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A Sociology of Institutionalisation of the 'Mentally Ill' in Ireland

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A dissertation submitted to the Department of Sociology at Trinity College, the University of Dublin, in fulfilment of the requirements for the award of Doctor of Philosophy.

September 2006

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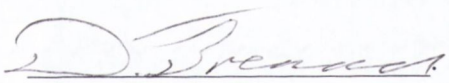

Damien Brennan

16/2/2007

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Abstract
A Sociology of Institutionalisation of the 'Mentally ill' in Ireland.

This dissertation proposes that the trajectory of the institutionalisation of 'mentally ill' persons in Ireland can be understood as a multi-layered social process resulting from an interconnectivity of various social forces and human actions, rather than any biological or psychological phenomenon that is situated within the mental state of those institutionalised.

A national public asylum system was established during the early nineteenth century, which developed into a significant physical and social feature of Irish communities. This system entailed the building of a network of asylum buildings, the establishing of an administrative bureaucracy and the development of institutional policy and routine, all of which were controlled centrally through the colonial administrative centre at Dublin Castle. These asylum buildings were added to and expanded throughout the mid to late nineteenth century and, along with other institutions such as workhouses, private asylums and gaols, they provided accommodation for individuals who were constructed as being 'mentally ill'. The utilisation of these institutions continued uninterrupted post partition in 1922, their eventual closure and sale being officially endorsed in national social policy in 2006.

This dissertation draws from historical sociology, particularly interpretative and critical methodologies, to guide an analysis of the social forces that have underpinned the trajectory of these institutions on the island of Ireland from 1800-1922 and the Republic of Ireland thereafter. A central feature of this study is the identification of long term trends in institutional residency across this time span. This is achieved though the development of a detailed empirical data set that is based on an analysis of original copies of each report of the Inspector of Asylums in Ireland, later the Inspector for Mental Hospitals, for each year from 1846 to 2000, along with other parliamentary papers, special reports and archival material. This data is presented through the use of scatter plot graphs and tables that illustrate the gross level of residency and rates per 100,000, along with the level and gender of residency within each institution type. The comparative international context is also examined along with several axes of stratification including urban / rural divides and social class.

This analysis reveals an overall trajectory of institutional residency that commenced in the early nineteenth century, a period of significant growth between 1830 and 1890, increased utilisation up to a high point in 1956, and a steady decline from that time to the present. It is also demonstrated that the actual rate of institutional utilisation in Ireland is particularly high by international standards.

This empirical information provides a foundation on which the various social forces pertinent to the trajectory of institutional usage can be considered. This is presented in two sections, the first addresses the foundation and expansion of these institutions, the second their demise and eventual closure. Core features that are identified as being important include: the political context, governance and social policy; the relationship between church and state; changing economic structures and social deprivation; professionalisation; legalisation and systems of admission and discharge; categorisation and diagnostic criteria; international developments; and family dynamics. Based on this analysis it is proposed that Irish institutionalisation of the 'mentally ill' resulted from the interaction of these social forces along with human action of individuals, families and communities. A core sociological understanding that emerges is the impact of particular conjunctures of social forces that have punctuated the major points of change within the trajectory of institutional usage.

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The first year of this study was jointly supervised by Dr Brian Torode and Professor Robert Holton. This year provided the space to explore different aspects of this field of research and to develop a detailed research agenda. I would particularly like to thank Dr Torode for his guidance during this time. Throughout the four years of this study Professor Holton has been a constant source of intellectual insight, willing and able supervisor, and mentor in terms of collegial encouragement and common sense advice. I am deeply grateful for his time and support and also for the kind hospitality he and his wife Sandra have afforded me during my supervision visits to their home.

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Introduction

> While grand theories speculating about racial decline and colonial trauma are unconvincing, the question of why Ireland used asylums/mental hospitals more intensively and for longer than most other countries still awaits a wholly satisfactory explanation (Malcolm 2003: 333).

The past two hundred years has seen the development of an extensive psychiatric system in Ireland. This entailed the building and utilisation of a national network of publicly funded asylum institutions and the setting up of an overarching bureaucracy to support this form of social intervention. Established through colonial social policy, these asylums were a significant phenomenon within Irish social life. These institutions became a major physical and social feature of the communities in which they were situated, fulfilling a spectrum of social functions such as a site of social assistance, the consumption of locally produced goods, a source of employment and a location for the development of professional practice.

This dissertation provides an empirically based historical sociology of institutional residency for the 'mentally ill' in Ireland from 1800 to 2000. In particular, this study demonstrates that this institutionalisation is a process underpinned by the combined impact of various social forces; hence the existence of a bio-medical epidemic of 'insanity' is disputed. As such, it is proposed that the establishment, expansion and contemporary demise of these institutions is a complex and multi-layered social process, punctuated by identifiable points of conjuncture of social forces.

Asylums have been socially constructed as intimidating but tragically necessary sites of caring interventions enacted by the state and local communities on behalf and for the good of individuals perceived as mentally dysfunctional, a critical deconstruction of which has been provided by Foucault (1967, 1973); Parry-Jones (1972); Scull (2005) and Turner (1995). Drawing from such critical approaches, this dissertation argues that social, political, legal, economic and medical contexts have influenced both the identification and response to what is perceived as 'insanity', 'madness' or 'mental illness', which are time-bound concepts that reflect the particular era and social milieu of their production.

While large social processes have influenced the selection of the 'mentally ill', interventions in Ireland have primarily focused on the mental state of the categorised individual. Two predominant forms of intervention have emerged. The first has involved the removal of the 'mentally ill' from society through policies of long-term institutionalisation. The second has been concerned with methods of adjusting the individual so as to achieve compliance with the perception of sanity in a particular era. These include 'moral intervention', drug treatments, electro convulsive treatment (shock treatment) and psychological methods. Contemporary psychiatry is relocating this institutional practice to a multitude of locations within the community setting including day centres, psychiatric hostels and acute psychiatric wards within general hospitals (Samson 1995). In parallel to these developments, there is increasing activity in what is described as 'mental health promotion' (Brennan 2000).

The time frame being considered within this dissertation is 1800 to 2000. The earlier date precedes the existence of the national asylum system, which was established

in response the recommendations made in the *Report of the Select Committee to Consider the State of the Lunatic Poor in Ireland* (1817), while the latter follows the introduction of social policy that officially endorsed the scaling down of these buildings (Department of Health 1984). In addition, relevant factors that fall outside these dates are considered, for example the early legal provisions for 'mental illness' within ancient Brehon law is examined, as is social policy proposing the sale of asylum buildings in Ireland in 2006 (Department of Health 2006). The physical and political jurisdiction examined in this dissertation is the island of Ireland up to 1922 and the Republic of Ireland thereafter. As such, Northern Ireland is not the focus of this study, however some consideration of the extent of mental health service provision within post partition Northern Ireland is provided. This draws from the work of Pauline Prior (1993, 1996, 2001).

The issue of language needs to be addressed from the outset. Terms such as, 'insanity', 'lunatic', 'madness', 'mental illness', and 'mental patient' have frequently been utilised in public discourse as phrases which reproduced the experience of stigma and the oppression of individuals perceived as fitting such categories. These phrases are utilised within this dissertation where necessary as a means of exploring the historical context of their social construction. However, the conceptualisation of such terms as descriptive realities situated within the individual body or mind is challenged. The working term 'mentally ill' is utilised in this dissertation as a means of denoting the condition attributed to individuals constructed as fitting the above categories. Other terms may be used where historically appropriate. The words 'asylum', 'mental hospital' and 'psychiatric hospital' broadly refer to the same type of institutions. While these terms are commonly used interchangeably, in accordance with the convention adopted in

most official publications, the term 'asylum' is utilised in this dissertation to describe these institutions before 1922 and 'mental hospital' thereafter.

The initial decision to set up an expansive state-backed asylum system in 1817 was an unusual development within the Irish context. Up until this time there was limited centralised state backed social provision (Finnane 1981). For example, the national school system was not established until 1831 (Coolahan 1981). Hence this asylum system was a significant occurrence which entailed the construction of a large network of asylum buildings, the establishing of a national bureaucratic administrative structure and the utilisation of other institutions such as workhouses and gaols. The establishing of a national asylum system in Ireland in 1817 was also early within the international context. It was 1838 before such a system was established in France, 1845 in England, and 1857 in Scotland (Reuber 1999: 208).

Indeed when compared to other European countries a number of features of the trajectory of the Irish asylum system are atypical. The level of institutional residency outpaced that of England, Wales and Scotland during the nineteenth and twentieth centuries, and during the 1950s Ireland had the highest level of bed availability internationally. The empirical data set out in Chapter 3 analyses these developments in detail. However a seminal fact worth noting from the outset is that the most intensive period of asylum expansion occurred during the mid to late nineteenth century, which was a time of acute population decline in Ireland.

The Irish experience of asylum is also unusual as there was minimal private enterprise in the provision of asylum accommodation in Ireland. This contrasts with many Europe countries and the USA, where private enterprise was a central aspect of the

development and expansion of asylum systems (Parry-Jones 1972). Furthermore, industrialisation, which has been identified as a driving force behind asylum expansion, (Scull 1979) was not a dominant feature of Irish society throughout the period of asylum expansion from 1817 to 1956 (Arensberg and Kimball 2001). The involvement of religious organisations in asylum construction and management has also been identified as a common feature of asylum expansion across Europe. However, this contrasts with the Irish case, where religious bureaucratic administrative frameworks had only marginal involvement in the national asylum infrastructure. This is also unusual in the internal Irish context, as religious organisations established control over most other systems of social intervention such as schools, orphanages and hospitals.

In essence the Irish experience of institutional residency for the 'mentally ill' is interesting in terms of its developmental trajectory, administrative structure, high rate of utilisation, social function within communities and the lived reality of those institutionalised. This dissertation provides an analysis of the various social forces that have underpinned the rise and fall of these institutions. The initial phase of this research process focused on a literature review of studies pertinent to Irish asylums, which is set out in Chapter 1. This entailed library searches, web-based searches and consultation with academics working in this field. Based on this review of the literature, it became apparent that there was an absence of a detailed empirical year-on-year account and analysis of the extent of institutional residency for the 'mentally ill' in Ireland from 1800 to date. This was identified as a significant obstacle to the examination of the overall trajectory of institutional utilisation, as trends over prolonged periods of time are difficult to establish in the absence of such data.

The research process and methodology that guide this study are set out in Chapter 2. The approach adopted may be described as interpretive-critical historical sociology. This type of approach to sociological research is identified by Turner (1992) and Holton (2003) as a feature of the research process engaged by Weber and Foucault, particularly their rejection of evolutionism, engagement of a comparative process and search for multi-causality.

The empirical aspect of this study entailed the development of a data-set which provides a detailed account of institutional residency for the 'mentally ill' in Ireland from the early nineteenth century to 2000. This data was gleaned primarily from an analysis of original copies of each report of the Inspector of Asylums in Ireland, later the Inspector for Mental Hospitals, for each year from 1846 to 2000. Where these reports proved to be insufficient for particular years, other parliamentary papers, special reports and archival material were utilised. This data is presented in table format in Appendix 1 and illustrated through scatter plot graphs in Chapter 3, with each data point linked to its precise original source. This data set includes an analysis of the gross level of institutional residency, rates per 100,000 of population, a full breakdown of institution type and a gender breakdown within each institution type. This chapter also provides a consideration of stratification such as social class and rural / urban divides, while also placing the Irish empirical data within a comparative international context. A critical consideration of the dynamic social milieu within which the original data was recorded is also set out, particularly the professional agendas served by the production of this data.

A data set of this kind has not previously been published and as such this particular aspect of the dissertation provides a rich source of information that can be

drawn on by other academics interested in this or related fields of study. This data set provides a means of identifying a precise temporal dimension of trends in institutional residency, which in turn provides a clear focus for the analysis of the particular social forces that may explain these trends.

The analysis of trends within this data set reveals a pattern of institutional utilisation that commences in the early nineteenth century, which is followed by a period of significant expansion from the late 1830s to the 1890s. A continued pattern of increased utilisation is demonstrated from 1900 to 1956, with a steady decline then occurring from 1956 to 2000. The key social forces identified in this study which may be linked to this rise and fall of institutional utilisation include government policy, law, diagnostic criteria, professional power, demographic trends, economic forces, family dynamics, a need for social assistance, international influences, and the latent value of asylums within communities. These various pertinent social forces are considered in Chapter 4, which examines institutional expansion, and Chapter 5 which focuses on the demise of these establishments. As such, a sociological analysis of trends over a prolonged period of time is set out, rather than a history of any one aspect of Irish asylum provision at any one particular point in time.

A sociological understanding that emerges from this dissertation is the impact of particular conjunctures of various social forces, which have shaped and reshaped the utilisation of institutional residency. This draws from the understanding of conjuncture as a "particular combination of structural causes and events, in a particular time and place" (Paige 1999: 782). Three points of conjuncture are of particular note, (1) the early phase of asylum expansion and the creation of a 'tendency' to institutionalise during the

mid nineteenth century, (2) the interruption of this expansion during the late 1950s, and (3) the contemporary closure of asylum buildings in Ireland.

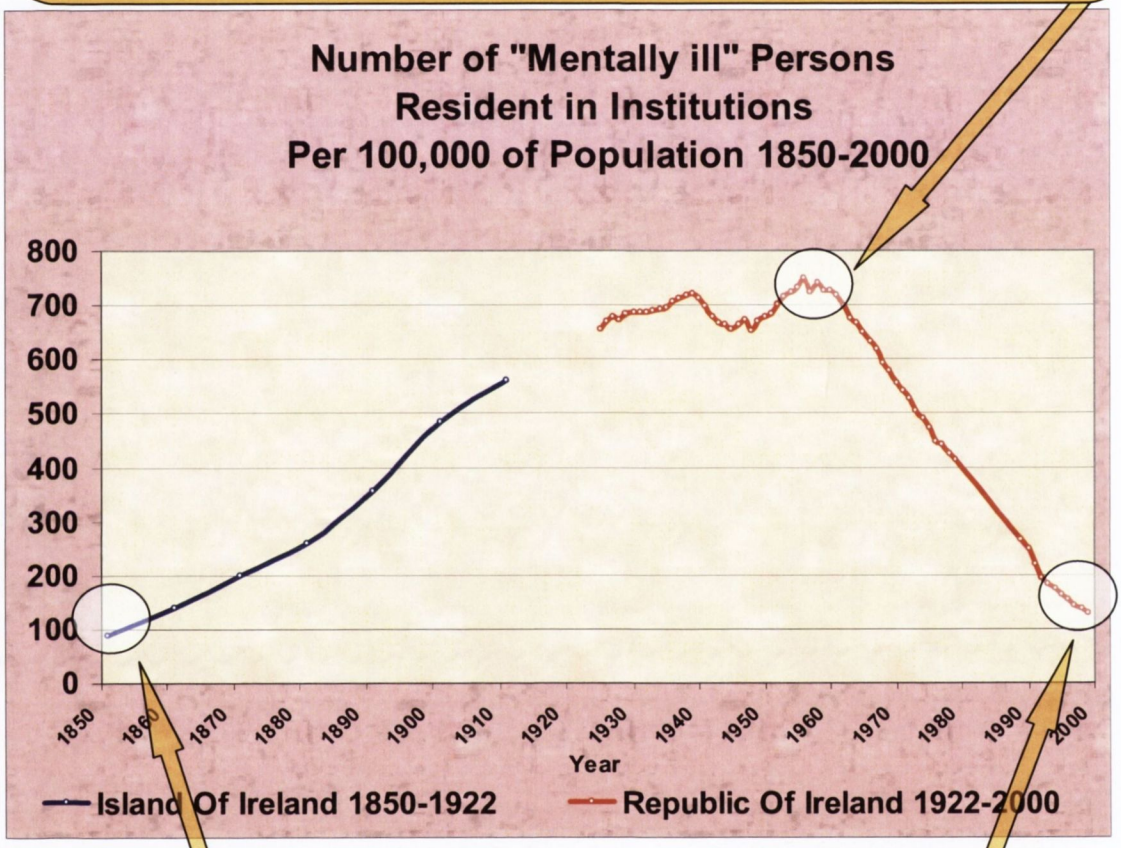
The three points of substantial change are set out in Illustration 1 below, which provides a summary of the historical architecture and temporal dimension of this study. This illustration is purposefully included in the introduction of this dissertation so as to provide the reader with a clear understanding and schematic portrayal of the general timing, connectivity and impact of the significant social forces that are considered in the chapters ahead.

This dissertation is offered as a contribution to this field of study, situated within and building on the work of other academics concerned with this sphere of enquiry. The particular contribution that this dissertation makes is an empirically based macro analysis of the social forces that have underpinned enduring trends in institutional provision for the 'mentally ill' in Ireland from the early nineteenth century to date. As such, it is proposed that this dissertation can add to the epistemological context within which the construction, classification and responses to 'mental illness' in Ireland can be considered beyond the context of the human body or individual mental state.

Illustration 1: Conjuncture and Institutionalisation of the 'Mentally ill' in Ireland

Interruption of Tendency to Institutionalise of the 'Mentally ill'

- 1945 Mental Treatment Act – Consolidated Medical Control of Admissions
- Introduction of Psychopharmacology / ECT and Psychological Interventions
- International Standardisation of Classification Systems
- European Convention on Human Rights & Fundamental Freedoms (1950)
- Belated Deinstitutionalisation Social Policy (1966 & 1984)
- Increased Urbanisation/Industrialising & Contestation of 'Traditional' Family



Creation of a Tendency to Institutionalise

- Centralised Social Policy Planning for Asylums Expansion / Fragmentation of Local Demand, Payment and Control
- Dangerous Lunatic Acts 1838 & 1867
- Fragmentation of Judicial / Medical Control over Admission
- Medical Takeover of Asylums / Establishing of Inspector of Asylums
- All Encapsulating Diagnostic Criteria
- 1843 Asylum Rules
- Family Participation in Asylum Admissions
- Poverty / Local Economic and Social Dependency on Asylums

Closure of Institutions

- 2001 Mental Health Act
- UN Principles for the Protection of Persons with Mental Illness (1991)
- Renewed System of Inspection / Mandatory Legal Advocacy
- End of Local Economic Dependency on Asylums
- Celtic Tiger and Full Employment
- Emergence Mental Health Promotion
- Sale of Asylum Buildings

Chapter One

Exploration of Field of Interest

Introduction

This dissertation seeks to set out a historical sociology of institutional residency for the 'mentally ill' in Ireland. Such a project requires a robust engagement with the 'social facts' pertinent to asylum expansion and demise in Ireland, an analysis of the various social forces that underpinned this trajectory and a consideration of the roles, functions and inter-dependencies that these institutions had with the communities in which they were situated. This research can be strengthened and contextualised by drawing on two bodies of work: sociological theory which addresses insanity and asylum institutions; and literature that considerers the particular trajectory of the Irish asylum system.

Sociological theories that address the social construction of insanity, related institutional practises and the development of psychiatry are considered in the first section of this chapter. In particular, the work of Michel Foucault, developed further by Bryan S Turner, is proposed as seminal to the theoretical approach to 'mental illness' that is adopted in this study. Within this Foucauldian approach the institutionalisation of 'mentally ill' persons is considered as a social process driven by a number of interacting social forces. This approach transcends bio-medical understandings that suggest that 'mental illness' is a physical entity originating from within the dysfunctional mind. The internal sociology of institutions is also considered, particularly Goffman's work on the

social nature of asylums, routinisation within asylums and the de-personalisation experienced by individuals living within such environments.

The second section of this chapter considers literature that examines the sociology and history of Irish asylums across a range of social settings from 1800 to 2000. This seeks to explore the volume, quality and limitations of research and literature that addresses this feature of Irish social life. A consideration of this literature reveals that 'mental illness' in Ireland, far from originating from within the individual mind, may have been influenced by changing economic, social, political and medical contexts, which is reflected in shifting constructions, identifications and responses to perceived 'madness', 'insanity' or 'mental illness'.

Some of the major contributions of these two bodies of work are explored in this chapter as a means of providing a clear theoretical basis and sociological orientation for this dissertation.

Social Theory: Insanity and Asylums

> It is not by confining one's neighbour that one is convinced of one's own sanity (Foucault 1967: xi).

Madness and Civilisation: a History of Insanity in the Age of Reason was first published in French as *Historie de le Folie* in 1961, and first published in Great Britain in 1967 (Foucault 1967). In this text, Foucault locates madness within a social context and discusses the construction of insanity with reference to a spectrum of social events, structures and representations. He proposes that the perceived common sense of insanity and responses to it may be understood in the context of production and reproduction of

structures and practices. These structures and practices are embedded in social norms, professional occupational security, economics, law and the built environments in which particular practices are formed and reproduced. Within this context a belief in the truth of insanity emerges and consequently the authority, respect for and perceived altruism of those who respond to it becomes unquestionable.

Foucault problematises the construction of madness as the fixed point of reference, proposing that such a reference point reduces the concept of sanity to a state of deviation from insanity. He proposes that understandings of the construction of madness as a truth cannot be found and problematised within the confines of the conceptual language, ideas or practices of modern psychiatry. Any analysis of insanity must, therefore, be considered through a process that transcends the acceptance of diagnostic language as a value-free principle. Hence, medical scientific rationality and 'truth' are concepts which need to be deconstructed rather that simply utilised as tools for considering insanity and its institutional responses. Language, particularly bio-medical diagnostic categories, is therefore the subject of inquiry rather than the conceptual means of inquiry. As such medical language addressing insanity is illuminated as a system of power that is developed and spoken by professional groups who have a vested interest in the kinds of social action that these words can produce.

> Sociology cannot be content with medical definitions of illness, health and disease any more than sociology can be content with legal categorizations of social deviance. There is throughout sociology a profound question of relativism which cannot be ignored in the area of medical enquiry. It is simply the case that different types of society have different types of disease and different approaches to therapy; these variations are the products of culture and social organization. This perspective from the sociology of knowledge leads us into the history of medical classifications (Turner 1995: 18).

Foucault (1967) asserts that in Europe the built environment and institutional practice of confinement had their roots in the classification and segregation of individuals suffering from leprosy. Responses to the spread of leprosy involved the widespread construction of leprosaria. Three dynamics are interesting here. Firstly the practice of segregation is established, with all its realities of classification, labelling and stigma. Secondly, a physical location is established as the place of confinement, which becomes both the site for sending the sick and paradoxically is perceived as a place of origin of disease. Thirdly, medical practice is established as a central agent within this process. Essentially, Foucault makes the point that this established a physical setting, diagnostic process and form of intervention that is later adopted in the construction of insanity and confinement of the insane. Within such a process, a medical monopoly is secured over both demand for services (diagnosis) and supply of services (control of institutional response).

> Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. 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, and we shall see what salvation was expected from this exclusion, for them and for those who excluded them as well (Foucault 1967: 5).

Hence, this transfer of functions is driven by the concerns of those employed in such enterprise who were eager to establish a new market for their services. This dynamic is considered by Foucault in the context of various institutional building projects around Europe, and while Ireland did not have a legacy of leprosy, the establishing of a work house in Dublin in 1703 is briefly mentioned (Foucault 1967: 41). Particular attention is given to the case of the Hospital General in Paris founded in 1656, which was not originally a classic site of medical power.

> From the very start, one thing is clear: the Hospital General is not a medical establishment. It is rather a sort of semi judicial structure, an administrative entity, which, along with the already constituted powers, and outside of the courts, decides, judges, and executes (Foucault 1967: 37).

A key point being made by Foucault is the lack of specialist expertise established within medicine available to place this profession in any legitimate position to claim authority over the governance of such institutions. This dynamic is considered in detail in Chapter 4 which examines the shift in control from 'lay moral management' to professional medical 'clinical' management in Irish asylums during the mid-nineteenth century. The medical take over of such institutions is interpreted as an occupational, professional and political process, which subsequently facilitated the development of psychiatry as a specialised area of medicine. In Chapter 5 a similar 'migration of clinical practice' is demonstrated within the context of the sale of Irish asylums. This draws on Samson's observation that the closure of asylums has created a new phase of psychiatric medicalistion of social life where:

> 'new' patient groups have been discovered. Most notable has been the psychiatrization of childhood, particularly evident in the diagnosis of hyperactivity . . . but also in the explosion in the numbers of adolescents, girls especially, diagnosed with eating disorders (Samson 1995: 70).

Foucault also deconstructs the complex dynamic relationship between such institutions and economic life. Here Foucault unpacks and explores the various manifest and latent activities of asylum systems. The asylum institution is problematised as a place that generates employment as well as being an economic opportunity for those interested in entering the business of private asylum provision within this trade in insanity. Asylum institutionalisation is also explored as a process that removes people without occupational or labour functionality from the capitalist market place. This serves

to maintain the supply and demand dynamic of labour provision that is required for the success of capitalism, which cannot exist in the presence of a cohort of individuals allowed to remain in a state of non-productivity. Hence, the asylum provides a stigmatised site for containing such individuals, thus removing them as a threat to the economic reality required by market-based economies.

However, the asylum also served as an arena that conversely utilised inmates to engage in forced productive labour. Foucault points out that the availability of such free labour within the asylum can actually provide a comparative economic advantage over capitalists engaged in the production of similar goods or services outside the institution. Such programmes of compulsory labour were common in Irish asylums throughout the nineteenth and twentieth centuries, described now as 'industrial therapy'. This labour might take the form of factory-based or agricultural work. This is explored in Chapter 4 and 5. Interestingly, while much of this work took place within asylums, patients were also sub-contracted to factory units and farms outside the asylum. As such, those once perceived as unproductive were institutionalised and then became a source of cheap productive labour.

The asylum institution has many economic dynamics. It is a place of opportunity for capitalists prepared to privately supply asylum services; it is a place of occupational employment for those directly employed by the institutions; it is a place that maintains a competitive labour market by providing a refuge for the unemployable within communities; and it is a place where free labour is expected from inmates. Hence Foucault argues that the asylum may be critically considered as a site that simultaneously maintains capitalist interests while at the same moment challenges such interests.

> The classical age used confinement in an equivocal manner, making it play a double role: to reabsorb unemployment, or at least eliminate its most visible social effects, and to control costs when they seemed likely to become too high; to act alternately on the manpower market and on the const of production. As it turned out, it does not seem that the houses of confinement were able to play effectively the double role that was expected of them. If they absorbed the unemployed, it was mostly to mask their poverty, and to avoid the social or political disadvantages of agitation; but at the very moment the unemployed were herded into forced-labour shops, unemployment increased in neighbouring regions in similar areas. As for the effect on production costs, it could only be artificial, the market price of such products being disproportionate to the costs of manufacture, calculated according to the expenses occasioned by confinement itself (Foucault 1967: 50).

The interface between industrialisation and asylum growth is also considered by Scull (1979). He argues that it is not the emergence of large urban centres that is the primary link between industrialisation and asylum growth, but the impact of capitalist industrialisation on the commercialisation of human social life which served to fragment the patterns of caring within the traditional family.

> No clear-cut connection exists, therefore, between the rise of large asylums and the growth of large cities. Instead, I suggest that the main driving force behind the rise of a segregative response to madness (and to other forms of deviance) can much more plausibly be asserted to lie in the effects of the advent of a mature capitalist marked economy and the associated ever more thorough-going commercialization of existence. While the urban conditions produced by industrialization had a direct impact which was originally limited in geographical scope, the market system observed few such restrictions, and had increasingly subversive effects on the whole traditional rural and urban social structure. These changes in turn prompted the abandonment of long-established techniques for coping with the poor or troublesome. . . I am concerned . . . with the massive reorganization of an entire society along market principles – what Karl Polanyi has termed 'the running of society as an adjunct to the market' (Scull 1979: 30).

Scull argues that Britain was in fact predominantly rural during the early phase of industrialisation. Large scale urbanisation was limited in 1801, with London having a population of 840,000 and only eight other cities having populations greater than 50,000. He also observed that the rate of institutionalisation of the 'mentally ill' was higher in

rural areas compared to urban areas. However, he argues that despite areas being rural, they were profoundly influenced by capitalist industrialisation at this time.

During the early nineteenth century, Ireland was rural, colonised, predominantly traditional and, with the exception of limited commercial enterprise in urban centres including Belfast, Dublin, and Limerick, Ireland did not experience a classic phase of industrialisation (Arensberg and Kimball 2000; first published in 1940). While rural Ireland did function as a supplier of raw materials to an industrialised England, rural areas in Ireland were influenced by industrialisation and capitalism much less so than rural areas within England. In effect Ireland was what may be described as a "later moderniser, a latecomer to modernity" (Tovey and Share 2000: 41) and hence, archetypal capitalist market dynamics had comparatively limited penetration in rural Ireland during the nineteenth century. Commenting on this, Scull notes that "The market system spread to incorporate all but the Celtic fringe" (Scull 1979: 30).

The Irish case of asylum expansion therefore creates some anomalies within the industrialisation thesis proposed by Scull. Within such a thesis, one would anticipate a comparatively conservative level of asylum residency in Ireland – with its restricted scale of industrialisation and limited capitalist economic dynamic in rural areas. However, as is set out in Chapter 3, asylum expansion in Ireland was very intensive by international standards, Ireland having the highest level of mental hospital bed availability per 100,000 when compared to any other country (See Chapter 3: Table B). This was most acute in the rural non-industrialised regions within Ireland (Finnane 1981, Walsh and Daly 2002). Indeed the statistics presented in Table B would appear to contradict the connection between asylum utilisation and 'a mature capitalist market economy'. This table sets out

the results of an analysis of the level of psychiatric bed availability in eighty-four countries for the year 1955, Ireland having the highest, followed by the USSR and then the USA, three locations with quite different economic orientations. This point is developed further in Chapter 4 which examines changing economic structures with reference to the empirical data of Irish institutionalisation, the international comparative context and the internal urban / rural divide in Ireland.

While un-employability is one factor that may result in institutionalisation, there are a host of other forms of socially constructed 'deviance' that generated stigma within families, which may also result in asylum committal.

> That which is called a base action is placed in the rank of those which public order does not permit us to tolerate . . . It seems that the honour of a family requires the disappearance from society of the individual which by vile and abject habits shames his relatives (Foucault 1967: 62).

In the context of 'deviance', Foucault examined the role of religious organisations in the provision of institutional services. The dual role engaged by religions organisations are identified and problematised - firstly their capacity to establish what is moral and sane vis-à-vis immoral and insane, and secondly their involvement in providing services to such categorised individuals. This proposal is developed by Foucault with particular reference to the French experience of institutional confinement. However, this contrasts with the experience of Ireland, which did not develop its national asylum infrastructure in conjunction with established religious bureaucracies. While the theme of the service provider's vested interest in the continuation of the asylum project is relevant to the Irish context, Foucault's analysis of church enterprise in asylum provision is not directly transferable to the Irish experience. Although asylum provision in Ireland

was expansive by international standards, it was one of the few social interventions not dominated by the Church. This is explored in more detail in Chapter 4.

As far as the phenomenology of 'mental illness' or deviance is concerned, Foucault does not dispute the existence of human experiences such as hallucinations. A similar argument is made by Turner, who proposes that "having recognised the importance of cultural categories, I wish to retain a foundationalist epistemology and phenomenology of the body, because I want to retain the view that body pain, for example, cannot be properly understood as only socially constructed" (Turner 1995: 18). As such, human experiences such as sadness or pain are not disputed, but the use of medical language as a means of constructing such experiences as 'deviant' is problematised. For example, human emotion or passion is perceived as 'insanity' in an age where reason and rationality are prescribed as fixed parameters in which individuals must negotiate their sane and rational lives. Hence, Foucault observes that the conceptualisation of madness is time-bound and shifts in the context of the perceived truths of particular eras, as are the actual interventions and responses to perceived insanity which also change and reshape as a consequence of the continuous 'developments' of medical practice informed by scientific positivism.

Thus, several lines of critical analysis can be drawn from *Madness and Civilisation*: asylums are identified as types of warehouses for the 'asocial'; the application of enlightenment ideas to such institutions (cure and care) is deconstructed; the medical take over of asylums is made political; and the application of scientific medicine to perceived insanity is problematised. This critical examination of the medicalistion of human life is further developed in *The Birth of the Clinic*:

> This book is about space, about language, and about death; it is about the act of seeing, the gaze. . . Modern medicine has fixed its own date of birth as being in the last years of the eighteenth century. Reflecting on its situation, it identifies the origin of its positivity with a return – over and above all theory – to the modest but effecting level of the perceived (Foucault 1973: ix and xii)

The Birth of the Clinic is particularly concerned with determining the conditions that provide the possibility of medical dominance in contemporary societies. Foucault attempts to understand the emergence of systems and rules of classification which underpin medical theory and practice. He identifies the 'clinical gaze', which involves various forms of examination, as the process through which classification is applied to the subject or human body that is being considered as potentially ill. The political environment of professional medicine and the built environment of the hospital are also considered as providing an opportune structure for the event of medical domination over areas of life such as birth, death, health and illness. Drawing from Foucault's analysis, medical dominance within Irish asylums is considered in Chapter 4, with particular reference to the official policy to "advance medical sciences in the case of lunacy, through the great range of experience which the public Asylums afford" (Inspectors-General 1844: 46).

> The space of *configuration* of the disease and the space of *localization* of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time – the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy (Foucault 1973: 2).

Foucault argues that the proposed legitimacy of the 'clinical gaze' is based on the application of science to illness, however, he also argues that while medicine creates its knowledge on the legitimacy of sickness it also transcends the limits that the scientific approach sets out. As a result health and illness are constructed dialectically, and categories of illness are considered in terms of their relationship to each other.

> The medical gaze circulates within an enclosed space in which it is controlled only by itself; in sovereign fashion, it distributes to daily experience the knowledge that it has borrowed from afar and of which it has made itself both the point of concentration and the centre of diffusion (Foucault 1973: 35).

In *The Birth of the Clinic* Foucault also considers the nature of epidemic as a social event. A description is provided of the setting up of groups of doctors to monitor and intervene in epidemics in France during the late eighteenth century. Foucault makes a connection between the personal body and the political or social reality of epidemic and goes on to illuminate how medics gained a monopoly of practice over both physical and social aspects of human life. As such, medical practice is proposed as a constructed technical set of skills and knowledge, but equally as a political process that is linked to wider political opportunities.

> The years preceding and immediately following the Revolution saw the birth of two great myths with opposing themes and polarities: the myth of a nationalized medical profession, organized like the clergy, and invested, at the level of man's bodily health, with powers similar to those exercised by the clergy over men's souls; and the myth of a total disappearance of disease in an untroubled, dispassionate society restored to its original state of health (Foucault 1973: 36).

The utopian vision of a disappearance of disease provided the context in which the expectation of a notion of health was established. This facilitated the proposal of a fixed point of normality from which illness was conceptualised:

> Generally speaking, it might be said that up to the end of the eighteenth century medicine related much more to health than to normality, it did not begin by analysing a 'regular' functioning of the organism and go on to seek where it had deviated. . . Nineteenth-century medicine on the other hand, was regulated more in accordance with normality than with healthy; it formed its concepts and prescribed its interventions in relation to a standard of functioning and organ structure (Foucault 1973: 40).

Hence, medical practice is observed as moving from the context of the healthy body to the context of normality, to which the body must be adjusted. This migration of

practice from the individual body to the society is interesting if one considers the contemporary shift of psychiatric practice in Ireland to areas of life such as mental health promotion and suicide prevention. Drawing from Foucault's proposal, this migration of practice is considered in Chapter 5. This is situated within professionals' concern for occupational security. Having lost their main source of practice within the asylum, these professional groups have been proactive in developing new markets for psychiatric intervention.

Traditionally the location of the process of health and illness was the family (Scull: 1979), whose members were interdependent in a manner that enabled mutual care provision or a 'natural duty of compassion', but it did not guarantee it. It would be unwise to suggest that mutual care was the sole feature of Irish family life. Indeed the family unit provided the context for most aspects of social life including birth, death, education, labour, and love - but also abuse and neglect. However, the development of scientific classification systems and the built environment of the hospital relieved the family of this duty of care during times of illness. Indeed within the ideology of altruistic and scientific medical practice, the family had a duty to surrender care of their kin to the 'expert' knowledge of the well-equipped practitioner.

Foucault's work on the historical trajectory of insanity, the nature of madness and power, particularly within the context of professional medicine, is significant in providing understandings of insanity that transcend the individual mental state. His consideration of a spectrum of social events provides a multi-layered and complex analysis of insanity, mediated by power, situated and reproduced within structures such as professional bodies, law, religion, governance, built environments and represented through literature,

festivals, paintings, mythology and in particular histories. Such an approach is extremely useful when considering the Irish case as it provides a theoretical foundation to enable an analysis of 'mental illness' not bound by the individual mental state or human flesh.

Drawing on Foucault, Turner proposes that a theoretically informed medical sociology is concerned with the role of choice, meaning, agency and power in the experience of illness (Turner 1995, 1996). This involves a consideration of the wider issues of the social forces and inequities, particularly the structural interface between religion, law and medicine as institutional forms of social control. Turner's approach to medical sociology involves a critical analysis of the histories of medicine which are problematised as legitimating reproductive precursors to medical power and practice. This approach is developed further by Samson (1995) in the context of contemporary asylum deinstitutionalisation and community mental health reforms, which he situates within the political economy of privatisation.

Samson examines a variety of perspectives on the nature, character and historical development of the concepts and treatments of insanity. He argues that mental illness continues to be seen primarily as organic in origin by the dominant mental health professionals. Drawing from labelling theory, Samson deconstructs the concept of mental illness itself. Hence the clinical responses and social policies resulting from such concepts are considered to be problematic. Similarly to Foucault, he observes that the expansion of the asylum system served many purposes and functions. These included a consolidation and reproduction of religious and moral virtue; the absorbing of the labour of the unemployed; and a political base for the development of medical science with the associated development of a new profession of psychiatry (Samson 1995: 56-57). The

more recent process of deinstitutionalisation is linked by Samson to the development of pharmacology treatments, economic considerations, moral criticisms of institutionalisation and research critiquing the social function of institutions. This critical approach deconstructs and problematises contemporary medical power and the 'common sense' of 'mental health' practice. This approach is drawn on in the critical analysis of declining Irish institutional utilisation, set out in chapter 5.

An analysis of the trajectory of institutional residency for the 'mentally ill' in Ireland also requires a consideration of the internal social life of individual asylum institutions. Sociological theory addressing institutional social life was significantly progressed by Erving Goffman during the early 1960s, particularly his seminal research at St Elizabeth's Psychiatric Hospital USA. Drawing from the anthropological tradition, this observational study sought to illuminate the social world of the psychiatric hospital and to explore patients' subjective experience of life in such institutions. While conducting his research, Goffman worked in St Elizabeth's as an assistant to the athletic director and as such he spent most of his day with patients. However he had separate sleeping quarters. Based on this study, Goffman observed that the segregation of authority over various aspects of normal social life is undermined within the asylum. This results in a reality where a single authority gains a monopoly of authority and becomes a singular controlling force under which individuals negotiate various aspects of their day to day life.

> A basic social arrangement in modern society is that the individual tends to sleep, play and work in different places, with different co-participants, under different authorities, and without an overall rational plan. The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life (Goffman 1961: 17).

Hence, a discontinuity is established between the individual within the institution and the community outside. This is symbolized by the barriers to social interaction with the outside world, which are often built into the physical structure of institutions in the form of locked doors, high walls and controlled points of entry and exit. Within this environment individualised existence is suppressed and of secondary importance to the overall functioning of the institution. Drawing on Goffman's work, Cockerham notes that there are four types of adjustment to total institutions "(1) situational withdrawal, (2) intransigence (rebellion), (3) colonization (using the experiences of the life in the outside world to demonstrate the desirability of life on the inside) and (4) conversion (living up to the staff sponsored, ideal model)" (Cockerham 2003: 264).

While institutionalisation will have a particular impact on each institutionalised person, Barton (1959) observed a common human response within the total institution, particularly for long stay inmates/patients, which he described as institutional-neurosis. This is a set of experiences and social realities that includes the eventual passive acceptance of the logic of the institution, a loss of social skills, a lowering of personal self-esteem and general social withdrawal. While these experiences are attributed directly to the effect of the institution, they can be held as actual signs and symptoms of a bio-medically constructed mental disorder, and consequently be used as justification for the necessity of continued institutionalisation.

A common ontological theme that underlines the theoretical perspectives offered by Foucault, Goffman, Samson, Scull and Turner, is their willingness to transcend conventional medical understandings of asylums, psychiatry and institutional practice. Clinical interventions within psychiatric practice, which 'seek to relieve the suffering of

the insane individual', are problematised and institutional interventions are not accepted as being a benign feature of social life. In Chapter 2 such theoretical perspectives are explored and contextualised within an overarching methodological approach to historical sociology, which is adopted as the guiding research process for this dissertation.

The Sociology and History of Irish Asylum and Psychiatric Services.

There have been some prolific contributions to the study of 'insanity', 'mental illness' and 'institutionalisation' in recent decades for example Scull (1979, 2005), Parry-Jones (1972) and Porter (1981, 1986, 2003, 2004). However, much of this work relates to the English context and does not take account of the particular trajectory of asylum expansion and demise in Ireland. Several historical accounts of individual Irish asylums have been published and a limited volume of material has been published that addresses the particular social context of the Irish asylum system as a whole.

Firstly, it is worth noting that annual reports have been provided from 1846 to date by the Inspector of Lunatic Asylums / Inspector of Mental Hospitals. Collectively, these annual reports provide valuable statistical data, along with an account of the general state and utilisation of asylums, the psychiatric services and more recently mental health services in Ireland. These reports are of historical importance for two reasons. Firstly, they provide a consistent source of empirical data relating to asylum utilisation. Secondly, they provide a rich source of discourse which affords an insight into Irish asylum life across a time span of over one hundred and fifty years. For example the

changing classification systems adopted at various points in time illustrate the temporal nature of diagnostic criteria. Furthermore, these reports provide an account of the medicalistion of perceived insanity in Ireland. Effectively, these reports were produced within a dynamic context in which those writing the reports had strategic interests in the picture they portrayed, this is explored in some detail in Chapters 3 and 4.

These reports are critical to this dissertation as they provide an 'official' account of asylum utilisation in Ireland. The statistical data contained in these reports is illustrated graphically and analysed in Chapter 3 and collated in table format in Appendix 1, with each data point referenced to a precise date (day / month and year) and source. These reports are available at the National Library of Ireland within the collection of Parliamentary Papers, which also contain other special reports and policy documents concerned with asylums in Ireland. An important example is the *General Rules for the Government of all the District Lunatic Asylums in Ireland* published 1843 (Inspectors-General 1844: Appendix No. 3. 43-48) and 1885 (Lord Lieutenant 1885), which stipulated and prescribed procedures for most aspects of life within asylums, such as management structures, admission procedures and daily routines.

While being limited by its progressive and uncritical historical approach, Kirkpatrick's *A Note on the History of the Care of the Insane in Ireland: up to the end of the Nineteenth Century* (1931) provides an early historical account of the trajectory of the asylum system as a whole. This text is particularly useful in its observations regarding the lack of institutional provision for the insane in Ireland during the pre-colonial era.

> There does not seem to have been any provision made in ancient Ireland for the institutional care of lunatics by the country at large, but probably each tribe had to make some provision for its own members who might become insane (Kirkpatrick 1931: 7).

A substantive contribution to the academic literature addressing mental illness and psychiatry in Ireland can be found in the research conducted by Dermot Walsh, a psychiatrist who has been the director of a major psychiatric hospital while also holding the national position of the Inspector of Mental Hospitals in Ireland from 1987 to 2001. Linked to his annual publications as the Inspector on Mental Hospital, Walsh has published detailed data with regard to psychiatric illness morbidity in Ireland and rates of hospital utilisation such as *Hospitalized Psychiatric Morbidity in the Republic of Ireland* (Walsh 1968) and the *Irish Psychiatric Hospitals and Units Census 2001* (Walsh and Daly 2002). In *Mental Health Policy Developments in Ireland* (Walsh 1987) a consideration is given to the wider social context of psychiatric social policy reform, particularly the impact the policy document entitled *Planning for the Future* (Study Group of the Development of the Psychiatric Services 1984). In this article Walsh critically observes political resistance to job losses which may result from the social policy of deinstitutionalisation. This is also considered in a chapter entitled *Mental Health Care in Ireland 1945-1997* (Walsh 1997) which is included in a collection of chapters edited by Joseph Robins (1997).

Walsh adopts a 'progressive' historical approach in *Mental Illness in Ireland 1750-2002: Reflection on the Rise and Fall of Institutional Care* (2004) which provides a narrative of ongoing 'progress' in institutional interventions for the 'mentally ill'. While this study seeks to provide a macro-view of Irish asylums, it fails to provide a year on year account of the rate of utilisation since its establishment in 1817. A broadly generous and uncritical interpretation of psychiatric practice is provided in this study, which fails to take account of the vested interests of groups including psychiatrists, medical directors

of mental hospitals, and inspectors of mental hospitals, all of which Walsh has been a member. A similarly 'progressive' bio-medical approach is taken in Keane's edited collection *Mental Health in Ireland* (Keane 1991). While all of the contributors to this text are psychiatrists, some chapters provide interesting considerations which are pertinent to the sociology of Irish asylums including suicide, crime, schizophrenia, alcohol excess, and sexuality. However throughout these chapters there is a lack of any critical exploration of the role and power of psychiatry and psychiatry practice in mediating who is ill, what constitutes mental health and what forms of intervention should be sought.

An interesting anthropological analysis of the relationship and interaction between a community on the Dingle peninsula of Kerry and the psychiatric services during the mid 1970's is provided by Nancy Scheper-Hughes. This study, *Saints, Scholars and Schizophrenics: Mental Illness in Rural Ireland* (1977), utilised historical, ethnographic and phenomenological methods to examine the high rate of admission to psychiatric hospitals in this area. Shaper-Hughes proposed that this phenomenon can be best understood by uncovering the lived experience and social life of individuals living in, what she presents as, a conservative, rural, traditional and overly religions society in decay. In particular she argued that rural social life in Kerry was substantially undermined through the disintegration of traditional family units, the devaluation of farming and rural trades and a growing penetration of urban capitalism. Furthermore she argues that a pattern of chronic rural depopulation, particularly in the case of young women, eroded the potential for young men to establish life pathways which were in keeping with the local tradition way of life.

Scheper-Hughes proposes that these factors created psychological distress that is diagnosed as mental illness and is primarily managed through admission to the local asylum. She also observed a counter reliance between the communities in Kerry and the local asylum, which generated a fatalistic acceptance of asylum admission as an appropriate intervention during times of life crises.

