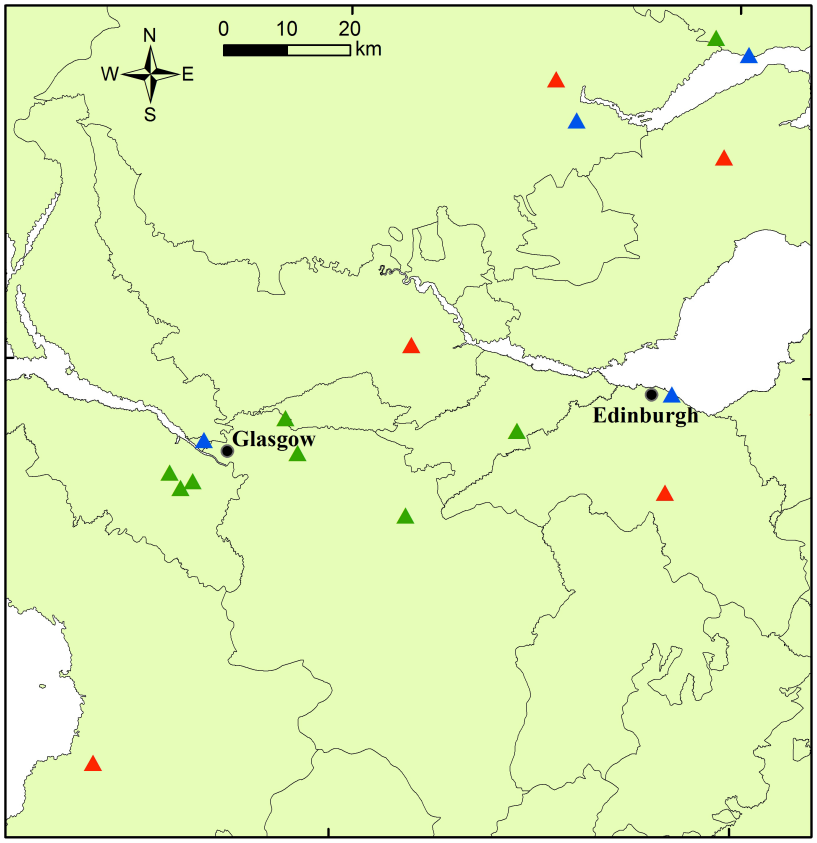


Figure 6.8 – Close up showing Central Belt asylums. Royal asylums (built pre-1857), blue; early district asylums (built 1863-1874), red; late district asylums (built 1895-1913), green.

## CONCLUSIONS

This chapter has detailed the passing of the *Lunacy (Scotland) Act*, 1857, and its impact on pauper lunacy provision and numbers in Scotland until succeeded by the *Mental Deficiency and Lunacy Act*, 1913. It is important to realise the stark rise in the numbers of persons registered as insane within Scotland during these decades, as the figures had a direct impact on the extent of the district asylum system, as well as the designs of the buildings. In the opening years after the 1857 Act, in response to the findings of the 1855-57 inquiry, the newly appointed Commissioners were keen to follow movements across Europe, "in England, France, Germany, Belgium, and even Spain" (SCL,1859:ix), that called for modifications in the constitution of lunatic asylums. This was seen as essential to tackle the ever-increasing numbers of the insane, and to keep Scotland in line with the growing realisation that treatment could possibly be secured through specially designed environments. In the opening years after the 1857 Act, the General Board held that, "beyond all question", transfer to an asylum was "very generally calculated to prove most beneficial to an insane patient" (SCL, 1859:x), but that the asylum's ability actually to reduce insanity was less easily determined, particularly as Commissioners could only draw from past experiences. They argued that previously the "curative agency" of the asylum

"has to a very considerable extent been neutralised by the combined effect of neglect, prejudice, and ignorance" (SCL,1859:x), believing, therefore, that great potential still lay in the reform of the asylum system. Asylums were to be used as an apparatus to tackle insanity, and would provide a commendable service to both the patients and the general public. As such, there was initially no question that the asylum network was to be expanded.

Despite the progression of asylums along moral and, to an extent, medical trajectories – embodied in the determined effort by the General Board to provide an asylum in each of the districts, and thus the continual construction of district asylums across the country until the first decade of the twentieth century – doubts began to creep in at a relatively early stage as to the effectiveness of the system as a method of reducing insanity in Scotland. Notwithstanding the recognition of many beneficial aspects, the General Board admitted, only eleven years after the first report, that the provision of district asylums had "totally failed to arrest the increase of lunacy" (SCL, 1870:v), and so they began to explore alternative ways in which the increasing numbers of patients could be halted. Yet, despite stating as early as 1870 that the asylum was "ineffectual in producing any permanent good in the way of reducing the number of the insane" (SCL, 1870:xiii), rather than removing more patients who no longer required the treatment provided by an asylum (the numbers boarded-out remained relatively low), they continued with their plan of extending both the existing institutions and the network of asylums across the country for another forty years. This plan remained despite the knowledge that the relief obtained through expansion was only temporary:

> The removal of the pressure seems merely to increase the demand for accommodation by causing to be enrolled as lunatics, and sent to asylums at the public expense, many persons of feeble or decayed mental powers, who under other circumstances would have been tended at home. (SCL, 1871:xliii)

Less than fifteen years after the 1857 Act, there hence appeared to be an almost complete lack of faith in the asylum as a *curative* instrument, and in many ways the *failure* of the district asylum system was already being acknowledged. Lunatic asylums were becoming viewed as providing only a "palliative measure, and one, moreover, which experience shows to be ineffectual in producing any permanent good in the way of reducing the number of the insane" (SCL, 1870:xiii). It was recognised that if society was content with relying on the asylum for the treatment of lunacy, then "we may lay our account with the continued growth of lunacy, and of its concomitant burdens" (1870:xiii).

At this time, therefore, the construction of new district asylums was halted for over twenty years (although the existing buildings were greatly expanded). As an alternative to institutionalisation, time and again the Commissioners voiced:

> … that more successful results would be obtained from the rational education of the people and from the introduction into schools of physiological instruction, may very reasonably be expected. At all events, we should then be striving to arrest the evil at its source, instead of merely relying on expedients to neutralize its effects, after permitting its development. (SCL, 1870:vi)

The Commissioners began to advocate the mantra 'prevention is better than cure', believing that, rather than "the erection of hospitals, prisons, poorhouses, and lunatic asylums to neutralize the evils which we have allowed to grow up", their energies would better be spent by checking the growth of insanity through "moral, hygienic, and physiological instruction, and by so enabling every man to be a guide unto himself" (SCL, 1870:xiii). Failing to stem the flow of numbers requiring institutional accommodation, however, the construction of asylums was reignited as a goal at the end of the nineteenth century, arguably as a kind of default, or inertia, of practical ideas. In Scotland, there was, therefore, a growing asylum system *after* the 'Asylum Golden Age' had collapsed (or at least had begun to unravel), and the changing geographies of the district asylums, as indeed of the whole district asylum system, has to be understood against this somewhat paradoxical picture.

# Chapter 7

# Spatial Themes I: Sites and Situations

## INTRODUCTION

> You might, at first, conceive that if mere salubrity and drainage were secured, the choice of the site of an asylum might be left to the architect. This is the error of a prehistoric age. I hold that the choice should be the business of the physician. I believe firmly, moreover, in what the pious poet said, "God made the country, man made the town;" and in this country it seems to have been his object to make the towns as ugly, as dirty, and as insalubrious as possible. I hold in equal faith and reverence that there is a love for and a delight in the beauties of external nature implanted in every heart, so intense as occasionally to assume the aspect of nostalgia, and so undecaying that few minds are so blind or dead as to be unaffected by it. (Browne, 1864:9-10)

The following chapter, by giving attention to 'site and situation', echoes a venerable old geographical tradition of inquiry usually associated with settlement geography. Here, however, following recent trends towards a 'spatial turn', particularly in the sub-discipline of historical geography and around the geographies of science (see Livingstone, 1995, 2003; Withers 2009), the emphasis on 'site and situation' is re-appropriated, and put into a rather different context. Hence, drawing inspiration from Livingstone (2003:3), who calls for increased attention to site, locality and atmosphere, believing that there are "questions of fundamental importance to be asked about *all* the spaces of scientific inquiry," the following will address more critically the traditional settlement geography questions of where buildings were and why they were there (see Stone, 1965) by investigating the discourses and decisions embedded within site selection. Expanding further, Livingstone (2003:7) argues:

> It is plain that space is far from a neutral 'container' in which social life is transacted. Space is not (to change the metaphor) simply the stage on which the real action takes place. Rather, it is itself constitutive of systems of human interaction. At every scale from the international to the domestic, we inhabit locations that at once enable and constrain routine social relations.

Precisely where the Scottish district asylums were located, and why they were located there, is hence of great significance as the locations of asylums can give an insight into the

social construction and control of madness. The correct site and situation, which incorporated the appropriate physical geographical attributes, was the initial step in securing an affective asylum atmosphere, one which had the ability directly to affect the behaviour and emotion of the patients through "a range of *sensory* experiences that such sites induce with their different sights, sounds, and smells" (Livingstone, 2003:18).

For the most part, the General Board actively promoted the spatial separation of the insane from society in purpose-built asylums. This process of exclusion was motivated by a desire to place particular people in perceived therapeutic environments, but always with an undercurrent of social control and custody, as, it should be recognised, therapeutic environments, supposedly designed to create individuals capable of re-taking their place in society as "docile bodies", were of course *also* a form of ('soft') social control. Moreover, there was at bottom a profoundly 'environmentalist' conception, with the General Board relying on the affective qualities of the place in which the mad person was to be consigned. But what it also implies is that the substantive details of a site were arguably of secondary importance, indeed, to the basic fact of 'exclusion' – of spatial removal to an asylum.

As explained in the previous chapter, the General Board was not prescriptive, but rather provided guidelines for consultation, accordingly leaving the specific decisions regarding the location and construction of the new district asylums to the individual district boards. Accordingly, the General Board provided only outline recommendations for the ideal asylum site (location; size; type of land; form of ground; water supply) and situation (in relation to surrounding places, such as towns and transport), although ultimately their approval had to be sought before the construction of the site was initiated. After the 1857 Act, the district boards not possessing 'suitable accommodation' proceeded to purchase estates guided by the requirements laid out by the General Board.

The following chapter will detail the blueprint for the ideal site and situation as it was recorded in the Commissioners' First Report, thus making clear the General Board's vision. It will then turn to explore the actual locations chosen by the district boards as the sites for their district asylums, which were purchased or leased by the boards over the decades after the 1857 Act, focusing on the different district asylum building periods in order to appreciate the changing priorities around site selection. The details in the archives vary greatly, yet it has been possible to uncover some of the negotiations surrounding the acquisition of a site prior to asylum construction for a number of districts, and the varying importance thereby given to different aspects such as water supply, cheerful views and

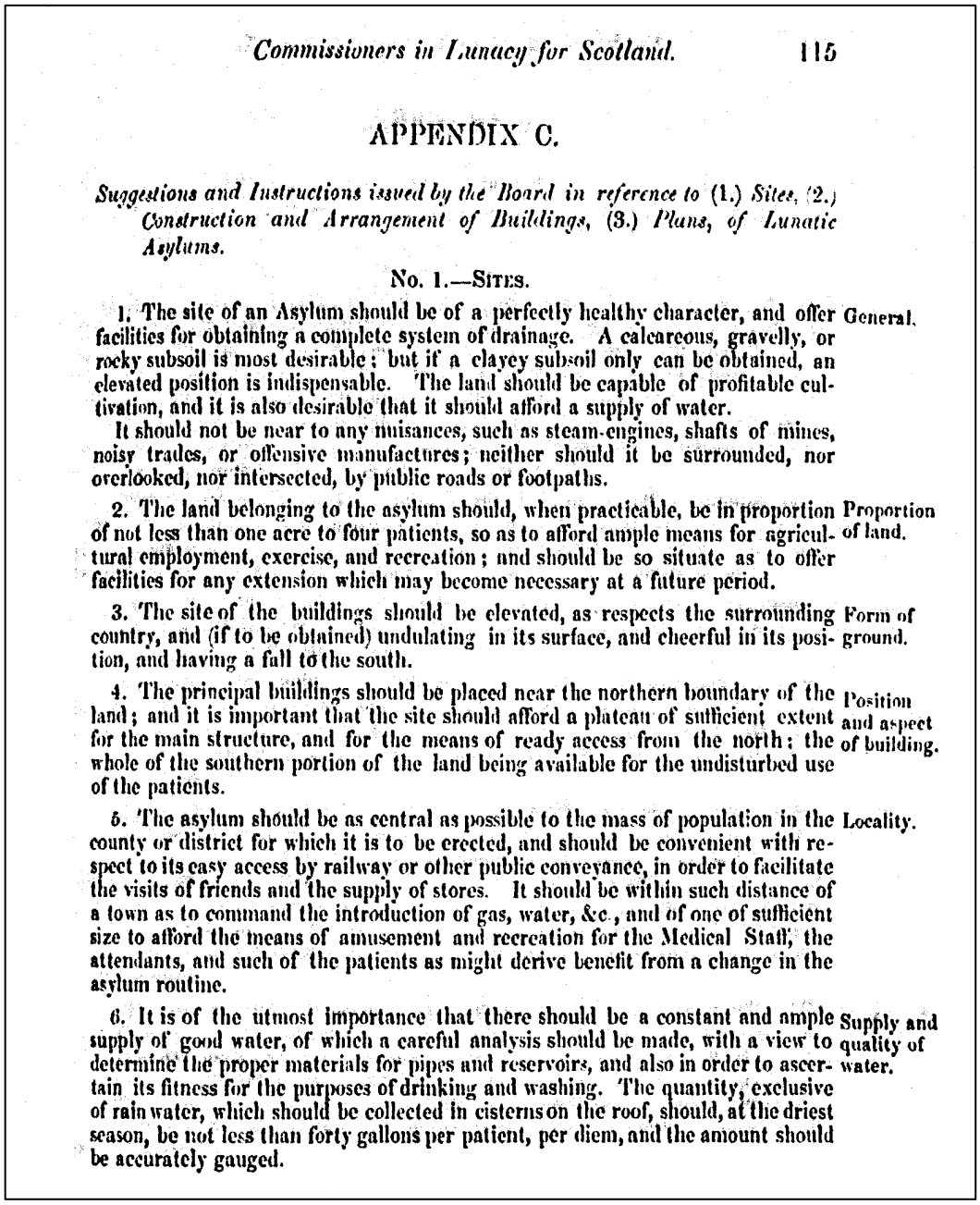
extent of land. Consequently, assessments can be made as to how closely the actual locations chosen matched the initial blueprint, and also to what extent the preferred site changed as the years progressed. Significantly, choosing a site with the correct physical attributes that would pass the General Board's approval was the first major decision for the district boards in establishing a new institution. As such, they strove to acquire a site which would work towards their ambition of creating a hygienic, therapeutic, and curative atmosphere, which, alongside separation and distance from wider society, would aid in the control of the insane population.

## COMMISSIONERS' BLUEPRINT AND RECOMMENDATIONS

The key siting suggestions and instructions put forward by the General Board drew together moral, medical and hygienic dimensions (see Figure 7.1).[159] Although it would be possible to specify quite precisely which guidelines appealed respectively to moral, medical, hygienic or even 'social control' ambitions, in practice the Commissioners ran all of the specifications together, implying an overall holistic locational vision. They advised that an asylum's site should "be of a perfectly healthy character" and have the ability to offer a "complete system of drainage" (SCL, 1859:115), as well as, importantly, a sufficient water supply of good quality. To achieve this end, they proposed calcareous, gravelly or rocky subsoil, but, if subsoil was clayey, it was imperative that the site was in an elevated position. The elevated position was not just important for drainage, but also to give a cheerful view of the surrounding countryside. The institution was preferably to be accessed from the north of the site, so as to keep the southern area solely for patients, and the plateau was to be of such an extent as to accommodate the main asylum buildings. The position of the buildings on the site should give "an uninterrupted view of the surrounding country, and the free access of sun and air" (SCL, 1859:115), with the principal rooms facing the remaining land, which should ideally fall to the south (to catch the best of the daily sunshine/light). This land would be "available for the undisturbed use of the patients" (SCL, 1859:115), and it was suggested that, if possible, the ground should have an undulating surface, presumably to provide an aesthetically pleasing landscape for the patients. It was ideally to be in the proportion of one acre to four patients, but also to have ample room for future expansion. The Commissioners believed the land attached to the

[159] There are, unsurprisingly, parallels with the English Lunacy Commissioners' six siting specifications, which were appended to the 1847 Further Report of the Commissioners in Lunacy. See Philo 2004, Chapter Seven, for discussion.

royal asylums to be of an insufficient quantity (on average 31 acres), and thus it was deemed vital that the new asylums were more adequately provided so as to allow profitable cultivation and agricultural employment (particularly for the male patients), as well as space for exercise and recreation.



*Commissioners in Lunacy for Scotland.* 115

## APPENDIX C.

*Suggestions and Instructions issued by the Board in reference to* (1.) *Sites*, (2.) *Construction and Arrangement of Buildings*, (3.) *Plans, of Lunatic Asylums.*

### No. 1.—Sites.

1. The site of an Asylum should be of a perfectly healthy character, and offer facilities for obtaining a complete system of drainage. A calcareous, gravelly, or rocky subsoil is most desirable; but if a clayey subsoil only can be obtained, an elevated position is indispensable. The land should be capable of profitable cultivation, and it is also desirable that it should afford a supply of water. General.

It should not be near to any nuisances, such as steam-engines, shafts of mines, noisy trades, or offensive manufactures; neither should it be surrounded, nor overlooked, nor intersected, by public roads or footpaths.

2. The land belonging to the asylum should, when practicable, be in proportion of not less than one acre to four patients, so as to afford ample means for agricultural employment, exercise, and recreation; and should be so situate as to offer facilities for any extension which may become necessary at a future period. Proportion of land.

3. The site of the buildings should be elevated, as respects the surrounding country, and (if to be obtained) undulating in its surface, and cheerful in its position, and having a fall to the south. Form of ground.

4. The principal buildings should be placed near the northern boundary of the land; and it is important that the site should afford a plateau of sufficient extent for the main structure, and for the means of ready access from the north; the whole of the southern portion of the land being available for the undisturbed use of the patients. Position and aspect of building.

5. The asylum should be as central as possible to the mass of population in the county or district for which it is to be erected, and should be convenient with respect to its easy access by railway or other public conveyance, in order to facilitate the visits of friends and the supply of stores. It should be within such distance of a town as to command the introduction of gas, water, &c., and of one of sufficient size to afford the means of amusement and recreation for the Medical Staff, the attendants, and such of the patients as might derive benefit from a change in the asylum routine. Locality.

6. It is of the utmost importance that there should be a constant and ample supply of good water, of which a careful analysis should be made, with a view to determine the proper materials for pipes and reservoirs, and also in order to ascertain its fitness for the purposes of drinking and washing. The quantity, exclusive of rain water, which should be collected in cisterns on the roof, should, at the driest season, be not less than forty gallons per patient, per diem, and the amount should be accurately gauged. Supply and quality of water.

Figure 7.1 – Suggestions and Instructions issued by the Board in reference to site (SCL, 1859:115).

It was specifically stated that the access roads and public entrance should not cross the grounds, with the general entrance, the porter's room, the reception rooms, the committee room, the store rooms, and other offices being located so as not to interfere with the buildings occupied by the patients (therefore ideally situated to the north). Furthermore, the whole asylum site:

> … should not be near to any nuisances, such as steam-engines, shafts of mines, noisy trades, or offensive manufactures; neither should it be surrounded, nor overlooked, nor intersected, by public roads or footpaths. (SCL, 1859:115)

The site should, however, be situated "as central as possible to the mass of population in the county or district for which it is to be erected" (SCL, 1859:115), and be a convenient distance from transport connections, such as a railway station, to allow friends or family to visit and supplies to be delivered. The distance to a nearby town of sufficient size was also important for more practical reasons such as the supply of utilities, and to provide amusement and recreation for the asylum staff and some of the patients who "might benefit from a change in the asylum routine" (SCL, 1859:115).

Yet, it was deemed vital that the asylum was situated in a rural setting, a theme that recurred throughout the General Board reports into at least the 1870s, but tailing off thereafter. At this stage, the Commissioners thought that exposure to an urban and manufacturing environment, which they characterised as including "overcrowding, impure air, exhausting labour, insufficient diet, abuse of stimulants and contagious diseases" (SCL, 1868:xxi), had a detrimental effect on a person's mental activity. Therefore, removal from the setting "which produced the mischief" would be the first step in prompting recovery, followed by "kindly treatment and attention to the general rules of health" (SCL, 1871:xliii) in a quite different setting. Advancing this idea further, the Commissioners hinted that they believed a site's *atmosphere* to have capacities to affect the mind:

> It has … occurred to us that the form which insanity assumes is in some degree dependent on atmospherical influences; that is, on the amount of heat, moisture, electricity, and ozone which the atmosphere contains; on the clearness or dullness of the sky; and on the force and direction of the wind. (SCL, 1870:xv)

This notion chimes with Franklin's theory of electrical atmospheres, which had been developed in the mid-eighteenth century. The theory, advanced later by other physicists, was "based for the first time on the view that the electrification of a body involved the accumulation of a 'charge' from elsewhere, rather than the excitation of matter already present in the body" (Home, 1972:131). The chemical compound of ozone and the 'odour of electricity' was first discovered by Schönbein in 1828. By 1840, Schönbein proposed and confirmed that ozone was found in the atmosphere, and acknowledged that it "had a variety of very unpleasant side effects" which was a concern that he held until the end of his life (Rubin, 2001). Following these discoveries, the relatively modern conceptions of 'electricity' and 'ozone' possibly implied an intriguing sense of how the technological

developments of urban-industrial areas could be 'polluting' local atmospheres. Additionally, Browne (1837:181) thought that ideally the asylum should be located far enough into the countryside to benefit from the "unpolluted atmosphere", but near enough to a town "to enjoy all the comforts and privileges and intercourse which can only be obtained in large communities". He advocated elevated sites, if possible above rivers or streams to help with waste disposal, but also to aid in the circulation of air, as low-lying or swampy grounds were linked to the production of 'miasma', which was thought to breed and circulate fevers through the atmosphere. This removed the asylum away from its familiar place and reputation in towns and from the perceived unhealthy and disease-ridden atmosphere:

> As if, by the antidote of fresh country air, the new model asylum escaped in its countrified setting the long-standing and immediate association of 'confinement' with close spaces, fetid and noxious air, filth, contagion, and disease. (Donnelly, 1983:32)

As well as benefitting from the affective qualities of the therapeutic landscape, removal to a rural location would, it was hoped, have a direct impact on the eradication of a person's insanity through exposure to cleaner, healthier air (see Hickman, 2013). Furthermore, through placing the insane in a purpose-built asylum, there could be a greater degree of control over the atmosphere surrounding the patient, which would, it was supposed, have a positive effect on health, behaviour and mental affliction.

The Commissioners highlighted many examples in their reports of sites that they believed to be unsuitable due to their closeness to urban environments, undoubtedly drawing on the perceived negative experiences of these institutions, when putting forward their advice for the ideal district asylum site. For example, the Parochial Asylum of Greenock had "been so injuriously affected by the erection of dwelling-houses, which completely over-look the airing courts and destroy their privacy, that a proposition to remove the Establishment to another site has been under the consideration of the Parochial Board" (SCL, 1865:xxi).[160] In this case, the Commissioners so strongly agreed with the unsuitability of the site that they were going to restrict the asylum's license to the admission of incurable and harmless patients only. Dwelling houses had been erected within 50 feet of the boundary wall, and it was "proposed to remedy this annoyance by raising the level of the courts, and

[160] The original building was condemned shortly afterwards, and rebuilt on an 80 acre site on the Smithston estate, around a mile and a half to the south-west of the town of Greenock. The institution was built to accommodate 150 lunatic patients in the asylum section and 450 paupers in the poorhouse section (*The Builder,* 1879:np).

subsequently increasing the height of the external walls" (SCL, 1865:211). The Tenth Report notes that the Glasgow Parochial Asylum's "urban position deprives it of the advantages of pure air and cheerful views, and of the means of adequate exercise and occupation" (SCL, 1868:lvii). Similarly, of continuous concern to the Commissioners, worthy of special attention, was the Dundee Royal Asylum. By 1862, the asylum was described as being "in a suburb", due to the encroaching town, and the grounds were reported as being "small" (SCL, 1863:140) (see Figure 7.2). Thus:

> It is much to be regretted that the general grounds of the asylum do not afford a very satisfactory field for extended exercise, partly from being almost entirely laid out in gardens, and partly from being enclosed with walls which shut out the view of the neighbouring country; and that the vicinity of the town should place obstacles in the way of taking patients beyond the premises. (SCL, 1863:141)

The following year, aware that the Asylum did not adhere to the discourses promoted by the Commissioners, they recommended the following:

> There is no doubt that the situation of the Asylum, so close to a large town, places impediments in the way of agricultural employment, but this difficulty might be overcome by procuring land at some little distance in the country, and sending out the patients to cultivate it. (SCL, 1864:147)

By the Thirteenth Report, the Commissioners were still reporting on the site's "grave defects", observing that the establishment was still being conducted "under many difficulties and discouragements … and cannot give to its inmates many advantages which are given by other similar institutions" (SCL, 1871:191).

It is clear, therefore, that the Commissioners' vision for the district asylum drew from contemporary discourses around the care and treatment of the insane,[161] such as Browne's well-known siting recommendations (from his 1837 book: see Chapter Five), and learning from examples of poorly sited institutions. Furthermore, countryside sites often enabled the purchase of extensive grounds, not only acting as a buffer between the institution and the neighbouring areas, but also used as the basis for the asylum's internal economy, through agriculture, "cultivated by or under the direction of lunatics" (Browne, 1837:193). For this reason, soil had to be suitable so as to permit growth:

> [The site] should possess the advantage of a dry cultivated soil and an ample supply of water … I am acquainted with asylums placed on ground so sandy and

[161] See also Philo (2004), where the wider discourses (of various contemporary lunacy experts) have already been anatomised.

> unproductive that common garden vegetables could not be raised from it. (Browne, 1837:181-182)

Browne (1837:221) drew on examples from various asylums, such as Esquirol's private establishment at Ivry, near Paris, which was "placed in a beautiful and airy situation, with a pleasant exposure; and its general aspect is that of an inhabited and well kept villa".

Figure 7.2 – Royal Lunatic Asylum, *Ordnance Survey*, 1871 (SCRAN). When built in 1820, the Dundee Royal Asylum was in open countryside, but due to the rapid industry and population growth in Dundee, it was soon surrounded by jute spinning factories, weaving factories and residential houses. Consequently, a farm was acquired at West Green in 1874, and a new building for pauper and private patients was constructed. In 1903 the asylum at West Green was to become known as the Dundee District Asylum, under the authority of the Dundee District Board.

These recommendations obviously travelled with Browne into the General Board's deliberations, as well as learning from the already established institutions in Scotland. The aim was to remove the insane further from urban settlements, relocating them in

institutions constructed on elevated, south-facing and well-drained sites, supplied with both extensive grounds and an abundant water supply. Moreover, in order to ensure that institutions were more easily accessible to greater numbers of the population, the Commissioners proposed that "small asylums in convenient situations" were more desirable than larger, more centralised institutions, which of necessity would "be remote from considerable portions of the extensive districts which they are designed to accommodate" (SCL, 1860:x). This meta-level perspective on the spatial organisation of an emerging district asylum system must be kept in mind. The first districts to purchase sites and construct asylums resulted from an obvious push to fill in the blanks on the map, especially in the Highlands, and also to combat private provisions, but there was less of a perceived need in districts already served by the 'royals' (as already discussed in Chapter Six).

## DISTRICT ASYLUM SITES AND SITUATIONS

As the Commissioners' stipulations highlight, acquiring a suitable site for the construction of the new institutions was a task requiring considerable attention and negotiation. It is unsurprising, therefore, that time and care was taken by the district boards in procuring land that best matched the recommendations, but also reflecting a play of power: the Commissioners *did* have considerable power to block the choices made by districts. The following section will detail the various instances where information regarding the purchase of a site for a district asylum was recorded in the archives. Not all of the district boards documented this information, yet the examples here help to recover the undoubted importance placed on purchasing the correct site in a suitable situation, viewed as imperative in presenting the asylum as an institution for the care, treatment and control of the insane.

### *The Early District Asylums (1860-1874)*

Unsurprisingly, the initial district asylums were to be constructed in locations found to be lacking 'suitable' asylum accommodation during the 1855 inquiry. As it was deemed imperative that asylums were rolled out across the country, negotiations for the purchase of sites by a number of district boards started almost immediately after the 1857 Act, continuing until 1870 when all districts were either provided with suitable estates for the construction of their asylums, or were deemed to have appropriate existing accommodation

in the form of royal asylums. Table 7.1 shows the year the sites were purchased, [162] and the size of the estate for each of the district boards constructing institutions in the initial phase of district asylum building. There was often a delay between the district boards acquiring their site and the date of the asylum opening, hence different dates here to those recorded in Table 6.6.

| Year | District | Site Purchased/Acquired (acres) |
|---|---|---|
| **1858** | Haddington | 16 |
| **1858** | Inverness | 100 |
| **1858** | Perth | 60 |
| **1859** | Argyll | 45 |
| **1859** | Stirling | 74 |
| **1862** | Banff | 20 |
| **1865** | Ayr | 30 |
| **1868** | Roxburgh | 20 |
| **1870** | Peebles | 40 |

Table 7.1 – District Boards and the year that they acquired the site for their asylum (see later table for continuation).

An early example of site purchase comes from the Ayr District Board, whose negotiations, as recorded in the General Board's reports, shed light on the difficulty that the district faced when trying to secure suitable grounds. An initial site at Prestwick, near Ayr, was rejected without hesitation due to its physical attributes. The soil consisted of loose sand, incapable of supporting the weight of the structure and unsuitable for the profitable cultivation of the land. Furthermore, the site had the double drawback of having no suitable elevation for the building, yet with the area still exposed to strong gales from the sea. Another site was also rejected as it was considered inconveniently situated relative to the main population of the county (SCL, 1859), and a further was rejected "in consequence of difficulties which it was feared might arise in connexion with the minerals which it was supposed to contain" (SCL, 1865:xviii). The Ayr Board finally agreed on a 30 acre site at High Glengall, about three miles from the town of Ayr, which had a view to the Carrick Hill and the valley of the Doon that was "both extensive and beautiful" (Ayr D.B., A.R., 1880:16).

[162] This table does not include Fife and Kinross, as the information could not be found in the available records.

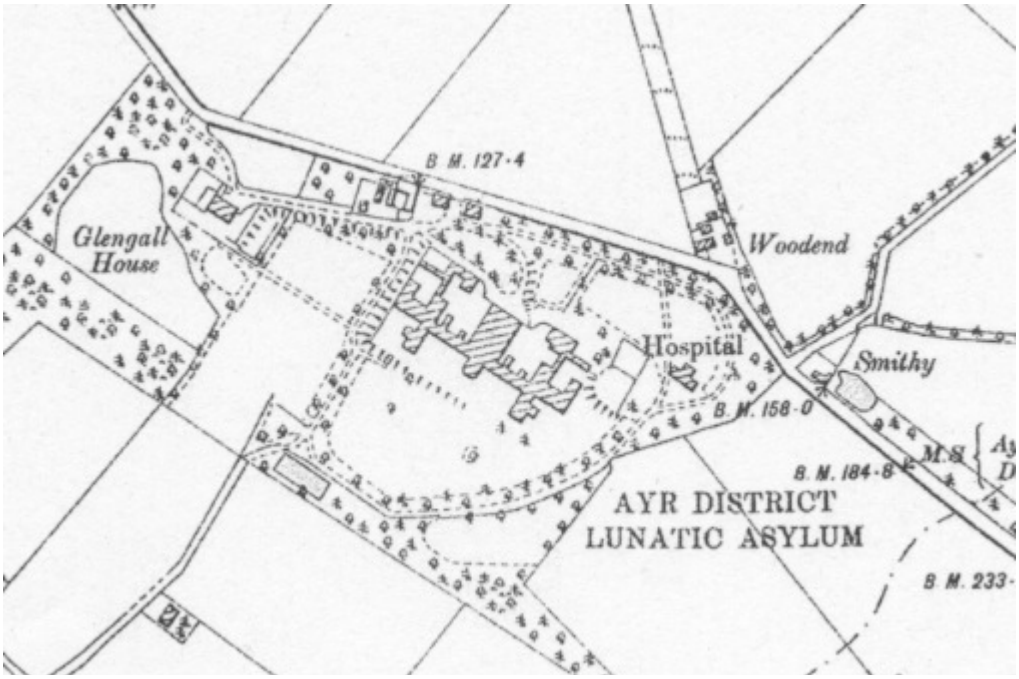


Figure 7.3 – Ayr District Lunatic Asylum, *Ordnance Survey*, 2nd edition, 1897, ©nls (Darragh, 2011b:32) (see also map in previous chapter showing location at a national scale).

The District Board of Midlothian and Peebles also divulged information about sites discarded as unsuitable, and stated that it had great difficulty in finding an appropriate site at a moderate cost.[163] An area of land near Penicuick was rejected due to being cold and exposed, and, although another area of land at Howgate was more sheltered, both of these locations were found to have a poor water supply. A further site at the Estate of Eagrie was rejected as it was found to be undermined and again lacked a sufficient water supply. The Midlothian and Peebles Board went on to explain that it reckoned the most suitable site for a centrally situated district asylum would be on the Whitehill property, in the area to the south, or upper side, of the Penicuick railway line, close to Rosslynlee Station. The estate was divided into seven fields, each a potential site for the Board to consider. They rejected field one[164] as they were informed by the overseer of the estate that it was objectionably close to a number of houses, and that the land would be more expensive. This could possibly have been to dissuade the Board from considering this site further; hinting at 'NIMBY' attitudes from the estate's other residents.[165] Fields four, five and six were easily discarded, as the only easily accessible water supply was discoloured and not suitable for domestic purposes. A further available water source was not suitable as the asylum would

[163] Cost is an interesting aspect, although one not often directly referenced by the General and district boards. See Philo 2004, Chapter Seven, for economic explanations around site selection south of the border.

[164] The field numbers were written in the Report, referred to by the District Board.

[165] The NIMBY debate emerged around the 1980s, and was centred around community opposition to public facilities for groups that were considered 'outsiders'. For evidence of such attitudes existing around the location of asylums in the nineteenth century, see Philo (1987 and forthcoming).

have to have been built in the centre of the Whitehill estate. The clinching argument for the field finally chosen within this estate, rather than field two or three situated higher up, was that an abundant supply of water could be guaranteed even in the driest of weather by gravitation from the stream, meaning a storage reservoir was not likely to be needed in the immediate future. The chosen site, which amounted to 40 acres and situated 700 feet above sea level, commanded "most extensive views of the country" (M.P. D.B., A.R., 1878:17) while being completely isolated from the village population, with the Board having to construct a road of half a mile from the gate house near Rosslyn station to the institution. They were nonetheless able to take advantage of the close proximity to the railway line, negotiating the construction of a siding on the asylum grounds to be used for delivering coal, heavy goods and passengers travelling to and from the institution (M.P. D.B., A.R., 1878:4).

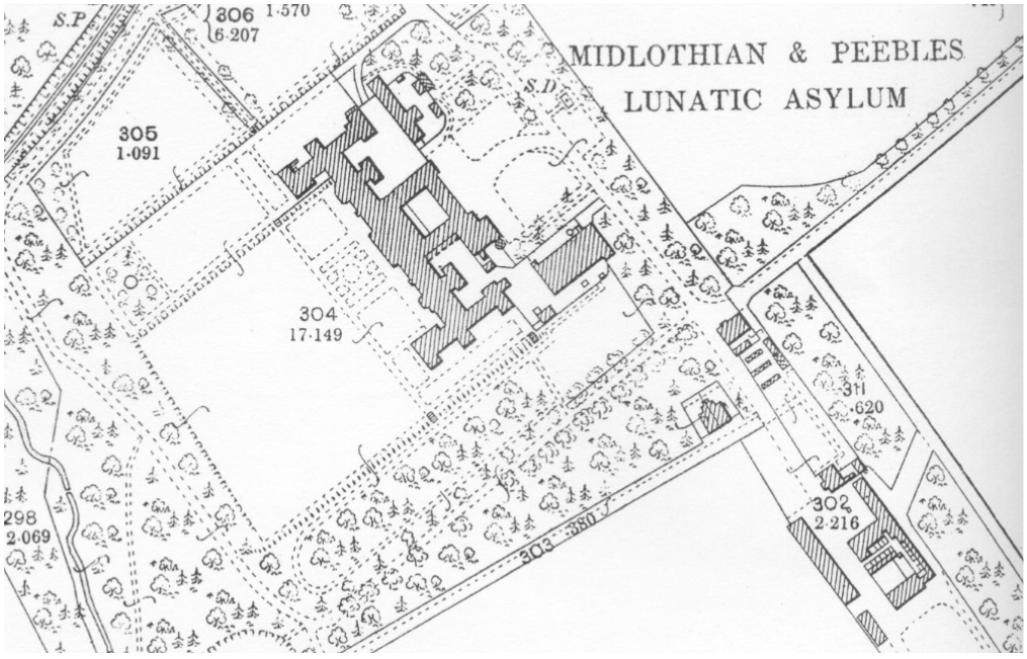


Figure 7.4 – Mid Lothian and Peebles District Asylum, *Ordnance Survey*, 2nd edition, 1892, ©nls (Darragh, 2011b:114).

In line with the General Board's recommendations, the District Board here envisaged that the front of the main building would be constructed "so as to face as much as possible towards the south and west to command the view of the open country in this direction from the windows of the dayrooms, and from the airing courts" (M.P. D.B., M.B., 1870:11), which were to be at the front of the institution. But, having chosen the specific site on the estate and planned the orientation of the buildings, the Board was immediately confronted with problems. Although initially stating that a reservoir would not be necessary, when working out the details of the particular site, a reservoir was proposed, one which would effectively limit or stop the water supply to the houses on the estate below the site of the

proposed institution. Furthermore, the sewage supply from the asylum would be discharged into the stream at its point of exit from the institution. The minutes record the negotiations, site visits and inspections carried out by the Board when trying to propose solutions to the water supply problems, which included: installing ball cocks in the cisterns of the asylum so it did not take any more water than was necessary; and searching for alternative water supplies through bore holes. Regarding the sewage run-off problems, the solution was to carry the waste away in a different direction from the burn:

> The Sewage from the Asylum can be conveyed in a clay pipe northward across the railway to the middle of the fields lying to the South of Kirkettle Farm Steading and thence eastwards to the Hare Craig Burn which enters the Esk below the carpet manufactory at Roslin. (M.P. D.B., M.B., 1870:38)

Despite this convoluted method of disposing of sewer waste and the difficulties in negotiating a sufficient water supply, the Board stated that "the site of the Building [appears] to be well chosen and to be admirably suited from its airing position and fine view for an Asylum" (M.P. D.B., M.B., 1872:98).

Discussion by the Banff Board indicates two different methods in their quest for the procurement of land. Initially, they appointed all of their members to an open committee who were to look out for a suitable site. Following this, they placed an advertisement for the required extent of land in the local newspapers, asking any suitable landowners to approach the Clerk with descriptions and sketches of the land, which were then passed to the open committee for deliberation. The advertisement read as follows, almost directly emulating the General Board's words:

> The District Lunacy Board for the County of Banff, having in view the erection of a district asylum, with sufficient ground for airing and exercising the patients, for which purpose from 20 to 25 acres of ground will be required, having a fall to the south, facilities for complete drainage, capable of profitable cultivation, on a calcareous, gravelly, or rocky subsoil, if possible; but, if on a clayey subsoil, in an elevated position, distant from steam engines or offensive manufactures, and not surrounded, overlooked, or intersected by public roads or foot paths, hereby invite parties having such, and desirous of disposing, to send in plans of any piece or pieces of ground answering the above, stating where situated, with descriptions, and mentioning the terms on which they would be disposed to sell the same, to William Coutts, Solicitor in Banff, Clerk to the Board, against Monday the 1st day of July next, after which the same will be submitted to the Board. Banff, 15th May, 1861. (*The Aberdeen Journal*, 1861:np)

The Banff Board did not state how many responses were gained from the advertisement, but it was made clear that they received a reply from the estate of the Earl of Seafield who proposed three possible sites, which the Board then inspected. Unfortunately, no detail of these sites or of the inspections was included in their reports, but they did, however, state that they were unanimous in deciding that site two was the most suitable: "a very desirable one, and eligible for the district asylum" (Banff D.B., M.B., 1861:np).

As can be seen in the Ordnance Survey map (Figure 7.5), the site was located next to the Ladysbridge Station on the Banff, Portsoy and Strathisla Railway line, which was three miles from the town of Banff. Negotiations proceeded with Lord Seafield regarding access to water, the possibility of future extension to the west at the same rate, and whether they would have access to the Lord's stone and sand quarries for building materials. It was settled that the quarries could be accessed for the price of surface damage, but that Lord Seafield would only consider leasing more land to the east or north at the same initial rates in the future, not willing to be placed under obligation regarding land to the west. By 1861, site two had been approved by the General Board, and purchased from the Earl of Seafield.

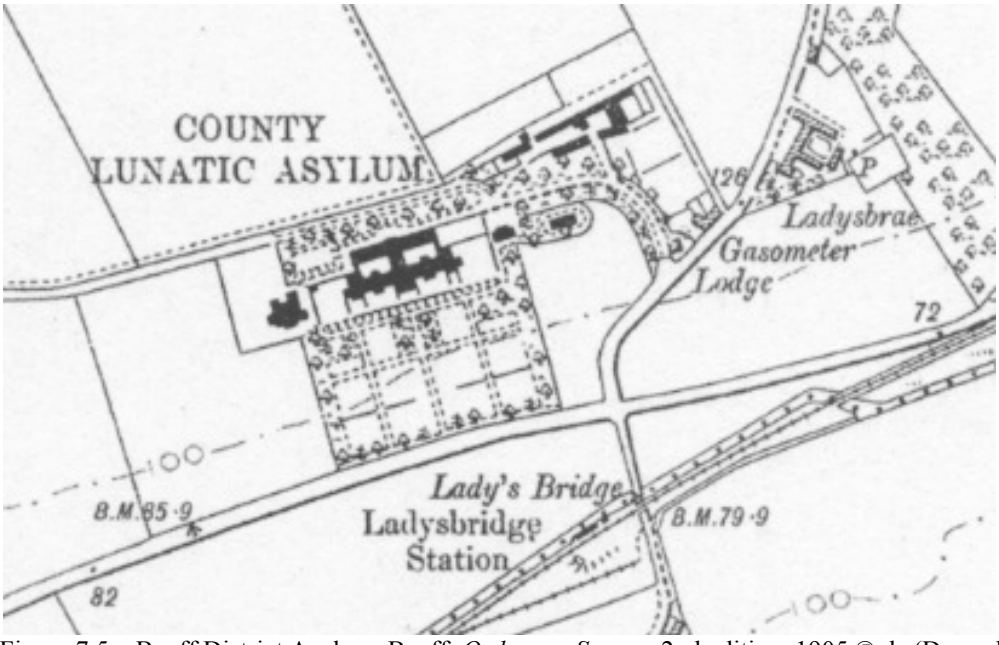


Figure 7.5 – Banff District Asylum, Banff, *Ordnance Survey*, 2nd edition, 1905 ©nls (Darragh, 2011b:35).

