Mental Health Law in Ireland, 1821 to 1902: Building the Asylums

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Introduction
The nineteenth century was a time of intensive legislative reform in relation to the management of mental illness in many countries, including the United Kingdom. Among the important initiatives taken in Ireland at this time, arguably the most enduring resulted in the establishment of an extensive system of public asylums which, in turn, heralded substantial changes to the conceptualisation and experience of mental illness in Ireland (Finnane 1981; Robins, 1986; Reynolds, 1992; Walsh & Daly, 2004). This paper (a) summarises the central legislative and administrative changes in Irish mental health services between 1821 and 1902, and (b) relates these reforms to prevailing therapeutic paradigms.

Legislative Provisions Prior to 1821
There was scant specific legislative provision for the mentally ill in Ireland in the seventeenth and eighteenth centuries and while various pieces of legislation in the 1700s established a network of workhouses and houses of industry for the destitute poor, many individuals with mental illness spent significant periods in workhouses which were inadequate and inappropriate for their needs (Robins, 1986; Kelly, 2004) as there was no dedicated asylum accommodation. In 1944, an anonymous psychiatrist, writing in The Bell, an Irish literary periodical, noted that:

“In 1728 cells were erected in the Dublin House of Industry, and later similar provisions were made in houses of industry throughout the country. These, however, could not be classified as institutions. The term ‘cells’ is sufficiently informative.” (Psychiatrist, 1944)

Ireland had no tradition of private asylums unlike England where significant numbers of individuals with mental illness were housed either in private asylums or admitted as private patients to large public asylums, such as Bethlem (Shorter, 1997). Without such dedicated public or private provision, the mentally ill in Ireland tended to lives of vagrancy, homelessness and destitution (Robins, 1986). When St Patrick’s Hospital, Dublin opened in 1757, following a bequest by the author Jonathan Swift (Malcolm, 1989), things changed a little. By 1817, St Patrick’s Hospital had 150 inpatients, including 96 “paupers” (Finnane, 1981). This development was welcome but isolated, and there was a serious lack of provision for the mentally ill both in Dublin and throughout Ireland for most of the 1700s. The first systematic change occurred in 1787, when the Prisons Act empowered Grand Juries to establish lunatic wards in houses of industry and dictated that such wards were to be inspected by the inspector-general of prisons. The response to the 1787 legislation was modest, however,
and by 1804 lunatic wards had only been established in Dublin, Cork, Waterford and Limerick (Finnane, 1981). In Cork, however, a pioneering psychiatrist, Dr William Saunders Hallaran, founded the Cork Lunatic Asylum in 1791 which was an important step in establishing dedicated services for the mentally ill in this region (Williamson, 1970). This period also saw a steady expansion in private care with the opening of a private asylum in Cork in 1799 and further private facilities in Bloomfield, Donnybrook (1810), Farnham House, Finglas (1814) and Hampstead House (1826) (Williamson, 1970). Generally, however, there was still a paucity of accommodation and treatment facilities for the mentally ill, especially the destitute mentally ill which put substantial pressure on what was available, especially the houses of industry. This concern was highlighted by Dr Hallaran in Cork, in his 1810 textbook, *An Enquiry into the Causes producing the Extraordinary Addition to the Number of Insane together with Extended Observations on the Cure of Insanity with hints as to the Better Management of Public Asylums for Insane Persons* (Hallaran, 1810). Following a discussion of treatment modalities in early nineteenth century psychiatry (Kelly, 2007a), Dr Hallaran commented:

“It has been for some few years back a subject of deep regret, as well as of speculative research, with several humane and intelligent persons of this vicinity, who have had frequent occasions to remark the progressive increase of insane persons, as returned at each Assizes to the Grand Juries, and claiming support from the public purse. To me it has been at times a source of extreme difficulty to contrive the means of accommodation for this hurried weight of human calamity!” (Hallaran, 1810)

This “hurried weight of human calamity” continued to pose substantial problems for legislators and social service providers throughout the remainder of the nineteenth century. Public and government concern were fuelled in large part by a widespread belief that rates of mental illness were increasing rapidly in the population, placing further stress on facilities that were already over-stretched and inappropriate (Tuke, 1894; Smith, 1990; Torrey & Miller, 2001; Prior, 2003; Kelly, 2004). The formal response to this situation was underpinned by an extraordinary period of legislative activity, commencing with the Lunatic Asylums (Ireland) Act of 1821.

**Building the Asylums**

Between 1820 and 1898 there was intensive legislative activity: the need for extensive and systematic reform had been highlighted in 1804 by a Select Committee of the House of Commons which recommended the establishment of four provincial asylums dedicated to the treatment of the mentally ill so as to minimise the numbers residing in prisons and houses of industry (O’Neill, 2005). There was a time of substantial reform in England (Jones, 1955) but progress was slow in Ireland. The Richmond Asylum in Grangegorman, Dublin eventually opened its doors in 1815. It had a Board of Governors with powers “for the regulation, direction and management of themselves and of the said asylum and of all the patients therein and of all and every physician, surgeons, apothecaries, housekeepers, nursetenders, and other attendants, officers and servants of what nature and description soever of or belonging to the same” (Reynolds, 1992). The Board was answerable to the Lord Lieutenant (the chief administrator of British government in Ireland), the Duke of Richmond, after whom the asylum was named (Kelly, 2007b). Patients were admitted to the asylum on the basis of a certificate of insanity which had to be signed by a medical practitioner, clergyman or magistrate (O’Neill, 2005).