In *Schizophrenia: the myth and the reality* (Walsh 1991), a strongly critical comment is made on the Shaper-Hughes study. Walsh proposes that "While some of these findings may have had some basis in reality a quarter of a century or more ago, it is doubtful if this is the case today. Anyway, there are serious scientific difficulties with the studies of the kind from which these findings derive" (Walsh 1991: 35). However, much of this critique concerns the research approach adopted by Scheper-Hughes and it should be understood that the predominant research approach adopted by Walsh in his own research is quantitative and 'progressive'. As such the critical and anthropological approaches used by Shaper-Hughes deviate from those familiar to Walsh. However, further critical comment of *Saints, Scholars and Schizophrenics: Mental Illness in Rural Ireland* was also put forward by Elizabeth Malcolm who argued:

> Some psychiatrists identified what they term an 'epidemic' of schizophrenia in the west of Ireland. This interpretation was presented most controversially in 1979 by an American anthropologist, Nancy Scheper-Hughes . . .-Professor Scheper-Hughes – even if she did not realize it – was offering an interpretation with a very long pedigree [an assumed natural propensity of Irish insanity], although her argument was decked out with detailed recent field research and the latest elaborate statistics (Malcolm 2003: 329).

A significant analytical advancement in the study of the social nature of mental illness in Ireland was achieved with the publication of a study by the Australian academic Mark Finnane (1981). This is a important study, which deals with most aspects of the

development and early utilisation of psychiatry and asylum institutions in Ireland. This study, *Insanity and the Insane in Post Famine Ireland*, was published in 1981, a time when the Irish psychiatric services continued to operate within a paradigm of the centrality of the mental hospital in the delivery of 'care' to those perceived by society to be 'mentally ill, and classified as such through a medical process.

Essentially, Finnane goes beyond the romantic and progressive histories of psychiatry as an unsuccessful but gallant effort on the part of government, medicine and society generally to relieve the suffering of the 'insane'. Drawing from Oliver MacDonagh's work on the colonial administration of Ireland during the nineteenth century (MacDonagh 1977), Finnane locates the development of the Irish asylum system beyond the context of the individual person who requires assistance due to their personal tragedy of insanity, and places the asylum system within a dynamic set of social forces. Hence the asylum is considered to be a social entity which responds to, is shaped by, and influences, family structure, employment opportunity, local economies, professional power, politics, law and demographics.

One temporal limitation of this study is that it is primarily concerned with developments from 1817 to 1914. Only a few points beyond 1914, such as the 1945 Mental Treatment Act, are mentioned in the epilogue of this text. However, this is a seminal study for those interested in the social history of Irish asylums during the mid to late nineteenth century. The depth of analysis achieved by Finnane is outstanding and most subsequent academic publications within this field draw on his work and acknowledge it as a central point of reference. Indeed it is considered by academic peers as being both pioneering and ground breaking (Malcolm 1999).

In *Fools and Mad: A History of the Insane in Ireland* (1986) Robins draws on Finnane's study, and while this text lacks the depth of discursive analysis provided by Finnane, it deals with a more extensive period of time and a wider range of thematic issues. Robins narrates insanity and mental illness in Ireland from pre-Christian times, when insanity was managed by communities within the context of Brehon laws, through the establishing of asylum institutions during colonial rule, partition and the establishing of the free-state in Ireland, and the eventual commencement of deinstitutionalisation.

Both Finnane's and Robin's is work drawn on and utilised by Malcolm in *Swift's Hospital: A History of St Patrick's Hospital, Dublin 1746-1989* (Malcolm 1989). This text offers an indepth and detailed insight into the local history of St Patrick's, particularly relating to the economic and political precursors to the establishment of this hospital. However it is somewhat uncritical and gives a largely progressive account of institutional development. This is understandable as the study was initiated and supported by the then Chairman, Dennis Wardell and Governors of St Patrick's Hospital. A similar historical approach has been adopted in studies of other Irish asylum institutions, for example, *Grangegorman: Psychiatric Care in Dublin since 1815* (Reynolds 1992) and *St. Mary's Hospital Castlebar: Serving Mayo Mental Health from* 1866 (Mc Dermot 1999). While these texts require contextualisation with reference to the social function that they perform, they do provide a rich source of information concerning the interaction of local communities, individual institutions and the national asylum system as a whole.

In *The House of Strident Shadows: the Asylum, the Family and Emigration in Post-Famine Rural Ireland* (Malcolm 1999) and *'Ireland's crowded madhouses : the*

institutional confinement of the insane in nineteenth - and twentieth - century Ireland' (Malcolm 2003), a more critical and multi-layered analysis is given of issues concerned with the social and political dynamics in which various Irish health and social services developed, including the asylum system. In particular, Malcolm problematises any simplistic utilisation and application of theory emerging from international research when considering the Irish case. Her critique of the work of Scull (1979) is especially significant.

As explored above, a key point within Scull's proposal is that asylums allowed industrializing society to isolate the economically unproductive and socially disruptive, thus maintaining competitiveness within the labour market. Hence, an individual who is not useful in terms of the provision of labour may be constructed as mentally ill and managed through asylum institutionalisation. While Malcolm does not directly dispute Scull's proposal, she argues that:

> In Ireland committal had little to do with industrialization or urbanization. What it more reflected was the growing power and prosperity of the small farming class. Committal was a method by which families of this class could control and neutralize their 'strident' members: those who had not emigrated, but still sought to resist the demands of the family backed by the Church (Malcolm 1999: 186).

Malcolm suggests that many Irish families used the asylum to discipline unruly family members and that the Irish families never feared the asylum in the way that they feared the workhouse. Whereas the workhouse was viewed as the enemy of the family, Malcolm proposes that the asylum was conceived more as a resource. In essence, while Malcolm considers factors such as asylum policy, law, diagnostic systems and occupational opportunity, she identifies family dynamics as a predominant driving force behind asylum committal.

Malcolm is critical of theories that emphasise the psychological impact of the colonial and post-colonial context. In particular she describes Liam Greenslade's works as being "as dramatic and colorful as Scheper-Hughes's, but with more of a political bent" (Malcolm 2003: 329). However, Greenslade's analysis, in *The Blackbird Calls in Grief: Colonialism, Health and Identity among Irish Immigrants in Britain* (Greenslade 1997) and *White Skin, White Masks: Psychological Distress among the Irish in Britain* (Greenslade 1992), does provide an interesting insight into the experience of Irish immigrants in asylums abroad.

Greenslade draws from statistics provided in *Mental Hospital Admission rates of Immigrants to England: A Comparison of 1971 and 1981* (Cochrane and Bal 1989) which demonstrate an over-representation in psychiatric diagnosis and mental hospital institutionalisation of Irish immigrants living in England. His post-colonial analysis explores the sense of bereavement, confusion and rejection experienced within a process of forced emigration, which has it roots in the colonial experience. Greenslade considers how such emotions are lived out in the day-to-day experiences of Irish people who work within a state which they perceive as responsible for their forced emigration. It is proposed that such contradictions lead to human experiences which are subsequently diagnosed through the medical model as psychiatric disorders. Hence while Greenslade disputes the social construction of mental illness, he suggests that the Irish are prone to psychological distress as a result of their colonial experience, this is explored further in Chapter 4.

The Irish experience of psychiatric services is considered in *150 Years of British Psychiatry Volume: the aftermath* edited by Freeman and Berrios (1996). Included in this

set of edited chapters is *A History of the Richmond Asylum (St Brendan's Hospital), Dublin* (O'Shea and Falvey 1996) which illuminates a dynamic between the national setting and the local experience of asylum provision within an urban setting. Of particular interest is a chapter entitled *Irish Psychiatry in the Twentieth Century* (Healy 1996), which considers the role of the Church in Ireland. Healy proposes that Catholic social thinking provided a distinctive character to services in Ireland for the mentally ill, and also argues that it is "reasonable to suggest that the determinants of bed usage in Ireland must have been in part the same as those that determined usage in the rest of the British Isles" (Healy 1996: 282).

There would appear to be two major limitations to Healy's proposal. Firstly it fails to take account of the differences between Ireland and other places in the British Isles. For example there is the relative lack of industrialisation and the minimal development of a private market in asylum provision in Ireland. Secondly, Healy does not consider the atypically low level of Church involvement in the administration and management of asylums in Ireland.

150 Years of British Psychiatry Volume: the aftermath (Freeman and Berrios 1996) also includes a chapter by Pauline M. Prior (1996) which, draws on her earlier work, *Mental Health and Politics in Northern Ireland: A history of service development* (Prior 1993). These publications, along with others such as *Gender trends in occupancy rates in mental health beds in Northern Ireland* (Prior and Hayes 2001), provide a detailed analysis of the trajectory of mental health service provision in Northern Ireland. As discussed earlier, Northern Ireland is not the focus of this dissertation. However, Prior's work is drawn on to provide an account of institutional residency in Northern

Ireland for comparative purposes, and her work is the key point of reference for those interested in the Northern context.

Prior has also made an ongoing and significant contribution to this field of study in the context of the Island of Ireland, particularly relating to the historic legacy and gender dynamic of legislative provisions including: *Dangerous Lunacy: The misuse of metnal health law in nineteenth-century Ireland* (Prior 2003), *Prisoner or patient? The official debate on the criminal lunatic in nineteenth-century Ireland* (Prior 2004), and *Murder and Madness: Gender and the Insanity Defence in Nineteenth-century Ireland* (Prior 2005). A broader examination of gender is also provided in *Gender and Mental Health* (Prior 1999). These publications are drawn upon in Chapter 4, which considers a number of social forces that have influenced asylum expansion in Ireland, including the various legislative provisions for admission. A detailed technical consideration of psychiatric legislation within contemporary psychiatric practice can be found in *Psychiatry and the Law* (Casey and Craven 1999), which is utilised when considering the legislative precursors to deinstitutionalisation, set out in Chapter 5.

Jamie Saris draws on Finnane's work to provide an overview of the social context of the development of Irish asylums in *The Asylum In Ireland: A Brief Institutional History and Some Local Effects* (Saris 1997) and also an anthropological consideration of the interaction between community life in Ireland and the local asylums (Saris 1996). The local community context and experience of asylums is also considered in detail by Oonagh Walsh in studies including *'A Lightness of Mind': Gender and Insanity* (Walsh, O. 1997), *The Designs of Providence': Race, Religion and Irish Insanity* (Walsh, O. 1999) and *Lunatic and Criminal Alliances in Nineteenth-Century Ireland* (Walsh, O.

1999b). In these edited chapters Walsh is particularly interested in exploring aspects of the cultural and historical significance of the Connaught District Asylum in Ballinasloe. Attention is given to religious tension and power dynamics, for instance, the struggle between the Protestant management and the Catholic priests who attended the patients (Walsh, O. 1999). Walsh also considers gender differences in the rates of asylum utilisation and diagnosis (Walsh, O. 1997) and the localised interconnectivity between asylums, gaols and warehouses (Walsh, O. 1999b). These studies are drawn on in the examining this relationship between local communities and the asylum buildings which is considered in Chapters 4 and 5. The physical architectural significance of these of buildings is considered briefly by Frederick O'Dwyer in *Irish Hospital Architecture: a pictorial history* (O'Dwyer 1997). A more detailed examination of the architectural functioning of these institutions, particularly those erected in the early nineteenth century is provided in *Moral Management and the 'Unseen Eye' Public Lunatic Asylum in Ireland 1800-1845* (Reuber 1999). These are valuable texts as many of these buildings are currently being sold for private development without regard to or consideration of their past and present significance to both the social and physical landscape of Ireland.

Drawing from Goffman and Foucault, an analysis of 'the community' as the contemporary space of psychiatric practice is provided by Ciaran Smyth (2004). This study provides a series of dialogic explorations conducted with a range of psychiatric services providers, along with an in-depth ethnographic description of the life world of one patient. This is an innovative study, which provides a rich insight into, and analysis of, the physical spaces and power structures that mediate post-institutional psychiatric practice in Ireland.

Conclusion

This dissertation provides a historical sociology of the institutional residency of the 'mentally ill' on the Island of Ireland from 1800-1922 and the Republic of Ireland from 1922-2000. As such it seeks to examine the various social forces that have influenced this institutionalisation across a span of some two hundred years. This research agenda draws on the sociological theory that addresses institutional confinement and the social nature of 'mental illness', particular the work of Foucault, Goffman, Samson, Scull and Turner. While these theorists do not share a singular or united theoretical perspective, there are ontological similarities in their approach to the study of 'mental illness' and institutional confinement. Most notable is their reference to wider societal forces, rather than a narrow focus on the individual mental state. Hence, 'mental illness' and institutionalisation are understood as social processes that are situated within dynamic societal power arrangements. Drawing on this, the institutionalisation of 'mentally ill' persons in Ireland can be explored by examining its interconnectivity with law, religion, industrialisation, urbanisation, capitalism, politics, social policy, professional occupation opportunity, the need for social intervention and the action of individuals and groups.

The latter part of this chapter provides an overview of studies that have features pertinent to Irish asylum utilisation. There are some rich sources of information and analysis, most notably the work of Finnane, Malcolm and Prior, which predominantly consider the early development and expansion of the Irish asylum system. However, the same extent of analysis has not been provided on the demise of these institutions during the past fifty years or the contemporary closure of asylums in Ireland.

This dissertation will build on these publications, while also bringing something new to this field of analysis. In particular this dissertation provides for the first time a precise account of the level and rate of institutional residency for the 'mentally ill' from the early nineteenth century to date, within the limits of available data. This includes a full breakdown of institution type and gender within these various institutions, with each data point being linked to its precise date (day / month and year) and reference to its original source. This data is set out in graphs in Chapter 3 and in table format in Appendix 1. This macro series allows for a more detailed observation and analysis of trends over a more lengthy timeframe than has been possible hitherto. These trends, once identified, are then considered with reference to the various social forces at play at any particular point in time, and also the cumulative effect of social forces over time. These issues are considered in Chapter 4 in the context of asylum expansion, and Chapter 5 in the context of the demise of this system.

Chapter Two

Historical Sociology: Research Approach and Methodology

> We have yet to write the history of that other form of madness, by which men, in an act of sovereign reason, confine their neighbours, and communicate and recognize each other through the merciless language of non-madness; to define the moment of this conspiracy before it was permanently established in the realm of truth, before it was reviewed by the lyricism of protest. We must try to return, in history, to that zero point in the course of madness at which madness is an undifferentiated experience, a not yet divided experience of division itself. We must describe, from the start of its trajectory, that "other form" which relegates Reason and Madness to one side or the other of its action as things henceforth external, deaf to all exchange, and as though dead to one another (Foucault 1967: xi).

Introduction

The methodological approach that guides this dissertation is situated within what may be broadly described as 'historical sociology'. While the term 'historical sociology' is a relatively recent one, the practice of historical sociology was an aspect of the research approaches adopted and developed by classical sociologists including Comte, Durkheim, Marx and Weber. These theorists employed historical comparative methods which can be interpreted as developing understandings of modernity and the circumstances that stimulate or retard modernity including the division of labour, capitalist enterprise, urbanisation, legal systems and various forms of western governance. This approach

> ... occupies an ambiguous space between history and sociology. . . . One of its defining characteristics is a concern with the formation and transformation of modernity. In this respect the orientation of historical sociology concerns the present, viewed as both shaped by and shaping the past (Delanty and Isin 2003: 1).

Competing approaches to historical sociology are grouped across several axes by various social theorists. For example, Stephen Kalberg gathers historical sociology theory within three categories; World Systems, Interpretive Historical Approaches, and Causal Analytic Approaches (Kalberg 1994: 9). Similar groupings are proposed by Mitchell Dean; Progressive Theory, Critical Theory, and Problematising Approaches (Dean 1994: 3-4). These approaches to historical sociology broadly concur with the major divisions in epistemological perspectives described by Michael Crotty as Objectivism, Constructionism and Subjectivism (Crotty 2003: 5). However, Delanty and Isin (2003) have called for a multi-layered strategy which adopts combinations of the above approaches, coupled with insights emerging from other disciplines, applied as required for the engagement of research within a spectrum of fields.

> In our view, historical sociology, like many approaches to inquiry, has entered a post-disciplinary and, to coin a new word, post-orientalist period. It cannot claim an exclusive methodological approach as its own (Delanty and Isin 2003: 6).

This post-orientalist, or "de-formalisation" (Dean 1994: 11) movement has strong resonance with intellectual inquiry prior to the erection, separation and academic protection of disciplinary boundaries, and in practice there is a considerable legacy of inter-disciplinary research.

> Drawing up the disciplinary drawbridge has never been a good idea for historians. For centuries they have profited immeasurably from the invasion of neighbouring disciplines, starting with philology, the foundation of methods of source-criticism … in the nineteenth century, and moving on through economics, sociology, anthropology, statistics, geography, psychology (Evans 1997: 8).

This chapter is presented in two main sections as a means of exploring the theoretical orientation of this dissertation. Firstly, competing theoretical perspectives within historical sociology are explored. Drawing from this the second section sets out

the methodological framework, research phases, methods and procedures that are utilised in this study. This also includes a short narrative that addresses the reflective positionality of the researcher.

Historical Sociology: Competing Theoretical Perspectives

Historical approaches based on progressive evolutionism are firstly considered and problematised in this section. It is proposed that there are critical limitations to the adoption of this approach, particularly as this dissertation seeks to transcend anecdotal, evolutionary or progressive accounts of what may be described as 'caring' interventions within the context of institutional residency for the mentally ill in Ireland.

In contrast to this 'progressive' approach, some of the core tenets of the interpretive tradition within historical sociology are considered. In particular Weber's interpretive approach is drawn on in the development of a methodological framework. This includes his utilisation of a comparative research process, his recognition of value relevance, and his multi-causal approach to understanding historical trajectories. Building on this interpretive tradition, aspects of 'critical' perspectives are then considered. It is proposed that a fusion of these interpretive and critical perspectives offers some epistemological and methodological insights that are both useful and usable in providing an overarching research agenda to guide this dissertation.

Histories of Progress

This impulse within historical sociology discusses social change in terms of the progressive or evolutionary development of social institutions. Within macro theories, this approach can be found within the Marxist traditions and post-war modernisation theory. Similarly, within the study of more micro or personal experiences such as birth, death, health and illness, progressive histories can be found within accounts of scientific positivism and the application of science to 'ever improving' medical practice.

In *Karl Mark and Historical Sociology*, an evolutionary and deterministic reading of Marx is set out by Kelly (2003: 14). Here societies are viewed as moving through identifiable stages of development, for example, ancient, feudal and bourgeois capitalist, while others may have structural obstacles which prevent such development. This progressive approach is quite anthropological in orientation and harmonizes with nineteenth century grand narratives of human development, for example Darwinian theory of human evolution and the wider eugenics movement.

This approach to researching and portraying societal 'evolution' was substantively challenged and redeveloped in a number of directions during the twentieth century. One re-cast form of evolutionism is associated with Parsons and modernisation theory as Kalberg points out.

> The Parsonian foundation of these theories oriented "modernization studies" toward assessment of empirical movement in various nations along pathways demarcated by a set of dichotomous "pattern variables" (particularism /universalism, ascription/achievement, diffuseness/specificity, and affect/affect neutrality). All retain a strongly evolutionary emphasis and a concern with "integration," "strain," and "differentiation" (Kalberg 1994: 3).

Holton (1985) is critical of the teleological assumptions within such approaches and Elias argued that this redevelopment of the progressive tradition has led to 'the

retreat of sociologists into the present' (Elias 1987), a retreat retarded somewhat by the rejection of grand narratives of global theoretical schemas, which emerged from theorists influenced by the cultural and linguistic turn of the 1970s (Dean 1994). An influential figure slowing this retreat to the present was Foucault. He argued that progressivist histories are actually central to the continued reproduction of dominant power structures, a similar argument as that made by Illich in *Limits to Medicine, Medical Nemesis: The Expropriation of Health* (1976). For example, the maintenance and reproduction of progressive histories of medical altruism situates any challenge to medical domination within the realm of heresy. As such, critical accounts of medical intervention can be rejected from the outset by the 'fact' of their departure from a shared 'common sense' construction of the progressive and positive role of medicine within society:

> Medicine had tended, since the eighteenth century, to recount its own history as if the patient's bedside had always been a place of constant, stable experience, in contrast to theories and systems, which had been in perpetual change and masked beneath their speculation and purity of clinical evidence (Foucault 1973: 64).

Such critical observations posed profound epistemological questions regarding the process, validity and relevance of progressive historical sociology. A core criticism relates to the sequential ordering of societies and the assertion of a universal societal drive towards a shared vision of modernity. In particular the interpretive relativism within postmodernist theory undermined such progressive approaches. Writing from the historian's perspective, Richard Evans sets out some critical concerns arising from these challenges to the progressive tradition;

> ..History has been shaken right down to its scientific and cultural foundations...The postmodernist view that language could not relate to anything except itself must ... entail the dissolution of history and necessarily jeopardizes historical study as normally understood' (Evans 1997: 4).

An early example of the adoption of a progressive historical approach within the field of Irish psychiatry and psychiatric practice can be found in *A Note on the History of the Care of the Insane in Ireland: Up to the End of the Nineteenth Century* (Kirkpatrick 1931). This text is characterised by a non-critical progressive history of clinical achievement, a 'then and now' account of ongoing evolution in Irish psychiatry. For example, while other accounts of the activities of the Inspectors of Lunatic Asylums during the mid to late nineteenth century are highly critical, Kirkpatrick states that:

> It is not any part of the intention of this paper to apportion credit to the many medical men who throughout the century worked so well for the case of the insane in Ireland. A tribute must, however, be paid to a few (Kirkpatrick 1931: 37).

Kirkpatrick provides an extensively upbeat account of the role and function of the Irish Inspectors of Lunatics and while this study is successful in plotting aspects of the growth of the Irish asylum system, it fails to provide any critical account of the social function of this system, particularly of power dynamics between the institution, individual, local communities and those with vested interests in the continued expansion of the asylum system. Practice within institutions has also been the subject of such progressive histories which include, in the case of nursing, *A History of Mental Health Nursing* (Nolan 1993) and in the Irish context *Care to Remember : Nursing and Midwifery in Ireland* (Fealy 2005). Similarly, Irish medicine has also engaged in a degree of self congratulation within publications such as *Patients, Potions and Physicians: A Social History of Medicine in Ireland* (Farmar 2004). This approach is also evident in *Mental Illness in Ireland 1750-2002: Reflection on the Rise and Fall of Institutional Care* (Walsh and Daly 2004), which maintains a detached observation and portrayal of linear progress in Irish psychiatric services.

Interpretive Historical Approaches

> In order to understand the meaning and structure of clinical experience, we must first rewrite the history of the institutions in which its organizational effort has been manifested (Foucault 1973: 68).

The interpretive tradition within historical sociology draws on the work of Weber, who tried to reject grand evolutionary schemas that propose the existence of innate universal tendencies of progressive societal change. Seminal features of Weber's approach include: the empirical grounding of his research and theory formulation; the rejection of evolutionism; an open-ended comparative process; and an analysis of the multi-causal social forces that result in social change. This approach contrasts with the dominant nineteenth century sociological theories which tended to set out materialist theories of cyclical and progressive social change (Kalberg 1994). This profusion of theories of progression, and their application of historical methodology, is observed by Holton:

> For much of the nineteenth century, and indeed for a good deal of the twentieth century, evolutionism, dominated much thinking about social change. The nature of history was to be resolved through the discovery of endogenous laws of development which would explain the unfolding of changing modes of social life and organization (Holton 2003: 31).

A key proposal set out by Weber, is the lack of a macro purposeful directionality within social life. However, Holton (2003: 32) argues that this rejection of evolutionism is not completely consistent in Weber's work, particularly his work on rationalisation and bureaucratisation which tend towards an evolutionary argument.

Weber proposes that while the interrelationships of multiple actors, structures and systems enable change, there is no organic unity, shared agenda or predestined plan of evolutionary change shared between actors, structures and systems. Hence, there is a

rejection of generic schemas that are proposed as providing linear models of societal development. Monocausal schemas are not only disputed epistemologically, but the functionality of such approaches within the social sciences is also rejected: "It can never be the task of an empirical science to provide binding norms and ideals from which directives for immediate practical activity can be derived" (Weber 1949: 52). In contrast, Weber proposes an interpretive and multidimensional approach, focused on both the formation of understandings into social realties and the development of theories and methodologies for generating such understandings.

> It is simply naïve to believe, although there are many specialists who even now occasionally do, that it is possible to establish and to demonstrate as scientifically valid "a principle" for practical social science from which the norms for the solution of practical problems can be unambiguously derived" (Weber 1949: 56).

While Weber rejects positivistic methodologies, he argues that empirical enquiry is central to the research process. However, such empirical enquiry is informed by individual value judgments. Hence, during the research process the individual is viewed as being actively instrumental in the production, interpretation and the attachment of significance to empirical sources of knowledge. Importantly, Weber not only considers what is valued but also what is rejected, with the process of inclusion and exclusion considered as central to meaning making, which is mediated through personal value judgments. As such, sociological scholarship should endeavour to interpret empirical knowledge, explore value judgments and to reflectively propose meaning and theory. Hence "we cannot learn the *meaning* of the world from the results of its analysis, be it ever so perfect; it must rather be in a position to create this meaning itself" (Weber 1949: 57).

The research agenda undertaken in this dissertation involves the collation and analysis of statistical data along with the exploration of documentation concerned with the Irish asylum system. This is approached taking cognisance of Weber's overarching methodology of empirical enquiry situated within value relevance. In particular, the actual raw data utilised to formulate statistical insights is contextualised within the social processes through which this data was originally recorded, and as such, data is considered to be informed by values rather than value-free. This is of critical relevance in the interpretation of data contained within the annual reports of the Inspector of Asylums (later the Inspector of Mental Hospitals) from 1846 to 2000, which forms the basis of the empirical aspect of this dissertation. Such reports were produced within, and informed by various agendas, some of which are explicit, others which are more opaque, which are explored in Chapter 3.

Within the context of the research processes undertaken for this dissertation, the researcher's personal occupational involvement within the asylum / mental hospital system is explored in the latter part of this chapter. This is done as a means of illuminating, as far as possible, the researcher's personal positionality. The rationale for such a reflective account is to provide an insight to the researchers own life context.

> To apply the results of this analysis in the making of a decision, however, is not a task which science can undertake; it is rather the task of the acting, willing person: he weighs and chooses from among the values involved according to his own conscience and his personal views of the world (Weber 1949: 53).

Hence, Weber arguers that scientific rigour is not value-free, but equally argues that value relevance does not imply an epistemological relativism that blindly accepts any interpretation as valid. A multi-causal research process is proposed which calls for high standards of rigour in empirical enquiry, while simultaneously pursuing insight into the

value relevance integral to data production and interpretation. This is approached through a comparative process that provides for the deconstruction and critical consideration of the way meaning is created, embodied, reproduced, read and understood.

The identification of the individual as an active creator and producer of meanings and histories provides for the continuous reintegration of data, as a means of generating multiple histories of the present. Such an approach creates the possibility for revisionist histories which transcend unicausal histories that portray the present as some agreed point of arrival. This revisionist approach requires the researcher to actively engage in a consideration of the multicausal trajectories which led to a present moment, which itself can be conceptualised and deconstructed in multiple ways. Such an approach provides for the exploration of social process, such as the trajectory of the Irish Asylum System, which draws on, but is not limited by, empiricism.

> One thing is certain under all circumstances, namely, the more "general" the problem involved, i.e., in this case, the broader its cultural significance, the less subject it is to a single unambiguous answer on the basis of the data of empirical sciences and the greater the role played by value-ideas (Weber 1949: 56).

This departure from unicausal linear representations of social life has been coined "Radical-Multicausality" (Kalberg 1994: 10), which proposes that all assertions of a universal and constant relationship between values and material interests remain foreign to Weber whose:

> historicist stress upon the individual constellations and the dynamics of historical contingency, as well as his refusal to view "abstract uniformities", including even ideal types, as other than heuristic concepts, indicates a deep commitment to a broadly multicausal methodology, as does his explicit rejection of all theories that argue on behalf of the empirical validity and necessary unfolding of universal stages and laws (Kalberg 1994: 52).

While there are significant differences in the theoretical perspectives offered by Weber and Foucault, some parallels can be observed with regard to the research approaches they adopted. In particular, Turner (1992) and Holton (2003) have highlighted some continuity between Weber's comparative and multicausal approach and the methodologies adopted and developed by Foucault:

> In areas of historical sociology where key contributors such as Foucault of the *Annales* school make few explicit references to the Weberian legacy, there are none the less clear parallels with a number of aspects of his work. In Foucault's case these parallels are evident as Turner (1992) points out, in discussions of the construction of and (especially in technologies for the) cultivation of self, arising in Weber's case from issues of spirituality and suffering (Holton 2003: 36-37).

For example, aspects of Weber's interpretive multi-causal approach can be found in *Madness and Civilization: A History of Insanity in the Age of Reason* (Foucault 1967). Throughout this text, Foucault engages in a comparative consideration of a spectrum of social events, structures and representations. Foucault draws on a variety of medical discourses and discusses economic, political, technological and cultural issues in an integrated way, rather than as separate differentiated fields. Similarly this interpretive approach is present in *The Trade in Lunacy* (Parry-Jones 1972), *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (Scull 1979), and *Madness and Psychiatry* (Samson 1995). However, one limitation of these studies is that they are all primarily concerned with institutional utilisation within the context of modernity, punctuated by the industrial revolution, capitalism and urbanisation, and are therefore not geared to analysis of weak or uneven modernity.

Methodologically Finnane's (1981) text can be positioned within the interpretive and multicausal Weberian tradition. In particular Finnane is successful in providing a multi-layered analysis of Irish asylum policy from 1845 to 1921, which is robustly

grounded within empirical and discursive data. The key sources for this study included the Chief Secretary's office papers, The Inspector of Lunatic Asylums annual reports, the minute books of the board of governors of particular asylums, and also some mid nineteenth century medical journals. A similar research approach is engaged in Prior's *Mental Health and Politics in Northern Ireland : a History of Service Development.* While Prior proposes that "The methodology used for this study was that of Historical research" (Prior 1993: 8), this study can be broadly situated within the multicausal interpretive tradition. Prior's multi-layered analysis is drawn primarily from the papers and reports of both official and voluntary bodies connected to mental health in Northern Ireland, which are supplemented by interviews with people involved in policy formation, hospitals case records and informal meetings with patients. Other examples of research in the field of Irish insanity/mental illness which transcend the progressive historical tradition are Malcolm's *The House of Strident Shadows: the Asylum, the Family and Emigration in Post-Famine Rural Ireland* (1999) and *Ireland's crowded madhouses : the institutional confinement of the insane in nineteenth - and twentieth - century Ireland* (2003), which also use a mixture of official sources along with patient registers and case books of particular hospitals.

Building on the interpretive approach, this dissertation provides a multicausal analysis of the long-term trajectory of institutional residency of the 'mentally ill' in Ireland. This is non-evolutionary but still historical in its approach and uses the comparative method to explore what is distinctive about the Irish experience. This study also draws on aspects of a critical approach. As such a historical fusion of critical

perspectives and the interpretive tradition is adopted as a means of providing an overarching methodology framework to guide this dissertation.

Critical Perspectives and the Interpretive Tradition

Drawing from Nietzsche (1983), Dean describes three uses of history; the monumental, devoted to the veneration of great events and deeds; the antiquarian, dedicated to the preservation of the past as the continuity of identity in tradition; and the critical, directed to the judgment and condemnation of parts of the past in the name of present truths (Dean 1994: 18). While endeavouring to avoid the adoption of naive pre-emptive judgment or condemnation, the utilisation of aspects of this critical historical approach is particularly valuable in the exploration of structures, systems, discourses and practices within Irish psychiatry.

For example, a critical historical approach can be drawn on so as to deconstruct the progressive discourses of present day psychiatric practice, particularly the migration of professional practice from the institutional setting to the community setting under the auspices of mental health promotion. This historical methodology incorporates what is described as the causal analytic school (Kalberg 1994) and an archaeology of the present (Foucault 1972), which seek to interrupt and interrogate narratives, both progressive and revisionist, through creating new questions which encourage answers beyond the meanings that exist before such questions are raised. As such, the present is problematised in a manner that "establishes an analysis of the trajectory of the historical forms of truth and knowledge without origin or end" (Dean 1994: 4).

This type of critical historical perspective is drawn on in *The Birth of the Clinic* (Foucault 1973). Here the political environment of professional medicine and the built environment of the hospital are critically considered as providing the opportunity structure for medical domination over areas of life such as birth, death, health and illness. In effect, the challenge to medical positivism that Foucault presents is not in the detail of his argument, but rather his willingness to create new histories, which are corrosive to the unified foundations provided by unicausal histories of altruistic acts of caring intervention.

Dean suggests the adoption of an instrumental utilisation of Foucault's work which he describes as both 'critical' and 'effective'. 'Critical' in its problematising and non-acceptance of progressive histories, and 'effective' in its ability to produce new meanings that can contribute to the formation of explanatory theories, which themselves can be subject to further critical inquiry. Such a critical and effective approach requires a problematising of both the process of meaning-making and histories that have been produced, colonised, reproduced and proposed as value-free.

> Historical study can become effective because it is able to exercise a perpetual vigilance and scepticism toward the claims of various philosophies to prescribe the meaning of history (Dean 1994: 4).

This critical perspective requires the researcher to remain open to theoretical shifts during the research process and to embrace re-conceptualisations of historical timing, the sequencing of events, power dynamics, vested interests, and 'common sense' or established understandings. Hence, the familiar is deconstructed and re-imagined beyond a perceived ahistorical existence. For example, the permanent existence of the Irish asylum system beyond any living memory is not accepted as inferring a logic or

reason to its existence. As such the neutrality or common sense of social structures, systems and discourses is deconstructed within this critical approach, which allows for an exploration of their active function and dysfunction in mediating power and meaning.

This Foucauldianism may be fused with the more Weberian emphasis on interpretation through the comparative analysis of cases of a phenomenon. "The particular case itself – its integrity, complexity, historical development and social context – constitutes the focus of the interpretive historical approach" (Kalberg 1994: 5). The 'case' is thereby valued, unpacked and explored so as to expose meanings on which explanatory theories can be based. Examples of 'cases' that are of interest to the research agenda being pursued in this dissertation include: forms of practice (diagnosis systems); physical structures (the architecture of modern psychiatric wards); or events within psychiatric hospitals.

While empirical data is utilised and categorised in this dissertation so as to allow meaning to emerge, empirical positivism is avoided. Such a process draws from Foucault's assertion that one should avoid approaching discursive 'facts' as fixed entities or 'things', rather as 'fields' or as systems of dispersed relations, which are both interpreted and re-formed through the process of their consideration. Hence, the establishment of precise cross case multicausal relationships is not the aim of this interpretive / critical research process, rather a multi-layered description of a social process is sought, which is not informed by the patterned thinking of progressive histories. As such, a 'history of the present'

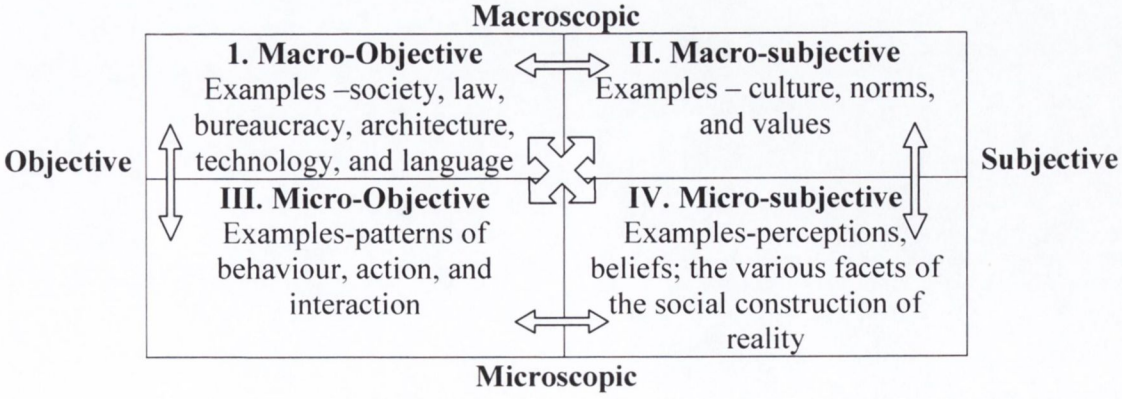
> ... may be loosely characterised by its use of historical resources to reflect upon the contingency, singularity, interconnections, and potentialities of the diverse trajectories of those elements which compose present social arrangements and experience (Dean 1994: 21).

Dean goes on to propose that studies adopting this approach:

> ... represent the first fruits of a new style of engaged historical practice in the space marked out between and in contradistinction to two competing 'regimes of truth': on the one hand, a social theory and sociology that seeks to sacrifice historical intelligibility in favour of models, types, and method; on the other, a conventional historiography that seeks to abandon concepts in the quest for exhaustive reconstruction of the past, for telling it like it was (Dean 1994: 21).

One way of examining mutilcausal inter-actions is through George Ritzer's "Major Levels of Social Analysis". Ritzer's framework provides for an analysis across four axes, Microscopic / Macroscopic / Objective / Subjective. He argues that "sociologists must focus on the dialectical interrelationship among these levels" (Ritzer 2000: 496-498). This framework enables a consideration of social processes and actions which have origins and consequences in both large scale social systems and in the personal lives of individuals. For example, in *Expressing America: A Critique of the Global Credit Card Society*, Ritzer utilises this model to explore both the personal and societal experience of credit card usage, (Ritzer 1995). The major features of this framework of analysis are as follows;

Illustration 2: Major Levels of Social Analysis (Ritzer 2000: 497)



Ritzer's framework is drawn on in Chapters 4, 5 and 6 as a means of exploring the emerging research findings, particularly points of conjuncture that punctuate change in the trajectory of institutional utilisation for the 'mentally ill' in Ireland.

Methodological Approach and Phases of Research Process

Methodologically, this dissertation draws primarily from the interpretive and critical historical approaches set out above. What is sought is an overarching understanding of the multicausal features of the trajectory of institutional confinement for the 'mentally ill' in Ireland from 1800 to 2000. By pursuing such a research agenda, the Irish asylum system can be explored beyond its portrayal as a retrospective novelty that confirms contemporary psychiatric / mental health practice as an evolutionary point of arrival. This interpretive / critical approach also provides the potential for considering future 'emotional caring labour' beyond psychiatry as the central point of reference. Hence the motivation for pursuing this study is similar to that proposed by Foucault in *Discipline and Punish: The Birth of the Prison* (1977):

> Simply because I am interested in the past? No, if one means by that writing the history of the past in terms of the present. Yes, if one means writing the history of the present (Foucault 1977: 31).

The initial phase of this research process focused on establishing the extent of previously published literature in this field. The major contributions are set out briefly in Chapter 1. Based on this review of the literature, it became apparent that there was an absence of an empirical year-on-year account of the precise extent and detail of institutional residency for the 'mentally ill' across the various institutions in Ireland from

1800 to date. This was identified as a significant obstacle to the examination of the overall trajectory of institutional utilisation, as trends over prolonged periods of time are difficult to establish in the absence of such data.

The development of such a data set formed a major aspect of this dissertation. This entailed the undertaking of a pilot study to establish the extent of data sources along with anomalies and potential obstacles. The data set was compiled through a process of collating and analysing empirical data contained within official documents, particularly the reports of the Inspector of Lunatic / Mental Hospitals from 1846 to 2000. With technical advice from a professional statistician, the data-set was compiled over a period of four years.

This data is presented in various scatter plot graphs in Chapter 3, which provides the basis for the clear identification of long-term trends. This affords a firm foundation on which to examine the overall trajectory of these institutions, which is set out in Chapters 4 and 5. The emerging findings of this research were further tested, refined and validated through an ongoing process of peer reviewed conference presentation, informal meetings with seminal academics in this field, and a continuous process of engagement with academic and official publications relating to these institutions. As a means of contextualising these findings, several asylums were also visited and photographed during the process of conducting this research.

Reflective Positionality of Researcher

Throughout the conducting of this research process, the researcher has endeavoured to be reflective of his personal agency in shaping the research process itself.

The field of this study emerged as a direct result of the researcher's employment within the Irish mental health services, which the researcher began to deconstruct during the pursuit of academic studies. The following reflective passage is set out as a means of locating the researcher within this field of study.

"I trained as a psychiatric nurse in a major psychiatric hospital in Dublin and have worked in this capacity both within institutional and community settings. I became a nurse tutor some years ago, have educated nurses to work within the Irish Psychiatric services / mental health services, and am now employed as a lecturer at Trinity College in the School of Nursing and Midwifery. I have therefore gained my occupational and financial security within the context of asylum, psychiatric and mental health service provision. The core area of my research is to critically consider the construction, classification and responses to madness, insanity and mental illness in Ireland over the past two-hundred years. This dissertation is particularly concerned with examining the extent and social context of institutional residency during this time. This presents an obvious dilemma, as the concepts, structures and practices that I wish to deconstruct are the ones that I have utilised in developing my career to date.

I am equally aware of a growing acceptance amongst mental health service providers of the need to distance their practice from its roots within the asylum. Academic analysis of the demise of institutional care and the potential for post institutional service provision is increasingly welcomed by 'mental health professionals'. As such, this dissertation further secures my usefulness within this business. Hence I must declare that I have benefited directly from both the existence and contemporary deconstruction (physical and intellectual) of asylums in Ireland.

I have endeavoured to be reflective of my personal positionality during the process of conducting this research. I am mindful that my previous exposure to and participation in psychiatric services provision in Ireland provides both opportunities and limitations in my endeavour to deconstruct the trajectory of institutional residency."

Conclusion

> ... historical sociology is carried out by historians and sociologists who investigate the mutual interpenetration of past and present, events and processes, acting and structuration. They try to marry conceptual clarification, comparative generalizations and empirical exploration (Smith 1991: 3).

Drawing from a fusion of the interpretive and critical methodological approaches to historical sociology, this dissertation seeks to explore the empirical data and pertinent

social forces relating to the institutionalisation of 'mentally ill' people in Ireland. Both the theoretical orientation and research methodology emerge from the research agenda itself, rather than leading and defining both the field and scope of what can be known. In essence, a synthesis is pursued that situates methodology within the intrinsic needs of the research agenda being undertaken. This draws on Shils observation about Weber's essays on methodology that were:

> ... written, as all methodological essays should be written, in the closest intimacy with actual research and against a background of constant and intensive meditation on the substantive problems of the theory and strategy of the social sciences (Shils 1949: iii).

Such a purposeful engagement of historical sociology as a 'means to' rather than an end itself is proposed by Dean (1994). This perspective draws on Foucault's heuristic approach to historical sociological methodology, which is adopted for its usefulness rather than its theoretical purity (Foucault 1967, 1972). Hence, rigid conformity to any form of Foucauldian orthodoxy is rejected as this would be internally self-limiting, a critical deconstruction of orthodoxy itself being common in Foucault's own approaches to developing human knowledge and insight.

> I feel compelled to take an instrumental attitude toward Foucault's work and to admit that what follows is a use of his work for particular objectives. . . It is my general hypothesis that Foucault's contribution to this historical sociology can be best understood as a delineation of a form of history which is both *critical* and *effective* and which displaces the invasion of historical analysis by what I shall call the *philosophy* of history. . . Foucault engaged in the task of methodological formalisation in the *Archaeology* only after he had completed his 'empirical' studies (Dean 1994: 13-14).

Chapter Three

Irish Asylum Utilisation 1800-2000

Introduction

This chapter has an unambiguous and ambitious objective: that is to chart the year-on-year features of the most enduring programme of centrally controlled institutional social intervention ever to have taken place on the island of Ireland.

In response to the recommendations made in the *Report of the Select Committee to Consider the State of the Lunatic Poor in Ireland* (1817), an expansive public asylum was established entailing the construction of a network of asylum buildings. While mental health policy shifted during the late 1960s and 1980s, it was not until 2006, with the publication of *A vision for Change: Report of the expert group on Mental Health Policy* (Department of Health 2006) that a decision was made to close and sell these asylum buildings. This expansive asylum system is a significant social phenomenon in Irish life. Spanning a period of almost two hundred years, these institutions became a major source of social intervention. They also developed into institutions of substantive social and economic importance to the communities in which they were situated.

This dissertation seeks to provide "A Sociology of the Institutionalisation of the 'Mentally Ill' in Ireland". This requires a sociological analysis of the social forces that have underpinned enduring trends in institutional provision over a prolonged period of time, rather than a history of any one aspect at any particular point in time.

To date there is an absence of a definitive data set that charts the precise extent and detail of institutional residency for the 'mentally ill', which spans the full duration of the existence of the Irish asylum system. This lack of data creates an uneven foundation on which to provide explanations of the overall trajectory of Irish asylum utilisation, from its inception in 1817 to it eventual demise in the late 1990s.

This chapter sets out a detailed year on year account of the number of 'mentally ill' persons resident in institutions on the Island of Ireland from 1817 to 1922 and in the Republic of Ireland thereafter. While Northern Ireland is not the focus of this dissertation some data relating to Northern Ireland is set out for comparative purposes. This data is presented through the use of scatter plot graphs, which are based on tables of data provided in Appendix 1. This time series has not been previously assembled or published, so the tables in Appendix 1 are fully expanded with every individual data point presented on each scatter plot linked to its original source and precise date. This information is presented so as to illustrate clearly the gross level of residency, rates of residency per 100,000 of population, levels of residency by institution type and a gender breakdown within each category. The data allows for the identification of enduring trends in the level of institutional residency for the 'mentally ill', which are then examined in detailed in Chapters 4 and 5.

The data provided in this chapter was gathered through a research process that involved the identification of data sources, the securing of access to this data, the completion of a pilot study, and the final collection, analysis and presentation of data. During this process several obstacles were encountered, in particular many of the data sources are dated, some almost two hundred years old and no complete run of this data is

available in any single source. The expertise and kind assistance of the staff of the National Library of Ireland and the Keeper of Early Printed Books at Trinity College Dublin were of much benefit in overcoming difficulties regarding the securing of access to older documentation.

This chapter firstly considers the context and processes through which the original data relating to Irish asylums was recorded. The overall extent and rate of institutional residency of the 'mentally ill' in Ireland is illustrated, followed by a consideration of this data within the international context. The overall rate is then considered in the context of gender, regional variations and the socio-economic position of those institutionalised. As the overall of rate institutional residency encompasses a range of types of institutions, each having a particular trajectory and gender dynamic, the data relating to each type of institution is presented and considered in the latter part of this chapter.

The Context and Process of Data Production

Data relating to the rate of institutional residency of the 'mentally ill' was generated within particular administrative, governmental, medical and institutional contexts. As such the data relating to Irish asylums was influenced by the agendas of those producing the data, both explicit and implicit. A detailed sociology of Irish asylum institutionalisation, including the role of professional groups, is set out in Chapters 4 and 5. However, the context and process of data production is briefly explored below so as to contextualise the data presented in this chapter.