The Inverness Board selected and purchased "an unusually large piece of ground" of one hundred acres, which extended "from an arable plateau up to the top of the hill called the Leachkin, and back to the old district road passing along the boundary of the estate of Bunchrew" (*Caledonian Mercury*, 1859:np), situated between Dunain Hill and Craig Phadrig. It was reported in the *Aberdeen Journal* (1865:np) that the institution occupied "a splendid position" with the centenary booklet stating the site could only have been chosen

by "men of vision" as for centuries it had "looked down on history" (Whittet, 1964:14).[166] Additionally, Browne (1864:11) highlighted that "the magnificent District Asylum at Inverness has no wall nor fence around grounds 175 acres in extent,"[167] with the First Annual Report of the District Board expanding:

> One of the most important features in connection with the institution, the magnificent landscape presenting itself on every side, must also be looked upon as exercising a salutary moral influence. Few scenes, indeed, are more varied and striking, and the numerous expressions regarding it on the part of the patients have proved the pleasurable impressions it conveys. (Inverness D.B., A.R., 1865:18)

This remark shows the genuine belief held by the Inverness Board that the landscape surrounding the institution had the power to affect the behaviour of the patients, and was accordingly viewed as an influential tool with the capacity, if not to cure, then at least to settle the behaviour of the resident insane through stimulating the mind with wide-ranging views. The fortunes of this asylum were mixed, however, with the high death and physical illness rates appearing to be connected to the site of the institution, which gives evidence to a general connection which the General Board drew out in their Thirteenth Report:

> The different rates of mortality which prevail in different asylums … seem to be more dependent on something connected with the site and buildings, than on the condition of the patients on admission, or their subsequent medical treatment. (SCL, 1871:iv)

Initially, the Inverness Board attributed the lack of epidemics primarily to the elevated position, which, they stated, "commands at all times a thorough and perfect ventilation of the structure" (Inverness D.B., A.R., 1865:16) Despite this obvious initial enthusiasm for the location, however, it was later viewed to be "situated in a high, cold, and windy position" (SCL, 1878:xlvi). It was suggested that this could be partly alleviated by extensive planting of trees, but the problems with the asylum ran deeper than its atmospheric situation. An investigation into the high rates of lung disease in the 1880s drew connections between the dampness of the soil caused by the impermeable boulder clay and the high rates of phthisis occurring in the institution. Furthermore, the granite and gneiss rocks which characterised the site did not store heat, remaining cold and damp, therefore exacerbating the propensity for physical illness (Mitchell, 1888). In effect, this was a sustained discussion of 'medical geology', which, although not directly referenced

[166] For a further brief discussion of this asylum site see Parr *et al.* (2003) and Philo (2004)

[167] See also Philo (2004a, 2007).

by the Commissioners, was well established by the nineteenth century (see Duffin, 2013). It would appear, therefore, that both the situation and the site were in fact not best suited for the treatment and health of the resident population.

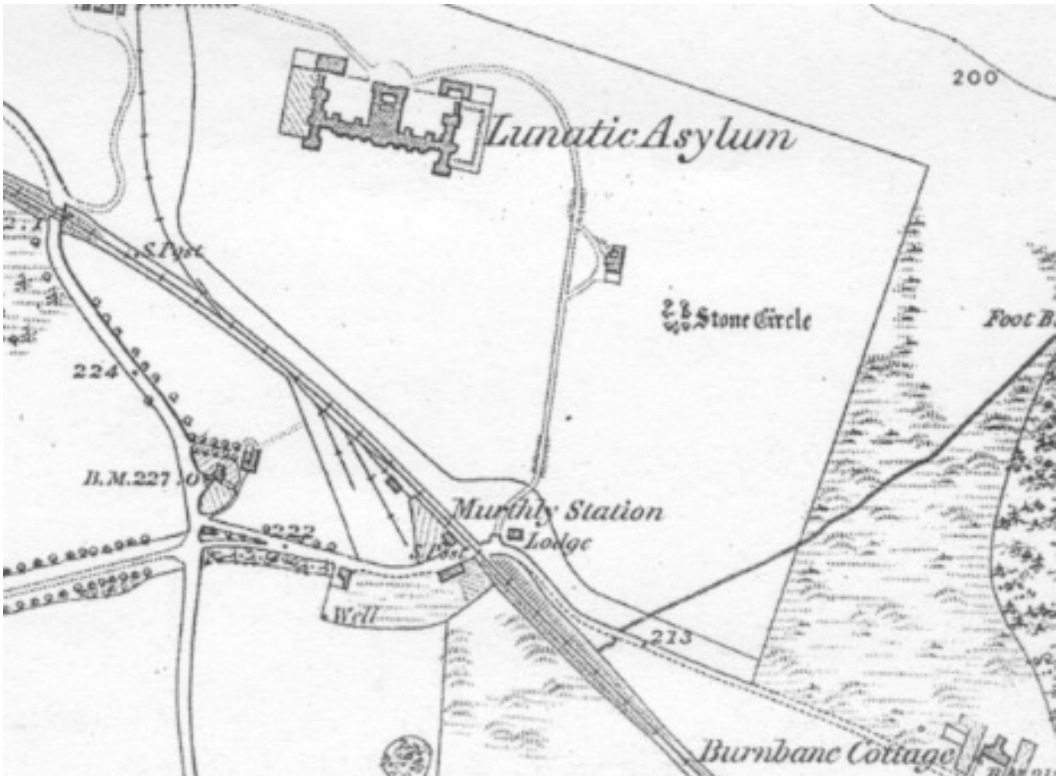


Figure 7.6 – Perthshire District Asylum, Murthly, *Ordnance Survey*, 2nd edition, 1864 ©nls (Darragh, 2011b:132).

Extensive information concerning the physical geography of the chosen site of the Perth District Asylum is also detailed in the First Annual Report of the Perth Board:

> The Asylum is situated on what was probably an ancient lake bed, but now an undulating tract, characterised by a very gravelly subsoil; and surrounded by its grounds of 60 acres of moor (formerly an interesting Druidical site)[168] … The light nature of the soil, with its gravely substratum … answers admirably for Asylum purposes. (Perth D.B., A.R., 1865:5)

The Board continued by stating that the cheap rate at which they managed to secure the land was undoubtedly due to the type of soil being less suited to "ordinary cultivators" (Perth D.B., A.R., 1865:5). Importantly, of course, this type of soil was in line with the General Board's requirements, stipulated due to its drainage qualities, but the Perth Board further recognised its advantage as it would allow the easy construction of dry walkways and terraces for recreational exercise. Other reasons for securing this particular site included its close vicinity to the Inverness and Aberdeen Junction Railway, with the

[168] As far as I could find, this was the only insertion of such a random bit of locational detail.

Murthly Station situated at the main gate (see Figure 7.6), which allowed rail lines to be constructed from there to the main building for the convenient delivery of goods to the stores. Significantly too, the outlook from the site secured extensive, pleasantly varied views, as well as, according to the Perth Board, "a pure and salubrious atmosphere" (Perth D.B., A.R., 1865:6), and it was reported in the *Caledonian Mercury* (1862:np) that its "situation was a very retired one, being surrounded with woods".

The Stirling Board purchased a site roughly three miles from Falkirk, on the farm of Gowkhill, on the estate of Carronhill, owned by Lieutenant-Colonel Dundas. The land was close to the Larbert Station on the Scottish Central Railway, with the *Dundee Courier and Argus* (1866:np) reporting that it was "situated a stone-cast from the north-east corner of Stenhouse Moor". The paper was highly complimentary of the site, stating:

> Perhaps a more suitable or excellent site could not have been secured in the district, whether looked upon as regards its wholesome locality, its excellent adaptation, and ready access so far as railway and road are concerned, its bountiful supply of water, amplitude of good surrounding ground, or the splendour of the country within its view. (*Dundee Courier and Argus*, 1866:np)

Not as much information has been recorded or retained for the sites of the other early district asylums. Briefly: the Argyll Board acquired the estate of Auchindarroch, a hill above Lochgilphead which provided good views; and the Roxburgh Board obtained a site one mile south west of the town of Melrose, situated on Bowden Moor to the north of the Eildon Hills, in an elevated position, at 600 feet above sea level, and 300 feet above the level of the River Tweed (*The Border Advertiser*, 17/05/1872).

***The Middle Period: Continuity and Change (1874-1887)***

As noted previously, by 1875 all institutionalised pauper lunatics in Scotland were accommodated in establishments supported by the state, with the situation of these early asylums praised by the General Board, who commented:

> Gratuitous[169] treatment in Asylums is now obtained with greater ease; our institutions are more scattered over the country, and the patients entering them do not require to be removed so far from home and friends. (SCL, 1875:xiii)

A key meta-level spatial claim, this quote shows that the Commissioners now perceived a more even distribution of asylum provision across Scotland, lessening the distances that

[169] Here, 'gratuitous' means asylums provided for pauper patients on the Poor Roll.

anybody needed to travel to access them. As such, no new district asylums were constructed during this middle period (although the existing district asylums were greatly extended to combat overcrowding: see Chapter Nine). Interestingly, though, a comment written in the Twelfth Report of the General Board indicates that opinions surrounding the siting of an asylum may have started to shift towards the end of the construction period for the early district asylums. It noted that "the bustle of a city is not *per se* detrimental to asylums. No inconveniences … [have] been experienced, either from noise in the street, from the patients gazing from the windows, or from the curiosity of their neighbours opposite" (SCL, 1870:lxix). This view was brought up later in the same Report, stating that "insanity affords no adequate cause for complete isolation from the outer world" (SCL, 1870:168). Furthermore, as increasing emphasis was placed on the medical understanding and treatment of insanity, the asylums were noted to be a "generally inconvenient distance" (SCL, 1870:xliv) from medical students who might otherwise have sought placements in the institution. This may be an anomaly in the Reports, perhaps the view held by an individual rather than the collective, or more likely it reflected the first indication that Scottish opinions about the ideal site of an asylum were mutating once more, and, although similar shifts were hinted at down south (see Philo, 1987), it is intriguing to hear such views expressed so clearly in the central inspectorate's reports.

Yet, although there may have been some ideological shifts in opinion regarding the ideal site, and changing discourses around treatment towards a more medical understanding of madness, which altered greatly the arrangements of the asylum grounds and buildings (see Chapters Eight and Nine), in reality economic constraints and 'othering' desires ensured the sites stayed firmly rooted in rural locations. Perhaps showing this more deep-seated segregationist impulse ('us' and 'them'; othering/exclusion), the wish to continue the clear spatial separation between the sane and insane populations, with further hints of NIMBY attitudes, was implied in some reports. For example, it was recorded in the Forty-Fifth Report that, where the insane community was "making use of the public road", it was "apt to be disliked by the sane community, and is clearly undesirable when it can be avoided" (SCL, 1904:lv).

In their First Report, the Commissioners were of the belief that employment in agricultural labour was the best curative agent for insanity (SCL, 1859), and despite the increased medicalisation of insanity, the importance of large extents of land for recreation and occupation was evident throughout the decades, with the Commissioners commenting in 1879:

> We regard the possession of a considerable extent of land as of great use to all classes of establishments where lunatics are detained. The benefits that it confers are of various kinds. It affords the means of healthy occupation, invaluable as a curative agent in a large number of curable cases; and it affords an opportunity of placing many chronic and incurable patients in conditions more nearly resembling the ordinary life of sane persons than can be obtained in any other way. (SCL, 1879:xxx)

Again, in their 1904 report, the Commissioners revisited and quoted from their First Report, following with:

> Although recent advances in the medical treatment of some forms of acute insanity have modified older views to a certain extent … the views expressed in this [First] Report were from the first, are still, accepted by the Board as essentially sound, and the justification of District Lunacy Boards for the acquisition of farms rests mainly upon such considerations … The possession of a farm further gives a special tone to asylum life of much value, as it furnishes, even to patients who may not be fitted for active work in connection with it, a natural healthy and sane interest, which tends to promote recovery, or at all events, contentment and easy management. (SCL, 1904:lv-lvi)

Additionally, although the number of patients was undoubtedly increasing, resulting in a corresponding increase in the size of asylum estates, by the time that the later asylum sites were being acquired the General Board had altered their views on the recommended number of acres per patient. In the First Report, the Board stated that the land ratio should ideally be a quarter of an acre per patient, but by the end of the nineteenth century this had increased to half an acre per patient, or, ideally, one-and-a-half acres of arable land per male patient (although with one acre per male patient being "amply sufficient": SCL, 1904:lxv). It was therefore deemed imperative throughout the reports to obtain a site of such an extent that it would provide adequate land for these purposes. Again, a suitable site was more easily attained in a rural location, particularly as industrialisation and urbanisation were likely pushing up the price of land close to cities, and the Commissioners were keen to continue to keep the cost of district asylum construction to a minimum.

The following section will explore the locational discussions in much the same way as the previous section, and will uncover whether the shift in ideological thinking in the 1870s really did mark a turning point in the Commissioners' opinions regarding the ideal siting of the institution.

### *The Late District Asylums (1887-1913)*

The majority of asylums constructed in the later period were situated in the Greater Glasgow area, as a response to the *Lunacy Districts (Scotland) Act*, 1887, which divided the Glasgow district into four new districts, coupled with alterations to Renfrew. The newly formed/modified districts – Barony, Govan, Lanark, Glasgow and Renfrew – were subsequently all responsible for providing district institutions for their pauper lunatics. The Barony district, already provided with suitable accommodation, opened in 1875, was consequently disbanded as it successfully argued that the Barony Parochial Asylum at Woodilee was providing adequate accommodation for the parish, but the four others each purchased sites in the years after the Act (see Table 7.2).[170] The new institutions for these districts opened between 1895 and 1909, collectively producing a 'ring' of asylums around the city of Glasgow, holding, as it were, the city and the countryside in a sort of delicate balance (see also Chapter Six). There was remarkable variety displayed between these asylums, themselves expressing different leanings, ideologies and experiments, despite being proximate to one another in a relatively small region. Through looking closely at the available archive material for each, the later nineteenth-century rural/urban siting tensions are apparent.

| Year | District | Site Acquired/purchased (acres) |
|---|---|---|
| **1888** | Lanark | 600 |
| **1888** | Glasgow | 340 |
| **1890** | Govan | 190[171] |
| **1897** | Edinburgh | 905 |
| **1899** | Aberdeen | 347.5 |
| **1902** | Renfrew | 537 |

Table 7.2 – District Boards and the year that they acquired the site for their asylum.

The conflicting opinions about siting towards the end of the nineteenth century is most clearly evident when looking at the discussions around the site for the Lanark Asylum. A number of representatives from the Barony, City and Govan Combination Parochial Boards believed that the proposed site, the Hartwood estate,[172] was highly objectionable as it was:

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[170] Again there is a difference between site acquisition date and date of opening, shown in Table 6.7.

[171] It is possible that the Govan Board purchased a smaller site because there was already a Parochial Asylum in this district, although this is not explicitly stated in the records.

[172] This site was purchased by the Glasgow District Board before the division of the parishes into separate districts. The Glasgow Board were planning on constructing an asylum for 1,032 patients but this proposal was shelved after the separation of the Glasgow District, a consequence of the 1887 Act. The site was then brought under the control of the Lanark District Board, where they proceeded to construct their asylum.

> Situated at a distance of nearly twenty miles from the city of Glasgow, which is the chief centre of population in the County of Lanark; and that to remove Lunatic Paupers to such a great distance would be at once injurious to the Lunatics themselves, dangerous to the passengers who might require to travel by the same train, and expensive to the Parishes removing them, and most inconvenient to the relatives of the Lunatics who desired to visit their afflicted friends. (Minutes from Conference Meeting of Representatives of the Barony, City, and Govan Combination Parochial Boards , 1888:np)

This site had been purchased by the Glasgow Board before the division of the parishes into separate districts, and the plan had been to construct an asylum for 1,032 patients but this proposal was shelved after the separation of the Glasgow District, a consequence of the 1887 Act. Despite the apparent drawbacks as highlighted in the above quote, the site was brought under the control of the Lanark Board, where they proceeded to construct their asylum.

The first verse of a poem, written circa 1922, helps to form an understanding of the rurality of the site and the distance needed to travel to the institution:

> Far o'er the fields, the moor, the wood,
> And burns that sometimes rise in flood,
> From out the haze of distant gloom,
> The twin towers of Hartwood loom. (Calder-Nethan, circa 1922)[173]

It was recorded in the Centenary booklet of the Lanark Asylum that, due to its isolated position, the architect, Mr Murray of Heavyside, Biggar, overcame his struggle to get to the site by buying the second car in Scotland, a Panhard, although, as cars at this time had to be led by a man walking in front waving a red flag, it is doubtful whether this purchase speeded up proceedings. A further drawback to the site's situation was the response time by police when responding to incidents of theft and vandalism, which were notably frequent, with the Lanark Board trying to stem the occurrences by offering the Chief Constable of Lanarkshire two houses for resident Police Officers at the institution, a proposal politely declined. Another move to help overcome the difficulty of distance was the provision of a private branch railway line to the site, constructed during the building of the asylum but continued for the delivery of coal and goods (Figure 7.7). It connected the kitchen, scullery and general stores to the main Caledonian Railway Company's Glasgow

[173] This poem was included in the Centenary pamphlet for the Lanark District Asylum, later Hartwood Hospital, written by ex-senior charge nurse Tony Fitzpatrick. I was put in touch with Tony after a number of email exchanges inquiring on the whereabouts of the Lanark District Board archives, and although that search proved futile (see Chapter Four), he was able to provide me with the pamphlet and some photographs of the institution.

to Edinburgh line, which skirted the asylum grounds. The branch line is clearly visible on the Ordnance Survey map from 1898 and again in 1912 (Figure 7.8), where it is labelled 'mineral railway', and it was in use until 1945.

Figure 7.7 – 'Pug' steam engine pulled these carriages for store supplies and coal (Fitzpatrick, 1995:7).

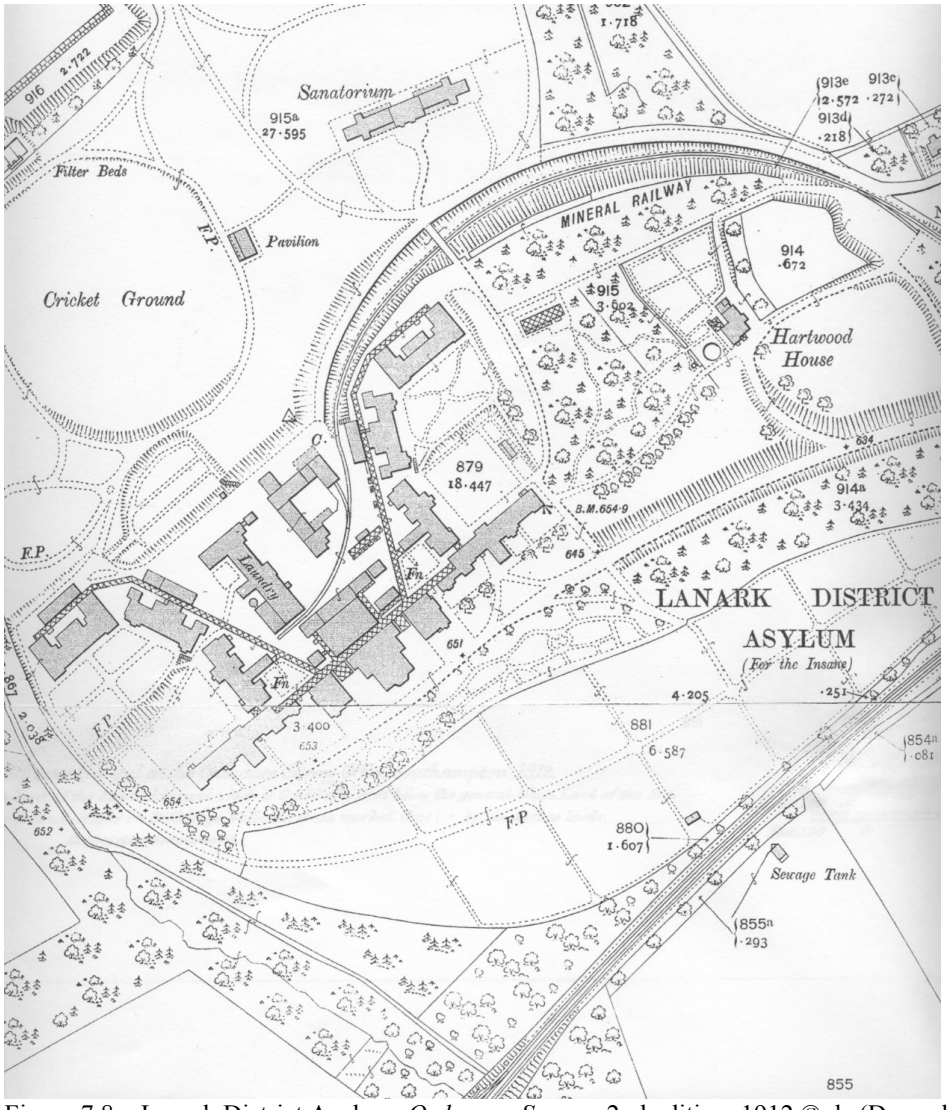

Figure 7.8 – Lanark District Asylum, *Ordnance Survey*, 2nd edition, 1912 ©nls (Darragh, 2011b:79).

From the available evidence, it is possible to deduce that the Glasgow Board was clearly swayed by the prospect of saving money when they decided on a suitable site for their new

asylum. In advertising for a site, the Board stipulated that it must be within twelve miles of Glasgow, and include between 250 to 350 acres of land. They visited four sites (Auchinloch, Robroyston, Crookston (near Paisley) and Gartloch), and deliberated over the merits of each estate, before announcing that the 347-acre site at Gartloch was the most favourable, despite difficulties with water supply and sewage disposal. That it was the cheapest by far, at £24 per acre rather than £80-£120 per acre, was probably a major influence in this estate being chosen, despite its drawbacks. The estate included a mix of wood, pasture and moorland, and was bounded on one side (one-third of a mile) by the Bishop Loch. The area of the site chosen for the buildings was in an elevated position, with the General Board explaining that, when viewed from the west, the grounds and buildings had "a graceful and handsome appearance" (Glasgow D.B., A.R., 1898:22), as is evident in Figures 7.9 and 7.10.

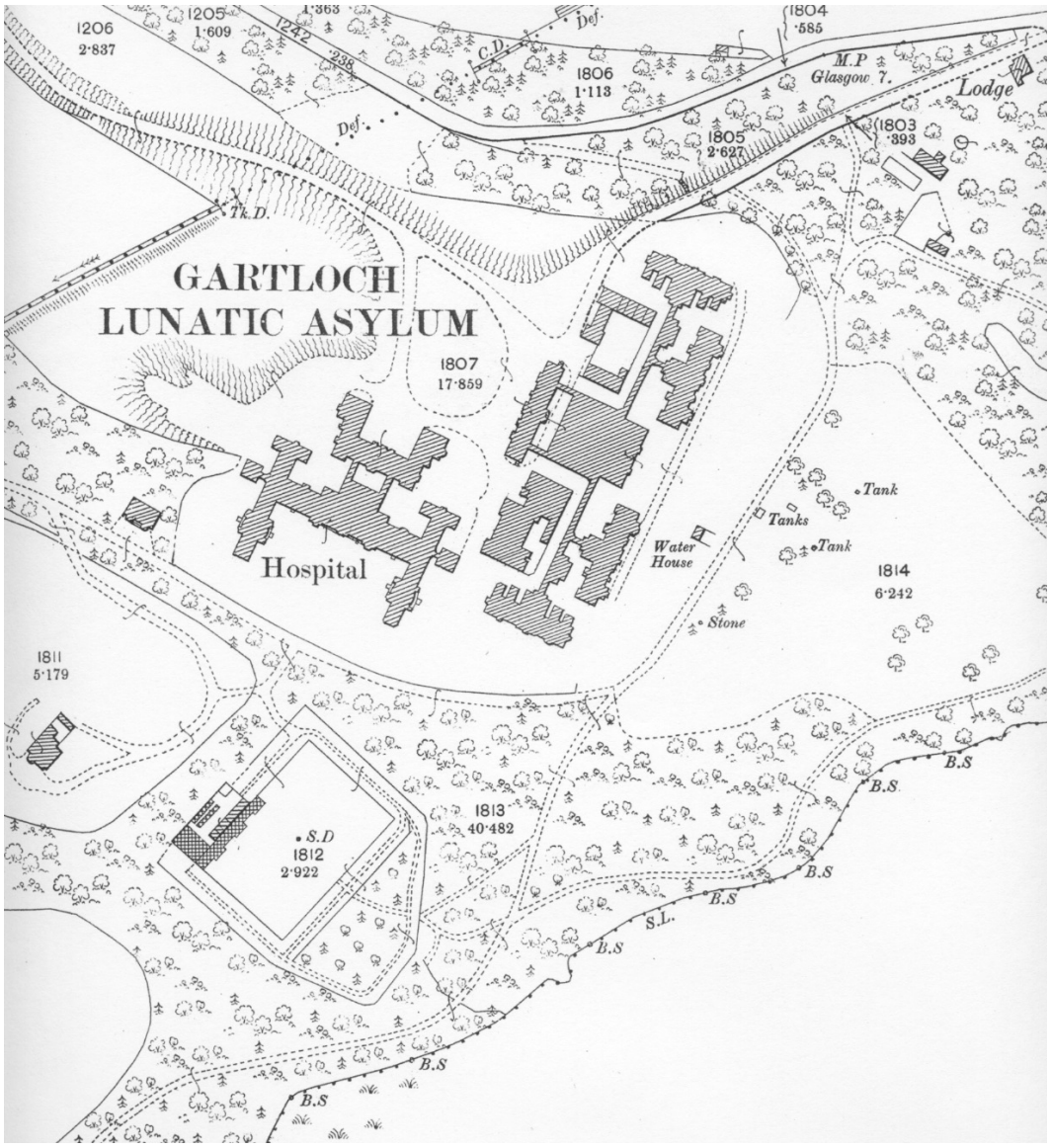

Figure 7.9 – Glasgow District Asylum, Gartloch, *Ordnance Survey*, 2nd edition, 1898 ©nls (Darragh, 2011b:79).

Figure 7.10 – Aerial photography oblique aerial view centred on the hospital, halls, nurses home, former mortuary, and workshops, taken from the SSE (©RCAHMS, 2001)

Regarding the District of Govan, there were initial calls that any additional asylum accommodation should be located at the site of the Govan Combination Poorhouse and Parochial Asylum at Merryflats,[174] with the parochial asylum buildings providing the "nucleus of the district asylum for the Govan Combination" (Minutes from Conference Meeting of Representatives of the Barony, City, and Govan Combination Parochial Boards, 1888:7). But, difficulties with overcrowding, the acquisition of more land, and adequate means of employment at this site – all hazards of a more urban site – had been reported by the Commissioners on numerous occasions, with examples from 1865 to 1886 included in the minutes from the conference meeting of representatives of the Barony, City, and Govan Combination Parochial Boards (1887:3-4). Consequently, the Govan Board proceeded to enquire about purchasing a new site, appointing a lands committee to assess possible estates at Giffnock, Dripps, Hawkhead, Heirmyres and Peel Park, all within

[174] The Govan Poorhouse and Parochial Asylum at Merryflats was opened in 1872, with accommodation for 750 paupers and 180 pauper lunatics. It later became the Glasgow Southern General Hospital.

the vicinity of Govan. The committee inquired into water and gas supplies and drainage for each site, as well as gathering quotations for the carriage of goods to the closest railway stations from the different railway companies. After weighing up the different options, the lands committee came to the conclusion that:

> As regards situation, convenience of access, adundant water supply, and suitability for drainage, the lands of Hawkhead being well adapted for the erection thereon of an Asylum for the Govan District, and the price at which the proprietor offers them being deemed a fair one, the Board is of opinion that their purchase for this purpose should be at once be concluded, subject to the necessary approval of the General Board of Lunacy. (Govan D.B., M.B., 1889:7)

The Govan Board subsequently showed four members of the General Board[175] around the 171-acre site at Hawkshead in the company of all members of the land committee, with the Commissioners expressing "their entire approval of the lands as a site for the proposed District Asylum" (Govan D.B., M.B., 1889:9). In the immediate correspondence after this approval, the General Board nonetheless recommended that, in addition to the 171 acres, the Govan Board should "acquire the ridge to the north-east corner of the grounds (should be the south-west corner),[176] so as to command the eminence and thus add to the amenity of the grounds" (Govan D.B., M.B., 1889:9). The raising of funds was then passed over to the finance committee of the Govan Board, who proceeded to purchase the estate in 1890, and construct the asylum buildings on an area which was elevated and south facing.

Finally, in 1902, the Renfrew Board purchased the 537-acre estate of Dykebar. The General Board were wary of this purchase, viewing it as too extensive and consequently too expensive for the needs of the district, stating that it was "of greater extent than the District Board is ever likely to need for asylum purposes, and its cost must add disproportionately to the expense of what will be, at all events to begin with, a small asylum" (SCL, 1904:liv). They advised that the surplus land should be sold as soon as possible, the only time that they recommended such an action.

The Edinburgh and Aberdeen Boards also built asylums in the late period, both planned on the village, or segregated, layout (see Chapter Nine), but they included only limited discussion about acquisition of a site in the archive. The Edinburgh Board purchased the Bangour estate for only £15,000, which included 960 acres of land which sloped to the

[175] Sir J. Don Wauchope (Chairman), Sir Arthur Mitchell, Dr Sibbald, and Mr Cowan.

[176] This correction was inserted by the Govan Board, indicating that the General Board had perhaps got their bearings wrong by 180 degrees when visiting the site.

south, situated eleven miles from the city of Edinburgh (see Figure 7.11). The buildings were to be constructed on the lower part of the estate, close to the Edinburgh-Glasgow road. Most were south-facing, with the appearance of being randomly spaced throughout the landscaped grounds (although still highly planned to allow classification). Further land was acquired in addition to the asylum site for the construction of a private railway line to the asylum for the transferal of goods, patients and visitors. No negative comments were recorded about the situation, except that the only suitably elevated site for the construction of a reservoir was found to be porous, causing the Board "serious and unexpected difficulties" (SCL, 1902:li) with obtaining a sufficient water supply. The Aberdeen District Board purchased a 347.5-acre site in 1899, at a cost of around £12,000 from the estate of Kingseat, situated eleven-and-a-half miles north of the city of Aberdeen by rail. Once constructed, it was reported in the *Evening Gazette* in 1906 that the institution formed "a picturesque little village on the fine slopes of Beauty Hill" (*Evening Gazette*, 1906:np).

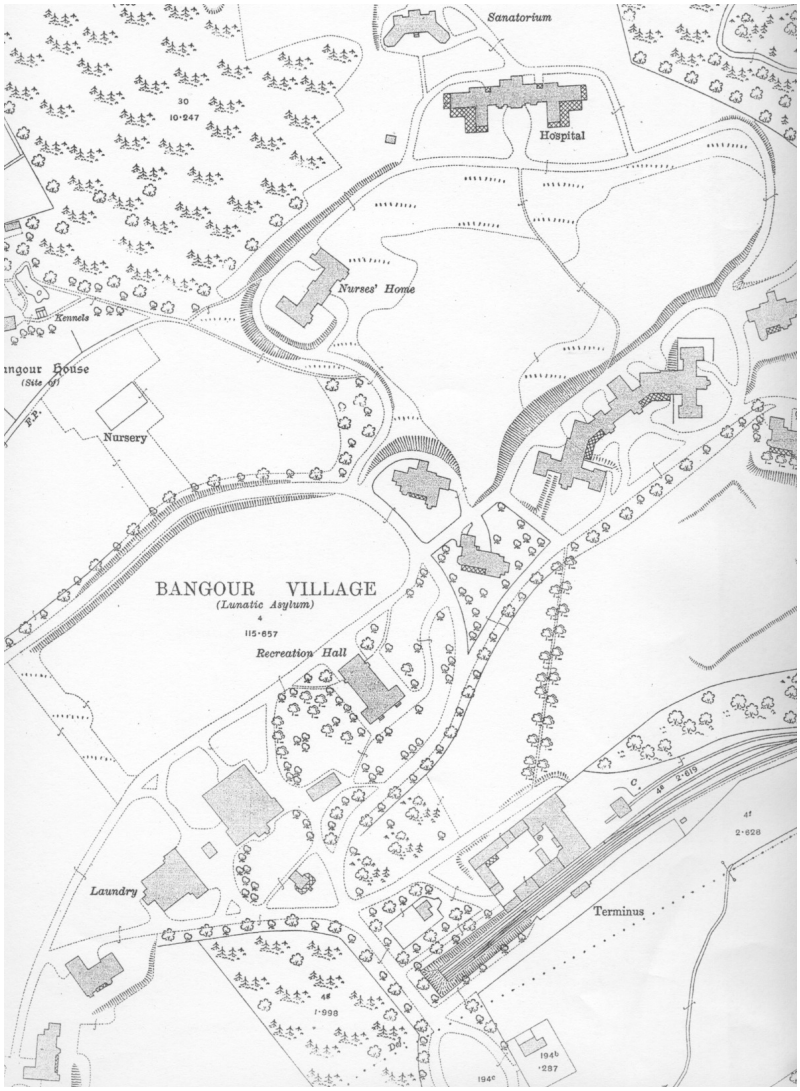


Figure 7.11 – Edinburgh District Asylum, Bangour, *Ordnance Survey*, 2nd edition, 1915 ©nls (Darragh, 2011b:58).

***Renfrew District Asylum site visit***

*The rain pounds against the windscreen, and the wipers struggle to keep it clear. When we left the flat, it was drizzly but the weather has definitely taken a turn for the worse. It's probably not the best conditions to be exploring, but we are half way there, and decide to keep driving. This is our first trip to a site that is still in use as a hospital and I'm intrigued by what it will be like, and how it will have been brought into the twenty-first century. Our destination is Dykebar hospital, or Renfrew Asylum, the last of the districts to be built, completing the 'circle' of asylums around Glasgow. The archival records had been sparse, and I am not sure what to expect. Leaving the city behind us, we wind our way down the road, taking it easy as the rain bounces off the tarmac. The pavements and roads are deserted, although we pass a few bungalows on the left. Unkempt shrubs and overgrown bushes line the road to the right. Eventually we reach the hospital, and turn into the entrance. Still we see no one – a combination of the wet weather and the fact it is a Sunday afternoon.*

*The entrance driveway is tree-lined, providing some shelter from the rain. A road sign warns of the fifteen mile per hour speed limit, and we slow down. A car park lies to the right, empty. Ahead, through the trees and the rain, I glimpse the red sandstone Edwardian buildings. Although built of the same stone as Gartloch, it lacks the grand, imposing towers and decorative details, and appears markedly more subdued. It almost looks like a school in appearance: simple, low storey buildings surrounded by either tarmac or neat cut grass. Modern access handrails, new NHS signs and a recent porticabin extension indicate that it is still in use as a hospital, the old and new buildings blended together on the single small site. Continuing round the road, half hidden by the trees, appears an old derelict mansion house. I recognise it from online photographs. It had been built as the superintendent's house, but after they were no longer required to live on site, it had presumably been abandoned.*

*The rain has still not eased, and we decide this would purely be a 'drive-through' exploration. I also feel uneasy at wandering around a site that is clearly still functional. Situated on a flat piece of land, I can't help but question why this site had been chosen, as apart from being remote, it doesn't appear to have the same characteristics or imposing views as the other sites we have visited. I feel underwhelmed and a little disappointed: a mixture of the weather and the quite simple architectural structures. Continuing forward, wipers still on full, we drive to the front of the buildings. I gasp. Through a wide clearing in the trees, the landscape stretches before us, gently sloping to the south. A neat lawn gives way to heather, dotted with an array of different trees. I smile as I realise that this view, the extensive expanse of open countryside spread to the south of the main buildings, was likely a strong selling point for the District Board when choosing the site for the Renfrew District Asylum.*

## CONCLUSIONS

When the General Board was first established in 1857, their vision was in line with contemporary views when it came to the ideal site and situation for the new district asylums, which would ideally hold a rurally situated, elevated position, with extensive views of the surrounding landscape. Their recommendations were driven by both practical considerations, such as soil type, access and supply of water, essential in the day-to-day running of an institution, as well as decisions around the affective qualities of a site to alter patient behaviour. It was believed that a site with a cheerful outlook and salubrious nature would have the power to produce a curative affect, while also manufacturing a community that was easier to manage. The landscape was viewed as having the ability to exert a subtle power over the insane population, with its affective qualities recognised as the first step in controlling and manipulating the behaviour of the insane population. It was deemed of great importance to obtain a desirable site which would serve as the background to the more obvious visual machine of the institution, with the evidence uncovered in the archives showing that the district boards actively sought land that matched the Commissioners' blueprint. This growth in central direction over the localities hints at the power relations between the district boards and the General Board, which arguably was part of the nineteenth-century 'revolution in government' reaching Scotland.[177]

As recognised in Chapter Six, there was a move over the second half of the nineteenth century from a more moral-centred approach to treating the insane, towards a more medicalised understanding of, increasingly, mental illness. Despite this move, which was to have a more marked effect on the arrangement and management of the grounds and buildings of the asylum (to be explored in Chapters Eight and Nine), throughout the General Board's existence there remained a consistency in the acquired site and situation of the asylum estate. Yet, there were ideological shifts in thinking around the ideal location of asylums in the middle years between the acquisition of the early and later asylum sites. This was particularly evident in the Twelfth Report, which argued that the insane did not need to be so isolated from the general population, and would possibly benefit from contact with the 'normal', non-institutional world. But the desire to acquire ever larger estates at affordable rates, and possible hints of a more deep-seated 'exclusionary ambition' (although difficult to prove), appeared to push the institutions to even greater distances from the main urban settlements by the beginning of the twentieth century.

[177] See, for instance, Driver's discussion of such matters in his 1993 book.

Through looking at the sites of the late district asylums, it appears that the initial requirements outlined in the Commissioners' First Report – the requisite for a large area of affordable but suitably salubrious land – were continued into the twentieth century, despite hints that the asylum should be less removed from the urban environment. The majority of the district boards purchased land situated an even greater distance from the nearest urban settlements, most likely to secure spatial separation as well as the desired extensive land at affordable rates. Comparing the original sites of the early asylums with the institutions built in the later period, the biggest difference was in the initial size of the estates, which evidently was becoming increasingly important as the ratio of land to patient altered and asylum numbers increased.[178] Consequently, all of the later institutions were much larger, both regarding the number of patients that they could admit into the asylum and the extent of their land, with growing emphasis on farm land for occupational and economic purposes.

There was, therefore, a certain *inertia* of the locational vision, the root 'site and situation' thinking. There were some signs of shifting ideas, which could have sanctioned a more *urban* locational solution, but in practice various forces conspired to keep the asylum rural. Furthermore, there was no hint of pressure to *re*locate the asylums back to more 'settled' areas and in practice too, the later asylums continued to seek out rural, perhaps even *more* remote, locations. It was almost as if there was this hesitation, a pause, a deep breath, in the progress of the district asylum system (circa 1875-1890), when just possibly, a new locational ('site and situation') vision could have asserted itself, only for the 'default' of the standard rural model to *re*assert itself after 1890. What arguably did change, however, after 1890, were more detailed spatial arrangements in the grounds and buildings, which will be explored in Chapters Eight and Nine.

[178] The early asylums had also undergone considerable expansion to buildings and grounds. The different and changing uses of the asylum estate will be detailed in Chapter Eight.

# Chapter 8

# Spatial Themes II: Grounds

## INTRODUCTION

> Experience shows that the general behaviour and aspect of insane patients are in a very great degree influenced by the nature of their surroundings. (SCL, 1870:171)

The need to (re)create a tranquil, secluded and aesthetic yet still functional space was recognised as a crucial component of the nineteenth-century asylum, affecting the physical and mental health of individual patients and also the management and treatment of the insane population as a whole (see Hickman, 2005, 2009, 2013). Indeed, the key variance between the poorhouse grounds and asylum grounds lay in the addition of therapeutic and ornamental purposes alongside the more practical economic function (Rutherford, 2003). The effect of landscape aesthetics on the mind had long been recognised, with Addison commenting in 1712:

> Delightful scenes, whether in nature, painting, or poetry, have a kindly influence on the body, as well as the mind, and not only serve to clear and brighten the imagination, but are able to disperse grief and melancholy, and to set the animal spirits in pleasing and agreeable motions. (Addison, 1712:191-192)

As such, asylums had long been set within substantial grounds, in many ways modelled on, and therefore often giving the impression of, a grand country estate.[179] Furthermore, within the wider Victorian era, connections between environmental reform, health and moral behaviour were being recognised, with groups such as the National Health Society established to promote the advantages of urban green space, and to encourage the growth of planned parks within the city, which, it was hoped, would limit the impacts of industrialisation and urbanisation on society (see Conway, 1991; Thorsheim, 2006; Hickman, 2013). Jones and Wills (2005:44) argue that "reformers hoped that by retreating into the park urban workers would not only feel healthier – by virtue of taking exercise and breathing 'country air' – but also psychologically refreshed". The growing popularity of literature on the Romantic conception of the rural landscape further promoted the image

[179] See Rutherford (2003) for early development of asylum landscapes and the connection with country estates.

that the countryside was "a place that could offer both 'refreshment and renewal' in terms of physical, mental and spiritual health" (Hickman, 2013:114). Consequently, the popularity and perceived affective potential of such environments resulted in the promotion and creation of new spaces which would foster "alternative forms of behaviour, alternative moral habits" (Hickman, 2013:14) both within the city, and evidently, within the asylum.

The district asylums in Scotland followed from, and fitted into, this wider model. The institutions, "inserted into the mature landscape" (Rutherford, 2003:18), were surrounded by substantial grounds that were customised to incorporate mixes of garden, park, farm and woodland (see Table 8.1). The space was to be used for the recreation and occupational employment of the patients, and of a character that would sculpt the mental responses of the inhabitants. Both elements were mutually inclusive, central components in the administration and supervision of the asylum population. Furthermore, the grounds were also to be functional spaces, enabling the day-to-day running of an expansive institution by providing water supplies and sewage disposal, although these were not always straightforward givens, with many difficulties arising due to the population demands on a once natural habitat (as already explained in Chapter Seven).