The prevailing therapeutic paradigm was that of “moral management”, an approach which had emerged as an alternative to traditional “medical” treatments such as blood-letting, the use of “circulating chairs”, etc (Hallaran, 1810). Jean-Étienne Esquirol (1772–1840), an influential French psychiatrist, defined “moral treatment” as “the application of the faculty of intelligence and of emotions in the treatment of mental illness” (Esquirol, 1805). The “moral” approach
emphasised the importance of the doctor-patient relationship and employed the principles of reward and punishment, reason and emotion, in order to reduce symptoms (Carlson & Dain, 1960). It was followed in Ireland in the early decades of the nineteenth century (Williamson, 1992; Reuber, 1996) and practised with enthusiasm when the new Richmond Asylum opened in 1815.

The Richmond Asylum was quickly overcrowded and it was soon apparent that systematic reform at national level was needed. Following considerable discussion in parliament (Williamson, 1970), a bill to establish such a system of asylums was presented by William Vesey Fitzgerald and passed on July 11 1817. This legislation, amended in 1820, 1821, 1825 and 1826, set in motion the creation of Ireland’s extensive system of district asylums, many of which remained in use for over 150 years.

It was the Lunatic Asylums (Ireland) Act 1821 that empowered the Lord Lieutenant (chief administrator of British government in Ireland) to direct the erection of asylums throughout Ireland which were funded by both central government (nationally) and grand juries (locally). The establishment and planning of asylums were to be directed centrally by “Commissioners for General Control and Correspondence” but local responsibility for directing asylum activity resided with boards of governors for each asylum (Robins, 1986).

In 1825, the first asylum was established in Armagh followed by a further seven asylums in Limerick, Belfast, Derry, Carlow, Portlaoise, Clonmel and Waterford, at a total cost of £245,000 (Williamson, 1970) and completed within ten years. The asylums reflected the therapeutic paradigms practised throughout the 1800s; for example, as the emphasis on isolation and classification in the early part of the century yielded to the moral management approach (Williamson, 1992), asylums assumed a “panoptic” or radial design that was deemed consistent with the principles underlying moral management (Reuber, 1996).

As asylum-building continued, so the numbers of individuals resident in asylums increased significantly: by 1851 there were 3,234 individuals resident in Irish asylums. By 1891 there were 11,265 (Inspectors of Lunatics, 1893). The Lunacy (Ireland) Act 1821 had directed that applications for admission needed to be accompanied by a medical certificate of insanity and a statement from next-of-kin confirming poverty; applications were then considered by the physician and manager of the asylum, and presented to the Board for acceptance (O’Neill, 2005).

The 1821 legislation also directed that individuals who were insane at the time of a crime or at the time of indictment could be acquitted in court but detained in indefinite custody at a psychiatric institution “at the pleasure” of the Lord Lieutenant. In 1850 the Central Mental Hospital was opened in Dundrum, Dublin under provisions of the Central Criminal Lunatic Asylum (Ireland) Act (1845, 1846) to provide “a central asylum for insane persons charged with offences in Ireland” and detained indefinitely under this legislation (Smith, 1990).

The Case of Mr A, Detained “at the Lord Lieutenant’s Pleasure”

Mr A was a 37-year old man admitted to the Central Mental Hospital in the late 1860s having been convicted of the murder of a fellow patient in a large district asylum. Found to be “insane on arraignment” he was sentenced to be detained in the Central Mental Hospital “at the Lord Lieutenant’s pleasure” (i.e. indefinitely). On admission, Mr A’s level of education was recorded as “nil” (i.e. he could neither read nor write) and he had “no occupation”. Admission notes at the Central Mental Hospital describe Mr A as “intemperate” and his “mental state on admission” was one of “recurrent mania with dementia”.

Medical notes record that Mr A “denies his crime [and] states that he is unjustly detained here”. He showed symptoms of “chronic mania and dementia” and was “constantly talking to himself and imaginary people”. It is important to note that, in the nineteenth century, the meaning of the term “dementia” differed from its contemporary meaning; in the nineteenth century, “dementia” denoted any severe mental illness with delusions and hallucinations (e.g.
schizophrenia), whereas currently the term refers to certain chronic brain syndromes chiefly seen in later life (e.g. Alzheimer’s disease). These changes in the uses of psychiatric terminology over time make it difficult to interpret clinical diagnoses from the nineteenth century and provide accurate contemporary equivalents of psychiatric disorders recorded at that time.

In accordance with the principles of moral management, Mr A was put to work as a “division cleaner” and while he was “quiet and well conducted as a rule” he was also “excitable at times”. Some 27 years after admission, Mr A was still a “very quiet and well behaved patient” and a “useful and obliging worker”. He was, however, “in a weakly state of health [and] slightly depressed”. Mr A’s heart was “weak” and late one evening, some 33 years after admission, the asylum doctor found Mr A “in great pain, in a state of almost complete prostration, his heart weak and fluttering”. Mr A recovered from this episode but remained “very weakly”. Some months later he again “suddenly became collapsed, had an attack of vomiting” and “sank fast”. Mr A died later that night and an inquest confirmed he “died from heart disease”. Aged 70 years at his death, Mr A had spent 33 years in the Central Mental Hospital.