Irish asylum provision developed at an earlier time and within a different set of social dynamics than that experienced in most other European countries (Finnane 1981; Robins 1986; Malcolm 2003). Three macro features of the Irish case are worth noting from the outset. Firstly, during the nineteenth century Ireland was predominantly agrarian and rural rather that industrialised and urbanised (Arensberg and Kimball 2001: 224, Tovey and Share 2000: 41). Secondly, the national asylum system was publicly owned and as such was not driven by direct capitalist enterprise in asylum provision. Thirdly, the Irish asylum system expanded during a period of population decline and conversely the level of residency within these institutions reduced during a period of population growth.

State care for the mentally ill commenced in the early years of the nineteenth century, at which time Ireland was under British colonial rule. Resulting from the 1800 Act of Union, Irish administrative governance was predominantly centralised with parliamentary power resting in Westminster, and was operationally administered through Dublin Castle. This centralisation of administration occurred during a time that saw the increased utilisation of expert groups by Government as a means of examining social problems. These expert groups were mandated to produce and analyse statistical data and to propose social interventions that would rectify, or at least control, social problems. An example of such centralised-expert decision making is *Report of the Select Committee to Consider the State of the Lunatic Poor in Ireland* (1817). Based on this enquiry the Committee recommended the establishment of a national asylums system, and as such this represents the policy point of departure that instigated public asylum provision in Ireland. This form of social policy intervention in the field of insanity was ground-

breaking both in Irish and international contexts particularly as it was a national public system that was centrally planned, implemented and administered.

> In 1817, mandatory legislation made Ireland the first country in the western world with a system of public asylums for the insane (Reuber 1999: 208).

While Ireland was a part of Great Britain at this time, provisions made for the construction of public asylums in 1817 were particular to Ireland, developed as a national system rather that on a county by county basis as was the case for England. Consistent data relating to this national asylum system is provided in the reports of the Inspector of Lunatic Asylums in Ireland, later the Inspector for Mental Hospitals, for each year from 1846 to 2000. It is important to note from the outset that the inspectors producing these reports had their own professional agendas. In practice these reports not only provided the inspectors an opportunity to set out data relating to asylum utilisation, they also provided a platform to make recommendations relating to asylum social policy, managerial structures and administrative systems, and the inspectors had a personal career interest in all these matters.

The Inspectors' reports are available in the Parliamentary Papers at the National Library of Ireland and the full details relating to each report utilised is set out in the reference list. The non publication of reports for particular years and the non inclusion of basic data in some published reports was managed through the analysis of data provided in other sources that were analysed in the following order of priority (1) Retrospective data contained in subsequent Reports of the Inspector of Lunatic Asylums / Inspector of Mental Hospitals (2) Other Parliamentary Papers and Special Reports (3) The Statistical Abstract of Ireland (4) The Irish Psychiatric Hospital Census 1971, 1981 and 1991 (5) Archival material from the Central Mental Hospital for the Criminally Insane in Dublin.

Data relating to Northern Ireland was kindly provided by Pauline Prior both through her publications (1993, 1996) and her personal academic notes.

The securing of reliable data for the early years of the nineteenth century is particularly problematic. Before the establishing of the Inspectorate of Lunatics in 1846, the statutory reports relating to prisons in Ireland contained some data relating to the extent of Irish asylum utilisation.

> The inspection of these important Institutions having been placed by Legislative enactment under our superintendence, in conjunction with the Prisons, we were in the habit of submitting to Parliament our reports upon both in the same volume (Inspectors-General 1844: 3).

Several reports on the *General State of Prisons in Ireland* (Inspectors-General 1823-1830) were utilised in this dissertation as a source of data relating to asylums, prior to the appointment of the Inspector of Asylums in 1846. However, while information concerning asylums is provided in these reports, many fail to provide consistent data that lend themselves to providing a year-on-year account of asylum utilisation for the early part of the nineteenth century. In particular, the categorisations, locations and types of institutions are repeatedly changed and in many cases are simply not given. For example, the Inspector General's 1818 *Report on the State of Prisons in Ireland* does not list asylums or provide statistics for such institutions, while a similar report for 1824 does list asylums but does not provide statistics. The reports for 1825 and 1826 do list asylums and provide some data, including the number of patients in particular asylums such as the Richmond asylum. However, no firm national statistics can be established from the data provided. A national statistic is provided in the 1830 prisons' report, which states that the number of 'mentally ill' persons in institutions for the year 1829 amounted to 2,097.

This data provides some base data points for early nineteenth century asylum utilisation prior to the rapid expansion that commenced during the 1830s and 1840s.

The Irish Inspector of Lunatic Asylums, having being appointed on a statutory basis in 1846, was required to publish an annual report detailing the extent and general activities of asylums in Ireland. With the establishing of the Irish Free State in 1922, the title of "Inspector of Lunatics" was changed to "Inspector of Mental Hospitals", but the role and function of inspection and annual reporting remained much the same. However, contrary to statutory requirements, there have been significant gaps in the production of annual reports. For example, the reports for 1944, 1945 and 1946 are combined, as are the reports for 1961 and 1962. No reports were produced for the years 1962 to 1977 and the 1977, 1978 and 1979 reports are combined. Again, no reports were produced for the years 1980 to 1987 and the 1988 and 1989 reports are combined. Regular annual publication of these reports resumed from 1990 onwards. The retrospective data produced in later reports provides data for most of these gap years, as does *The Statistical Abstract of Ireland* and the *Irish Psychiatric Hospital Census* 1971, 1981 and 1991. However, a gender breakdown of this data is absent in many of these reports.

In terms of presentation style and general content there is a good degree of consistency between the Inspectors' reports from 1846 to 2000. However, there are some significant differences regarding the quality and general presentation of the statistical data. In particular the inclusion and exclusion criteria shift at various points within these reports, with classification and diagnostic systems changing in response to developments within medical practice and wider social policy. The impact of changing classification systems is explored in detail in chapters 4 and 5. However, it is important to note that the

emphasis of this chapter is not on what was meant by the labels used at any particular point in time, but to chart the precise number of people actually resident in asylums and other institutions used to accommodate the 'insane' or 'mentally ill' on a particular date of each year.

There are several anomalies and contradictions within and between various reports produced. For example in the opening lines of 20th Report of the Inspector of Lunatic Asylums (1871), the number of persons in public asylums in 1870 is put at 6,663. However, in the table provided in this report, the figure is given as 3,574 males and 3,081 females, giving a total of 6,655 on December 31st 1870. These discrepancies arise as the narrative of the Inspectors' reports often describes the state of affairs on the actual date that institutions were visited, whereas the figures provided in the tables are primarily given for the close of each year. Where such discrepancies exist between data referred to in narrative and data provided in table format, the data in the table format has been utilised in the graphs provided.

Where anomalies arise in the data provided in the Inspectors' reports for different years, the original report for each year has been utilised as the first point of reference. For example, again considering the year 1870, the 21st report of the Inspector of Lunatics (1872), which is primarily concerned with 1871, states that the number of persons in public asylums on December 31st 1870 was 3,571 males and 3,083 females giving a total of 6,674. This data is slightly different than the data originally given in the 20th report as described above. While such anomalies are not significant to the overall trends of asylum usage, it is important to establish the exact source of each data point in the graphs

provided. In all cases, the original data provided in table format for each particular year has been accepted as the principal data source.

The actual date on which the statistics were recorded is also of significance. Predominantly the 31st of December is utilised as the count date in the Inspectors' reports. However, there is some variation in this count date in the earlier reports with the 31st of March being used during the 1850s. The precise date on which each count was originally taken is recorded in the tables presented in Appendix 1 as "Date of Count", with each corresponding year listed as "Year End". However in some reports the 1st of January is given as the day of the yearly count. This data was intended as the statement of the state of affairs upon the close of the previous year. For example the Inspector of Lunatic Asylums 29th report (1880) gives figures for 1st of January 1880 and the 30th report (1881) gives figures for 31st of December 1880. In this case the figures for the 1st of January 1880 are taken to indicate the count for the year ending 1879, and the figures given for the 31st of December are taken to indicate the count for the year ending 1880. This principle is applied accordingly to any similar cases that arise, all of which are detailed in the tables provided in Appendix 1.

The Inspectors of Lunatic Asylums / Mental Hospital utilisation of the 31st of December as the predominant date of reference provides some potential for the under representation of average levels of residency. The 31st of December is an unusual date, it being New Year's Eve and a date during the traditional Irish family winter holiday period. The extent of the practice of families 'taking home' family members during this time of the year can only be speculated upon. This potential anomaly continues to exist within contemporary data relating to institutional residency. For example, referring to

differences in the data contained in various hospital censuses, the Inspector of Mental Hospitals noted that:

> It must be borne in mind that figures for these intervening years are lower than those derived from the MSRB/HRB censuses as many patients were discharged for the Christmas period and thus the numbers were lower than they would be on 31 March (Walsh and Daly 2002: 21)

The Extent and Rate of Institutional Residency of 'Mentally Ill' Persons in Ireland

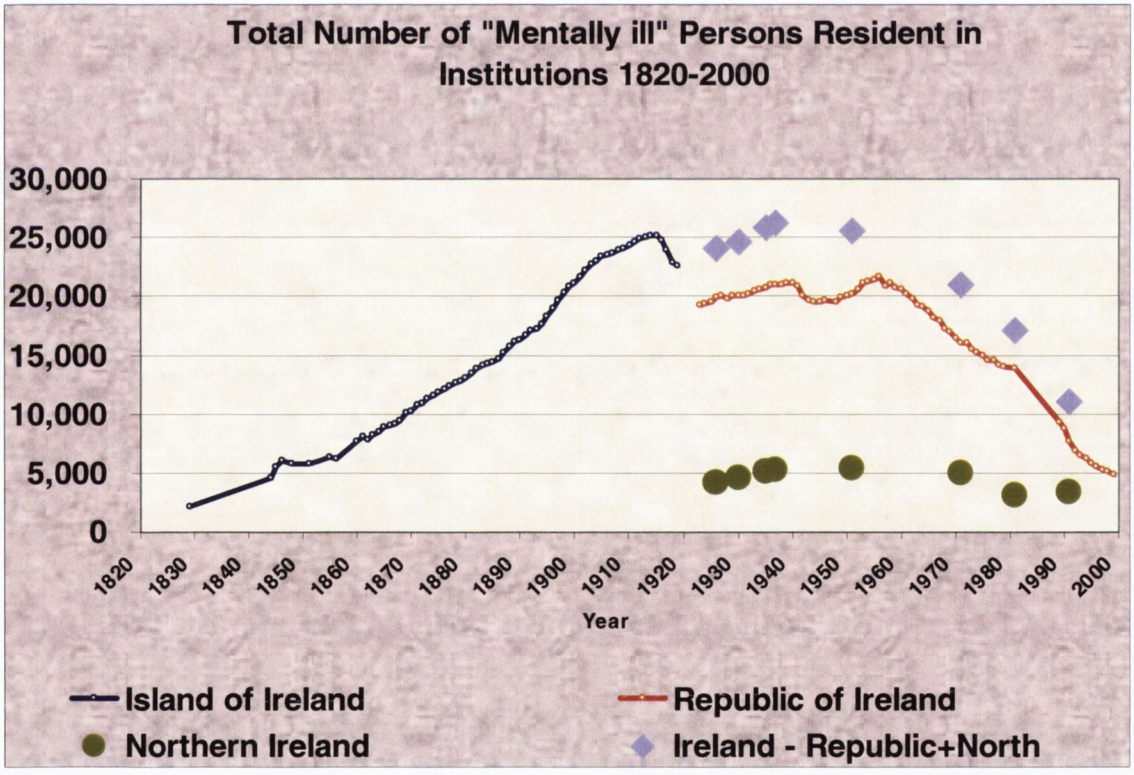
This section narrates the overall rate and gender of 'mentally ill' persons resident in institutions during the past two centuries. As this dissertation is primarily concerned with the growth and decline of institutions for the 'mentally ill', the particular 'rate' that is sought concerns the number of people resident within these institutions on a particular date of each year as a proportion of the general population for that year. Hence this study focuses on annual institutional capacity and usage rather than the frequency of admission and length of stay of individual patients.

Long term trends in the rate of institutional residency are established through firstly setting out the total number of 'Mentally ill' persons resident in institutions 1820-2000, which is presented in Graph 1. Graph 2 displays the overall population levels of the island of Ireland from 1820 to 1921, the Republic of Ireland from 1922 to 2000 and Northern Ireland 1922 to 2000. These two data sets are then integrated to demonstrate the interface of general population trends with asylum utilisation which are set out in Graphs 3, 4 and 5. These trend analyses demonstrate a pattern of asylum expansion during a period of Irish population decline and conversely a decline in asylum usage

during population increase. All of the above data is then integrated in Graph 6 which sets out the number of 'Mentally ill' persons resident in institutions per 100,000 of population.

This rate per 100,000 of population is key data required to underpin any sociological analysis of Irish Asylums. As this data has not been previously available for the time period being examined, 1800-2000, all idiosyncrasies and anomalies relating to the data collection and utilisation are explored in detail so to provide greater clarity, reliability and rigour in data analysis.

Graph 1



Based on data contained in Tables 1, 2 and 3 of Appendix 1, Graph 1 charts the gross number of 'mentally ill' persons actually resident in institutions from the late 1820s to 2000. A trend line with data points is used for the Island of Ireland 1820-1921 and the Republic of Ireland 1922-2000, which are the primary focus of this study. Data relating

to Northern Ireland and the sum of the Republic and Northern Ireland are shown as individual data points.

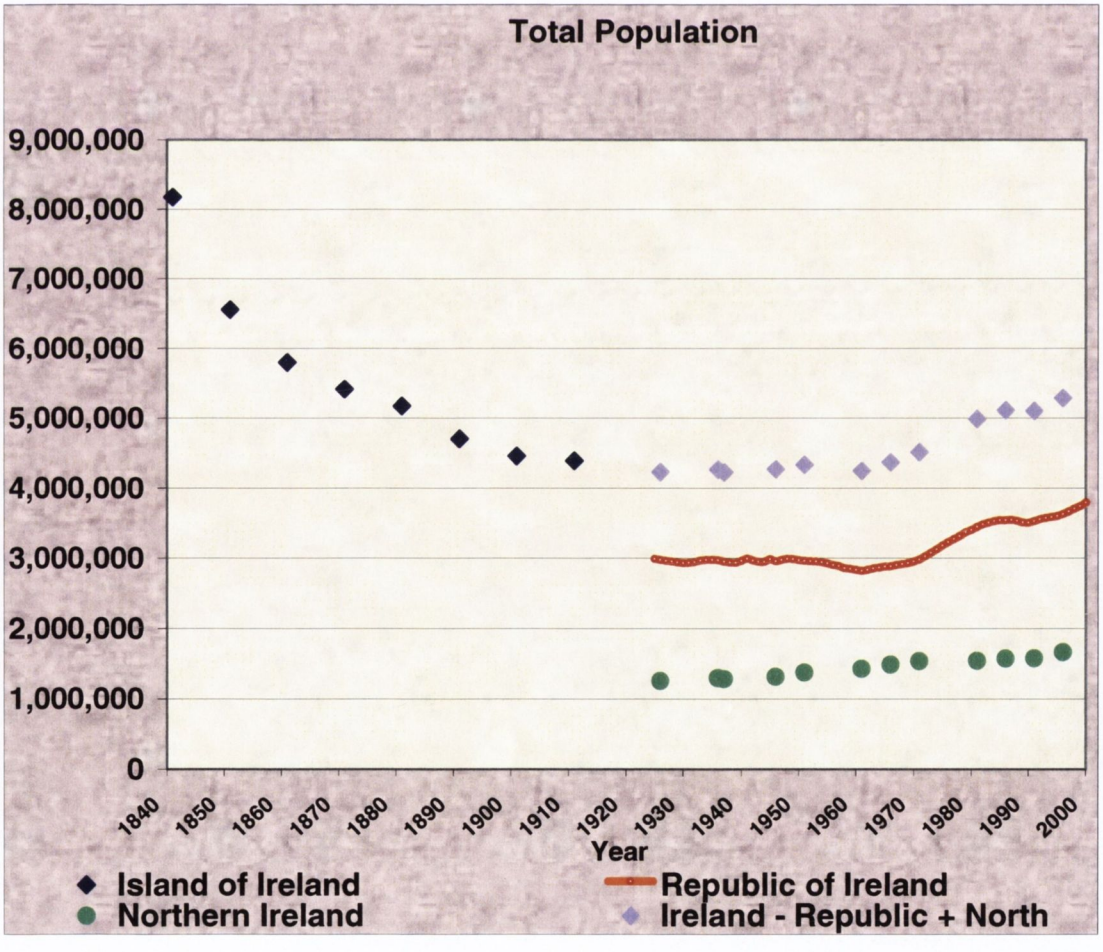
As can be observed, asylum utilisation accelerates on the Island of Ireland during the 1830s and 1840s, establishing a trend of continuous growth until 1914. With the establishing of the Free State one can observe a period of sustained usage, punctuated by minor increases and decreases, from 1922 to a high point in 1956. From 1956 onwards a trend of continuous decline is established until 2000.

Each data point in Graph 1 indicates a complete set of data for that particular year. If a report for a particular year omits a particular type of institution, the data point for that year is not included as it would be an inaccurate representation of actual institutional usage. For example, no data point is given in Graph 1 for the year 1853, as the report for this year only provides data for Public and Private Asylums (Inspector of Lunatic Asylums 1853). This report omits data relating to The Central Mental Hospital, workhouses and other locations listed in previous and later reports as sites of confinement for the 'mentally ill'. This principle is applied to each data point in each graph provided in this study. Essentially, if there is not a complete set of data for a particular year or institution being examined, that data point is excluded so as to allow a valid trend across the relevant years to be displayed.

A cohort of patients resident in mental hospitals is not included in the official statistics from 1989 onwards. This cohort of patients is described in the Inspector of Mental Hospital reports as "Mental Handicap and Geriatric Patients" resident in what became known as "De-designated Facilities" (Inspector of Mental Hospitals 1988-1989: 230). The total number of patients placed in this category is 597 for the year 1989.

While these patients are mentioned in the narrative of the Inspectors' reports, they are excluded from the total considered resident in mental hospitals from 1989 onwards. In reality no actual change happened, these patients and the de-designated wards remained in psychiatric hospitals. They were the very same patients and wards which were included in the Inspectors' reports before this change in policy. The motivation for this shift appears to be linked to cost saving through the lower staff nurse - patient ratios required in de-designated units. While these patients are removed from the overall total considered to be officially resident in mental hospitals, the details of the number of these patients are listed in Table 23 of Appendix 1.

Graph 2



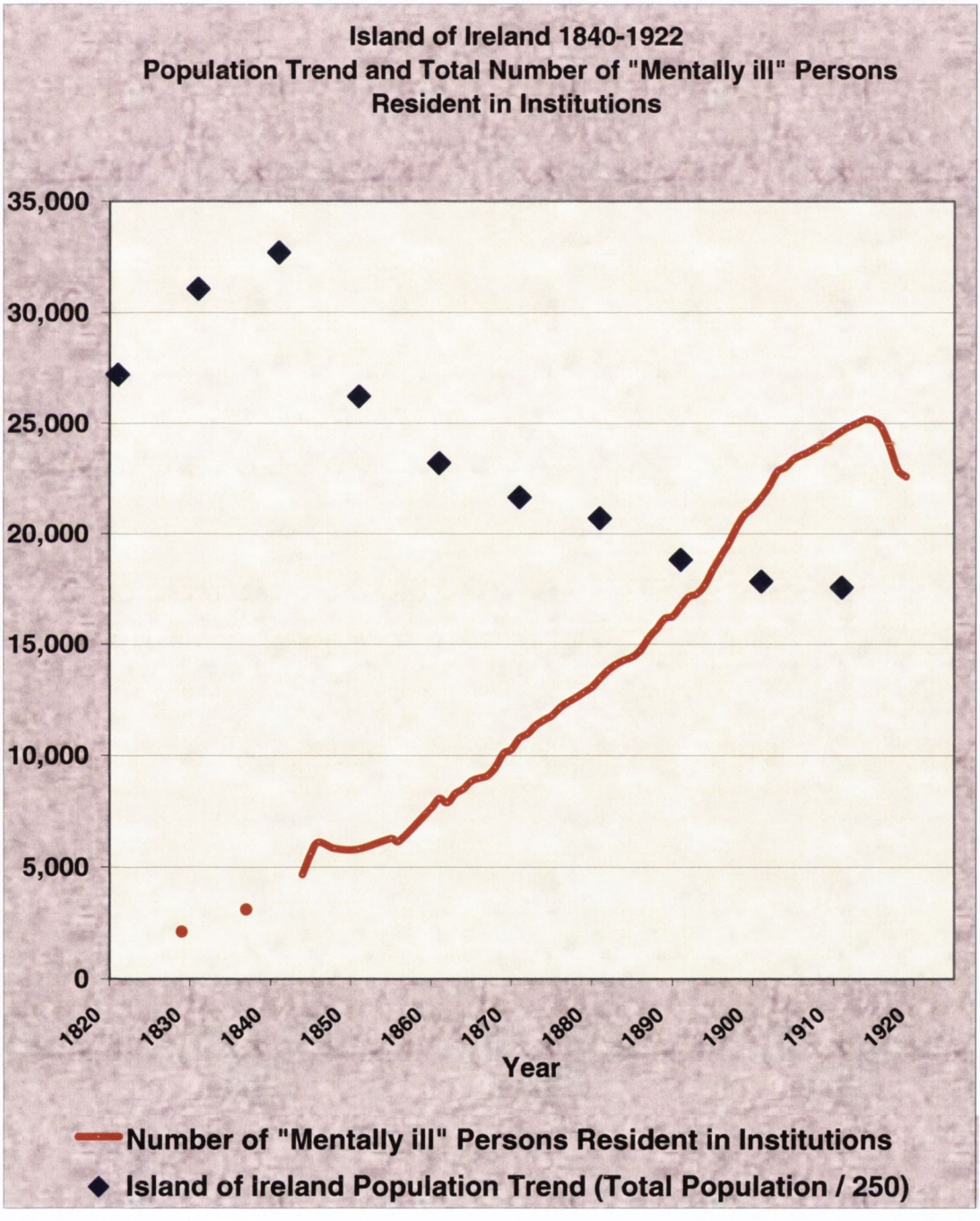
Graph 2 provides an account of the total population on the island of Ireland from 1840 to 1921, the Republic of Ireland from 1922 to 2000 and Northern Ireland from 1922 to 2000. Each data point is referenced to its source in Tables 24, 25, and 26 of Appendix 1. What is most notable at first inspection of these population trends is the rapid decrease in population from 1840-1920. This is attributed to major events such as the famine during the 1840s, coupled with a long-term pattern of chronically high emigration. This population decline ceased during the 1920s and from this time onwards there is minimal population increase or decline until the 1970s. From the 1970s onwards a gradual trend of population growth is established, particularly in the Republic of Ireland. The early stage of this population growth is attributed to a sustained high birth rate. From the mid 1980s onwards this increase gains momentum due to a decreasing pattern of emigration with net immigration being realised during the mid 1990s.

The growth and decline of asylum utilisation in Ireland is most remarkable when considered alongside changes in population. The dynamic nature of the trajectories in these two variables, total population and the institutional residency of the 'mentally ill', can be visualised by displaying both trend lines on the same axis, which is set out in Graph 3 for the Island of Ireland, Graph 4 for the Republic of Ireland and Graph 5 for Northern Ireland. These graphs represent important data as they demonstrate the interacting trends that lie behind the rate of institutional residency of the 'mentally ill' per 100,000 of population.

To enable an illustration of both trends on the same axis, one variable needs to be adjusted so as to bring it into a range broadly comparable with the other. To allow for this, the total population data points in Graphs 3, 4, and 5 that relate to the population

statistics presented in Tables 24, 25, and 26 of Appendix 1, are divided by a factor of 250. This maintains the actual population trend, however, each point represents 250 people. This provides for a clear comparison of both population and asylum utilisation trends on the same graph.

Graph 3

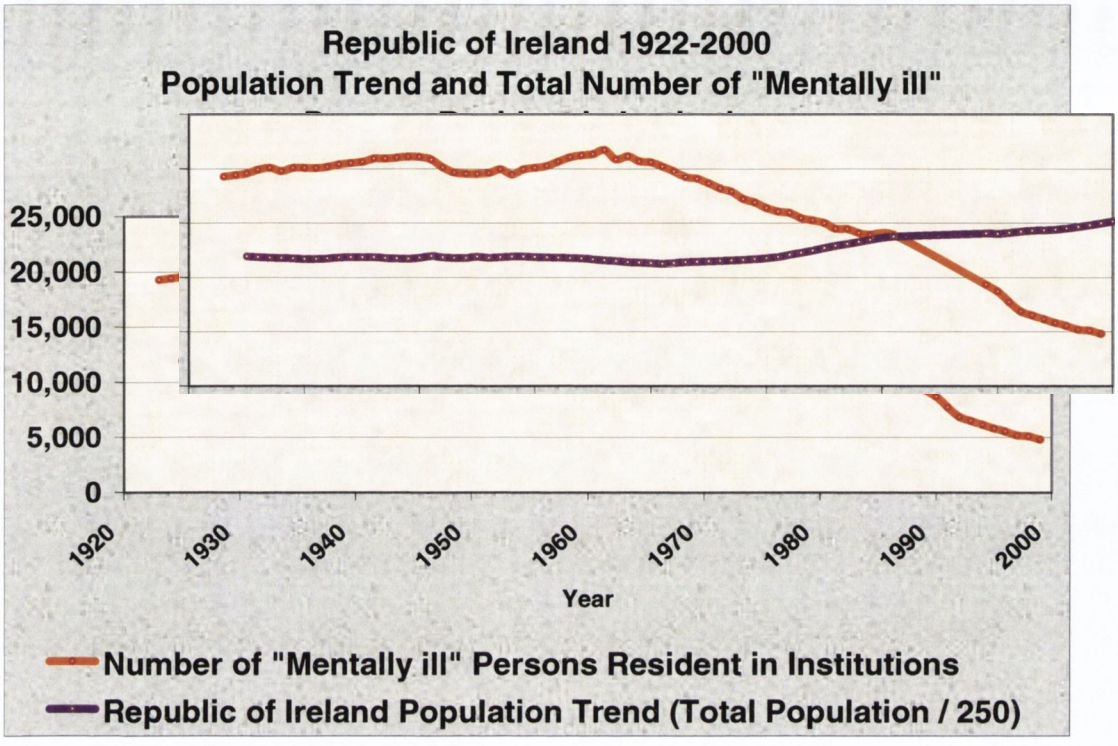


As can be observed in Graph 3, there is a strong inverse relationship between the level of institutional residence of the 'mentally ill' and the overall population trend. This is a significant finding, as it indicates that asylum expansion occurred during the same period of time that saw the general population of Ireland in rapid decline. This indicates a substantive acceleration of the actual rate of asylum utilisation per 100,000 of population between 1830 and 1915, a fact that is illustrated in Graph 6. There is one notable spurt and one notable decline in asylum usage which are not typical of the overall smooth pattern of continuous asylum expansion displayed in Graph 3 above, a brief explanation of which is required.

The first period that is atypical of the overall trend is the sharp increase in institutional residency during the late 1840s. This increase occurred at the same time as the Great Famine of 1845-1847 and would appear to indicate the utilisation of these institutions as a location of refuge during this time. The second period that deviates from the overall trend is the declining level of institutional residency between 1915 and 1922. This is attributed to an unusually high death rate rather that a reduction in the admission rates during this time:

> The decrease in the total number of the insane under care which, as pointed out in previous Reports, has been going on since 1915, still continues, although at a reduced rate, the decrease in 1919 having been 290, as compared with 1,025 in 1918. The total decrease during the five years from 1914 to 1919 amounted to 2,602, or an average of 520 per annum. . . In our last report we referred to the fact that the reduction in the numbers was not due to any lessening of the admission rate in the District Asylums but to a heavy death rate . . . which amounted to 10.5 per cent of the average number resident in 1917 (Inspector of Lunatic Asylums 1921: vi).

Graph 4

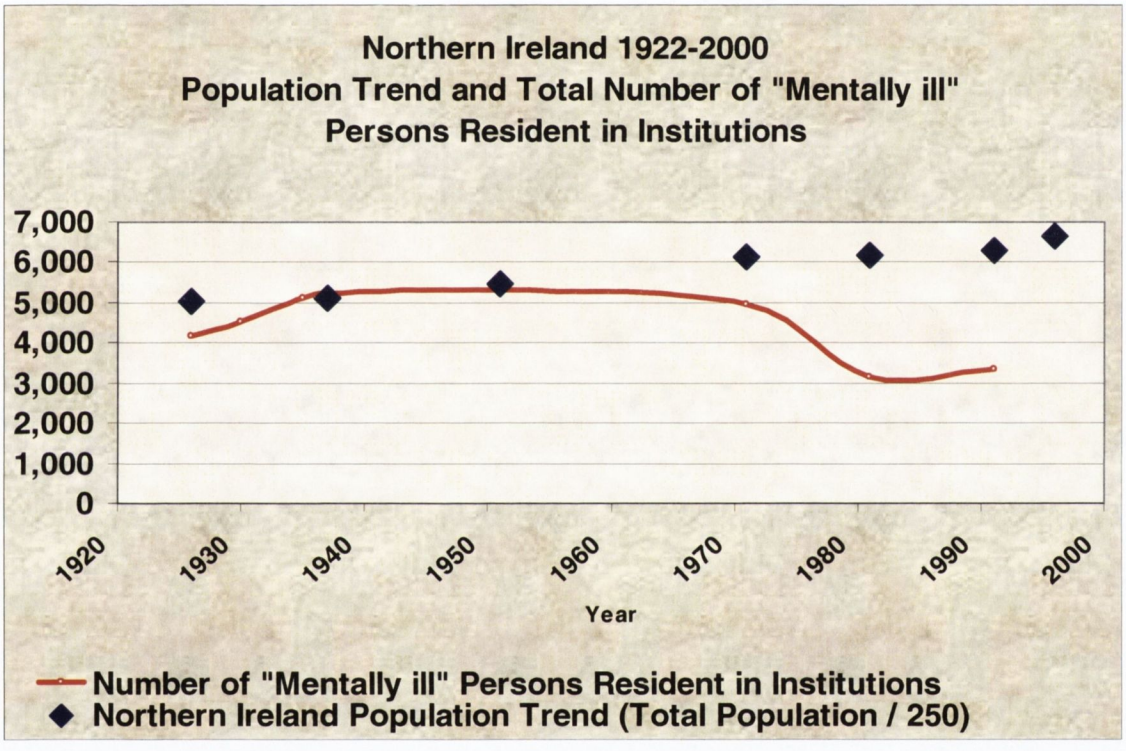


Graph 4 demonstrates that the Republic of Ireland experienced an overall pattern of slow growth in the number of 'mentally ill persons' resident in institutions from 19,398 in 1924 to the high point of 21,720 persons resident in 1956. This rate of growth is far slower than that observed in Graph 3 for the years 1830-1910 and there is a period of declining usage between 1939 and 1948 when the level of occupancy returned to a level very close to that at the foundation of the Free State in 1922. As can be observed from the population trend line, there was limited movement in the total population during this time.

A pattern of declining institutional residency is established from 1956 onwards, which continues at a steady rate reducing to a level of 4,522 persons at the commencement of the twenty-first century. Significantly, the population trend commences a slow and steady upward growth from 1962 onwards. This indicates an

inverse relationship between the institutional residency of the 'mentally ill' and overall population growth. When this receding asylum usage is considered along with general population increase, a rapid decline in the rate of institutional residency per 100,000 of total population is observable from 1956 onwards. This decline mirrors the period of rapid growth in the rate of asylum use from 1830-1910.

Graph 5

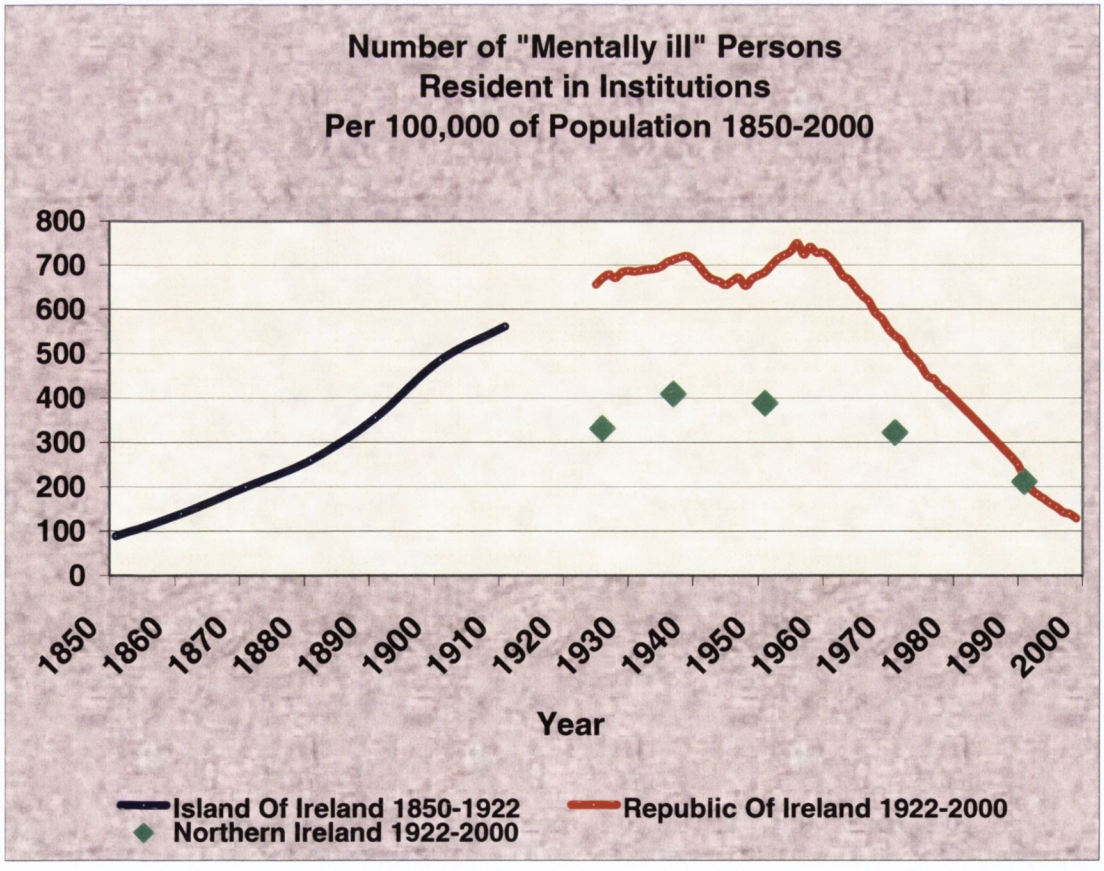


As discussed earlier, the focus of this dissertation is the island of Ireland for 1817-1922 and the Republic of Ireland 1922-2000, for which all data has been collated from their original primary sources, predominately the Inspectors' reports. However, the trends in Northern Ireland from 1922 are interesting to note so as to provide a point of comparison with the Republic. The data points charting the number of 'mentally ill' persons resident in institutions in Graph 5 are adopted from the work of Prior (1993, 1996, 2001 and personal correspondence), which were originally sourced from the

Northern Ireland Census which lists 'Occupants of Mental Health Beds'. As can be observed in Graph 5, Northern Ireland had a similar pattern to that experienced in the Republic, with a declining trend in institutional usage coupled with population growth. Again this indicates an inverse relationship between asylum utilisation and population growth. However, as can be observed in Graph 6, while these trends are similar, the actual rate per 100,000 of population is significantly lower in Northern Ireland compared to the Republic.

Hence, in Ireland there has been a marked increase in the actual rate of institutional residency of the 'mentally ill' per 100,000 of population during the period of population decline and conversely a marked decrease at a time of population growth, which is illustrated in Graph 6.

Graph 6



Graph 6 is crucial to this study as it provides an illustration of the complete integration of the various data sets provided in Appendix 1. Data points are only given for years that have a complete set of verifiable data for each type of institution utilised for the 'mentally ill', along with a verifiable total population. As such this graph provides a synthesis of the base information required to examine the expansion and decline of residential care for the 'mentally ill' in Ireland. A simple calculation (total residency * 100,000 / total population of that year) is then applied for all valid years to give a verifiable rate per 100,000 of population. Each data point illustrated on this graph is presented numerically in Tables 4, 5 and 6 of Appendix 1.

The trend lines in Graph 6 demonstrate that the increased rate of asylum residency from the early nineteenth century is actually more acute than the simple gross total as shown in Graph 1. When calculated with population trends, we observe that the actual rate of institutional residency of the 'mentally ill' per 100,000 of population increases almost six fold, from 88.43 in 1851, to 561.59 in 1911. As can be observed, increasing rates of asylums / mental hospital residency was a feature of Irish society both under colonial rule and post independence in 1922, with rates of residency reaching a high point of 749.35 in 1956. The pace of decreasing asylum utilisation from 1956 to 2000 is more substantive if considered as a rate per 100,000 when compared to simple occupancy levels illustrated in Graph 1, as the rate per 100,000 takes account of an actual decreasing asylum occupancy coupled with an increase in the general population. This dissertation is focused on providing a valid sociological explanation for the overall institutional residency of the 'mentally ill' on the island of Ireland from 1800 to 1922 and the

Republic of Ireland since Independence. As such Graph 6 is a key presentation of the data that underpins this study.

As noted above, Graph 6 provides aggregate data of the collective rate of residency from a spectrum of institution types, each of which has its own particular course and gender dynamic. As a means of illustrating and exploring these various institutions that collectively formed the national system, data charting the trajectory of each institution type is set out in the latter part of this chapter along with a gender breakdown for that institution. The overall trajectory is placed in an international context below along with consideration of gender, regional variations and the socio-economic dynamics within this overall trajectory.

Irish Institutionalisation of the 'Mentally ill' and the International Context

There are several obstacles to providing consistent comparative statistics between countries during the time span being considered in this dissertation. One particular difficulty arises from the fact that the systems for providing accommodation for the 'mentally ill' differ between countries as do the administrative structures for these various types of institutions. For example, in England insanity was predominately managed alongside the provisions for poverty alleviation. As such, 'mentally ill' persons in England were predominately recorded as being 'Insane Poor', a category which was technically incompatible with the system of residential provision within the Irish district asylum system, established specifically for the care and cure of insanity, rather than a

poverty alleviation strategy. Commenting on this distinction when endeavouring to provide a comparative analysis of insanity in England, Scotland and Ireland in 1891, the Inspector of Lunatic Asylums noted that:

> In Ireland the insane poor in District Asylums are not pauper lunatics, nor indeed are the insane poor in Workhouses, because the insane in Workhouses are there simply as destitute persons. There are thus no persons in Ireland who are technically Pauper Lunatics. This introduces a difficulty into such comparisons. (Inspector of Lunatic Asylums 1891: 60)

This is complicated further by various methods of data recording being utilised in different countries at various points in time. Commenting on these difficulties the Irish Inspector of Lunatic Asylums notes;

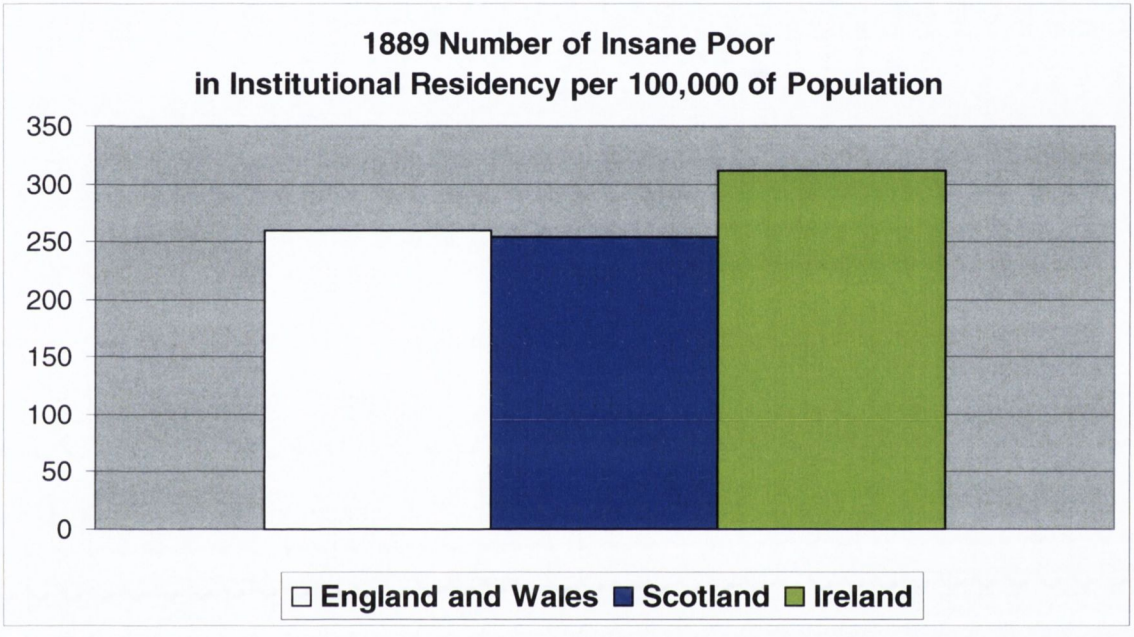
> For these and other such reasons it is impossible to institute any true comparison between the proportions of the insane *poor* to population in the three countries. But the figures of the Table leave no doubt as to the proportion being higher in Ireland than in England and Scotland, and to this extent the effort to institute a comparison proves useful (Inspector of Lunatics 1891: 61).

The statistics provided by the Inspector in 1891 set out the 'Proportion of the Insane Poor per 100,000'. For the year 1889 these figures are recorded as England 260 per 100,000, Scotland 245 per 100,000, and Ireland 312 per 100,000. The data relating to Ireland is recorded with an explanatory note stating that this figure is "Exclusive of 'unregistered Lunatics at Large,' but inclusive of Insane in Workhouses" (Inspector of Lunatics 1891: 60).

While there are serious limitations in endeavouring to provide a precise cross case international comparative analysis, some general observations can be made. What is important is that the overall trajectory of institutional utilisation in Ireland can be understood with reference to similar trajectories in other countries, while also acknowledging and exploring differences in terms of institutional provision, forms of

institutional utilisation and variations in systems of data recording. As such the 1891 report provides some useful comparative data, with is presented in Bar Chart 1 below, but importantly this report also provides some insightful discourses and critical comment which further contextualises the limitations of this data.

Bar Chart 1



The rate of institutional residency for the 'mentally ill' increased in most countries during the late nineteenth and early twentieth centuries. However, the rate of such residency accelerated in Ireland to such an extent that by 1955 the Irish case was significantly greater when compared with other countries. This atypical high rate in Ireland can be observed by comparing national statistics provided in the World Health Organisation *Annual Epidemiological and Vital Statistics 1955* (WHO 1958). This report provides statistics including total population, the number of psychiatric hospitals and the

number of psychiatric beds within each country. Based on this data a rate of bed availability per 100,000 of population within each country is analysed below.

Only countries which have official, or officially "Estimate, preliminary or approximate" (WHO 1958: 6) data for population and psychiatric bed numbers are included in the analysis set out below. For example, the population data for Surinam could not be utilised in the analysis below as it "excluded 'Bush Negroes' and Indians" (WHO 1958: 15) and Uruguay is not included as that population data is given for the year 1908, (WHO 1958: 14). Similarly, a small number of number of countries, the most notable being China, did not provide data relating to psychiatric beds. Table A provides the relevant data as set out in this WHO report for the year 1955. Also included is the actual years that statistics were originally recorded, which in some cases are different for the general population statistic and psychiatric hospital statistics.