On the south-facing slopes to the front of the buildings, the grounds were to be laid out with flowerbeds and gardens, aesthetically landscaped spaces for recreation such as walking, but also with the potential to exert more affective subtle visual experiences and 'cheerfulness' on the inhabitants. Trees were planted that would in time provide shelter and walkways, growing and maturing in much the same way as those in public parks.[180] At a further distance from the buildings, the land was farmed, providing employment for (predominantly) male patients, which was an essential component in the control of the population, the promotion of recovery and the economic viability of the institution. Crucially, the landscape and grounds were viewed as being a 'productive' rather than a 'repressive' form of power, embodying 'soft-disciplinary' techniques which were central in controlling and treating the insane population. In order to incorporate all of these functions, the estates were of an extensive size, although they were not static entities. As the second half of the nineteenth century progressed, asylum populations increased and discourses were adapted, causing the grounds and the arrangement of the buildings

[180] When I visited the sites, particularly the Glasgow asylum, it was obvious that the grounds were landscaped, and even though the gardens were overgrown, the planned nature of the environment was striking, particularly regarding the big, mature oak and fir trees.

(discussed in Chapter Nine) to be extended, modified and developed as methods of controlling, managing and treating the insane shifted.

The following chapter will look at the proposed layout and use of the asylum grounds as put forward by the Commissioners after the 1857 Act. It will then move on to examine in detail the changing use of the outdoor spaces of the institution due to developments in the methods of management, treatment and understandings of madness, but also how the grounds were manipulated in order for these developments to occur. It will additionally look at how the modifications were a response to the shifting character of asylum inmates over the study period, particularly the 'splitting apart' of the industrial and medical sections of the institution, which, although more a 'buildings' issue (see Chapter Nine), did have repercussions for the management of the outside spaces of the institutions. Although advocated by the General Board, the changing arrangements and uses of the asylum spaces generally originated with the asylum superintendents, who continually modified, added and developed their institutions to achieve the desired results. Examples are drawn from the different district asylums, which, although adhering to the broader discourses regarding treatment of the insane, developed in their own distinct ways due to the independence given to the superintendents, but also as reactions to the challenges and benefits of each distinct site and input from the General Board.

## COMMISSIONERS' BLUEPRINT AND RECOMMENDATIONS

In part likely due to the ideal landscape model being established and continued from the earlier decades of the nineteenth century (see Rutherford, 2003), and in keeping with the desire for no 'strict uniformity' across the different asylums to allow independent developments by the different institutions, the blueprint for the layout of the asylum grounds included in the First Report of the General Board was very brief, providing only limited information as to how the grounds should be configured and used. As was stated in Chapter Seven, the Commissioners originally thought it desirable that the land connected to the asylum should be not less than one acre to four patients, with room for extension should the institution increase in size at a future date. The aim was to provide sufficient outdoor space for agricultural employment, exercise and recreation, and for the site never to seem cramped even with growing inmate populations. The only other information in the 'suggestions and instructions' was that there was no need for more than two enclosed airing courts on each side of the building, which "should be of ample extent so as to afford

proper means for healthful exercise. They should be planted and cultivated, and any trees already existing within them should be preserved for shade" (SCL, 1859:118). A shift already anticipated earlier in the thesis, it will become apparent below that the 'blueprint' altered as opinions regarding the safe-keeping and treatment of the insane were modified, most notably as a response to the increasingly moral-cum-medical discourses that took precedence as the century progressed.

***Affective Environment***

It was widely believed that outdoor recreation and occupation would have a positive affect on the mental condition of a person. The Commissioners', explicitly reflecting a 'social control' model of what an asylum offers, stated:

> The experience of common life proves that when we are in a state of nervous irritation, fidgety, and out of sorts, comfort and calm are best restored by active exercise in the open air. To be locked up in a remote room would certainly prevent us from proving a nuisance to other people, and distracting their attention from their own occupations; but it would be far better for ourselves that we should work off the cause of irritation in active exercise than in battering the door of the room or destroying the furniture and bedding. (SCL, 1871:xlvi)

Thus, rather than purely banishing a patient to a "remote room", the Commissioners continually advocated the use of the asylum estates for treatment, which, through careful planning and management, were believed to hold the 'power' to act as a crucial tool in the treatment of the insane. One method of achieving the desired affective atmosphere was through the laying out of the grounds in order to achieve a healthful, cheerful and, if not curative, then at least calming environment. This was done by planting trees and bushes, and laying out walkways and terraces, which had the dual result of providing outdoor employment for a number of patients (to supplement agricultural employment: see below), as well as attaining an aesthetically pleasing appearance (see Figure 8.1). Furthermore, asylums increasingly provided outdoor recreation in their grounds, which it was hoped would act as a deterrent from morbid thoughts, distracting and engaging the patients' mind through mirroring the entertainment found in 'ordinary' life:

> Amusement in a pauper establishment may to some appear as an anomaly, but it must be borne in mind that this Institution is a hospital requiring curative agents of every description, among which amusements hold a well-defined position. They act in various ways; they have in many instances a decided curative effect, the apathetic, the melancholic and demented have often dated their awakening into mental vigour from an evening's fun or some stirring pastime; they break the

> monotony of routine which must necessarily exist in such an establishment, and they form an incentive to, and a reward for industry and good behaviour. A good proportion of the inmates are young, and to them amusement is very attractive. It will therefore be evident that amusements are necessary for the good and wellbeing of the patients. This year they have received due attention. Dances, concerts, Highland games and pic-nics [*sic*] continue to take place at proper intervals. I am grateful to those friends who show their interest in the Institution by their occasional presence and assistance at these festivities. (Fife & Kinross D.B., A.R., 1875:17)

As such, a number of institutions were increasingly provided with facilities such as bowling greens, curling ponds, and, in particular, cricket, as it was "regarded as a healthy, orderly game which encouraged self-respect, self-control and respect for rules of behaviour, both written and unwritten" (Cherry and Munting, 2005:48).[181]

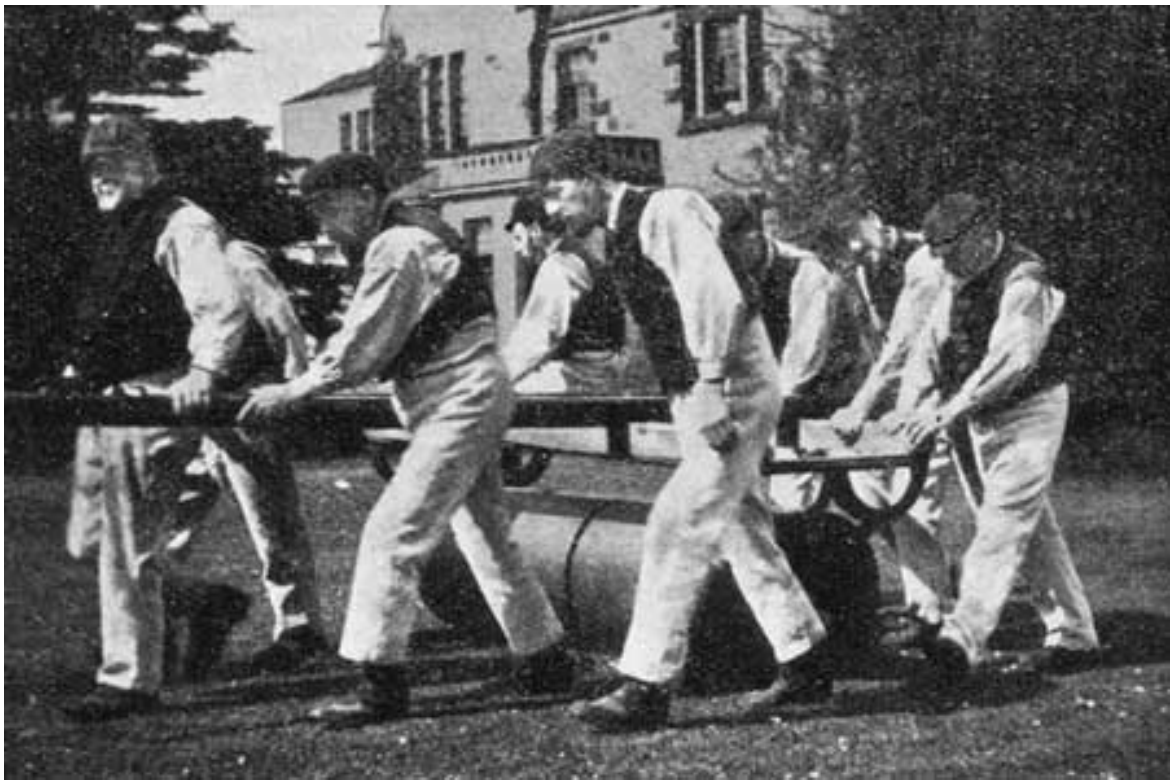

Figure 8.1 – The Roller Squad (SCRAN). Eight uniformed men (presumably patients) at Stirling District Asylum pull a roller over the grass in front of one of the asylum buildings. Date not known.

At the Ayr Asylum, improvements in the layout and appearance of the ground were realised in the first year after opening through the planting of shrubs at the front of the main building. Furthermore, a walk was constructed round the grounds "which affords daily exercise to all those who are not physically incapable of exertion" (Ayr D.B., A.R., 1871:18). Yet, a number of years later the Commissioners reported that the institution had

[181] The Ayr Asylum grounds included a curling pond situated about 200 yards from the house. Sadly, in 1880 Mrs Sheddon, a patient from the district of Sutherland, took her own life by drowning in the pond, which was only fifteen inches deep with water (Ayr D.B., M.B., 1880:46).

a “bare and naked aspect” (SCL, 1878:xxxix), and recommended planting more greenery in the grounds. The Ayr Board responded by suggesting that a budget of £8 should be spent on planting flowering shrubs such as hawthorn, lilacs and guilder rose (Ayr D.B., M.B., 1879), and employed a new gardener, Mr Scott, who was praised for engaging the patients in garden work and bringing new sections of land under cultivation. Figure 8.2 shows the extent of the planted areas surrounding the asylum by the 1890s, which would have given the grounds and the buildings some privacy from the road that ran behind the institution. The circular shape below the Smithy was probably the curling pond.

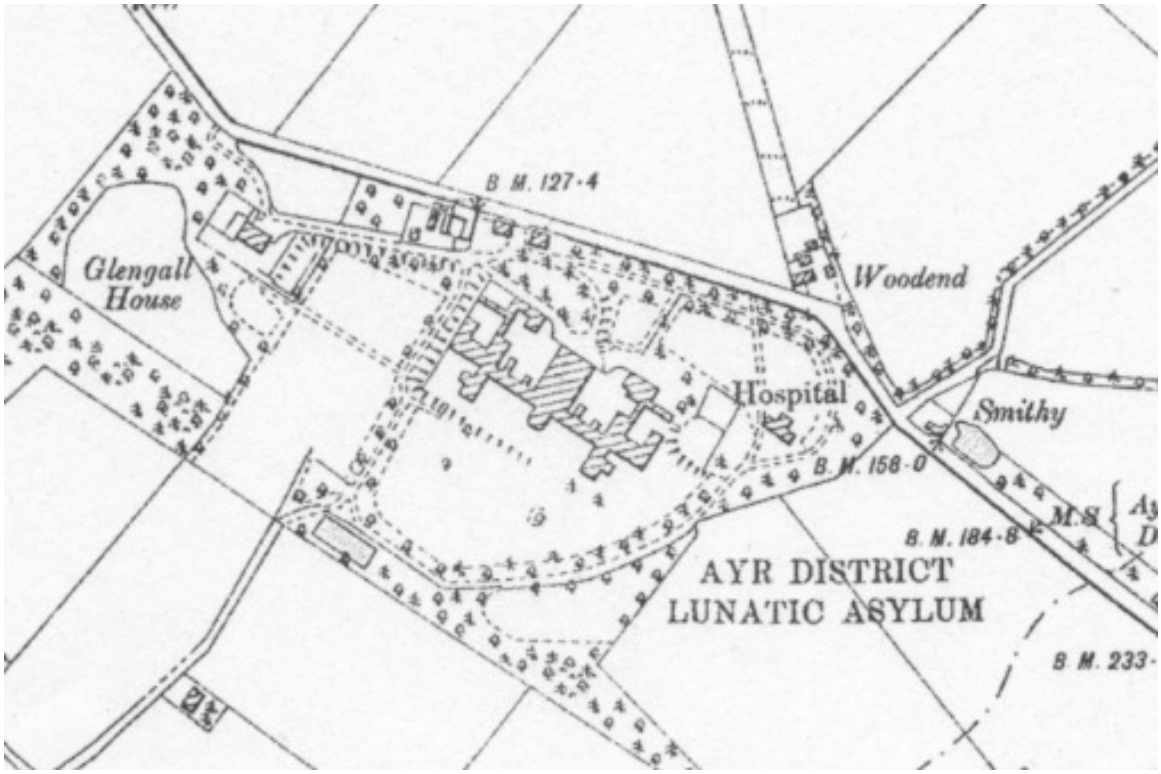

Figure 8.2 – Ayr District Asylum, *Ordnance Survey*, second edition, 1897, ©nls (Darragh, 2011b:32).

At the Inverness Asylum, the planting had a more practical element, being recommended as an attempt to overcome the high, cold and windy situation of the asylum, giving some shelter to patients taking exercise in the grounds (see Chapter Seven for difficulties with this site). Trees were donated to the institution by Colonel Fraser-Tytler of Aldour, A Forbes (Esq of Culloden) and Messrs Howden, and it was reported that they had the affect of “soften[ing] the aspect of the surroundings of the institution” (Inverness D.B., A.R., 1866:27). The Inverness Board also recognised the importance of keeping the asylum surroundings “carefully and neatly kept” as, they stated, “it serves to impress the inmates, and aids, to a great extent, the moral discipline of the establishment” (Inverness D.B., A.R., 1866:29). In 1880, the Roxburgh Asylum grounds were described as being “naked” and the walks “unsheltered”, so the plantation of trees and hedges in “appropriate localities”

was urged by the Commissioners (SCL, 1880:xl). Conversely, in 1905 it was reported that the Perth Asylum had removed a number of trees and underwood close to the asylum and around the walks in the grounds, which "greatly added to the brightness of the buildings and the dryness of the roads" (SCL, 1905:xxxvi). It was reported in the *Daily Journal* in 1905 that the Aberdeen Asylum authorities had:

> … effected a wonderful transformation on what was, a short time ago, rather a bleak and barren hillside. Paths through the grounds have been well laid out and bordered with grass, and clumps of trees have already attained to come considerable size, and looks as if they mean to thrive. (*Daily Journal*, 19/07/1905:np)

The newspaper continued by stating that, "in a very short time Kingseat will be a beautifully wooded village", claiming that it would soon be possible to say that the Board had "made the desert to blossom as the rose" (*Daily Journal*, 19/07/1905:np). The Edinburgh Board reported that the gardens at their asylum were continually being developed, with the flowers from the beds and the greenhouses being used to decorate the wards and dayrooms (Edinburgh D.B., A.R., 1910).

***Industrial/Agricultural Occupation***

Although recognised as essential in the early years of the General Board, and mentioned in Chapter Seven as important when choosing the site of the asylum, as the nineteenth century progressed, increased emphasis was given to the extent of land attached to the asylum for industrial occupation and, in particular, farming.[182] This was partly enabled as a result of the removal of the physical restraints on liberty, which will be detailed later in the chapter, yet conversely was also an essential component in facilitating this increased freedom. Occupation was a beneficial method of keeping the population under control and supervision. Indeed, it engaged the attention of the small number of individuals who might actively try to escape, as well as acting as a distraction for the larger number of patients inclined to wander without definite purpose. The attendants were increasingly encouraged "to devote themselves to engaging the patients in occupation" (SCL, 1881:xxxvi) in a manner not previously met.[183] This could of course refer to many forms of 'occupation',

[182] 'Industrial' here included 'agricultural' work – albeit in other domains the two terms are seen as opposed, different forms of activity. This point should be kept in mind, as it is crucial for the remainder of the thesis.

[183] In 1877, the Commissioners cautioned that the control of the patients was still to lie with the medical superintendent, warning that the farm manager should not adopt an independent authority. This appears to contradict their intention outlined above that the attendants should have increased powers over the supervision of the insane population. Yet, the comment about the farm manager did appear a few years prior

including *in*door activity such as basket-weaving, pointing and so on (see Laws, 2011), but for male patients, in particular, the reference was to agricultural labour. Formerly, at a time when patients were secured within airing-courts, or "marched in military order at stated periods of exercise" (SCL, 1881:xxxv), there was no motivation or desire for the attendants to absorb the patients in work. But agricultural work, predominantly for the men but also for a number of the female patients,[184] was designed in a way so as to interest the patients, and as such was ideally of a varied nature. It was seen as a curative agent in curable cases of insanity, and as a method of placing incurable, chronic patients in a situation that closely resembled ordinary life; and ultimately it was deemed easier for the attendants to supervise a group of patients at work, rather than patients drifting aimlessly about the asylum spaces.

As part of the individualisation of patients, which occurred increasingly throughout the study period (and to be substantiated below), it became ever-more important to provide varied employment that was suited to the "peculiarities of each case" (SCL, 1881:xxxviii). A criticism of the system was still that the asylums found it difficult to provide occupations appropriate for the different working classes. The Commissioners, however, argued that "it does not follow, from its being impossible in an asylum to give a patient exactly the kind of work to which he has been accustomed, that he should not engage in any kind of work" (SCL, 1881:xxxviii). Thus, as far as possible patients were employed in work that suited their skills and capabilities, but the overall aim was to engage patients in employment that was deemed useful and desirable for the creation of the institution as a *community* (or set of communities). As such, farmwork was seen as particularly useful, especially in non-agricultural districts, as the occupation was accessible and suitable for those patients unable to be employed in their own trades, and was even seen as providing more benefits than perseverance in the patient's previous ordinary occupation, presumably as it provided new challenges for the mind.

Regarding the female population of the institutions, criticisms arose around the volume of physical outdoor occupations available. Particularly earlier in the century, the only mentally stimulating employment given to the women was needlework, which did not achieve the desired level of activity needed to "satisfy the morbid energy" (SCL, 1881:xl), and did not allow females to spend extended periods of time outdoors. As shown in Table

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to the statement about attendants having increased powers, and so the difference between the two views may show a shifting method of management as the decades of the nineteenth century progressed, or it may have been a passing comment at one specific farm manager who was stepping too far out of the hierarchical structure, which ultimately was to remain in place.

[184] Suitable industrial work for female patients was more difficult, and a large number were engaged in kitchen and laundry duties, to be discussed below.

8.1, by 1904 only a small number of district asylums engaged the female population in outside labour, either on the farm, particularly during harvest time, or the grounds and gardens.[185] Although the numbers of female patients employed outside remained low throughout the study period, the deficiency of any form of employment was rectified to an extent as the century progressed, with many female patients employed indoors in the laundry and washing-houses, which were viewed as a suitable source of heavy manual labour.[186] Two methods were used in order to guarantee a steady and sufficient supply of work: firstly, mechanical machinery was kept to a minimum, with all washing being done by hand power; and secondly, if there was still surplus labour, a number of asylums opened the service up to the neighbourhood.

| District Asylum | Farm | | Grounds and Garden | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| **Argyll** | 10 | 2.8 | 31.8 | - |
| **Ayr** | 1.8 | - | 31.1 | - |
| **Banff** | 40 | - | 7.1 | - |
| **Elgin** | 35.5 | - | 15.8 | - |
| **Fife** | 22.5 | - | 5.7 | 2.7 |
| **Glasgow** | 15.1 | - | 28.2 | 9 |
| **Govan** | 8.8 | - | 40.7 | - |
| **Haddington** | 46.9 | 12.8 | 7.8 | - |
| **Inverness** | 16.7 | - | 42 | - |
| **Lanark** | 7.1 | 4.9 | 51 | - |
| **Midlothian** | 23 | 7.2 | 4.4 | 7.2 |
| **Perth** | 2.7 | - | 29.2 | 6.9 |
| **Roxburgh** | - | - | 42 | - |
| **Stirling** | 6.3 | - | 18.3 | - |

Table 8.1 – Average maximum number of males and females employed on land as a per cent of average number of residents from 1901 to 1902, (SCL, 1904:lvii)

In a similar vein, in order to procure the desired industrial employment of the inmates at the Elgin Asylum, some male patients were employed alongside the attendants doing farm work in the neighbourhood when not required to work on the asylum farm. The system reportedly benefitted the patients, the ratepayers and public attitudes:

> Not only are the public led in this way to look without ignorant fear upon the inmates of asylums, but the patients contribute materially to their own support, and

[185] See McGuire (2012) on how dairy work held out in Scotland as a preserve of female labour.

[186] Although predominantly referring to indoor spaces, female occupation will be considered briefly here rather than in Chapter Nine as it fits neatly into the section on industrial labour and occupation. The situation of the service buildings (kitchen, laundry) will, however, be detailed in Chapter Nine.

> a sense is produced in many of them that they are still recognised as useful members of the general community. (SCL, 1883:xix)[187]

Securing cultivatable land was considered to be of particular importance, with far-reaching benefits: it allowed the employment of male patients, which was considered central to their treatment by producing a more easily managed, if not docile population; it was seen as increasing the mental and physical health and well-being of the whole asylum population through the consumption of a healthy diet (in particular good meat, vegetables and milk); it benefitted the overall economy of the institution, as increased cultivatable land procured a positive effect of the rate of board as, the Commissioners stated, "under no conditions should the cultivation of land be more profitable than where the labour is gratuitous and the market for the product at the door" (SCL, 1877:xxxvi); and finally, it was believed that the healthful occupation and exercise "in the strictest sense furnishes a means of medical treatment" (SCL, 1878:xxxiv). In short:

> The possession of a considerable extent of land is being more and more clearly recognised as an important adjunct to an asylum. This is found to be beneficial not only to those patients who actually work it, but also to those who are otherwise employed or are incapable of employment, - a consequence of the fullness of the milk, vegetables, and meat supplies which it occasions, and of the means of extended out-door exercise which it affords. (SCL, 1877:xxvii)

This was clearly moving the institution towards the self-sufficient 'colony' ideal, with the district boards constantly discussing the benefits of farming, and attempting to acquire additional land over the decades for both the occupation of patients and economic advantage of the institution. In comparison to books and games, which only occupied a minority of the working class inmates, even simple outdoor employment and labour was preferred.

It was recognised that management of an asylum farm was somewhat different to that of an 'ordinary' farm, particularly when it came to economising labour. Ordinary farm management would typically aim to economise on the human workforce, but, similar to the female population and laundry work as above, an asylum farm always had an abundant supply of workers, which meant that time-saving and person-saving machinery was avoided, such as the plough, with preference lent to spade husbandry. Furthermore, in what the Commissioners' called "the elasticity of the land as a source of labour" (SCL,

[187] This quote is remarkably similar to claims made about 'nature work' for/by people with mental health problems (PwMHP) in the present (see Parr, 2006 and 2007).

1881:xxxix), the continual improvement of the asylum farm gave opportunities for employment:

> If the land attached to an asylum is of any considerable extent, it will nearly always happen that important rearrangements are deemed desirable; and when there is a disposition to encourage improvements of this kind, it is generally found that they afford a very abundant and varied source of labour. Road making, embanking, draining, fencing, planting, and even building, are generally found to be required; and in connection with these things, and with the work more accurately included under the term agricultural, there are subsidiary forms of industry developed. (SCL, 1881:xxxix)

Industrial occupation provided by an asylum farm, therefore, provided varied work and labour, even of the simplest kind, which was suitable for a range of patients.

Regarding the mental health of the patients, it was believed that the farm provided an affective environment of even greater weight than the internal engineered environment of the asylum:

> The healthy mental action which we try to evoke in a somewhat artificial manner by furnishing the walls of the rooms in which the patients live with artistic decoration, is naturally supplied by the farm. For one patient who will be stirred to rational reflection or conversation by such a thing as a picture, twenty of the ordinary inmates of asylums will be so stirred in a connection with the prospects of the crops, the points of a horse, the illness of a cow, the lifting of the potatoes, the laying out of a road, the growth of the trees, the state of the fences, or the sale of the pigs. (SCL, 1881:xl)

There were clear affective resonances, therefore, as this was not about 'rational reflection' but about more spontaneous, organic 'stirring' of positive emotions. It was evidently believed that the naturally occurring aesthetic qualities of the landscape, and indeed the embodied 'taskscapes'[188] of work outdoors, held much more power and potential to alter the processes of the mind than the internally constructed spaces of the asylum buildings. With intimations of the seventeenth-century Lockean model of the association of ideas, this quote underlines the Commissioners' belief that immersion in different landscapes and scenarios had the ability to affect the mind (Hickman, 2009). This quote perhaps also suggests an awareness of the appreciation of objects and spaces by different classes, with the Commissioners hinting that agricultural process, rather than art, would have a stronger influence on the mind of the pauper lunatic.

[188] This is a term associated with Ingold (1993).

By 1878 it was reported that almost all the asylums were now in possession of such an area of land that they may properly be called 'farms'. In order to obtain the desired extent of such land, a number of districts leased farms adjacent to their institutions, such as Argyll and Bute, which for a number of decades leased about 500 acres of arable land, and the small Banff asylum, which had 150 acres.[189] In the 1880s these two institutions, along with the Montrose Royal Asylum, charged the lowest rate of board for pauper patients, as well as having the largest farms, a correlation that was attributed to the recognition by these boards that increased farmwork had a positive effect on the economy of the institution.

Throughout the reports of the General Board, though, a number of districts were criticised for the quality, extent and use of the land attached to their asylums. This became increasingly apparent as the asylum populations rose, which resulted in both increasing the portion of land given over to the asylum buildings, and put pressure on the extent of arable and recreational land, which was gradually being divided among an ever larger number of patients. In the decades that followed the 1857 Act, therefore, the Commissioners increasingly recommended that district boards should seek the purchase or lease of additional land to ensure that each patient had sufficient outdoor space and recreational and occupational facilities. This demand grew in importance as the management of the outdoor spaces shifted, and more weight was given to the affective impact that agricultural employment and outdoor exercise exerted on the minds of both the curable and incurable patients.

Unfortunately, in 1892 it was reported that the Argyll and Bute Board had been unable to renew the lease for the farm, leaving them with only 50 acres of land in total (including land occupied by buildings and gardens), which was far less than appropriate for the size of the institution. Indeed, it was now unable to offer suitable space for exercise or a sufficient variety of labour for the insane population. The loss was described as a "grave occurrence" (SCL, 1892:xxv), but the Board faced great difficulties in procuring more land. For a number of years, some male patients were employed in constructing a new road round the asylum grounds, but this did not provide as much, or as varied an extent of, work as had been provided by the farm, and was regarded as only a temporary solution to the dearth of appropriate labour opportunities.

[189] The Banff Asylum purchased a further thirty-two acres in 1899 in order to continue employing a large number of patients in farmwork, as well as to secure a more efficient water supply, but the Argyll and Bute Asylum lost the lease of the neighbouring farm, reducing the extent of their land to only 50 acres (see below) (SCL, 1899).

The Ayr Board had mixed fortunes with the land attached to their asylum. In 1877, the land belonging to the institution was described as being "of poor quality and difficult of cultivation" (SCL, 1877:lix). It was reported that the Ayr Board were "fully aware of the great advantages which the possession of an asylum farm confers upon the patients" (SCL, 1881:xvi), but that they were finding it difficult to secure appropriate land at a moderate price. This lack was eventually rectified in 1885 when they acquired 66 acres of land, bringing their total to 108 acres (SCL, 1885), but in 1898 it was reported that the grounds of the asylum were in an "untidy condition". It was recommended that this "unsatisfactory state of matters" could be rectified through the "proper organisation of the outdoor work of the male patients" (SCL, 1898:xxvii).

Figure 8.3 – Patients 'at work amang the neeps' (SCRAN). Photo shows uniformed patients at Stirling District Asylum in 1902, gathering turnips into wheelbarrows using forks. Turnips were widely fed to both humans and animals.

In 1878 the Elgin Asylum was found to have an insufficient milk supply, with the General Board suggesting "that land should be acquired on a permanent footing in the neighbourhood of the asylum, and that the farming operations should be so planned as to supply the patients with work of a varied and interesting character" (SCL, 1878:xliii). The Elgin Board was slow to rectify this deficiency, with extra land not secured until 1900, when they managed to obtain a further fifty acres close (but not attached) to the asylum site at Bilbohall. This extended the grounds under the management of the asylum to 165 acres. The Perth Asylum was reported in 1880 as having a deficient extent of land for the

occupation of a large number of patients, as it had no farmland at all. The problem was exacerbated in this year due to the completion of the laying out of the grounds. This deficiency continued for a number of years, and seemingly had a detrimental effect on the employment of the male patients. The female patients, on the other hand, were found to be usefully and healthfully engaged in laundry work. In 1889, however, it was reported that additional land had been acquired by the Perth Board, which was proving to be of great value to the institution, "both in furnishing outdoor employment for the men, and in remedying the deficient supply of vegetables" (SCL, 1889:xxviii). Again, in 1906, it was reported that this asylum had secured a further 95 acres, as it leased the neighbouring farm of Broompark for nineteen years, with the Commissioners stating that the land would "afford increased opportunities of employing the male patients in active outdoor work" (SCL, 1906:xxxvii).

In 1883, at the Fife and Kinross Asylum, "an entire absence of excitement and discontent among the patients" was noted, attributed to the amount of personal liberty enjoyed by these patients, as well as the "healthful active occupation in laundry and field work" (SCL, 1883:xix). However, it was not long until the Commissioners reported that the extent of land attached to the asylum, which came to ninety-five acres, was deficient for the number of patients in the institution, then over 400. As the patient numbers continued to rise, the lack of arable land became more pressing, with the Commissioners urging the purchase or lease of additional grounds, so as to ensure "the means of outdoor occupation, and to secure an ample supply of such things as milk and vegetables" (SCL, 1894:xxvi) for the growing population. This goal was realised in 1901 when the Fife and Kinross Board purchased the 160-acre farm of East Springfield, giving the asylum a total of 268 acres (SCL, 1901).

In 1895, the Commissioners drew attention to the insufficient water supply and the small amount of land attached to the Roxburgh Asylum, both considered as great drawbacks to the institution, particularly as it was in an overcrowded state. It was reported that the land only amounted to twenty-three acres, far less than was appropriate for the size of the asylum and the number of patients. A year later the Roxburgh Board attempted to double the estate by acquiring a further twenty-three acres, with the transaction being completed in 1897, apparently "proving a great advantage in affording outdoor work for the male patients" (SCL, 1898:xxxiii). Providing a small window on changing 'animal geographies', and the changing views about (un)suitable proximities of animals to humans (see Philo, 1995), in 1903 it was reported that the piggeries were located in too close a proximity to

the asylum, and that they should be removed to a more appropriate site on the new section of grounds. This move was realised a number of years later, when the pigs were transferred to a site as far away from the asylum as possible, right on the boundary of the institutional grounds.

A number of other asylums were eventually required to purchase or lease more land. The Haddington Asylum was criticised in 1891 as having to give up some of its estate and thus was suffering from too small an extent of land, but this loss was quickly rectified in 1892 by the acquisition of an even greater lease, which resulted in the institution occupying 121 acres, equalling about one acre to each patient (SCL, 1892). In 1899, it was reported that the Midlothian and Peebles Asylum had secured a further 140 acres of land in connection with the farm, which also ensured a more reliable water supply for the use of the institution (SCL, 1899). The Stirling Asylum was advised to acquire more land in 1900 (SCL, 1900), while in 1904 it was reported that the Inverness Board had purchased the neighbouring estate of Kinmylies, consisting of a mansion-house and 200 acres of land. Forty cows were also bought, rectifying the problem of a defective milk supply at the asylum (SCL, 1904).

TABLE I.

| Name of Asylum. | Extent of Asylum Lands, and how appropriated. | | | | | | | Average Number of Patients Resident during the Year 1901. | | | Average Maximum Number of Males, and Maximum Number of Females, employed between February 1901 and February 1902. | | | | Average Maximum Number of Males, and Maximum Number of Females, employed on Land per cent. of Average Number Resident. | | | | Total of Percentages for Male Patients. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Farm. | | | Grounds. | Garden. | Occupied by Buildings. | Total Extent of Land. | | | | On Farm. | | On Grounds and Garden. | | Employed on Farm. | | Employed on Grounds and Garden. | | |
| | Under Rotation of Crop. | In Pasture. | Non-Arable, Woods, Roads, &c. | | | | | | | | | | | | | | | | |
| | Acres. | Acres. | Acres. | Acres. | Acres. | Acres. | Acres. | M. | F. | Total. | M. | F. | M. | F. | M. | F. | M. | F. | |
| 1. Aberdeen Royal Asylum, | 289 | 23 | 41 | 44 | 22¾ | 9¾ | 430 | 416 | 485 | 901 | 70 | ... | 138 | ... | 16·8 | ... | 33·2 | ... | 50·0 |
| 2. Crichton Royal Institution, | 310 | 270 | 100 | 40 | 11 | 50 | 781 | 157 | 153 | 310 | 60 | ... | 20 | ... | 38·2 | ... | 12·7 | ... | 50·9 |
| 3. Dundee Royal Asylum, | 137 | 49½ | 42½ | 14½ | 8 | 6 | 257 | 174 | 241 | 415 | 9 | 1 | 33 | 18 | 5·2 | 0·4 | 19·0 | 7·5 | 24·2 |
| 4. Edinburgh do., | 14½ | ... | 9½ | 9 | 13½ | 2½ | 49 | 359 | 374 | 733 | 55 | ... | 90 | ... | 15·3 | ... | 25·1 | ... | 40·4 |
| 5. Montrose do., | 238 | 5 | 46 | 14 | 9 | 9 | 321 | 266 | 314 | 580 | 54 | 16 | 62 | 15 | 20·3 | 5·1 | 23·3 | 4·8 | 43·6 |
| 6. Argyll District Asylum, | 17 | ... | 19 | 7 | 3 | 4 | 50 | 220 | 212 | 432 | 22 | 6 | 70 | ... | 10·0 | 2·8 | 31·8 | ... | 41·8 |
| 7. Ayr do., | 7 | 56 | 12 | 25½ | 6½ | 2½ | 109 | 219 | 266 | 485 | 4 | ... | 68 | ... | 1·8 | ... | 31·1 | ... | 32·9 |
| 8. Banff do., | 194 | 7½ | 10 | 6 | 4 | 1½ | 223 | 85 | 79 | 164 | 34 | ... | 6 | ... | 40·0 | ... | 7·1 | ... | 47·1 |
| 9. Elgin do., | 96 | 63¼ | 7 | 2¾ | 2¼ | 1½ | 173 | 76 | 106 | 182 | 27 | ... | 12 | ... | 35·5 | ... | 15·8 | ... | 51·3 |
| 10. Fife do., | 209½ | 14 | 5 | 22¼ | 5 | 6 | 262 | 244 | 292 | 536 | 55 | ... | 14 | 8 | 22·5 | ... | 5·7 | 2·7 | 28·2 |
| 11. Glasgow† do. (Gartloch), | 106½ | 66¾ | 140 | 14 | 5 | 11 | 343 | 291 | 277 | 568 | 44 | ... | 82 | 25 | 15·1 | ... | 28·2 | 9·0 | 43·3 |
| 12. Glasgow† do. (Woodilee), | 374¼ | 21 | 5 | 30¼ | 14¼ | 10½ | 455 | 433 | 410 | 843 | 113 | 19 | 137 | 18 | 26·1 | 4·6 | 31·6 | 4·4 | 57·7 |
| 13. Govan† do., | 207 | 34 | 47 | 37 | 7 | 6 | 338 | 226 | 227 | 453 | 20 | ... | 92 | ... | 8·8 | ... | 40·7 | ... | 49·5 |
| 14. Haddington do., | 103¼ | 29½ | 6¼ | 2½ | 1¾ | ¾ | 144 | 64 | 78 | 142 | 30 | 10 | 5 | ... | 46·9 | 12·8 | 7·8 | ... | 54·7 |
| 15. Inverness† do., | 101 | ... | 66 | 9 | 11 | 4 | 191 | 300 | 286 | 586 | 50 | ... | 126 | ... | 16·7 | ... | 42·0 | ... | 58·7 |
| 16. Kirklands do., | 9 | ... | ... | 1 | 5¾ | 1¾ | 18 | 102 | 92 | 194 | 18 | 14 | 7 | 14 | 17·6 | 15·2 | 6·9 | 15·2 | 24·5 |
| 17. Lanark do., | 104 | 130 | 324 | 25 | 12 | 10 | 605 | 365 | 325 | 690 | 26 | 16 | 186 | ... | 7·1 | 4·9 | 51·0 | ... | 58·1 |
| 18. Midlothian do., | 232 | ... | ... | 15½ | 5¼ | 3½ | 256 | 135 | 125 | 260 | 31 | 9 | 6 | 9 | 23·0 | 7·2 | 4·4 | 7·2 | 27·4 |
| 19. Perth do., | 37 | ... | 13 | 45 | 10 | 1½ | 107 | 185 | 173 | 358 | 5 | ... | 54 | 12 | 2·7 | ... | 29·2 | 6·9 | 31·9 |
| 20. Roxburgh do., | 19½ | 15 | 30 | 8¼ | 3¼ | 3¼ | 80 | 143 | 171 | 314 | * ... | ... | 60 | ... | * ... | ... | 42·0 | ... | 42·0 |
| 21. Stirling do., | 48 | 13 | ... | 21¾ | 8¼ | 18¾ | 110 | 334 | 323 | 657 | 21 | ... | 61 | ... | 6·3 | ... | 18·3 | ... | 24·6 |

* In the Roxburgh Asylum no distinction is made between workers on agricultural land and on the grounds and garden, and all have been returned under the latter head. It is, however, understood that a considerable number of the patients were employed at times on the 19½ acres of arable land which it possesses.

Note.—Since this Return was called for the Asylums marked † have acquired additional land to the following extent:—Woodilee 206 acres, Gartloch (Glasgow District) 93 acres, Govan 146 acres, and Inverness 200.

Table 8.2 – Extent of land and outdoor employment information. Table extracted from the Forty-Sixth Annual Report of the General Board (SCL, 1904:lvii)

As discussed in Chapter Seven, the later asylum sites purchased after the 1887 Act all included a markedly bigger proportion of land than the asylum sites acquired immediately after the 1857 Act. For example, 242 acres of the 344-acre estate purchased by the Glasgow Board was arable and grazing grounds (Glasgow D. B., A.R., 1898:24), and, in

order to have safe access to the northern parts of their grounds, the Lanark Asylum constructed a bridge over the asylum railway shortly after the line's construction. Furthermore, a number of these institutions, such as the Lanark and Glasgow Asylums, constructed or purchased farm steadings within the grounds, which could be occupied by easily managed and useful male labourers. Yet it was not long until the newer (post-1887) asylums also had to obtain additional land, with the Govan Asylum leasing an adjoining farm a few years after it was opened, which extended the grounds by 145 acres (SCL, 1902).

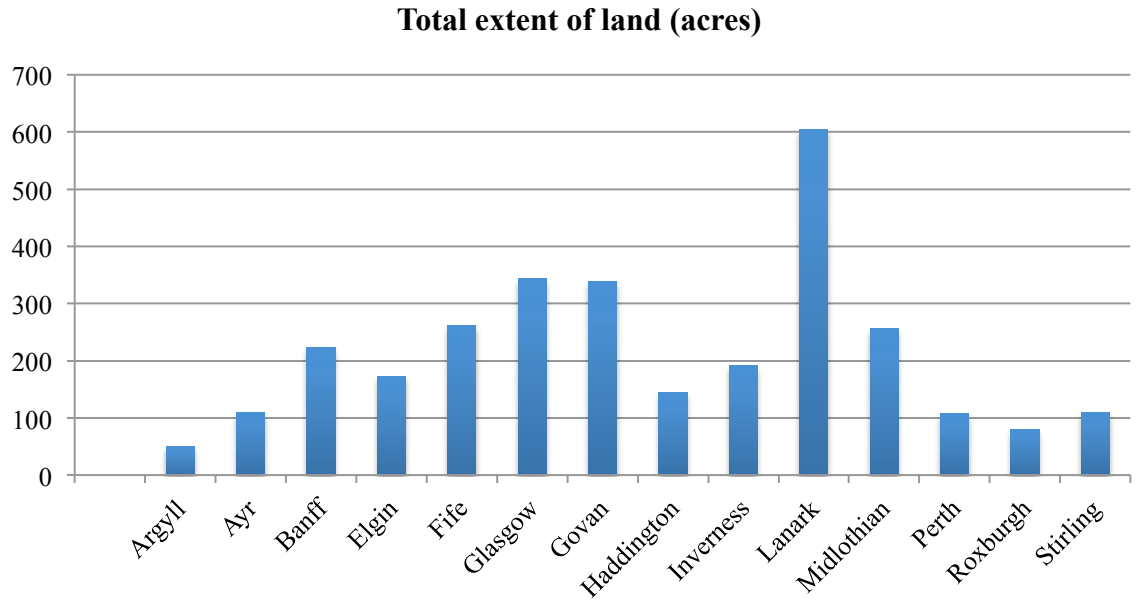


Figure 8.4 – Extent of land in acres for each district asylum site from 1901 to 1902 (SCL, 1904:lvii)[190]

In 1904, a table was published in the Annual Report of the General Board showing: the extent of land possessed by each institution and the different uses; the number of both male and female patients; and the numbers employed in farm, grounds and garden between February 1901 and February 1902 (see Table 8.2). Extracting information from this table, as shown in Figure 8.4, it can be seen that the district asylums were made up of vastly different sizes of estate at the turn of the century. The largest was the Lanark Asylum, occupying 605 acres, with the smallest, the Argyll Asylum, possessing only 50 acres. The institutions were of course designed to hold different sizes of population, and therefore of more significance is the breakdown of the land uses of the estates, shown in Figure 8.5, which confirms marked differences between each site. For example, of the Lanark Asylum's 605 acres, 324 were considered non-arable, mostly consisting of moorland, with

[190] There are less asylums shown in this figure (fourteen) compared to Table 8.2 (twenty-one) as Table 8.2 includes the royal asylums as well as Kirklands and Woodilee, which as stated previously, I have not included in my research as they were not purpose built district asylums.

the 130 acres of pasture "probably in the main of a kind which might not repay the cost of cultivation" (SCL, 1904:lviii).[191] Many of the other asylums had a "considerable extent" (SCL, 1904:lviii) of non-arable land, such as 200 acres of the Glasgow Asylum estate (66 acres in pasture and 140 acres of non-arable woodland and roads). This land was probably acquired at a cheap rate, and often secured sufficient and good quality water, opportunities for employment through reclamation, or could be used for the site of future additional buildings. The district asylums with the greatest extent of land under cultivation were the Banff, Fife, Haddington and Midlothian asylums, whereas Ayr, Perth and Roxburgh had much smaller proportions of agricultural land, with the Commissioners claiming that, "they cannot properly be regarded as possessing farms" (SCL, 1904:lviii).