The case of Mr A sheds some light on both the criminal justice system and forensic psychiatric services in nineteenth-century Ireland. Like Mr A many patients were detained for decades at the Central Mental Hospital at this time (Gibbons, Mulryan & O’Connor, 1997; Mulryan, Gibbons & O’Connor, 2002). His death at the asylum was not unusual; all Irish asylums experienced significant mortality rates during the nineteenth century, mainly due to illnesses such as syphilis, dysentery, heart disease, epilepsy and tuberculosis (Kelly, 2007b). The emphasis placed on Mr A’s performance as a “division cleaner” was typical of the times and reflects the importance that “moral management” accorded to gainful occupation as a key component of treatment (Robins, 1986).

Other Legislative Initiatives in Ireland Throughout the 1800s

There was further legislative activity in Ireland as the nineteenth century progressed. The Criminal Lunatics (Ireland) Act 1838, for example, provided a separate form of admission to district asylums for individuals who were considered to be dangerous; such individuals could be detained indefinitely by two justices of the peace, who had the option of using medical evidence to inform their decision. The involvement of the judicial authorities in this way was by no means unique to Ireland: similar laws were introduced at around this time in Canada (Wright, Moran & Gouglas, 2003), Australia (Coleburn, 2003), Switzerland (Gasser & Heller, 2003) and France, with the 1838 French law establishing “official committal” as the normal means of committal for individuals who were deemed to represent a danger to public safety or order (Prestwich, 2003). Unfortunately, it was soon apparent that the “dangerous lunacy” procedures were commonly misused in Ireland (Prior, 2003) and in 1867 the Lunacy (Ireland) Act made it mandatory to seek a medical opinion prior to committal to a district asylum.

Laws passed towards the end of the nineteenth century dealt with overcrowding in district asylums by simply decanting patients into workhouses. The relevant implications of the Lunatic Asylums (Ireland) Act 1875 were outlined by William Dillon, law adviser to the Richmond Asylum Joint Committee, in 1907:

“By Section 9 of the Lunatic Asylums (Ireland) Act, 1875, it is provided that the Guardians of any Poor Law Union in Ireland may, with the consent of the Local Government Board and the Inspectors of Lunatics, and, subject to such regulations as they shall respectively prescribe, receive into the workhouse any chronic lunatic, not being dangerous, who may have been received into a district asylum, and who may be certified by the Resident Medical Superintendent as fit to be so removed, and upon such terms as may be arranged between the union and governors (not the Committee), and such lunatic shall remain on the books of the Asylum as a patient and the expenses of such patient shall be paid by the governors of such
district asylum. This section does not compel the Guardians to receive such lunatic; it makes it optional with the Guardians to accept or refuse the custody of a patient.” (Dillon, 1907)

However, it was the number of patients from workhouses presenting to the asylum that generated greatest cause for concern at this time and, by 1907, workhouse residents accounted for some 30% of all admissions to the Richmond Asylum (Kelly, 2007b). Moreover, Mr Dillon advised the Richmond Asylum Joint Committee that “under Section 9 of the Local Government (Ireland) Act [1898], it would appear that the Joint Committee is liable for the maintenance of all the lunatic poor in the City and Counties comprising the district, and they are bound to receive all insane persons into the asylum” (Dillon, 1907). The 1898 Act, however, also presented a solution to the capacity problems presented by workhouse populations:

“By the Local Government (Ireland) Act, 1898, aforesaid, Section 76, power is given to Asylum Committees to take over a workhouse or other suitable building from the Guardians of a Union, or to erect buildings themselves under Section 9 of said Act for the reception of chronic lunatics who, not being dangerous to themselves or others, are certified by the Resident Medical Superintendent of the Committee’s Asylum not to require special care and treatment in a fully equipped lunatic asylum” (Dillon, 1907).

The resident medical superintendent, Dr Conolly Norman, however, opposed the establishment of auxiliary asylums, noting that “attempts have been made in several countries, notably in Germany and in the State of New York, to establish ‘chronic’ or ‘incurable’ asylums as distinct from acute asylums, but the system has failed … It was found that the notion of incurability attached to an asylum demoralized patients and staff” (Norman, 1907).

Other legislation introduced throughout the 1800s though not primarily directed at the emerging asylum system occasionally impacted on it: the Prison (Ireland) Act of 1826, for example, required private asylums to be inspected by the inspector-general of prisons. In 1842, the Private Lunatic Asylums (Ireland) Act required private asylums to be licensed on an annual basis; patients could only be detained following receipt of a certificate signed by two doctors; and private asylums were subject to visits from the inspectors of lunacy. Throughout the 19th century, the number of private asylums continued to increase and, by 1844, there were fourteen registered private asylums in Ireland, of which seven were in the Dublin area (Robins, 1986). The growth of these institutions prompted further legislation including the Private Lunatic Asylums (Ireland) Act 1874; by 1893 there were 644 inpatients in twenty private asylums throughout the country (Inspectors of Lunatics, 1893) and as a result of the Lunacy Asylums (Ireland) Act of 1875 paying patients could be admitted to district asylums; this was a thought-provoking legislative change that had a significant effect on public perceptions of asylum care (O’Neill, 2005).