Table A **1955 Total Population, Number of Psychiatric Hospitals and Number of Psychiatric Beds in 84 Countries**

Country	Year	Population / Estimated Population	Year	Number of Psychiatric Hospitals	Number of Psychiatric Beds
Africa					
French West Africa	1956	19,031,000	1954	5	118
Algeria	1954	9,529,726	1955	1	2,221
Cameroon's (French Admin)	1955	3,146,000	1955	3	55
Egypt	1947	19,021,840	1955	8	3,596
Ethiopia	1956	20,000,000	1953	1	80
Gambia	1951	279,689	1954	1	42
Kenya	1957	6,261,000	1955	1	600
Libya	1954	1,091,830	1955	2	328
Mauritius	1952	516,285	1955	1	707
Uganda	1957	5,679,000	1955	1	426
Reunion	1954	274,370	1953	1	249
St Helena	1946	5,226	1955	1	20
Seychelles	1947	34,632	1955	1	32
Sierra Leone	1956	2,100,000	1955	1	112

Country	Year	Population / Estimated Population	Year	Number of Psychiatric Hospitals	Number of Psychiatric Beds
Somaliland (British Protect.)	1956	650,000	1955	1	65
Zanzibar and Pemba	1948	264,162	1955	1	130
America					
Netherlands Antilles	1948	150,219	1957	1	400
Barbados	1946	192,800	1955	1	785
Bermuda	1950	37,403	1954	1	113
Brazil	1950	51,976,357	1954	107	38,793
Chile	1952	6,206,544	1955	3	3,520
Colombia	1951	11,548,172	1957	16	5,911
Costa Rica	1950	800,875	1953	2	853
Cuba	1953	5,829,029	1957	1	3,700
United States	1950	151,132,000	1955	586	772,852
Guadeloupe	1954	229,120	1957	1	450
Guatemala	1950	2,790,868	1957	1	824
St. Vincent	1946	61,647	1955	1	100
St. Lucia	1946	70,113	1957	1	120
Leeward Is.	1946	108,838	1955	1	200
Jamaica	1943	1,249,871	1955	1	2,985
Martinique	1954	239,130	1953	1	90
Mexico	1950	25,791,017	1955	8	3,860
Nicaragua	1950	1,057,023	1956	1	224
Dominican Republic	1950	2,135,872	1954	2	218
El Salvador	1950	1,855,917	1955	1	525
Trinidad and Tobago	1946	557,970	1955	1	1,032
Asia					
Burma	1957	20,054,116	1956	1	582
North Borneo	1951	334,141	1955	1	100
Cambodia	1955	4,358,000	1956	1	673
Ceylon	1953	8,097,895	1955	2	2,308
Cyprus	1946	450,114	1955	1	550
Hong Kong	1956	2,440,000	1955	1	140
India	1951	356,879,394	1954	33	10,888
Portuguese India	1950	637,846	1956	1	110
Indonesia	1956	84,000,000	1955	25	6,988
Japan	1955	89,275,529	1955	260	35,841
Jordan	1952	1,329,174	1955	1	247
Lebanon	1956	1,450,000	1955	2	1,026
Malay, Fed. Of	1947	4,908,986	1955	2	4,200

Country	Year	Population / Estimated Population	Year	Number of Psychiatric Hospitals	Number of Psychiatric Beds
Philippines	1948	19,234,182	1955	1	1,600
Sarawak	1947	546,385	1955	1	207
Syria	1956	4,025,165	1955	2	550
Thailand	1947	17,442,689	1954	5	3,123
Viet Nam (South)	1956	26,600,000	1955	2	1,249
Europe					
Germany: Democratic Republic	1950	17,199,098	1955	29	21,762
Germany: Federal Republic	1950	47,695,972	1955	156	92,009
Belgium	1947	8,512,195	1955	50	26,305
Spain	1950	27,976,755	1949	87	25,711
Finland	1950	4,029,830	1955	30	10,333
France	1954	42,900,000	1955	94	93,000
Gibraltar	1951	23,232	1955	1	42
Greece	1951	7,632,801	1955	7	5,191
Ireland	1956	2,894,822	1953	31	20,563
Iceland	1950	143,973	1954	1	240
Italy	1951	47,158,738	1954	138	88,214
Luxembourg	1947	290,992	1955	1	800
Malta and Gozo	1948	306,996	1955	2	954
Norway	1950	3,278,546	1954	127	8,619
Portugal	1950	8,441,312	1955	18	7,320
England and Wales	1951	43,757,888	1955		156,257
Scotland	1951	5,096,415	1955		22,225
Northern Ireland	1951	1,370,921	1955		6,033
Sweden	1950	7,041,829	1955	171	29,779
Switzerland	1950	4,714,992	1953	55	17,576
Czechoslovakia	1950	12,338,450	1955	20	13,793
Yugoslavia	1956	17,886,000	1955	13	6,075
Oceania					
Australia	1954	8,986,530	1956	38	29,840
Fiji	1956	345,737	1955	1	100
Hawaii	1950	499,794	1955	2	1,907
New Hebrides	1955	53,000	1955	1	17
Pacific Islands	1956	65,000	1955	1	20
British Solomon Is.	1953	99,200	1957	1	20
U.S.S.R	1956	20,020,000	1955		123,640

Based on this information the level of psychiatric bed availability per 100,000 of population can be calculated by applying the simple equation (bed availability * 100,000 / total population). As can be observed in Table A, the statistics given were originally recorded in various years between 1947 and 1957. A more accurate comparative analysis would be possible if all data related to the same year. However the data provided in the *Annual Epidemiological and Vital Statistics* is internationally accepted as the most accurate account of the state of affairs across all countries at a particular point in time. The statistics given in the 1955 report (WHO 1958) were used in this comparative study as this year corresponds with the end stage of institutional expansion in Ireland, the absolute peak being recoded in 1956 with a total of 21,720 'mentally ill' persons resident in Irish Institutions (Appendix 1: Table 2). Hence, while acknowledging the limitations of providing a comparative analysis based on data relating to different years, Table B places countries in a rank order from highest to lowest in terms of psychiatric bed provision per 100,000 as recorded in the 1955 WHO report of *Annual Epidemiological and Vital Statistics.*

Table B **1955 Number of Psychiatric Beds Per 100,000 of Population: Rank Order of 84 Counties**

Ranked	Country	Number of Psychiatric Beds Per 100,000 of Population: WHO *Annual Epidemiological and Vital Statistics Report for 1955*
1	Ireland	710.34
2	U.S.S.R	617.58
3	United States	511.38
4	Northern Ireland	440.07
5	Scotland	436.09
6	Sweden	422.89
7	Barbados	407.16
8	St Helena	382.70

Ranked	Country	Number of Psychiatric Beds Per 100,000 of Population: WHO *Annual Epidemiological and Vital Statistics Report for 1955*
9	Hawaii	381.56
10	Switzerland	372.77
11	England and Wales	357.09
12	Australia	332.05
13	Malta and Gozo	310.75
14	Belgium	309.03
15	Bermuda	302.11
16	Luxembourg	274.92
17	Netherlands Antilles	266.28
18	Norway	262.89
19	Finland	256.41
20	Jamaica	238.82
21	France	216.78
22	Guadeloupe	196.40
23	Germany: Federal Republic	192.91
24	Italy	187.06
25	Trinidad and Tobago	184.96
26	Leeward Is.	183.76
27	Gibraltar	180.79
28	St. Lucia	171.15
29	Iceland	166.70
30	St. Vincent	162.21
31	Mauritius	136.94
32	Germany: Democratic Republic	126.53
33	Cyprus	122.19
34	Czechoslovakia	111.79
35	Costa Rica	106.51
36	Seychelles	92.40
37	Spain	91.90
38	Reunion	90.75
39	Portugal	86.72
40	Malay, Fed. Of	85.56
41	Brazil	74.64
42	Lebanon	70.76
43	Greece	68.01
44	Cuba	63.48
45	Chile	56.71
46	Colombia	51.19
47	Zanzibar and Pemba	49.21
48	Japan	40.15
49	Sarawak	37.89

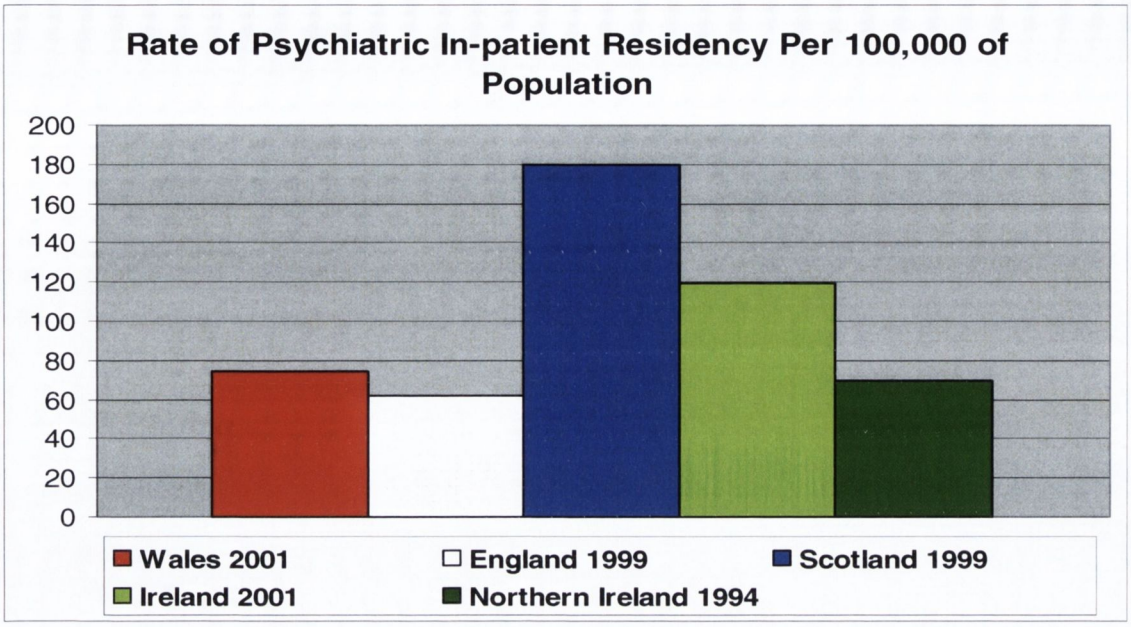
Ranked	Country	Number of Psychiatric Beds Per 100,000 of Population: WHO *Annual Epidemiological and Vital Statistics Report for 1955*
50	Martinique	37.64
51	Yugoslavia	33.97
52	New Hebrides	32.08
53	Pacific Islands	30.77
54	Libya	30.04
55	North Borneo	29.93
56	Guatemala	29.52
57	Fiji	28.92
58	Ceylon	28.50
59	El Salvador	28.29
60	Algeria	23.31
61	Nicaragua	21.19
62	British Solomon Is.	20.16
63	Egypt	18.90
64	Jordan	18.58
65	Thailand	17.90
66	Portuguese India	17.25
67	Cambodia	15.44
68	Gambia	15.02
69	Mexico	14.97
70	Syria	13.66
71	Dominican Republic	10.21
72	Somaliland (British Protect.)	10.00
73	Kenya	9.58
74	Indonesia	8.32
75	Philippines	8.32
76	Uganda	7.50
77	Hong Kong	5.74
78	Sierra Leone	5.33
79	Viet Nam (South)	4.70
80	India	3.05
81	Burma	2.90
82	Cameroon's (French Admin)	1.75
83	French West Africa	0.62
84	Ethiopia	0.40

As can be observed in Table B, Ireland had the highest rate of psychiatric bed availability reported internationally in 1955. As will be explored in Chapter 5, unified

international classification systems were developed in the late 1940s. As such the magnitude of the above differential cannot be simply explained in terms of variations in diagnostic systems that may have caused an underestimation or overestimation of rates of psychiatric illness.

Table B examines the international comparative context during the peak phase of Irish institutional usage as a means of further contextualising the particular Irish trajectory which is illustrated in Graph 6. Hence, it must be borne in mind that other countries may have peak periods of intensive institutional usage at other points in time. However, a decrease in psychiatric hospital utilisation was experienced in most countries during the past half century and this decrease was significant and acute in Ireland. For example, this reduction of institutional residency can be observed in the most recent comparative analysis which is provided within the *Irish Psychiatric Hospitals and Units Census 2001* (Walsh and Daly 2002). This census examines psychiatric bed usage within traditional psychiatric hospitals along with other residential settings such as psychiatric wards within general hospitals. This census also contained comparative data relating to Northern Ireland, England, Scotland, and Wales. While the data provided relates to different years for each country, ranging from 1994 to 2001, a useful comparative analysis can be drawn. The rates of in-patient residents per 100,000 of total population are given as: Wales 74.8, England 62.0, Scotland 179.5, Ireland 119.2, and Northern Ireland 70.1 which are illustrated in Bar Chart 2 below.

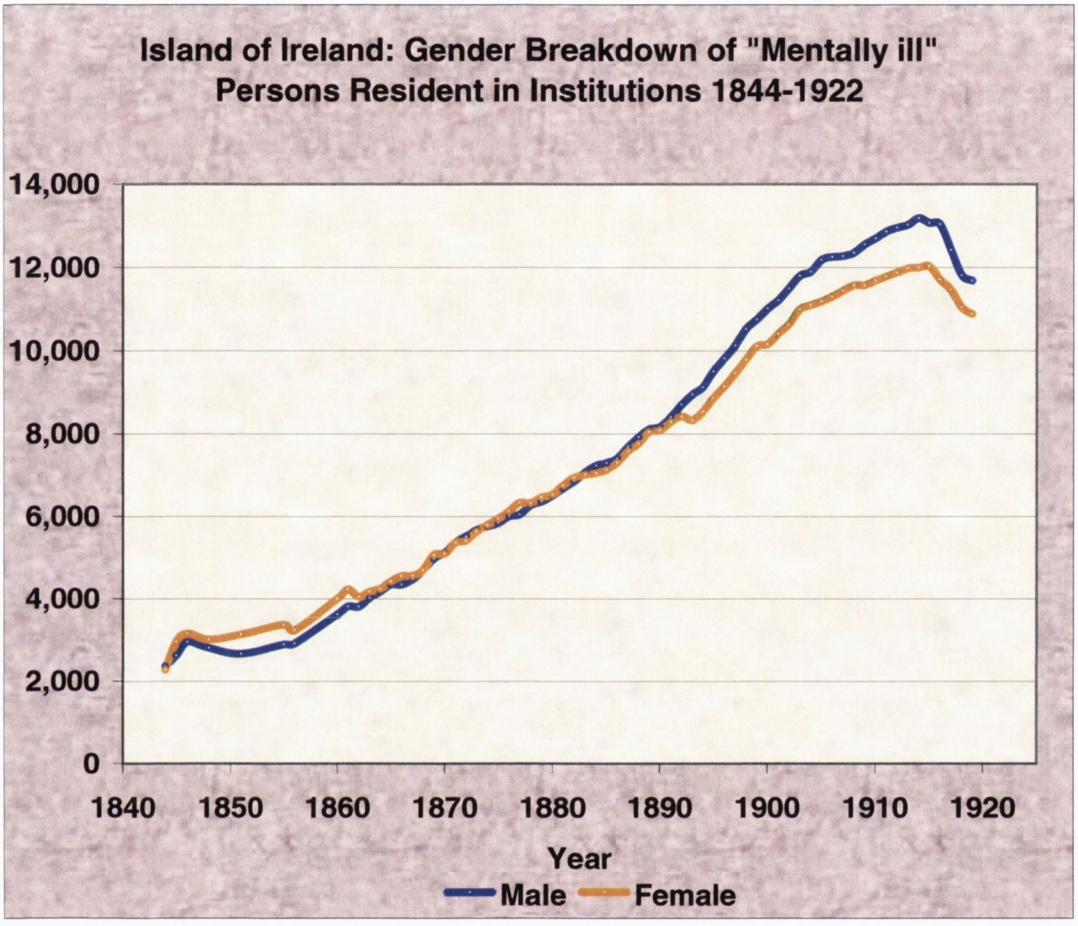
Bar Chart 2



As can be observed in Graph 6, Ireland's experience of institutionalisation of the 'mentally ill' is characterised by rapid expansion during the mid nineteenth century with continued growth until 1956, followed by a sustained period of decline from 1956 to 2000. While this pattern of expansion and decline is common with that experienced in other countries, what is most notable about the Irish case is the magnitude and level of institutional expansion and de-institutionalisation. In essence, the rate of Irish asylum expansion was extremely acute and sustained by international standards. Similarly the rapid decline in institutional residency is particularly notable in the context of the high rate of bed availability reported in 1955. As can be observed in Bar Chart 2, this declining institutional residency is comparatively acute in Ireland, the rate of in patient residency in Ireland now being lower than Scotland, which previously had a significantly lower rate of bed availability than the Irish case. The social forces underpinning this comparatively rapid and expansive growth and decline will be explored in detail in Chapters 4 and 5.

Gender and the Institutional Residency of the "Mentally ill"

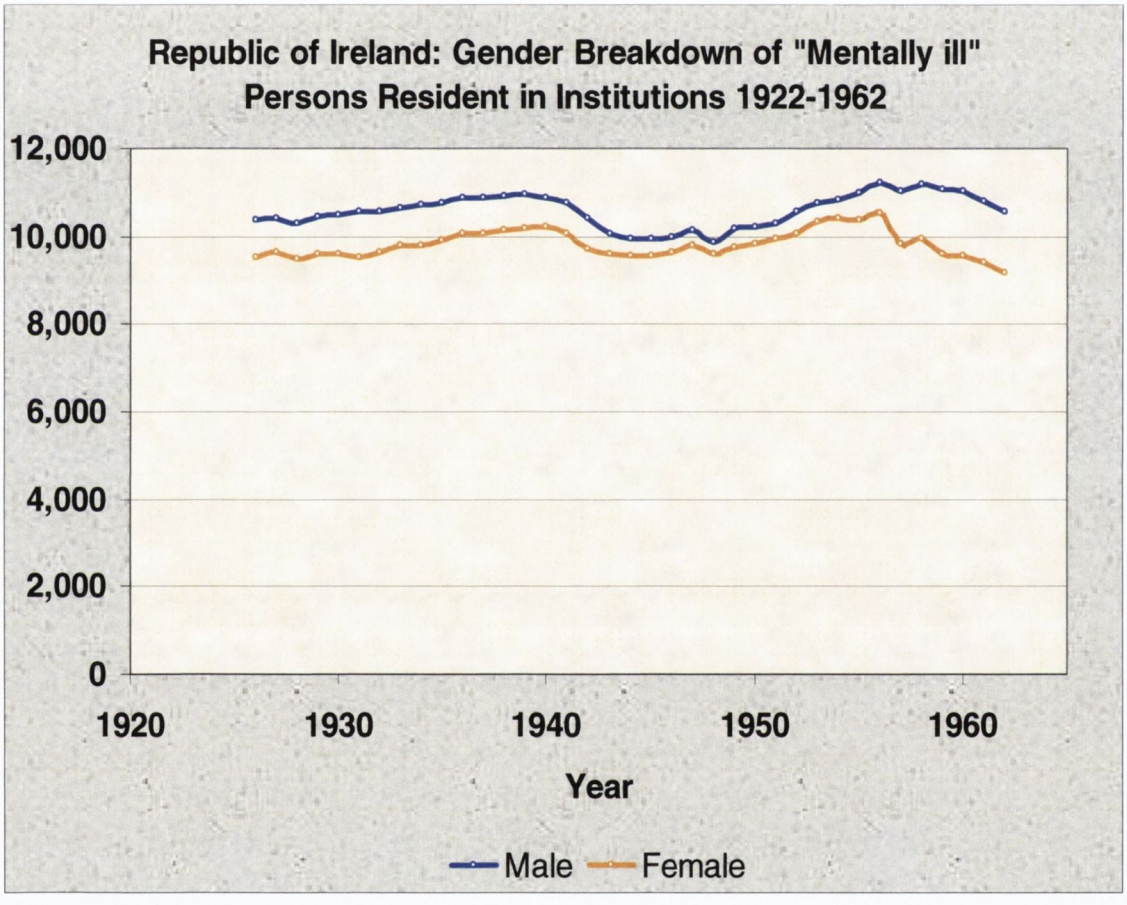
Graph 7



Based on the Inspector of Lunatic Asylums reports, Graph 7 illustrates the gender break-down of the overall institutional residency of persons classified as insane from 1845-1921 on the island of Ireland, the detail of which is contained in Table 1 of Appendix 1. There are marginally greater numbers of females as compared to males in these institutions up until the mid 1860s, followed by a thirty year pattern of almost identical residency for both sexes. A trend of higher male residency is established during the early 1890s, which is a trend that continues in the Republic of Ireland after 1922.

However, a more complex gender dynamic is observable when one examines various types of institution, with male and female over-representation altering depending on the type of institution examined. This is displayed in detail in Graphs 14, 16, 18, 20, 22, 24, 26 and 28 later in this chapter. The marginally higher representation of males within residential institutions sustained post independence as can observed in Graph 8 below.

Graph 8

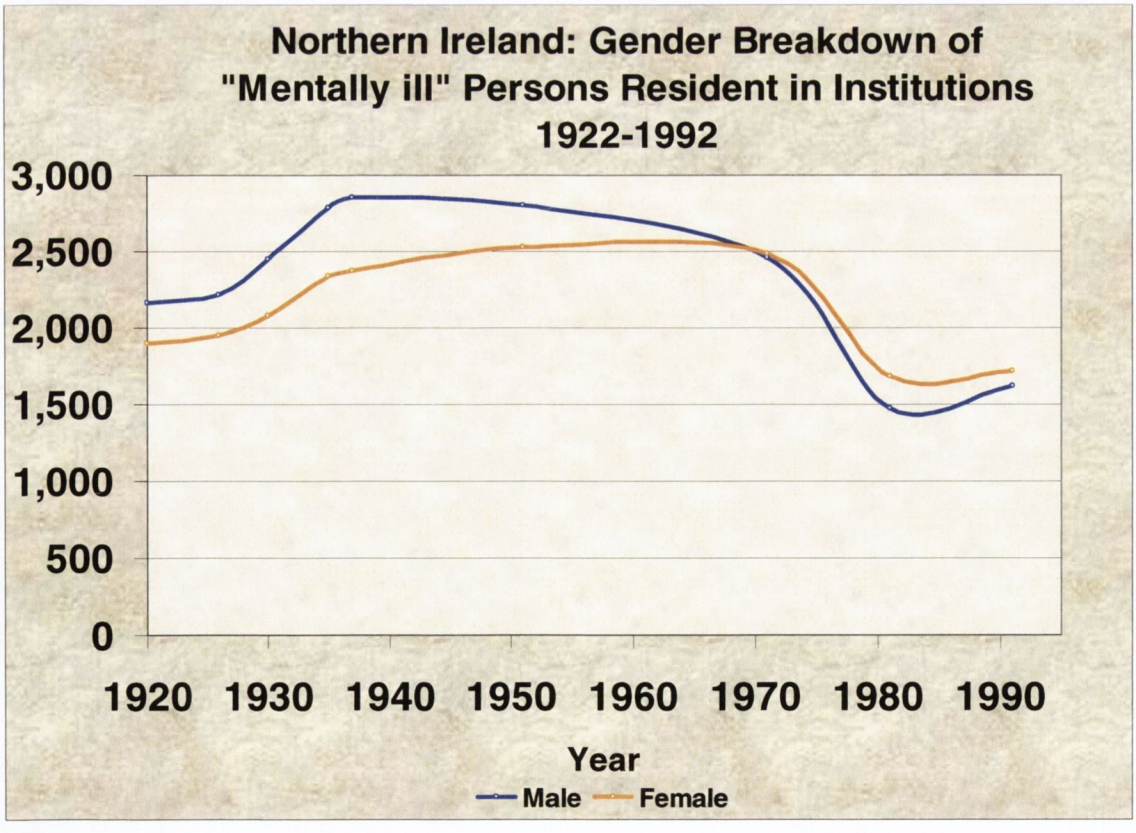


While a statistic for the total residency of the 'mentally ill' in institutions is available in official publications for most years post 1922, a gender breakdown of this total is only available for the years 1926 to 1962. From 1962 onwards, the data provided in *Reports of the Inspector of Mental Hospitals* is limited to simple totals. This, as discussed above, is further complicated by the non publication of these reports for several

years between 1962 and 1990. All sources pertaining to an overall gender breakdown for 1962-2000 were examined during this research process, including the possible use of reliable secondary sources and through making personal contact with the last Inspector for Mental Health who held this post for the years 1988-2002. However the data available only allows for a gender analysis for the years 1926-1962.

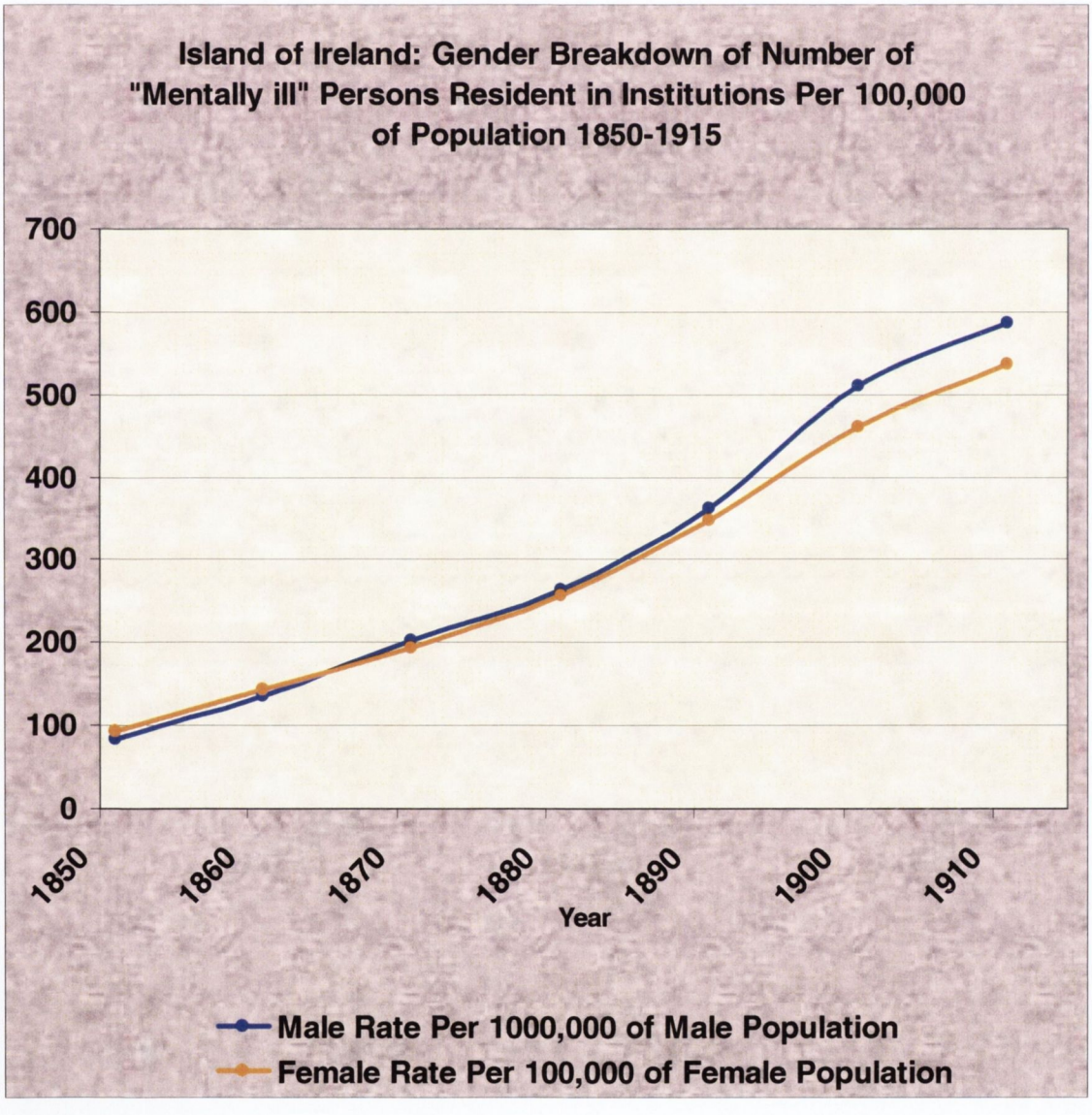
The gender breakdown for 1922-1962 illustrates a continuation of the trend established in the 1890s, with a consistently higher male representation in these institutions. One notable feature of Graph 8 is the pattern of parallel sequence in the rise and fall in the level of asylum usage of both sexes. This is more pronounced when gender and institutional residency is analysed as a rate of 100,000 which is demonstrated in Graph 11.

Graph 9

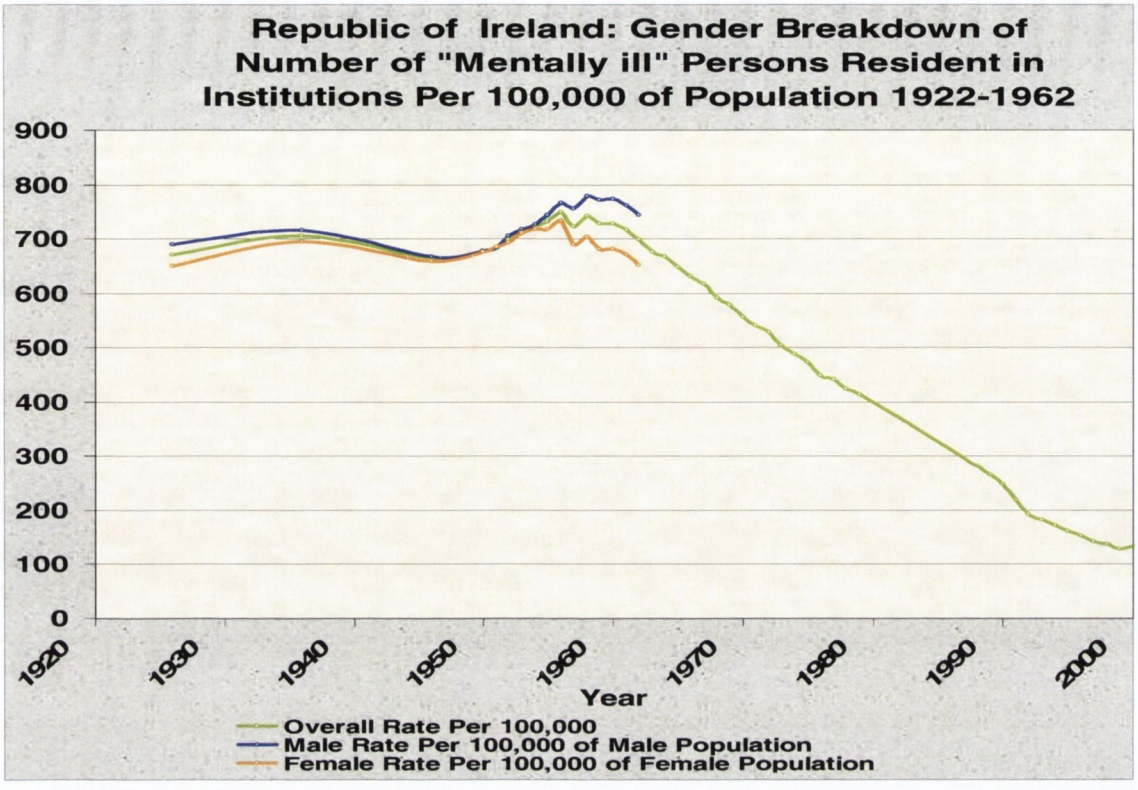


Northern Ireland also had an over-representation of males in institutions for the 'mentally ill' in the early part of the twentieth century. An equal representation of the sexes occurs in the early 1970s followed by a marginal over-representation of females from that date onwards. Graphs 10, 11 and 12 express these gender dynamics as a rate of 100,000 of the male and female population respectively.

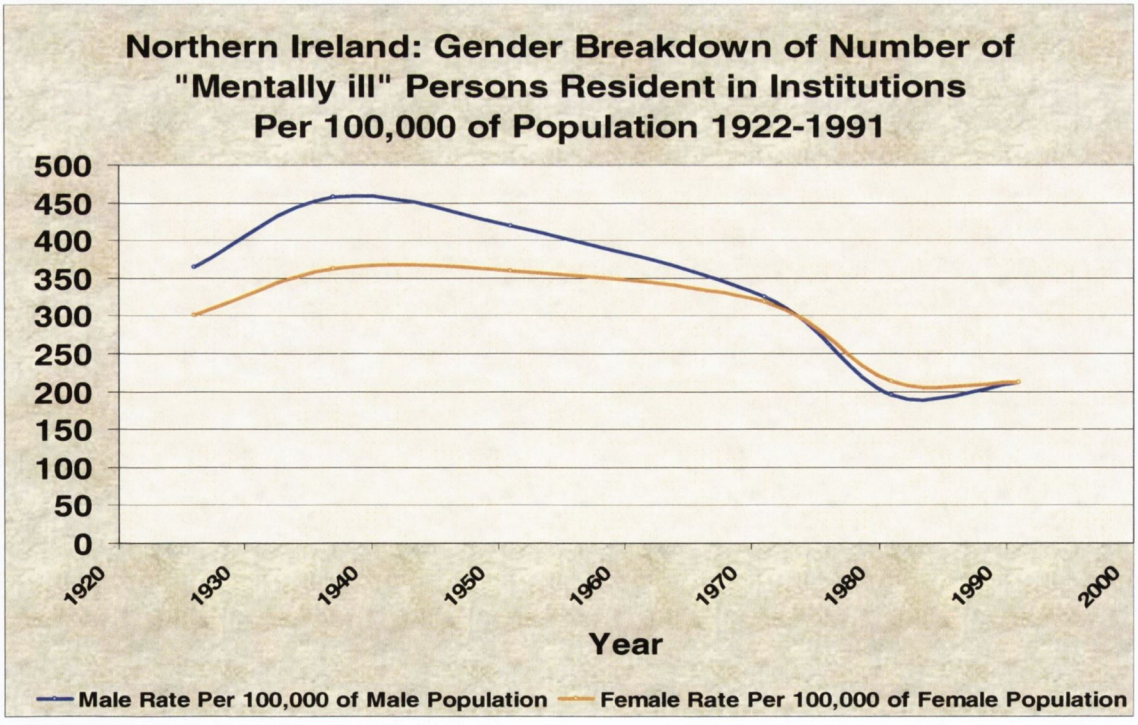
Graph 10



Graph 11



Graph 12



Regional Variations

In the context of institutional residency for the 'mentally ill', the divide between urban and rural rates of utilisation is complex, inconsistent at particular points in time, and changes across the time span being considered in this dissertation, 1800-2000. An early comparison of regional variations can be drawn from the statistics provided in the 1843 report of the *Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland* (1843: iii-iv). This data provides an average level of occupancy within public asylums, along with the general population of the districts that each asylum served as illustrated in Table C below.

Table C 1841 Asylum Districts, District Population and Average Number of Patients at any One Time

Asylum	District Population 1841	Average Number of Patients at Any One Time
Armagh	832,474	122
Belfast	722,321	249
Londonderry	831,578	211
Richmond	810,984	290
Carlow	605,169	168
Maryborough	557,578	167
Connaught	1,418,973	271
Limerick	910,303	352
Clonmel	435,553	103
Waterford	196,187	115
Cork	854,118	423

A snap shot of regional variations for 1841 can be derived by converting the above data into rates per 100,000 of population and then ordering each district from the highest to the lowest rate of asylum occupancy, which is set out in Table D below.

Table D **1841 Rank Order of Occupancy Per 100,000 of Population in District Asylums**

Order of rate of Occupancy	Asylum	1841 Rate of Occupancy Per 100,000 of Population
1	Waterford	58.62
2	Cork	49.52
3	Limerick	38.67
4	Richmond	35.76
5	Belfast	34.47
6	Maryborough	29.95
7	Carlow	27.76
8	Londonderry	25.37
9	Clonmel	23.65
10	Connaught	19.10
11	Armagh	14.66

The data in Table D illustrates a mixed and inconsistent urban / rural divide in rates of asylum utilisation. Waterford and Cork are reported as having the highest rates of occupancy in 1841. While each of these districts contained a city, both districts were predominately rural at this time. The report from the1843 Select Committee records Waterford district as comprising 23,261 persons living within Waterford city compared with 172,971 persons living in Waterford county. Similarly, Cork city had a population of 80,720 persons and Cork county 773,398 (1843: iii-iv). However, it does not consistently follow that rural areas had the highest rates of asylum utilisation at this time. Connaught which was a predominately rural district is placed tenth in Table D, whilst the Richmond Asylum situated in the city of Dublin, which was a comparatively industrialised area at this time, is placed forth.

Variations in the rates of urban and rural asylum utilisation is observed by Finnane who disputes the assertion by Walsh (1970) that before 1900 "there was little variation in the regional distribution of Irish first admission rates" (Finnane 1981: 135-

136). Finnane observed a comparatively high rate of asylum occupancy in Dublin in 1871 followed by a gradual move to rural overrepresentation by 1911.

> In 1871 and for the following two decades the admission rates were highest in Dublin and were particularly low in most asylums serving the west: Ballinsloe (Galway and Roscommon), Castlebar (Mayo), Cork, Killarney (Kerry) and Sligo (Sligo and Leitrim). It was these asylums in the west which, by 1911, had doubled or trebled their 1871 admission rates (Finnane 1981: 136).

Established in the late nineteenth century, this trend of high admission and residency in district asylums along the west coast of Ireland is consistently maintained up until the early the mid 1980s. Commenting on regional variations in both rates of residency and diagnoses Schaper-Hughes observes that:

> Regional variations affect not only the rates of hospitalisation (with the lowest rates coming from the developed and industrialized east, and the highest rates from the underdeveloped and under populated west), but diagnoses as well. The highest rates for schizophrenia and affective psychosis (including endogenous depression) are from the west, with the highest rates for simple neurosis come from the east (Scheper-Hughes. 1979: 141)

The enduring nature and extent of this East – West divide can be observed in the data contained in the Mental Hospital Census. For example, in 1971 the highest rates of mental hospital residency per 100,000 of population were reported to be in the Western Health Board at 912.7; North-Western Health Board at 685.4; and Mid-Western Health Board at 685.4. This is in stark contrast with the Eastern Health Board which had a rate of 424.7 per 100,000 during this year (Walsh 2002: 37).

The policy of deinstitutionalisation, introduced in 1984, consolidated the trend of declining institutional residency in all regions, which is considered in detail in Chapter 5. However, this policy was adopted inconsistently across Ireland, which resulted in a change to the overrepresentation of people from the west of Ireland within institutions for the 'mentally ill'. For example, the 2001 Irish Psychiatric Hospital and Units Census

reports rates of hospitalisation per 100,000 as being lowest in the North-Western Health Board at 100.9 and highest in the South-Eastern Health Board at 239.1 (Walsh 2002: 37). Commenting on such regional variations the 2004 Report of the Mental Health Commission states that:

> The rate of inpatient beds ranges from a low of 35.0 per 100,000 population over 16 in the HSE-South West Area, to a high of 235.8 in the HSE- South Eastern Area. This low provision in the HSE – South West Area is in spite of the fact that this HSE Area is known to have high levels of deprivation in comparison to other HSE Areas (Mental Health Commission 2004: 33).

Hence, a mixed regional pattern of institutional residency existed. No overall urban / rural pattern is observable in 1841 (Table D), but this is followed by a short period of comparatively high rates in Dublin in the 1870s. This is then superseded by sustained overrepresentation of rural areas, particularly along the west coast of Ireland, which is continuous from the turn of the early nineteenth century until the mid 1990s. This trend is then interrupted by the uneven introduction of deinstitutionalisation within the various Health Board areas in Ireland, with the 2001 Census reporting a mixed urban / rural and East / West pattern of institutional utilisation. The regional variations are, therefore, mixed depending on the time period being considered. However the most enduring period of overrepresentation was in western rural areas of Ireland.

Occupational Status and 'Mental Illness'

Unlike other demographic features, the occupational groups of those admitted to asylums are not provided consistently within the Inspectors' reports. This creates some difficulties when analysing the socio-economic circumstances of individuals resident in

these institutions. Furthermore, no definitive account of long-term trends or correlation between Irish asylum residency and occupational status has been published to date. Even when information relating to occupational groups is provided within Inspectors' reports, it is ambiguous and poorly formulated, often using open-ended categories such as 'unknown' or 'no previous occupation'. Commenting on this, Finnane observed that "the variations in this category may be due more to different principles of classification adopted by the medical superintendents than a reflection of regional variations" (Finnane 1981: 133). However, with reference to the general demographic profile of the residents within these institutions, most studies, including Finnane (1981), Malcolm (1999), Robins (1986) and Scheper-Hughes (1979) observe that patients were predominately from rural areas, had a low level of occupational security and were not married. For example Malcolm points out that:

> Among males in all the asylums studied, the largest occupational category was labourer. In rural asylums labourers generally made up at least half of male patients, with farmers and their sons being the next largest group. Among women the largest category was also none or unknown, while in rural asylums, farmers' wives and daughters and female farmers formed the next largest group (Malcolm: 1999: 180).

While Finnane acknowledges the poor quality of the data relating to occupational status, he proposes that those resident in asylums from 1840-1922 were:

> ...relatively young, more often single than not . . . and predominantly from the peasantry and working class (though probably only to the extent that these classes formed the great majority of Ireland's population anyway) (Finnane 1981: 135).

The poor quality of recorded data concerning the occupational status of 'mentally ill' persons in residential institutions continues to be a problem. For example, the most recent Irish Psychiatric Hospitals and Units Census, carried out in 2001, observes that "it is worth noting that 50% of occupations returned were classified as 'unknown', making it

impossible to assign them to a socio-economic group" (Walsh and Daly 2002: 26). Psychiatric hospital censuses were carried in 1963, 1971, 1981, 1991 and 2001. In the context of the poor rate of census returns detailing socio-economic groupings, definitive proposals linking residency with socio-economic circumstances is not possible. However, some general observations can be made. The data returned for the years 1963, 1971, 1981, 1991 indicates a socio-economic profile similar to that which existed at the close of the nineteenth century, with the socio-economic group described as 'other agricultural workers' having the highest rate of residency. Based on the data contained in these censuses, Table E contrasts 'other agricultural workers' with the socio-economic group described as 'Employers and Managers' who had the lowest rate of occupancy.

Table E **Rates of Occupancy Per 100,000 of Population for Socio-Economic Groups 'Other Agricultural' and 'Employers and Managers'**

Socio-Economic Group	Rates of Occupancy Per 100,000 of Population			
	1963	1971	1981	1991
Other Agricultural	3,465	1,771.7	1,206.3	621.9
Employers and Managers	123	183.1	65.8	26.9

Source: Irish Psychiatric Hospitals and Units Census 2001

In 2001, 'Agricultural Workers' became the second most over represented group within psychiatric hospitals at 252.8 per 100,000, replaced by 'Unskilled Manual Workers' who had the highest rate at 314.3 per 100,000 of population for this year. At the other end of the scale, 'Employers and Managers' having a rate of 30.4 per 100,000 were replaced as the least represented group resident within these institutions, 'Salaried Employees/Own Account Workers' having the lowest rate at 5.8 per 100,000 of population.

In general, the reports of the Inspectors of Lunatic Asylums / Mental Hospitals provide a rich source of data relating to institutional residency across a time span of some

one hundred and fifty years. However, only limited information relating to occupational status is provided in these reports. While a full correlation study of occupational status is not feasible based on this information, the available data suggests that higher socio-economic circumstances reduced the probability of asylum admission, and conversely poor socio-economic conditions, particularly in rural areas, increased this probability.

Levels of Residency and Gender by Institution Type

While the main component of the Irish national asylum system was the network of publicly owned and administered asylums, a number of other institutions were utilised as sites of residence for the 'mentally ill' and were integral to the overall system. The total level and rate of institutional residency set out in Graphs 1 and 6 respectively are an illustration of the collective sum of these institutions. While Graphs 1 and 6 indicate a relatively smooth trajectory of growth and decline in the usage of these institutions, the graphs set out below indicate that each individual type of institution had it own course of expansion and demise.

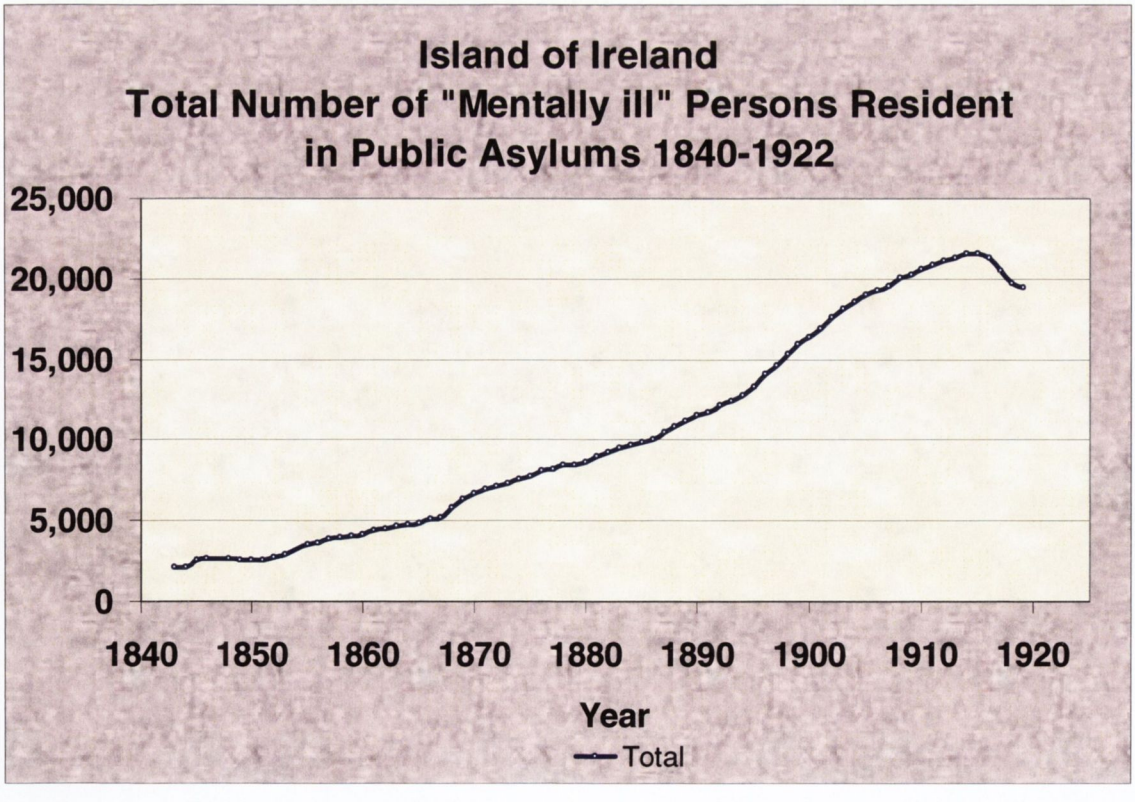
Public Asylums

The primary focus of the *Reports of the Inspector of Lunatics / Inspector of Mental Hospitals* is consistently the public asylum system, which is the largest location of institutional residency for the 'mentally ill' in Ireland. These public institutions have also the infamous legacy of being the largest sites of committal on the island of Ireland when compared to prisons, industrial schools and institutes for single pregnant women.

The actual title used to describe these institutions changes slightly from report to report. For example, the 1961-62 report uses the category "District and Auxiliary Mental Hospitals" whereas the 1977-79 report uses the category "District Mental Hospitals and Psychiatric Units", which is subsequently changed to "Public Psychiatric Units and Hospitals" in the report for 1988-89. However, in all cases the inspector is referring to the publicly owned, funded and managed institutions, which constituted the core of the national asylum / mental hospital system.