TABLE II.

| Column 1. | | Column 2. | | Column 3. | |
|---|---|---|---|---|---|
| Average Maximum Number of Male Patients employed in Agricultural Work. | | Average Maximum Number of Male Patients employed on Grounds and Garden. | | Total of Columns 1 and 2. | |
| Asylums. | Percentage to Number Resident. | Asylums. | Percentage to Number Resident. | Asylums. | Percentage to Number Resident. |
| Haddington, | 47 | Lanark, | 51 | Inverness, | 59 |
| Banff, | 40 | Inverness, | 42 | Lanark, | 58 |
| Crichton, | 38 | Roxburgh, | 42 | Woodilee, | 58 |
| Elgin, | 36 | Govan, | 41 | Haddington, | 55 |
| Woodilee, | 26 | Aberdeen, | 33 | Elgin, | 51 |
| Midlothian, | 23 | Argyll, | 32 | Crichton, | 51 |
| Fife, | 23 | Woodilee, | 32 | Aberdeen, | 50 |
| Montrose, | 20 | Ayr, | 31 | Govan, | 50 |
| Kirklands, | 18 | Perth, | 29 | Banff, | 47 |
| Aberdeen, | 17 | Gartloch, | 28 | Montrose, | 44 |
| Inverness, | 17 | Edinburgh, | 25 | Gartloch, | 43 |
| Edinburgh, | 15 | Montrose, | 23 | Roxburgh, | 42 |
| Gartloch, | 15 | Dundee, | 19 | Argyll, | 42 |
| Argyll, | 10 | Stirling, | 18 | Edinburgh, | 40 |
| Govan, | 9 | Elgin, | 16 | Ayr, | 33 |
| Lanark, | 7 | Crichton, | 13 | Perth, | 32 |
| Stirling, | 6 | Haddington, | 8 | Fife, | 28 |
| Dundee, | 5 | Banff, | 7 | Midlothian, | 27 |
| Perth, | 3 | Kirklands, | 7 | Stirling, | 25 |
| Ayr, | 2 | Fife, | 6 | Kirklands, | 25 |
| Roxburgh, | * | Midlothian, | 4 | Dundee, | 24 |

* See Footnote to Table I.

Table 8.3 – Percentage of male patients employed in agricultural, ground and garden work (SCL, 1904:lvii)

[191] In 1905, 250 acres of bog land in the asylum estate was drained, which provided employment for the male patients, and resulted in a five-acre recreation field as well as cultivatable land.

As noted above, the asylums were built to occupy very different sizes of population, and therefore a further table included in the report must be consulted in order to gauge the extent to which the different grounds provided employment for the male patients (Table 8.3). Firstly, the table highlights that the percentage of patients employed in agricultural work varied greatly across the different institutions, with the Haddington Asylum providing the highest proportion of farmwork for its male patients at 47 per cent. Unsurprisingly, the asylums possessing less land per population had a lower percentage of patients employed in outdoor work. Yet, possession of a large acreage of cultivatable land did not necessarily equate to high levels of employment, as the Govan Asylum attests, employing only nine per cent of male patients (see Figure 8.5).

Combining the information on extent of land and percentage of male patients engaged in occupation, despite all of the asylums having a sufficient proportion of land given over to gardens, lawns and pleasure grounds, each institution had a markedly different number of males employed, with the Commissioners stating that "the extreme variation is as much as from four per cent of resident populations in the Midlothian to fifty-one per cent in the Lanark Asylum" (SCL, 1904:lx). It is evident from the table that asylums employing more patients in agricultural work generally employed fewer patients in the gardens, partly due to the reduced available labour force, but also because these asylums, such as Banff and Haddington, had limited grounds laid out as gardens and thus required less work. Some asylums, such as Fife, Midlothian and Stirling, employed very low numbers of patients in either type of outdoor work. Furthermore, and linking back to the previous statement about the lack of outdoor employment for females, it was revealed that the district asylums of Ayr, Banff, Edinburgh, Elgin, Govan, Inverness, Roxburgh and Stirling employed no female patients at all in outdoor work, either on the farm or in the grounds more generally:

> This is not satisfactory, as it implies that many of the women can obtain no other form of outdoor exercise throughout the year than walking through the grounds of the asylum … an exercise which, however necessary to health it may be, must soon become exceedingly monotonous and depressing. (SCL, 1904:lxii)

Therefore, although in principle the Commissioners encouraged the outdoor occupation of patients due to the reasons outlined above, in practice the individual asylums faced many hurdles in engaging patients in agricultural or grounds work:

> The soils vary in quality, and may require different methods of treatment, involving, for instance, drainage operations, which may be made to employ a large number of patients, or farm roads may require to be made, giving employment to a

number of patients out of proportion to the land under cultivation. In the other hand, new asylums like Lanark and Govan may find in their comparatively rough grounds work for their patients as useful and necessary as work on the farm. (SCL, 1904:lxiii)

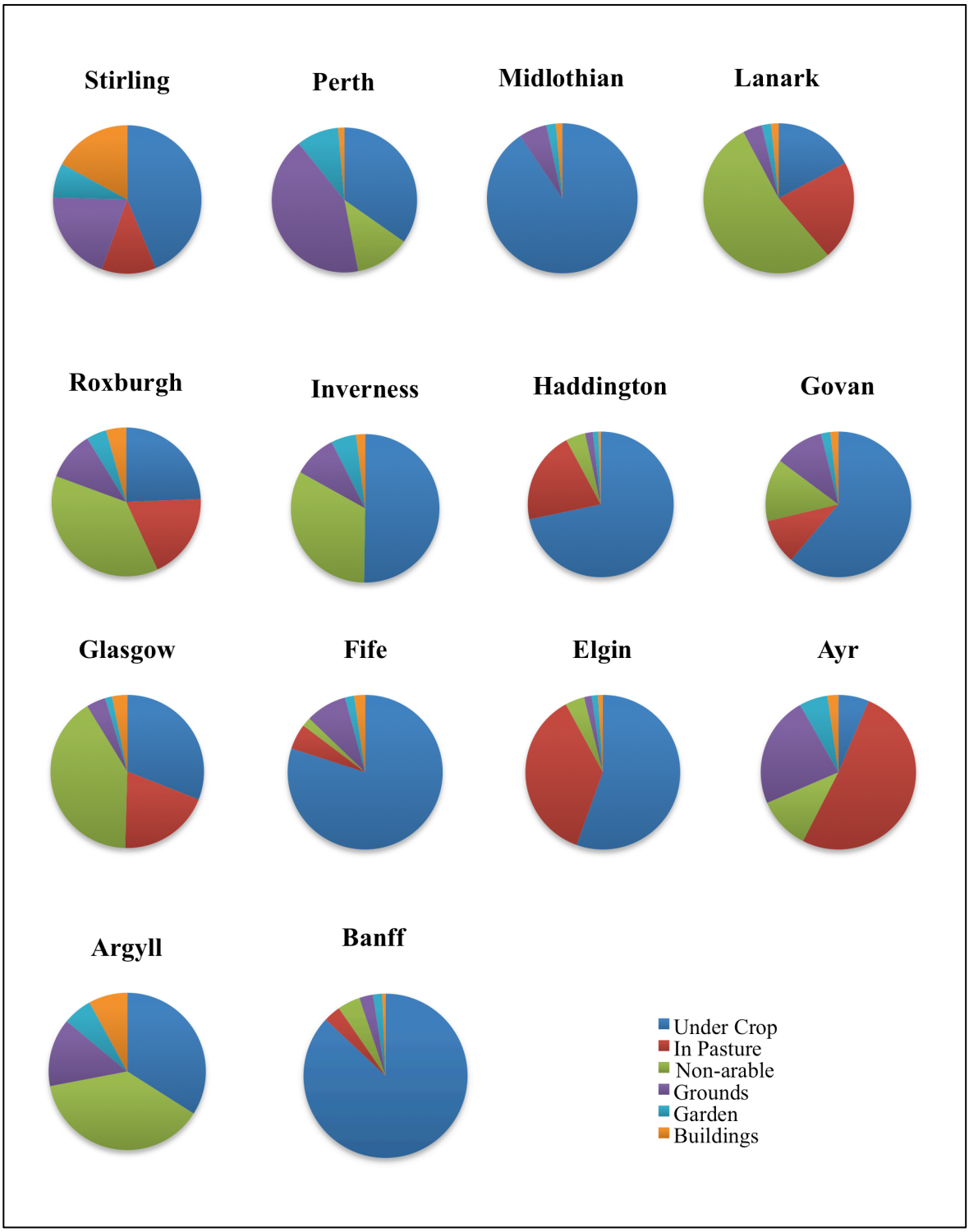


Figure 8.5 – Pie charts showing break-down of land type for each institution (SCL, 1904:lvii)

On average, the Commissioners concluded that no more than forty per cent of male patients were realistically likely to be employed in agricultural work in an asylum due to

the physical/mental capacities of the patients. Additional land, it was found, did not have any effect on this percentage:

> For most asylums an acre of arable land per male patient (or, roughly speaking, half an acre for the entire asylum population) is amply sufficient, and that though in some cases a larger holding may lead to a larger employment of patients, it cannot be hoped, even in asylums where the importance of such work is fully recognised and fostered, that a considerable increase of holding would lead to a considerable increase in the number of patients employed. (SCL, 1904:lxv)

It was nevertheless considered important that the amount of land should not fall below this level, for it then had a serious detrimental impact on the agricultural labour available for each patient and, indeed, on the economy of the institution more generally.

## CHANGES IN MANAGEMENT

As alluded in Chapter Three, as the nineteenth century progressed, placing people in asylums became more 'normalised', arguably creating an ongoing shift in the character of the asylum patients towards the inoffensive and incurable, the infirm (in body and mind) and those only suffering mild forms of insanity. In a remarkably candid acknowledgement about how admission systems were potentially being misused,[192] the Commissioners admitted that "many such persons, indeed, are sent to asylums not so much to promote their own well-being and happiness as to promote the comfort and convenience of others" (SCL, 1878:xxxi). The General Board suggested that it was this changing nature of maladies, and the expanding numbers of inmates, that caused the asylum spaces to progress in the way that they did. Added to this, in Scotland there was no strict uniformity regarding asylum structure or patient management stretching across all districts, which the General Board argued had the beneficial result of admitting and encouraging individual practices and plans of management by the different superintendents. This non-prescriptive system allowed ideas and improvements to be led by the superintendent's own experiences, permitting changes to be tailored to the specific asylum site and patient population. The Commissioners commented:

> So long as the aim is good, so long as the purpose is benevolent and honest, the intelligence of such Superintendents as preside over Scotch asylums may with safety be trusted not to propose the introduction of changes which have not a

[192] See also Donoho, 2012 for explanations of increasing asylum numbers as the nineteenth century progressed.

> reasonable prospect of attaining their end … and so it happens that many things are now considered possible and proper in the treatment of the insane, which, not long ago, would have been regarded as unsafe or improper. (SCL, 1878:xxxi)

Particularly apparent from the 1870s onwards, there was a concerted effort to remove, both from the structure of the grounds/ buildings and the inmates' life in general, "some of the more distinctive features which were deviations from the conditions of ordinary life" (SCL, 1879:xxix), ones hence deemed as restrictive to the patients' liberty. This was an extension of the changes first advocated by the likes of Pinel and Tuke at the end of the eighteenth century, which began to move away from the physical or mechanical restraint of the patient towards a more moral method of treatment achieved through subtle techniques of control.

The General Board supposed that the modifications and alterations of the asylum spaces and management of the patients was an extension of the attitudes and discourses surrounding the treatment of the insane which had prevailed for a number of years:

> All these changes are in the direction of substituting moral for physical restraint, and of relaxing the discipline of asylums in its prison aspect and introducing in its stead a greater amount of intelligent supervision and guidance. (SCL, 1879:xxx)

The Commissioners recognised that this "intelligent supervision and guidance" was best met through "artificial discipline" (SCL, 1879:xxx), which both promoted the recovery and improvement of patients, as well as enforcing order over the population, by preventing escapes and providing occupation and recreation. The asylum spaces were therefore designed in such a way as to enable the easiest, safest and most intelligent method of creating artificial 'ordinary' life through subtle forms of discipline, which were to be as invisible as possible to the patients. As the Commissioners remarked, "the more a patient can be made to feel himself a voluntary agent rather than a person under tutelage, the more may his mental state be expected to be healthy" (SCL, 1879:xxxi). A practical reason that made this possible was the possession of ever-greater extents of land by the asylums, as outlined above, which had further-reaching consequences than just the employment of male patients in agricultural labour. As the Commissioners noted in their final report, the extra grounds acquired since 1857:

> … facilitated the introduction of other changes which were not contemplated in the early years of Scottish lunacy administration or by the persons who acquired the land. In addition to the arable farm land, gardens, and land actually occupied by the site of buildings, the 21 asylums referred to possessed pasture land, woods, and

> grounds amounting to 2,015 acres, which gave an average of 100 acres to each asylum for open air exercise and recreation alone, and irrespective of arable land. When an asylum is built surrounded by 250 acres of land it is of course found impossible, at any rate inexpedient, to surround the estate with fences or walls. (SCL, 1914:xc-xci)

Changes to the grounds of the institutions hence included the destruction of the airing court walls, the removal of high boundary fences, it simply not being practical to extend such fences to incorporate growing estates, as well as increased outdoor exercise, recreation and occupation in the newly configured asylum spaces. The overall aim was creating an increasingly refined method of managing asylum populations with an enhanced sense of 'freedom' for the patients. Another of these changes, indicated by the General Board in 1878, was the apparent decrease in the consumption of stimulants for the treatment and management of the patients. The Commissioners speculated that this change could be due to the increased attention given to "exercise and occupation in the open air, the greater tranquillity and contentment of the patients, and the more careful consideration which is given to the preparation of the food and to the varying of the dietary" (SCL, 1878:xxxiv),[193] all made possible through the expanding estates, the increased farming and closer supervision. As far as possible, the asylum was to be organised as an 'industrial community' as found in 'ordinary' life, predominantly organised through altering restrictions on the patients' liberty, producing instead an *apparent* sense of freedom, conducted through increasingly 'invisible' control methods.

### *Walled Airing Courts and Boundary Fences*

The first significant alteration in the arrangement of the asylum grounds after the 1857 Act was discussed in the Seventeenth Report of the General Board. Previously, it was deemed necessary that asylums be provided with walled airing courts to allow patients (particularly those suffering from maniacal excitement) outdoor exercise in a controlled, safe environment (see Figure 8.6). Yet, as the nineteenth century progressed, it was increasingly recognised that "the association, in confined areas, of patients in this state, whether with one another, or with other patients in calmer mental states, is attended with various disadvantages" (SCL, 1881:xxxii). Giving 'excited' patients more space, and in more direct contact with the attendants, was seen remarkably to reduce their maniacal episodes. Furthermore, the confined areas were increasingly considered to be a form of mechanical

[193] It was also recognised the reduction of narcotics could be due to a change in the opinion of medical men, yet this was a secondary point to the more strongly argued increase in the use of outdoor space.

restraint, especially the smaller airing courts, although all forms were gradually to be viewed as spaces of detention and thus against the principles of moral treatment. The exercise that could be taken in airing courts was in many instances "nothing more than lounging about … a dreary, cheerless, unexhilarating business" (SCL, 1878:xxxiv). It was therefore argued that "their disuse would be a widening of the idea and practice of non-restraint, which, perhaps erroneously, has been held to refer only to such things as belts, muffs, and strait-jackets" (SCL, 1875:lvi). This sense of widening the conception of 'non-restraint', to include removing spatial barriers such as walls, would require increasing vigilance on behalf of the attendants in order to continue the successful control of the patient population.


Figure 8.6 – District Asylum, Inverness, *Ordnance Survey,* 2nd edition, 1868 ©nls (Darragh, 2011b:127). Plan of Inverness Asylum showing position of walled airing-courts in 1868 before they were pulled down in 1873. Although the quality of the image is not good, the small size of the spaces is clearly evident, and it would have undoubtedly emitted prison-like feelings.

Although the Commissioners did view some advantages in free access to these spaces by the patients, which they argued aided the contentment, comfort and health of the inmates, the superintendents regarded them as unnecessary, partly as a response to the growing acceptance and evidence that patients could be healthfully and safely managed in private dwellings. Thus, Scottish asylums were to be increasingly brought in line with the idea of the 'ordinary' dwelling, with the abolishment of the airing courts, and gradually, the outer walls and fences, "a feature of asylum construction and management to which … prevails

in no other country" (SCL, 1877:xxvi). Yet, the Commissioners did not explicitly recommend the abolition of walled-airing courts, but rather the change of practice was due to the experience and opinions of the asylum superintendents, resulting in the abandonment of first the smaller and then the larger walled airing courts. A direct consequence of the abolition of the walls was the increased liberty of a greater number of patients, who were able to take exercise and parole within, and often beyond, the greater asylum grounds. Accordingly, the General Board considered that "many inmates of asylums have almost as much personal freedom as they could have if they were in their own houses" (SCL, 1878:xxxiii).

As such, the Haddington Asylum, opened in 1866, although its authorities having taken the time, space and expense to construct walled airing courts, never put them into use, instead converting them into a vegetable garden and a poultry yard within the original walls. The walls finally began to be pulled down in 1877, with one area converted into a flower garden for the aesthetic pleasure of the patients both within this outdoor space and for the decoration of the wards with cut flowers. The other space, initially used as a poultry yard, which was of "considerable interest to the patients" (Haddington D.B., P.B., 1873:np), was finally converted into a 'pleasure-ground' a few years later.

The first asylum permanently to do away with the walled airing courts was the Argyll and Bute Asylum, which, after its expansion in 1868, never reconstructed the structures. It was originally intended to replace the walls; but, after the superintendent, Dr Sibbald, recognised that the management of the patients was not detrimentally affected by their removal, it was recommended that they should not be rebuilt. Dr Aitken, superintendent of the Inverness Asylum, followed suit in 1873 by symbolically pulling down the walls of the airing courts, showing his confidence that they were no longer of use to his institution. Around the same time, both the Perth and Fife and Kinross Asylums ceased sending patients to their airing courts, although initially did not go as far as pulling down the structures, with Dr McIntosh at Perth intending instead to make use of the space by turning it into a covered winter garden. Other asylums closely followed suit, with some lowering the walls, and others replacing them with fences. Not all were able to remove the walls completely, due to their close proximity to urban settlements and "intrusive observation from the public" (SCL, 1881:xxxii), although this issue was less pertinent in the case of the district asylums, which had generally been constructed a suitable distance away from towns. This situation was evident at the Ayr Asylum, however, where only the walls of the female airing courts were completely removed, and only one wall of the male airing court.

The retention of walls here was an attempt to stop this part of the grounds being overlooked by the public from the high road. Despite some walls still existing around the male court, the space was nonetheless reported to be as open as the female side, with both courts forming sections of the terrace surrounding the asylum (Ayr D.B., A.R. 1880:14).

The Commissioners reported in 1876 that:

> It is probable that nowhere in Scotland would walled airing-courts now form a part of the plan of a new asylum, so decidedly is experience held to have shown that their disuse is an advantage. So far as we are aware, the feature of asylum construction and management to which we here refer prevails in no other country. (SCL, 1876:xxvi)

Showing further extension of the principles of non-restraint, it was also remarked that nearly all of the district asylums constructed after the 1857 Act were without external boundary walls or fences,[194] with the Commissioners' opinion being that:

> If these changes have not increased the number of escapes, it must be due either to a better supervision, or to an abatement of the desire to escape by the removal of erections obviously designed to serve as obstacles. (SCL, 1875:lvi)

The desired affective response to removing the walls was, therefore, to produce a greater feeling of liberty, of not being confined forcibly which would in principle result in fewer escape attempts.[195] Following this lead, any asylums that had constructed walls and fences began their removal. The Midlothian and Peebles Asylum reported in 1877 that they were planning "to remove even the light garden fence" (SCL, 1877:xxxiv) which, it was remarked, limited the open courts in front of the asylum. Despite the removal of the fences, as well as the airing court walls, it was documented that sixty-five of the eighty-four female patients were allowed to leave the day-rooms at their own pleasure, freely accessing the general grounds unattended, which, it was found, still resulted in infrequent escapes. Similarly, the Perth Asylum considerably increased the extent of the unfenced area of land to the front of the asylum. In 1907 it was noted with approval that the Roxburgh Asylum had removed "the high massive iron railing which surrounded the exercise court", replacing it with "an ornamental fence" (SCL, 1907:xxxix) which was much more aesthetically pleasing. No boundary walls or entrance gates were ever built at the large

[194] The Commissioners did not make it clear which institutions never had external boundary walls, and which removed the walls at a later date; although the Centenary pamphlet for Inverness alluded that this asylum never built a boundary wall.

[195] See Foucault (1977) for a discussion of Mettray's lack of external walls and why there were so few escape attempts.

estate that made up the Edinburgh Asylum, despite the grounds being bounded on two sides by public roads.[196]

Despite the relaxation in the use of walled airing courts and boundary walls and fences, the low overall number of escapes was noted on a regular basis as *not* being affected by the changing arrangements. The Commissioners further remarked that "the increased population of asylums makes the diminution greater than the figures indicate when they are considered without this increase in view", a claim of particular significance when it is kept in mind that patients generally enjoyed greater freedoms of liberty than was previously the case. Excerpts from two newspapers reporting on the Aberdeen Asylum provide a vignette that neatly summarises the liberty of the patients and the attitude of one asylum worker at this institution in the early-twentieth century. It was stated that, at this asylum, the patients freely walked among the gardens of the institution, and that there was no "forbidding wall" which would have given a "prison-like appearance" (*Daily Journal*, 19/07/1905:np). A reporter from the Evening Gazette asked a workman on the grounds whether the patients ever attempted to run away, with the workman replying, "Na … they dinna ken whau ti rin. Ye see, there's nae dykes here, an' they dinna ken when they're in an' when they're oot" (*Evening Gazette*, 06/06/1906:np). Roughly translated from northern Scots, this reads 'No, they do not know where to run. You see, there are no walls here, and they do not know when they are in and when they are out' [of the asylum estate]. This highlights the complex issue of not necessarily knowing exactly where the asylum estate ends, as there were no obvious boundary-markings.

### *Liberty on Parole*

This liberty was further extended by the increasing move to allow certain patients to work and walk within the grounds without being under constant supervision. Extending these freedoms even more, a number of patients were permitted to move beyond the asylum boundaries for the purpose of exercise, visiting friends and attending worship:

> The practice of allowing the inmates of asylums to attend places of public worship is becoming much more general, and so also is the practice of allowing them to be absent for a few days from the asylum on pass, for the purpose of visiting friends.

[196] A later report considered this is a drawback, as, particularly on Sundays in summer time, people from the near-by villages would "come to satisfy an idle curiosity by watching the patients" (Edinburgh D.B., A.R, 1912:19). This is a different but intriguing issue, and does reference another reason for walls (not to prevent escapes but being over-seen by the public), which is a 'locational' issue noted by the English Commissioners. The suggested solution in this instance was that the road be closed to the public, diverting traffic to a different road further west of the institution.

> Such visits give pleasure and increase contentment, and rarely do harm. (SCL, 1878:xxxiii)

The superintendents viewed this removal of restrictions favourably, noticing the benefits to the patients' behaviour and well-being, with the practice having the effect of "making their residence in an asylum less irksome, [and] also by improving their mental condition" (SCL, 1881:xxxiv). Contrariwise, they were generally of the opinion that greater limitations and control over the patients in order to prevent accidents had a detrimental effect on the health of the population, although they did state that "the adoption or rejection of any restrictive measure must … be settled by carefully weighing both its advantages and its disadvantages" (SCL, 1881:xxxiv). An example is shown by the Roxburgh Asylum, where, weather permitting, the Saturday half-holiday was always spent outside. The asylum was given permission by their neighbour, Mr Turnbull, to access the slopes of the Eildon Hills, and it was claimed that it was not unusual for around one hundred patients, equal numbers of males and females, to be seen "scrambling or basking, with a back-look over one of the most charming prospects in the south of Scotland" (Roxburgh D.B., A.R., 1874:13).

After close examination, and similar to the abolition of the walls and fences as outlined above, the removal of restrictions on liberty through the increasing use of 'parole' did not appear to result in more escapes and accidents. It was even found, due to the freer condition of the patients' lives, to result in greater calm and orderly behaviour, as:

> The imprisonment in wards under lock and key, the confinement within high-walled airing-courts, and even the feeling of being under the constant supervision of attendants, were sources of irritation and excitement and causes of violent conduct. (SCL, 1881:xxxiv-xxxv)

The Commissioners recognised, however, that the move relied on improved attention to the individual condition and character of patients. As they stated, "it is only after a careful study of the disposition and tendencies of a patient that a trustworthy opinion can be formed as to the amount of liberty that he [or she] is fit to enjoy" (SCL, 1881:xxxiv). This was to be achieved through what the Commissioners called the "intelligent observation" of the patient from the moment that he or she arrived in the asylum and throughout their stay by the superintendent and, also increasingly, by the attendants:

> The general effect of the change of system is to raise the position of the attendants from being mere servants who carry out more or less efficiently the orders of the superintendent, to that of persons who have a direct interest in promoting the

> improvement of the patients, and who find it an advantage to themselves to carry out, to the best of their ability, whatever instructions they receive, with that end in view. A good attendant must always have had more or less of this character, it is true; but even good attendants are stimulated under the freer system to become better still. (SCL, 1881:xxxv)

Thus, the changing system, alterations to the use of outer space and the relaxation of restrictions on liberty were all deeply embedded within the shifting discourses of treatment. Increased power was given to the attendants, ultimately spreading the system of control more evenly across the institution. The attendants were to become extensions of the superintendent's gaze, consequently allowing a perceived greater sense of freedom among the patients. The crucial caveat was that this 'freedom' was only possible through more intricate yet invisible forms of control, and was essentially only available to a certain 'type' of patient. As more manageable, incurable and docile patients gradually occupied the asylums, despite the constant push to board-out such persons, it was inevitable that restrictions on liberty could be relaxed. Yet, the Commissioners championed the movement as an extension of the humane, moral treatment, only possible through the individualisation of patients and careful micro-management of space.

### *The Division of the Industrial and Medical sections: "The two great functions of asylums"*[197]

Although the tendency spatially to separate out the "two great functions" was a fundamentally new *internal* asylum geography, and therefore predominantly explored in Chapter Nine, the later-nineteenth century separation of the 'industrial' and 'medical' (or 'hospital') spaces of the asylum rebounded upon patient labour in the grounds. As has been hinted, industrial work was not appropriate for all asylum patients, with a number not able to be engaged in physical occupation due, predominantly, to physical weaknesses.[198] The general solution in these cases was to move these patients to the infirmary or, in later years, to the hospital section of the institution, which was also reserved for patients who required specific medical treatment for their maladies (see Chapter Nine). This separation of the 'industrial' and 'hospital' sections of the asylum was an important move in the care and

[197] SCL, 1892:xlvi.

[198] Although of less relevance to the district asylums, whose population was drawn predominantly from the pauper classes, it is worthy of note that particular difficulty was met when trying to engage private patients in physical work, particularly when the attendants were from a lower social class. This situation, it was recorded, often prevented "many patients from yielding to useful suggestions from attendants, merely because they regard the persons giving them as being in the position of servants" (SCL, 1881:xxxvi).

treatment of the patients as, in order to determine who was fit to perform industrial labour, the individual inspection of the patients was increased:

> Indeed, in some of the asylums where the industrial system is more fully developed, it is the practice to place all patients who are unfit for work in the hospital section of the establishment during the day; and in order that this may be systematically done there is a regular morning parade at which a medical inspection takes place, and all patients about whose fitness any doubt is suggested are examined and if necessary relegated to the hospital. (SCL, 1881:xxxvii)

Ironically, therefore, many who were *incapable* of work on 'mental' grounds were potentially more *curable* (acute, manic cases, rather than chronic, melancholic cases). This was a very clear *new* division around issues of capability for labour, and, as it was imperative that the two sections of the institution were administratively connected, it was highly likely that this resulted in some patients slipping back and forth between the two categories/sections.

Unfortunately, however, with this system of separate divisions, and the ever-growing sizes of the institutions, the Commissioners reported that it appeared to result in "an inducement to retain in [the asylum] a larger and larger number of useful working patients whose services help to lower the cost of maintaining the establishment" (SCL, 1905:lxxviii). Furthermore, the growth in numbers had a detrimental affect on the individualisation of patients, particularly within the industrial section, as the working patients became 'cogs' in the asylum machine, central to its functioning as an economically viable institution. Despite the daily assessment of hospital patients, it was found over time that less attention was being given to each patient in the industrial section, and so crucial moments when discharge may have been possible were often missed. This then increasingly resulted in patients becoming less adapted to ordinary life, instead becoming "moulded" (SCL, 1905:lxxviii) into institutional life.

***Inverness District Asylum site visit:***

*I have just spent the day in the Highland archive centre, reading annual reports for the Inverness District Asylum. Unlike my previous visit when I arrived by train, this time I have driven up in my mum's car. On returning to the car, I have a thought, perhaps I should have a little look around the old Inverness asylum site, a short drive up the hill from where I am just now. I pull over, and have a quick look on my phone to confirm the directions. I then set off, and start winding my way up the hill, through a number of modern housing estates. I guess I'm probably about five miles from the city centre. A bus drives by, taking people down the hill and into town. I see a sign for 'New Craigs', the new psychiatric unit built in the grounds of the old asylum. I indicate and turn, glimpsing a sight of the modern, low-lying building on my left. Continuing forward, a tall white construction fence lies to my left, shielding the land behind. New pavements and street lamps line either side of the road. Attached to one is a bright yellow SNP sign. A young woman pushing a pram is walking along the pavement towards me. Perhaps she lives in the modern housing estate that lies ahead.*

*I'd heard local rumours that the old asylum site was in the process of conversion into flats, following a fire a few years after it had closed. It appears that the process has resumed, with small cranes and temporary work offices tucked behind the fence. The old asylum buildings themselves have been stripped of windows, perhaps by the fire, or maybe as part of the conversion process. Flags flutter softly in the breeze advertising the company responsible for the alterations. The Victorian building is extensive, stretching for hundreds of meters with no apparent breaks in the structure. I reach a roundabout, taking a right leads to the new housing estate, straight on towards thick woods, and left appears to lead to the front of the old asylum building. I take the first exit, following the road which eventually leads to the end of the old asylum. The last section has been fully converted, perhaps providing show homes, or a more permanent site office. The whole place feels sanitised, scrubbed of its previous use and history.*

*I park the car, and get out for a stroll. Moving round to the front of the building, I realise how much height I have gained, the countryside stretches below to the south and I imagine that, during winter, the place would have felt very exposed and cold. It's no wonder the General Board suggested that many trees be planted to try to shelter the site and the patients. Some of these, bought with money donated by local benefactors, are probably still standing, as many tall, mature trees lie in a forest to my right. I return to the car, thinking through the reports I have read that day in the archive, and the impact the decisions had on the buildings, grounds and patients. I think also about the new inhabitants, what use they will make of the extensive woodlands, and how they will feel perched on the side of Craig Dunain hill during a particularly harsh Highland winter.*

## CONCLUSIONS

As shown throughout this chapter, the asylum grounds were continually adapted and expanded as discourses around treatment of the insane, and the characteristics of the asylum population, progressed through the decades after the *Lunacy (Scotland) Act*, 1857. The Commissioners and asylum staff, and in particular the medical superintendents, utilised the outdoor space of the asylums in a manner that benefited the management and treatment of the patients, as well as the economy of the institution, in order to achieve two different functions: the most efficient machine for the treatment of insanity and the control of the asylum population. They were able to manipulate the affective power of the environment to control the patients, which, conjoined with the individualised management of the patients, ultimately enabled the removal of more subtle forms of mechanical restraint, such as the airing court walls. The walls were pulled down in a gesture that echoed the late-eighteenth century metaphorical removal of the chains by Pinel at Bicêtre. The more subtle methods of control, such as the improved opportunities for engaging the mind through wider occupation and recreation, were central in reconfiguring the asylum grounds:

> Each of these changes has been a distinct improvement, and has conferred important benefits on the insane; but the effect of each has been made much more complete from the support if has obtained by being associated with the others. For instance, the removal of restrictions upon liberty could not have been carried so far, had steps not been taken to engage the energies of the patients in such occupations as tend both to check the morbid current of their thoughts, and to prevent them from fretting at the control to which they must always be more or less subjected; while it is no less true, that the comforts with which they are now surrounded render them both more able and more willing to engage in health occupations." (SCL, 1880:xxx)

Through mimicking, as far as possible, 'ordinary' life, the patients were encouraged to 'act' as members of a sane community, particularly through employment on the cultivatable land:

> One of the results, indeed, of the removal of the restrictions to which we have drawn attention, is to assimilate the asylum community in many ways more to the condition of ordinary society than it could previously have been; and this is true largely of its industrial condition. Those persons who require, on account of their health, to be relieved of work are placed under special medical supervision, while those who can work have every inducement to engage in it. (SCL, 1881:xxxvii)

Demonstrably, the extension of, as Foucault recognises it, the superintendent's 'will' over the patients' 'will' enabled the extension of the principles of non-restraint. Furthermore, directly correlating to the arguments laid out in PP, in order to maintain control over the asylum population the institution had to retain its spatial separation from ordinary society, yet mirror this society as fully as possible. Taking Foucault's understanding further, it has been shown how the superintendents and the Commissioners exploited the affective powers of the environment, not only through the physical setting and the landscape of the institution, but through actively tailoring the site: for example, by the planting of gardens and constructing walkways, with the purpose of creating an aesthetic groundscape capable of affecting the emotional responses of the patient. Principally, this was in order to generate 'docile' individuals who were more easily managed. These individuals could be absorbed in agricultural employment, which further encouraged their docility and, it was hoped, their cure, through engaging the mind in useful work.

Yet over time, potentially 'curable' patients, who tended to be those suffering from physical ailments or weaknesses (including those ostensibly more *acutely* mentally unwell), were sent to the hospital division of the institution. This heralded a 'splitting apart' of the asylum grounds, buildings and patients into two distinct sections – the 'curable' and 'incurable' – with the latter group becoming ever more important in the day-to-day workings of the agricultural section of the institution, arguably resulting in some patients being retained in the asylum in order for it to continue functioning as an institution. The division separated the institution into a 'curative' machine and an 'agricultural' machine, with two separate affective spaces being increasingly arranged/engineered differently: on the one hand, an environment that had the ability to 'cure', which was an increasingly medicalised space; and on the other, a 'home-like' environment for long-stay patients, progressively needed for the agricultural day-to-day running of the institution. It was not, therefore, as Foucault recognises in PP, a complex medical division demarcated by different illness. The creation of these two affective spaces within the grounds of the asylum has been explored in this chapter, with the following chapter investigating this division further through the engineering of the buildings and the architectural spaces of the institution.

# Chapter 9

# Spatial Themes III: Buildings

## INTRODUCTION

> The treatment of the insane is conducted not only *in*, but *by*, the asylum. (Fairless, 1861:7, original emphasis)
>
> The history of the construction of asylums is … interesting, because we find in the changes that have been effected in the arrangements of these institutions a reflection of the successive stages in the development of one of the most humane phases of modern civilisation. (Sibbald, 1897:5)

Similarly to the grounds of the institution, the asylum buildings were viewed as a crucial device in treating and managing the insane. Although buildings had long been used to constrain and segregate the mad, by the nineteenth century it was recognised that they could be designed and manipulated in such a way so as to classify populations, enabling more tailored management and treatment, and could also be engineered to produce certain behaviours within the population.[199] Consequently, they were viewed as a powerful tool, central to controlling and producing docile bodies within the carefully planned spaces. The asylums constructed after the *Lunacy (Scotland) Act*, 1857, were one stage in a long trajectory of institutional design. The General and district boards clearly took inspiration from the buildings preceding the Act; advancing, modernising and tailoring the royal asylum and poorhouse plans, learning from their deficiencies and manipulating designs to create buildings that would be fit for purpose. The buildings' goal was the safe incarceration of a specific population, but also they needed to be both functional and curative spaces, with the ability to exert diverse influences over the patients. The buildings were also designed to make the attendance, observation and nursing of the patients within the institution as efficient as possible, with the architecture and the staff working together to achieve two goals: the discharge of curable patients; and the creation of a homelike environment for long-stay, incurable patients. These goals arguably fitted together

[199] See also Tomes' (1994) book on 'moral architectures' and T.S. Kirkbride (the American version of the Tukes in England) and Topp *et al*.'s (2012) text *Madness, Architecture and the Built Environment* for further work on the use of architecture in treating/controlling the mad in the nineteenth century.

somewhat awkwardly: a point of tension and fragmentation that was recurrently to play out in the design and practices.

The following chapter will look in detail at the Commissioners' ideal blueprint for the building design and layout in 1857, before moving to describe the early district asylums that were built in the 1860s. These were inevitably heavily influenced by the Commissioners' vision, and consequently were all very similar in design, with the key, common feature being the single T- or E- shaped central block. Yet, as the asylum populations continued to increase, as shown in Chapter Six, the district boards inevitably had to expand the accommodation. As a result of the tendency to retain incurable patients within the institution, and as families started to send more of this type to the asylum, the additional buildings constructed were, initially, detached, simple constructions, suitable for harmless long-stay inhabitants, often functioning as self-contained communities within the wider institution. This can be viewed as the first step towards the splitting-up of the asylum spaces, as alluded to in Chapter Eight, which was accelerated by the creeping recognition that the asylums needed to adapt to incorporate advances to the medical treatment of insanity. As the original infirmary wards became over-crowded with 'incurable' patients, alongside the recognition that asylum spaces should also include comfortable surroundings for long-stay residents, the Commissioners advocated the construction of completely detached hospital sections in an attempt to install conditions that more closely resembled general hospitals. Crucially there was, therefore, the emergence of a sharp divergence of visions/roles that linked to different spatial requirements within the institutions. Similarly to Chapter Eight, examples are drawn from the different district asylums in order to understand the evolution of the buildings through the decades, which were influenced by both the changing and ever-growing asylum population, and the altering discourses around the treatment of insanity. Attention will be drawn to both the overall layout of the buildings, but also the more micro-spatial internal arrangements, which were central to the management and control of the population and the functioning of the institution.

Before continuing, clarification needs to be given to the proliferation of terms being used to describe different sets of physical spaces in the asylum – 'sections', 'parts', 'sides', 'blocks', 'villas' and so on were all being deployed in the archival documentation. There was, however, an order to these terms and a *hierarchy* of 'divisions'. Sections and sides tended to refer to different parts of the institution, but then there were obviously various subdivisions of these sides and sections, along, for example, gender lines, diagnosis lines, and so on. Blocks, units and villas refer to the physical buildings as functional structures

(such as accommodation and administration blocks, laboratories, mortuaries, and so on). Crucially, there were varied/overlaying spatial components throughout the institution; for example, sections and sides would be found *within* and *between* blocks and units.

## COMMISSIONERS' BLUEPRINT AND RECOMMENDATIONS

Following confirmation that asylums were to be constructed in districts that did not possess suitable 'existing accommodation', many of the district boards applied for model plans to guide the architects in the designs of the new institutions. Initially, the General Board thought this a plausible idea, but after some consideration felt that providing such information "might fetter the energies of proposing competitors" (SCL, 1859:xii). So, instead they outlined the "broad principles" by which they believed asylums ought to be constructed, thus leaving "the working out of the practical details to minds unbiased by models" (SCL, 1859:xii). They hence provided the most general of blueprints, rather than engaging in micro-specifications, which consequently allowed a diversity of actual asylums to appear on the landscape. As stated previously, this information was included in Appendix C of the First Report, and it provides the first evidence for what the Commissioners' believed to be the ideal district asylum, guiding the district boards rather than giving specific details for each individual site.[200]

The district boards and their appointed architects were guided by the following "broad principles" put forward by the General Board, which, similarly to siting and grounds, closely matched the suggestions put forward by the English Commissioners in Lunacy, but, according to Darragh (2011a:209), "seemed to afford greater choice and flexibility".[201] The Commissioners believed that the buildings, to be used predominantly for pauper patients, should achieve a cheerful and attractive appearance, as far as economy would allow, although with no unessential external decoration (and therefore being much simpler in character than the royal asylums). Also, it was recommended that the main buildings should not exceed three storeys, with each storey not less than eleven feet high.[202] Echoing

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[200] In the Third Annual Report (SCL, 1861), correspondence between the Argyll District Board and the General Board included in the appendix claims that the Commissioners believed that these suggestions should have been modified when the districts were further divided. The Argyll District Board requested new "suggestions and instructions" be circulated, but this never occurred, and reference to any disagreements or changes were not mentioned in the main body of the reports.

[201] For example, information such as placing windows not more than four feet from the floor, and directions as to attendants' rooms, were omitted from the Scottish guidelines.

[202] The reasons for these specifications were not made clear, but it could range from fears of patient suicides by jumping to attempts at creating smaller, less imposing structures.

Browne's belief that the architectural spaces of the asylum could be manipulated to allow for the complex classification of different types of maladies through the structural differentiation of space, it was deemed important that the structure of the buildings allowed the separation of males and females of different classes – idiotic, imbecile and fatuous patients; and chronic patients – with the numbers in each class being such that they would only require two attendants per unit. The section for working patients should entail detached cheap and simple buildings, with the males close to the workshops and farm buildings and the females close to the wash-house and laundry. Similar simple and inexpensive buildings were recommended for the other two classes of patients.

The main service buildings (kitchen, scullery, wash-house, laundry, workshops and store rooms) were to be conveniently placed, and made spacious in case of expansion in the overall number of patients in future years. Furthermore, a general dining hall (close to the kitchen), a library and a reading room were all recommended, "capable of serving the general purposes of instruction and recreation" (SCL, 1859:116). It was also suggested that a church be constructed, as close to a normal chapel as possible, with no special arrangement for separating the sexes. Residences for the medical superintendent (with a separate kitchen), assistant medical officers and pupils, the steward, the matron and appropriate sleeping accommodation for the domestic servants were also necessary. Regarding lunacy accommodation, the proportion of single rooms did not have to exceed one third, and should be situated predominantly in the wards set aside for the excitable, sick and patients of dirty habits. These rooms should be not less than nine feet by seven feet, and eleven feet high, with some specifically for the physically sick, which should be slightly larger and provided with a fireplace. The doors of these rooms should open outwards, and be hung so as to fall towards the wall when open, rather than closing automatically. General bedrooms must have no less than six, and no more than fourteen, beds per room, with not less than fifty square feet per bed.

Rather than wide corridors, the "passages of communication" (SCL, 1859:116) should be of moderate width, with the dayrooms and dormitories placed on one side and to the south, so as to frame the southern aspect in the windows of these rooms. In some cases, it was possible that these rooms might take up the whole width of the building, but it was requested that the buildings, for both circulation and surveillance, should be laid out so that the medical officer, attendants and others "may pass through from one part to another without necessarily retracing their steps" (SCL, 1859:116). There should be at least one dayroom per ward, providing not less than twenty square feet for each patient, with the

windows of these rooms, as well as the corridors, being "large and of a cheerful character", easily opened with the purpose of providing the circulation of air, but not so as to put the patients at danger (by falling or jumping out). Flues were recommended for ventilation; and, where smoke flues were used, they should be constructed entirely of brick. Heating all rooms should be through open fireplaces, with large rooms requiring two fires. Further detailed recommendations included good quality wooden floors in the day and sleeping rooms, fireproof separation of the timbers in the roof, and Roman cement[203] generally being used to plaster the walls. The internal stairs were to be built of stone and provided with handrails. For safety reasons, winders and long straight flights were both to be avoided, with the central well to be built up. Rainwater was to be collected in tanks placed close to the wash-houses, and the rainwater pipes were to have lightning conductors attached to them.