Conclusions and Contemporary Relevance

A major shift took place in the provision of care for the mentally ill and destitute in Ireland during the nineteenth century. The minimal provision for the destitute mentally ill in Ireland gave way to a system of large district asylums dotted around the country, mostly filled to capacity and some twenty private asylums registered in 1893, located chiefly in Dublin and its surrounding towns.

In addition to sweeping legislative reform there were significant changes in management with the emergence of “moral management” as the dominant therapeutic paradigm (Williamson, 1992). The case of Mr A, discussed above, illustrates many features of the nineteenth-century institutional experience (lengthy detention, ongoing symptoms of mental and physical illness, etc) and the early tensions that emerged between medical, administrative, containment and correctional requirements.
The emphasis placed on Mr A’s performance as a “division cleaner” as part of his moral management indicates this was a key component of treatment (Robins, 1986). This broad, humanistic approach of moral management contrasted sharply with the traditional medical approach which tended to focus on physical treatments such as blood-letting and the use of physical devices such as “circulating chairs” (Hallaran, 1810; Kelly, 2007a). Moreover, moral managers at the asylum tended not to be medical doctors, further highlighting the contrasts between the moral management approach and the traditional medical paradigm.

By the start of the twentieth century in Ireland, there were also significant problems with morale not helped by intractable overcrowding in the asylums and a perception that rates of mental illness were increasing in the population (Anonymous, 1861; Tuke, 1894; Smith, 1990; Torrey & Miller, 2001). Many of these issues were to dominate the Conference of the Irish Asylums Committee convened at the Richmond Asylum, Dublin in 1903 (Healy, 1996) and along with public and governmental concern about the mentally ill, led to further substantive reform as the twentieth century progressed. The Mental Treatment Act 1945 was intended to stem the ever-rising tide of admissions to asylums and provide more appropriate, acceptable care to individuals with mental illness.

Tensions between medical and non-medical input and management continue with the divergence of approach in the nineteenth century prefiguring further fundamental tensions that were to emerge later, for example between the psychological and biological approaches in the twentieth century (Shorter, 1997) and between medical autonomy and external management in the twenty-first century (Connolly & Jones, 2003). The “new managerialism” within the National Health Service (NHS) has imposed increased use of service targets and external management strategies in the planning and delivery of services has resulted in a significant shift in professional power with a struggle for control of health services between clinical and non-clinical actors (Thorne, 2002). Different groups of health professionals have responded differently to these changes (Connolly & Jones, 2003) but the overall effect on staff morale within the NHS appears mixed at best and divisive at worst (Tempest, 2006). We should learn from the experience of the nineteenth century and indeed twentieth century and take steps to safeguard staff morale which should involve the monitoring of the tense relationships between clinical and non-clinical actors in the health service.

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Mental Health Law in Ireland, 1821 to 1902: Dealing with “the Increase of Insanity in Ireland”

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Introduction

Institutional provision for the mentally ill in Ireland was substantially expanded throughout the nineteenth century with the establishment of large public “district asylums” at multiple locations throughout the country (Williamson, 1970). There was an analogous increase in private asylum capacity during this period and by 1893 there were twenty private asylums in Ireland, located chiefly in Dublin and surrounding towns. These developments occurred during a period of intensive legislative activity in relation to mental illness including, most notably, the passage of the Lunatic Asylums (Ireland) Act (1821) and the Criminal Lunatics (Ireland) Act (1838).

These increases in institutional provision coincided with increased concern about an apparent rise in the number of mentally ill individuals in Ireland. This paper aims to (a) summarise the reasons underlying concerns about the apparent increase in mental illness in Ireland during this time, and (b) outline the central medical, legislative and administrative concerns in Irish mental health services between 1903 and 1944.

“The Increase of Insanity in Ireland”

The nineteenth century was characterised by increasing public, professional and governmental concern about the incidence of mental illness in Ireland. As early as 1810, Dr William Saunders...
Hallaran, in Cork, lamented the “hurried weight of human calamity” for which he sought to provide accommodation in Cork Lunatic Asylum (Hallaran, 1810). This concern intensified as the century progressed, and as the nineteenth century drew to a close the Inspectors of Lunatics (1893) reported that “the number of the insane [receiving treatment] has increased from 249 per 100,000 of the population in 1880, to 839 per 100,000 in 1892.” Dr Daniel Hack Tuke (1827–1895), a prominent psychiatrist and mental health reformer, reviewed official statistics in the 1890s and published an influential paper on the “increase of insanity in Ireland” in the Journal of Mental Science:

“No, taking first the number of certified lunatics and idiots in the asylums of Ireland during each of the 19 years 1875 to 1893 inclusive, I find that the rate of increase during the last over the first quinquennium is as high as 60 per cent, after allowing for the decrease of population. In England and Wales during a corresponding period the rise did not exceed 22 per cent. If next we ascertain the total number of lunatics and idiots in Ireland on January 1, 1875, and subsequent years (except those ‘at large’), and the rate of increase we find that the rate of this increase during the last over the first quinquennium has been 53 per cent .” (Tuke, 1894).

After careful consideration of further statistics and possible confounding issues, Dr Tuke was “disposed to admit [that] there is … some actual as well as apparent increase of mental disorder” (Tuke, 1894). Dr Tuke’s concern was widely echoed in both public and professional circles (Anonymous, 1861; Torrey & Miller, 2001).