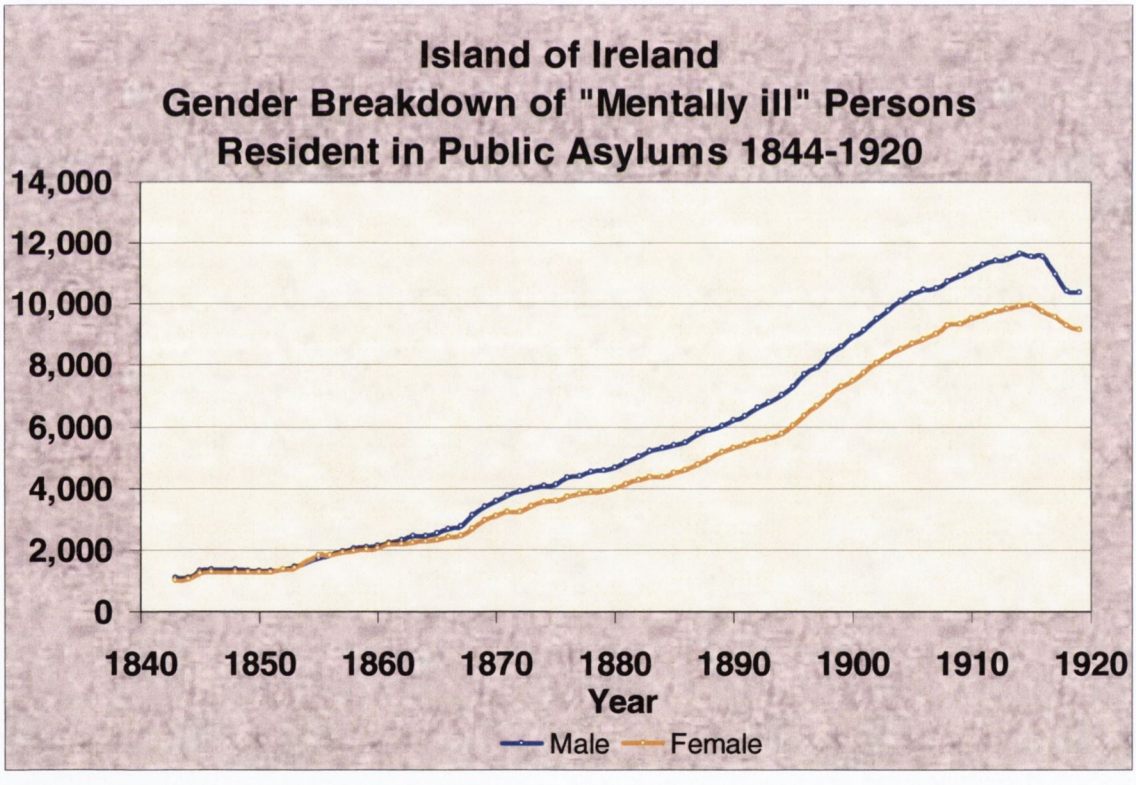
Some reports present a set of statistics for district mental hospitals and a second set of statistics for auxiliary mental hospitals. This is essentially an arbitrary administrative divide that is not applied consistently across reports. When such a divide occurs, the two statistics are added so as to allow a trend to be illustrated for all public asylums / mental hospitals.

Graph 13



Graph 13 is based on data contained in Table 7 of Appendix 1. This Graph illustrates that the overall growth in the level of institutional residency of the mentally ill, as set out in Graph 1, is primarily driven by the expansion of the public system. As will be examined in Chapters 4 and 5, this expansion was stimulated by a multitude of social forces including public social policy, legal structures, professional politics and a need for social intervention. Collectively these public asylums formed a substantive national bureaucratic network and individually these buildings were major physical structures, which generated many latent consequences, such as the provision of employment opportunities and the enhancement of local economies.

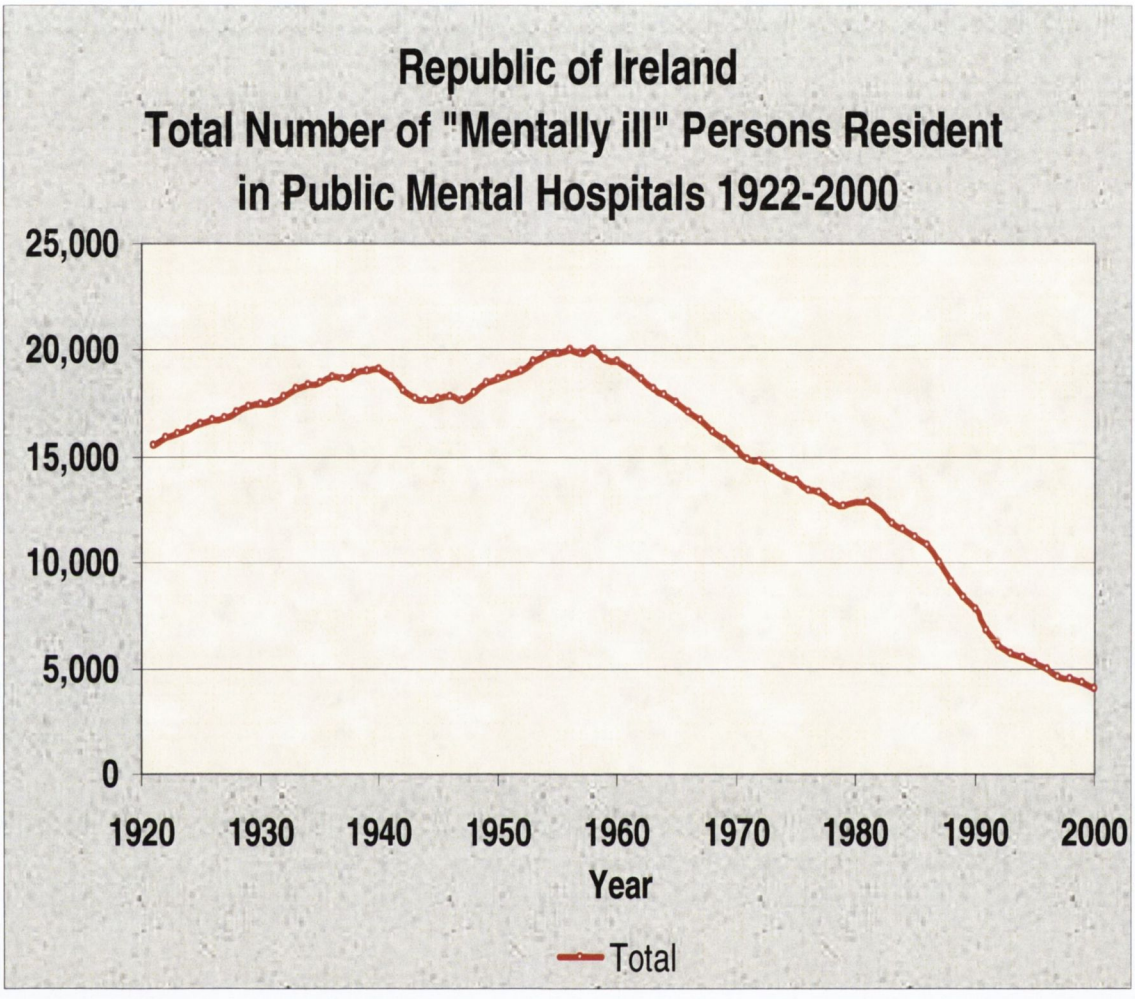
Graph 14



As can be observed in Graph 14, a pattern of higher male than female utilisation of public asylums was established in 1860 which continues up until the establishment of

the Free State in 1922, which is consistent with the overall gender dynamic shown in Graphs 7 and 10.

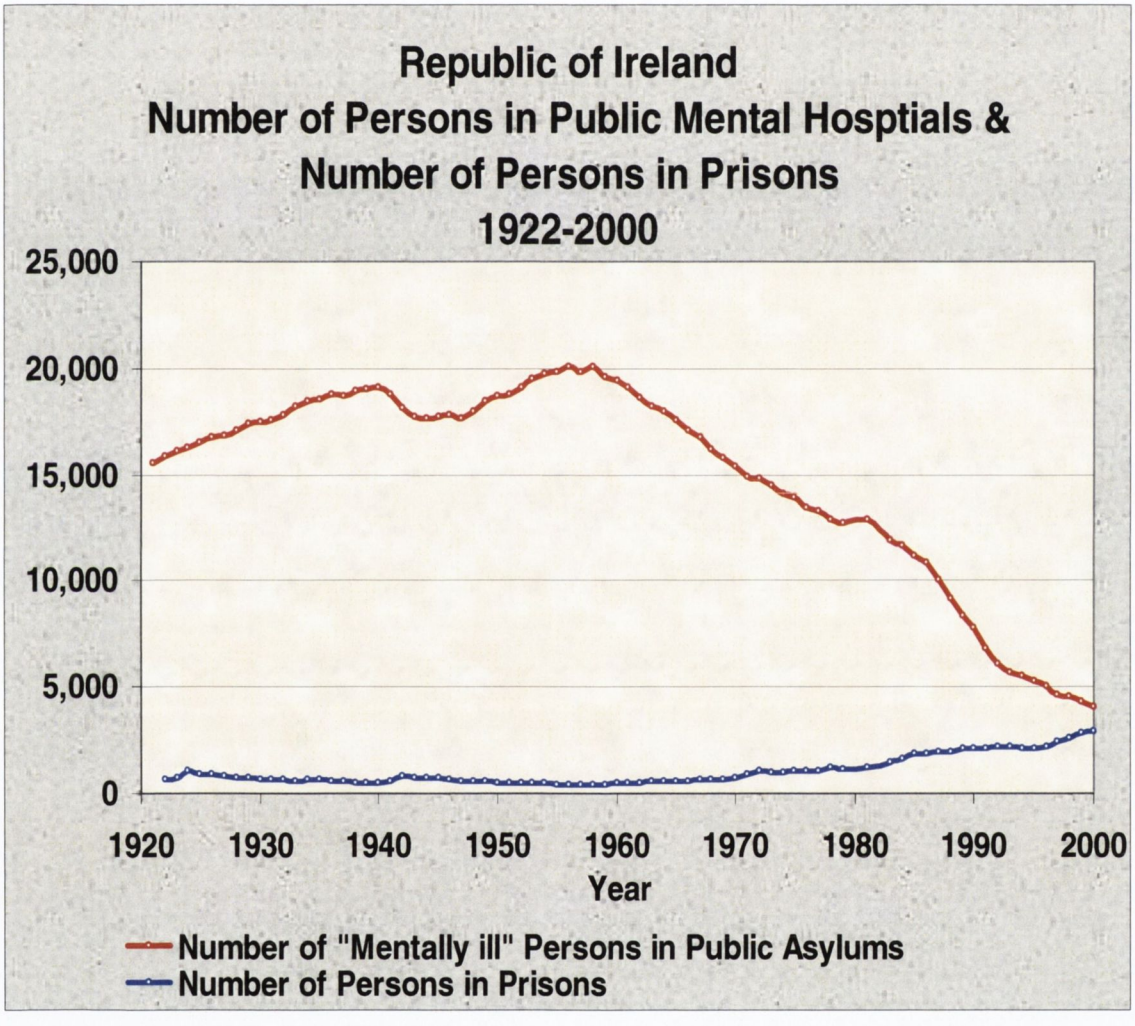
Graph 15



Graph 15 is based on data set out in Table 17 of Appendix 1. As can be seen, the high level of public asylum utilisation is continued post Independence. This level of public asylum utilisation is truly spectacular if contrasted with other locations of institutional residency. For example, when public asylum utilisation reached a peak in 1956 with 20,063 persons resident, only 401 persons were in custody in prisons and only 172 juveniles were resident in Reformatory Schools (O'Donnell et al. 2005). This comparatively high utilisation of public asylums as compared to prisons is illustrated in

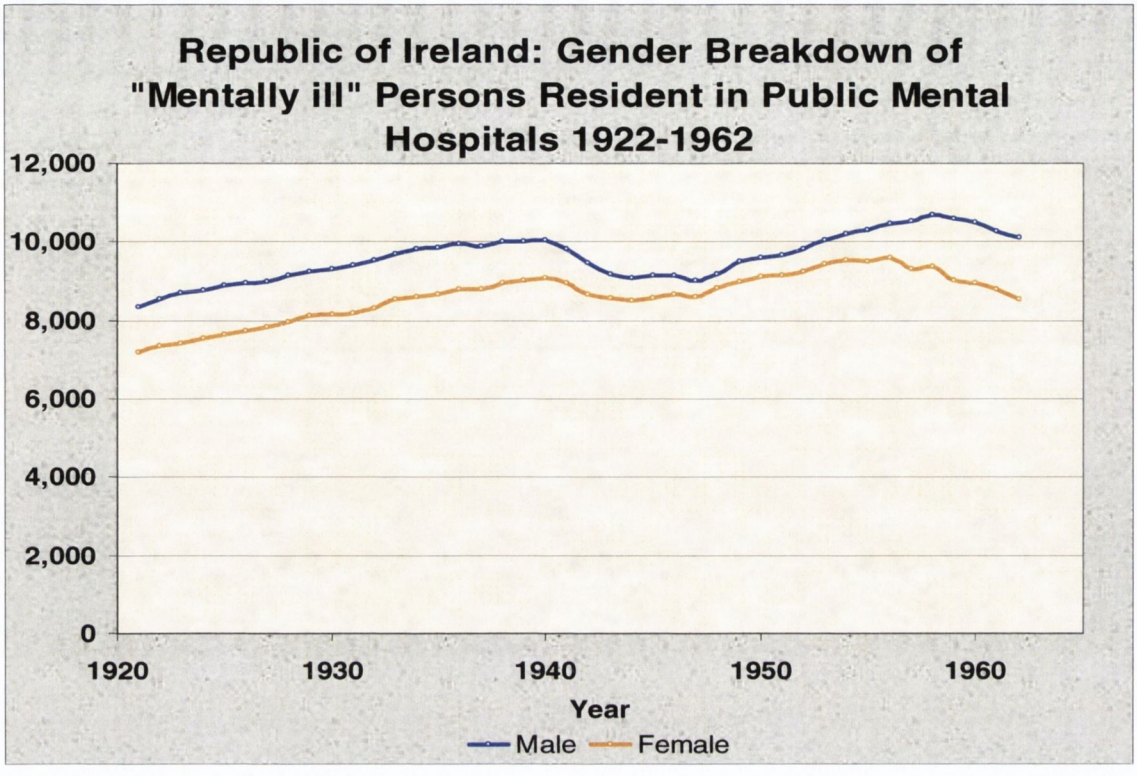
Graph 15.1, which demonstrates that the scaling down and closure of public asylum institutions occurs simultaneously with an expansion in prison building and utilisation in the Republic of Ireland. The data relating to prisons is contained in Table 27 of Appendix 1.

Graph 15.1



A gender breakdown of public asylum utilisation is given in Graph 16. As explained above, data is only available for such a gender analysis for the years 1922 to 1962. Graph 16 demonstrates a continuous higher male to female representation in these public institutions.

Graph 16

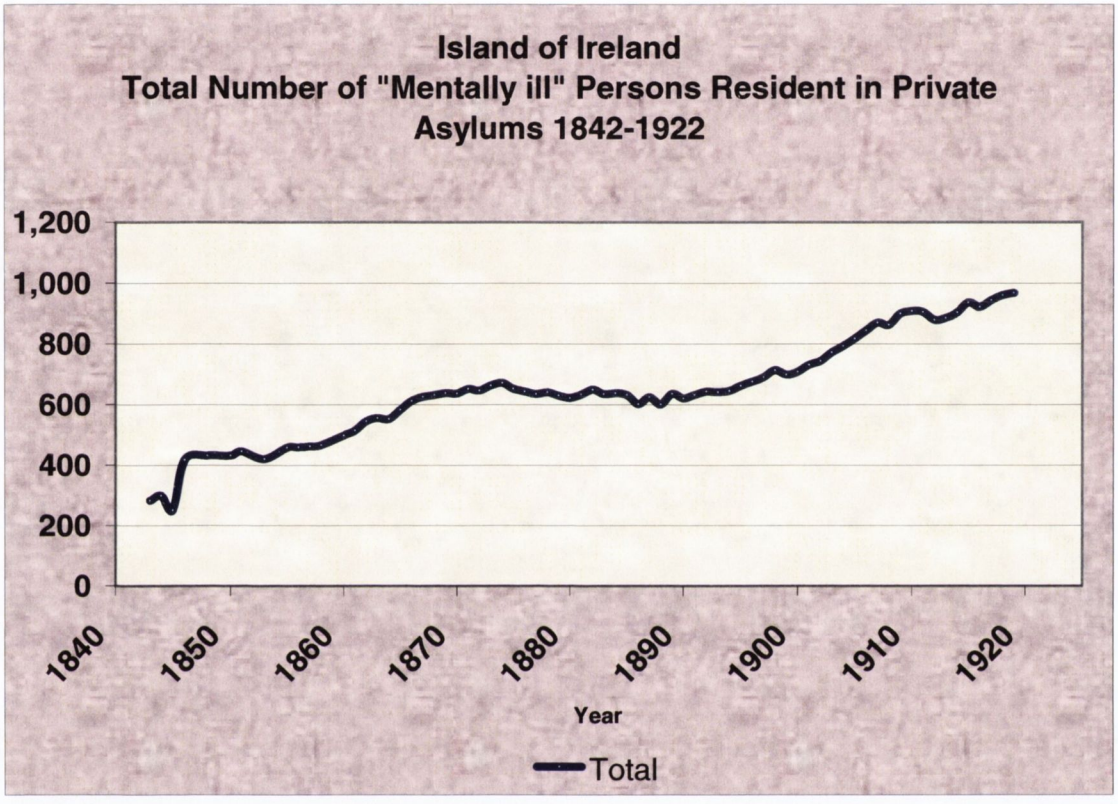


Private Asylums

Private asylum are those set up by private interests, in some cases through religious orders and in other cases purely as capitalist enterprises. These institutions receive direct payment on behalf of the bed occupant, either through personal resources or in more contemporary times through the provision of private health insurance companies. While private asylums have a similar trajectory to public asylums in that they have expanded and contracted during the past two centuries, the trajectory of these private institutions differs from public institutions in a number of ways. Firstly, the scale of utilisation of private asylums is minimal compared to public asylums. This is an important factor, as it illustrates a limited level of private capitalist enterprise in Irish asylum provision, which be expanded upon in Chapter 4 and 5. A second feature of note is the gender dynamic in private asylums, which is patterned differently from public

institutions as set out in Graphs 16 and 14 above. Thirdly, there is a period of continuous declining utilisation of Irish private asylums from 1922 to 1946, which is contrary to the overall trend of institutional residency of the "mentally ill" as illustrated in Graph 1.

Graph 17

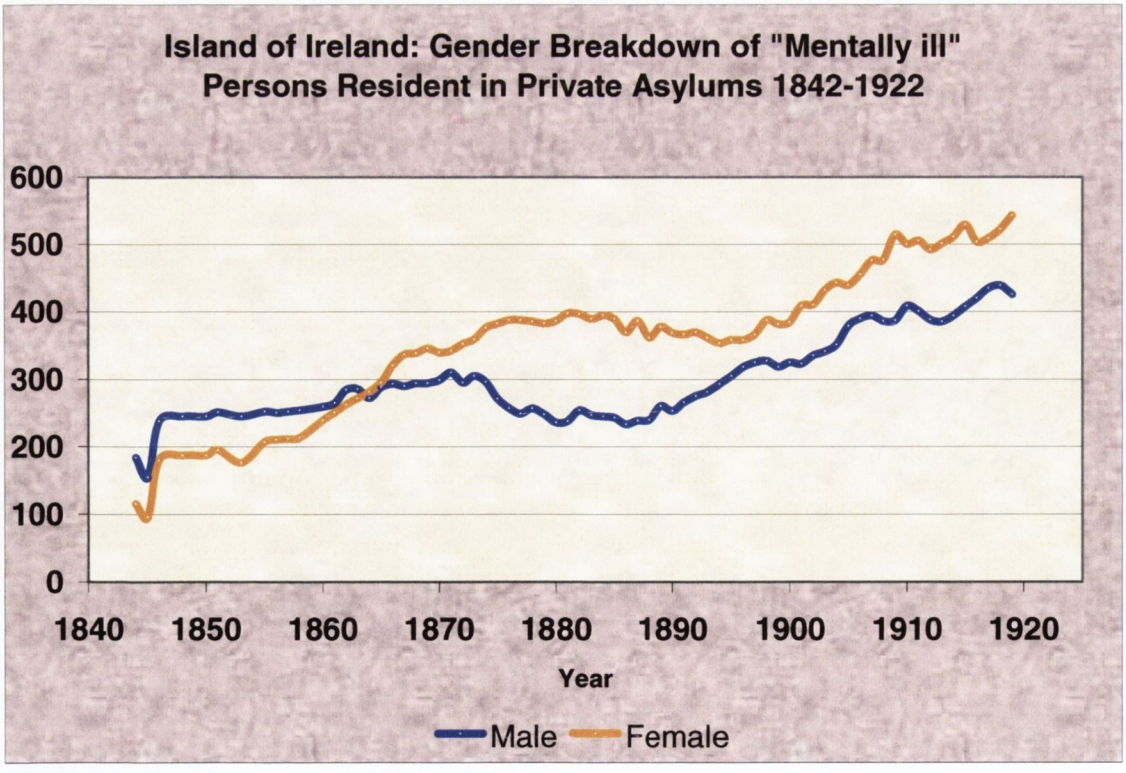


The category of private mental hospitals changes continuously in various reports of the Inspector of Mental Hospitals. Categories utilised include: "Private Mental Hospitals" from 1921-1945; "Private, Private Charitable and Authorised Mental Institutions" from 1945-1956; "Private, Private Charitable, Authorised and Approved Institutions" from 1957-1962; "Private Mental Hospitals" from 1963-1979; "Registered Psychiatric Hospitals" from 1986-1989; "Registered Private Psychiatric Hospitals" from 1990-1992; and "Registered Psychiatric Hospitals" in 1993. However, throughout these category changes, the Inspector of Lunatics / Mental Hospitals consistently refers to those

institutions that are privately owned and charge fees with a view to generating profit. Along with public asylums / mental hospitals and the Central Mental Hospital for the criminally insane, these institutions are a constant feature of the Inspectors' reports from 1846 to the present day.

Graph 17 is based on data contained in Table 8 of Appendix 1. When compared to public asylums, a similar but slower pattern of growth can be observed in these private institutions. This entails a rapid expansion during the late 1840s, followed by a continued pattern of overall growth up to 1922. Interestingly, the sizable dip in the public asylum utilisation from 1915-1920, which was attributed to a high death rate, is not mirrored in these private institutions. The peak point in Graph 17 is the year 1919, with 969 persons resident is these private institutions, however, this represents only 4.3 % of the 22,578 'mentally ill' persons resident in institutions for that year.

Graph 18



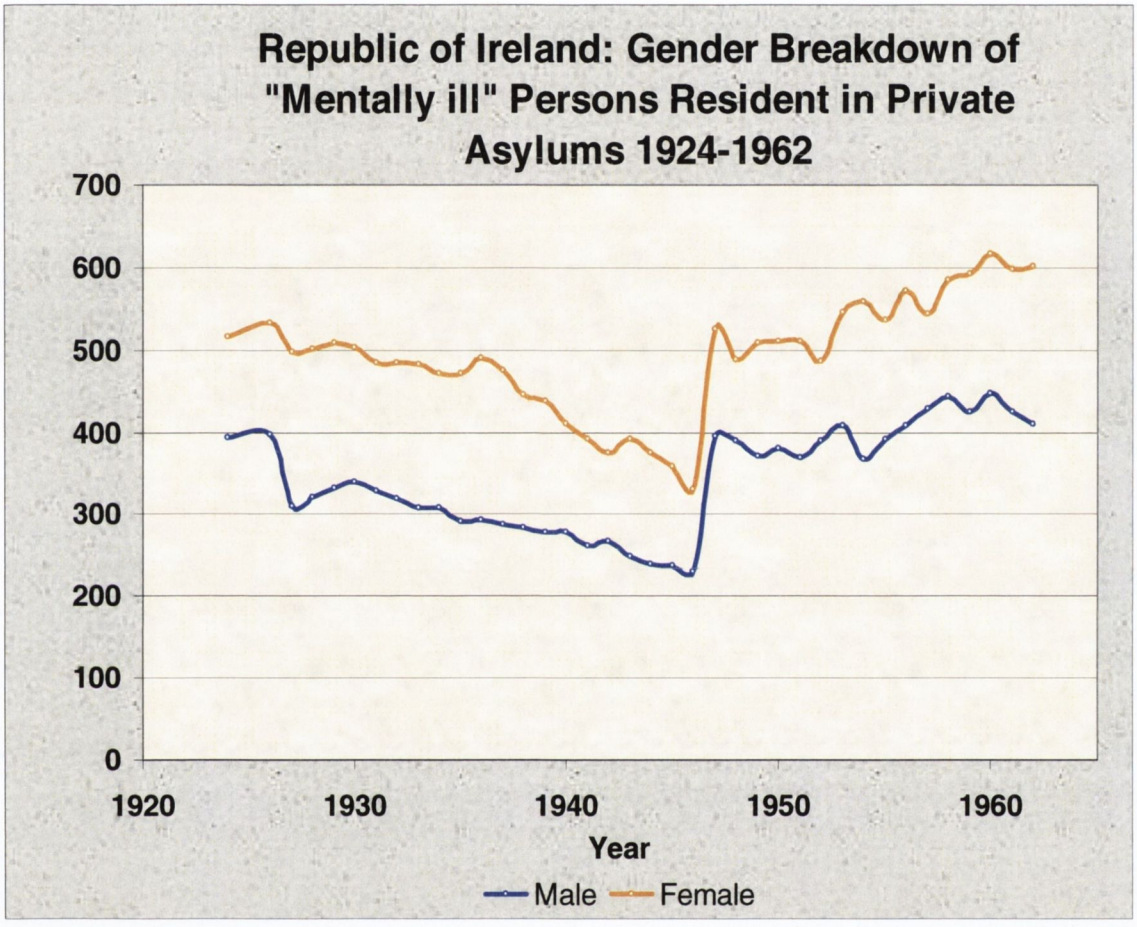
As can be observed in Graph 18, the gender dynamic of private asylums prior to 1922 is almost the reverse of that in public asylums. From the mid 1860s, females outnumber males in these institutions, a trend that is maintained from 1860 to the present day.

Graph 19

Graph 19 is based on data contained in Table 18 of Appendix 1. As mentioned above, the trajectory of private asylum usage deviates from the overall national trend. A continuous trend of declining usage of private asylums is illustrated in Graph 19, commencing at Independence and reaching a low point in 1946 with 561 persons resident. While graphically this decrease looks significant, the overall low numbers of persons in these institutions needs to be borne in mind. Essentially, while the decline in

usage is notable in the context of private asylums, amounting to some four hundred persons between 1921 and 1946, this does not influence the national trend to any significant extent.

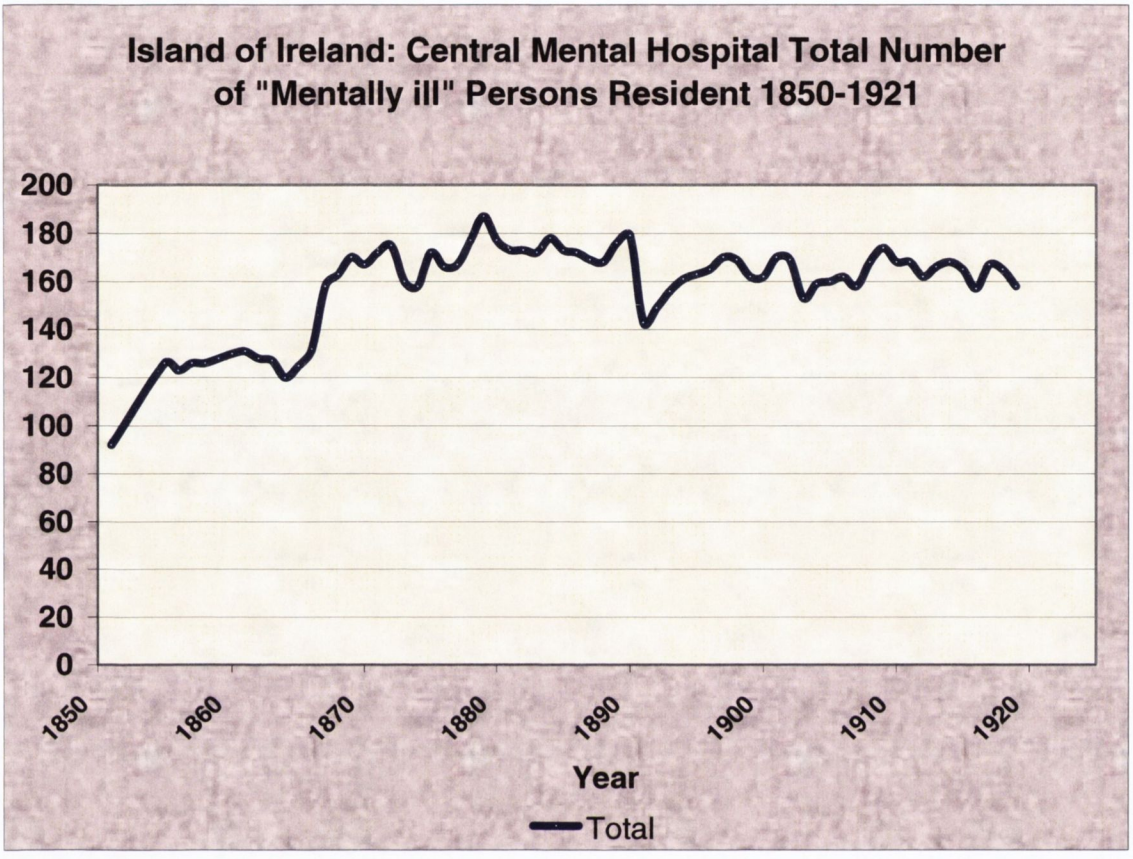
Graph 20



Graph 20 illustrates the continued over representation of females as compared to males in private mental hospitals from 1922 to 1962. A notable feature of this graph is the parallel trend of private occupancy rates for men and women. Not only do the overall trends mirror each other but some of the peaks and drops occur for men and women simultaneously. For example the rapid rise in private asylum usage during the late 1940s occurs similarly for both sexes.

Central Mental Hospital (For the Criminally Insane)

Graph 21



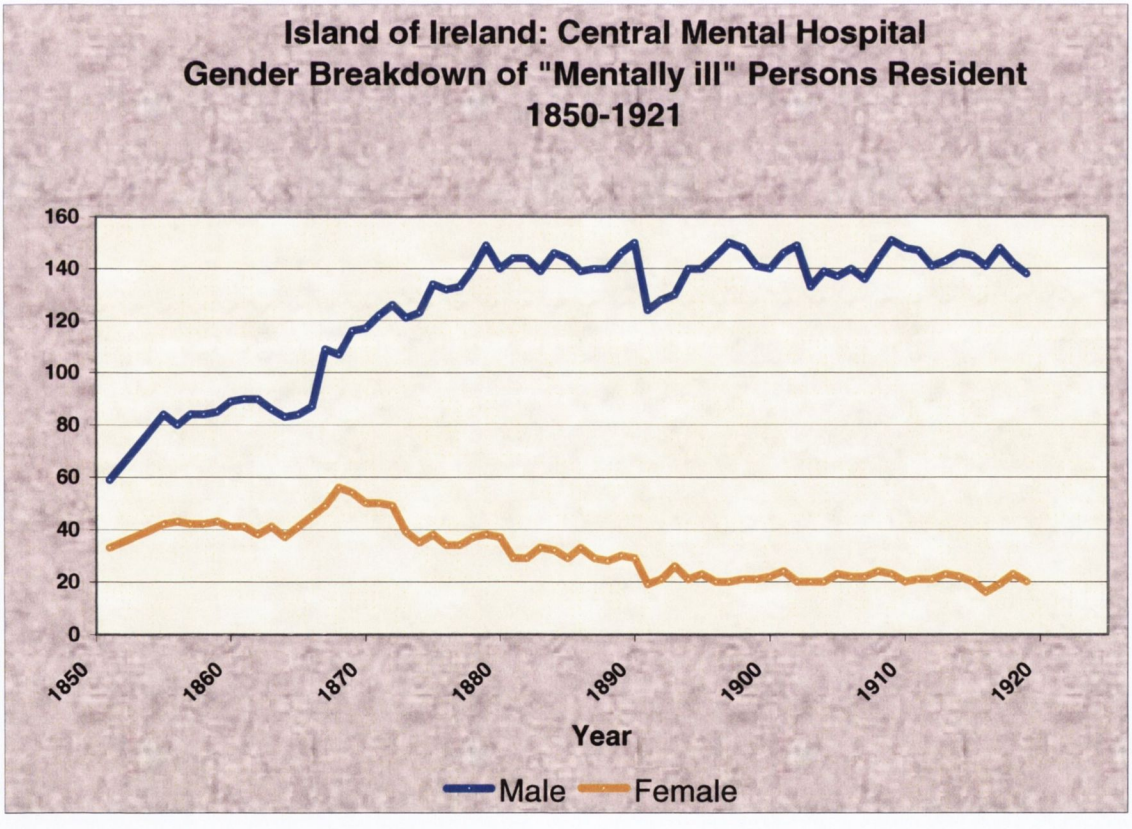
The Central Mental Hospital in Dundrum, Dublin, is the only high security institution for the criminally insane in the Republic of Ireland. Based on the provisions made in the 1845 Central Criminal Asylum (Ireland) Act, it opened in 1850 and provides accommodation for persons who are convicted of an offence, but deemed to be insane and also for prisoners who become 'mentally ill' while in prison.

The gathering of data concerning the Central Mental Hospital is problematic, particularly for dates pertaining to the past 40 years. As discussed earlier, gaps in the publication of the annual reports of the Inspector of Mental Hospitals is an obstacle in itself. This is compounded further by the non-inclusion of retrospective data relating to the Central Mental Hospital in the reports that follow these gap years. An overall year-

on-year account of occupancy data is surprisingly not currently compiled and kept at this institution. With the kind permission of the Medical Director and the Director of Nursing, access was provided to archives at the Central Mental Hospital. These documents are currently in a very poor state of upkeep and are not catalogued in any coherent fashion. Through a process of reviewing various 'Night Reports' contained in this archive, the data relating to several of the gap years were successfully obtained.

The trend line shown in Graph 21 is based on the data in Table 9 of Appendix 1. This illustrates a comparatively small but sustained usage of this institution between 1850 and 1922, ranging predominately between 120 and 180 persons at any one time.

Graph 22



The gender breakdown of those resident in Dundrum illustrated in Graph 22 demonstrates a consistently higher representation of males. However, the actual ratio of

male to female occupancy fluctuates substantially, with comparatively higher female occupancy from 1850 to 1890. The highest level of female occupancy is in 1868 when 107 males and 56 females were resident, a ratio of roughly 2:1. This is a remarkably high level for females, particularly if compared to the occupancy rates post 1922 as set out in Graph 24 below. For example in 1999 there were 81 males, as compared to 5 females, resident in this institution, a ratio of roughly 16:1.

Graph 23

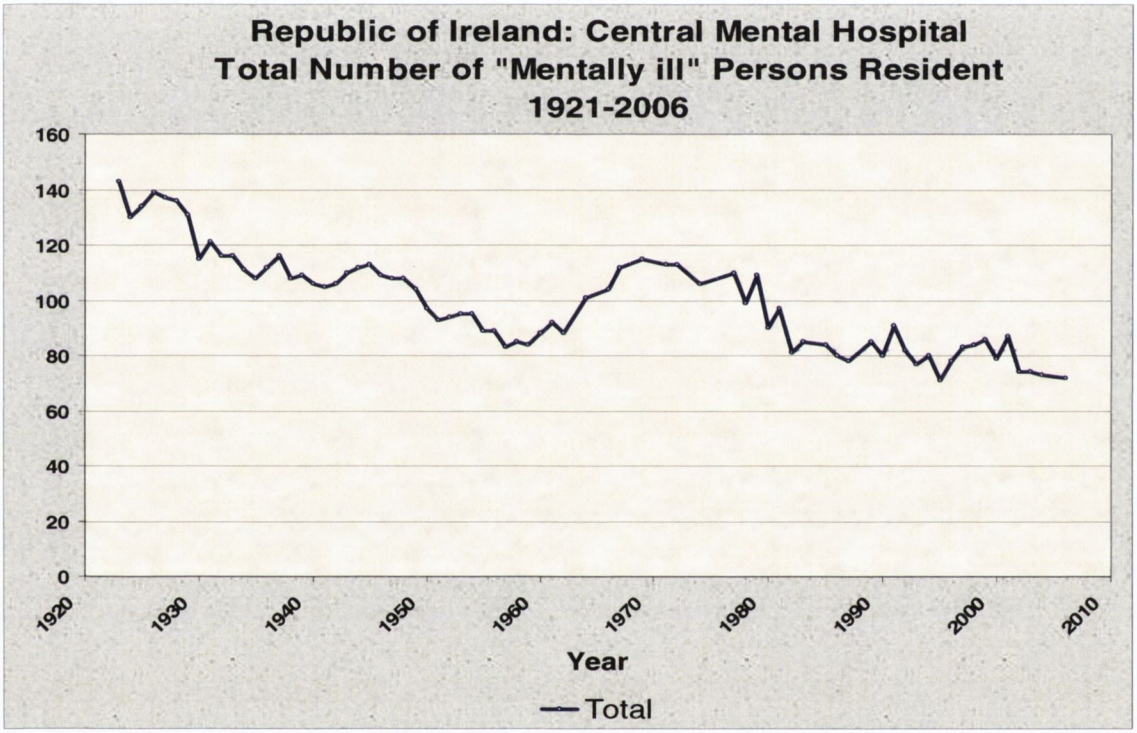
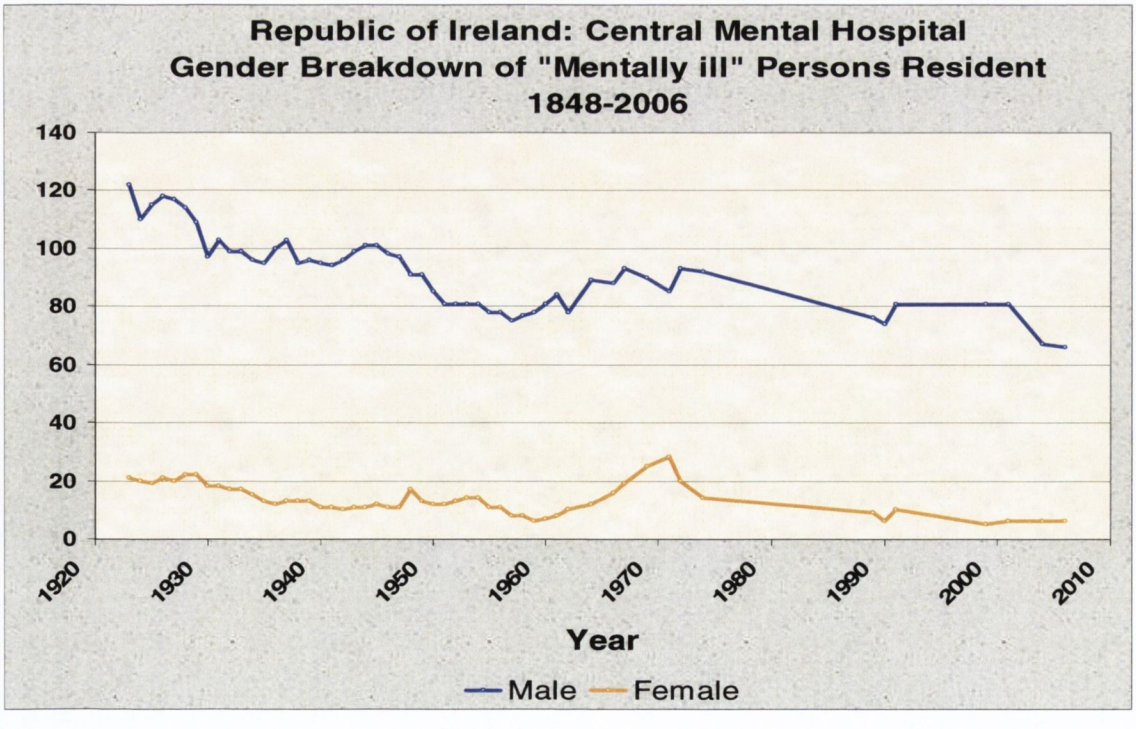


Table 19 of Appendix 1 details the source of each data point presented in Graphs 23 and 24. As can be observed from Graph 23, the trend in occupancy at the Central Mental Hospital is an overall decline since the establishing of the Free State, with a peak in 1923 when 143 persons were resident in this institution. One notable feature mentioned in the reports of the Inspector of Mental Hospitals for the years 1922 to 1930, is the continued residency of patients from Northern Ireland post partition. The number

of these patients is not specified in the report for 1923. However data is given in the Inspectors' Report for 1924 when there were 21 males and 5 females from Northern Ireland resident in the Central Mental Hospital. Again, no data for these patients is specified in the Inspectors' Report for 1925, but data is provided for 1926 (18 males and 4 females); 1927 (18 males and 4 females); 1928 (18 males and 4 females) and 1929 (12 males and 4 females). The report for 1930 states that "all patients chargeable to the Government of Northern Ireland have now been transferred" (Inspectors of Mental Hospitals 1930: 22)

The overall declining trend ends in 1962 and is followed by an increase in utilisation up to 1980. A consistent occupancy rate of between 70 and 100 persons is then established up to 2000. In comparison with public asylums, the Central Mental Hospital occupancy rates are quite small and, therefore have a minimal impact on the level and rate of national occupancy as set out in Graphs 1 and 6.

Graph 24

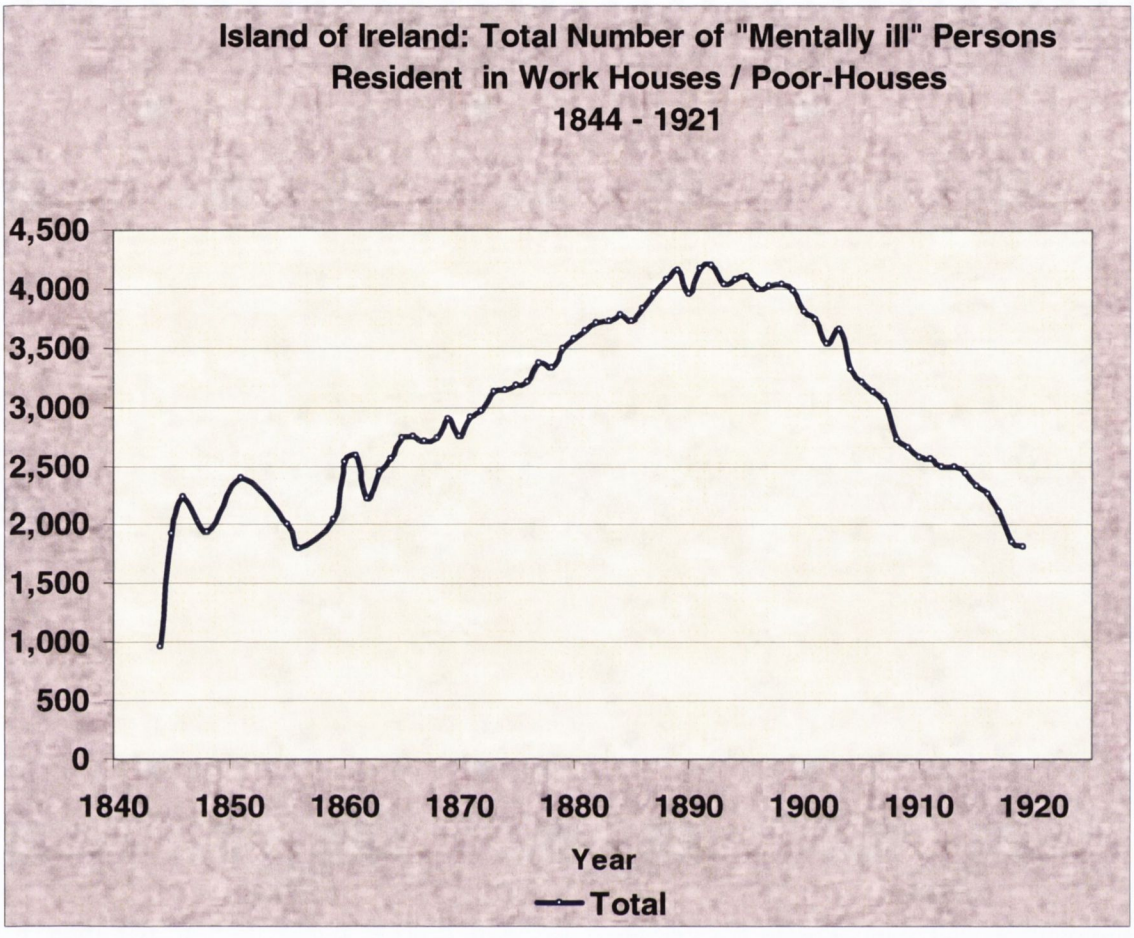


As mentioned earlier, the gender breakdown for the Central Mental Hospital since 1922 indicates a high level of male occupancy. Of all institutions that catered for the 'mentally ill' in Ireland, the Central Mental Hospital has the greatest gender discrepancy. As demonstrated in Graph 24, this is a trend that is consistent for the past eighty years. However, it must be borne in mind that, while the Central Mental Hospital is a hospital, it is also effectively a prison. If considered within the context of the gender breakdown of prisons, this institution is in keeping with the trend of a consistent and chronic over representation of males within the Irish prison population (O'Donnell et al, 2005).

Work Houses/ Poor-Houses / Poor Law Institutions / Public Assistance Institutions / Health Institutions

This set of institutions were not exclusively for the 'mentally ill'. However, persons occupying these institutions who were deemed to be 'mentally ill' are a consistent feature of the Inspector of Lunatics / Mental Hospitals reports from 1846 to 1957. The actual title of these institutions changes several times in the Inspectors' reports. They appear as "Poor Houses" up to 1890 and "Work Houses" in the reports from 1891-1921. Post Independence, the term "Poor Law Institutions" is used from 1922 to 1940. This changes to "Public Assistance Institutions" from 1941, and changed again to "Health Institutions" in 1955. After 1957 these institutions do not form a part of the national mental hospital residency system, and accordingly no 'mentally ill' persons resident in these institutions are recorded in the Inspector of Mental Hospitals reports from 1957 onwards.