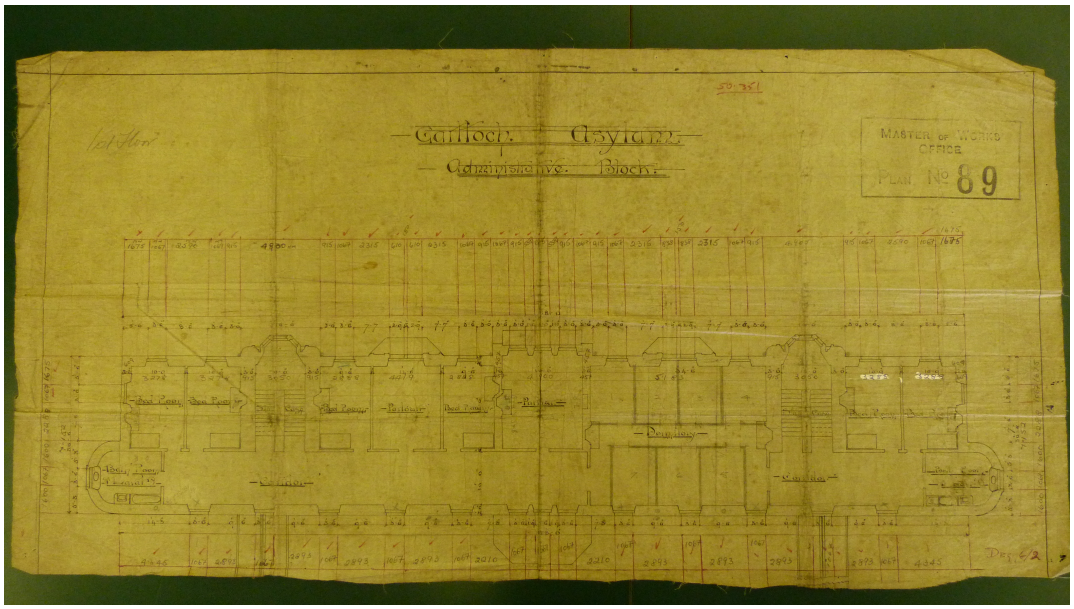


Figure 9.1 – Plan of Glasgow Asylum Administration Block held in the NHS GGCA collection. Although very faded, it was possible to make out the measurements, which can be seen faintly in red (own photograph, 2012).

Initially, the General Board strongly advocated the construction of "small asylums in convenient locations" (SCL, 1860:x). This was not only so as they could be accessible to the majority of a district's population, as discussed in Chapter Seven, but also because it was understood that "the aggregation of the insane in large masses greatly increases the difficulty of providing for their proper care and treatment" (SCL, 1860:x). This preference had direct consequences for the asylums constructed shortly after the 1857 Act, and

[203] Roman cement was a 'natural cement' developed in the late-eighteenth century by James Parker. It was made by burning clay deposits containing clay minerals and calcium carbonate, which were then ground to a fine powder and, when mixed with sand and water, set in less than fifteen minutes.

inevitably, along with the other guidelines, had to be kept in mind by the architects submitting plans for selection and recommendation. The Commissioners indicated:

> In large asylums generally, it is too frequently the case that the demented patients suffer not perhaps so much from being inadequately clothed or fed, as from not receiving that degree of individual attention that would be extended to them in smaller communities. No sufficient efforts are made for their occupation and exercise. In this respect large asylums are real evils. (SCL, 1869:xli)

These initial recommendations were evidently driven by the mid-ninteenth century discourses surrounding treatment and care held by the General Board, and were summarised by Commissioner Coxe:[204]

> As a rule recovery from insanity is due far more to attention to the rules of hygiene than to any peculiarity in the treatment. In supplying abundance of food and clothing, in providing comfortable lodging and in giving proper attention to cleanliness, and in affording ample means of occupation and exercise in the open air, lies the great secret of the successful treatment of insanity. (SCL, 1914:lxxxix)

There was clearly no 'magic' formula here, but rather a simple and practical insistence on comfort and cleanliness. Consequently, the architects, sometimes found through competition,[205] had to work with the district boards to work out the practical details of an asylum, and hence to put together plans for the approval of the General Board. These plans were to include: an Ordnance map outlining the county, borough or district in which the asylum was to be constructed, with the purpose of showing the situation of the proposed institution, particularly in relation to public roads and footpaths; a general plan of the land, outlining the block of buildings and the exercise grounds, garden and approach road; floor plans of all the buildings; elevations of the buildings, particularly the principal front; and transverse and longitudinal sections to show the construction of every part of the building (see Figure 9.1).[206] Further plans and sections showing proportions, methods of warming and ventilation of a sleeping room, dormitory, washing room and eating and day room were also to be enclosed, as well as draft contracts and detailed estimates of costs.[207] Each

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[204] Sir James Coxe was one of the first members of the General Board of Lunacy, but this quote was from his Presidential address to the Medico-Psychological Association in 1872, recalled in the final Lunacy Commissioners' Report, 1914.

[205] The Argyll, Inverness, Banff, Fife and Kinross, Ayr and Roxburgh District Boards all held a competition to find their architect.

[206] From these requirements, it can be assumed that a district board had already selected the site before the architect drew up the plans, and that the designs were then tailored to the local geographies of the estate.

[207] Some of these were retained in the archive, and I was able to consult the original plans for the Stirling, Banff, Glasgow and Govan Asylums.

of the plans was to include "the several classes and numbers of patients to be accommodated, in the wards, dayrooms, dormitories, cells, galleries, and airing courts" (SCL, 1859:119).

Similarly to the asylum grounds, however, the arrangement of the buildings and the internal spaces of the rooms were inevitably to undergo considerable modifications and alterations during the study period. Again this was a response to changing attitudes and discourses regarding the most appropriate spaces for treating and housing the insane population, as well as a response to the shifting demographics and the rapidly expanding numbers being institutionalised.

## THE EARLY DISTRICT ASYLUMS (1860-1874)

The first institution to be opened after the 1857 Act was the Argyll District Asylum. The District Board contracted three architects to design different plans for the new institution, prepared by Mr Mathews (the successful competitor for the Inverness District Asylum), Mr Cousins (employed by the city of Edinburgh) and Mr Walker (architect to the Society for Improvement of the Dwellings of the Labouring Classes). Yet, before commissioning a design, the District Board, disgruntled with the lack of specificity given by the General Board and believing that all three of the plans appeared more expensive than was necessary, posed a series of questions requesting further clarification about the Commissioners' guidelines. They felt the request for further information to be necessary given the "very responsible and public duty" (SCL, 1861:206) that faced them, and they invited further advice on, for example: the overall population to be housed in the institution given the population of the district; the necessity of single rooms for attendants; the ratio of single rooms to dormitories, and the appropriate numbers to be accommodated in each dormitory; whether corridors were essential (is it "preferable that the rooms should extend across the building so as to have windows on both sides for cheerfulness and air?": SCL, 1861:206); and the necessity for a separate chapel or whether the recreation room could be converted on Sundays. Finally, the District Board asked that, as many private asylums were based in adapted old dwelling-houses and provided comfortable accommodation and efficient management, could the possibility of a range of houses "similar to the best class of farm-dwellings" be considered? They supposed that "the more domestic and home-like nature of such buildings seems more suitable for paupers, and might probably conduce

more to their comfort and cure" (SCL, 1861:206), compared to the large public institutions being advocated by the General Board:[208]

> An expensively constructed asylum, such as might be appropriate for a wealthy or metropolitan county, was not required for the accommodation of the pauper lunatics of Argyllshire. The Highland peasantry, and more especially that of the western districts, are commonly very wretchedly lodged. We are, therefore, of opinion that asylum accommodation, such as has been provided by the English counties, and the wealthier Scotch districts, for their insane poor, is not requisite for the pauper lunatics of Argyll-shire. (SCL, 1861:xi-xii).[209]

This commentary is intriguing as it in effect poses a fundamentally different possibility to the Commissioners faith in purpose-built institutions. The correspondence, which lasted over a year, illuminates negotiations and tensions between the different tiers of the lunacy administration which are otherwise absent from the archive. The 'discussion' delayed the construction of the first district asylum, primarily as the District Board in question stated themselves "at a loss to comprehend what the views and objects of the Commissioners are" (SCL, 1861:209), but also because the Board reckoned that "even the most moderated of the plans seemed to be more expensive than was necessary" (SCL, 1861:206).

After a period of toing-and-froing between the two Boards in which heated opinions were exchanged, one of the most important conclusions was that the General Boards viewed the construction of one single block as the most economical option. They argued that "detached buildings are more expensive in themselves … than portions of a single block" (SCL, 1861:212), despite the District Board's opinion that separate buildings may provide more suitable, home-like, accommodation. The preference of the General Board at this stage is again interesting, as it was not long before the "detached block" solution became officially sanctioned/advocated, with the reasons detailed below. The Argyll District Board finally settled on an appropriate design for their asylum, despite rejecting all three of the original plans. A single block was constructed with the architect, Mr Cousin, deciding to place the day-room accommodation on the ground floor, with the dormitories on the second floor. For "obvious reasons" (SCL, 1862:xvii), a number of single rooms, together with the dormitories for the infirmary, were to be located on the ground floor. The

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[208] Interestingly, the expert opinion appeared to veer *towards* the favoured Argyll solution as the century progressed.

[209] This also suggests a 'class' dimension, where class and space intersect in a suggestion that these 'peasants' *here* do not need/expect anything better. There was, therefore, an evident geographical variation as to the type and standard of asylum accommodation recommended by the General Board.

institution was to have 142 beds, but with day-room accommodation for 200 patients, to allow for potential future expansion.

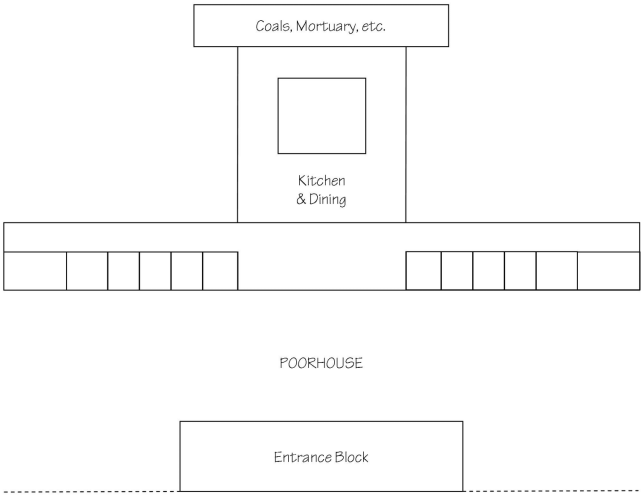


Figure 9.2 – Sketch plan of Poorhouse layout (Darragh, 2011a:222)[210]

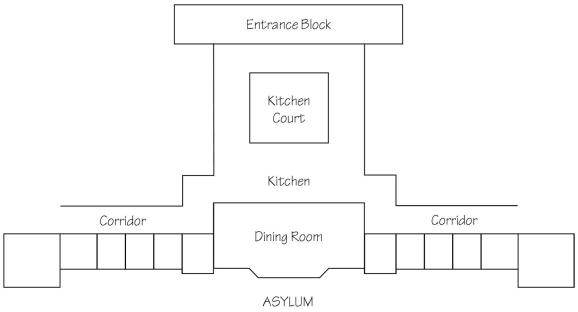


Figure 9.3 – Sketch plan of typical asylum T/E-plan (Darragh, 2011a:222). This was a popular design for the asylums constructed shortly after the *Lunacy (Scotland) Act*, 1857.

The discussions between the General Board and the Argyll District Board, as well as the design of the final institution constructed for this district, appear to be somewhat of an anomaly. The other asylums being constructed during this period, by the Banff, Inverness, Haddington and Fife and Kinross[211] Boards, were all of a similar design and, as far as can be ascertained from the available evidence, did not go through the same painstaking negotiations with the General Board. These early asylums were very similar in design and layout to the Scottish poorhouses from the mid-1840s, generally in a T- or E-shape, but

[210] See also Driver (1993) for geographical research on designing and building the workhouse and the workhouse system south of the border.

[211] The construction of the Fife and Kinross District Asylum was delayed slightly because the iron support beams for the central block were lost at sea (SCL, 1865:xvii).

with the omission of the detached reception block to the front of the main building (see Figure 9.2 and Figure 9.3).

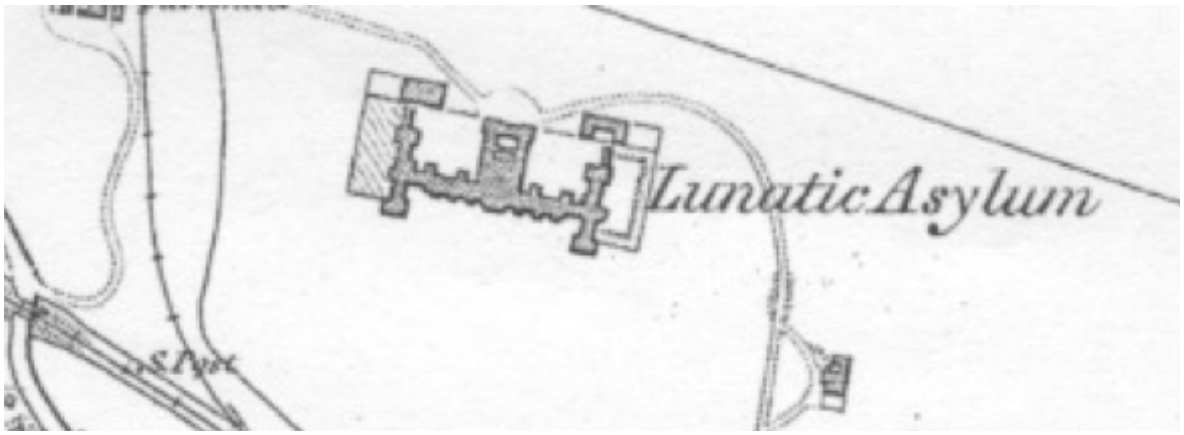


Figure 9.4 – Perth District Asylum, Murthly, *Ordnance Survey,* 2nd edition, 1864 ©nls (Darragh, 2011b:132). The image shows the symmetrical design of the institution, with the wings extending out from each side of the central block. The detached asylum superintendent's house can be seen to the right of the picture just back from the entrance driveway. The buildings just cut-off at the top left of the image are the farm offices and gas works.

Extensive detail was given regarding the Perth District Asylum, and can be outlined here to give a more detailed understanding of the typical style of asylums being constructed by these district boards. After a competition to find an architect, Mr Edward and Mr Robertson of Dundee secured the contract to design the Perth District Asylum, which was initially to accommodate 202 patients, although was later extended (see Figure 9.4). When opened, the main building was two storeys high and 400 feet long, and built in a simple Renaissance-style[212] (see Figure 9.5). The central block, which divided the asylum into two almost identical sections, contained the general rooms. The dining hall was situated on the ground floor, with the amusement hall, also to be used as the chapel, directly above it on the second floor. Both these rooms measured fifty by forty-eight feet. The bathrooms, kitchen, scullery and culinary offices were positioned immediately behind the dining hall. Directly underneath these rooms there was a large cellar and directly above was the servants' accommodation (two rooms, each twenty-six by seventeen feet). The entrance space housed the boardroom, dispensary and porter's room, as well as the matron and assistant medical superintendent's accommodation. Either side of this central section were the "advancing and receding wings at the extreme ends" (SCL, 1862:xxii), each 158 feet long, which were structurally identical and allowed the separation of the sexes, with the females in the west wing and the males in the east. Within these wings, the patients were

[212] Renaissance architecture describes the style of buildings designed between the early-fifteenth and early-seventeenth centuries initially in Italy but spreading across Europe. It combined features of ancient Greek and Roman thought and material culture, and emphasised symmetry, proportion and geometry in orderly arches, columns and lintels (Summerson, 1977).

separated according to affliction. Immediately situated either side of the dining hall on the ground floor were the day rooms (280 cubic feet per patient), including the day rooms for the infirmary patients (306 cubic feet per patient). The institution initially had fifty single rooms in the main asylum (693 cubic feet each), with a further four, slightly larger, in conjunction with the infirmary wards (891 cubic feet each). The dormitory accommodation housed 152 patients, each designed to afford 617 cubic feet of space per patient. There was separate sleeping accommodation for up to sixteen infirmary patients (664 cubic feet per patient), as well as two night rooms for 'restless' patients, which each measured sixteen by ten feet. The remarkable precision about *cubic* feet is intriguing and revealing, as it shows a concern not just for two-dimensional plans, but also three-dimensional volumetric space, which was in line with the concern for atmospheres, as you need volume to have atmospheres. The term nonetheless implies a much more developed 'science' of madness and space than was probably really the case, in that nothing in the literature/studies of the time appears to warrant the apparent exactitude of the figures given.

Figure 9.5 – Perth District Asylum, South Front, 1883 (CAIS). The photograph shows the long south-facing front with original wings designed by architects Edward and Robertson. The two-storeyed block in the centre, topped with the large octagonal timber observation tower, was added circa 1871.

Situated on either side of the entrance area, but in detached buildings, were the wash-houses, laundries, workshops (smith, joiner, plumber, painter, shoemakers, and tailors), a

bake-house, dead-house and a *post-mortem* room.[213] Finally, the detached medical superintendent's house was located about 350 yards to the east of the main building, just to the side of the main approach to the asylum, with the farm offices and gas works situated an equal distance away but to the west of the main building (SCL, 1863).

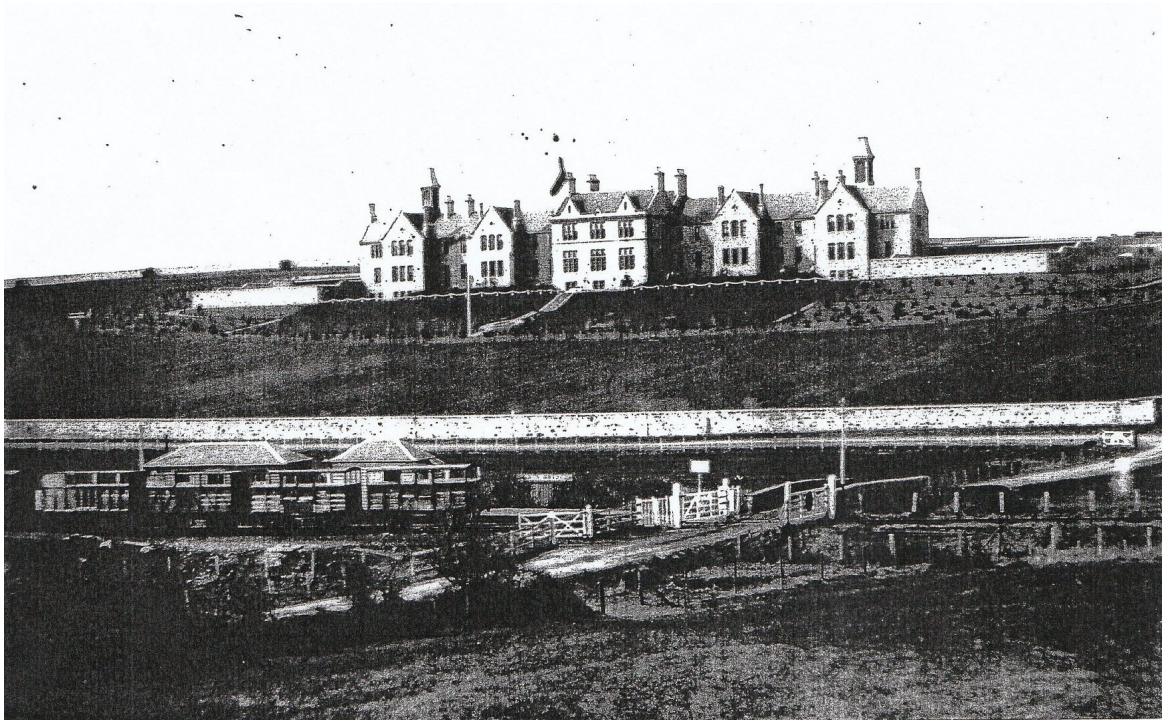

Figure 9.6 – Banff District Asylum, circa 1870s (Flickr). Image shows the symmetrical structure of the institution, and its quite imposing, south-facing position on a slight hill. The building in the foreground is the Ladysbridge railway station.

The Banff Board invited three architects to submit plans, and sent two of these to the General Board for approval. The Commissioners intimated that they preferred the design by Mr Reid of Elgin, although put forward suggestions for modification and requested to meet the architect to discuss the changes. The asylum was to be of a similar construction to the Perth Asylum detailed above, but on a smaller scale (see Figure 9.6):

> The asylum will be of a plain structure, facing the south, with accommodation for ninety patients. The main or front building will be chiefly two storeys in height. On the ground floor there will be a dining-hall in the centre of the front, with a range of single rooms on each side, entering from a wide corridor which, enlarged by a central projection to the front, serves also as a day-room. In cross wings, at each end of the front building, will be the wards for the infirm patients, and for those requiring more special supervision. A projection at each end, and another behind the range of single rooms on each side, will contain the lavatories, etc., on both

[213] By the twentieth century, dead-houses were more commonly known as mortuaries. They were not only used for the storage of bodies, however, but also commonly as a space for the funeral service in the absence of an asylum chapel, and for the reception of the deceased's family. The *post-mortem* space was used for pathological research. For further discussions, see Andrews, 2012.

> floors. In the rear of the dining-hall are the dispensary and waiting-room, and in a lower building, extending backwards, are the kitchen and scullery. A range of buildings at the back, running parallel to the front building, contains the other domestic offices, workshops, etc. with the general entrance to the asylum in the centre. (SCL, 1863:viii)

The inner enclosed courts (see Figure 9.7) would have initially provided supervised outdoor space, with the general airing courts situated just to the east and west of the main block, as shown in Figure 9.8. When the construction work commenced on the asylum, it was not long before the lead builder complained that the Morayshire stone being used was too soft, and asked for the building material be changed to Rhynie freestone, which was agreed by the District Board.

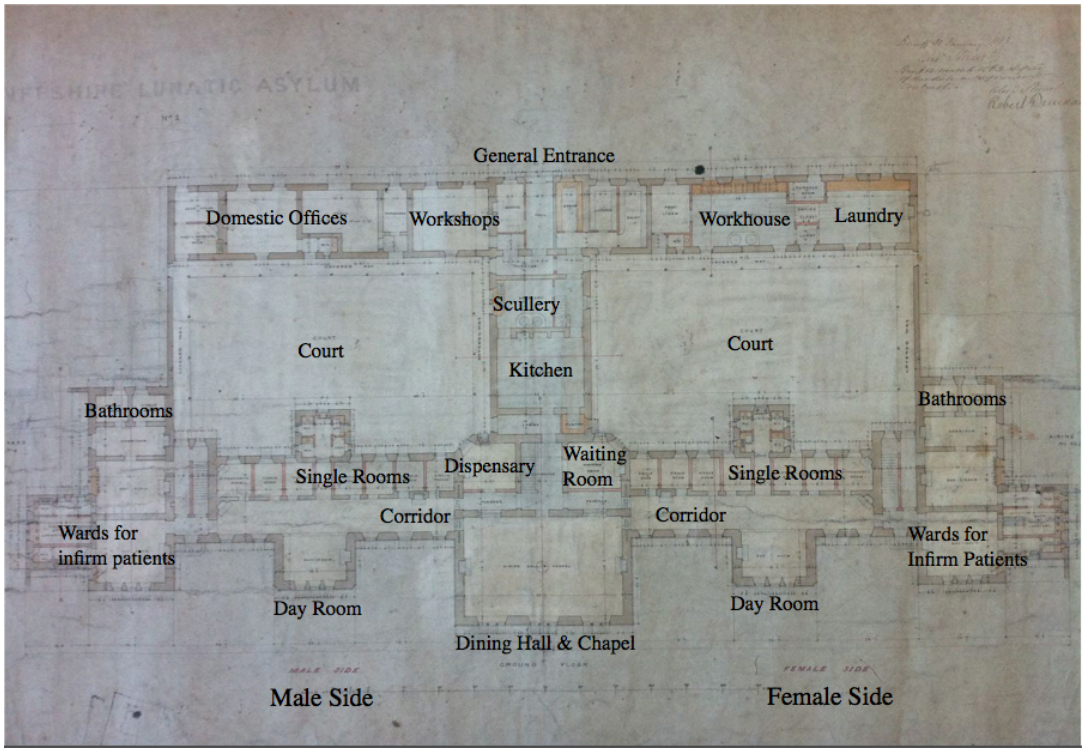


Figure 9.7 – Banff District Asylum, plan by A. & W. Reid, Architects, No. 2, *Ground Floor Plan*, (1863) (original in Darragh, 2011a:224), annotation added to show locations of various rooms.

There were a number of small differences to the larger early district asylums, however, such as the superintendent's accommodation being incorporated into the main building rather than kept separate. It included a sitting room and a bedroom and was located in the central section above the dining-hall, where a large workroom for the female patients was also situated. On the first floor too, on either side of the central block, directly above the corridors and single rooms, were the general dormitories. Each slept twenty-three patients, which was far above the ideal number envisaged by the Commissioners, outlined above.

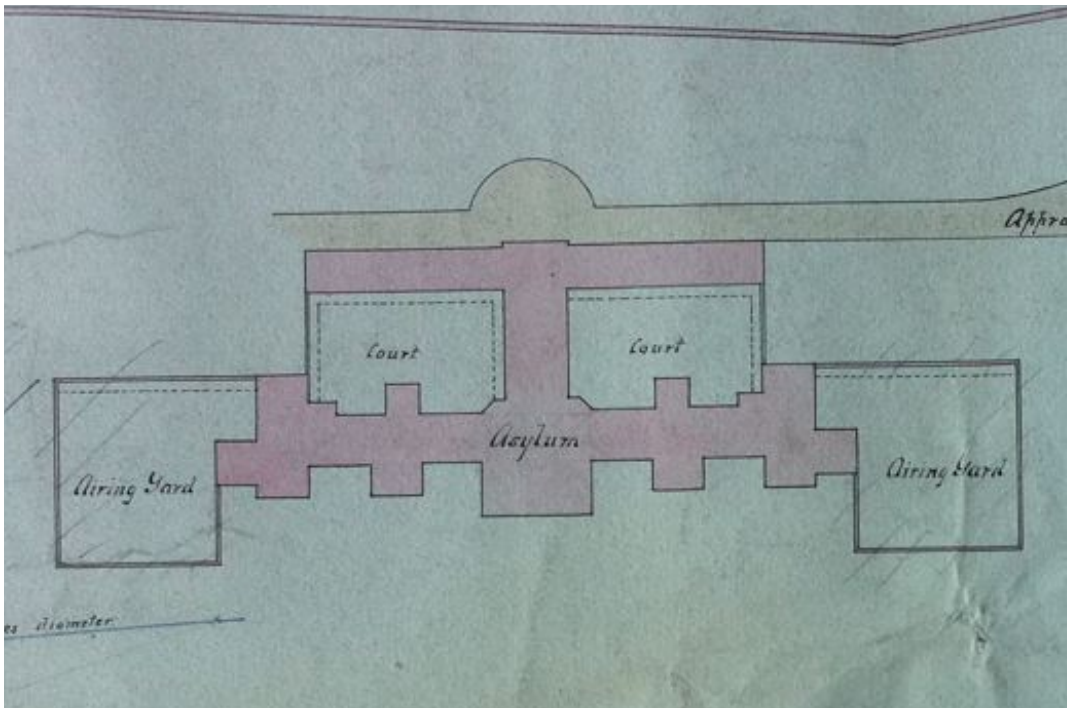

Figure 9.8 – Banff District Asylum, plan by A. & W. Reid, No. 12, Plan of Site, 1863 (Darragh, 2011a:225). This image also shows that the asylum was accessed from the north, as recommended by the Commissioners (see Chapter Six).

The preferred position of the superintendent's house was open to debate:

> For the one side, it has been argued that the nearer the superintendent is to his patients the better they will be looked after; and for the other, that, to enable him properly to discharge his functions, he should be secured from constant and unnecessary interruptions. (SCL, 1874:lii)

But the Commissioners were of the belief that:

> With a superintendent whose soul is in his work, it will signify little which arrangement has been adopted, but when he is indifferent, or allows himself to be taken up with other pursuits, we fear there is considerable risk of the supervision being less constant and efficient when his house is at some distance from the asylum, than when it is in close proximity to it. (SCL, 1874:lii)

These quotes chime with Foucault's claim in PP about the asylum as the extension of the superintendent's 'body' and 'soul', with the location of his residence crucial in performing everyday supervisory tasks and maintaining affective power over the asylum spaces. It was, however, the personal preference of the boards which arrangement they adopted, with most choosing a detached superintendent's house, albeit within close proximity to the main asylum building. This was a compromise that allowed the superintendent to undertake his duties as overseer and manager of the institution, but also granting some personal space, important for his, and his family's, welfare.

Figure 9.9 – Specimen Ward, Inverness Asylum (SCRAN, no date). In the original plans for the Inverness Asylum, each patient was to have a single room, but due to pressure on accommodation space, and a more wide-spread move towards 'Nightingale Wards'[214] within asylums, wards such as this housed the majority of patients.

Common traits within these early institutions are worthy of note before moving on to detail the changing character of the asylums throughout the study period. In these first district institutions, as they generally consisted of single blocks, the infirmary wards were located within the main building. Moreover, there were a substantial number of single rooms used for the treatment and management of patients whose behaviour was considered difficult. Emphasis was put on the classification of the patients, but this was done predominantly by dividing the space internally within the single building. There were, of course, spaces inhabited predominantly by patients, such as the dormitories and day rooms, and spaces used mainly by staff, such as the kitchen and laundry, but there was inevitably some cross-over within these spaces, such as female patients being employed in laundry work. Examples of the different internal spaces of earlier asylums can be seen in Figures 9.9 and 9.10.

[214] Nightingale wards, named after Florence Nightingale, were an attempt to improve circulation within hospitals. Nightingale thought that infectious diseases and miasmas were transferred through the air, and could pollute the atmosphere of the hospital. As a response, hospital designers tried to create spaces where air would not stagnate. Nightingale wards were, therefore, large oblong wards with windows on each side, and without patient subdivisions (Richardson, 2010).

Figure 9.10 – Kitchen in main building, Inverness Asylum (SCRAN, no date). This image shows part of the kitchen facilities that were situated behind the main dining hall.

## ASYLUMS WITHOUT RESTRAINTS

Paralleling the reduction in the use of walled airing courts and boundaries as an extension of the principles of non-restraint, as outlined in Chapter Eight, changes to the modes of management within the asylum buildings, namely the disuse of locked doors, also started to be trialled around the same time: a further attempt "to make asylum life resemble ordinary life" (SCL, 1878:xxx) and to move away from the last subtle strains of mechanical restraint.[215] The Commissioners stated:

> The development of these modifications has indeed gone so far, that it is now held wrong not only to use any form of mechanical restraint on the person, but even to put restrictions of any other kind on the liberty of a patient, which cannot be shown to be necessary either for his own welfare of the safety of the public. (SCL, 1881:xxxi)

[215] Unfortunately, due to an incident between a female patient and a male attendant, which resulted in pregnancy, the locks at the Ayr District Asylum were initially reinforced rather removed, as a reaction to the case (Ayr D.B., M.B., 1879:34).

Again, the individual asylum superintendents, rather than the General Board, initiated these systems, and so Dr Tuke[216] at the Fife and Kinross Asylum first implemented the open-door policy in 1869, as, the District Board stated, "there is nothing people dislike so much as being locked up; to some it is positive agony. If such be true of the sane, it is equally true of the insane" (F.K. D.B., A.R., 1875:15). Many "distinguished physicians and others" visited this institution to see the system in process, arriving, it was said, "incredulous, as most physicians in the speciality are, but after a day's thorough insight went away convinced of the truthfulness and reality of the movement" (F.K. D.B., A.R., 1875:15). Due to its obvious success, it was extended year on year in this institution and others.[217] The policy meant that attendants and patients could freely move around and even beyond the institution with minimal need for a key, increasing the liberty of the patients, and removing the prison-like atmosphere of the buildings. It was remarked with satisfaction "that the disuse of the airing courts, instead of leading to a more strict confinement of the patients to the wards, has been followed by a marked relaxation of restraints on personal freedom within the buildings" (SCL, 1878:xxxii). The policy appeared to result in increased tranquillity, improvements in the patients' habits, "and in the general satisfactory condition of the establishment" (SCL, 1875:xxix). In this institution, the policy was extended throughout the nineteenth and into the twentieth century, with the Commissioners reporting in 1902 that:

> It was possible to pass from end to end of the female division of the asylum without the use of a key, and that, with one exception, the doors of all the female wards were unlocked, so that the great majority of the female patients can pass at will into the open air. Practically the same freedom prevails on the male side. (SCL, 1902:xxx)

At the Fife and Kinross Asylum, 200 of the 272 patients were accommodated in wards where the doors were always open during the day (SCL, 1878:xliv) and, remarkably, four of the patients at the Inverness District Asylum were trusted enough to be given their own set of keys so they could enter and leave the asylum at their own will (SCL, 1879:xli). The system transferred a greater level of personal responsibility to the inmates, and empowered them to take more of their own decisions; for instance, by allowing free access to the

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[216] It is unclear the relation between Dr John Batty Tuke and the York Tukes, if any, with his obituary simply saying that Dr Tuke found "his life-work in the department of medicine which deals with the treatment of the insane, a sphere in which earlier Tukes had borne an honourable part" (*British Medical Journal*, 1913:1045).

[217] It was apparently declared by an American physician that this system should go down in history alongside the movements of Pinel and Tuke towards the end of the eighteenth-century, and of Connolly and Griesinger in the middle of the nineteenth century (F.K. D.B., A.R., 1875).

grounds unaccompanied by an attendant. The system was also emulated elsewhere: it was reported that seventy per cent of the female patients at the Midlothian and Peebles Asylum were free to move between their day-room and the grounds, and that, despite this liberty, the number of escapes were markedly small (SCL, 1878:xlvii).

Although initially not going as far as a complete open-door policy, in some asylums, for example at Ayr and Perth, the locks and handles on the doors were changed to ones found in ordinary dwellings, again in an attempt to increase the effect of the asylum mirroring ordinary life:

> It is consequently desirable to introduce as much as possible into the daily routine of an asylum, such arrangements as will easily commend themselves to the minds of such patients without suggesting ideas of discipline or treatment. The more a patient can be made to feel himself a voluntary agent rather than a person under tutelage, the more may his mental state be expected to be healthy. (SCL, 1879:xxxi)

It was reported that, through all of these changes in management, the relationship between the patients and the staff was strengthened, becoming kindlier, although it was admitted that proof of this shift was difficult to observe (SCL, 1878). Resonating with the arguments developed by Foucault in PP, it did, however, definitely force the attendants to practise more continuous and intelligent supervision through more subtle 'soft' methods of control. As they could no longer rely on locked doors for the confinement of troublesome and disgruntled patients, they inevitably had to become more aware at all times of where these patients were and what they were doing. As the Commissioners commented, "the relations of an attendant to his patients thus assumed less of the character of a gaoler, and more the character of a companion or nurse" (SCL, 1881:xxxiii). It was acknowledged that this change in the control of patients could be more widely used, with the recognition that the disuse of locked doors reduced the desire for escape in a number of patients:

> Under the system of locked doors, a patient with that desire was apt to allow his mind to be engrossed by the idea of watching for the opportunity of an open door, and it was by no means infrequent to find such a patient watching with cat-like eagerness for this chance. The effect of the constantly open door upon such a patient, when the novelty of the thing had worn off, was to deprive him of *special* chances of escape on which to exercise his vigilance, since, so far as doors were to be considered, it was as easy to escape at one time as another; and it was found that the desire often become dormant and inoperative if not called into action by the stimulus of *special* opportunity. It is indeed a thing of common experience, that the mere feeling of being locked in is sufficient to awaken a desire to get out. (SCL, 1881:xxxiii)

Hence, by the 1880s most of the asylums in Scotland had embraced the principles of the open door policy, although to varying degrees. It was reported that the removal of the restrictions of liberty, including the open door policy as well as the removal of airing courts and increased parole, as outlined in Chapter Eight, positively influenced the behaviour of the patients, producing a calming affect, bringing increased order to the institution. Conversely, when institutions were found to have unusually high levels of restraint and seclusion, such as was reported in the Ayr Asylum in 1884, it was suggested that the cause was either inefficient management by, or insufficient numbers of, attendants (SCL, 1884), hence laying blame on the 'underlings'.

Public opinion posed a significant challenge to the relaxation of restrictions on liberty, which the superintendents and Commissioners worked hard to overcome. The general public was seemingly under the impression that persons suffering from insanity were not fit to be trusted with *any* level of liberty.[218] They believed that reducing a person's liberty would reduce the chance of accidents, and thus, if a superintendent had allowed too much freedom and an accident had occurred, he would be wholly to blame for the incident. It was thanks to this point of view that mechanical restraint had been so widely accepted and also why reformers met with such challenges from the public when it was proposed that restrictions be decreased:

> It was not recognised that in taking precautions against one set of evils, other evils of a graver character were created. Even the evils which it was sought to avoid were not avoided … The superintendent who really takes most precautions against violence is not the man who applies the most complete restrictions upon liberty, but he who weighs the general results of different modes of treatment, and selects that which proves in practice most successful in decreasing the number of violent acts. (SCL, 1881:xli-xlii)

The public, the Commissioners continued, needed to be aware that restrictions, far from being a guard against evil, were actually malicious: engendering evil through mechanical control.

Despite the push to eradicate all mechanical restraint, barriers and seclusion from the asylum, there remained a realisation that in some cases it was essential for, and even beneficial to, the welfare of the patient or the safety of the wider asylum population. Therefore, although markedly reduced through the changing methods of managing and

[218] There are contemporary parallels here with achingly all-familiar scares about homicidal schizophrenics 'at liberty' on the streets (see also Moon, 2000).

controlling the insane within these institutions, it was recognised that restraint would probably always be needed for a handful of reasons, including "promoting the healing of injuries by rest, or as a means of preventing the removal of surgical dressings in the case of patients whose mental condition is so confused or disturbed as to necessitate the use of such precautions" (SCL, 1912:lix). It was also recognised that it would be applied to patients with violent dispositions, either homicidal or suicidal. Yet, as different asylums recorded varying levels of restraint and the like, the Commissioners concluded that the levels were very much determined by the modes of management operative within each institution. The responsibility always rested on the medical superintendent as to the extent they resorted to these methods of control, and some did refrain from these systems completely, particularly towards the end of the study period.

Along with industrial occupation, as detailed in Chapter Eight, recreation and amusements were seen as an important element in being able to reduce mechanical restraint and implementing policies such as open doors. The Fife and Kinross Board commented that "amusement in a pauper establishment may to some appear as an anomaly, but it must be borne in mind that this institution is a hospital requiring curative agents of every description, among which amusements hold a well-defined position" (F.K. D.B., A.R., 1875:17). As such, dances, concerts, reading material, lectures, games, and picnics were all provided to varying degrees in the institutions, predominantly in the recreation hall, a space specifically designed for this purpose (see Figure 9.11). The activities were viewed as an essential tool in reducing the boredom and monotony that otherwise would inevitably transpire within the institution. Entertainments were also used as incentives and rewards for good behaviour, and were, therefore, a fundamental element in the management of the patients, viewed as "necessary for the good wellbeing of the patients" (F.K. D.B., A.R., 1875:17), changing the 'atmosphere' of a place through such recreations and amusements.

## ENGINEERING AFFECTIVE 'ASYLUM' SPACES

As the nineteenth century progressed, therefore, there was an increased understanding that "the condition of the insane is modified by the nature of their accommodation" (SCL, 1873:viii), resulting in still more attention to the external and internal aesthetics of the asylum. These views were embedded within the wider movement of reducing restrictions on liberty, as it was advocated that more could always be done to "secure the contentment of the patients so that they might the more readily conform to what was required of them"

(SCL, 1881:xliii). Echoing Foucault's claims in MC and PP, this revealing quote highlights that what was in play here was 'soft' disciplinary power: persuading the insane to perform sanity. Central to this ambition was the crafting of physical spaces for rest, relaxation and recreation within the asylums, such as the recreation hall shown in Figure 9.11 and the 'Blue Room' shown in Figure 9.12.

Figure 9.11 – Colour Scheme, Recreation Hall, Gartloch Hospital, Glasgow (GGCA).

It was thought that attention to micro-spatial arrangements was useful, "not merely by conferring temporary ease or pleasure, but also, and chiefly, by raising the general *mental tone* of the patients, and making them more amenable to treatment" (SCL, 1862:lxxx, emphasis added). Here reference to the 'tone' of people and place precisely suggests a concern for affective 'atmospheres' and, particularly as the institution began to split into medical and asylum sections, devoted to quite different methods of treatment and management, there was increasing attention paid to developing a 'home-like' ambiance

and a "comfortable domestic appearance" (SCL, 1864:li) within the asylum division. It was recognised of these efforts that:

> They may not, it is true, directly affect the health of the patients, but they tell directly on their comfort; and if it be the case that nine-tenths of asylum inmates are incurable, it is evident that attention to these details must be of as much practical importance to the bulk of the patients as medical supervision in its restricted sense. (SCL, 1870:xlvii)

This quote emphasises the accumulation of the chronic patients and the irony that it was to *this* cohort that 'moral architecture' claims became most relevant and applied. Crucially, the sense conveyed in this quote and those that follow was that these developments were less about cure – as in older/original claims about 'moral architecture' – and more about general orderliness through the creation of spaces capable of soft control.

For example, the Midlothian and Peebles Asylum increased the "home-like aspect of wards … by additions to furniture and the carpeting of several of the day-rooms and dormitories" (SCL, 1878:xlii). The Commissioners continued:

> Considering the class of patients for whom the Institution exists, it might perhaps be thought that the furnishing and decoration had been carried to excess; but it is pointed out that the satisfactory condition of an asylum is greatly dependent on the influence which is exercised on its inmates by the circumstances in which they are placed. Experience shows that their behaviour improves with their surroundings; that, when these are comfortable and cheerful, there is less noise and excitement, less destruction of property, and less indulgence in degraded habits. (SCL, 1878:xlii)

The creation of such an atmosphere was believed to have a calming influence on the patients' often long-term surroundings. Time and again the Commissioners praised this aspect of the institutional spaces created by the district boards, commending, for example, "the civilising effects of floral decoration" (SCL, 1876:xxvii) at the Ayr District Asylum, or the extension of the ornamental painting and papering of the walls and the additions to furniture at the Fife and Kinross Asylum. It was stated in 1877 that the decoration of the wards at the Roxburgh Asylum was progressing rapidly and was of a "highly satisfactory and tasteful manner" (SCL, 1877:xxxvi), with much of the work being done by the male attendants and the patients together. Similar improvements were made to the Perth Asylum, which included replacing worn-out furniture with new and comfortable items, in particular armchairs, which were reportedly "much liked by the patients" (SCL, 1892:xxix)

and said to increase their tranquillity and contentment. Objects that would amuse the patients such as games were also purchased, and the wards were decorated:

> These, it is reported, have added greatly to the cheerfulness and comfort of the asylum, and have been appreciated by the patients. The asylum was found in excellent order, and the condition of the patients was in all respects satisfactory. (SCL, 1891:xxvii)

Figure 9.12 – Female 'blue room', Inverness Asylum (SCRAN, no date). The blue room was designed as a space where female patients could relax. The colour blue was chosen as it was considered to be calming. There was a similar 'Blue Room' on the male side. As SCRAN note, this institution "served the whole Highland region, including the Western Isles. In theory the patients were meant to feel secure and comfortable in these surroundings but it must have been difficult for people from small crofting communities to feel at home in this bewilderingly large, rather formal institution."