While it is beyond doubt that the perception of increased rates of mental illness was a real and significant concern in the nineteenth century, it is substantially less clear to what extent such an increase truly occurred and, if it did occur, what factors may have produced it. It is likely that a variety of factors were relevant in this context, including (a) increased recognition and diagnosis of mental illness; (b) mutually re-enforcing patterns of asylum-building and psychiatric committal, underpinned by legislative change; (c) changes in diagnostic practices; and (d) possible epidemiological change owing to socio-demographic changes and/or unidentified biological factors. Difficulties in establishing the precise relevance of each of these factors make it virtually impossible to establish whether or not there was a true increase in rates of illness at this time. Nonetheless, closer examination of these four areas is useful in understanding nineteenth-century concerns about rates of mental illness and the response of the authorities in terms of institutional provision for the mentally ill.

(a) Increased Recognition and Diagnosis of Mental Illness

The end of the eighteenth century saw substantial changes in societal attitudes to mental illness throughout Europe. In a detailed examination of rates of schizophrenia in Ireland over the past two centuries, Walsh (1992) notes the relevance of the “humanitarian climate of the nineteenth century” which may have lead to increased efforts to provide care to individuals with mental illness, resulting in an apparent increase in population rates of illness. This change in attitude was evident at several locations throughout Europe in the late eighteenth and early nineteenth centuries.

In 1796, William Tuke, a Quaker tea merchant, founded the “York Retreat” in England, with the explicit intent of providing care for the mentally ill in a humane and nurturing setting (Shorter, 1997). In 1801, Phillipe Pinel, a physician at the Salpêtrière Hospital in Paris, independently published an influential textbook promoting similar principles and many of his proposals were later championed by Jean-Etienne-Dominique Esquirol in Charenton, Paris and at the Salpêtrière. These changes in attitudes resulted in greater recognition that mental illness was a significant problem for which society had responsibility to provide solutions in terms of both treatment and accommodation for the mentally ill.
These changes in attitudes led to considerable efforts at systematic, governmental reform in many countries, including the United Kingdom (Jones, 1955; Torrey and Miller, 2001). In Ireland, a Select Committee of the House of Commons in 1804 recommended the establishment of four provincial asylums dedicated to the treatment of the mentally ill (O’Neill, 2005); in 1815 one such establishment, the Richmond Asylum, finally opened its doors in Dublin (Reynolds, 1992). While it is difficult to quantify the precise effects of these changes in professional and public attitudes to mental illness, it is likely that they contributed to increased recognition and diagnosis of mental illness and, in turn, increased presentations to the newly-established asylums.

Increased recognition and diagnosis of mental illness may also be attributable to societal or political factors. Dr William Hallaran, in his 1810 textbook, emphasised the roles of warfare and social unrest in increasing presentations to asylums:

“To account therefore correctly for this unlooked for pressure of a public and private calamity, it appears to be indispensably requisite to take into account the high degree of corporeal as well as of mental excitement, which may be supposed a consequence of continued warfare in the general sense … Such I know to have been but too frequently the tragical events of the late unhappy disturbances, which it is to be confessed, have added but little to the character of this country; and to which may be ascribed in a principal degree, the enormous augmentation to the lists of insane persons who have within the last ten years been received into our public Asylum.” (Hallaran, 1810)

The latter part of the nineteenth century was also a time of industrialisation, resulting in significant changes at community and societal levels in many European countries. Walsh (1992) notes that community changes associated with industrialisation in Ireland may have increased the visibility of individuals with mental illness in the community, resulting in increased presentations to asylums and an apparent increase in rates of mental illness.

Dr Hack Tuke, in his 1894 paper, also notes the emphasis that Dr Conolly Norman (medical superintendent of the Richmond Asylum) placed on social attitudes in producing increased rates of presentation to asylums:

“Although the number of persons under treatment in the Dublin Asylum has risen from 1,055 in 1883 to 1,467 at the end of 1892 (or 412 more) the medical Reporter, Dr Conolly Norman, observes: ‘At the same time, as the result of much consideration, it is not thought that the facts warrant the conclusion that there has been during the period any very marked increase in the tendency to insanity among the inhabitants of the district.’ So far as there is an apparent increase, Dr Norman attributes it to: (1) Decreased prejudice against asylums; (2) The friends of patients being less tolerant of having insane persons in their midst; (3) Poor-Law Authorities being more sensible of the unsuitability of most workhouses to provide for the insane; (4) The fact that the increase is almost confined to Dublin itself, where the population is increasing. The death-rate and the recovery-rate have also decreased, and will largely account for the accumulation of cases, though, as I have already said, not for the rise in admissions.” (Tuke, 1894)

These changes in social attitudes, societal structures and patterns of presentation, as well as changes in diagnostic practices (see below), represented significant changes in the interpretation and experience of mental illness at both individual and societal levels. At the same time as these attitudinal changes were taking place, an elaborate process of legislative reform and asylum-building began to occur and inexorably gathered pace as the nineteenth century progressed.
(b) Legislative Change, Asylum-Building and Psychiatric Committal

The nineteenth century was a time of unprecedented legislative activity in relation to mental health in Ireland. The Lunatic Asylums (Ireland) Act 1821, in particular, authorised the establishment of a network of district asylums throughout the country and within fifteen years there were large public asylums established in Armagh, Limerick, Belfast, Derry, Carlow, Portlaoise, Clonmel and Waterford (Williamson, 1970). The reports of the inspectors of lunacy for this period demonstrate that these asylums were rapidly filled to capacity soon after opening (Walsh, 1992). This trend continued for the remainder of the nineteenth century: in 1851 there were 3,234 individuals resident in asylums and by 1891 this had increased to 11,265 (Inspectors of Lunatics, 1893).