Graph 25

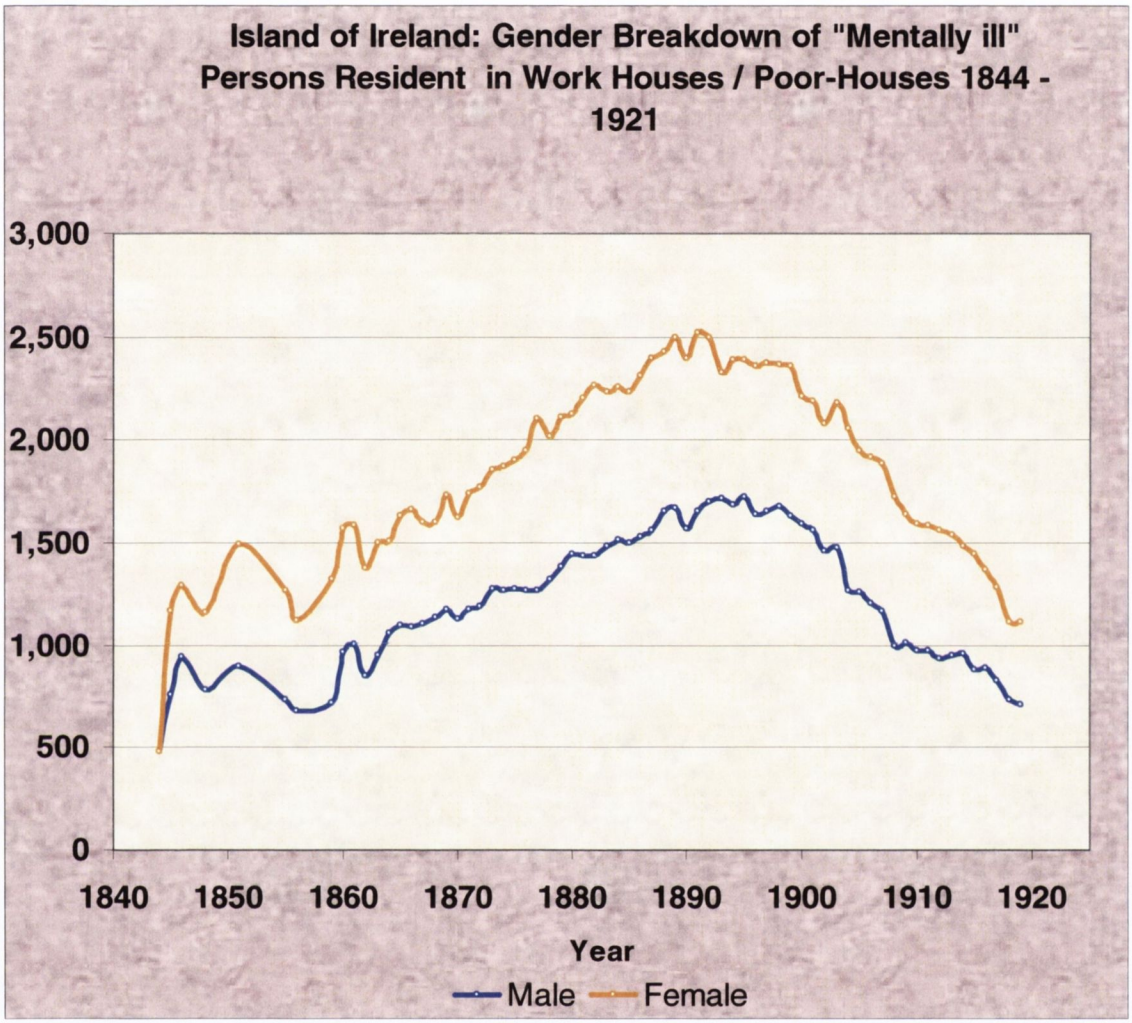


Graph 25 is based on data contained in Table 10 of Appendix 1. If compared to the other institutions explored above, one observes that these institutions represent the second largest sites of residency for the 'mentally ill' in Ireland between 1846 and 1947, next only to the public asylums, which are set out in Graphs 13 and 15 above. The peak point for these institutions is 1892 with 4,192 'mentally ill' persons in residence. This forms 24.5% of the total institutional residency of the 'mentally ill' for this year which amounted to 17,124 persons, 12,133 of whom were in public asylums.

The trend line in Graph 25 indicates a trajectory that deviates from the overall institutional residency trend in Ireland set out above. While these institutions formed a major aspect of the early stages of the increased institutionalisation of the 'mentally ill'

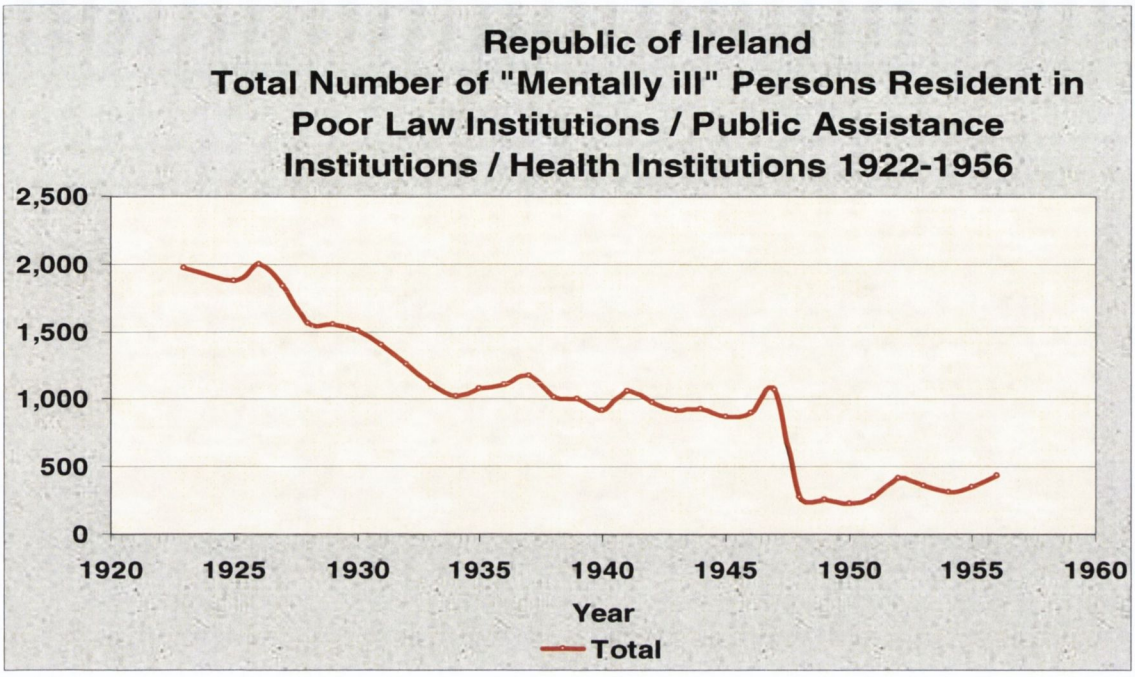
during the 1840s, the downward trend of 'mentally ill' occupancy for these particular institutions commences in the 1890s, which is earlier than the overall national pattern.

Graph 26



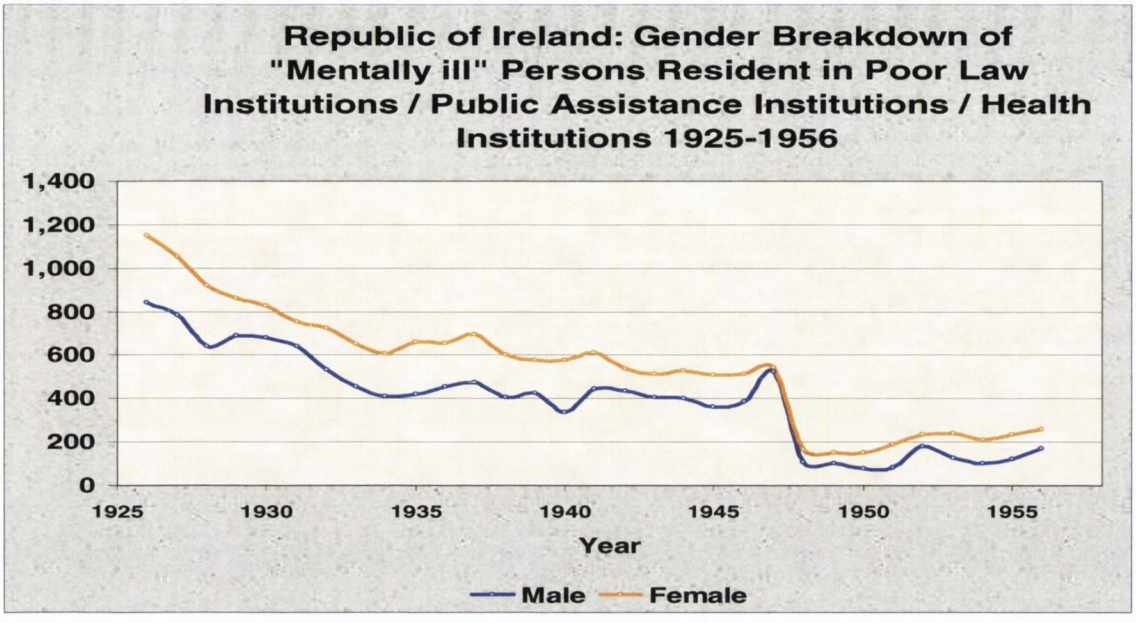
The gender breakdown of these institutions illustrated in Graph 26 shows a consistently higher representation of females as compared to males, which is the reverse of the gender representation in public asylums as shown in Graph 14. The higher incidence of female 'mentally ill' occupancy in these poor houses / work houses, serves to reduce the overall differential between males and females in the national total for all types of institutions, as shown in Graph 7 and 10.

Graph 27



The trend line in Graph 27, which is based on data set out in Table 20 of Appendix 1, illustrates that the overall decline in the use of these institutions as a place of residency for the "mentally ill", which commenced in the 1890s is continued up until 1957. A marked drop in the level of occupancy can be observed in the late 1940s, which coincided with the passing of the 1945 Mental Treatment Act which is explored in detail in Chapter 5. As mentioned earlier, at their height, these institutions constituted 24.5% of the total institutional residency of the "mentally ill" in Ireland. However, this steadily reduced with the continued expansion of public asylums, coupled with the progressive declining usage of Poor Law / Public Assistance / Health Institutions. For example the Inspector of Mental Hospitals Report for 1950 records only 227 'mentally ill' persons as being resident in these institutions. This constitutes only 1.13% of the national total for all 'mentally ill' persons resident in institutions for 1950 which stood at 20,079 persons, 18,677 of whom were in public mental hospitals.

Graph 28



Post 1922, the pattern of overrepresentation of females in these institutions is continued up until the cessation of utilisation of these institutions as locations for the residency of "mentally ill persons".

Other Institutions used for the 'Mentally ill'.

A number of other sites of institutional residency for the 'mentally ill' appear in the reports of the Inspector of Lunatic Asylums / Mental Hospitals. These institutions are not set out in graphs above, but are included in calculating the total level and rate for all institutions presented in Graphs 1 and 6. While being important, these institutions do not span the full time period being considered in this study. Individually the level of occupancy in these institutions is generally low and does not influence the national trend. However, the detailed data relating to each of these institutions, linked to and exact source for each year is set out in the Tables 11, 12, 13, 14, 15, 16, 21, 22, and 23 contained in Appendix 1.

Persons resident in prisons who were 'mentally ill' are included in the Inspector of Lunatics reports from 1846 to 1899, with a range of between 0 and a high point of 493, which occurred in 1865, as listed in Table 11 of Appendix 1. A separate listing is given for "Mentally ill Persons Resident in Convict Prisons with a Sentence of Imprisonment or Transportation, who became Insane in Prison" for the years 1856-1862. The number of persons in this category is small ranging from 2 to a high point of 10 in the year 1861, the details of which are given in Table 12, Appendix 1.

The Inspectors' reports for the decade 1843 to 1853 records a substantial cohort of 'mentally ill' persons as resident in "Island Bridge" and "Hardwich Cells" and "House of Industry Patients In Hardwich Cells and Local Asylums", the details of which are illustrated in Table 13 of Appendix 1. This group of people ranged in number from a high point of 957 persons in 1844 to 293 persons in 1853.

The reports relating to the years 1861 to 1874 refer to a cohort of 'mentally ill' persons resident in "Lucan Spa and Houses of Industry Supported by Government." This ranges from 80 patients in 1861 to 25 patients in 1874, as set out in Table 14 of Appendix 1. The "Stewart Institution" which is in Lucan, County Dublin is included in the Inspectors' reports from 1875 to 1888. Table 15 in Appendix 1 illustrates that the occupancy rate for this cohort of people ranges from 29 in the year 1875 to 8 in the year 1888. These 'mentally ill' persons are people who developed what is now referred to as psychiatric illness, such as schizophrenia. Stewarts' institution was originally established, and continues today, to provide a place of residency for people with what became known as 'mental handicap', now referred to as 'intellectual disability'. These are congenital disorders that are present from birth, such as Down-Syndrome. The

persons listed in the Inspector of Lunatics' reports are limited to 'mentally ill' persons accommodated in these institutions, rather than the larger cohort of 'mental handicap' persons who constituted the majority of residents in this institution.

Details relating to 'mentally ill' persons resident in "Single Chancery and Unlicensed Houses" appear in the Inspector of Lunatics Asylums Reports for the years 1895 to 1921, which are set out in Table 16 of Appendix 1. Post 1922, the title of this category changes to "In Single Care in Unlicensed Houses", a category which continues to be used up until the Inspector of Mental Hospitals 1946 Report. A new category, referred to as "In Court Care in Unregistered Houses", appears in the 1949 report, which continues to be referred to until 1956. The details for these categories are set out in Table 21 of Appendix 1. The number of patients in these categories ranges from 86 persons in 1895 to a high point of 266 persons in 1941, which has little impact on the national trend as set out in Graphs 1 and 6.

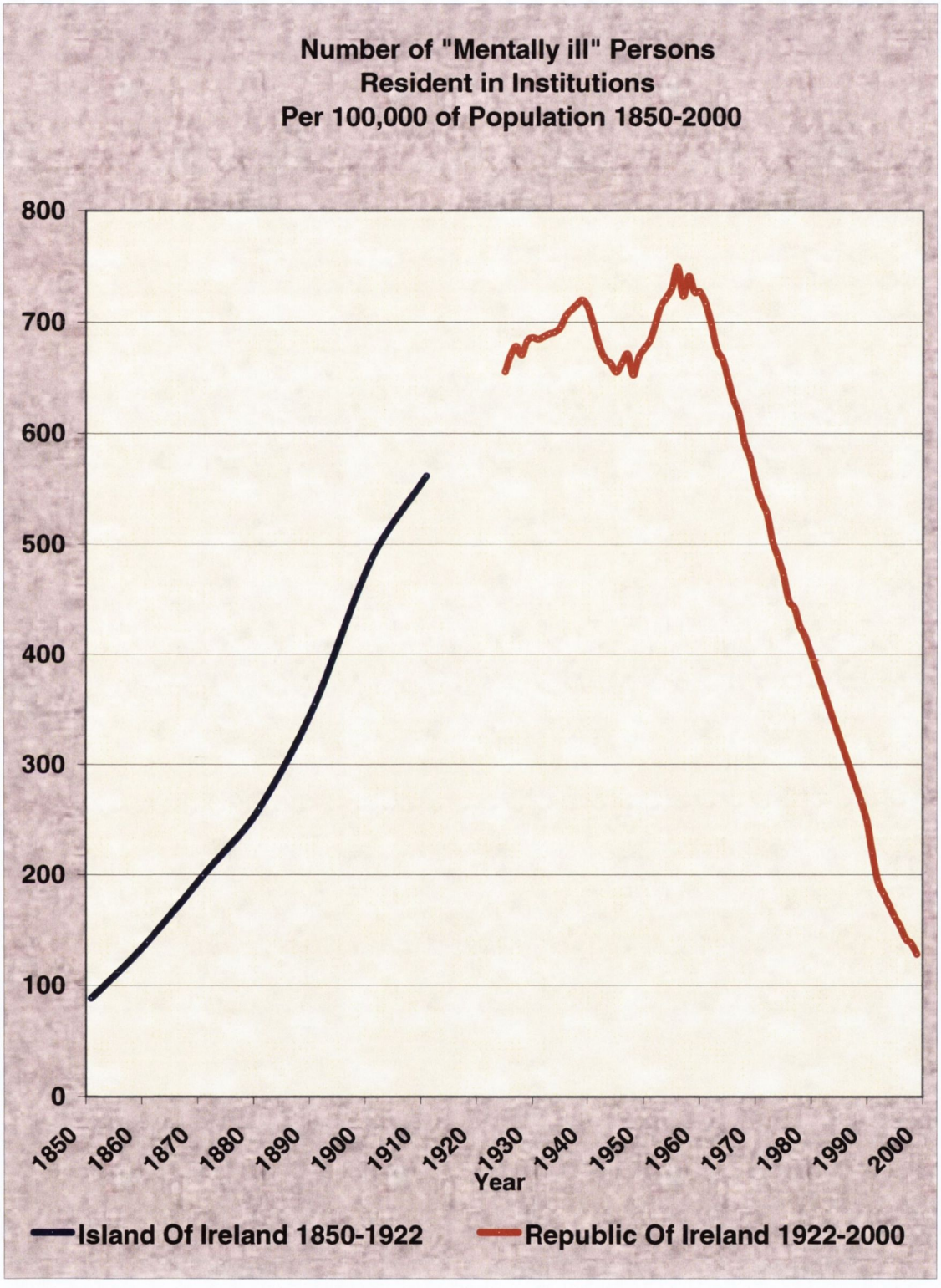
A category of persons appears in the Inspector of Mental Hospitals report for 1927, described as 'mentally ill' persons "Resident in Institutions for Mental Defectives". The number of persons in this category is given as 147 males and 149 females, which is set out in Table 22 of Appendix 1, a category which is only used by the Inspector in the 1927 report. The addition of this category for a single year does increase the overall total of 'mentally ill' persons resident in institutions recorded in 1927 by 296 persons. However, the inclusion of this additional category in 1927 does not affect the overall national trends as set out in Graphs 1 and 6. A total of 20,064 'mentally ill' persons are recorded as being resident in institutions in 1927, which is consistent with the totals from 1925 to 1935, which ranges between 19,500 and 20,500 persons.

Conclusion

This dissertation seeks to provide a historical sociology of institutionalisation of the 'mentally ill' in Ireland, on the Island of Ireland 1800-1921 and in the Republic of Ireland 1922-2000. This chapter presents data which has not been previously available, in particularly a complete and detailed account of the level and rate of institutional residency of the 'mentally ill' in Ireland, including a breakdown of institution type and gender. Comparative international data is also provided so as to indicate and contextualise the empirical idiosyncrasies of the per capita rate of institutional provision in Ireland. This analysis provides for the identification of long-term trends, from the early phases of asylum construction in the early nineteenth century to the demise of these institutions at the turn of the millennium.

The data relating to gender and institution type is important in the understanding of the component parts that constitute the overall national rate of institutional residency of the 'mentally ill' in Ireland. The data set out in this chapter illustrates these features while also giving an account of some relevant socio-economic factors including urban / rural dynamics and occupational status. This data is offered as a contribution to this field of study and it is hoped that it may provide some base information which will be drawn on in studies by other academics in the future. However the primary concern of this dissertation is the provision of a sociological analysis of the long-term aggregate rate of annual institutional utilisation for the 'mentally ill'. Based on Graph 6, the long term rate of utilisation per 100,000 of population is set out in Graph 6.1 below. The various social forces that have shaped the trajectory of the trend line illustrated in this graph are explored in Chapters 4 and 5.

Graph 6.1


Number of "Mentally ill" Persons
Resident in Institutions
Per 100,000 of Population 1850-2000
800
700
600
500
400
300
200
100
0
1850
1860
1870
1880
1890
1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
Year
Island Of Ireland 1850-1922
Republic Of Ireland 1922-2000

Chapter Four

Irish Asylum Expansion 1817-1956

> One of the first tasks to which the Commission addressed itself was to consider the exceptional rates of residency in the psychiatric hospitals in Ireland. No clear explanation has emerged. There are indications that mental illness may be more prevalent in Ireland than in other countries; however there are many factors involved, and in the absence of more detailed research, the evidence to this effect cannot be said to be conclusive (Commission of Inquiry on Mental Illness 1966: xiv)

Introduction

As seen in Chapter 3, large numbers of 'mentally ill' people were institutionalised in Ireland over a prolonged period of time. An analysis of this phenomenon requires a structure that organises the examination of multiple themes across a time span of almost two hundred years. Two core challenges are posed in developing such a structure. Firstly, a thematic analysis needs to provide a detailed consideration of the trajectory of each social force that influenced asylum utilisation. Secondly, a thematic analysis needs to provide for a comprehensive understanding of the interconnectivity of various social forces. As a means of managing these two challenges, the residency of 'mentally ill' persons in Ireland will be considered thematically but across two distinct phases. The rise of institutional utilisation, which commenced in the early nineteenth century and continued until 1956, is examined in this Chapter, while Chapter 5 explores the interruption and demise of such institutional residency from 1956 to date.

This chapter seeks an understanding of the rising trajectory of institutional use beyond the context of the individual mental state. While the existence of human experiences such as profound sadness or emotional distress is not challenged, an actual epidemic of Irish insanity is disputed and it is argued that 'mental illness' and disease are "indeed socially constructed products of cultural and social arrangements" (Turner 1995: 18).

The empirical data required for this study is the precise level and rate of utilisation of Irish asylums / psychiatric institutions over the past two centuries, which is set out in Chapter 3. This data provides both clarity and context on the extent of institutional residency for the 'mentally ill' in Ireland, along with a detailed account of gender and asylum type. Several features pertinent to the expansion phase of institutional utilisation are considered in Chapter 4, each one building on the last so as to develop a multi-layered understanding of institutionalisation in Ireland. The macro-political context, asylum governance and national asylum social policy are firstly explored as a means of setting out the broader context in which these institutions were initially constructed and developed. Against this background the particular relationship, or lack of it, between Church and State in asylum administration is then examined. A consideration of various economic dynamics that are relevant to asylum growth in Ireland is then set out, which leads to examination of the relationship between social deprivation and asylum usage. The last three sections focus on practice specific to Irish asylums including professionalisation, systems of admission and discharge, and the changing nature of categorisation and diagnosis.

The Political Context / Asylum Governance and Asylum Social policy

The Creation of a National Asylum System

> The only Provision made for the Relief of the Insane by the Parliament of Ireland was not merely objectionable in its Principle, but was also wholly inadequate and ineffectual. The Establishment of district Hospitals for the Lunatic Poor does not seem to have been contemplated by the Irish Legislature; a few Cells in Houses of Industry or Workhouses, and in the County Gaols, were the only Places provided for the Reception of Pauper Lunatics. (Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland 1843: i).

Prior to the Act of Union (1800) there was limited social policy or legislative provision set out by the Irish Parliament for the institutional care of 'mentally ill' persons in Ireland. While workhouses did provide a form of public provision for the 'mentally ill', this was minimal, often arising from the initiative of individuals, and it did not constitute a national system "... the cells erected at the Dublin workhouse in 1708, through the activity of Sri William Fownes, were the first public provision made for the care of lunatics in modern Ireland" (Kirkpatrick 1931: 12). Commenting on the uniqueness of the asylum system within the context of early nineteenth century Ireland Hensey observed that;

> The care of the mentally ill formed perhaps the greatest single unit in the health services of the time. Institutions were provided throughout the entire country but, of course, they were simply lunatic asylums. Proper treatment and nursing of the mentally ill was a matter for the future (Hensey, 1959: 7).

At this time Ireland was under British colonial rule and any major decisions relating to state-backed social intervention in Ireland required agreement at parliamentary level in Westminster prior to its administration through Dublin Castle. This created a

degree of disconnection between local demand for state-backed social interventions, the legislative action required to meet social needs, the administration of interventions, and the systems of payment for any such activity. As such during the early years of the nineteenth century there was limited activity at the national level relating to centrally administered service provision such as health care, education and welfare.

Discourse relating to the nature of insanity and technologies for managing those 'afflicted' during the early nineteenth century were stimulated by the development of 'moral interventions' that were proposed and pioneered by a Quaker family, the Tukes, in York, England and Philippe Pinel in Paris. Within these discourses, the existence of organised social interventions, particularly institutional care designed for relieving the suffering of the insane, was considered to be a feature of any progressive, ordered and caring society. Particularly influential was Samuel Tuke's publication *Description of The Retreat, and Institution Near York for Insane Persons of the Society of Friends: Containing an Account of its Origin and Progress, the Modes of Treatment, and a Statement of Cases* (1813), which, based on his broader beliefs as a Quaker, advocated a moral and caring approach to the care of the insane.

Tuke's first publication occurred two years earlier. It resulted after he sent a copy of a paper to an influential Quaker philanthropist and chemist William Allen who was based in Philadelphia (Hunter and Macalpine 1965: 769). Allen had founded an annual *The Philanthropist: or Repository for Hints and Suggestions Calculated to Promote the Comfort and Happiness of Man*, within which Tuke's paper was published under letters to the editor (Tuke 1811). In this paper Tuke stressed the need to avoid

> ..."every appearance of a place of confinement", the need to obtain the patient's "entire confidence and good opinion" and to treat him "with uniform kindness" ...

> The idea ... that it is necessary to commence an acquaintance with lunatics with and exhibition of strength, or an appearance of austerity, has been found, at The Retreat, extremely erroneous, and to be a part of that cruel system, dictated perhaps by timidity, which has so long prevailed, and unhappily still prevails, in many of the receptacles for the insane." (Hunter and Macalpine 1965: 771).

While 'moral intervention' informed the philosophy guiding the early construction of asylums, once established, these institutions were brought under medical control during the mid-nineteenth century, which was discursively portrayed as an aspect of any 'civilised' society. For example, in the second edition of *The Asylum Journal: Published by the Authority of the Association of Medical Officers of Asylums and Hospital of the Insane* the 'Editorial Prospectus' notes that:

> Pinel vindicated the rights of science against the usurpations of superstition and brutality; and rescued the victims of cerebro-mental disease from the exorcist and gaoler. But the victory was not gained in one battle ... The Physician is now the responsible guardian of the lunatic, and must remain so unless by some calamitous reverse the progress of the world in civilization should be arrested and turned back in the direction of practical barbarism. Since the public in all civilized countries have recognized the fact, that insanity lies strictly within the domain of medical science, new responsibilities and new duties have devolved upon those who have devoted themselves to its investigation and treatment (Bucknill 1853: 1).

The emerging guiding principle for such social intervention concerning insanity was classification, a system that provides an organisational framework around deciding who is sane and insane, divided thereafter into curable and incurable. A practice of segregation is then enacted through admission of the insane to an asylum institution specifically constructed to cure, or at least relieve the symptoms of insanity.

Social policy particular to the development of an Irish national asylum system was advocated during the first decade of the nineteenth century. One of the first national initiatives was undertaken in 1805 by the MP for Waterford, Sir John Newport who unsuccessfully attempted to obtain legislation to establish four asylums in Ireland

(Williamson 1970) that would have constituted a national system. While legislation was passed in 1808 providing for the establishment of asylums on a county by county basis in England, this legislation did not provide for similar asylums to be established in Ireland.

Newport's continued advocacy for social intervention influenced the Irish Chief Secretary, Robert Peel, who in 1814 set up an enquiry into the extent of provisions for the 'insane' in Ireland. This enquiry found that the public provision for the 'insane' was both limited and inadequate. In effect, no national asylum system existed at this time. However there was some provision at Cork asylum, founded in 1791, at the Richmond Asylum in Dublin which opened in 1815, and through ad hoc accommodation in prisons and houses of industry. Resulting from this enquiry a 'Select Committee on the Lunatic Poor in Ireland' was established, the principal duty of which was to inquire into the expediency of making further provision for the relief of the lunatic poor in Ireland.

The report of this Committee had a direct and lasting impact on the trajectory of Irish asylum construction. The national network of district asylums that was constructed in light of this report became the cornerstone of institutional residency for the insane from the early nineteenth century until their eventual closure and sale, which was not proposed as public policy until 2006 (Department of Health and Children 2006). This system was national, expansive and expensive and entailed "the establishment of a system of district asylums throughout Ireland... The system, moreover, was to receive central-government loans and was also largely to be regulated centrally" (Malcolm 2003: 317). Drawing on the predominant discourses concerning insanity at this time, classification, segregation, specialisation and moral intervention were endorsed in the

report of the 1817 committee as principles that should guide the establishment of this national Irish asylum system:

> Your Committee beg leave to call the attention of the House to the detailed Opinion expressed by the Governors of the Richmond Asylum, -that the only mode of effectual relief will be found in the formation of District Asylums, exclusively appointed for the reception of the Insane. They can have no doubt that the successful treatment of Patients depends more on the adoption of a regular system of moral treatment, than upon casual medical prescription (Select Committee to Consider the State of the Lunatic Poor in Ireland 1817: 4).

The 1817 report had an almost immediate effect and an Act was passed in 1817 to instigate the establishment of asylums for the lunatic poor in Ireland. This act, along with amendments made in 1820, and a further act, Lunatic Act Ireland 1921, centralised overall responsibility for Irish asylum provision and administration within Dublin Castle, including construction, financing and inspection.

> It will be also observed that finally, in 1817, a Committee of the House of Commons gave it as their opinion, that the only mode of effectual relief would be found in the formation of District Asylums exclusively appropriated to the reception of the Insane, and that effect was given to their recommendation by an Act passed in the same year, 57 Geo. III., 106, granting the necessary powers to the Irish Government to carry out the measure. Under this and the subsequent enactments, 1 & 2 Geo. IV., c. 33; 6 Geo Iv., c.54; and 7 Geo. IV., c.14, nine District Asylums were successively erected and established in different parts of the country (Inspector of Lunatic Asylums 1846: 5).

In effect the 1817 and 1821 Acts led to the initial asylum building project, overseen by the Commissioners for the Erection of Lunatic Asylums, which resulted in the construction of nine district asylums in Armagh, Ballinasloe, Belfast, Carlow, Clonmel, Derry, Limerick, Maryborough and Waterford. This initial phase of the asylum building programme was relatively slow and conservative compared with asylum construction from the mid 1830s onwards. During this initial expansion "there was no great rush to put stones and mortar together" (Walsh and Daly 2004: 16). The initial

scale of the individual asylums building was also comparatively conservative, for example Ballinasloe had only 150 beds on first construction. Also forming part of the national network of asylums was the Richmond Institution in Dublin and the Cork asylum. Although these institutions remained operationally outside the district system until later, 1830 in the case of the Richmond and 1845 in the case of Cork, they were integral to the overall national asylum system from 1817 onwards.

The development of an extensive asylum system in Ireland was very much an exception to the overall pattern of minimal state-backed social intervention. While a small number of workhouses and local infirmaries were established in Ireland during the eighteenth century (Kirkpatrick, 1931), which did receive limited government funding, these were situated within the context of localised intervention rather than national policy:

> ... the Irish authorities had been slow and reluctant to accept any public responsibility for the poor. Workhouses (Dublin 1703; Cork 1735 or houses of industry (Dublin 1773, Limerick 1774) had been much more dependent on local initiative than on central legislation for funding (Reuber 1999: 209)

An important point to note is that the Irish asylum system developed earlier to and operated outside the context of national social policy that was focused on poverty relief. A centralised national system for such relief was not to emerge until the passing of the 1838 Poor Law Act which

> established a tightly organised administration for the relief of the poor, which became responsible for the development of a number of the health services. Substantial powers were reserved under this legislation to the central authority, which in the first instance was the English Poor Law Commissioners. While this body accomplished its initial task of equipping the country with work-houses, remoteness of the Commissioners from the services here made the arrangement an unsatisfactory one for the continued operation of the services. In 1847, the Irish Poor Law Commissioners were appointed to take over the functions of the English Commissioners (Hensey, 1959: 2-3).

In essence, the asylum system was the first centrally controlled national bureaucracy of social intervention, it being established some fifteen years earlier than the national primary schooling system, which was not initiated until the 1831 (Collahan 1981: 4). Hence, if understood as a system of social assistance, the public asylum system was groundbreaking in the Irish colonial context. Alternatively, if contextualised as a system of social control, the asylum system was equally remarkable as it far outpaced prisons in terms of utilisation, a phenomena that continued into the twentieth century and to date, as can be observed in Graph 15.1.

The 1843 *Report of Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland* sets out a succinct account of the operational arrangements of these institutions within this colonial context,

> ... the cost of purchasing a Site, building the Asylum, and supporting the Establishment, is advanced from the Consolidation Fund, but repaid by the contributory Counties. All the principal Officers are appointed by the Lord Lieutenant, and the general Superintendence and financial Administration of the Asylums are vested in Boards of Commissioners, also named by the Government, but acting gratuitously. The annual Accounts are required to be examined and passed before the Board of Audit, and the Asylums are brought under the annual Review of the Inspectors General of Prisons (Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland 1843: iii).

Hence the physical construction, system of financing and inspection of these asylums was under the direct control of the centralised administration in Dublin Castle, administrated through the office of the Inspector of Lunatics after 1846. While the local administration of these institutions was managed by Asylum Boards, they were directly appointed by the Lord Lieutenant. Under this centralised system of control the Irish national asylum system developed and expanded during the early nineteenth century, a positive interpretation of which is given by Walsh:

> The bringing of social order involved the establishment of new social systems, including those for the containment of the lunatic poor. Whether this movement was also driven by a real increase in the incidence of major mental illness around 1800, brought about by forces other that social change, as some have suggested, remains an open question. In any event, as far as Ireland was concerned, the ultimate result was a national lunatic asylum system that was the envy of many other jurisdictions (Walsh and Daly 2004: 15).

Consolidation and Expansion and Continued Utilisation

> The history of the care of the insane in Ireland during the second half of the nineteenth century need not detain us long. It is the record of the consolidation of positions already won, rather than of new ground captured; of steady advance along the lines already laid down, and although at the end of the century there remained much to be done, much had already been accomplished, which, we feel sure, will remain a permanent asset to the community. (Kirkpatrick 1931: 34)

Kirkpatrick's analysis of late nineteenth century asylum expansion is extensively positive and 'progressive'. However his observation of continued growth and consolidation rather than new innovation is quite accurate. While the early network of asylums was initially small, it provided for a centralised bureaucracy that formed an administrative path dependency that shaped the later governance of what was to become a most extensive programme of institutionalisation. However, as we will see later in this chapter, asylum growth in Ireland was shaped by a spectrum of social forces. As such, the centralised administrative system enabled a high rate of occupancy rather than determining it.

Adopting the principles of classification and segregation, these asylum institutions were initially intended for 'the curable' insane. However, this became increasingly ambiguous and the distinction between 'curable' and 'incurable' was not clear from the outset. This distinction was further blurred by legislation introduced in the 1830s and 1860s, which facilitated increasingly ad hoc admission criteria for asylums, this is

discussed in detail later in this Chapter. These admissions were catered for through a continued programme of asylum expansion, which rather than being managed at a local level, were planned, enacted and monitored by the centralised administration based in Dublin Castle.

> Rhetoric identical to that abroad in England of humanitarian concern, of the necessity of classifying the institutionalized poor, criminal and mad, of the superiority of moral therapy to physical remedies was adopted by Irish founders. But in the final analysis this rhetoric was of less consequence than the especially powerful position of the state in early nineteenth-century Ireland. What England saw only in 1845, or France in 1838, Ireland had already witnessed in its essentials in 1817: the legislative provision of public asylums for the entire country (Finnane 1981: 14).

While central government planned and financed the initial construction of asylum buildings, this was repaid through local taxation collected from the counties served by that asylum (Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland 1843: iii). Hence, while local taxes provided the resources for the asylum system, taxpayers did not have any direct power to control the extent of asylum construction and utilisation. As such, there was a lack of connection between the central planning for asylums and the local payment for this expansion.

By the mid-nineteenth century the Irish asylum system was a large and sophisticated entity both in terms of the physical size of its buildings and its extensive national bureaucracy. The existence of this system posed several questions: was expenditure on this asylum system having an impact?; what was the nature and extent of Irish insanity?; and how should this system be further developed? As a means of assessing the overall state of service provision within Irish asylums, a Select Committee was appointed by the House of Commons in 1843 and mandated to consider and report on the 'State of the Lunatic Poor in Ireland'. The Committee was unambiguous in its

recommendation: continued asylum construction and expansion was needed to cater for the insane of Ireland.

> It has been unfortunately found, that although the Accommodation provided in the Ten District Asylums very considerably exceeds that which was contemplated by the Committee of 1817, it is very far from meeting the Necessity of the Case. The Asylums were originally intended but for 1,220 Patients; they now contain 2,028 (Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland 1843: iv).

The committee went on to state that they have formed "the strongest opinion" regarding:

> The Necessity of increasing the Accommodation for Pauper Lunatics in Ireland, and of providing for the Cases of Epilepsy, Idiocy, and chronic Disease, by an increased Number of the District Asylums, by an Enlargement of those Asylums, or by the Erection of Separate Establishments specially appropriated for these Classes of Patients (Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland 1843: xxv).

Responsibility for both inspection and overall policy planning for asylums was consolidated in the office of Inspector of Asylums in the mid 1840s, which will be considered later in this chapter. The predominant themes that emerge from the inspectors' annual reports from 1846-1922 demonstrate a circular pattern of policy planning which entailed a number of characteristics: a perception of the existence of an unusually high rate of insanity in Ireland; the need to relieve communities of the burden of insanity; a colonial duty of care for insane subjects; chronic overcrowding within asylums; concern for the spiralling cost of asylum provision; and further plans for expansion in the form of extensions, annexes and new building projects, which starts this cycle once again. In essence, the inspectors' reports from 1846 to 1922 reinforce the perceptions expressed in the 1817 and 1843 Select Committee Reports, that there is an

actual high rate of insanity in Ireland, while also accepting and advocating the policy of asylum building and expansion as a logical social intervention for the relief of insanity.

Driven by the 1843 Select Committee report and the annual reports of the Inspectors of Asylums, a second phase of building took place in the 1850s with new asylums constructed in Cork, Kilkenny, Killarney, Mullingar, Omagh and Sligo, buildings that were all larger than those constructed in the first wave of asylum building. The 1860s saw further asylum construction and expansion with the establishment of another six district asylums at Castlebar, Downpatrick, Ennis, Enniscorthy, Letterkenny and Monaghan. However, during this phase of expansion there was some discursive critical comment regarding the overall direction of asylum policy in Ireland. For example editorial comment is provided by Charles Bucknill in the *Asylum Journal of Mental Science* who refers to the *1856-1857 Commission of Enquiry into the State of the Lunatics Asylums and other Institutions for the Custody and Treatment of the Insane in Ireland* noting that:

> Since our last issue a royal commission has been issued to inquire into the government and condition of Irish asylums. Ireland is the peculiar land of commissions, because it is the country where no two people can agree upon any one thing. Our only objection to the present commission is that it removes from England the services of Mr. Wilkes and Mr. Lutwidge, and as the number of the English Commissioners is inadequate to the discharge of their own duties, the loss of these valuable services cannot fail to be detrimental to the public interests of this country [England] (Bucknill 1857: 283).

The continued increase in the rate of asylum utilisation during the mid to late nineteenth century, illustrated in Graph 6.1, needs to be contextualised within a wider political dynamic, particularly the increased agitation for Home Rule and the political drive towards Irish Independence. While the asylum system was administered centrally, questions relating to its shortcomings were not a priority of this centralised

administration. During the mid to late nineteenth century, the national question, security and political unrest became the primary issues concerning Dublin Castle and these issues consumed the bulk of the operational capacity of this administration. Similarly, the political energies of those who opposed the Colonial administration were focused on the achieving of independence. Any issue relating to the shortcomings of particular social policy, including the activities concerning the national asylum system, was secondary to the struggle for independence. As such there was limited medical or political discourse within Ireland that was advocating an alternative vision to asylum usage.

> ... while in the early 1900s Britain was stirred by a new discourse on the relation between society and the insane, Ireland remained unmoved: the authority of the state was by this time so seriously compromised that the debate on the 'feeble-minded' passed by without any discernible effect in law or social policy (Finnane 1981: 15).

Finnane also suggests that the principal political dynamic within the boards of individual asylums was competition for representation based on sectarian political interests, essentially party political antagonism along the Catholic / Protestant divide (Finnane 1981). Sectarian antagonism also existed within the context of disputes over the refusal of some asylum boards to appoint chaplains, particularly in the Belfast Asylum. This became a major source of tension between these boards and the central administration at Dublin Castle, which was commented on in *The Asylum Journal* in an article entitled "The Chaplaincy Question at the Belfast Asylum" (Arlidge 1854). An optimistic note regarding this sectarian tension was made two years later by the editor of this journal, who seems to suggest that Irish asylums actually provide potential for sectarian reconciliation.

> The real difficulty of the asylum chaplaincy question in Ireland arises, not from any doubt as the propriety and advantage of affording to the insane the means of

> public worship, but from the fear of introducing into these institutions the elements of religious discord dependent upon the rival faiths which have been so fruitful a source of misery to the country at large. It may be that the Catholic and the Protestant Priest will, in such an abode of suffering humanity as the hospital for the insane, consent to waive their differences, to suspend their antagonism, and to behave towards each other as they never yet have behaved at any time, or in any place. It may be that on ground so sacred they will act towards each other in perfect charity, or at least in strict neutrality." (Bucknill 1856: 135)

Oonagh Walsh (1999) examined some aspects of sectarian tension and the internal politics of asylums, particularly at the Ballinasloe asylum during the late nineteenth century where conflict between Catholic priests and the Protestant management revolved around issues such as the construction of a Catholic Church on the asylum grounds. Walsh proposes that such tensions created alliances that bonded Catholic staff and inmates together. However, the potential for such alliances was limited by the fact that most Irish asylums functioned as 'total institutions' (Goffman 1966), organised through the *Rules for the Regulation of District Asylums* (Inspectors-General 1844: Appendix No. 3. 43-48). These rules dictated clear organisational and operational policies and procedures that ensured the maintenance of clear barriers, both physical and social, between staff and patients. As such powerful social divisions existed within asylums, which militated against strong alliances between staff and patients.

Hence, while there was some sectarian political dynamic within asylums, there was no political agitation for reform of the asylum system as whole. In effect, while there was political consensus regarding concerns over the spiralling scale and cost of the asylum system, no alternative to the national asylum system was proposed from any political quarter during the late nineteenth century.

The massive scale of both the individual buildings and the national asylum system as a whole is recognised by O'Dwyer in *Irish Hospital Architecture: a pictorial history*

who observes that "The lunatic asylums erected in Ireland in the nineteenth century were individually the largest, and in planning terms the most complex, public buildings of their day (O'Dwyer 1997: 10). The earlier buildings were designed by architects, Johnston and Murray, and were generally built to a classic style with a two-storied front elevation and wards containing blocks of individual cells to each side. O'Dwyer notes a design change during the second half of the nineteenth-century with Gothic or Tudor style asylums being built, having three storeys and wards rather than individual cells, which were constructed purposefully so as to allow for the close observation of patients (Reuber 1999).

As mentioned earlier, there was a lack of connection between the central administration, which planned asylum construction and expansion, and the local communities who funded this activity through their taxation. Arising from this there was sustained local protest concerning the tax burden incurred as a result of these institutions, and similar concerns were voiced in relation to asylums in Britain. This tension resulted in the Chancellor of the Exchequer introducing a centralised contribution towards the running costs of asylums in 1874. This payment provided for a fixed rate payment of four shillings per head per week for the maintenance of lunatics in public asylums in Britain and Ireland, with the remainder of costs coming from local taxes (Finnane 1981: 58). While this revenue was intended to both ease the burden of local taxation and improve conditions within the existing asylums, its effect was to inject cash into the asylum system during a period when the Irish inspectors were recommending continued expansion so as to relieve overcrowding, a theme that continued to be a dominant feature of the annual reports up until 1950s. The result of this new flow of revenue was further

asylum construction, particularly in the shape of large scale extensions to existing asylum buildings.

While inspection and control of national asylum policy remained in the Office of the Inspector of Asylums, responsibility for the direct provision and maintenance of asylums was transferred from the central administration in Dublin to elected local county councils during the closing years of the nineteenth century. Commenting on this Hensey notes that;

> The final change in the nineteenth century administration came with the Local government (Ireland) Act, 1898. Under that Act there were established elective county councils, urban district councils and rural district councils... The county councils took over the administration (either direct or through joint committees) of the district lunatic asylums but were not otherwise concerned at the time with the health services (Hensey, 1959: 5).

In practice this provided for a level of coherence in control over both planning and payment of asylum provision. However, at this stage an extensive publicly funded asylum system was already built and fully operational. This system now entailed a large national network of buildings, each with its administration and staffing structure, along with an overarching national bureaucratic and administrative system. While the introduction of limited local governance may have retarded further asylum construction after 1898, the scaling down or closure of these institutions would have been politically difficult. By the close of the nineteenth century, asylum institutions were perceived as a necessary social intervention, while also being of economic advantage to towns in which they were situated. This was particularly the case in rural areas where asylums were one of the largest direct employers, the largest source of cash flow within local economies and the largest consumer of locally produced goods. While there was limited new building compared with the periods of rapid expansion during the mid nineteenth century,

the late nineteenth century did see some continued extension of asylums, a significant example being Portrane in North County Dublin, which was initially built as an auxiliary hospital for the Richmond in Dublin.

The singularity of the institutional policy approach to insanity remained unaltered throughout the struggle for independence, civil war and the setting up of the new state. As set out in Table 24 of Appendix 1, the population of Ireland almost halved from 1841 to 1911, decreasing from 8,175,124 to 4,390,319. This is the same period that saw the institutional residency of the 'mentally ill' increase more than seven times, from 3,498 to 24,655. Hence, at the setting up of the Free State the incoming government was inheriting a large and expensive public asylum system. However, unlike the iconic action of "Philip Pinel striking the chains off the lunatics at Bicetre at the time of the French Revolution" (Saris 1997: 211), national revolution in Ireland did not usher in 'liberation' of asylums, instead they were expanded further.

Within the context of the free state, the Ministers and Secretaries Act of 1924 provided for the establishing of a Minister and Department of Local Government and Public Health, which consolidated statutory authority for all health related services, including lunatic asylums. However, with the exception of the legal changes for asylum admission in 1945, there is a notable absence until the mid 1960s of any strategic policy that provides an alternative to mental hospital utilisation. Hence, the relatively smooth and continuous rise in the level and rate of residential occupancy of the 'mentally ill' from 1830-1956, illustrated in Graphs 1 and 6.1, was underpinned by social policy which was focused solely on institutional provision as the appropriate social intervention for perceived insanity.

Hence, as far as asylum institutionalisation was concerned, partition simply changed the location of government, while the actual physical structures, internal administrative bureaucracy and modus operandi of institutions remained intact. An analogy can be drawn here with the Irish postal system. The post-boxes which were red and embossed with a Royal Crown, were simply painted green and continued to be used in the Irish Republic. This continued usage and expansion of the Irish asylum system would appear to refute theories that locate colonial oppression as the cause of Irish asylum utilisation. However, such theories have continued to be applied in recent years, generally based on the presupposition that colonialism continued to have both a structural and psychological impact after Independence.

For example, Greenslade (1992) proposes that the incidence and characteristics of mental illness among Irish people in the United Kingdom can be understood by drawing on the theoretical work of Fanon, which examines the effects of colonialism (Fanon 1967, 1970), and by deconstructing the diagnoses of mental illness amongst Irish immigrants. "Illness, even in the physical sense, is a socially constructed notion that has consequences independent of the biological organism" (Greenslade 1992: 202). Within this analysis, emotional distress is conceptualised as a sort of cathartic experience of one's historical and social reality, which is subsequently constructed within bio-medical discourse and consequentially diagnosed as mental ill-health. What is constructed as mental illness is proposed as a natural manifestation of the symptoms of colonial oppression coupled with contradictions within the lived experiences of Irish immigrants in the United Kingdom. However, this analysis does not consider the comparatively high rate of psychiatric institutionalisation in Ireland, as illustrated in Bar Chart 1 and Table B

of Chapter 3, and the familiarity that Irish people have with these institutions as locations for intervention during times of life crises.