Again, the Commissioners noted that the Stirling Asylum had done much "to add to the comfort and contentment of the patients" such as "repainting rooms, relaying flooring with pitch pine, procuring comfortable couches and a larger number of chairs, adding to the decoration of the wards, and by many other similar arrangements" (SCL, 1891:xxvii). At the Ayr Asylum, the medical superintendent reported that "the internal appearance and comfort of the House is much improved by papering the walls with pretty lively patterns, hanging numerous coloured pictures, furnishing the windows with valances, and providing

additional chairs" (Ayr D.B., A.R., 1872:15). In 1879 a "handsome carpet of good quality" was laid in the female day room, which was said to add "much to the comfort and appearance of the room" (Ayr D.B., M.B., 1879:8), and in the early years of the twentieth century the use of pillows in the beds was commended, as well as the large number of easy chairs, which, "are said to be liked by the patients, and are believed to add to their comfort and peacefulness" (SCL, 1903:xxviii). At the Haddington Asylum, it was reported that additions had been made to the furnishings, which included "chairs, rugs, tables, and small decorative articles" (SCL, 1903:xxxiii), and improvements had been made to the dormitories such as reflooring in pitch-pine wood, as well as strips of carpet between the beds and blue blinds fitted to the windows. As today,[219] blue was viewed as a calming colour, and was most evident in the so-called 'Blue Rooms' at the Inverness Asylum, as shown in Figure 9.12.

The Aberdeen Board showed their awareness of the importance of engineering affective spaces when observing: "pleasant and comfortable surroundings have a marked influence in diminishing irritability and restlessness, and in contributing to the happiness of the patients" (*Free Press,* 1904:np); and apparently the medical superintendent's motto regarding the villas (see below for more commentary) was "keep them lively and home-like" so that cure would result if it was within possibility (*Evening Gazette*, 1906:np). As such, the villas were provided with sofas and easy chairs for comfort and contentment, a piano for entertainment, and pictures, plants and other objects for decoration, which all added to the cheerful and bright aspect of the wards. Within a year of opening, though, the *Evening Express* (1904:np) reported that the arrangements in regard to furnishings were not in "apple-pie order", and that the District Board should thoroughly investigate this claim, as the ratepayers were "entitled to know whether or not they have got good value for money".

The creation and engineering of affective spaces was hence viewed as a powerful tool in the management of the patients, albeit there was a tendency not to emphasise the 'management' angle as such. Furthermore, the creation of such spaces often had the dual effect of not only resulting in an affective atmosphere, but also engaging the patients' minds by employing them in the construction of such spaces. For example, the patients at the Banff Asylum were responsible for crafting the valances and rugs, which added to the

[219] The psychological properties of colour have received great attention, particularly in the mid-twentieth century. See, for example, Wilson (1966). According to the Colour Affects System, developed by Wright (1998), the colour blue is mentally soothing, and connected to serenity, reflection and calm.

"cheerful and comfortable appearance of the wards" (SCL, 1883:xvi). Browne (1864:7), however, cautioned against over-decorating the asylums, claiming:

> The hospitals for the non-affluent classes, however spacious and comfortable, should *not* be palatial; they should resemble, at many points, the homes from which their inmates have been withdrawn, because they love and have been accustomed to the very homeliness of these dwellings. They should be beautified, but in a manner which the inmates can understand and appreciate; their refinements and elegances should not interfere with their comfort, ease, or freedom, nor be calculated to create tastes and elevate, but their lessons should speak of early habits, former pursuits, natural proclivities, rather than of the glitter and gaudiness of tinsel luxury. The pets and sights and sounds of happier days, and birds and flowers, are more health-giving and hope-inspiring to the unsophisticated heart than gorgeous vestibules, black-oak furniture, or copies of Raphael's cartoons.[220]

It was suggested in 1873 that, in order to achieve tranquillity in the larger asylums, each ward should be arranged as if it were "a small independent establishment" (1873:lii), not only through the better classification of patients, but also – again showing the importance of 'extending' the superintendent's body through the asylum spaces – by more regular visits from the central authoritative figure of the medical superintendent, "who should show himself to be in reality, as well as in name, the friend and guardian of the patients, and their shield and protection against the roughness and caprice of the attendants" (SCL, 1873:lii).

Tranquillity was also achieved through entertaining the patients with amusements, games, concerts and such like. Of particular interest was the connection between the institution and the Brabazon Society at the Glasgow Asylum at Woodilee (previously the Barony Parochial Asylum). The Society consisted of a number of local ladies from the neighbourhood who visited the asylum and engaged the patients in, among other activities, rug making, wood-carving, wood painting and bent-metal work (SCL, 1900).[221] Ladies from a Brabazon society also visited the Midlothian and Peebles Asylum, and their visits were reported to "lend brightness and fresh interests to many of the inmates" (SCL, 1911:xxxvi). These examples give a glimpse into the relationship between the institution and its neighbours, with a number of the locals taking an interest in the wellbeing of the patients through an early form of occupational therapy. Another example of a special feature that was implemented with ease into the asylum arrangements was first trialled at the Haddington Asylum, where the male and female patients sat alternately at the dining

[220] See also caption under Figure 9.12, which speaks to similar themes.

[221] See Laws (2011).

tables during meals (Haddington D.B., P.B., 1868:np). Far from producing disorderly conduct, the arrangement further introduced into asylum life a characteristic of ordinary life, and was praised as a useful tool in the management of the patients.[222] At the Lanark Asylum, the Commissioners praised the large amount of literature available, which was distributed throughout the wards but, they exclaimed, "such a generous and thoughtful provision for the entertainment and mental occupation of the inmates of asylums, is, it is regretted far from being common". They believed that "the arrangement in question … adds greatly to the homeliness of the wards, and it no doubt increases the contentment of the patients" (SCL, 1903:xxxiv) and should be advocated in other institutions. Also praised at the Lanark Asylum was the manner in which the tea was served at the 'family' tables in the dining-hall, where it was made in separate teapots for up to eighteen people: "the difference in the flavour of the tea thus infused is so remarkable, and its appreciation by the patients so evident, that a hope is expressed that all the inmates may in time be supplied with tea prepared in this way" (SCL, 1905:xxxiv). At the Glasgow Asylum, the crockery was praised as being "home-like … free from any special institution design" (D.B., A.R., 1898:22). These examples again highlight the desire to bring into the asylum more 'normal' objects and practices, creating a normal environment for the patients by implementing small gestures that closely match ordinary life, despite the wider institutional setting.

The district boards continually sought to modify the physical structure of the asylum buildings, again to produce the most a/effective arrangement for the treatment and management of the patients. In 1878, it was reported that the Perth Asylum had "undergone extensive structural changes" which not only considerably increased the accommodation, but also involved "the removal of many grave structural defects in the old asylum building" (SCL, 1878:xlviii). Along with updates to the fittings and furniture, the changes placed the asylum "in harmony with the most advanced views of treatment, and render the house a cheerful and comfortable place of residence" (SCL, 1878:xlviii). In a similar vein, the Stirling Asylum was said to have improved its accommodation through simplifying the arrangements of the interior of the building; and, although the report did not give detail as to exactly what was altered, it did state that as a result "its efficient management has been greatly facilitated" and that "much greater cheerfulness of aspect has also been obtained in the new day-rooms than existed under the previous arrangements",

[222] This set-up echoes Foucault's passage laid out in MC which explores how William Tuke forced maniacal patients to eat meals at the table with his family, "where everyone was obliged to imitate all the formal requirements of social existence" (Foucault, 1965:249).

an upgrade further "increased by the addition of decorations and objects of interest" (SCL, 1878:xliv). The partition between the main gallery and the corridors was removed on the male side of the Ayr Asylum, which greatly increased the day-room accommodation for these patients (Ayr D.B., M.B., 1880:39), and in the Haddington Asylum dark passages and partitions that "divided apartments unnecessarily" (SCL, 1884:xxvi) were removed. This removal had the effect of permitting more light and air into the spaces, as well as creating more 'elbow-room' for the patients. Similar alterations at the Stirling Asylum that increased the space allocated to each person, as well as improvements in the sanitary arrangements, reportedly resulted in an exceptionally high recovery rate at this institution (SCL, 1887). In 1903 the structural re-arrangements at the Midlothian and Peebles Asylum seemingly produced "a very marked improvement … in the order and restfulness of the patients and in the smoothness of administration" (SCL, 1903:xxxiv). At the Glasgow Asylum, the sitting-rooms in the asylum section were of an irregular shape, to induce the feeling that the patients were in a home "not of inordinate size" (Glasgow D.B., M.B., 1898:6).

Extending 'affective atmosphere' claims to hygienic and technological spaces,[223] the Commissioners and superintendents also sought to engineer institutional spaces that would reduce the risk of infection and the spread of physical disease, presumably due to an increased awareness of germ theory arising in the late-nineteenth century, As such, increasing reference was made, for example, to removing water closets and lavatories from the dormitory floors because of their connection to soil pipe and sewers, which were emitting foul air into the rooms (SCL, 1884). Further recommendations included waxing and polishing the wooden floors to avoid having to wet scrub, which was recorded as detrimental to the physical health of the patients, apparently causing illnesses such as phthisis. At the Fife and Kinross Asylum, the hospital spaces were found to be "well adapted for their purpose, being light, cheerful and efficient in their arrangements. The ventilation of the building is said to be working satisfactorily, fresh air being driven by a circular fan through flues to different parts" (SCL, 1897:xxviii). Towards the end of the nineteenth century, the first mentions of modern developments such as electric lighting, improved hot water heating systems, sewage filtration and telephonic communications started to appear in the reports; all a form of technological 'atmospheric' manipulation of light, sound and smell. The later asylums were constructed with these provisions installed

[223] See also Thrift's (1994) claims around speed, light and power and the "mechanic complex of mobility" (1994:201).

from the outset, with the earlier asylums updating as the district boards saw fit. The electric light was hailed as a "great benefit" to the institution, as it was "safer, cooler, and cleaner than gas" (SCL, 1895:xxxi), and the new hot-water systems "not only secure[d] an equable temperature throughout the buildings, but … [were] a cleaner and safer mode of heating than open fires" (SCL, 1908:xxviii).

***Nursing***[224]

As an extension of claims about engineering affective institutional spaces, the management of the patients within the new medicalised spaces in the *hospital* section was also of increasing importance. Advancing the reliance on female staff, a feature advocated towards the end of the nineteenth century, was the employment of female nurses in the male sick rooms, which was "found to conduce to the more efficient care and treatment of the patients" (SCL, 1897:xxviii). This approach was implemented in a number of asylums towards the close of the nineteenth century; for example, in 1898 it was reported that the hospital section of the Perth Asylum was under the charge of trained hospital nurses, so as to bring the nursing of the insane more in line with the nursing in general hospitals. Similarly, the use of female nurses in the male wards was favourably reported at the Lanark Asylum, with the Commissioners declaring:

> From what was witnessed in this section it is stated to be abundantly evident that female nurses are not only capable of efficiently supervising infirm male wards, but that the patients under this form of care receive benefits which they could not otherwise possibly obtain. (SCL, 1901:xxxii)

Finally, the arrangement at the Stirling Asylum, where the superintendent appointed a female matron to be in charge of the whole male division, was again highly praised:

> This system, which has been in force for about a year, is said to work well and to be advantageous in many respects. The motives which actuated these changes – the desire to introduce among the male insane the gentleness and tenderness which female nursing admittedly confers upon the sane inmates of other kinds of public institutions – are entirely laudable, and it is earnestly hoped that Dr Robertson's efforts in this direction may be successful. (SCL, 1901:xxxix)

Initially, the Commissioners criticised the district boards for not implementing this method of management to a greater extent, blaming prejudice and tradition for slowing the process in many institutions. They argued that the system had great potential, it being found that

[224] For a more detailed discussion on the use of female nurses within the asylum, see Walsh, 1999).

male patients were more docile, more amenable and less violent under the charge of female nurses, and as such they supposed that it should be embraced by those asylums where it was not yet occurring, and rolled out even further in the others. By the end of the study period, the Commissioners reported that "the system has … passed from the experimental to the accepted order of asylum administration" (SCL, 1914:ci).

Advancing this method of management further, the use of night nursing was incorporated within the institution, with the Commissioners reporting:

> In cases of sickness, bodily disease or enfeeblement, and of tendencies to suicide or self injury, the need for such nursing has been long recognised; and its protective influence has also been recognised in the case of patients suffering from epilepsy. But there are good reasons for thinking not only that night nursing and supervision might with great benefit to the insane be more fully developed in regard to the classes of patients above described than is at present the case in many asylums in Scotland, but that probably in all of them, it might with great benefit to the insane be extended so as to bring under its influence many patients who have not hitherto been looked upon as suitable for, or as being likely to be benefited by, such a mode of treatment. (SCL, 1899:xlvii-iii)

More vigilant supervision was key to individualised treatment, but also allowed the asylums to move away from using single rooms, which were increasingly recognised as a form of mechanical restraint. In the later asylums, the number of single rooms occupied a subordinate position in the institution, where once they had been predominant, particularly for the control of noisy and troublesome patients.[225] Preference moved towards the use of open dormitories, which permitted improved observation and management of the patients, particularly enabled by the increase in the use of night nurses. The Commissioners reported that, "when properly and persistently subjected to systematic night-supervision, a large number of these patients who, on account of their habits, had formerly been secluded during the night in single rooms, were permanently cured of their tendencies" (SCL, 1914:xcviii). Therefore, despite the added expense, which, on top of hiring the night nurses, often included replacing articles of furniture that had been damaged during outbursts by patients, the Commissioners were strongly of the belief that this change in the layout and atmosphere of the spaces of treatment, and the changed management of the patients, was essential in helping the asylum run as a curative institution. Moreover, showing a complete turn-around in the use of single rooms, by the start of the twentieth-century these spaces at the Stirling Asylum were used for the accommodation of quiet

[225] For example, the Edinburgh District Asylum, which had accommodation for 900 patients by 1914, only had thirty-two single rooms (SCL, 1914:c).

patients, "by whom they are regarded as bedrooms and are looked upon as a privilege" (SCL, 1902:xxxv).

## OVERCROWDING AND EXPANSION

> We have become so accustomed to regard the gathering together of insane patients in large numbers in asylums, as the most appropriate manner of disposing of them, that we rarely pause to inquire the grounds on which this system has become so general. Nevertheless, it would not be easy to defend it, except on reasons of convenience and economy. Impassionately and closely investigated, it bears in many respects the aspect of an evil; but an evil for which, under the circumstances of modern life, it may be difficult to find a complete remedy. (SCL, 1870:xliv)

This was an extraordinary claim in many ways, barely thirteen years after the district asylum solution was proposed, and was, in a sense, a result of the systems own 'success'. The construction of asylums prompted a vast increase in the insane population clamouring to use these institutions, and it was not long before the district boards had to consider either reducing the number of incurable inmates or expanding their accommodation, or in most instances both, as it was widely recognised that overcrowding "injuriously affects the comfort and health of the inmates, and increases the difficulties of management" (SCL, 1877:xxxiv). The Argyll Asylum was reported as being fully occupied only five years after it opened, blamed on the "prolonged detention of chronic cases" (SCL, 1865:xvii). The Commissioners wanted this problem rectified as quickly as possible, by boarding-out the patients, transferring them to lunatic wards of poorhouses or by the rapid extension of the asylum accommodation. The next institution to report that it was full was the Fife and Kinross Asylum in 1868, only two years after opening, with the District Board already having to consider extending the accommodation.[226] Exacerbating the problem further over time, the desired space thought as ideal for each patient increased, meaning that many asylum spaces were considered even more over-crowded than first thought. Whereas initially the General Board declared twenty square feet for dayrooms and fifty square feet for dormitories per patient to be the minimum allowance, within ten years these figures were viewed as being far too little, being less than the required amount in English workhouses (twenty square feet for dayrooms and sixty-five for dormitories per patient), soldiers in barracks (600 cubic feet per man) or general hospitals (1,200 cubic feet per patient) (F.K. D.B., A.R., 1878).

[226] On 1st January 1869, there were 232 patients occupying accommodation that had been designed for 210 patients (SCL, 1869:xxiv).

As detailed in Chapter Six, over the years the General Board encouraged a number of methods to tackle the expanding numbers and crowded spaces. Initially, they proposed that, in order to be properly suited to asylum treatment, a patient must not only be of unsound mind, but also "a proper person to be detained and taken care of" (SCL, 1868:xxxvii). They requested better judgement and discretion by the superintendents when deciding whether an individual should be institutionalised, and urged that their "practical power of detention" should not be abused, calling for increased considerations of whether continued confinement was necessary. As they stated, "detention in an asylum partakes a good deal of the character of imprisonment" (SCL, 1868:xxxvii). Furthermore, they remarked:

> As we have seen, the statistics of England, Scotland, and France, all show that, contrary to the expectations that were previously entertained, the erection of asylums exercises no influence in checking the growth of insanity. On the contrary, with the development of the asylum system, the growth of lunacy, or, at all events, the known existence of lunacy, has immensely increased, and, as yet, shows no signs of diminished progress … At the best, provision of asylums is but a palliative measure. (SCL, 1869:xv-xvi)[227]

Ordinary hospitals removed even incurable patients after a prescribed time, but in asylums they accumulated, resulting in nine-tenths of inmates belonging to this class. In particular, if the parish was meeting the cost, there was no incentive for removal:[228]

> Hence the wards of every asylum are encumbered with mindless cases, totally incapable of deriving any benefit from the costly appliances designed for the treatment for the curable, and the occupation and recreation of those whose minds are deranged or perverted without being distinguished. (SCL, 1869xli)

There was a decided attempt to remove these patients through systems such as boarding-out (see also Chapter Five):

> The withdrawal from asylums of patients in this condition can scarcely fail to render those institutions better able to discharge their higher functions, by diminishing the degree in which they merely act as boarding-houses, and by leaving them in a better position to act efficiently as hospitals for the treatment and care of those forms of sickness which have mental alienation for their prominent symptom or outcome. (SCL, 1878:iv)

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[227] This, of course, was the hinge of Scull's critique in *Museums of Madness* (1979).

[228] As a solution, it was suggested that, after a patient had received two to three years of 'free' treatment, his or her relatives should then be responsible for maintenance payments, but this scheme was never implemented.

Boarding-out those thought to be no longer benefitting from the asylum system, such as incurable and harmless patients, was recognised as one of the only methods of reducing overcrowding and the progressively pressing need for expansion. Although it was advocated with increasing strength by the Commissioners as the asylum populations increased, in some cases almost beyond control, the energies dedicated to the process by the district boards waxed and waned, depending on the immediate pressures on their existing accommodation. Many of the boards reported years when boarding-out was implemented as a priority, such as the Roxburgh Board in 1887, which, through the removal of many unrecovered patients, reversed the otherwise imminent need for expansion that had been inevitable six years previously. In this short period of time, they had turned a pressing over-crowding situation into a surplus of accommodation, which not only saved money in parochial rates but also resulted in many insane persons being "restored to comparative freedom and to the enjoyment of a natural home life" (SCL, 1887:xxviii).

A different tack was attempted in the 1880s, with the Commissioners now striving to deter persons from ever being placed in the increasingly over-crowded asylums, stating that transferral might not be in the best interest of every person. Moreover, the following quote further demonstrates a rowing back from the asylum ideal – suggesting that homespaces might, after all, be the most beneficial to well-being of individuals, *contra* to the surety of previous claims about how individuals' problems *must* be bound up in problematic 'home' life and experiences. It also follows on from comments detailed above which highlight a switch in thinking about the benefits of asylum spaces. The Commissioners were mindful that:

> There are families everywhere with whom squalor is the natural substitute for luxuriousness, who wear filth as a jewel, and who will sacrifice much for the sake of being allowed to live in delicious discomfort. It cannot be expected that the insane relatives of such as these can have much happiness, according to our meaning of the word; but it has to be remembered that their standpoint is a different one from ours, and much consideration is at all times required before active steps are taken to break up a home, when in reality there may be much enjoyment of life, though the standard of taste may be very different from our own … [H]andsome and costly abodes are not necessary either for the well-being or happiness of the insane poor. The homes of the poor afford advantages which are not at first sight apparent, and which are often not properly appreciated. Family life, in spite of what

> may be regarded as discomforts and defects, is that which is desired by, and is best for, the bulk of … patients. (SCL, 1880:lii-liii)[229]

Exacerbating the imbalance of curable and incurable patients further, there appeared to be a rising trend among the inspectors of poor to send persons to the asylum who only required protection and care, rather than medical treatment, and there was a growing concern that the misuse of asylums had set in, resulting in them being seen as "a convenient place to get rid of inconvenient people" (Scull, 1980). This development was to have a marked effect on how the district asylums evolved in the subsequent years.

There was a worry arising from the 1880s that the imbalance of patients, partly due to the nature of the persons being admitted under the parliamentary grant as detailed in Chapter Six, was causing the character of the asylum to resemble a boarding-house rather than a medical institution. There was an anxiety that this was injuriously affecting the medical superintendent's professional position, with "administrative tact" (SCL, 1870:xlvi) becoming a more pertinent attribute than medical knowledge and skills. Indeed, it was stipulated whether "a knack of rule and a knowledge of agriculture may be of as much consequence to a superintendent as purely medical qualifications" (SCL, 1870:xlvii).[230] Furthermore, as the numbers increased and the asylums expanded in size, it was thought unavoidable that the ability to individualise the patients and their treatment would diminish, resulting in "time and chance" having more of an influence on recovery rather than "any special treatment which he may have ordered" (SCL, 1871:xliii). Yet, despite this push to discharge any patient who was no longer benefitting from the asylum system, the numbers of long-stay patients almost inevitably increased. Consequently, despite the initial push for smaller asylums, as detailed above, in reality the district asylums became ever-larger, extensive institutions, with some eventually accommodating over one thousand patients. In order to manage such large populations, new methods of classifying the patients and dividing the asylum spaces needed to be developed.

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[229] This quote was one of the only hints that the Commissioners were aware of the disparities between their standard of 'home-like' and that to which the pauper lunatics were apparently accustomed (although this was outlined by Browne, see above). The statement has a telling 'us' and 'them' quality, starkly positioning a professional/class relation between the Commissioners and their insane charges.

[230] There was no resident medical superintendent at either the Elgin or the Haddington District Asylums, and no adverse effects were reported from this system of management, partly ascribed to the small size of these institutions.

## THE 'SPLITTING-APART' OF THE ASYLUM

### *Succursal Asylums, Auxiliary Accommodation and Detached Cottages*

In order to accommodate the increasing numbers of patients, institutions had to expand their accommodation, sometimes quickly. The district boards tackled the problem of overcrowding in a number of ways, with solutions regularly recommended by the visiting Commissioners. Rooms often had to be converted into sleeping accommodation: for example, at the Ayr Asylum in 1876 the Board Room and Medical Assistant's room were converted into dormitories to relieve the overcrowding on the female side (Ayr D.B., A.R., 1877), and in 1879 one of the day rooms in the Refractory Gallery was converted into a dormitory with eight beds for male patients (Ayr D.B., M.B., 1879). An additional arrangement at this institution was the construction of an extra storey on the corridors that connected the administration block to the main building, supplying accommodation for thirty male and thirty female patients (Ayr D.B., M.B., 1879). Other solutions included constructing detached cottages around the site. For example, when the Elgin Asylum was found by the Commissioners to be so overcrowded that "several of the patients occupy the bathroom as a dormitory" (SCL, 1871:xxix), they suggested that auxiliary accommodation in the form of cottages should be constructed, situated at the farm or near the main building. In the same report it was noted that a detached building for thirty patients of each sex had been constructed in connection with the Fife and Kinross Asylum. In 1875 it was reported that the Inverness Board had requested their architect to draw up plans for an auxiliary building for fifty male and fifty female patients, but it was decided that this option was too expensive, and the Board instead pursued the possibility of extending the main building to accommodate thirty more patients (SCL, 1875). The Inverness Asylum did lease a cottage at Balphatrick for fifteen patients and their attendant, however, and it was reported in 1884 that they were "judiciously left practically to manage themselves, and are happy, contented, and comfortable" (SCL, 1884:xxvi). In other institutions, notably the Ayr and Haddington Asylums, the problem of overcrowding was temporarily relieved by the conversion of space into dormitory accommodation that had originally been planned for other purposes, such as the upper floor of the administration block in the case of the Ayr Asylum. This solution was short-lived, though, as the institution was reported to be "dangerously over-crowded" in the 1893 Report (SCL, 1893:xxv). Other temporary solutions included structural alterations of the wards more generally, such as was reported in the Perth Asylum in 1888 (SCL, 1888:xxviii).

More permanent solutions were often found in the reconstruction and extension of existing spaces, such as occurred at the Stirling Asylum in the early-1890s. The dining hall and amusement hall were both enlarged, the stores were reconstructed and new shoe-rooms, lavatories, water-closets, laundry, administrative block and hospital were all erected. The Commissioners commented:

> Most careful and intelligent consideration has been given to the planning of these structures, and the plans are being carried out with judicious liberality by the District Board. When they are finished, the asylum will be put into a state of efficiency, which, it is said, will confer a benefit on the insane poor of the district, and will render the institution one of the most perfect of its kind in the country. (SCL, 1893:xxix)

Similarly, in 1895 (SCL, 1895:xxxii) it was reported that the Perth Asylum was greatly overcrowded and, as well as constructing two detached buildings for fifty men and fifty women respectively, the kitchen and scullery were also being enlarged to manage the increased number of patients.

In a further attempt to combat overcrowding, a number of asylums built off-shoot 'succursal' buildings, separate to the main asylum institutions but administratively attached. It is likely that the term 'succursal' derived from the French *succursale* which means a branch or subsidiary of an establishment. The Banff Board was the first to deploy the term, and commissioned the construction of such an asylum in the late 1870s. The succursal asylum that they described was in essence an independent institution, a new space for 'chronic' patients, providing dormitory accommodation, kitchen facilities and a laundry.[231] It was designed to house thirty women, under the charge of a matron. Suitable patients would be transferred to this establishment from the existing asylum, with the population consisting "as far as possible, of patients who can be certified to be incurable and inoffensive" (SCL, 1879:lxiii). With this in mind, it was requested that the structural arrangements be of a simple and inexpensive character, and once opened it was reported to have "an aspect of comfort, both externally and internally, and has few of the characteristics peculiar to public institutions" (SCL, 1881:xvii).[232] A similar separate block was proposed for the Fife and Kinross Asylum for the accommodation of seventy women (SCL, 1880). A separate block for 150 patients was opened at the Stirling Asylum in the

[231] It was hoped that the patients in this institution might be able to undertake public laundry work.

[232] The two institutions were amalgamated in 1890, to be known collectively as the Banff District Asylum, rather than the 'Banff District Asylum, Ladysbridge' and 'Banff District Succursal Asylum, Woodpark'. This appears to be a purely administrative shift, with the two asylums being managed as before. Importantly, they were never recognised as two separate district asylums.

early-1880s, but the Commissioners were far from satisfied with the arrangements of this building (SCL, 1884). Many defects were noted, such as the lack of attendants' rooms and storerooms, which had originally been planned but were converted into an office and boardroom for the superintendent. Furthermore, there were faultily constructed partitions in the dormitories, and benches instead of chairs in the day rooms. It was recognised that many of these shortcomings were easily remedied, and alternatives were recommended to bring the spaces up to the higher standard that was expected for such an institution.

Figure 9.13 – Nurses' Home, Perth Asylum, from the NE (SCRAN, no date). This building was opened in 1885, originally as a convalescent hospital but was later converted. Other asylums such as Lanark, Glasgow and Roxburgh constructed purpose-built, detached nurses homes in the twentieth century.

A further change was the move to provide separate cottages for male married attendants, which were to be scattered within the asylum grounds. The importance of retaining reliable staff was recognised by all the boards, so the cottages were to be supplied as an attempt to reduce the staff turnover. The benefit of hiring married men, according to the Commissioners, resulted in a greater "stability of service" as well as ensuring "to a large extent a more judicious supervision of the patients" (SCL,1901:xxxii). Assumedly, married men were more settled, less likely to terminate their work contracts, and, as they possibly had familial influence, were presumed to exhibit more patience and kindness towards their charges, with the General Board arguing the arrangements were "calculated to produce confidence with respect to care and treatment" (SCL, 1901:xxxii). When the Lanark Asylum was constructed, it was provided with twenty-seven cottages on the asylum estate,

married attendants occupied eighteen of these, with the remaining nine housing artisan attendants. Sixty-four per cent of the attendants at this institution were married, and it was reported that the management was "conducted in an enlightened, progressive, and successful manner" (SCL, 1898:xxxii).

On the other hand, female attendants, or nurses as they began to be called in the final years of the nineteenth century, were, from the late-1890s, accommodated in large detached 'Nurses' Homes'. This was not only to free up some of the accommodation in the increasingly overcrowded main buildings, but also allowed the staff some privacy and time away from the patients (even though they still lived on site). It was also part of a professionalisation and medicalisation of the profession, exhibiting a move from predominantly untrained female attendants to trained nurses. Very clearly expressing the need for nurses' 'colonies', the Lord Balfour of Burleigh commented:

> If they were to go in for hospital treatment with an hospital staff in their Asylum they must assimilate the conditions under which that staff was to do its work. If they wanted to draw into their service women of a kindly nature and a kindly disposition, if they wished nurses of a well-educated and refined class, they must give them the conditions which they reasonably demanded. They must enable them to do their duty, give them civilised conditions of life, and they must keep them out of the sphere of their work during the time of their recreation. They must give them a residence where they could see one another, compare notes, and help one another, and at the same time live the life of honest and cultured human beings. The work was trying and difficult work. The more trying and difficult it was the more they were bound – if they wanted to have it done successfully, and if it were to be done under humane and civilised conditions – to have a reasonable number of nurses to relieve one another, and to give them reasonable time for self-improvement and recreation. (Edinburgh D.B., A.R. 1908:11)

Consequently, many of the asylums started to construct detached nurses' homes on their premises. At the Perth Asylum, instead of constructing a purpose-built home, the institution converted the old convalescent hospital,[233] as shown in Figure 9.3, which the Commissioners were pleased to report had been "nicely furnished as a 'home'" (SCL, 1901:xxxiii). At the Glasgow Asylum, the nurses' home consisted of "a detached building situated at a convenient distance from the asylum", which contained sitting-rooms, a writing-room, a waiting-room, a library, and "excellent bedrooms", and was said to be "an admirable addition to the resources of the asylum and an arrangement which will promote

[233] The convalescent hospital was constructed in 1885 to the south-west of the main asylum. It is not clear from the records whether this was for asylum patients or general patients.

the comfort and the social condition of those whose trying lot is to wait upon and live daily in the society of the insane" (SCL, 1901:xxx). The building housed all of the female employees of the institution.

The accommodation arrangements for male and female staff of the institution were hence markedly different, with the institutions employing, predominantly, single females and married males, since it was these groups that were viewed as being able to provide the most reliable, consistent and safe service. An anomaly to this rule occurred at the Haddington Asylum, where it was reported in 1901 that the newly appointed superintendent and matron were husband and wife, Mr and Mrs Macrae (SCL, 1901). Another anomaly occurred at the Stirling Asylum, which, from the turn of the century, was under the charge of one lady superintendent and six female assistant matrons, which was reportedly to bring it "more into line with the methods which have been so well established in the management of general hospitals" (SCL, 1905:xxxvii). This last example highlights the shifting preference within the institution for female nurses, detailed below, and could possibly be linked to the 'Nightingale' effect, also highlighting the predominant move to recognising insanity, or, mental illness, as a medical phenomenon (although still predominantly as a *male* profession).

***The Creation of 'Sections': the separation of asylum spaces and hospital spaces within the institution***

As shown by, for example, the construction of separate succursal institutions, shifts in management towards that found in general hospitals and the amassing of incurable patients, the purposes and desired outcomes of the district asylum slowly started to change during the study period. Combined with the want to advance the medical understanding of madness, the demographic shift was a further catalyst to creating more specific spaces and the separation of buildings. As such, the asylum was slowly divided into two administratively attached but spatially separated sections, as reported in Chapter Eight. The Commissioners remarked:

> It has to be kept in mind that an asylum fulfils the double purpose of an hospital and a boarding house. (SCL, 1873:xxiv)

With this in mind, the existing hospital accommodation that was constructed when the district asylums were first opened was increasingly criticised as no longer fit-for-purpose. For example, from the mid-1880s it was remarked that the infirmary wards of the Argyll and Bute Asylum were seriously overcrowded, to an extent that it was "prejudicial both to

the mental and bodily condition of the inmates" (SCL, 1889:xxiv). As well as actively trying to reduce the number of patients, the District Board, after consultation, converted disused wards on both the male and female side into hospital accommodation. This was not done in time, however, to provide isolation space to contain an outbreak of measles in 1890, which resulted in the death of one patient and one attendant. The patients harbouring the disease were separated as best as possible by placing them in the tailor's workshop, "which was capable more than any other part of the building of being shut off from the rest of the asylum" (SCL, 1890:xxiv). Consequently, the Commissioners recommended that, as well as increasing the hospital space, a small infectious diseases hospital should also be constructed. The existing hospital arrangements were also criticised at the Fife and Kinross Asylum, with the Commissioners reporting that "the means of nursing the sick and those requiring special care [have] in this asylum been for some time markedly deficient" (SCL, 1891:xxv).

As a result of these obvious and increasingly apparent defects in the infirmary wards, as well as changing priorities in the spaces of treatment across the asylums, as remarked above, the district boards slowly began to advocate structural alterations to their institutions. Many examples can be extracted from the documents to show the progressive attempts at separating out the different asylum functions, as well as (re)instating medicalised spaces back into the institutions (which were believed to have been reduced due to the increased number of incurable patients: see above). The Perth Asylum was reported in 1878 to have updated its mortuary facilities, creating an important functional space for the scientific study of mental disease (SCL, 1878). Similarly, a new mortuary and research room were provided at the Stirling Asylum in 1893, "said to be highly satisfactory and to place the asylum in advance, in this respect, of every asylum in Scotland" (SCL, 1893:xxviii). In 1883, it was suggested that the Banff Asylum construct an infectious diseases ward in the corner of the airing court (SCL, 1883:xvi),[234] while a small cottage hospital to allow the isolation of patients with infectious diseases was to be constructed at the Perth Asylum (SCL, 1885:xxvi).

Further enhancing the medical understanding of so-called 'mental disease', a number of the institutions either constructed their own pathological laboratories on site, or were

[234] It was suggested that the stones from the airing court walls be used as material for building the new ward.

involved with the 'Pathological Laboratory of the Scottish Asylums'.[235] Funded by voluntary contributions from eighteen of the Scottish asylums (although mainly from three royals: the REA, Glasgow and Crichton, Dumfries), its primary objective was "the direct promotion of pathological research into the causes of insanity and the changes which occur in the nervous system in the course of mental affections" (SCL, 1901:lviii). For the first eight years, the emphasis of research was histological, but after 1904, this changed to research predominantly based on the chemical and bacteriological changes that occurred in mental diseases.[236] Eventually, defying fears that central laboratories would stifle the scientific research at individual institutions, a number of asylums set up their own laboratory spaces, such as Perth and Glasgow. The Commissioners described the one founded at the Glasgow Woodilee Asylum:

> It is large, well constructed, and very liberally supplied with every appliance of a modern description for clinical research in nervous disease, and for the investigation of pathological details. It contains a waiting room, a *post mortem* room, with cold chamber, and adjacent microscopic and section-cutting rooms, a chemical room, a lecture room or library, and smaller rooms for private research. It is stated to be perhaps the most complete and best equipped institution for nervous pathology in the United Kingdom. (SCL, 1905:xxxii)

The inclusion of teaching space as described above was to be used for the training of assistant medical officers and was an important outcome of the scheme. Crucially, it was hoped that providing such facilities would "foster a scientific interest in pathological research throughout the associated asylums" (SCL, 1901:lviii).

These alterations and additions were all precursors to the chief distinctive characteristic of internal spatial arrangements in the later district asylums, which was the division of the institution into two distinct sections, with greater significance given to fully appointed, purpose-built separate hospital facilities. The move was an extension of recent alterations to the infirmary wards at the older institutions, which the Commissioners recognised as occurring "due to a desire to increase the efficiency of asylums as curative institutions" (SCL, 1892:xliii). Advancing the idea further, it was acknowledged that this curative

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[235] This institute, founded early in 1897 by Clouston, was situated at the REA and was established to conduct scientific work into the nature of mental disease, taking inspiration from the laboratory set up at the Claybury Asylum in Essex in 1895 and the Scheme of Research and Study in New York (Davis, 2008).

[236] In order to cater for asylums in the west of the country, many of which had withdrawn their contributions to the Scottish Laboratory due to feelings that it was serving the east-coast asylums more, a second laboratory was opened in the grounds of the GRA in 1909. Known as the Scottish Western Asylums' Research Institute, it was supported by eight asylums in this area, and run by a board consisting of one representative and the superintendent from each contributing institution, as well as by the Professors of Practice of Medicine and Pathology at the University of Glasgow (Davis, 2008).

ability would be more greatly enhanced if the specially designed hospitals were "kept to a great extent separate from those which have more immediately in view the providing of a home for the inmates" (SCL, 1892:xliii). The new hospital sections would ideally "be devoid of unpleasing asylum features in all its arrangements, being purely hospital in character", which, it was hoped, would help aid in the early recovery of curable patients.

It was believed that the separation of these two main functions of the asylum would allow for a more efficient medical service for those patients requiring treatment for both acute mental ailments and bodily needs "such as acute mental afflictions, physical infirmity, or physical illnesses" (SCL, 1914:xcv). There was an acknowledgment and identification between somatic/organic illnesses and 'mental diseases', with appropriate treatment facilities being advocated and manipulated to treat physical symptoms which in return, it was hoped, would return reason. Examples include the construction of verandas and windows designed to allow the open air to intrude, hence changing the atmospheres of the spaces, particularly for the treatment of patients whose nutrition was defective, and those suffering from tuberculosis. At the same time, this separation and division of the institution enabled improved arrangements for those patients in the 'asylum' section – those unfit for life in the 'outer world' – through the enhancement of the 'normal' home-like atmosphere and the recreational and occupational facilities.

This change in the view of what constituted the ideal layout of the asylum buildings reportedly came about "gradually and as the result of experience" (SCL, 1892:xliii). The first institution to trial a bigger hospital space was the West House of the REA, which, under the superintendence of Dr Clouston,[237] converted the refractory wards into hospital accommodation. This was a single-storey separate building situated in the section of the institution that housed the pauper and lower classes, and, despite being an old building not designed for this new purpose, the conversion reportedly worked exceptionally well. The Commissioners testified that "the experience gained in these wards did much to show the advantage, at least for large asylums, of having the hospital buildings completely separate from the rest of the institution" (SCL, 1892:xliv).

[237] Thomas Smith Clouston (1840-1915), born in Orkney, went on to become a notable Scottish physician. He studied under Laycock at the University of Edinburgh and, upon graduating, worked as assistant physician to Skae at the REA. When he was still only twenty-three, he was employed as the superintendent of the Cumberland and Westmorland Asylum at Carlisle, staying there for ten years until moving back to Edinburgh to assume the post of superintendent at the REA after Skae's death. Other achievements included his appointment as the official lecturer in mental diseases at the University of Edinburgh in 1879, becoming editor of the *Journal of Mental Science* and writing *Clinical Lectures on Mental Disease* in 1883, which went through six editions by 1904 (see Beveridge, 1991, 1998 and 2004).

Following on from this conversion, and in anticipation of the construction of new district asylums, particularly around Glasgow, as a result of the 1887 Act, the General Board requested their architect, Mr Sydney Mitchell, to draw a set of model plans providing a visual representation of changing views of asylum construction, which could therefore, provide an updated blueprint for the district boards (SCL, 1892).[238] The plans were to be for an institution that would accommodate 1,000 patients, which was markedly greater than the smaller asylums advocated during the middle of the century, offering a further indication that the asylum populations had grown exponentially over the decades. The model institution was to be divided into two main sides, with the hospital section constituting one-third of the total accommodation. This side was to house patients suffering from acute illness, as well as those needing special medical treatment and general nursing or those with suicidal tendencies. In order to assess new patients, all persons were to be admitted to the hospital on arrival at the institution. To facilitate the increased classification of patients suffering different maladies, ideally the space was to be divided as follows:

> Two divisions of the hospital were devoted to the accommodation of these patients, one on the male side, and one on the female side. A second division on each side was devoted to the purposes of a sick-room or hospital ward in the ordinary sense of the words. In this division would be placed all patients requiring ordinary hospital treatment on account of either bodily or mental illness. A third division on each side was devoted to patients requiring special nursing on account of general feebleness, wet or dirty habits, or other peculiarities which require treatment of a special kind. (SCL, 1892:xliv)

Crucially, the hospital section would constitute an almost independent institution, with its own small secretarial block, kitchen and dining hall, all embodying the distinctive characteristics of a medical institution. There would, however, be administrative and managerial connections to allow the transferral of patients between the two sections of the institution as necessary.

The other two-thirds of the asylum would continue to provide the main administrative centre, as well as the accommodation for "patients for whom medical treatment in the more restricted sense of the words is not required" (SCL, 1892:xlv), including the convalescent

[238] As far as I am aware, these plans have not survived, and it is not even clear whether they were ever physically produced, as this is the only reference to them that I came across.

and chronic patients.[239] The architect divided this section into two pavilions of equal size, which would be situated on either side of the administrative block. One pavilion would be reserved for the most easily managed patients who required low levels of supervision, consisting of the majority of the regular workers (and as such the pavilion would be mostly empty during working hours). This space would be organised as an 'industrial' community, with its arrangements "of the simplest kind, and having as little as possible of the special features characteristic of an asylum" (SCL, 1892:xlv). The other pavilion would house patients who needed closer supervision, and would likely be a mix of working and non-working patients.

The Commissioners reported that this latter section would "necessarily have more of the asylum character", although they recognised that "the absence of patients requiring the special attention provided in the hospital section would prevent the need for many of the ordinary asylum features" (SCL, 1892:xlv). As before, the central block would consist of the main offices for the whole asylum, the general stores, the general recreation-hall, a kitchen, and a general dining-hall. The workshops and laundry would also be administratively connected to this section of the institution, although their exact location was not specified. As can be seen, this was still to be a highly classified space, with the separation of different 'types' of patients pertinent to the successful functioning of the institution. A chief advantage of the asylum section was the simplicity and economy of administration:

> All the patients in that section of the asylum would take their meals in the general dining-hall, no special diets would require to be prepared, and the hours for meals, for work, and for everything in the daily routine would be adapted to the regulation of an industrial community. (SCL, 1892:xlv)

The Commissioners reported that the most recently constructed asylums had taken on board the general elements of this new institutional blueprint, and that a number of the older district asylums either approved, or were recommended to consider, the construction of hospital sections apart from their asylum sections, to bring them in line with the new facilities being provided at both the most recently constructed district asylums and the Royal institutions.