There can be little doubt that the sudden availability of hundreds of asylum beds led to increased rates of presentation by mentally ill individuals who had previously lived with families, lodged in workhouses, or been homeless – and had not, therefore, been counted in official estimates of the number of the mentally ill prior to that. The Irish potato famine of the 1840s is also likely to have played a role in increasing social need and pressure for accommodation and food. It is unclear, however, what proportion of admissions to the new asylums was truly suffering from mental illness and what proportion was admitted for other reasons (e.g. intellectual disability, social problems). Prior (2003) draws particular attention to the misuse of “dangerous lunacy” procedures which offered several practical advantages to families seeking to have family members committed to psychiatric institutions; e.g. the asylum could not refuse to admit a “dangerous lunatic”. The true diagnostic mix in admissions to Irish asylums during this period is not clear and undoubtedly merits further systematic study.

It is clear, however, that the rapid overcrowding in asylums was related not only to increased rates of presentation, but also prolonged length of stay or “accumulation by non-discharge” (Walsh, 1992). Between the years 1850 and 1890, the excess of admissions over discharges was approximately 200 annually; i.e. there were, potentially, 200 new long-stay patients created in district asylums each year (Walsh, 1992). The type of patients that generated some of these statistics are demonstrated by the cases of Mr B and Mr C, which are outlined here based on their case records from the Central Mental Hospital, Dublin.

The Case of Mr B

Mr B was a 28-year old Irish man convicted of murder in the mid-1880s. He was “acquitted on the grounds of insanity” and sentenced to be detained at the Central Mental Hospital (Ireland’s only forensic psychiatry facility) “at the Lord Lieutenant’s Pleasure” (i.e. indefinitely, at the discretion of the chief administrator of British government in Ireland). Mr B was a married shop-keeper who was able to “read and write”.

Admission notes record that Mr B was “subject to epilepsy” and the cause of his mental illness was “drink”. He had a family history of epilepsy and problems with alcohol: his “father died in an epileptic fit; one sister died in [an] asylum; and two brothers are epileptics … the two epileptic brothers are intemperate”. Mr B’s admission diagnosis was “epileptic insanity”. Medical notes shortly after admission record that “epileptic attacks and fits of violent maniacal excitement now began to occur frequently and his face has assumed a congested and demented appearance. [His] language [is] incoherent and violent.”

Over time, Mr B’s symptoms subsided and ten years after admission he was “quiet and well conducted; works on the land. Health good. Mental condition has much improved…” Twenty years after admission he was “quite harmless and easily managed” although he had “fixed delusions that his time has expired and is unjustly detained here”. Later that year, Mr B was transferred back to a district asylum close to his home – the same asylum in which his sister had died many years earlier. There is no further record of Mr B’s clinical course or outcome, but it is likely that his stay in the district asylum was a lengthy one: Walsh (2004) notes that residence
within an Irish asylum for more than five years almost invariably meant that the individual would spend the rest of their lives behind asylum walls.

**The Case of Mr C**

Mr C was a 33-year old Irish man convicted of the murder of his wife in the early 1870s. He was found to be insane on arraignment and sentenced to be detained at the Central Mental Hospital “at the Lord Lieutenant’s Pleasure”. Mr C was a tin-smith with eight children and was able to read but not write.

Admission notes record that the cause of Mr C’s mental illness was “syphilis” and note that he had two previous admissions to his local asylum including one “for attempted suicide by cutting his throat”. There was a family history of “phthisis” and “scrofulous”, both of which refer to tuberculosis, which was a common problem in both general (Jones 1999) and asylum populations (McCandless 2003) at this time.

On admission Mr C was diagnosed as “a case of recurrent mania. Patient has had syphilis and states that on two occasions he has suffered from Delirium Tremens. [He] suffers from hallucinations and delusions, voices, ‘poisoned by medicine in his food’, ‘conspiracy against him’. [He] is noisy and talkative at night; has a peculiar way of making up his bed; states ‘it is to keep the bad air out and the electricity from playing on him’.”

Despite these symptoms, Mr C was “quiet and well behaved [and] makes himself generally useful … is possessed of marked ability and is very clever with his hands.”

Notwithstanding these positive observations, Mr C’s detention at the Central Mental Hospital was a lengthy one, owing to a combination of psychiatric symptoms, physical illnesses and a paucity of discharge options. Some four decades after his original committal, at the age of 73, Mr C’s physical health had become the chief focus of concern. He was “confined to bed almost continuously during the winter and is very feeble. He suffers from chronic bronchitis and rheumatic arthritis.” The following year, Mr C “developed hemiplaegia on right side of his body” and died some days later, owing to an “effusion of blood on the brain”. Mr C was 74 years of age at his death and had spent 41 years in the Central Mental Hospital.