An alternative explanation may be that the comparatively high rate of asylum utilisation amongst the Irish living in the United Kingdom is a result of the interdependency between communities in Ireland and the asylum as a system of social intervention, coupled with the distress of emigration itself. As such, Irish emigrant communities would be familiar with asylum usage during times of life crises and the act of emigration can provide a context in which such crises occur.

However, a broad colonial or post-colonial theory that seeks to explain asylum expansion is difficult to sustain, particularly if one examines the international experience. For example, Table B of Chapter 3 sets out in rank order the reported level of psychiatric bed provision in 1955 across 84 different countries. No clear pattern relating to a national colonial legacy emerges from this analysis: In fact, countries that have experienced colonial control are ranked at top, middle and bottom of this table.

The Relationship between Church and State

With regard to the relationship between Church and State, the asylum system was administered differently when compared to most other aspects of social intervention in Irish life. The dual roles of the religious in moral intervention and the provision of institutional services in France during the 18th and 19th centuries are highlighted by

Foucault (1967), with religious organisations establishing what is moral and sane or immoral and insane. Foucault also observed the involvement of religious organisations in the provision of services for individuals so categorised. In effect these religious organisations gained control over both the supply and demand for asylum services. A similar analysis of church control is applied to the Irish context by Healy in *Irish Psychiatry in the Twentieth Century* who proposes that "there was a specific interaction between the mental health services and Irish Catholicism that has contributed to the peculiarities of Irish psychiatry bed usage in the 20th century" (Healy 1996: 283).

However, Healy does not demonstrate how this interaction generated increased bed usage. In fact the national asylum infrastructure in Ireland did not develop in conjunction with established religious bureaucratic administrative frameworks. This is unusual in the Irish context as the Church has been central to institutional service provision including hospitals, schools, and reform schools. For example, the church was centrally involved in the prescription of the nature of female sexuality, that being the virginal / maternal (virginal and single or married and procreating), and in providing institutional interventions, in the form of Magdalene laundries, for those who deviated from this norm (Finnegan 2001). While perceived deviance such as homosexuality, alcohol dependence and general non-conformity with social norms were condemned by the Church as immoral and diagnosed by the medics as insanity, the Church had limited involvement on the supply side of this 'market in deviance'.

This lack of Church-State cooperation in asylum administration can be understood by examining the timing of the establishing of cooperation in other areas of social intervention, first realised in the provision of Irish primary schooling. This arrangement

commenced in the 1830's and created an administrative path dependency that resulted in similar arrangements being adopted for many other institutional social interventions from that time onwards. This Church-State cooperation was established within the wider context of the achievement of Catholic Emancipation in 1829. Commenting on this Coolahan notes that;

> This conflict between state and church on the control of schooling pursued a tortuous and labyrinthine path resulting in the state's retaining the concept of a de jure mixed system, which from the mid-century onwards, became increasingly denominational in fact (Coolahan: 1981: 5).

While Government and Church authorities were in conflict they both stood to further their strategic interests through cooperation. For example, in the case of primary education, the Government maintained control over the school structure and curriculum, but by co-opting the administrative structures of the Church it gained both organisational capacity and local compliance. The Church equally befitted by gaining local control over the delivery of education while receiving direct government financing.

However, the administrative structures for the Irish asylum system, having being established in 1817, predated this Church–State arrangement and consequently the Church organisations remained predominantly outside the direct control of the boards of Irish asylums. Furthermore the Church had little control over the education and training of asylum staff. For example, attendants and nurses were educated and trained within the asylums. More crucially, prior to the setting up of the Free State, the Inspector of Asylums was appointed directly by Dublin Castle and all of these men had been educated in institutions that were beyond the particular control of Catholic social teaching. Of the five inspectors appointed during the nineteenth century one was educated at Stevens Hospital and the College of Surgeons Dublin, one in Glasgow and three at Trinity

College Dublin. These inspectors of asylums/mental hospital are considered in more detail later in this chapter.

As such the asylum was one of the few areas of Irish social intervention that remained predominately secular in its administration. It is interesting that unlike reform schools and Magdalene laundries which were Church / State partnerships, extensive contemporary public scrutiny has not focused on the largest sites of Irish confinement, the state-run psychiatric asylums. The reality of the limited impact of independence on the trajectory of asylum utilisation rates, as illustrated in Graph 6.1, coupled with the lack of Church control of asylum social policy, planning and administration, seems to refute Healy's thesis which proposes that:

> ...the process leading to and stemming from Irish liberation lent a distinctive character to services in Ireland for the mentally ill and that they did so in great part through an interaction with Catholic social thinking of the time (Healy 1996: 269).

Changing Economic Structures

The macro economic milieu in Ireland, particularly during the mid nineteenth and early twentieth century, is a factor that also requires consideration when examining the rise and fall of institutions for the 'mentally ill'. As explored in Chapter 1, a complex and dynamic relationship exists between asylum institutions and economic life. The parallel trajectory of industrialisation and asylum construction is a core feature of economic theories proposed as explanations for asylum growth (Foucault 1967). Such a

thesis is further developed by Scull who locates industrialisation as a social force that undermined the capacity of communities to care for the 'mentally ill':

> I suggest that the main driving force behind the rise of a segregative response to madness (and to other forms of deviance) can much more plausibly be asserted to lie in the effects of the advent of a mature capitalist market economy and the associated ever more thorough-going commercialisation of existence. While the urban conditions produced by industrialization had a direct impact which was originally limited in geographical scope, the market system observed few such restrictions, and had increasingly subversive effects on the whole traditional rural and urban social structure. These changes in turn prompted the abandonment of long-established techniques for coping with the poor and troublesome (Scull 1979: 30).

Within this proposal, industrialisation had an impact on both urban and rural communities in a manner which stimulated the development of asylums as an organisational structure and system that would cater for the 'mentally ill'. These institutions also served to separate the unemployable, insane and unproductive from the able, rational and productive, thus providing a society organised in a manner that facilitated the continued smooth development of capitalist enterprise. The application of such economic theories to the Irish case would suggest that asylum expansion during the nineteenth century was a consequence of the penetration of capitalism in Irish society.

However the limited penetration of both capitalism and industrialisation within Irish economic life is a theme explored in some detail in *Family and Community in Ireland*, first published in 1940 by Conrad M. Arensberg and Solon T. Kimball (2001). This was essentially a comparative ethnographic study of rural and small town life in the west of Ireland, particular of county Clare and the town of Ennis. Concurring with O'Brien's (1921) assertion that industrialisation was only tentatively developed and then abandoned in Ireland during the late eighteenth century they argue that:

> the result of the first fifty years of the nineteenth century was that Ireland abandoned all pretence of being an industrial country and came to rely on agriculture to a greater extent than any time formerly and even than in the eighteenth century. The accounts of Ireland at the time of the famine and after it bear him [O'Brien] out. They show a very great lack of any kind of industrial activity other that agriculture. (Arensberg & Kimball 2001: 226)

> County Clare, like other more westerly Irish counties agricultural in outlook, presents a picture in which there is little industrial activity at all, comparatively speaking, other than that involved in agriculture, trading in market towns, and administration and communication. The fact holds pretty generally for the whole of the south of Ireland. (Arensberg & Kimball 2001: 224)

This study does not present Ireland as a static and isolated society. However it argues that the continuity and centrality of the traditional family as the core social and economic system served to comparatively limit the impact of industrialisation and capitalism in Ireland. Commenting on this Byrne, Edmondson and Varley, observed that, "For these authors, change wrought by economic or technological demands continually impinged on the ways Irish people lived, but it was absorbed at a pace allowing it to fit the way of life pursued by the members of the community" (Byrne, Edmondson and Varley 2001: iii).

As demonstrated in Chapter 3 "Regional Variations" and in Tables C and D, there is no sustained correlation between high rates of asylum utilisation and industrialised living within the localised internal Irish context. In fact non-industrialised regions in Ireland, particularly along the west coast, had the most enduring pattern of over-representation within residential institutions from the 'mentally ill'. As such, in contrast to Scull's theory that links industrialisation, changing family dynamics and asylum usage (Scull 1979), the traditional family unit was an enduring feature particularly in the non-industrialised rural regions in Ireland that were over-represented within asylums from the early 1900s to mid 1990s. This period of time saw the most intensive utilisation of these

institutions, reaching a high point in 1956 when Irish mental hospital provision was reported as being the highest recorded internationally, as demonstrated in Chapter 3, Table B.

Conversely, declining asylum utilisation in Ireland as a whole occurred at a time that saw increased economic industrialisation and capitalist enterprise. In 1958 Department of Finance Civil Servant, T.K. Whittaker proposed a series of economic reforms that initiated a concerted government effort to increase industrial activity in Ireland (Lee 1989, Breen et al. 1990). While the results were slow, with continued economic depression and enduring emigration up until the late 1980s, the so-called 'Celtic tiger economy' from the early 1990s to date is very much a product of this pursuit of industrialisation in Irish economic life (Kirby et al. 2002). As can be observed in Graphs 1 and 6.1, there is a marked decline in both the level and rate of institutional residency during this time of industrial growth. Hence, the industrialisation theory of asylum expansion does not explain many key features of the Irish case. The rise in the institutional residency of the 'mentally ill' simply did not occur during industrialisation or advanced capitalism, and conversely the decline in the level and rate of such residency occurred in parallel to the increased industrial economic enterprise in Ireland.

A second thesis that links asylum growth with industrialisation, proposes that 'mental illness' is a consequence of the mental strain induced by the complexity of living in a 'civilised' modern, industrialised and urbanised society. Critiquing this proposal, Saris (1997) observes that the Irish case saw rapid asylum growth within a predominantly traditional and rural society. Based on the regional variations explored in Chapter 3 such

urbanisation theses do not fit with the empirical reality of rural / non-industrialised overrepresentation in asylums within Ireland

Foucault (1967) also explored the asylum as an arena that utilised inmates to engage in forced labour. Those who are socially constructed as 'mentally ill' and hence 'legitimately' unemployable are actually put to productive labour within the asylum. This is an interesting economic analysis that encapsulates several economic dynamics, which sometimes are contradictory. For example, capitalist productivity is realised within the asylum through the labour of those categorised as dysfunctional, either mentally, morally or otherwise, and profit is realised through the successful production of goods or services, derived from the free labour of these asylum residents.

An insight into how the Irish asylum system operated as an entity of production is provided in the Inspector of Lunatics 1845 Report, which provides a detailed breakdown of the type of labour, financial outlay, level of production and net profit arising from such labour. Employment for males included "Gardening Labour, Agricultural Labour, Weaving and Winding, Tailoring, Shoemaking, Carpentering, Cleaning the House, and Miscellaneous Employment". For females, employment included, "Spinning, Needlework, Knitting, Quilting, Fancy work, Assisting in Laundry, Cleaning the House, and Miscellaneous Employment" (Inspector of Lunatic Asylums 1846: Schedule G). Labour for this year provided a source of profit of £2124. 10s. 11.d, which further advanced the logic and rationale for asylum provision. However, this 'free labour' comes at a high cost, as asylum inmates must be housed, fed and supervised, all of which cost more than the profits produced within the asylum.

During the twentieth century, the outsourcing of work from private companies to asylums also became a feature of what was known as 'Industrial Therapy', which was recommended for long-term patients in the 1966 *Report of the Commission of Inquiry on Mental Illness* (Butler 2005). The Commission's views of the benefits of this type of labour were in keeping with those circulating in medical discourse at the time. For example, an article in the *British Journal of Psychiatry* in 1965 notes that

> If patients are to be rehabilitated and the best use made of their personality resources, their lives within the hospital should be as close as possible to normal life in the community, and it follows that like normal citizens they should be employed at productive, useful and satisfying work for which they should receive proper economic rewards. This work may be in a factory setting, but need not exclude in some circumstances work in certain hospital departments (Kidd 1965: 1250).

Industrial therapy in Irish mental hospitals involved the setting up of industrial units on the grounds of asylums, or in some cases in public industrial estates. These units took in outsourced contract work from private businesses, which included contracts such as the packaging of black plastic refuse bags for sale in Irish supermarkets, the construction of electrical wiring looms for a German car manufacturer, and the labelling of plastic security clips for stout barrels for a major Irish drinks company. (The author has personal experience of supervising such work when employed as a psychiatric nurse during the 1980s and 1990s). Patients received a nominal income in return for this labour, and as many of them did not have permission to leave the hospital grounds, this money was often spent in the hospital shop. Such industrial therapy would appear to have assisted private industry by providing a source of labour that could be called on when increased output was required.

The utilisation of free labour within asylums also provided a certain degree of comparative advantage over local industries engaged in the production of similar goods or services. For example, local farmers were at a distinct disadvantage when competing against the agricultural production emanating from asylums, which had the advantage of land and labour at little or no cost. Such agricultural production became a major aspect of asylum life, particularly in rural areas, which was perceived as being both an economic and therapeutic advantage.

> In 1950 the area under cultivation in the farms associated with District and Auxiliary Mental Hospitals was 2,190 acres . . . Apart from the obvious advantage of having a farm attached to a large institution these farms offer a most valuable opportunity for providing a suitable form of occupational therapy for the patients, particularly in this country where so many are engaged in agricultural pursuits in ordinary life (Inspector of Mental Hospitals for the Year 1950: 32).

Hence, in terms of locations of productivity, Irish asylums have a complex set of economic dynamics. While there has been ongoing agricultural and industrial employment of the 'mentally ill' in Irish asylums, profits generated were artificial within the context of the asylum institutions being an overall net sum cost. Hence a point of actual economic profitability was never realised by Irish asylums, as these institutions were a continuous source of exchequer spending. Thus, the expansion and decline of the Irish asylum system would not appear to be as a result of their potential as sites of economic production.

The extent to which private enterprise in direct asylum provision was a driving force in asylum expansion in Ireland also requires consideration. Commenting on this Bartlett and Wright note that

> boarding-out was official policy following the 1857 Lunacy (Scotland) Act. Up to one-quarter of registered pauper and private patients were relocated to households where (usually non-related) families were paid to care for a mentally

> disordered person... Irish authorities, by contrast, apparently resisted attempts to impose a state-sanctioned system of boarding out before World War 1 (Bartlett and Wright 1999: 7).

Indeed the data presented in Graphs 17 & 19, and Tables 8, 16, 18 & 21 of Appendix 1, demonstrates that the use of both 'Unlicensed Houses' and 'Private asylums' was very limited in Ireland during both the nineteenth and twentieth century. While these establishments did exist in parallel to the national asylum system, and at times did receive some government and local-authority funding, the number of patients resident in these establishments was extremely small compared to that of public asylums. The Irish national asylum system was in fact public in all aspects, including planning, financing and administration and there was an absence of what Parry-Jones (1972) described as a 'trade in lunacy', or the franchising out of responsibility for care of the 'mentally ill' to private enterprise. Hence, the analysis that the expansion of the asylum system was a result of capitalist opportunism within a free market in madness is not directly applicable to the Irish case. As such the view that "private provision was indeed very important in certain regions of Britain and Ireland, and did not cease with the rise of the public asylum" (Bartlett and Wright 1999: 10), does not entirely hold when considered within the context of the empirical data presented in Chapter 3.

Social Deprivation

Asylum expansion occurred during the mid nineteenth and early twentieth centuries, which is a period that also saw considerable social deprivation in Ireland

characterised by high unemployment, chronic emigration and at times acute food insecurity. For example, if one considers the Great Famine of the mid to late 1840s, the data illustrated in Graphs 1 and 6.1 demonstrates a rapid increase in overall institutional residency levels between 1844 and 1848. Graphs 13, 17, and 25 illustrate that this increase was a common experience in public asylums, private asylums and work houses, the primary locations of institutional confinement at this time. Oonagh Walsh (1997) observed a 53% cent increase in admission to the Connaught District Asylum in Ballinasloe during 1847. However, the increased institutional occupancy by 'insane persons' was actually most acute in the workhouses rather than asylums during this time. These workhouses had a gross increase from 954 to 2,238 persons considered 'insane' between 1844 and 1846, an increase of 234% over two years (Table 10, Appendix 1). This increased level of admission of 'mentally ill' persons across the various institutions may have reflected a strategy for securing food, as regular meals were served in these institutions throughout the famine.

The impact of the famine on the level of institutional residency of the 'mentally ill' is complex. As demonstrated in Graph 1, the actual gross level of residency was affected, but only in the short-term. The spike in occupancy between 1844 and 1848 is not sustained and, therefore, is not significant to the long-term upward trend in the gross level of occupancy, which rose consistently from the 1820s to 1914. However, population decline, which was accelerated by the famine, as illustrated in Graph 2, did have a profound long-term impact by increasing the rate of institutional residency per 100,000 of population, as demonstrated in Graphs 3 and 6.1.

Within the context of enduring social deprivation, the presence of an asylum within a community provided a major source of social security. While the expressed function of these institutions was to cure or care for the 'mentally ill' they developed a spectrum of other functions, latent functions and at times dysfunctions. These institutions were physically and economically the largest structures in many of the towns in which they were situated and as such they developed a strong connection with the social life of local communities. The close connection between community life and asylum is well illustrated in the case of St. Mary's Hospital Castlebar in publications such as *St. Mary's Hospital Castlebar: Serving Mayo Mental Health from 1866* (McDermot 1999) and *St Mary's Hospital, Castlebar "Snapshots in Time"* (Mayo Mental Health Services Arts Committee 2005), the latter being a photographic history. Nineteen photographs are included in this publication, most of which feature groups or individual staff members and many of these pictures illustrate the enduring nature of connectivity between this institution and its local community. For example, a photograph of St. Mary's Hospital Staff Band in uniform in 1893 is shown on page 7 and page 29 shows a group at a staff Retirement Function some one hundred years later in 1998. These types of social networks provided a strong and enduring bond between staff and the institutions in which they worked, which was also consolidated through various sporting teams and events. The most public sporting event in most asylum institutions was the annual sports days which saw patients, staff and people from the local community participating in various sporting competitions. This is illustrated on page 19 which shows the 1930 sports day at St Mary's with several hundred people watching a race.

The ability of asylum institutions to generate secondary economic activity is illustrated on page 13 of *St Mary's Hospital, Castlebar "Snapshots in Time,* which shows approximately twenty-five people, mostly teenagers delivering turf to the asylum in 1900. Similarly, page 15 shows hospital staff and technicians prior to the installation of the electrical plant at St. Mary's in 1924. While these activities are not directly linked to the confining of the insane or the treatment of insanity, those involved in providing these auxiliary services are reliant on the existence of persons categorised as insane within such institutions to sustain the demand for their labour. As such these institutions provided both a physical and bureaucratic structure within which occupational security could be found by those willing to fulfil various roles such as cooks, gardeners and maintenance personnel and hence there was a local need for the continued usage of the local asylum, which in turn encouraged a high rate of admission. More significantly, certain cohorts of staff developed an occupational function that was specific to asylum life, while also becoming influential to the development of asylum social policy. This is particularly the case for the 'medical managers' of asylums who later became known as psychiatrists, and to lesser extent asylum attendants who became known as psychiatric nurses.

The Professionalisation of Irish Asylums

The Irish asylum system provided an arena in which various occupational groups competed for control. Two professional groups have been most prevalent in developing their practice within asylums - medics and psychiatric nurses. The medical profession was particularly successful in securing the most prominent positions of decision-making

and power within asylums, while the largest professional group was attendants who later became known as psychiatric nurses. These attendants / psychiatric nurses, had overall responsibility for day-to-day patient care, the implementation of prescribed medical interventions and general ward management. This arrangement of medical control and attendant / nurse operationalisation has been reproduced from the mid 1840s until the late twentieth century, and arguably to date.

While a number of texts have been published on the history of medicine in Ireland, there is only limited literature addressing the history and sociology of the professional groups within Irish asylums. Medical history in general, and the history of psychiatry in particular, are often written from within the medical profession itself. Commenting on the limitations of such histories, Nolan observes that, "...these histories have been written mainly by retired psychiatrists who have had particular messages to convey to a particular audience" (Nolan 1993: 1). Such histories tend towards providing progressive histories which chart a progression of ever improving professional intervention. Examples of such histories within the Irish medical context include *Patients, Potions and Physicians: A Social History of Medicine in Ireland* (Farmar 2004) and *Mental Illness in Ireland 1750-2002: Reflection on the Rise and Fall of Institutional Care* (Walsh and Daly 2004). Within the nursing context this style of sympathetic and 'progressive' historical analysis is set out in *Care To Remember: Nursing and Midwifery in Ireland* (Fealy 2005). These histories provide a 'then and now' account of altruistic caring intervention. As such past failings are held as examples of how far the profession has advanced, rather than wrongdoing for which the profession should be called to account. Hence professions write their own history and shortcomings are only

considered in retrospect, which consequentially reassures the profession of its advanced contemporary clinical progress, thus reinforcing its continuing legitimacy and monopoly of clinical practice.

Writings of Foucault (1967, 1973) and Illich (1976) have been influential in providing a theoretical basis on which to challenge positive and progressive assumptions associated with the professionalisation of caring. However, histories of psychiatric care based on such critical theories tend to adopt a philosophical position that situates professional groups as self serving abusers of power. While this certainly provides a context for critical enquiry, it can be done at the expense of acknowledging the existence of human psychological or emotional distress which may benefit from some form of assistance or intervention. This is most prevalent in what is described as the anti-psychiatry movement, which contextualises past users of psychiatric services as 'survivors', which is discussed in some detail in Chapter 5. A more subtle critical analysis of the professionalisation process is provided by Davis and Porter, both of whom transcend simplistic analysis of professional competition, while also exploring the benefits and limitations of professionalisation, both in the context of professional groups and the consumers of their services (Davis 1995, 1996; Porter 1990, 1992, 1993). The core features of health care professionalism are identified by Davis, which includes autonomy, peer accountability, self-regulated registration and a monopoly over an identifiable knowledge and practice base.

It would appear that a contributing factor underpinning the rise of asylum occupancy, illustrated in Graphs 3 and 6.1, is the role and function of the professional groups responsible for the management and operationalisation of these institutions,

particularly doctors and nurses. In providing a consideration of these professional groups care has been taken to avoid a progressive narrative of professional charity and ethical interventions, whilst also endeavouring to resist an anti-psychiatry counterpoint that situates professional groups as solely self serving.

The Medical Takeover

As mentioned earlier, the initial wave of Irish asylum construction in the 1820s and 1830s was informed by a philosophy that proposed moral intervention as the most enlightened and effective response to insanity (Select Committee to Consider the State of the Lunatic Poor in Ireland 1817: 4). Clinical psychiatry had not commenced as a speciality in medicine at this time and hence a medical qualification was not required to secure an appointment as asylum manager. The moral character, temperament and disposition of those appointed to such positions was expected to be high. Commenting on this Hunter and Macalpine note that "Tuke was concerned with the 'importance of personal qualities in those connected with the care of the insane especially in the selection of a manager'" (Hunter and Macalpine 1965: 770). These asylum managers, often referred to as 'moral superintendents', were appointed by the Lord-Lieutenant and in operational terms they were answerable to the asylum boards. These managers had overall responsibility for the day-to-day management of asylums. However, physical needs and ailments of patients were attended to by medics who were appointed on a visiting basis. Prior to 1845, the inspection of asylums came under the responsibility of the Inspector of Prisons.

By the mid-nineteenth century Irish asylums were large scale and complex institutions and as such their potential as locations of occupational power and security increasingly came to the attention of professional bodies. A number of individuals, most notably Francis White, moved to secure leadership and management roles for medically qualified persons within this expanding asylum system.

Kirkpatrick (1931) provides a brief but glowing bibliography of White stating that he "Both as Inspector General of Prisons and as Inspector of Lunatics did yeoman work for the insane" (Kirkpatrick 1931: 37). Born at Carrick-on-Suir in 1787, White studied medicine at Dr Steevens' Hospital after which he opened a hospital on Ormond Quay (on the banks of the river Liffey in Central Dublin), specialising in diseases of the eyes. His professional capacity as a medic within the public health sphere was recognised most notably through his work as Secretary to the Board of Health on the cholera epidemic in 1832 and as surgeon for the Richmond Asylum (Finnane 1981: 41). In 1841 he was appointed one of the Inspectors General of Prisons.

From his position as Inspector General, White was influential in setting out of the *Rules for the Regulation of District Asylums* in 1843. He also advanced the case for the separation of the inspection of prisons and asylums, which was realised in 1845:

> The duties connected with the inspection of these Institutions [Asylums], hitherto performed by the Inspectors-General of Prisons, under the Prison Act, 7 Geo, IV., c. 74 have under the late Act, 8 & 9 Vic. c. 107, been taken from these officers and transferred to a newly appointed Inspector of Lunatic Asylums (Inspector of Lunatic Asylums 1846: 3).

Provision was made for the appointment of two inspectors, and having successfully argued for an independent inspectorate of lunatic asylums, White was appointed to this post in early 1846. One year later John Nugent, a graduate from Trinity

College, was also appointed as Inspector of Lunatics (Inspector of Lunatic Asylums 1846). White served as inspector for a total of eleven years and he died in 1859 "as the result of an injury received in a railway accident while on an inspection tour in 1857" (Kirkpatrick 1831: 37).

White's professional career pathway is interesting as it closely resembles the migration of professional practice that was observed by Foucault in *Birth of the Clinic* (1973). As explored in Chapter 1, Foucault identified a movement of clinical control and medical practice from the context of identifiable disease within the individuals physical body (eye diseases in White's case), to the public social sphere of epidemic (White's role in managing the 1832 cholera epidemic), followed by a medical takeover of control of major public institutions (White's appointment as the first Irish Inspector of Lunatic Asylums).

The principal duties of the inspector of asylums included yearly inspection of public asylums and other places of confinement for the insane. They were also required to produce and publish an annual report. Since 1845, the role of Inspector of Lunatics / Inspector of Mental Hospitals was held by a medic (men in all cases) and it is a role that has continually existed until the passing of the 2001 Mental Health Act which established an Inspector of Mental Health.

Once appointed as inspectors, White and Nugent quickly moved to utilise their position to progress a practice of reserving asylum manager appointments to medically qualified persons, which was assisted greatly by the various provisions set out in the *General Rules for District Lunatic Asylums*. These rules were published within the 1843 *Report on the District, Local and Private Lunatic Asylums in Ireland* (Inspectors-General

1844: Appendix No. 3. 43-48), and in practice they served to consolidate medical authority within these institutions. For example, with regard to the care and treatment of patients, these rules placed the asylum manager in a subordinate position to the asylum medical physician. Rule 16 states that the manager "... shall under the direction of the Board, and subject to the directions of the Physician as to the treatment of the patients, superintend and regulate the whole of the establishment". Rule 29 goes on to state "He is from time to time to report to the Physician such cases as appear to require particular attention or treatment, and cause to be carefully observed such directions as may be given by the Physician" (Inspectors-General 1844: 44-45).

The rules detailing the duties of the physician further reinforced medical authority by making it explicit that visiting physicians' responsibilities were to extend beyond the physical needs of patients. Rule 45 states that "... the Physician is to direct the course of moral and medical treatment of the patients and constant regard is to be had to the means of amusement and employment afforded to them" (Inspectors-General 1844: 46).

Under White's influence, the concept of medical intervention based on scientific process was also introduced within these rules. While, the existence of scientific medical knowledge is not proposed as the rationale for medical control of asylums, medical control of asylums is actually proposed as affording opportunities for developing scientific interventions. In this regard rule 49 states that;

> Every Physician holding or accepting of an appointment is requested to bear in mind, that the object of the Government is not simply to have the bodily ailments of the patients attended, but to assist their recovery by moral or medical means, and to advance medical sciences in the case of lunacy, through the great range of experience which the public Asylums afford (Inspectors-General 1844: 46).

The use of asylums as sites of experimentation was not a new venture. While the philosophy of moral intervention underpinned the early phase of asylum management, patients in asylums across the world were often exposed to bizarre and barbaric interventions, a detailed historical account of which is provided by Porter (2004). Examples of such experimentation in Ireland included the "use of a rapidly revolving swing chair developed by Dr Hallaran of Cork (Robins 1986: 59), copious bloodletting, practised by Dr Edward Percival of the Dublin House of Industry, and the "bath of surprize", a cold bath into which an unsuspecting patient was suddenly plunged" (Williamson 1970: 287).

Supported by the 1843 Asylum rules, White and Nugent strategically utilised their annual reports to progress the medicalistion of patient care, while also advocating the case for the appointing of medics as asylum managers. For example, they fully endorsed the early development of medical education in matters relating to the clinical treatment of 'mentally ill' persons. Such training provided a rationale and justification for the appointment of medics as asylum managers as they now had specialist training and hence 'superior' knowledge relating to insanity.

> An important feature has been added to the medical department of the District Asylums, by the power given by the late Act of the Lord Lieutenant, to establish a system of Clinical Lectures on Insanity by the medical attendants to students of a certain standing, and the system has been already introduced at the Richmond Asylum by an Order in Council date 16th April last; the details are given in the Special Report on the Richmond Asylum...For the advantages to be anticipated for this system of clinical instruction, and for other measures of improvement which have been the result of recent legislation, the Lunatic Institutions of this county are deeply indebted to the late Lord Chancellor (Inspector of Lunatic Asylums 1846: 9-10).

A Special Report on the Richmond asylum makes a brief mention of these lectures stating that:

> ... arrangements have been made by the Board of Governors for having regular clinical instructions given to a few medical students who shall be selected from the other hospitals to attend the asylum at such hours as shall be found most convenient (Inspector of Lunatic Asylums 1846: 13).

Similarly education programmes were also developed in England, for example the following advertisement was placed in *The Asylum Journal* in 1855;

> **Bethlem Hospital. Medical School.**
> The Summer Term for the Study of Mental Diseases in Bethlem Hospital will commence on Monday, the 2nd July, and terminate on Saturday, the 29th of September next. Members of the Medical Profession and Medical Students, desirous of attending the Hospital Practice, are required to enter their names at the Hospital. Admission Fee, £3.3s. The Medical Officers will enter Students and give all necessary information (Bethlem Hospital Advertisement 1855: 224).

These series of clinical lectures, which were restricted to medics, provided an organisational structure for education and training based on a scientific approach to understanding the nature of insanity and the appropriate treatments thereafter. The strategic importance of such 'scientific' education schemes in establishing professional power, which can be maintained and reproduced through the development of medical language, was critically observed by Foucault (1967, 1973). It is interesting to note that these education schemes were in complete contrast to the views expressed during the initial establishing of asylums, when medical intervention was considered secondary to moral intervention. At that time there was "no doubt that the successful treatment of Patients depends more on the adoption of a regular system of moral treatment, than upon casual medical prescription" (Select Committee to Consider the State of the Lunatic Poor in Ireland 1817: 4).

The advantage of medical management over 'lay' management was not only argued on the grounds of superior scientific knowledge of 'mental illnesses'. The higher level of integrity and organisational capacity of medical men was also discursively

advanced during the 1840s and 1850s. For example, in 1856 the editor of the *Asylum Journal of Mental Science* discussed two incidents in Irish asylums, one relating to the violent death of a patient at the Ballinasloe asylum the other relating to corruption in purchasing and provision of supplies for the Londonderry asylum. He notes that:

> It is somewhat remarkable that both these unpleasant investigations took place in asylums in which there is no resident medical officer, both of the asylums being under the control of non-medical *managers*." (Bucknill 1856: 136)

By the mid 1860s the district asylums came under medical management with all new appointments being confined to medical qualified persons. This created a situation where there were two key medical appointments to each asylum, namely, the manager and the position of visiting asylum physician. In parallel with these appointments, the position of Inspector of Lunatics was also reserved for medics. Tensions and professional conflict within asylums emerged between the medical managers (medical superintendents as they became known), who held full-time posts but worked under an asylum board, and the visiting physician who were independent practitioners. While these were separate appointments there was an overlapping of responsibility, which led to conflict with regard to superiority and clinical autonomy.

Disputes relating to competing clinical autonomy within asylums gathered some momentum during the 1850s (Robins 1986), with various medical organisations taking opposing views. The Association of Medical Officers of Asylums and Hospitals for the Insane supported the medical managers and the Royal College of Physicians of Ireland backed the visiting physicians (Finnane 1981). It is interesting to note that this dispute for control was occurring at a time when medical training and practice had established little or no credible knowledge of mental illness, a fact that would appear to be an

impediment to either group claming clinical competence over this practice. This dispute was resolved somewhat in 1862 when a revision of the rules for the management of asylums gave the resident medical superintendents, who by this time had replaced most lay asylum managers, overall responsibility for patient care. However, this continued to be subject to consultation with the visiting physician and conflict continued until 1891 when the Lord-Lieutenant finally gave an order stating that any future vacancies for the position of visiting physician were not to be filled, and so the post became obsolete. This essentially confirmed the medical manager's position as the principal point of control over the asylum management and patient care, a situation that continued to exist until the close of the twentieth century.

The overall medical management of asylums provided an opportunity for the application of scientific principles to the already established practice of classification, segregation and selective intervention. In essence, such medical control over asylums, both in Ireland and abroad, provided the context for the development of a speciality within medicine which was later to become psychiatry. Hence, it was not the existence of a medical speciality that led to the medical management of asylums. In fact it was the securing of medical control over these institutions that led to the emergence of the speciality. There are three main phases within this process, firstly the development of social policy that instigates asylum construction, secondly the medical takeover of asylum administration and management, and thirdly the application of scientific and medical principles to asylum work and to the development of modern psychiatry.

A consideration of the various approaches adopted by those appointed as Inspector of Lunatics provides some insight into the power of individuals to alter the

trajectory of asylum growth. The White / Nugent inspection combination appears to have been quite energetic and driven. They appear to have been particularly instrumental in establishing medical control over asylum inspection and management. However, the appointment of George Hatchell, who succeeded White in 1857, led to a Nugent / Hatchell inspection regime. This partnership was to last some thirty-three years and there is more than one account of the work ethic that characterised this combination.

Kirkpatrick arguers that John Nugent, who was knighted after his retirement, was "a strenuous worker at a time when the work of an Inspector was much more difficult than it is at present" (Kirkpatrick 1931: 37). He also pays tribute to Hatchell, a Fellow of the College of Surgeons, who "was associated with Nugent as Inspector for thirty years" (Kirkpatrick 1931: 37). However, a very different account is given by Finnane who argues that:

> As with George Hatchell ... it is doubtful whether Nugent had any experience of lunatic asylums prior to his appointment. During more than forty years of office he failed to show that his conception of his role went any further than a rather mundane administration of institutions (Finnane 1981: 64).

A full chapter section, entitled *The Decline of the Inspectorate*, is provided by Finnane (1981), which explores the Nugent / Hatchell tenure of inspection in detail. This period of inspection was characterised by conflicting roles between inspection and administrative responsibility, nepotistic appointments (two sons of Hatchell were appointed asylum superintendents), conflict between asylum boards and inspectors and poor standards of investigating cases of mistreatment, including the death of patients. This situation was aggravated by the fact that Hatchell was unable to attend properly to his role as inspector during the 1880s and "Nugent, who turned 80 in 1886, was therefore left with the bulk of the duties" (Finnane 1981: 67). During this period confidence in the

inspectors was low and dissatisfaction was being expressed by asylum boards and by medical colleges.

This situation was 'redeemed' in the 1890s with the appointment two new young and energetic inspectors, George Plunkett O'Farrell and E. Maziere Courtenay. Both were high achieving medical graduates of Trinity College and these two men were held in high regard by their medical peers. O'Farrell had previously been an Inspector of the Local Government Board and Courtenay had been Medical Superintendent of the Limerick District Asylums (Kirkpatrick 1831: 38). "These new inspectors threw themselves into their work with a sense of mission, discovering abuses, negligence and degeneration of the system wherever they went" (Finnane 1981: 69). However, while these new inspectors were energetic in the role of inspector, their annual reports indicate that their vision for improvement was narrowly focused on asylum expansion.

These three early inspection partnerships, White / Nugent; Nugent / Hatchell; and O'Farrell / Courtney, had distinct characteristics - the Nugent / Hatchell tenure from 1857 to 1890 being distinctly less active and more problematic than the others. However, as can be observed in Graph 3 and 6.1, while there is marginally greater increase during the White / Nugent and O'Farrell / Courtney periods, the overall trajectory of institutional residency of the 'mentally ill' is reasonably consistent from the early 1850s to 1910. As such, it may be argued that individual actions have their greatest impact during times of change in broader social structures and systems. For example the influential activities of Francis White take place during the mid nineteenth century, which is the first point of conjuncture identified as having an enduring impact on institutional residency, as set out in Illustration 1. However, once the system of medical inspection was established it was

reproduced and continued to function regardless of the personal action, energy or intentionality of the later inspectors appointed to this role. This would appear to suggest that intentional individual agency is most influential at particular points of conjuncture when patterns of social action or 'tendencies' are being shaped. Once embedded within organisational systems and structures, these tendencies appear to have enduring influence. This theme is considered further in Chapter 6.

Psychiatric Nursing

When considering the professionalisation of asylums, the second professional group of particular note is psychiatric nurses. This profession emerged from the training of the cohort of staff that was responsible for day-to-day patient care. This cohort of staff members have been consistently employed in Irish asylums / mental health system since its inception in early 1817. However, the terms used to refer to these staff has changed several times including keeper, servant, attendant, nurse, asylum nurse, mental nurse, psychiatric nurse and now mental health nurse. The *General Rules for the Governance of all the District Lunatic Asylums in Ireland* 1843 sets out the duties for "Nurses", referring to female staff, and "Keepers," referring to male staff who had similar responsibilities to their female nursing counterparts. It is interesting that the term "Keeper" is used in these 1843 rules, which is a term particular to the English system referring to those running small private asylums. As mentioned earlier there was very limited private enterprise in providing asylum houses in Ireland, and hence while there were men employed on the public wards of Irish asylums, they are not directly comparable to asylum keepers in England.

> ... the term keeper was applied to those entrusted with the care of the mentally ill. 'Keeper' referred both to the owner of the house in which insane patients were cared for, and to those employed to run such houses (Nolan 1993: 6).

The 1885 *General Rules for the Government of District Lunatic Asylums in Ireland* does not set out the duties of nurses and keepers but does so for "Attendants and Servants", which closely corresponds to the duties listed in 1843. The hierarchical relationship between Attendants/Servants and medical superintendents is made clear in the 1885 rules:

> Attendants and servants, both male and female, in their various departments, shall be directly responsible to the Resident Medical Superintendent, and shall observe habits of cleanliness, order, and subordination (Lord Lieutenant and Council of Ireland 1885: 16).

The duties of attendants include getting patients up each morning, ensuring the ward is in proper order, ensuring patients are clean, serving food at meal times and reporting to and carrying out the instructions of the medical superintendent:

> They are to be present when the patients are at meals. They shall pay particular attention to the clothing and becoming appearance of the patients. . . They shall, in their communication with the Medical Officer and Matron, state all the circumstances relating to each patient within their knowledge, and study, as much as possible the character and peculiarities of the different lunatics under their charge (Lord Lieutenant and Council of Ireland 1885: 16).

As such the asylum rules firmly placed a large cohort of staff under the direct control of medics. The role of these staff rotated around the cleanness of both the ward and patients, observation of the patient and the implementation of medically prescribed interventions. Asylum institutions have demonstrated a remarkably robust capacity to reproduce practice, and the duties set out in 1843 and restated in 1885 closely resemble the practice of psychiatric nurses working in institutional settings at the close of the twentieth century.

Attendants / nurses held little power individually. However, collectively they constituted the largest group of employees and as such were a sizable social force within these asylums. This cohort of employees was also a social force in the communities in close proximity to asylums, as they provided both a direct and indirect injection of capital into local economies. However, the terms and conditions of employment for these staff were poor and there was limited protection with regard to security of tenure in the early years of asylum expansion. This situation was improved somewhat in 1896 with the formation of the National Union of Asylum Attendants in Ireland, a development which encountered significant resistance from the medical superintendents and the inspectors of asylums. Notes within the Inspectors' reports relating to strikes and industrial action portray the continued vulnerability of asylum staff within the context of employment rights. These notes also portray the Inspectors' general lack of support for this cohort of asylum staff. For example, in a drive to reduce costs in Letterkenny Mental Hospital during 1924, a management sub-committee recommended a 10% reduction in staff pay and the abolishing of certain allowances. Commenting on the ensuing strike, the Inspector of Mental Hospitals comments that:

> On the 1st of April at 7 am., (1924) the attendants, male and female went on strike, the engineer and plumber joined the strikers later in the day. Only seven officers remained in charge of 616 patients. On the 3rd April, the Committee held a meeting at which a deputation from the Mental Hospital Workers' Union was received. The Committee adhered to the decisions they had taken. As no settlement was arrived at, the recruitment of a new staff began on the following day and within a short period the places of those on strike were filled and normal conditions restored. At the annual inspection on the 20th November following, I found the institution in good order and the patients properly cared for. The new staff were carrying out their duties zealously and to the satisfaction of the Resident Medical Superintendent (Inspector of Mental Hospitals 1924 : 17).

In some cases the Inspectors' reports seem to indicate that asylums actually improved as a consequence of staff removing their services during strike action. For example, the report of a strike at Clonmel asylum in 1921 appears to indicate that the general health and indeed survival of patients was actually enhanced during the strike within the asylum:

> The most noteworthy event in the administration of this Asylum during the year was a strike amongst the attendants, which lasted three months, *i.e.* from 10th June to 9th September. Notwithstanding that the entire work of the institution during that period had to be carried on by the higher officials, with the assistance of patients, it was kept, on the whole, very clean and in good order. . . The patients had to live largely on tinned food, without fresh meat or vegetables, owing to the impossibility of doing more than the minimum of cooking. Washing had also to be done in cold water, and the clothes had to be dried in the open air. In spite of all these drawbacks, the health of the patients was wonderfully good, and the death-rate was only 7.4 per cent of the average number resident during the year, which is 1.9 per cent lower than the average of all the Asylums. The greatest credit is due to the Medical Superintendent, and the other superior officers, who, under extreme personal strain and risk, managed to maintain so tolerable a state of affairs ; and it is especially surprising that no suicide or fatal accident occurred, the only event of importance being the escape of about 37 patients. Apart from the consequences of the strike, the Asylum was maintained in excellent order throughout (Inspectors of Lunatic Asylums 69th Annual Report 1921: Page xx).

Localised programmes for the training of attendants began to be established at the close of the nineteenth century. For example "a course of lectures on elementary anatomy, physiology, and immediate treatment of injuries and accidents" was given to nurses and attendants at York asylum by Dr Hitchcock in 1886 (Rollin 2003: 295). Similarity "... in the 1890s, the then medical superintendent of the Richmond Asylum (Grangegorman Dublin) insisted that attendants seeking promotion should pass an examination" (Commission on Nursing 1998: 37). However, it was not until 1919 with the passing of the Nurses' Act that a national register for Asylum Nurses was established. This Act provided for the separate registration of asylum nurses and nurses who worked

in medical hospitals who were referred to as general nurses, a model which was subsequently adopted in the UK and later in its colonies. Entry to this register was secured through three years of training and the passing of examinations. This training and examination was overseen by medical personnel and was firmly based on the medical model. The effect of this formalisation of training was to further embed a system of medical control over patient care which was now implemented by a trained and disciplined nursing staff.

Hence, a medical takeover of Irish asylums occurred between 1840 and 1860 and was further embedded through the establishing of medical inspection along with hospital rules and regulations. This was further consolidated by the increased regulation and training of asylum attendants / nurses, who provided the labour force capacity required to enact medical control. This medical professionalisation of Irish asylums occurred during the same period that saw a rapid expansion of Irish asylum construction and utilisation, as illustrated in Graphs 3 and 6.1.

At first glance it would appear logical to apply an anti-psychiatry thesis to explain this expansion. Such an explanation would situate asylum growth within the context of the motivations of the medical profession who sought to expand their clinical power base. As such, psychiatric practice is considered to be a process that diagnoses, categorises and treats normal aspects of human life, resulting in the creation of an industry based on the biomedical correction of dysfunctional human emotion (Samson 1995).

While this proposal has some merit in the context of medical inspection and management of asylums, such an anti-psychiatry thesis does not take cognisance of the fact that Irish legislative provisions during the mid-nineteenth century actually moved

control of asylum admissions away from medics, placing admission within the judicial context. As such, while medical professionalisation appears to be a factor in Irish asylum expansion, the trajectory of this expansion cannot be explained through the blunt application of an anti-psychiatry thesis. In particular the fragmentation of control over asylum admissions requires some detailed consideration.

Admission and Discharge

As explored above, legislation passed in 1817 instigated the establishment of a centrally administered national asylum system in Ireland. A number of Acts and amendments were subsequently passed which provided for the construction, payment and inspection of asylums, which in essence underpinned the social policy of asylum provision.

Legislation that set out the procedures for asylum usage also had a direct and profound impact on the trajectory of Irish asylum growth. Of particular importance is the passing of various Acts that regulated the modes of admission to asylums. These Acts set out the rights and responsibilities of the various parties involved in this admission process including the admitted person and their family, doctors, attendants and nurses, hospital management, the police and magistrates.

In essence, admission to an asylum or mental hospital, particularly if involuntary, entails the removal of certain civil liberties. Such an encroachment on one's rights and freedoms is usually confined to the context of criminality, which is established through a

judicial process. However, a number of Acts passed in the mid-nineteenth century created a practice and tendency which saw asylum admission being administered through a judicial process, which blurred the distinction between criminality and mental illness. The nature of such legislative provisions would appear to be closely linked to the rise of the level and rate of asylum utilisation illustrated in Graphs 1 and 6.1.

Early Provisions

While the focus of this study is the nineteenth and twentieth centuries, a brief consideration of early legal provisions for insanity are worth noting. Robins (1986) considered the legal provisions set out in Brehon Law in Ireland, which he suggests encompassed a complex and very complete body of ancient laws in the pre-Christian era. These laws had various provisions regarding the reduced rights and responsibilities relating to individuals categorised as insane, which afforded both protection from mistreatment and a degree of immunity from normal social responsibility. Contracts could not be made by 'fools', who were not held accountable to the same degree as 'sane' persons for wrongdoing or for crimes committed. If some incident did occur, those responsible for the care of the 'fool' or 'lunatic' could be held accountable if they had not taken measures to prevent such wrongdoing. Brehon Law also made provisions against the "insane copulating, marrying or bearing children" (Scheper-Hughes 1979: 153), and there were general obligations on the family of a fool or madman for their care, and non provision of such care would incur a fine.