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[239] 'Medical treatment', it can assumed, referred to focussed medical interventions directed at 'curing' a serious mental (and/or physical malady) – once deemed 'incurable', of course, such medical interventions became irrelevant.

This move was a logical step on from the previous infirmary ward 'hospital' facilities, which were quickly becoming too small for purpose, particularly as the demographics of the asylum population were shifting and the emphasis on distinct, purpose-built medical space was growing. Consequently, the Commissioners reported that plans for such a building at the Fife and Kinross Asylum had been "very carefully considered" and that, when the hospital was completed, it would "add greatly to the efficiency of the institution" (SCL, 1892:xxvi). It was proposed that Inverness Asylum should also consider constructing a separate hospital, which would not only relieve overcrowding but do so in a way that would be beneficial for those patients requiring special observation and nursing, also aiding the institution in becoming "fully efficient" (SCL, 1892:xxviii) in its purpose as a restorative machine. The Stirling Asylum tackled its overcrowding through extensive enlargements and improvements, which included a new separate hospital as well as a new administrative block and a new laundry. Similarly, when the Roxburgh Asylum was reported as suffering from overcrowding, particularly on the female side, it was recommended that this problem be tackled through the construction of a hospital "as the number of sick and infirm patients is large, and there is an absence of proper sick-room accommodation" (SCL, 1895:xxxii).

When planning these alterations, the special purpose of each section was carefully considered:

> Not only with a view to their adaption to a general scheme of management, previously thought out on lines intended to accord with what recent experience has shown to be best, but also with a view to the special purpose which each section is intended to serve. And not merely has careful thought been shown in the general scheme, and in adapting the additions and alterations to the special objects aimed at, but equally careful thought has been expended upon the arrangements in their minute details. (SCL, 1892:xxx)

Importantly, as discussed above, the buildings in the different sections were to be designed down to the micro-specifics in order to create spaces that would have the greatest potential for affecting the patients and achieving the desired results, both curative and calmative, for the Commissioners believed that, if it were only the general arrangements that were planned, these benefits would be diminished. For example, the new female hospital at the Roxburgh Asylum was reported to be excellent and that "its wards are being liberally furnished and equipped to meet the requirements of sick, helpless, and feeble patients" (SCL, 1899:xxxii). Ironically, it was the older 'moral' vision that remained for the 'incurable' patients, effectively becoming the locus of 'asylum' interventions and

architectures rather than the newer medical (clinical) vision in the 'hospital' section, where the real work of 'cure' was supposed to be going on. This remarkable shift in the use of spaces crucially provides a vital re-scripting of psychiatric history, and will be re-emphasised in the concluding chapter.

By the close of the study period, in many of the larger asylums up to half of their accommodation was provided in the hospital section. The Commissioners were keen to point out that this was not due to the Scottish insane being "unusually feeble and decrepit"[240] (SCL, 1914:xcvi), but rather was a consequence of a boarding-out system which resulted in many chronic, manageable insane being cared for in the community. They concluded:

> The increased recognition of the use of hospitals in asylums is the direct result of the advent of newer medical ideas of the treatment of insanity, and the suppression of them of the older ideas according to which insanity was regarded as a more or less social disease, capable of amelioration by hygienic measures. (SCL, 1914:xcvi)

This in effect refutes the older 'moral' concept of 'madness' and its treatments, masking a significant (on going) change that had multiple implications for asylum geographies at all scales. The Commissioners clarified that, although consisting of two separate sections, the asylum should still function as one institution managed by one medical superintendent. It was mentioned that in some countries institutions had been spatially *and* administratively separated, which resulted in difficulties such as hindrances around transferring patients between sections, such that the separate model "never fulfilled the expectations of [its] promoters" (SCL, 1892:xlvi). Keeping them united, it was believed, allowed the smoother transferral of patients between sections, particularly as the condition of patients varied over time.

## TRANSITIONS TO THE "VILLAGE OR SEGREGATE SYSTEM"[241]

Evidently, towards the end of the nineteenth century opinions about the ideal asylum configuration were transforming, and consequently the institutions increasingly 'split apart' into more classified, smaller and increasingly either medical or home-like components. Alongside constructing new hospital spaces within the institution, the district

[240] The hospital patients would surely have been configured as principally acute patients who could be cured, precisely not, then, 'feeble and decrepit', terms normally used for chronic patients.

[241] *The Builder*, 1906:544

boards also erected new spaces for the long-stay, chronic and industrial patients, most commonly in the form of detached blocks of a cheap and simple nature for the accommodation of between thirty and fifty patients. The erection of separate buildings, both to extend the older institutions and as part of the new layout of the institution as two spatially separated but administratively attached 'sections', permitted an even greater flexibility in classifying the patients to any extent that was desired. It was therefore viewed as a useful tool in both the management of the patients and making economic savings for the institution. Additional spaces to help create a more economical and self-sufficient institution (see Goffman, 1961) were also to be constructed, such as a new bakery at the Fife and Kinross Asylum. This was to be used for baking all the bread required by the asylum, as well as meat pies and fresh pork once a week. These alterations and developments in asylum design resulted in a transition towards a more segregated 'village' asylum layout, which was to be adopted by the district boards building asylums towards the end of the nineteenth and into the twentieth century. Dr Sibbald (1897:200-201) explained the transition to the village type of asylum as due to the following reason:

> At an early date, in what may be called the modern asylum epoch, small groups of the more trustworthy patients were placed in houses quite separate from the main asylum buildings. In most instances, such groups consisted of a few patients who lived at the farm steading attached to the asylum and were engaged in the work of the farm. In several places, especially on the continent, the buildings erected in connection with the farm steadings are of considerable size, and in France and Germany they are called agricultural colonies. The experience gained in the detached buildings, such as those just mentioned, has contributed to strengthen a conviction that has been growing in the minds of many persons acquainted with lunacy administration, that a large number of the inmates of these institutions require little more than kindly care and guidance to induce them to conduct themselves in an orderly and inoffensive manner; and it is becoming more and more recognised that, the nearer the conditions of asylum life are made to resemble those of a sane community, the more contented do the patients become, and the more successfully is their restoration to a really sound state of mind promoted and secured.[242]

Undoubtedly a result of observing the changing architectural structures of the older district asylums, the newer district asylums were designed either along 'pavilion' principles – a hybrid built upon the older, blocky institution, such as the Glasgow Asylum – or as completely segregated, village-type institutions, three of which were constructed within the

[242] Although most of the description here applies to thinking increasingly directed at 'incurable' patients, the end of the quote alludes to a continuing 'curative' ambition through the affective design/engineering of all of the asylum spaces.

final ten years of the study period: at Aberdeen, Edinburgh and Renfrew. The design of the village asylum constructed by these boards was apparently modelled on the German Asylum of Alt-Scherbitz[243] (see Figure 9.14) "which is composed of a series of detached buildings, distributed without formality or attempt at regularity" (*The Builder*, 1906:544), and guided by Sibbald's[244] 1897 text *On the Plans of Modern Asylums for the Insane Poor*. As has been shown above, however, the adoption of unconnected buildings had also evolved in Scottish institutions over time for a number of reasons.

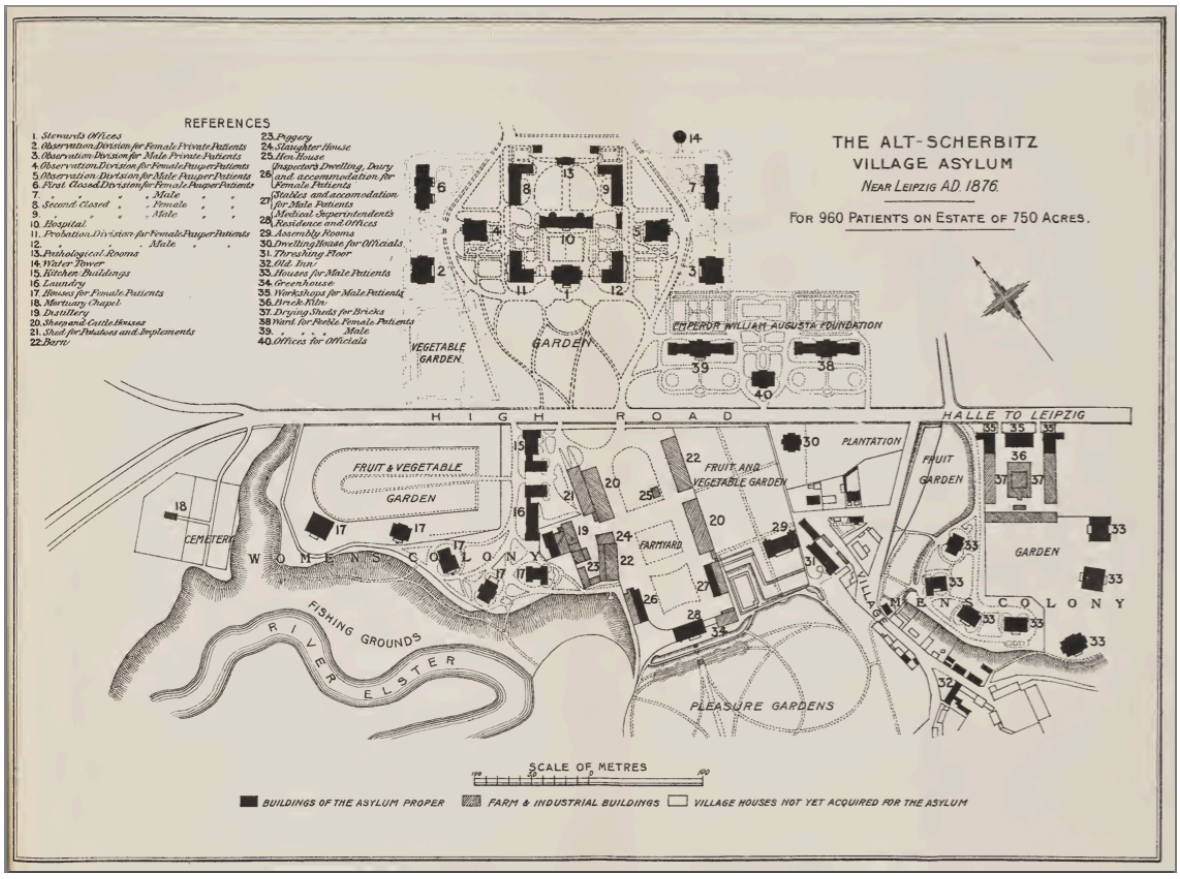

Figure 9.14 – Plan of Aly-Scherbitz Asylum (Sibbald, 1897:22)

The first of the district asylums to move away from the old single E- or T- shaped institution was the Glasgow Asylum, opened in 1896, initially with space for 530 patients.

[243] The construction of the Alt-Scherbitz Asylum began in 1876 and was completed in 1885, with accommodation for 800 patients, which was shortly after expanded to 960 patients. Most were pauper inmates, although there were a number of low fee-paying private patients. The estate was 750 acres, and when purchased included a mansion, a farm steading and a hamlet. The institution was divided into two sections: the hospital or medical section (known as the central establishment) and the non-medical section (known as the colony). The central establishment lay to the north of the site, and could accommodate 550 patients, and the colony, which was situated to the south, could accommodate 410 patients. The main public road from Halle to Leipzic divided the two sections. All the buildings were constructed to be as similar architecturally and in size to ordinary dwellings (Sibbald, 1897).

[244] John Sibbald was one of the Scottish Commissioners in Lunacy when he wrote this book, which was originally commissioned to "afford information to the authorities of the recently constituted Edinburgh Lunacy District [but was] reprinted because it was suggested that the information it contains might be acceptable to others who are interested in the construction of asylums" (Sibbald, 1897:3).

Clearly embracing the 'sections' just described, the winning architectural plans, titled "Health and Economy", were submitted by Thomson and Sandilands, and consisted of a main asylum, including an administration block (Figure 9.15), and a detached hospital (Figure 9.16).[245] The buildings were constructed of red stone on the outside and white stone internally, with the frontage stretching circa 700 feet. The buildings in the asylum section at this institution consisted of:

> An administrative block, behind which are the stores, kitchen, dining and amusement halls, and of four blocks, two on each side of the administrative section, containing day-room and sleeping accommodation for the patients. (SCL, 1898:xxx)

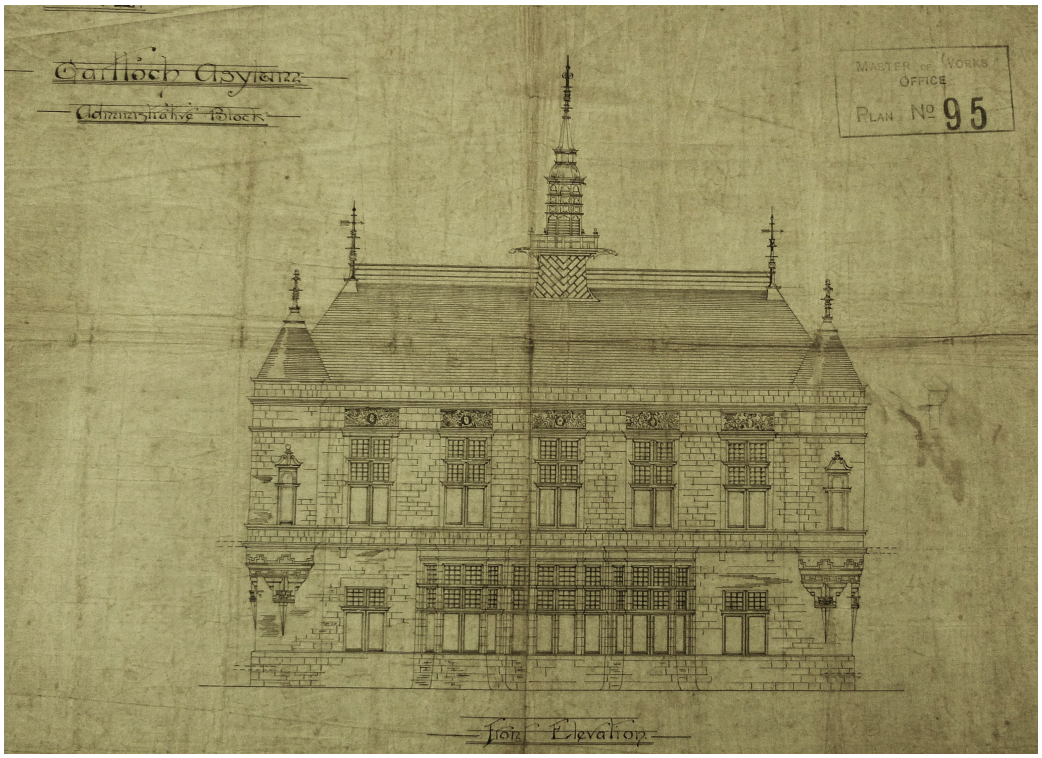

Figure 9.15 – Glasgow Asylum Administrative Block, 1892 (GGCA)

The administrative block was centrally situated, with the accommodation blocks situated on either side, one male and one female, each accommodating 200 patients. These blocks were spatially separate, yet joined to each other and the central block by linking corridors. The general bathrooms were also accessed from the corridors. The laundry and washing house were located on the female side of the building, with the workshops on the male side and this part of the institution was "organised along the lines of an industrial community" (Glasgow D.B., A.R., 1898:17). Sibbald (1897:14) commented that the separate blocks had the advantage of improving the atmosphere of the rooms by providing "an abundance of

[245] Many of the original plans are held at the Mitchell Library, Glasgow. I consulted and photographed them, but, unfortunately due to their age, the majority of the plans did not come up well when photographed.

light and air to all the apartments", as well as refining the management and control of the patients because "it also defines in an effective manner the responsibilities of every attendant in charge of a group of patients, each block providing accommodation, both night and day, for all his or her patients".

Figure 9.16 – Glasgow Asylum, original plan by Sandiland and Thomson (GGCA). The detached building to the left is the hospital block.

The hospital section was to house 140 patients and was designed as a general infirmary with, it was reported, many patients appreciating "the distinction between asylum and hospital" (D.B., A.R., 1898:17). Situated at the entrance were two parlours fitted out as medical consultation rooms. When a new patient arrived at the institution, they were taken directly to these rooms and examined by the medical officer, who recorded as much information as possible from those who had delivered the patient. From here, the patient was bathed and put to bed "before seeing any of the other patients, or anything special of an asylum character" (D.B., A.R., 1898:26). This procedure was not only used to start building up the case notes of the patients (see Morrison, forthcoming), but was also an attempt to gain the trust of the patients and ease them into the institutional setting, as it was held that "the importance, with a view to curative treatment, of making a favourable impression on the minds of patients on the threshold of their asylum life can scarcely be overestimated" (D.B., A.R., 1898:26).

Within only a few years of opening, the Glasgow Asylum was building five additional blocks to house 200 more patients. These blocks were all to be located in the asylum section, and consisted of a house for forty-five working patients in close proximity to the farm steading, a house for forty-five chronic male patients, and two houses each to

accommodate forty-five female patients. A separate reception house for the assessment of newly admitted patients was also constructed, and was said to be an "excellent idea both from the medical and administrative standpoints" (SCL, 1903:xxxii).

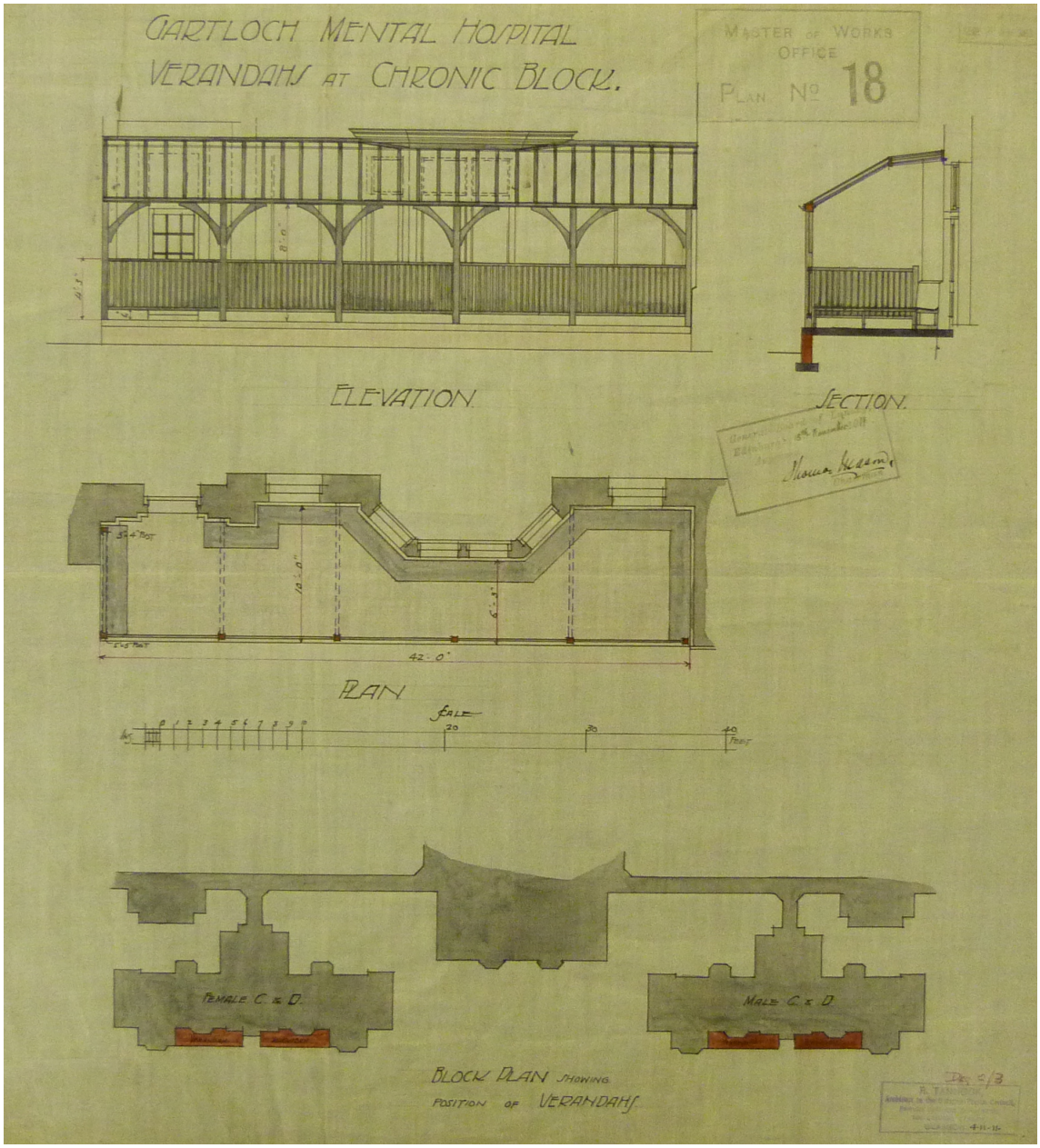

Figure 9.17 – Verandas of Chronic Block, R. Tannock Architect, 1911 (GGCA).

Further additions to the Glasgow Asylum included a sanatorium for consumptive patients, which had room for thirty male and thirty female patients, a nurses' home, and ten cottages for married male attendants. The sanatorium was constructed of wood and iron, completely surrounded by verandas, and the ward beds could be moved to allow bed-ridden patients the healthful benefits of fresh air. Verandas were also constructed in connection with the hospital, so as to enable open-air bed treatment for acute cases of mental disease (SCL, 1905) (see Figure 9.17), and in time a number of other institutions provided verandas in conjunction with their hospitals, in effect extending the tuberculosis model to 'madness'.

[246] For example, at the Ayr Asylum all newly admitted cases, acute cases and all chronic, noisy or troublesome patients were placed in beds on the verandas, and, apparently, under this method of management they became less restless, slept better and their appetites improved (SCL, 1908).

The Edinburgh Asylum, constructed in the opening years of the twentieth century, was said to be the first complete example of a 'village' asylum in Britain, with its defining feature being that it was "distributed without formality or attempt at regularity" (*The Builder*, 1906:544) (see Figure 9.18). As the building of the asylum had hit a number of obstacles, including financial limits, the building process had been grossly delayed, and thus the speed at which accommodation could be provided was imperative. As a consequence, the Board discussed ways in which the material cost could be lessened without reducing the overall floor space. This fact, together with severe and dangerous overcrowding in the REA and a lack of asylum accommodation generally across the country, resulted in the construction of five simple wood and iron villas which were much cheaper to construct than their stone counterparts, and could be erected in only a few months. Four were to accommodate working patients, and the fifth was to be used as a temporary administration centre, and they were to be assembled before the construction of the main asylum buildings. A further benefit of these small, detached villas was the reduction in the risk of fire compared to the block and corridor pavilions found in the earlier institutions. As such, the Commissioners reported:

> We have intimated that we will be prepared to regard these villas as forming a permanent part of the asylum, as we have reason to believe that, if due care is exercised in their preservation, they will furnish good and comfortable accommodation for a very long time. (SCL, 1903:lii)[247]

Over the next few years, the other necessary parts of the asylum were constructed, with the institution initially planned to provide accommodation for 744 patients and very specifically designed to allow detailed classification of patients. As such, it was to consist of a medical section to the east, which would comprise of an admission block with an administrative centre, a hospital, two observation villas, two closed villas and a nurses' home, and an industrial section to the west, which was to contain the farm house as well as

[246] For further research on the historical geographies of the sanatorium and tuberculosis, see Craddock (2001, 2008).

[247] This was almost a case of the 'portacabins' becoming permanent institutional spaces – as is a recognisable occurrence in many cases today. It also echoes the story of the field 'hut hospitals' proving better than permanent military hospitals (in terms of cure rates), which was a key influence on Nightingale's advocacy of a 'pavilion' (or villa) system for general hospitals (Richardson, 2010).

five homes for men and four for women (see Figure 9.19). Additionally, situated in the centre, there was to be a store, kitchen, power-house, laundry, bakery, steward's house and recreation hall for recreation, which was "completely fitted with platform, stage, and seat store" (*The Builder,* 1906:546).[248] The medical superintendent's house was located to the north, and was reportedly "a commodious dwelling, so situated as to command a view of all the buildings" (SCL, 1906:xxxii), thus retaining some indication of a superintendorial surveillance model. To the extreme west could be found a farm estate, which was modernised out of existing buildings. To ensure that the various buildings were aesthetically interesting, despite their low economic cost and simple designs, they were externally treated in different ways, with the walls consisting of either exposed stone or harling, and the roofs either tiled or slated using green slate. It was reported that "a fair architectural effect is obtained by simple variation in form, without superimposed decorative features" (*The Builder,* 1906:545).

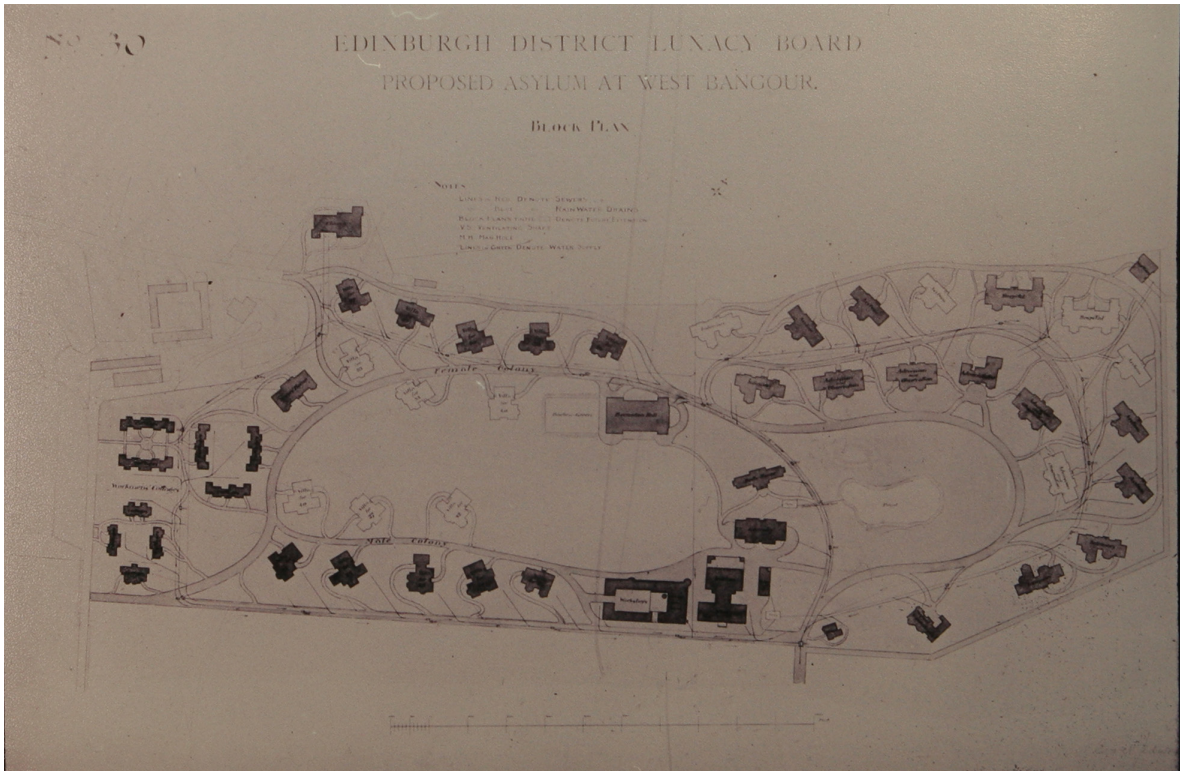

Figure 9.18 – Plan of proposed Edinburgh District Asylum at Bangour Estate (LHSA).

Commenting on the layout of this institution, the Commissioners exclaimed:

> It would have been impossible to have introduced this form of asylum into Scotland, were it not that during the last fifty years many important improvements in the treatment of the insane have been gradually introduced. Without these

[248] It was hoped that this central section would also include a church, and this was finally built in 1930 as a memorial church for the contribution made by the institution to WWI.

> reforms an asylum of this kind would scarcely have been possible. As it is, the system upon which it is constructed has undoubtedly proved beneficial to the patients. It marks an advance on the old "barrack" type of institution, and an approximation towards the normal mode of life of human beings, while it permits better classification of the patients, and greater freedom and greater facilities for work and exercise in the open air. (SCL, 1914:xxviii)

This absolutely crucial statement shows the clear sense of novelty of the new village asylum design. The new layout reflected approximately fifty years of accumulated experience under a changing district asylum model which culminated in the creation of a plan, if far removed from the original 'blueprint', which was still recognised to hold the affective power to cure, care and control its population.

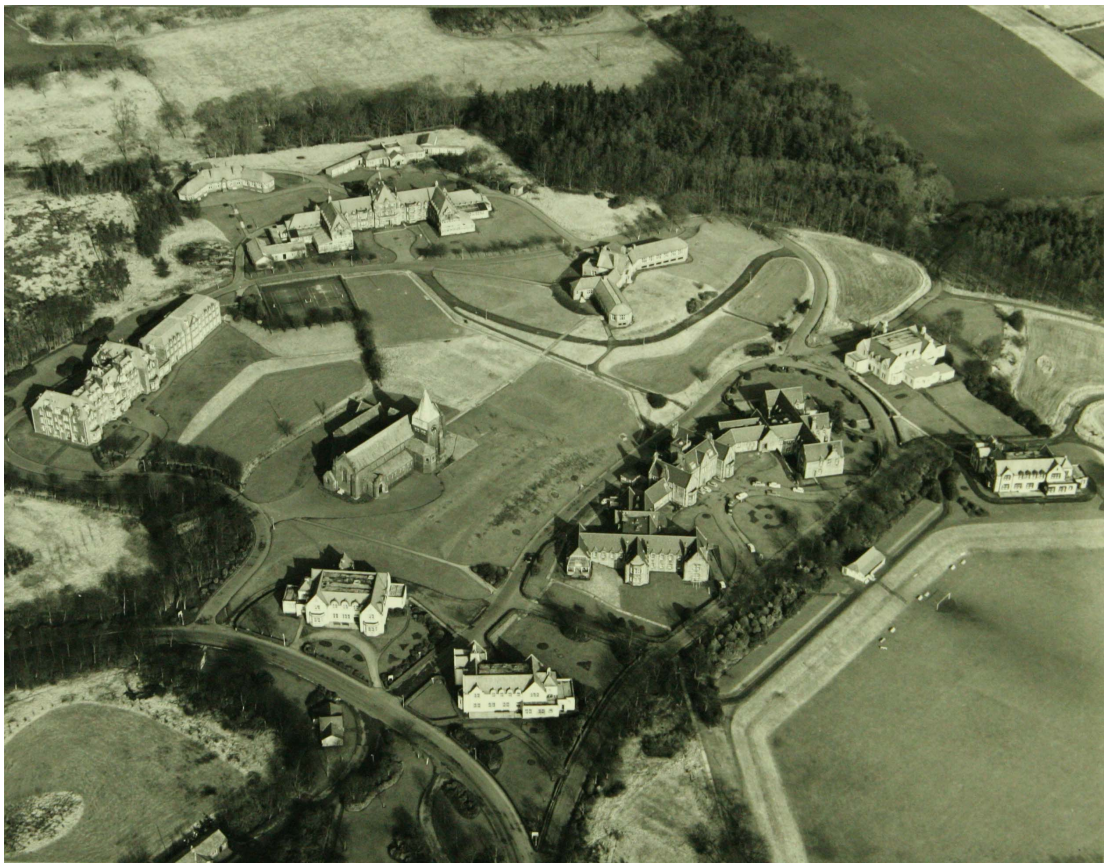

Figure 9.19 – Edinburgh District Asylum at Bangour Estate (LHSA). This image was taken after 1930, as the church can clearly be seen in the centre of the photograph.

Taking a closer look at the industrial section, it was divided so that the homes for labouring women were located on the lower, or southern, section of the industrial part of the estate. One of the villas, known as the 'laundry home', was conveniently located near to the laundry and central kitchen. The male industrial patients were housed in villas located in the northern portion of the industrial section. The villas were furnished to give the appearance of an ordinary home, with all asylum-type features avoided as far as possible. When opened, the industrial section had accommodation for 462 patients, while the

medical section had accommodation for 346, and there was space for 65 patients at Middleton Hall, a mansion house located two miles from the estate.[249] In total, therefore, there was space for 873 patients, but the administrative buildings had been constructed for the requirements of an asylum of 1,000 to 1,200 patients, meaning more villas could be constructed without placing undue pressures on the institution (Keay, 1911:410).

The hospital, situated within the medical section, originally contained accommodation for ninety patients in three wards and four side rooms. To enable open-air treatment, verandas and sun-rooms were attached to the wards, again an attempt to 'engineer' *real* atmospheric environments through enhancing natural air and light in the treatment spaces. As well as the accommodation, the hospital also contained an operation room, a laboratory for pathological and clinical studies, a lecture room used for training the nursing staff and an electrical[250] department. There was also a self-contained isolation hospital in the medical section, which was predominantly to isolate patients suffering from tuberculosis, and as such contained its own kitchen, stores and staff accommodation, as well as simple, inexpensive accommodation for senile and infirm patients. The view from the windows of this building were described as "extensive and beautiful" (Edinburgh D.B., A.R., 1912:33).

The recreation hall, situated in the centre of the institution, was initially used for church services as well as recreation, which consisted of weekly dances on Wednesdays and regular concerts and theatricals. The District Board reported that:

> The experience we have had of its use enables one to say that it is sufficient in size, comfortably warmed and well lighted; that the decoration though inexpensive is tasteful and effective; that the means of egress are ample and conveniently situated, and that the stage arrangements are very complete. Altogether, the Recreation Hall promises to be one of the most satisfactory buildings in the Village, and it has already been the means of giving pleasure to a large number of people. (Edinburgh D.B., A.R., 1909:12-13)

Exampled in this quote, it is interesting that the whole complex swiftly became known collectively as 'the Village', possibly attempting to draw on rural/countryside allusions, although, of course, this was not straightforwardly a return to/continuation with older

[249] Middleton Hall had previously been occupied by overflow patients from the lunatic wards of Craiglockhart poorhouse, Edinburgh, but was then transferred to the Edinburgh District Board. It was rented from the Broxburn Oil Company, and accommodated chronic patients, originally 15 females and 50 males, but it was soon changed to 50 females and 15 males, as there was a shortage of female accommodation at the main asylum (E.B., A.R., 1908:13).

[250] Although no further explanation is given, it can be assumed that the electrical department was responsible for providing the asylum with electricity such as lighting.

moral-locational proposals. Adding to this illusion was a space apparently unique to the Edinburgh Asylum, the Visitors' Tea Room, where friends and family of the patients could "obtain light refreshments for themselves, as well as entertain in a harmless way some of those they have come to visit" (Edinburgh D.B., A.R., 1909:14). Similarly, the asylum included a small shop (see Figure 9.20), for use by patients, staff and visitors, aiding in its illusion and aim of being a self-contained community. Both of these facilities would, the Board determined, provide profitable ventures for the institution. A challenge that had to be overcome arising from the segregated nature of the institution was that there was no communal dining hall as found in other asylums. Consequently, the food, which was prepared and cooked in the central kitchen, had to be carted to the different villas and wards in metal boxes that fitted into a specially designed wagon pulled by two horses. Apparently, despite the most remote building being a fifteen-minute journey from the kitchen, the food still arrived without much loss of heat, and as such the system was seen as admirable (Keay, 1911).


Figure 9.20 – Edinburgh District Asylum Shop (LHSA Twitter). Opened circa 1912, this photo was taken during WWI when the institution was transformed into an emergency war hospital.

The final asylums to be constructed as part of the district asylum roll-out were the Aberdeen Asylum and the Renfrew Asylum, both of which were of the detached, village type, similar to the Edinburgh Asylum described above. The Aberdeen Asylum consisted of a central hospital for one hundred patients, surrounded by ten villas (five for each sex),

an administrative block, with male attendants accommodated on the upper floor, a nurses' home, laundry and power house, kitchen and stores, recreation hall, workshops, a mortuary, a house for the medical superintendent, three lodges for officials and two double cottages to house an attendant, the blacksmith, and a number of farm servants (*Free Press*, 1904:np). The buildings were described as being of a "plain, but substantial character", and it was felt that "the position and internal construction of the several buildings [had] evidently received careful consideration" (*Free Press*, 1904:np). Eight of the villas were to be unlocked 'Colony Villas' for industrious, easily-managed patients, but two of the ten villas were to be 'closed', with the doors continuously locked due to the class of patients accommodated. This arrangement allowed for the detailed classification of the patients within the 'asylum' section of the institution and, similarly, the wards of the hospital section were divided in three, to accommodate respectively the sick, the depressed and recent and acute cases respectively. Modern communication technology meant that the buildings could be connected by telephone, rather than by the physical corridors of institutions built in the nineteenth century. Additionally, electric bells were installed in many of the dormitories, which could be used to summon nurses and attendants. Very similarly, the Renfrew Asylum included an "administrative centre, a separate hospital, and separate villas at suitable distances for the various classes of patients" (SCL, 1910:xxxii). Again, the wards had electric lighting and were connecting via a "telephonic intercommunication system" (SCL, 1910:xxxii).

The Edinburgh, Aberdeen and Renfrew Asylums were all very similar in design, but with local variations. Their common trait was that each building was separate. The administrative blocks (including kitchen, laundry and stores) were to be built for a fixed number of patients, but the accommodation could be increased as numbers required, by quickly constructing extra villas. The Commissioners commented:

> As has been already stated more than once, the primary aim of all the changes in lunacy administration referred to has been to assimilate the life of the insane, as nearly as possible, to ordinary social life. The unavoidable feature of the older asylum construction was the "barracks" type of the buildings; the village asylum is a step nearer home life. (SCL, 1914:cii)

The asylums built soon after the 1857 Act and those constructed in the decade before the 1913 Act were, therefore, markedly different, although the Commissioners and district boards had been advocating the production of 'home-like' spaces from early on in the study period. The opinion of 'home-like' had clearly shifted, though, perhaps with the

realisation that the perception of what constituted a 'home' by patients coming from predominantly pauper households was markedly different from the 'official' vision. Furthermore, there was also a growing need to create economically viable, easily constructed accommodation that had the ability to classify the patients to an even greater degree than was promoted in the early asylum design, particularly by creating clearly defined hospital and asylum (industrial/agricultural) sections within the overall frame of a 'village asylum' not a 'barracks'.

## CONCLUSIONS

Similarly to Chapter Eight, this Chapter has shown that neither the Commissioners' blueprint for the asylum buildings nor the bricks-and-mortar placed on the ground were static entities, but rather transformed over the study period due to shifting discourses of treatment and management, pressures of overcrowding and evolving technologies of diverse kinds. The internal spaces were viewed as a powerful affective/effective tool over the patients, with the superintendents and Commissioners constantly engineering their layout, design and atmosphere to achieve improved behaviour, and hence a population that was easier to control. Ultimately, even so, it was hoped that the designs would eventually induce both curative and calmative results. At a similar time as the walls of the airing courts were being pulled down, within the asylum buildings the doors were being unlocked. This was a further push to limit the use of mechanical restraint of any species, only made possible if the staff of the institutions showed greater vigilance in their roles and the individualisation of patients. In order to procure staff who would conform to this model, the central and district boards were aware that they needed to provide incentives for them to work within the institution, understanding that often it was a difficult and thankless task. As such, separate, detached staff accommodation was constructed. Emphasising the importance of subtle 'affective power' as a tool for the management of patients, Sibbald (1897:12) remarked:

> The removal of mechanical restrictions was the result of finding that most patients could be induced to submit to control when it was accompanied by efforts to gain their confidence by the exhibition of kindly sympathy and a desire to promote their comfort. It was found that the resistance of the patients to detention was, in most cases, diminished, if not removed, when it was made evident to them that those under whose charge they were placed were anxious to help and benefit them; and experience showed that the introduction of additional arrangements obviously intended for the advantage of patients, combined with the removal of irksome

> restrictions, had the effect of still further tranquillizing the patients and promoting their contentment.

Yet, the ever mounting overcrowding of the asylum facilities was an evident undercurrent to the extensions and improvements of the institutions. Often the impression was given that buildings were constructed more as a coping mechanism to combat overcrowding, rather than the planned improvements of the asylum reflecting a drive to create a more curative apparatus. Yet, having said this, the extra buildings, although erected out of necessity and predominantly for incurable, chronic and long-stay patients, were still constructed and fitted out to foster as effective and affective an institution as possible. Furthermore, due to the increasingly medicalised understandings of madness as moral illness arising towards the turn of the century, boosted by the establishment of pathological laboratories, mortuaries and *post mortem* facilities, separate detached hospital blocks were constructed, which ultimately caused the 'splitting' apart of the asylum, creating two 'sections' within the one institution: a 'medical' or 'hospital' section, which was designed closely to resemble general hospitals and to house and treat the curable and physically ill patients; and an 'industrial' or 'asylum' section, which was designed to evoke a 'home-like', 'ordinary' atmosphere to produce a calming effect for the long-stay patients.

The master division of the physical spaces of the institution was therefore evidently that between the 'asylum' (chronic/incurable/long-term patients) and the 'hospital' (for acute/curable/recent patients). There was clearly an increasingly complex creation of medicalised spaces (associated with the 'hospital') and also the proliferation of the 'homely', villa-like accommodation for chronic patients on the 'asylum' side, and an irony lies in how it was the latter spaces that effectively became the locus of 'moral' interventions/architectures rather than the 'hospital' spaces where the real work of 'cure' was supposed to be occurring:

> With these improvements the necessity for restrictive discipline was diminished, and the benefit of diminishing it became better understood. The desirability of lessening the monotony of asylum life and the advantages derived from supplying occupation in healthy directions for both mind and body were rendered more apparent. The increased contentment of the patients and the greater ease in managing them produced by more comfortable surroundings made the beneficial influence of comfort more fully recognised; and the effect of good hospital treatment in alleviating the mental as well as the bodily condition of the insane caused increased attention to be given to the provision of good and sufficient hospital accommodation in asylums. In making asylums better adapted for the efficient treatment of insanity, they were also made suitable for the treatment of

> insane persons for whom asylum treatment was not at one time thought necessary. It has become less and less regarded as necessary that a patient should be in a state involving danger to himself or others to justify a resort to asylum treatment. The improvements of asylums has thus led to a disposition to make a more extensive and new use of them, involving as one of its results an increase of the number of persons classed or registered as lunatics. (SCL, 1890:lxi)

The latter persons arguably accumulated as the chronic, incurable and long-term patients, now configured as the principal occupants of the 'asylum' proper – with its morally-designed spaces harking back to the innovations of Tuke, Pinel, Browne and others from the earlier years of the 'Asylum Age'. At the same time, those acute patients who had always been potential admittees to asylums, since such institutions had first been mooted, became configured as suitable occupants of the 'hospital' section, hopefully as curable individuals who would not stay long. They witnessed the rise of a more medically-designed environment, wherein 'physical' medical interventions, perhaps deploying emergent neurological and other somatic procedures, began to shape the spaces and personnel involved. In effect, the previous balance between moral and medical components heralded by the reforms of the later-eighteenth and earlier-nineteenth century – wherein the moralised spaces were deemed the premier, curative ones, while the medicalised spaces (of blood-letting, purges and dubious potions) were secondary or virtually non-existent[251] – had been entirely reversed.