The cases of Mr B and Mr C demonstrate the complex tangle of legal, psychiatric and medical problems that presented substantial challenges to discharge from psychiatric care; this paucity of discharge options undoubtedly contributed to “accumulation by non-discharge” (Walsh, 1992), which, in turn, compounded the apparently intractable overcrowding in Irish asylums throughout the nineteenth century.

**Changes in Diagnostic Practices**

Diagnostic practices in psychiatry are continually changing and there are significant difficulties in establishing the contemporary equivalents of diagnoses made in the nineteenth century, especially when retrospective diagnostic endeavours are based on inconsistent, incomplete medical records (Mulryan, Gibbons & O’Connor, 2002). Walsh (1992), for example, notes that there were four nineteenth-century terms that correlated with diagnoses that are now known as “functional psychoses” (i.e. schizophrenia and bipolar affective disorder): mania, melancholia, mono-mania and dementia. The confusion and conflation of these terms in the literature of the times adds greatly to the difficulties of interpreting statistics provided for admissions and discharges throughout the 1800s. Some of these diagnostic challenges, along with the difficulties in separating mental illness from socio-economically driven concerns, are demonstrated by the case of Ms D, which is outlined here based on her original case records from the Central Mental Hospital, Dublin.
**The Case of Ms D**

Ms D was a 40-year-old housekeeper with seven children who was charged with the manslaughter of her four-year-old child in the mid 1890s. She was “acquitted on the grounds of insanity” and sentenced to be detained at the Central Mental Hospital “at Her Majesty’s Pleasure” (i.e. indefinitely). Ms D’s admission diagnosis was “chronic melancholia” which was attributed to “heredity”; admission notes record that she had a sister in a district asylum.

Medical records note that Ms D’s “expression of face, attitude and gestures are characteristic of melancholia; she is emotional at times. [She] does not exhibit any delusion.” Her notes, however, also record that “she takes an interest in her surroundings and associates with the other patients; readily enters conversation. Appetite good, sleeps well, clean and tidy in dress and person. [She] is bad tempered and inclined to sulk if corrected. [She] does needlework and house cleaning.” Subsequent notes confirm that Ms D was consistently “well-behaved, quiet and respectable” and “an excellent worker”. Much of this is not consistent with a diagnosis of “chronic melancholia”. Indeed, notes from almost two years after her admission specify that Ms D “will cry when meditating on her misfortunes”; this reaction would appear understandable, at least in part, given Ms D’s situation (indefinite detention, the loss of her child, etc.).

Notes from six years after Ms D’s admission record that “this patient is perfectly sane and is most anxious for her discharge but there is some difficulty as her husband is in a workhouse and she has no friends sufficiently well off to provide for her”. Some arrangement must have been reached, however, as two years later Ms D, then described as “perfectly harmless,” was “discharged … in care of her daughter”. In this case, the diagnosis of “chronic melancholia” appears, by today’s diagnostic criteria, to be largely unsupported by the clinical details recorded in the sparse notes from Ms D’s stay in the Central Mental Hospital.

Notwithstanding these difficulties with the interpretation of clinical records, some general conclusions can still be drawn about changes in diagnostic practices throughout the nineteenth century. There is, for example, strong evidence to suggest there may have been a significant diagnostic shift from intellectual disability (“idiots”) towards mental illness (“lunatics”) during the latter part of the century. In 1893, for example, the Inspectors of Lunatics (1893) presented findings from the General Report of the Census Commissioners demonstrating a fall in the number of “idiots” (from 7,033 in 1861 to 6,243 in 1891) and a rise in the number of “lunatics” (from 7,065 in 1861 to 14,945 in 1891). There are many possible reasons for these changes, not least of which is the sudden availability of hundreds of asylum beds for individuals with mental illness, which may have prompted a re-classification of certain intellectually disabled individuals as “lunatics” in order to secure easier access to long-term asylum accommodation.

**(d) Epidemiological Change?**

The possibility of true change in the incidence of mental illness in nineteenth century Ireland is difficult to resolve definitively, owing to the absence of reliable data about both the incidence of mental illness and the precise population of Ireland in the 1800s. Even at the time, it was recognised that epidemiological analysis of the population of the United Kingdom (which then included Ireland) was significantly hampered by the absence of reliable data. Dr Richard Powell (1813), in a paper read to the Royal College of Physicians in London in 1810, noted that:

“In order to form a correct judgement respecting the increase or decrease of any particular disease, it is not sufficient merely to ascertain the number of cases in which it occurs within any given period or periods, but it is further necessary to examine the relative population of the country at exactly the same time, and to compare under the same dates the numbers of each. Now upon this subject our data are very deficient.” (Powell, 1813)
There were similar problems with data collection in Ireland, with the result that precise epidemiological analysis of the incidence of mental illness is essentially impossible. It is apparent, however, that certain demographic factors and changes in population structure may have played a role in producing, at the very least, an apparent increase in the rate of mental illness. Walsh (1992), for example, notes that there were substantial increases in life expectancy around 1800 and these may have increased the survival of individuals prone to develop schizophrenia. This would have increased the prevalence of mental illness (and therefore the burden of care) but not necessarily the incidence. In addition, increased preoccupation with quality of life, rather than mere survival, may have further increased rates of presentation to asylums (Walsh 1992), thus further increasing the burden of care without truly increasing incidence.

Notwithstanding these arguments, Torrey and Miller (2001) note that many medical directors in the nineteenth century believed there was a true increase in rates of mental illness, and they cast doubt on arguments suggesting this phenomenon was entirely attributable to accumulation of patients in asylums, decreased stigma, incarceration of individuals with alcohol problems, transfers from workhouses, heredity, the return of emigrants with mental illness, or a number of other factors. Torrey and Miller (2001) argue, in fact, that there has been an epidemic of mental illness over the past three centuries and that while this has gone largely unnoticed owing to its gradual onset, it represents an important but neglected force in world history. While the evidence presented by Torrey and Miller (2001) is persuasive in many respects, it remains, nonetheless, exceedingly difficult to determine, with any degree of accuracy, how much of the pressure on asylums in nineteenth-century Ireland was due to true epidemiological change and how much was due to other factors, such as changes in diagnostic practices and societal circumstances (e.g. the famine). The matter is further complicated by the fact that societal circumstances (e.g. conflict) may well produce a true increase in rates of certain illnesses, and not just an apparent increase due to increased rates of presentation.

In any case, while the causes of any true increase in the incidence of mental illness (if such truly did occur) are unclear, there is little doubt that the perception of such an increase had a decisive influence on both policy and legislation in Ireland. This perception was, in particular, associated with a remarkable and extensive asylum-building programme and a steady increase in asylum populations over the course of the 1800s. This accumulating inpatient population presented particularly urgent challenges to the managers of Irish asylums at the start of the twentieth century.

Into the Twentieth Century: 1903–1944

Issues relating to overcrowding in Irish asylums were to the fore of the agenda at the Conference of the Irish Asylums Committee convened at the Richmond Asylum in 1903 (Healy, 1996). By that time, it was felt that the increase in admissions was related in large part to “heredity” rather than poverty, adversity, religion or mental anxiety – a conclusion which contrasted with the emphasis Dr Hallaran had placed on political turmoil a century earlier in his influential textbook (Hallaran, 1810; Healy, 1996). Within a few short years of the 1903 conference, however, Dr Conolly Norman, resident medical superintendent of the Richmond Asylum, expressed cautious optimism that the number of individuals presenting with mental illness was finally in decline. In 1907, he reported to the Richmond Asylum Joint Committee that:

“The number of patients in the asylum has actually undergone a slight decrease since this time last year. It is, therefore, perhaps, possible, without being unduly optimistic, to indulge the expectation that the rate of increase may have reached its summit, and that the difficulty of dealing with the question may not progressively be augmented.” (Norman, 1907)
Dr Norman’s optimism was misplaced: Ireland’s overall asylum population continued to rise throughout the first half of the twentieth century, with just two short-lived declines during the two world wars; by 1945 there were 17,708 individuals resident in Irish asylums (Walsh & Daly, 2004). The extent of official concern about these trends was reflected by the establishment of three separate inquiries that dealt, to greater or lesser extents, with issues related to mental illness: the Viceregal Commission on Poor Law Reform in Ireland (1906), the Royal Commission on the Care and Control of the Feeble-Minded (1908) and the Royal Commission on the Poor Laws and Relief of Distress (1910). Notwithstanding the reports of these bodies (see O’Neill, 2005), there was little real change in the management or conditions of district asylums in the opening decades of the twentieth century. E Boyd Barrett SJ (1924), writing in Studies: An Irish Quarterly Review, noted that:

“One would suppose that it should be the first aim of asylum staffs to apply the best methods of treatment that science has evolved, and to keep au courant with psycho-therapeutic investigations. But there is little sign of this. The Medical Superintendent finds himself so engrossed in administrative duties (which should be done by a manager or steward) that he has little time to attend to patients. The zeal which, as a doctor, he should have for a generous outlay of money on medical requirements, is chilled by his anxiety as an administrator to cut down expenses … There should be strong public demand for immediate reform of the asylum system, and the complete segregation and scientific treatment of curable cases should be insisted upon. Suitable asylums should be built – healthy, bright, beautiful homes, where patients would be enticed by every art to renew their interests in things. Nerve clinics should be opened in every populous district, where advice and treatment should be available for ordinary cases of nerve trouble and incipient insanity.” (Boyd Barrett, 1924)

In 1925, another governmental commission was established to examine the nature and level of provision for the sick and destitute poor in Ireland, with a particular focus on individuals with mental illness. This commission’s report highlighted serious problems with overcrowding and lack of treatment in Irish asylums, and proposed the development of outpatient services and short-term admission facilities in general hospitals (O’Neill, 2005). Reform of the asylum system was, however, excruciatingly slow and another two decades were to elapse before voluntary admission procedures were introduced, in the Mental Treatment Act of 1945. Voluntary admission processes had been already introduced many years earlier in several other jurisdictions, including Switzerland (Glasser & Heller, 2003) and France (in 1876) (Prestwich, 2003).

The Mental Treatment Act was to re-energise the overall process of reform in Ireland not only through the introduction of new admission procedures but also through the establishment of a range of measures designed to improve practices and standards in mental health care in Ireland. Reducing the ever-rising tide of admissions, however, was to prove a more complex and challenging task that would occupy doctors, legislators and policy-makers throughout the remainder of the twentieth century.

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