[251] There was a determinedly *non*-medical face of the Retreat, despite subsequent rewriting of it as a 'medical' advance (see Philo, 2004, Chapter Six).

# Chapter 10

# Conclusions

## INTRODUCTION

Fifty-six years after the passing of the *Lunacy (Scotland) Act*, 1857, it was superseded by the *Mental Deficiency and Lunacy (Scotland) Act*, 1913. As has been explored in this thesis, 1857 marked the birth of the Scottish district asylums, which were to undergo a marked transformation in their spatial arrangements over the intervening years. The catalyst for their construction was the 1855-57 inquiry and subsequent report, which uncovered appalling conditions in a number of lunatic accommodations, particularly in private madhouses, and found that official oversight "remained at best variable and at worst simply inadequate" (Andrews, 1998:3). According to Sibbald (1897:7), the inquiry, the Act and the implementation of the district asylum network were collectively:

> The culmination of the efforts of philanthropists who, during the first half of the century, had striven to raise the nation to a sense of its duty to secure for the insane in every part of the country humane treatment in institutions suitably constructed and adequately equipped.

Consequently, after the formation of the General Board of Lunacy and the appointment of the Scottish Commissioners, the country was divided into twenty-one districts, each eventually to be provided with its own purpose-built asylum. Although not specifying a master design for the new institutions, the Commissioners laid out guidelines in their First Report for the benefit of the district boards. These were the only substantial recommendations provided by the General Board, with the subsequent alterations and shifting designs of the institutions occurring fluidly across the decades in different asylums, reflecting the visions of various local managements as they responded to increasing pressures on accommodation as well as shifting national and international discourses concerning the treatment and management of the insane. Through exploring the Commissioners' blueprint for the ideal district asylum location and design, and then investigating the institutions as they appeared in bricks-and-mortar on the landscape, this thesis has been able to track these changing spatial arrangements and altering discourses as the boards attempted to care, cure and control their pauper insane charges.

Crucially, this thesis is the only critically engaged, comprehensive study of the district asylum system, likely due to the perceived notion that these institutions were the 'poor relation' of the royal asylums. It has advanced significant new insights to stir back into work on the history of madness, asylums and psychiatry, showing that in Scotland there was arguably a *truncated* 'Asylum Age' (or, at least, 'Public Asylum Age'). There was a shockingly brief period of time from district asylums being regarded as *the* answer, to their *raison d'être* being deeply questioned; but what is also revealed is an 'inertia' of the older asylum model (what else could they really envisage/create?), with perhaps an oddly melancholic feel to the whole unfolding story, and with the Commissioners and other experts seemingly resigned to producing institutions doomed to be filled with 'chronic' cases. This was contrary to the optimism of the early-nineteenth century, particularly at the dawn of the English public county lunatic asylum system and Scotland's royal asylums, all of which were largely completed by the time of the first wave of Scottish district asylum building. That said, towards the end of the nineteenth century, there was a burst of new energy, spawning a new model in which older 'moral-spatial' logics could be refocused, particularly on the asylum section for incurable, long-stay patients. Arguably, then, a sustained encounter with the history, and historical geography, of the Scottish district asylum system allows a fresh look at certain stable assumptions of psychiatric history, throwing into new alignments many elements known (or half-known) in the existing historiography.

## SPACES OF CARE, CURE AND CONTROL

Previously, there were two opposing broad-brush views of the 'Asylum Age'. Initially, the asylum was narrated solely as a 'celebratory' account, and as evidence of improving 'medical-psychiatric' inventions. Against this stood the simplistic 'critical' account, which viewed the asylum simply as a vehicle of 'police' oppression and exclusion of troublesome individuals: the patients shut away 'out of sight, out of mind', with the ominous institutions creating a sealed-off apparatus of social control through the manipulation of both asylum location and architecture. The approach adopted within this thesis, however, can be construed as a 'middle way' between these two strands. The theoretical lens through which asylums and lunacy have been viewed offers a more nuanced approach to understanding the 'spatial relations' encompassing madness. Following Foucault, it was vital to extract the details of 'geography' from the documentary record, as it was clear that space (including the engineering of environmental sites and situations) was central to the

whole nexus of therapy-as-social-control. As recognised by Philo (2004), matters of location and architecture were indeed folded into the discourses and practices of those 'experts' responsible for producing the 'Asylum Age'.

Yet advancing these ideas further, through combining Foucault's theories of control and management, particularly the later ideas explored in his *Psychiatric Power* (PP) lectures, with non-representational theories about the engineering of affective atmospheres, the thesis has disclosed the creation of spaces of 'affective power', constructed and manipulated to care, cure and control insane populations in both overt (mechanical, concrete) ways and ones more covert (organic, even ethereal). This constellation of conceptual windows has thus enabled a 'middle way' to be fashioned between older traditions, 'celebratory' and 'critical', in the history of madness, asylums and psychiatry – a 'middle way' that is hence no easy or glib compromise, but rather aims to be itself a distinctive, carefully crafted perspective with its own (new, for the field) conceptual reference points.

Focusing on the spaces of the asylum showcases the increased 'normalisation' of madness within the institution, closely aligning to Foucault's understanding of the working of the asylum as a machine, or a 'battleground', with the precise language of the Commissioners and district boards lending itself to a Foucauldian interpretation. It is nonetheless recognised that the importance of a close, complete system of surveillance and management by the asylum staff must be coupled with a sensibility alert to how the physical environment of the asylum site, grounds and buildings – with the capacity, the power, to affect the behaviour of the patients – was also a vital tool for the superintendents. This tool allowed what was recognised as the last remains of mechanical restraint to be removed from the institutions, highlighting a shift of sorts from the mechanical to the organic, if still thoughtfully engineered, indexed most obviously by the cessation of mechanical restraints across diverse domains from chains and locks to the pulling down of walls.

The first of the district asylums to be built after the 1857 Act in effect borrowed and learned from many of the trends of the poorhouses and royal asylums already in operation in Scotland. As such, the districts building the first asylums opted for rurally-situated, T- or E- shaped central blocks incorporating walled airing courts for outdoor recreation and set in extensive farmland for occupation. The internal arrangements separated male and female patients, as well as different maladies, through separate floors and rooms, which

predominantly consisted of wards and dayrooms, but also included a small infirmary ward and single rooms for the isolation of infectious diseases or particularly troubled patients in need of solitary confinement. The predominant line of treatment followed moral discourses, with the internal and external spaces of the institutions designed and manipulated to control and a/effect the behaviour of the patients. It was strongly held that removal from the stresses of everyday life, particularly if this life was led in an urban environment, would eventually restore reason to individuals.

Yet, fitting Jones and Moon's (1987:209) premise that "the assumptions and viewpoints which structure these attitudes" of the insane and their treatment "have not been constant through time and … have had important consequences for the way in which the mentally ill have been treated", it was not long before the spaces of the asylum started to be altered by the district boards and superintendents. The first significant alterations to the management of the patients and the design of the institutions were the abolition of walled airing courts and the disuse of locked doors. These moves, indeed heralded as an extension of the principles of non-restraint, alongside the determination increasingly to 'normalise' the asylum spaces, allowed managements to bring the institutions closer in line with conditions found in ordinary dwellings. Moreover, the policies were embroiled in the rising medicalisation occurring within the institutions, and of course more widely in the emergent 'mad-doctorly' (proto-psychiatric) profession, as greater liberty was connected to the need to acquire a deeper understanding of individual mental conditions. The latter demand led to more attention to individual cases, maybe even a character assessment of each patient, which was viewed as central to the continued safe management of large (and growing) asylum populations. This transformation was supposed to hinge on intelligent observation on admission and throughout the whole residence of a patient in the institution, which relied on increased vigilance and note-keeping on the part of the attendants and superintendents.

After the 1857 Act, and in particular after 1868 when the first wave of district asylums had been constructed, there was – despite early reflection that the asylum was in fact *not* the ideal space for lunatics – a steady increase in pauper patient numbers flooding into the district asylums. Reasons for the increase included: the construction of asylums in locations which had otherwise had no facilities; improvements to transport and travel which gave easier access to institutions; and changing opinions towards asylums, such as:

> The gradual dying out among the public of feelings of dislike and suspicion towards asylums, a change which has resulted from an increasing recognition on

> the part of the community of the humane and enlightened methods of modern treatment, and of the protection, comforts, medical treatment, and curative influences generally which modern asylums afford. (SCL, 1892:lvii)

Also pertinent were: the increased willingness of the poorer classes to accept pauper relief and therefore to send family members to institutions as pauper patients; a growing reluctance to retain pauper lunatics at home, particularly in a small house; parochial authorities more likely to claim relief on the grounds of insanity; and finally the widening of the definition of insanity. Although the asylums were expanding to accommodate the extra population through modification of existing structures and the erection of new buildings, many continually suffered from overcrowding, often at such a rate that the extensions being constructed by the district boards were still not providing sufficient extra space by the time they were opened.

There was also a growing realisation that the success rates in returning the insane to reason and society after spending time within the asylum spaces were low. Numerous patients were considered incurable, many on admission to the asylum. Thus, towards the end of the nineteenth century – in order to retain the overarching aim of the institution, namely the cure of insanity – the asylum buildings gradually started to split apart, with the biggest alteration being the division of the institutions into two main sections. The initial steps towards this fundamental split in the spaces and management was the construction of simple buildings for convalescent patients, creating small self-contained communities administratively attached but spatially separated from the main asylum. Further separate buildings were erected for night nurses and married attendants in an attempt to raise the general professionalism of the asylum staff, drawing them more into line with the staff employed in general hospitals. The construction of detached buildings allowed the increased classification and separation of patients and staff, with the new buildings more able to be specifically tailored for its convalescent inhabitants. Most notably though, in line with the increasing medical understanding of insanity, a number of the district boards, under the recommendation of the General Board, erected separate ‘hospital’ blocks with space to accommodate approximately one-third of their overall asylum populations. The separation of the medical section permitted medical attention to be directed towards that section of the population who would supposedly respond to such management, the so-called acute rather than chronic patients, and this section was designed to encompass new therapeutic spaces of treatment and accommodate those patients who were deemed curable.

For those patients considered incurable, it was recognised that, through the separation of the asylum site and its grounds, "better arrangements can be made for giving interest, by occupation and otherwise, to the lives of those inmates of asylum, who, though unfit for the conditions of life in the outer world, do not require special medical treatment" (SCL, 1892:xliii), such as convalescent and chronic patients. Thus, the remaining two-thirds of the institution was to become the industrial 'asylum' section for incurable inhabitants. With the input of these residents, this section was to function as the workhouse of the institution, providing the power for the agricultural, laundry and kitchen work that would keep the asylum operational. With the realisation that the moral spaces of the early-nineteenth century were not achieving the desired outcomes of returning inhabitants to reason and society, the Commissioners were of the opinion that the "two great functions of asylums as medical institutions, and as homes for the insane … can be more efficiently performed when they are kept to a great extent separate from each other" (SCL, 1892:xlvi). The arrangement was adopted by the majority of district asylums being constructed or extended during the last decade of the nineteenth century.

The big twist in the history of the late 'Asylum Age', therefore, was that the spaces originally designated and designed for *moral* treatment aimed at curing acute cases were to be advanced in the industrial section, through the increased engineering of a home-like environment for predominantly *in*curable, long-stay patients. It had come to be realised that these spaces had not worked in the ways intended by the early-nineteenth-century philanthropists and alienists, and that they were more suited to creating a hospice-type environment. The move was to break up the architectural arrangement of the buildings, with emphasis on different blocks, resulting in the near-complete separation of the two different aspects of lunacy treatment. The hospital block was to be "arranged so as to form an institution separate from, and to a large extent independent of, the rest of the asylum … being designed with a view to the distinctive character of the section as a medical institution" (SCL, 1872:xliv). Accordingly, the buildings housing the incurable inhabitants were to become smaller to enable a more detailed separate spatial classification of the patients, with attempts made to remove any institutional or carceral atmospheres. Instead, 'comfortable' dignified settings were created, perhaps indeed in line with hospice ideas.[252] It was nonetheless considered of great importance that the two sections of the institution

[252] Although the modern hospice movement was not implemented until after WWII, the idea of providing palliative care in a suitable environment for incurable hospital patients was long established, often with religious or philanthropic connections (see Bennahum, 2003). For research into the geographies of hospices, see Brown (2003).

functioned administratively as one, under the control of a single responsible authority, allowing more efficient management and the easier transference of patients across the different sections.

The separation of the two institutional functions, the desire for smaller detached buildings for greater classification and the increased individualisation of patients through more vigilant attendants, all culminated in the adoption of the segregated or village asylum. The buildings were ideally to be spread semi-informally around the asylum estate, albeit with clear separation between the two sections, and between male and female patients. Yet, although the design of the last district asylums was far removed from the institutions constructed at the opening of the 'District Asylum Age' in Scotland, and the spaces had shifted to incorporate more medicalised understanding of insanity, increasingly becoming known as mental illness, the ethos of all of the various boards and superintendents had followed much the same path. Throughout the study period, a strong belief nonetheless remained that the affective power of the landscape, the manipulation of space by the superintendents and the close supervision of patients by the attendants could all conjoin to produce 'docile' productive subjects, whether leaving the asylum cured and heading back into social and working life, or remaining in the institution as good 'workers' supporting the running of the 'asylum' section for incurables. Therefore, the asylum ultimately had curative *and* caring potentials, either by restoring reason or at least by encouraging patients to act 'sane' through recreating 'ordinary' life.

## AFTER-LIVES

It is only very recently that many of these nineteenth and early-twentieth century 'products' have finally been closed, their locations, grounds and sites having been the backdrop to tens of thousands of patient and staff lives, for better or worse.[253] Studying the inception of the district asylums on Scotland's landscape has led me to be increasingly intrigued by the after-lives of the grounds and buildings, which, due to policies of deinstitutionalisation, often lie derelict and decaying, meagre shells of their former selves. What to do with these large institutions, often cloaked in stigma, is therefore an interesting question. There is scope, then, to investigate the fates of the district asylums, paying

[253] For research on the after-lives of asylums, see Cornish (1997), Kearns *et al.* (2012) and Joseph *et al.* (2013).

attention to the slow invasion of nature where the buildings lie in ruin,[254] but also the many local residents who now inhabit these abandoned spaces, whether long-term after the conversion of the buildings to new homes or short-term through the popular pastime of urban exploration. The research could concentrate on the contemporary affective atmospheres emitted by these spaces, as, even when razed to the ground, the sites still evoke emotions and memories. When mentioning my research, people were often quick to draw connections between themselves and these spaces; my uncle, for example, underwent the mental health block of his nurse training at the old Renfrew Asylum; a retired professor from my department could see the towers of the old Lanark Asylum on his commute to work; and I even met the son of the ferryman who transported the patients from North Uist to the mainland on their journey to the Inverness Asylum. The *stories* of these asylums and people's often diasporic connections to them (so absent in my archival work) would therefore also be fascinating, drawing in emotional and imagined geographies of place and landscapes.

Additional possibilities for future work in connection with this thesis could include, for example (although these suggestions are by no means exhaustive), more detailed focus on individual sites and spaces, such as case studies of specific asylums, or more thorough attention to the daily routines of staff and patients. Archival sources that could be more fully utilised include the patient records and casebooks, as well as the inventories of the asylum purchases. Connections between the institutions and the local communities would also be worth further study, as the construction workers through to the attendants would have been drawn to the institution for employment, aiding the local economy. Furthermore, there is a need, particularly in connection with service-user groups such as '*Oor Mad History*', to bring the histories and geographies of these institutions up-to-date. I am aware that I have concentrated on the early years of the asylums and then their after-lives, and thus there are huge possibilities to carry the investigation through the twentieth century to their closure.

Finally, there is potential to rework inquiries into the history and geography of madness, asylums and psychiatry through different lenses. The later Foucault together with non-representational theory has been a particular constellation of ideas used to prize open the empirical research in this thesis; but there are other tools in the contemporary geographers' armoury – psychoanalytic/psychotherapeutic geographies; emotional geographies; non-

[254] See emerging work on the geographies of ruins, especially Edensor (2005) and DeSilvey and Edensor (2012).

human geographies – echoes of which have reverberated through this thesis, but without being put into clear shape or sustainedly put to work. Many of these theories arguably lend themselves to methods of encounter, interviewing and ethnography and would maybe be more plausible/effective for the more recent periods of district asylum history and through to their after-lives.

## THE FINAL SITE VISIT

*The drive along the M8 between Glasgow and Edinburgh is a familiar journey. But, never have I known to look to my left just after Livingston and see the distant remains of the Edinburgh District Asylum, or Bangour Village Hospital, as it was most recently known. Or perhaps I have spotted them, dismissing it as simply another little village on the Forth-Clyde isthmus. Church tower, and a few scattered houses. The plan for this late-autumn excursion, however, is to visit the site and wander the grounds, in much the same way as we had done at other district asylums throughout my research. With David driving, I eagerly try to spot any sign of the buildings from the motorway, whilst at the same time looking out for the junction that would lead us to the estate. In the distance, I recognise the distinct, wide church tower, a later addition to the site, added in the 1920s. I'd seen photos of it in the archives. My excitement is building, eager to arrive and explore. Exiting the motorway, we guess the next turning, not having looked up the directions before leaving Glasgow. Always trying to catch glimpses of the church tower in order to keep our bearings. A handful of newer bungalows to the left. Young trees to our right, their few remaining leaves showing the last colours of autumn. A pavement on either side of the road, deserted. A large bus stop, empty. But, immediately afterwards, a handful of vehicles lie parked just off the road. Indicating, David pulls into what appears to have once been a street; the road markings and signs now faded. Grass and weeds are creeping up from cracks in the pavement, and potholes litter the road surface. A couple of dog walkers return to their car. A sign behind them, covered in green moss reads 'Welcome to Bangour Village Hospital'. We have arrived. But, despite their lack of leaves, the buildings are hidden behind tall, mature trees.*

*Opening the car door, I shiver as the cold autumn air hits my face. I quickly pull my hat onto my head and dig my hands deep into my jacket pockets. David changes into his wellies, and we leave the car, walking up a gradual slope to an open gate. The light is low among the trees. To our left, a little cottage has its lights on; a truck sits parked in the drive. 'Honeysuckle Cottage'. Cute name, I comment. I glimpse an office through the window. I think it's likely that this is some sort of site security workplace, although no one is around. Continuing forward, we pass a few faded, lichen-covered NHS signs pointing the direction to various works buildings: 'Engineering Depot', 'Transport', 'Works Stores'. Another little cottage sits on the right, this one red brick. Unusual, I remark, "It would look more at home in the North West of England". David agrees.*

*Further on, directly in front of us at a fork in the road, appears 'The Shop'. Autumn leaves lay scattered on the grass, and an overgrown path leads up to the building. I mention to*

*David that, according to one online blog, the prices inside are still marked in shillings, although I question the accuracy as the institution only closed in 2004. We can't confirm this ourselves, as the building is well boarded up, and a sign on the wall warns 'Danger, Keep Out'. We contemplate whether to turn left or right. Right first. We don't have too long before dusk, so push on up the hill. We pass an old bus stop, one of the seats dislodged at an awkward angle. It looks like it was once part of the public service, transporting patients, staff and visitors to and from the institution. Suddenly we emerge from the trees, and in front of us stands the church. Again derelict. Walking towards it, we pass one of the ruined villas on our right. It's crumbling into disrepair, paint flaking from the bricks, tiles missing from the roof. A high temporary metal fence surrounds it, attempting to keep intruders out. We move onwards to the church and walk round it, noting the architectural details, the inscription to God above the door, and then turn to look south. David points out the M8 below us and I am surprised at how much height we have gained.*

*Continuing onwards, moss creeps onto the road we've been following. The grass around us has turned dry and yellow. An older gentleman and his dog walk by. I recalled to David that earlier that year I had found a newspaper article warning that the local council were threatening to close the grounds for health and safety reasons. Thieves had been digging up the old pipes for scrap metal, leaving large uncovered holes across the site. The local dog-walking community had been up in arms, and the proposal had been temporarily shelved. We briefly glance around for evidence, but nothing is apparent. The final two buildings at this side of the estate surprise me. Having read the detailed archival records and plans for the 'village' asylum, I am confused to see two big, blocky buildings ahead. They look more like the pavilion architecture of the Victorian period, and are not what I was expecting to find at this site. I ponder whether one was the hospital block, but I couldn't remember what the other might have been. I must re-visit the plans later for confirmation.*[255]

*Aware that time is marching on, we turn to retrace our steps back to the shop and continue along the road to the left. There are many more detached villas on this side of the estate. Perhaps this was the industrial section. The old laundry and workhouses we pass, signs faded but legible, suggest that I am correct. I follow another sign that indicates left, and creep through a gap in the rhododendrons. In front of me lies a completely overgrown but recognisable bowling green. The discovery makes me smile. Returning to the road, we again come to a junction, the markings laid out as on any public highway. I hear a vehicle behind me, and step to the side. A security van is approaching, and I get a knot in my stomach. Although we have been keeping to the roads, I still feel like this is a prohibited site. The man drives past, giving us a friendly wave. I sigh with relief. A number of the villas before us look like cheaper structures, the tiles all stripped from their roofs and the windows boarded. I notice one uncovered window, and approach the building to peer inside. Empty, save one solitary beer can in the middle of the room, a hint at its most recent occupants. The sun is now beginning to set, and the security man drives by again.*

[255] The plans confirmed that the first building was the hospital block, and the second was the nurses home, which would not have accommodated patients.

*He stops and tells us the gates will soon be locked, securing the estate for the night. It's time to leave and I feel a hint of sadness. I have been enjoying my meander around the grounds, especially choosing which road to take next, guessing, and then finding out, where it leads. Some we still haven't managed to follow. Perhaps we'll come back, but for now, we stroll towards the entrance, give a nod goodbye to the security, and the gate is closed behind us.*

# Appendix A

Inventory of archives consulted:

| District Asylum | Opened | Archive | Document | Reference | Notes |
|---|---|---|---|---|---|
| **Elgin** | 1835 | NHS Grampian | Visitor's Book, 1835-1948 | GRHB 46/7/8 | A copy (by a patient) from the original. Consulted 1835-1864 |
| **Haddington** | 1866 | LHSA | Patient's Book, 1866-1873 | LHB 47/2/1/1 | Hand written entries by the General Commissioners in Lunacy from their bi-annual visits |
| | | | Rules and Regulations for the Management of the Haddingtonshire District Lunatic Asylum | LHB 47/2/2/1 | Printed information booklet |
| | | | Instructions to Inspectors of Poor | LHB 47/2/3/1 | Printed pamphlet prepared by the General Board for the guidance of Inspectors of the Poor |
| **Inverness** | 1864 | Inverness | Minutes of Meetings, 1891-1900 | HHB 3/1/2 | Printed minute book |
| | | | Patient's Book 1864-1867 | HHB 3/8/1 | Hand written entries by the General Commissioners in Lunacy from their bi-annual visits |
| | | | Second Annual Report of the Inverness District Lunatic Asylum, 1866 | HHB 3/8/8 | Printed |
| | | | Eighth Annual Report of the Inverness District Lunatic Asylum, 1872 | HHB 3/8/9 | Printed |
| | | | First Annual Report of the Inverness District Lunatic Asylum, 1865 | HHB 3/8/10 | Annual Reports Vol III from 1885-1894 |
| | | | Third Annual Report of the Inverness District Lunatic Asylum, 1867 | HHB 3/8/10 | |
| | | | Patient's Book 1894-1907 | HHB 3/8/3 | Consulted entries from 1894 to 1896 |
| | | Dundee | First Report of the Inverness District Lunatic Asylum | THB 30/1/6/5 | Printed |
| **Banff** | 1865 | LHSA | Minutes of the District Board of Lunacy for the County of Banff 1858-1865 | GRHB 35/1/1 | Hand-written minutes |
| | | | "Ladysbridge" The Story of an Archive, 1865-2003 | | Printed centenary booklet |
| | | | Letters regarding water supply at Asylum, 1866 | GRHB 35/8/9 | Hand-written letters |
| | | | Male Case Notes | GRHB 35/4/2 | Note in catalogue said "contains correspondence", however this referred to notes from the patient's previous asylum in the case transferals to Banff. No patient |

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| | | | | | letters or testimonies |
| **Fife and Kinross** | 1866 | Dundee | Ninth Annual Report of the Fife and Kinross District Board of Lunacy, 1875 | THB 30/6/1/14 | Printed |
| | | | Twelth Annual Report of the Fife and Kinross District Board of Lunacy, 1878 | THB 30/6/1/14 | |
| | | | Thirteenth Annual Report of the Fife and Kinross District Board of Lunacy, 1879 | THB 30/6/1/14 | |
| | | | Fourteenth Annual Report of the Fife and Kinross District Board of Lunacy, 1880 | THB 30/6/1/14 | |
| **Ayr** | 1869 | Ayr | Minute Book, 1878-93 | AA 17/4/2 | Consulted 1878-1880 |
| | | Dundee | First Annual Report of the Ayr District Asylum, 1870-71 | THB 30/6/1/8 | Printed |
| | | | Second Annual Report of the Ayr District Asylum, 1871-72 | THB 30/6/1/8 | |
| | | | Fourth Annual Report of the Ayr District Asylum, 1873-74 | THB 30/6/1/8 | |
| | | | Sixth Annual Report of the Ayr District Asylum, 1875-76 | THB 30/6/1/8 | |
| | | | Seventh Annual Report of the Ayr District Asylum, 1876-77 | THB 30/6/1/8 | |
| | | | Eighth Annual Report of the Ayr District Asylum, 1877-78 | THB 30/6/1/8 | |
| | | | Ninth Annual Report of the Ayr District Asylum, 1878-79 | THB 30/6/1/8 | |
| | | | Tenth Annual Report of the Ayr District Asylum, 1879-1880 | THB 30/6/1/8 | |
| | | | Eleventh Annual Report of the Ayr District Asylum, 1880-1881 | THB 30/6/1/8 | |
| **Perth** | 1864 | Dundee | First Annual Report of the Perth District Asylum, 1865 | THB 30/1/1/1 | |
| | | | Letter Book, 1891-1893 | THB 30/3/14/1 | Copies of letters sent from the asylum to the relatives of patients providing news of their condition. |
| | | | Newspaper Cuttings | THB 29/10/3/4 | Miscellaneous file of newspaper cuttings, mostly from twentieth century. |
| **Roxburgh** | 1872 | LHSA | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1874 | GD 30/3/1 | Printed report |

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| | | | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1875 | GD 30/3/1 | |
| | | | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1876 | GD 30/3/1 | |
| | | | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1877 | GD 30/3/1 | |
| | | | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1878 | GD 30/3/1 | |
| | | | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1879 | GD 30/3/1 | |
| | | | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1880 | GD 30/3/1 | |
| | | | Report of the Roxburgh, Berwick, and Selkirk District Board of Lunacy, 1882 | GD 30/3/2 | |
| | | | Centenary Booklet, 1872-1972 | GD 30/10/1 | |
| | | | "The Care and Cure of the Insane", 1875 | GD 30/66/2 | Reports of the *Lancet* Commission on Lunatic Asylums. |
| **Stirling** | 1865 | Dundee | Third Report of the Stirling District Lunacy Board, 1873 | THB 30/6/1/14 | For the Counties of Stirling, Dumbarton, Linlithgow, and Clackmannan |
| | | | Fourth Report of the Stirling District Lunacy Board, 1874 | THB 30/6/1/14 | |
| | | | Fifth Report of the Stirling District Lunacy Board, 1875 | THB 30/6/1/14 | |
| | | | Sixth Report of the Stirling District Lunacy Board, 1876 | THB 30/6/1/14 | |
| | | | Seventh Report of the Stirling District Lunacy Board, 1877 | THB 30/6/1/14 | |
| | | | Eighth Report of the Stirling District Lunacy Board, 1878 | THB 30/6/1/14 | |
| | | | Ninth Report of the Stirling District Lunacy Board, 1879 | THB 30/6/1/14 | |
| **Midlothian and Peebles** | 1874 | LHSA | Minute Book, 1870-1889 | LHB 33/1/1 | Hand-written minutes, consulted 1870-1876 |
| | | | First Report of the Midlothian and Peebles District Board of Lunacy, 1871-1877 | LHB 33/2/1 | |
| | | | Second Report of the Midlothian and | LHB 33/2/1 | |

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| | | | Peebles District Board of Lunacy, 1877-1880 | | |
| | | | Third Report of the Midlothian and Peebles District Board of Lunacy, 1880-1883 | LHB 33/2/1 | |
| | | | Patient's Book | LHB 33/4/16 | Hand-written reports written by the Commissioners in Lunacy for Scotland, reproduced in the District Board Annual Reports. |
| | | | Midlothian and Peebles Asylum Specifications and Schedules of Quantities, 1898 | LHB 33/16/3 | Hand-written accounts, detailing mason, brick, iron and steel works proposed. Lists of alterations including rate and costs. |
| | | | Letters from the Secretary of the General Board of Lunacy to Midlothian District Asylum, 1864-1896 | LHB 33/3/1 | Correspondance between General Board and District Board, also located in the National Library of Scotland. |
| **Govan** | 1895 | NHS GGCA | Minutes and miscellaneous correspondence, 1878-1892 | HB 24/1/1A | Notes regarding lunacy accommodation in Greater Glasgow area, including division of old District Board and minutes of new Govan Board. |
| | | | Loose sheets, estimates for furniture, clothing, ironmongery, brushes, material for clothing, etc., 1898 | HB 24/7/1 | Loose sheets |
| | | | General Rules for the Management of the District Asylum at Hawkhead | HB 24/7/45 | Miscellaneous collection of material for Hospital history |
| | | | From Here to Centenary - notes from an ex-charge nurse | HB 24/7/45 | |
| | | | Newspaper Cuttings, 1895 | HB 24/7/45 | Glasgow Herald |
| **Glasgow** | 1896 | NHS GGCA | First Report of the City of Glasgow District Lunacy Board, 1898 | HB 1/6/1 | Including Medical Superintendent's Report and Commissioners in Lunacy Report. |
| | | | Second Annual Report of Gartloch Asylum and Hospital for Mental Disorders, 1899 | HB 1/6/2ii | |
| | | | Minutes of the Board and Committees, 1898 | HB 30/1/1 | Says "For Private Use Only". |
| | | | Pamphlet "About Gartloch Asylum and Hospital for Mental Diseases", 1897 | HB 1/4/7 | Printed pamphlet about history of mental disease and Gartloch. |
| | | | Visitor's Book, 1897-1914 | HB 1/4/11 | Hand-written entries, c. 1-2 weeks, by a mixture of people (m & f), noting impressions of asylum, staff and patients. |
| | | | Patient's Book, 1897-1909 | HB 1/4/13 | Hand-written entries by the Commissioners in Lunacy. |
| | | | General Rules for the Management of the Glasgow District Asylum at Gartloch, 1898 | HB 1/4/24 | Drawn up by the Medical Superintendent. |

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| | | | Visitor's Book, 1897-1898 | HB 1/4/23 | Hand-written entries from visiting District Boards. |
| | | | Gartloch Magazine, 1909 | HB 1/4/72 | Hand-written magazine. |
| | | | Colour Scheme | HB 1/4/49 | Water painting showing the proposed colour scheme of the recreation hall. |
| | | | Grounds and gardens | HB 1/4/17 | Hand-written notes on gardens, grounds, woods, etc. |
| **Edinburgh** | 1905 | LHSA | The Builder, November 10th, 1906 | LHB 44/6/1 | Article with information regarding erection of Edinburgh District Asylum. |
| | | | Paper in the Journal of Mental Science, April 1911 "Bangour Village" | LHB 44/6/2 | Written by the medical superintendent, gives history of lead up to construction of asylum and after opening. |
| | | | Hand-written single sheet, no author, no date | LHB 44/6/11 | Brief history of lunatic asylums |
| | | | Photographs showing buildings, no dates | LHB 44/26/9 | Miscellaneous |
| | | | Photographs of interiors of rooms, no dates | LHB 44/26/10 | 6 photographs showing inside of some rooms, eg recreation hall, kitchen, interior of ward 18 |
| | | | Plans | LHB 44/26/5 | Proposed recreation hall (front, side and elevations) and estate of Bangur Village |
| | | | Third Annual Report of the Edinburgh District Board of Lunacy, 1907 | LHB 44/3/3 | |
| | | | Fourth Annual Report of the Edinburgh District Board of Lunacy, 1908 | LHB 44/3/4 | |
| | | | Fifth Annual Report of the Edinburgh District Board of Lunacy, 1909 | LHB 44/3/5 | |
| | | | Seventh Annual Report of the Edinburgh District Board of Lunacy, 19011 | LHB 44/3/7 | |
| | | | Schedule of Quantities for Works proposed to be executed | LHB 44/4/1 | |
| | | | Minutes, 1899-1900 | LHB 44/1/1 | Minutes of Lunacy Board and Committees |
| **Aberdeen** | 1904 | NHS Grampian | Newspaper Cuttings, 1904-1906 | GRHB 8/6/2 | |

# Appendix B

Contributors to Appendix M: Evidence Taken Before the Royal Lunacy Commissioners for Scotland (SLR, Appendix M, 1857)

| List of Witnesses | Occupation | Location |
|---|---|---|
| **Thomas Rennie Scott** | M.D. | Musselburgh |
| **Mr George Laurie** | Surgeon | Musselburgh |
| **Mr Alexander McDonald Sanderson** | Surgeon | Musselburgh |
| **William Malcolm** | M.D., Physician to Murray's Royal Asylum for Lunatics | |
| **Henry Sanderson, Esq.** | Surgeon | Musselburgh |
| **John Smith** | M.D., Fellow of the Royal College of Physicians | Edinburgh |
| **John Hill Burton, Esq.** | Secretary to the General Board of Directors of Prisons in Scotland | |
| **Mr John Gould** | Principal Clerk in the office of the General Board of Directors of Prisons in Scotland | |
| **Archibald Davidson, Esq.** | Sheriff of Aberdeenshire | |
| **William Stuart Walker, Esq.** | Secretary to the Board of Supervision for Relief of the Poor | |
| **Mr George Greig** | Inspector of Poor, St Cuthbert's parish | Edinburgh |
| **Mr John Hay** | Inspector of Poor, City parish | Edinburgh |
| **Mr Robert Wilson** | Surgeon, Inspector of Poor | Inveresk |
| **Sir Archibald Alison, Bart.** | Sheriff of Lanarkshire | |
| **John Coats** | M.D. | Glasgow |
| **Mr Robert Thomson** | Proprietor of Hillend Asylum | Greenock |
| **John Thomson Gordon, Esq.** | Sheriff of Edinburgh | |
| **Robert Renton** | M.D., Fellow of the Royal College of Physicians | Edinburgh |
| **James Howden** | M.D., Assistant Physician to the Royal Edinburgh Asylum | |
| **David Skae** | M.D., Fellow of the Royal College of Surgeons, and Physician to the Royal Edinburgh Asylum | Edinburgh |
| **Harry Rainy** | M.D., Fellow of the Faculty of Physicians and Surgeons | Glasgow |

| | | |
|---|---|---|
| **Mr George Croal** | Inspector of Poor | Perth |
| **Robert Hunter, Esq.** | Sheriff of Dumbarton and Bute | |
| **John Christison, Esq.** | Sheriff of Ayrshire | |
| **Mr William Porteous** | Clerk in the Sheriff-clerk's office | Edinburgh |
| **A. McIntosh** | M.D., F.R.C.P.E. and Professor of Materia Medica in the University | |
| **Robert Macfarlane, Esq.** | Sheriff of Renfrewshire | |
| **Mr James D. Kirkwood** | Inspector of Poor, Govan parish | Glasgow |
| **Maurice Lothian, Esq.** | Procurator-Fiscal for Edinburgh | |
| **Robert Christison** | M.D., F.R.C.P.E. and Professor of Materia Medica in the University | |
| **John Leech** | M.D., M.A. | Glasgow |
| **Charles Ford** | M.D., Surgeon to the Barony Poorhouse | Glasgow |
| **Mr John Charles Fraser** | Principal Clerk in the office of the Accountant of the Court of Session | |
| **John Maitland, Esq.** | Accountant of the Court of Session | |
| **W. A. F. Browne** | M.D., Physician to the Royal Asylum | Dumfries |
| **James Simson** | M.D., Fellow of the Royal College of Surgeons | Edinburgh |

# Appendix C

Outline of existing accommodation in relation to pauper lunatics (SCL, 1859).

| District | Existing Asylum Accomm. | No. of pauper lunatics chargeable to the district | Temporary Accomm./Distribution of Lunatics | Plans to Erect New Asylum |
|---|---|---|---|---|
| **Aberdeen** | Aberdeen Royal Asylum (201 paupers, 102m & 99f) | 318 (142m, 176f). 73m & 98f in RA, 2m & 1f in licensed house, 17m &18f in PH. 90 in need of asylum accomm. | St Nicholas PH(50 beds), Old Machar PH (20 beds). | No, but plans to extend RA. Pauper lunatics chargeable to other districts to be removed. |
| **Argyll** | None | 179 (86m, 93f) | 37m & 27f in asylums & PHs in other districts, 49m & 66f in private houses as single patients. | Yes, negotiations pending for the acquisition of a site at Lochgilphead to build an asylum for 148 patients. |
| **Ayr** | None | 112 (102m, 110f) | Cunninghame Combination PH (16 m, 16 f), 48m & 41f in asylums and PHs beyond the district | Yes, various sites under consideration. |
| **Banff** | None | 78 (27m, 53f) (estimated by the GB as 96) | 10m & 13f in asylums beyond the district, 17m & 40f as single patients in private houses. | DB contemplating erecting an asylum, but no site under consideration |
| **Bute** | None | 31 (15m, 16f) | 6m & 4f in asylums and PHs beyond the district, remainder as single patients in private houses. | Failed to unite with another county. Failed to think about providing separate asylum. |
| **Caithness** | None | 72 (38m, 34f) | 10m & 7f in asylums beyond the district, remainder (28m, 27f) in private houses. | Was part of Aberdeen, but since split, failed to enter new combination. DB contemplating erecting separate asylum for 62 pauper & 11 private lunatics. |
| **Dumfries** | Southern Counties Asylum | 258 (127m, 131f) | 75m & 55f in asylums and PHs, 52m & 76f in private houses as single patients. Additional accomm. needed for at least 71 patients. | Measures in place by DB to enlarge Asylum. Pauper lunatics belonging to other districts to be removed. |
| **Edinburgh** | Royal Asylum at Morningside | 617 (252m, 365f) | 123m & 111 in public asylums, 20m & 43f in licensed houses, 71m & 157f in PHs, 38m & 54f in private houses. Temp accomm: City (115), St Cuthbert's (86) & South Leith (20) PHs. | None. Deficiency of 149 if temp accomm is not recognised. |
| **Elgin** | Pauper | 70 (33m, 37f) (GB | 17m & 15f in asylums, 2m in | Construction and |

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|---|---|---|---|---|
| | Asylum (48 patients, 24m, 24f) | estimated 73) | PHs, 14m & 22f single patients in private houses. | arrangement of existing asylum bad, call to re-site & re-build an asylum for 63 lunatics. Negotiations for new site nearly complete. |
| **Fife** | None | 259 (123m, 131f). Recommended that provision be made for 243 | 28m & 27f in public asylums, 36m & 40f in licensed houses beyond the district, 25m and 24f in PHs within the district. c.50 harmless cases in Dunfermline & Kirkcaldy PHs. | Site secured for DA, 88 acres, proceeding to procure plans for building. |
| **Forfar** | Dundee & Montrose | 355 (171m, 184f). | 132m & 143f in public asylums, 5m & 8f in licensed houses, and 4m & 4f in PHs. £0m & 29f in private houses as single patients. | Erection of new house at Montrose for c.320 pauper patients, meaning excess of 121, thus Kincardine do not need to provide separate accomm. |
| **Glasgow** | Royal Asylum, Gartnavel (356 patients) | 663 (315m, 348f) | 91m & 105f in public asylums, 50m & 48f in licensed houses, and 122m & 138f in PHs. 52m & 57f in private houses. Extensive PH accommodation, eg. Hospital, City, lunatic wards of Barony parish & Govan. | None, due to extensive accomm. in PHs and RA. |
| **Haddington** | None | 83 (44m, 39f) | 14m & 7f in public asylums, 10m & 19f in licensed houses, and 1f in a PH. 20m & 12f in private houses as single patients. | DB have secured c.16 acre site & are proceeding to build a DA. |
| **Inverness** | None | 446 (218m, 228f) | 49m & 30f in public asylums, 18m & 28f in licensed houses beyond the district, and 5m & 4f in PHs within the district. 146m & 166f in private houses as single patients. | DB have purchased c.100 acre site and are awaiting approval of plans before proceeding. |
| **Kincardine** | Privileges at Montrose RA | 75 (31m & 44f) | 18m & 19f in public asylums, 1f in a licensed house, and 4m & 4f in PHs. 9m & 20f in private houses as single patients. | No need to provide separate DA due to privileges in connection with Montrose RA. |
| **Orkney** | None | 56 (23m, 33f) | 4m & 11f in public asylums, 1m & 1f in licensed houses. 18m & 21f in private houses as single patients. | Originally part of Edinburgh District, agreement with REA to send pauper lunatics there. |
| **Perth** | James Murray's Royal | 330 (166m, 164f) | 52m & 48f in public asylums, 34m & 39f in licensed houses, and 1m & 1f in PHs.79m & 76f in private houses as single patients. | JMR decided only to admit private insane, therefore separate DA needed. 60 acre site purchased. |
| **Renfrew** | None | 181 (82m & 99f) | 13m & 8f in public asylums, 1m & 1f in licensed houses, and 56m & 74f in PHs. 12m & 16f as single patients in private | Extremely unwilling to erect separate DA accomm. due to PH |

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|---|---|---|---|---|
| | | | houses. 3 PHs possessing lunatic wards, Abbey parish of Paisley, Burgh parish of Paisley & parish of Greenock. | provisions. |
| **Roxburgh** | None | 174 (77m, 97f) | 17m & 14f in public asylums, 15m & 26f in licensed houses, and 4mf in PHs. 45m & 53f as single patients in private houses. | Nothing done thus far to provide DA accomm. |
| **Shetland** | None | 42 (25m, 17f) | 7m & 6f in public asylums, 4m & 1f in licensed houses. 14m & 10f as single patients in private houses. | None, must be dependent on other district for accomm, was linked to Aberdeen but now isolated. |
| **Stirling** | None | 236 (110m & 126f) | 41m & 32f in public asylums, 13m & 19f in licensed houses, and 20m & 25 f in PHs. 36m & 50f as single patients in private houses. Lunatic wards of PHs, Stirling & Falkirk. Linlithgow likely to be added. | Negotiations started for choosing a site for DA. |

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