In essence, Brehon Law provided protection for insane individuals within a community setting. As such, its primary legacy was the absence of systems of mass

segregation and institutional confinement. The spread of Christianity, followed by colonisation, saw the influence of Brehon Law declining. Hence, nineteenth century legislative provisions for institutional practice did not build on a previous tradition or legal practice of institutionalisation.

Asylum Admissions Pre 1838

While early legislation for the construction of asylums was reasonably clear, legislation concerning admission to asylums developed through the passing of a number of Acts and amendments and these were not always sequentially logical and, at times, practice did not conform to the legal provisions set out. The confused nature of Irish insanity legalisation was commented on in the *Asylum Journal of Mental Science*, the editor noting that:

> These Acts have been so frequently amended, and have been so mixed up and intertwined with one another, that the most pressing necessity exists for reducing them into a simple and intelligible form, in the shape of one or two comprehensive statutes. (Bucknill 1856: 133).

Before 1838, admission to an asylum was primarily managed under Lunacy Acts of 1821 and 1826 (Prior 2003). Such admission was normally made through an application to the manager of the asylum and was subject to the approval of the Asylum Board. Such application was usually made by a family member, and the patient would be medically certified as to the nature of their insanity.

In the context of criminality the Act (1821) made provisions for the admission of a person who had committed a crime but was acquitted on the grounds of insanity. Such persons could be committed by a magistrate directly to an asylum and held there at the 'pleasure of the Lord-Lieutenant', which in effect entailed long-term asylum residence.

While this provided some grounds for admission through a judicial process, it was within the context of a crime actually being committed. However, this Act did not provide for any proactive asylum committal as a means of preventing future crimes. Hence, the persons appearing in front of the magistrate were there due to their criminality, not their insanity.

While the provisions for admission prior to 1838 did lead to overcrowding, the Asylum Boards and managers had a level of control over admission rates. This was to change radically with the judiciary gaining the power to legally categorise a person as a 'dangerous lunatic', a shift that was to have a profound impact on the trajectory of asylum usage in Ireland from 1838 onwards.

Dangerous Lunatics

The murder in Dublin of the Director of the Bank of Ireland resulted in a public outcry that was a catalyst to the passing of the 1838 Dangerous Lunatics Act (Robins 1986: 144). This murder was committed by a 'lunatic' wandering the streets of Dublin after being refused admission to the Richmond Asylum. The resulting Dangerous Lunatics Act provided for the proactive prevention of criminal acts, through the identification and detention of dangerous lunatics. This act allowed two magistrates to commit a person directly to a gaol if they were satisfied that he or she was a dangerous lunatic, and was likely to commit a criminal offence. In informing their view, the magistrates were entitled, but not obliged, to seek a medic to give an opinion regarding the mental state of the person in question.

However, no criteria for insanity were set out in this legislation, and as discussed later in this chapter, classification systems used in medical discourse frequently changed and included categories that were poorly defined and loosely applied. If found to be a dangerous lunatic, the person in question was committed to prison where they would remain or be transferred to a district asylum until they were released through a judicial order or by an order of the Lord-Lieutenant.

Hence, under this legislation magistrates had primary authority for deciding if individuals were insane and also if they were a dangerous lunatic. As magistrates were not empowered to commit such persons directly to asylums, the managers and boards of asylums maintained a degree of control over admission. However, a dangerous lunatic "... could be transferred to a district asylum without any further recourse to local magistrates, whenever a place became available" (Prior 2003: 529). This legislation had the effect of positioning asylum admission as a judicial matter rather that an issue of illness, which "in the early years of asylum construction in Ireland, established an intimate link between insanity and criminality" (Oonagh Walsh 1999: 225). This contrasts with the situation in England where insanity was linked with poverty rather than criminality, insanity in England being managed alongside the provisions for poverty alleviation.

In practice the implementation of the Dangerous Lunatics Act proved to be problematic. There were few checks and balances to prevent the misuse of its provisions, most notably evidence given by relatives seeking admission was not initially given under oath, a situation changed by an amendment made in 1845. Prompted by concerns regarding the loose utilisation and abuse of the Dangerous Lunatics Act, a circular was

sent to magistrates cautioning them on its proper use. This circular is interesting as it sets out both the manner in which the Dangerous Lunatics Act was being utilised and also the unintended consequences on asylums, particularly a pattern of judicial committal outside the control of asylum boards.

> The Lord Chancellor wishes to draw the Attention of the Magistracy of Ireland to the limited Power given by the 1st & 2nd Victoria, c. 27, as its Provisions appear to have been misunderstood. Their Power is confined to Cases where a person is discovered and apprehended in Ireland, under Circumstances denoting a Derangement of Mind, and a Purpose of committing Crime, for which, if committed, such Person would be liable to be indicted, and Two Magistrates have Power to act, it they are satisfied that such Person is a dangerous Lunatic or dangerous Idiot. The Power therefore can be exercised only where, 1, the Person is a *dangerous* Lunatic or Idiot, and-2, where he is discovered and apprehended under Circumstances denoting, 1, not merely a Derangement of Mind, but, 2, a Purpose of committing Crime, for which, if committed, he might be indicted. Now under this Power Lunatics in safe and proper Custody in a Poorhouse have been committed to Gaol merely to relieve the Poorhouse, at the Expense of Gaol; and the Act has been resorted to in order to procure a Place of Confinement for Lunatics where the District Asylums are full. With this view the Friends of a Lunatic induce him to commit some trifling Act-e.g. breaking a Window, or striking some Person,-and then take him before Magistrates, and procure his Committal as a dangerous Lunatic to Prison, from whence in the course of Time he is transferred to a Lunatic Asylum; and this Plan prevents those Checks against improper Admissions to the Asylum which are enforced in other Cases. These Abuses ought not to be permitted. The Lord Chancellor has desired that a Return may be regularly made to him of all Lunatics committed to Prison under the Act of Victoria, but he feels assured that the Powers of the Act will in future be exercised with great Caution, 18th March 1843. Edward B. Sugden, C. (Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland 1843: xii).

While admission as a dangerous lunatic became the predominant route of admission, a non-judicial admission directly to the asylum was possible. Such an admission could be enacted based on the recommendation of a family member or friend, endorsed by a medic and subject to approval by the Board of the asylum. In addition, the person seeking the admission of a relative or friend had to provide an undertaking to take back this person when requested to do so by the asylum Board. This power over

admission and discharge provided asylum boards a degree of power to act as gatekeepers. However, this power was undermined through the introduction of provisions for emergency admission, which were set out in the 1843 Rules for Public Asylums. The rules stated that:

> Every patient to be admitted upon a special direction by the Board, unless in cases of urgency, when the Physician may admit upon his own authority, stating of the face of his order the grounds upon which he acts (Inspector General 1844, Appendix No. 3: 44).

Hence, the power of asylum boards to control asylum growth rapidly eroded as a consequence of admissions being made through the emergency provisions within the asylum rules, coupled with the extensive use by magistrates of the 1838 Dangerous Lunatic Act.

The 1838 Dangerous Lunatics Act was passed for the purpose of public safety, and as such was a public provision for the protection of the community. The local enforcement of this Act was enabled through the establishment of the Royal Irish Constabulary in 1833, which provided the policing capacity required to make this legislation operational at a community level. As committal of a dangerous lunatic was made by a judicial order, it was not conditional on the provision of any undertaking by relatives to accept responsibility for the care of the confined person if discharged. Furthermore, the Act provided for the committal of all persons deemed to be dangerous lunatics, and as such there was no requirement to establish that the person being committed was living in a state of poverty. While access to work-houses, houses of industry and other institutes of social intervention was restricted to those who could demonstrate poverty, the lunacy laws did not restrict access to the poor. Hence, the confinement of a relative as a dangerous lunatic through a judicial process was more

permanent and carried fewer obligations than admission directly to the asylum. In essence "as far as the patient's family was concerned, this was the simplest method of ensuring admission" (Prior 2003: 531).

The question of different types of stigma arises here. While placing a relative in a poor-house signified a failed or impoverished family unit, having a relative confined as a dangerous lunatic was associated with a dysfunctional individual within a family unit. Indeed the community may expect the family to institutionalise a family member if they are perceived as a threat to the community.

Critically editorial comment of the Irish Dangerous Lunatic Act was provided in the *Asylum Journal of Mental Science*, particular attention being drawn to the bizarre situation where magistrates needed to ascertain derangement of mind while also predicting future crime:

> It appears that by the act above cited, which received the royal assent on the 11th of June 1838, two justices of the peace may commit to jail any person discovered and apprehended under circumstances denoting derangement of mind, and a *purpose* of committing an indictable offence; the Lord Lieutenant having the power to order the removal of patients thus committed to the district asylum. To the English reader this statute certainly appears a strange piece of legislative wisdom, since the power of attributing to an insane patient the purpose of committing an indictable offence, indicates a degree of mental introspection, in which imagination must take a greater part than common sense (Bucknill 1856: 130.

Bucknill goes on to suggest that the problem with this legalisation existed not in the provisions of the Act itself, but the manner in which these provisions were applied by Irish magistrates. While the provisions of the Dangerous Lunatics Act were confined to Ireland, he suggests that magistrates in England could in effect manage to commit 'insane' persons, if they were inclined to do so. Similar to the earlier criticism contained in the circular sent to magistrates by the Lord Chancellor in 1843, Bucknill makes the

point that Irish magistrates were over-zealous in the use of committal legalisation in comparison to the more conservative approach taken by their counterparts in England.

> Almost any insane person could, by a little management, be made actually to commit an indictable offence, and if the justices of the peace of this country [England] were ready to avail themselves of their power of committal to the same extent that we learn from the Inspectors that they have done in Ireland, the class of what is called criminal lunatics would be rapidly increased (Bucknill 1856: 130-131).

The high level of admission was further compounded by a comparatively low level of discharge which served to further swell the number of long-term residents in institutions for the 'mentally ill' in Ireland. This also received editorial comment in *Asylum Journal of Mental Science* with Bucknill noting that,

> The number of patients discharged cured from the Irish asylums does not present quite so favourable comparison with English institutions, the cures bearing the proportion of 38 per cent of patients admitted, while in the English asylums according to Dr. Parsey's calculations, the average proportion of cures is 42.9 per cent of the total number of admissions (Bucknill 1856: 134)

The utilisation of the 1838 Dangerous Lunatics Act served to blur the boundary between criminality and insanity. Both 'criminal' and 'lunatic' appeared before a magistrate and prison was the location of detention, dangerous lunatics being then transferred from prisons to district asylums when places became available. This system of criminalised admission to asylums was consolidated further by the passing of the Dangerous Lunatic Act of 1867 which provided for magistrates to commit an alleged dangerous lunatic directly to asylums rather than to a gaol in the first instance.

The 1867 Dangerous Lunatics Act operated in much the same way as the 1838 legislation. The alleged dangerous lunatic was brought before two magistrates, who were now compelled to obtain a medical certificate stating the mental state of the person in question. The magistrates could then decide if the person was in fact a 'dangerous

lunatic'. If satisfied that this was the case, they were now empowered to order a committal directly to a district asylum. Such an admission was not subject to the approval of the Board of the asylum and did not have any inbuilt system of automatic review.

Finnane (1981) makes two valid observations in relation to the role of doctors in these judicial admissions. Firstly, as discussed earlier in this chapter, medics during the mid-nineteenth century had not yet established expertise in matters relating to mental illness and there was nothing in their training that particularly equipped them for distinguishing the sane from the insane. Secondly, the judicial process contained an inbuilt financial incentive for doctors, hence "many doctors found it preferable to arrange a dangerous lunacy committal for their poor patients and receive a sizeable fee for it than to sign a 'house form' ... and receive nothing at all" (Finnane 1981: 112). A fee of £2 was provided as a means of covering all expenses associated with the admission including travel, daily expenses and police costs. However, it was common practice for the certifying doctor to receive this payment directly and in full.

The passing of this legislation had an almost instant effect on the number of mentally ill residents in prisons, decreasing from 334 in 1867 to 53 in 1868, and again in 1869 when only 5 persons in this category remained in Irish prisons (Inspector of Lunatics Reports 1868, 1869 & 1870), see Table 11 of Appendix 1. The wide scale and often indiscriminate use of the provisions of this Act were criticised by the boards of governors and the inspectors alike. However, the Act remained unchanged and was to provide the legal structure that underpinned asylum overcrowding. This overcrowding was eventually managed through the expansion of the asylum system which entailed the

construction of new asylums and the extension of those already in existence. Hence, a system and tendency of legally-backed, publicly-funded, admission to public asylums emerged, which was poorly controlled, had limited safeguards and no inbuilt system of review. Admission under this system became the predominant mode of admission with progressively fewer admissions made through the non-judicial systems provided in the rules for asylums. "By 1890 the authority of the dangerous lunatics Act was behind three out of four male admissions and nearly seven out of ten female admissions" (Finnane 1981: 100).

Graphs 1 and 6.1 demonstrate the close link between the passing of the 1838 and 1867 Dangerous Lunatics Acts and increasing levels and rates of institutional residency of 'mentally ill' persons in Ireland. This is particularly evident in public asylums which expanded from the mid-nineteenth century up to 1922, as demonstrated in Graph 13, with continued overall expansion in the Republic of Ireland until 1956, as revealed in Graph 15. These public asylums were the largest sites of institutional residence for 'mentally ill' persons, and as such it was the growth of these institutions that most influenced the overall upward trend of the total level and rate of institutional residence as illustrated in Graphs 1 and 6.1.

The provisions made in the 1838 and 1867 Dangerous Lunatics Acts continued to exist after Partition in Ireland, operated by peace commissioners rather than magistrates. As such these Acts provided the legislative context that underpinned asylum expansion in Ireland from 1838 until 1945, when a new Mental Treatment Act was passed. However, the enactment of this nineteenth century legislation was not passive and it required the active participation of family members to enable its operation.

Asylum Admission and the Family

The role of the family in asylum admission is considered in some detail by Elizabeth Malcolm who proposes that during the mid-nineteenth century, the family was the central entity that negotiated between the perceived insane individual and wider social structures. In *The House of Strident Shadows: the Asylum, the Family and Emigration in Post-Famine Rural Ireland* (1999), Malcolm examines case books and records as a means of providing insight into patterns of committal – all of which cite a family decision as the main reason for committal. This theme of family, particularly the relationship between the family, doctor and police during the committal process, is continued in *Ireland's Crowded Madhouses : The Institutional Confinement of the Insane in Nineteenth - and Twentieth - Century Ireland* (Malcolm 2003).

Malcolm observed that the vast majority of committals during the mid to late nineteenth century were initiated by families. As such, while structures and systems such as law, government, buildings, diagnostic systems, occupational opportunity and asylum administration are influential, the family is suggested as a central agent that facilitated the process of institutionalisation. A similar point is made by Oonagh Walsh with reference to the Ballinasloe asylum who observes that:

> ... if one examines the committal warrants themselves, and notes who made the allegation of insanity, the extent of family involvement becomes clear. To take just one year as an example: sixty two patients out of seventy two in 1879 were committed on the evidence of family members ... The committal process, far from being a disinterested and remote undertaking on the part of official bodies, was mediated through local practice and advice. Relatives were the key source of information for the asylum administrations. (Walsh 1999b 140-142)

The Dangerous Lunatics Acts provided very limited protection against inappropriate utilisation. As such, asylum admission, or even the threat of such

admission, could be used within the family to control the behaviour of family members. As discussed later in this chapter, the perceived underlying causes and diagnostic criteria for insanity were all-encompassing during the nineteenth century, and any non-conforming behaviour of children in their late adolescence or early adulthood could be used as justification for admission to an asylum. An important point here is that admission did not actually have to materialise to influence behaviour, the threat of admission was also a social force within family dynamics which could be used to discipline. Hence the power of asylums as a mechanism of social control over 'challenging' behaviour was extended beyond the confines of the boundary walls of Irish asylums.

However, it would be misleading to suggest that all asylum admissions instigated by family members were sinister or enacted as a means of social control. As mentioned earlier, Irish society experienced both acute and chronic periods of social deprivation. The asylum system provided a site of social intervention and as such could be utilised to strategically obtain services which were genuinely required by a family member. This is particularly the case for securing medical intervention for physical illness. As discussed above, admission to district asylums was predominantly publicly funded and not means tested, and so provided a context in which asylum admission was often the most practical way of obtaining medical intervention and institutional care for a physically ill family member. This has similarities with the contemporary practice or strategy of securing long-term care for older family members by presenting them at casualty units for some minor complaint. In effect once the person is admitted to a system of state backed social intervention, they become the responsibility of the State rather than the family, and

consequently can access services and interventions which could not be secured by the family in the first instance.

Hence, Irish asylum expansion from the mid-nineteenth to mid-twentieth century, illustrated in graphs 3 and 6.1, was underpinned by the Dangerous Lunatics Acts but enabled by the family, which combined to create a permissive system of judicial admission without automatic review. However, admission to asylums, be it through a judicial system or directly to the asylum, was premised on classification systems that could distinguish between the sane and insane. The medical professionalisation of asylums provided the context in which such classification systems were formed, which eventually evolved into bio-medical diagnostic criteria. However, as discussed below, these criteria were poorly defined, loosely applied and all embracing.

Categorisation and Diagnosis

Although large social processes are involved in the selection of the 'mentally ill' the actual prevalence of persons with a dysfunctional mental state has been constructed as the underlining logic for the establishment, expansion and continued existence of the Irish asylum system. The evidence given by Thomas Rice to the 1817 Select Committee on the Lunatic Poor in Ireland demonstrates this belief well. In his evidence Rice argues that there is an actual high rate of insanity in Ireland, and also goes on to provide his own analysis of the aetiology of this insanity.

> There is only one word which I have to add, in explanation a question put to me yesterday, "Whether I conceived that lunacy was actually increasing in Ireland, or whether the returns merely prove that more people were sent into the Asylum than usual?" I believe every gentleman acquainted with Ireland, will admit that the

> number of Lunatics wandering about the country, unprovided with any accommodation, has not decreased. I know this fact of my own experience; and every one acquainted with Ireland, is aware of its truth. But independent of this fact, the nature of the malady itself is such as to cause its continued increase. It is an hereditary malady, and therefore liable to be extended. It is connected with schrofulous habits, also hereditary, and therefore advances upon a double principle. It is connected with the habits of the lower classes of the people in Ireland, who addict themselves to the use of ardent spirits; and it is connected also with the use of mercury. These four causes are, *a priori*, sufficient to show that it is on the increase (Select Committee to Consider the State of the Lunatic Poor in Ireland 1817: 21).

While a sociology of the Irish institutional residency of the 'mentally ill' needs to transcend a narrow focus on the individual mental state, a consideration of diagnostic criteria is warranted, particularly as such criteria underpinned the rationale for admission. The development of diagnostic categories was particularly arbitrary during the nineteenth century and there was little agreement as to the underlying causes of insanity itself. For example, an article published in the *Medical Press and Circular* in 1866 illustrates an all encompassing understanding of insanity within scientific discourse. This article provides a narrative of a meeting of the 'Harveian Society', which was a medical scientific society based in London. At this meeting a paper on the causes of insanity was read by Dr. Henry Maudsley, which was followed by comments and discussion by his peers. A number of discursive extracts of this long article is set out below as a means of demonstrating the diversity of opinion pertaining to the anthology of insanity. These extracts also illustrate the gendered nature that medical discourses had in this field at this time, an issue that is examined in some depth by Jane Ussher in *Women's Madness: Misogyny or Mental Illness* (1991). The article commences with a narrative of the paper delivered;

> The author observed that it was almost impossible in many cases of insanity to assign any *one* cause as producing the disease there was, as usual in such

> questions, a plurality of causes to be taken into account in each case...Civilisation had been considered by many authors as a predisposing cause of insanity, but even here it seemed that there were some difficulties in arriving at any certainty, for, although there was said to be one in four hundred persons in civilized countries in a state of insanity, it was not possible to compare this fact with what occurred among savage tribes, because life was so short, and the weak succumbed so soon among such nations....One of the evident causes of insanity which must be looked for in the fierce struggle for existence which now causes so many social wrecks to take place. The weaker and less able were trampled under foot and thus ended their existence insane. A notable example of this was to be seen in the case of women; man had as yet taken the more lucrative employments as his prerogative, and left only the worst paid to women, who were thus confined almost entirely to a state of marriage, to secure anything like a certainty of existence. This was one of the most frequent causes of the breaking down of the mind in women. He [Dr Maudsley] did not think that self-abuse was a frequent cause of the breaking down of the mind in women but that it was rather one of the symptoms of the malady; among men, on the other hand, it was one of the common causes of insanity...Overcrowding and the brutal degradation of the poorest classes tended to produce physical and mental degeneration...Speculation in business was a common cause and the complete deadening and hardening of the emotions common among the commercial classes certainly tended to produce insanity among their offspring. Effeminacy and luxury also were in highly civilised countries conditions favouring insanity and deterioration of the race; they tended to produce a sort of cretinism, just as a similar condition was produced by bad air or water...Hereditary predisposition had been very variously estimated as a predisposing cause, some authors believing that nine-tenths of those affected were thus predisposed...Intoxication was in this country [England] by far the most common physical cause of mania and idiocy, sexual excesses came next...Injuries to the brain from railway accidents, and other causes, were followed by insanity in some causes. As to moral causes, single women in some instances became violently devout and ended in insanity, whilst disappointed affection also might some-times lead to a similar result (Harveian Society of London 1866: 510)

A number of comments and contributions by those present were made in response to this paper, which further demonstrate the lack of agreement and clarity regarding the underlying causes of that was constructed as insanity.

> Dr. Charles Drysdale, after remarking on the absorbing interest of the subject, one too little brought before the notice of medical men in medical societies observed that there could be no doubt that the struggle of existence...was one of the great causes why insanity and consumption were now such common diseases. In the case of French statistics, epilepsy and convulsions was assigned as the most common cause of insanity, but he could readily believe that in this country

> drunkenness was the chief cause; and this pointed towards something being done towards rendering life in this country more artistic and less monotonous. The next commonest physical cause was sexual excess, enforced celibacy, and self-abuse. All of these together caused a great amount of insanity, and Mr Holmes Coote had said that there was no cause of insanity among the young of both sexes more common than the last of the three. The enforced celibacy of so many of the women of the better classes was most dangerous, too, he thought, for the maintenance of that balance of the intellect and emotions necessary to sanity. He quite agreed with the noble remarks made by Dr. Maudsley upon the subject of the position of women...Loss of friends, disappointed ambition, and love, were the next most common causes of what the author of the paper had truly called the social disease (Harveian Society of London 1866: 510-511).

A more bio-medical anthology was proposed by Dr. Hughlings Jackson who responded by proposing that insanity may be caused by;

> What may be called coarse disease of the nervous system – *e.g.*, damage by blood-clot and tumours-and these cases are chiefly under the observation of those practising generally (Harveian Society of London 1866: 511).

An overtly gendered and alarming contribution to this debate was provided by Mr. Baker Brown who comments that;

> ... self-abuse in women was frequently to be considered rather as a symptom than as a cause of insanity. In lunatic asylums, the practice was very common among the insane. Some cases of insanity had derived benefit from the practice of excision of the clitoris, recommended by Mr. Brown; but the operation was chiefly beneficial to persons affected with acute hysterical symptoms. He could scarcely think with the author of the paper that sexual excesses were common among married persons; but thought that it was solely among the unmarried that these led to insanity; and, with regard to religion being a cause of insanity, he thought such cases were chiefly to be met with among partizans of the extreme orders of religious sects, such as Methodists on the one hand, or High Churchmen on the other; whilst he had remarked that the persons who adhered to the moderate established system were not so apt to go mad from religious zeal. (Harveian Society of London 1866: 513).

Agreeing with this latter comment Dr. Champs added that "He did not think that religion could justly be considered a frequent cause of insanity, indeed, in his opinion, true religion rather tended to ward of any tendency to insanity". This discussion was concluded by Dr Broadbent who said "he had rarely listened to a more instructive paper

and debate" (Harveian Society of London 1866: 513). In effect such discourses provided a context within which almost any person could be categorized and diagnosed as insane. It must also be borne in mind that from the mid-nineteenth century asylum admission in Ireland was primarily administered through a judicial process under the 1838 and 1867 Dangerous Lunatic Acts. As such, magistrates, who had little training in maters of insanity, were relying on the medical profession to provide clarity and guidance on these matters.

The language to describe the institutions for treating those dialogised as insane has also been contested. For example, this was the theme of a debate that took place at the Ninth Annual Meeting of the Association of Medical Superintendents of American Asylums for the Insane which was subsequently reported in *The Asylum Journal* in 1853;

> *Dr. Kirkbride* then read a paper "On the importance of precision and accuracy in the use of terms for insanity, and instructions for its treatment." He objected strongly to calling a sick man *moon-struck*, or, in other words, a *lunatic*. He also objected to the terms *asylums* and *retreat*, *keeper* and *cell*. *Dr. Stribling* thought the term, *hospital* for the insane, very objectionable; as in his State, a hospital "was regarded as a resort for paupers, the outcast, and friendless; and nothing would be more revolting to the feelings of a Virginian that to be taken to an institution with such a name." *Dr. Brown* remarked, that many of our institutions for the insane had rooms no better than prison cells, and he believed it best to call things by their right names. He thought the practice of calling institutions by the name of their principal benefactors, as in the case of the McLean and Butler Hospital, or by some pleasant local name, as in the case of the Bloomingdale Asylum, convenient and unobjectionable. Dr. Tyler said, the citizens of New Hampshire, besides employing the usual variety of synonyms to designate the institution under his charge, styled it an *Insanery* (Bucknill 1853: 130)

A rudimentary diagnostic system for the insane was developed early in Ireland, with Brehon Law providing a basic system for identifying various classifications. This system:

> distinguished broadly between idiots, fools and lunatics but frequently sub-classified each group in designation of their legal rights and obligations. . . A

> major influence of the classification appears to have been the extent to which the individual was adjudged capable of work or had the potential for being amusing or otherwise useful (Robins 1986: 14).

In many ways this early categorisation applied a similar process adopted later by medical science, which entailed the principles of classification and specific intervention. These early classifications often had mystical or quasi-religious connotations and it is difficult to draw direct comparisons between these and contemporary bio-medical categories, however, some parallels can be made. For example, the categorisation of a person as a fool was made during a child's seventh year. A similar diagnostic category later became known as 'mental handicap', and is now referred to as 'intellectual disability'. In the case of a lunatic or mad person, this condition would appear to be similar to what is now considered to be a 'mental disorder' or a 'psychiatric illness', rather than a congenital birth disorder.

As discussed earlier in this chapter, Irish asylums were increasingly professionalised during the 1840s and 1850s, a trend that occurred within most asylum systems across the western world (Porter and Wright 2003). This provided an organisational bureaucracy, physical structure and academic milieu in which scientific principles were applied to diagnostic criteria, which led to the medical model becoming the leading philosophy and approach adopted with regard to the identification, labelling and treatment of insanity. Turner critically deconstructed this process of medicalistion of human social life, arguing that:

> Sociology cannot be content with medical definitions of illness, health and disease any more than sociology can be content with legal categorizations of social deviance. There is throughout sociology a profound question of relativism which cannot be ignored in the area of medical enquiry. . . . This perspective from the sociology of knowledge leads us into the history of medical classifications (Turner 1995: 18).

At the core of the medical model is the proposal that mental illness, like all illness, is caused by an underlying physical pathology (Tucker 1997). In essence this approach suggests that there is something disordered with the structure or function of the body, particularly the brain. Hence, emotions, behaviours, thoughts or perceptions, which are constructed as dysfunctional, are considered to be signs and symptoms of a physical or functional abnormality of the flesh. Examples of the types of abnormality considered within the medical model included: genetic abnormalities; biochemical abnormalities such as dysfunctional dopamine circulation; physical abnormalities caused by trauma, for example brain damage inflicted in a car crash; or damage caused by toxins such as alcohol or drugs. The medical model also encompasses some psychological theories. For example, various types of stresses are considered as a precursor to physical or functional changes to the brain, resulting in signs and symptoms such as anxiety or depression.

Essentially, the convention utilised within the medical model entails signs and symptoms being considered within the language and structure of a standardised classification system. The outcome of this process is the application of a category of illness, or label, which is then used to guide the prescription of medical interventions with the intention of curing the illness or at least relieving the symptoms. This relationship between medical language and social intervention is critically considered by Turner who observed that:

> Foucault was concerned to examine the relationship between certain medical discourses and the exercise of power in society, that is the development of alliances between discourse, practice and professional groups (Turner 1995: 10).

The first report produced by the Inspector of Lunatics, divides patients into the categories of "Idiot, Epileptic and Mania". "Mania" is further sub-divided into "Curable and Incurable" (Inspector of Lunatic Asylums 1846: 30). These categories became increasingly specific and more complex diagnostic criteria were used during the second half of the nineteenth century. For example, the 'Supposed Causes of Mental Disease of Patients in Asylums' in Appendix T of the Inspectors of Lunatic Asylums Report for 1879 sets out three causes of mental illness: "Moral Causes, Physical Causes and Hereditary". A category of "Not Known" is also provided. The number of cases within these categories is reported as follows: Moral Causes 1639 cases; Physical Causes 2006 cases; Hereditary 1898 cases; and Not Known 4577 cases (Inspectors of Lunatic Asylums 1880: 65).

These categories are sub-divided further. For example, Moral Causes include the sub-divisions of "Poverty and Reverse of Fortune; Grief, Fear and Anxiety; Domestic Quarrels and Afflictions; Religious Excitement; Study and Mental Excitement, Ill-treatment; Pride; Anger; and Love, Jealousy and Seduction" (Cork having the highest instance of "Love, Jealousy and Seduction" with 8 male cases and 18 female cases reported in 1880). These categories provided a wide array of descriptions which in effect could be applied to justify the admission of almost any individual.

The utilisation of this categorisation varied widely from institution to institution. For example, Cork Asylum had fewer patents admitted for "Moral Cases" - 124 patients, compared to "Physical Causes" – 200 patients. In contrast Clonmel Asylum had more patients admitted for Moral Causes – 134 patients compared to "Physical Causes" - 97 patients. This differential in the utilisation of categorisation is quite clear if two

institutions of similar capacity are compared. For example Clonmel and Monaghan are compared in Table F set out below, both of which are asylums within midland market towns surrounded by a larger rural hinterland.

Table F 1879 Categories of Patients Resident in Clonmel and Monaghan Asylums

District Asylum	Moral Cause	Physical Cause	Hereditary	Not Known	Total In asylum 31st Dec 1879
Clonmel	134	97	134	29	394
Monaghan	106	129	49	87	371

(Inspectors of Lunatic Asylums 1880: 65)

While very detailed information of many aspects of asylums is provided in the inspectors' reports, for example, a breakdown of the costs of bedding and washing materials (Inspector of Mental Hospitals 1924: 32), data relating to the diagnosis of persons admitted to asylums is not provided for each year in any consistent way that allows a complete comparative analysis. However, the Inspectors' reports make it clear that during the period of asylum expansion, illustrated in Graph 6.1, diagnostic criteria changed, and as can be observed in the 1880 Report, these criteria were all encompassing and quite vague (Inspectors of Lunatic Asylums 1880: 65). This provided for a liberal utilisation of the concept of insanity as an organising principle relating to a wide spectrum of normal aspects of human social life. This was compounded further by the fact that admission to asylums, as discussed above, was being managed primarily through a judicial process.

Hence, those responsible for asylum admission had all encompassing criteria upon which to base their decisions, coupled with limited professional training in the utilisation of such criteria. The ensuing high rate of asylum utilisation provided an increasing demand for further asylum bed provision which, as discussed above, was

managed through the construction of new asylums and the expansion of those already in existence. As such these institutions became large social structures in themselves. These institutions also became integral to the social and economic life of the communities in which they were situated, which served to further strengthen and consolidate the reproductive momentum within Irish asylums.

Conclusion

It would appear that the establishment, expansion and utilisation of Irish asylums was not in response to an outbreak of insanity but was rather one factor in the creation of this socially constructed phenomenon. This trajectory of institutionalisation, illustrated in Graph 1 and 6.1, can be understood by examining the confluence of large social systems, structures and contexts, along with the personal action of individuals in carrying out the act of institutionalisation.

The political dynamic of colonisation is an important feature of this institutional expansion, particularly its role in removing the planning and control of localised social interventions for the 'mentally ill' from the local context. The social need for asylums was not articulated locally but ascertained through the use of expert groups such as *1817 Report of the Select Committee of the Lunatic Poor in Ireland.* As such, planning for asylum provision was based on the recommendations of parties that did not have a direct stake in the utilisation of the services they recommended. The resulting legislative provisions for asylum construction provided for a centrally administered system which resulted in rapid asylum construction, particularly between 1830 and 1880. Once

constructed, these buildings were utilised to full capacity and the development of policy and protocol within these institutions served to further consolidate and bed-down the administrative structures, which in turn sustained the reproductive momentum of these institutions.

The strategic personal career interests of individuals was also a driving force of asylum growth, particularly the Inspectors of Lunatic Asylums, a notable example being Francis White. From 1846 onwards these inspectors continuously proposed asylum expansion, institutions upon which their occupational security was based. This inspectorate was also instrumental in ensuring the medical takeover of asylum management and administration. Hence, asylums became hospitals, the insane became mental patients, science was applied to human emotion, new categories of illness were proposed, new interventions were developed and the speciality of psychiatry emerged within medical practice.

The broad context of chronic social deprivation during nineteenth century Ireland, which reached its most acute phase in rural areas during the 1840s also requires consideration. At various times during the nineteenth century, members of society, including the unemployed, the old and the sick, existed in a position of vulnerability and uncertainty. An absence of resources within the community, coupled with the existence of an extensive public asylum system, contributed to the tendency to institutionalise.

A liberal set of diagnostic criteria for insanity emerged as a prerequisite to asylum admission, which was administered primarily through a judicial process. This judicial process was underpinned by the Dangerous Lunatic Acts of 1838 and 1867, which located Irish insanity within the context of criminality. Essentially magistrates were

empowered to institutionalise people as 'dangerous lunatics', without due regard for the capacity of the asylum system to cater for such institutionalised individuals. Furthermore, these magistrates had no particular training in issues relating to 'mental illness', and this was compounded by the fact that the criteria for insanity was continuously changing during this time. The lack of structured points of review or discharge resulted in a comparatively low level of discharge, which served to further swell the number of long-term residents in Irish institutions for the 'mentally ill'.

The construction and categorisation of perceived 'madness' or 'mental illness' in Ireland is time-bound and changes continuously between 1800 and 1950 in response to the social, political and medical context at any particular point in time. In practice a looseness of diagnostic criteria emerged during the nineteenth century, which was exacerbated by a low level of clinical accountability. This interfaced with the system for judicial admission and led to a spectrum of emotions and social realities being medicalised and considered within a psychiatric context. Consequently a large cohort of Irish people were labelled as 'insane' and institutionalised within asylums.

However, the institutional confinement of the 'mentally ill' in Ireland was not a spontaneous development and it required the active and willing participation of individuals, families and communities who engaged directly with the committal process. Hence, while the institutions had their own social momentum and those directly employed within asylums had a interest in ensuring a continuous 'supply of patients', there is no evidence of a programme of active recruitment of patients. In practice Irish families were willing to admit their kin to asylums during times of crises or dispute and

in some cases when the individual was in genuine need of care due to a physical or psychological problem.

Hence, both individual acts of institutionalisation and the growth of institutional systems as whole can be understood as multi-layered social processes. The outcome was a national asylum system made up of a network of institutions that were securely embedded within local communities. These institutions served several social functions including the provision of a location for social intervention, a primary driver of local economic activity and a power base for medical politics. Thus by the early twentieth century, the reproductive social momentum of these institutions was sufficiently powerful and robust so as to ensure that they remained intact and largely unchanged during a period of profound social upheaval at the commencement of the Irish Free State.

This chapter demonstrates that no single agent or social force can account for the comparatively high level of residency for the 'mentally ill' in Ireland. However, it would appear that a particular conjuncture of social forces and human acts occurred during the mid nineteenth century, which punctuated the creation, consolidation and extensive utilisation of these institutions. As a means of summarising the arguments developed in this chapter, Illustration 3 sets out the key aspects of this point of conjuncture with reference to Ritzer's four major levels of social analysis, which are explored in Chapter 2. This is then graphically presented in Illustration 4 with reference to the data contained in Chapter 3 which charts institutional expansion during the nineteenth and early twentieth centuries.

Illustration 3: A Tendency to Institutionalise the 'Mentally ill' in Ireland – Established Through a Conjuncture of Social Forces 1835-1868.

Macroscopic

Objective	**I. Macro-Objective** • Administrative centralisation • Limited penetration of industrialisation and capitalism in rural areas • Legalisation and social policy for asylum building • Dangerous Lunatic Acts 1838/1867 • Population decline • Fragmentation of local payment and control of asylums • All encapsulating diagnostic criteria	**II. Macro-Subjective** • Public acceptance of medical science • Community demand for control of 'deviance' • Local experience of poverty • Emigration • Reliance on asylums as locations of social assistance • Predominance of traditional family structure • Family participation in asylum admission
	III. Micro-Objective • Asylum rules and routine • Medical inspection and control of asylums • Establishing of asylum staffing arrangements • Local economic and social dependency on asylums • Systems for admission and the enactment of institutionalisation	**IV. Micro-Subjective** • Personal and family shame of mental illness • Asylum staff pride in, and loyalty to institutions • Institutionalisation of the 'mentally ill' / loss of self-esteem / loss of contact with outside world / acceptance of ones role as a 'mental patient'

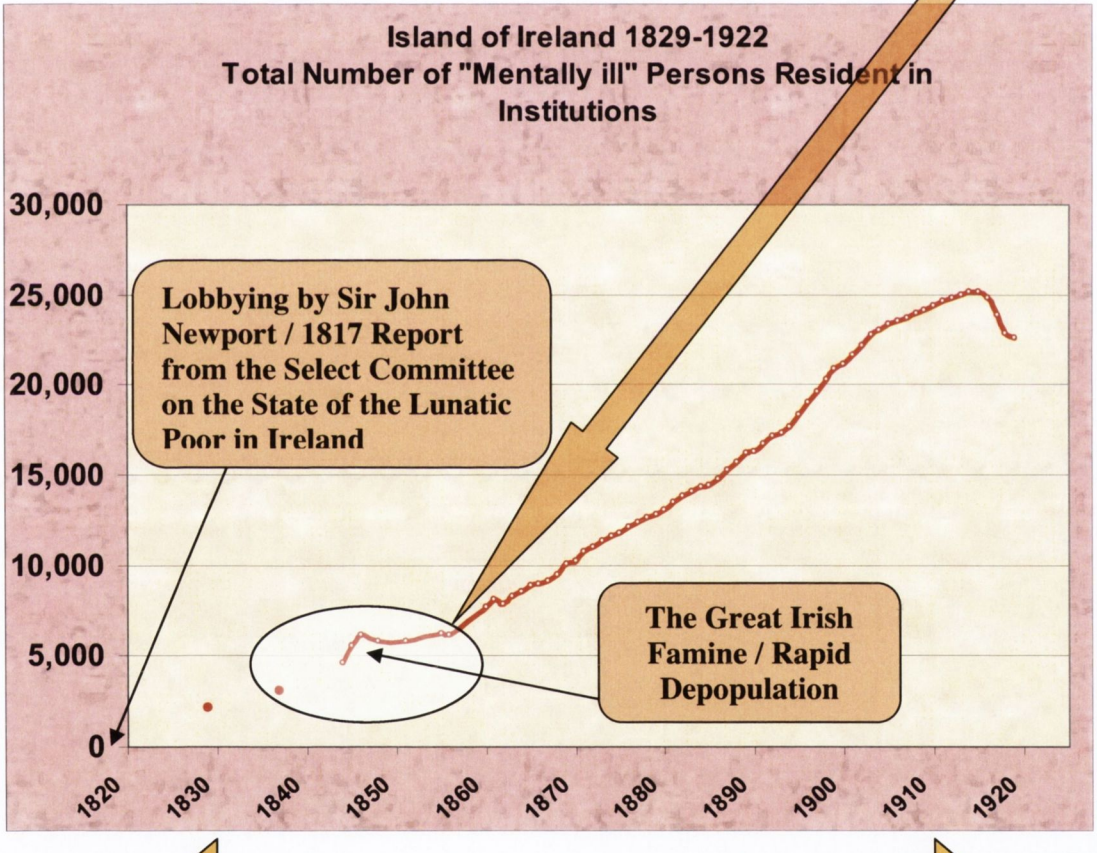
Subjective

Microscopic

Illustration 4: Conjuncture: The Rise of Institutions for the 'Mental ill' in Ireland

Principal Features of Conjuncture

- Centralised Social Policy Planning for Asylums Expansion
- Passing of the Dangerous Lunatic Acts 1838 & 1867 & Fragmentation of Judicial / Medical Control over Admission
- Medical Takeover of Asylums / Establishing of Inspector of Asylums
- Fragmentation of Local Demand, Payment and Control of Asylums
- All Encapsulating Diagnostic Criteria
- 1843 General Rules for the Government of District Asylums
- Family Participation in Asylum Admission Process is Established
- Local Economic and Social Dependency on Asylums



Macro Context

- Colonisation / Administrative Centralisation / Contested Authority of the State / Political Agitation
- Predominately Rural Society- Limited Industrialisation & Capitalism
- Limited Church / State Partnership in Asylum Administration
- Wide Scale Social Deprivation and Need of Social Assistance

Chapter Five

The Demise of the Asylum – 1956-2000

Introduction

> And then a scene change, somersaulted even, as if the old order had exhausted itself and was seeking newer sources of inspiration. The numbers institutionalised began to fall. In truth, no one knew why (Walsh and Daly 2004: 11).

This chapter seeks to explain this 'scene change' - the demise of the Irish institutional residency for the 'mentally ill'. As demonstrated in Chapter 4, the high rate of residency from the early nineteenth to mid-twentieth century, can be understood as a social process that emerged from a range of interconnected social forces and human action. Drawing on the data set out in Chapter 3, it is proposed that this rising trajectory of institutionalisation was punctuated by a particular point of conjuncture that culminated in the construction, utilisation and expansion of institutions for the 'mentally ill'. However, a sociology of residential institutions for the 'mentally ill' would be incomplete without a detailed consideration of the demise of these establishments.

In a similar fashion to Chapter 4, this chapter adopts a critical-interpretive historical sociological approach. Drawing from the empirical data provided in chapter 3 (Graph 15 for Public Asylums; Graph 19 for Private Asylums; Graph 23 for the Central Mental Hospital; and Graph 23 for Public Assistance / Health Institutions), it is demonstrated that a particular combination of social forces instigated a period of sustained decline in institutional residency between 1956 and 2000. This is presented

through a consideration of the following themes: The 1945 Mental Treatment Act; International Standardisation of Diagnostic Criteria; Social Policy and De-Institutionalisation; Professional 'Reform' and the Anti Psychiatry Movement; 'Modern Clinical Interventions'; Employment beyond the Institution; Irish Family Dynamics and the Demise of the Asylum; and Contemporary Legislative Protection.

1945 Mental Treatment Act

The 1838 and 1867 Dangerous Lunatics Acts, which are examined in Chapter 4, continued to be the principal legislation for admission to public asylums after Partition, and "Their provisions continued to govern Irish committal procedures, at least in the south of the country, until 1945" (Malcolm 2003: 324).

> The Mental Treatment Act, which became law on the 22nd of May 1945, made such fundamental changes in the law and practice relating to mental health as to constitute an entirely new code (Inspector of Mental Hospitals 1950: 5).

The 1945 Mental Treatment Act deals with a spectrum of issues relating to the administration of Irish mental hospitals and psychiatric services, which includes asylum financing, administration, pension arrangements for staff, and systems for admission and discharge. This legislation is significant as it was the first major legislative provision relating to the detention of persons in public and private psychiatric institutions since the setting up of the Free State. The Irish Constitution enshrined a right to civil liberty stating that "No Person shall be deprived of his liberty save in accordance with law" (Government of Ireland 1937: Article 40.4.). In effect, the 1945 Mental Treatment Act

set out the legislative provisions through which this liberty could be curtailed within the context of psychiatric care provision. What is most notable about the 1945 Act is its de-linking of psychiatric admission from criminality which had been established through the passing of the 1838 and 1867 Dangerous Lunatics Acts.

> Whereas previously, "civil" committal was a judicial process, involving the arrest and conveying of a patient to appear before two magistrates (subsequently peace commissioners) who then ordered – or refused to order – the patient's committal on foot of a doctor's certificate, the Act of 1945 relegated the issue solely to a matter of clinical decision-making (Casey and Craven 1999: 458).

In effect this legislation consolidated medical dominance in matters relating to asylum institutions. Doctors now controlled most principal positions of power relating to mental hospitals, including directorships, inspection, and now direct control over admission and discharge. While a spectrum of provisions were set out in this legalisation, three primary modes of admission to psychiatric hospitals were established, referred to as voluntary, temporary and persons of unsound mind. In practice most admissions to psychiatric hospitals were administered under these provisions from 1945 onwards.

Voluntary admission is relatively uncomplicated and entails an application being made by the person seeking admission on what is known as a 'blue form'. If the patient is less than sixteen years of age, the application is made by their parents or guardian. Following a medical examination the person may be admitted to the mental hospital and can receive treatment for their 'mental illness', followed by discharge. If the admitted person wishes to be discharged at any time, he or she must give 72 hours notice to the management of the mental hospital, after which time they must be allowed to leave the institution. This 72 hours notice effectively provides the authorities in charge of the

institution an opportunity to make arrangements for involuntary detention if they are of the opinion that the person admitted voluntarily is now not fit to leave. As Charles Smith puts it, "... the patient must give 72 hours written notice of his intention to leave, and a lot can and does happen during that time!" (Smith 1990: 1205).

Admission as a 'Temporary Patient' is a process that entails the admission of a person against their will. An application for such admission is made by a spouse or relative who is over 21 years of age, on what is known as a 'pink form'. A community welfare officer may also make such an application and in practice any person may make an application. However, they must give a statement as to why the application is not by a spouse or relative. The person making the application must sign a temporary admission form, which must also be signed by a medical practitioner, two practitioners in the case of a private patient. In most cases the medical practitioner is usually the patient's General Practitioner (GP), who must certify that the patient has been examined within the previous seven days and that they are satisfied that the patient is suffering from a mental illness or is an addict (Casey and Craven 1999: 464).

Within seven days of such a certificate being obtained, the person being admitted may then be moved to the mental hospital. On arrival at the hospital, the patient must be examined by a medical person in charge of the institution. They will consider the application and medical certificate and then make an order for involuntary committal of the person as a Temporary Patient if deemed appropriate. This must occur within twelve hours of the patient arriving at the institution, during which time they can be detained against their will. If a person is admitted as a temporary patient they may be detained for up to six months unless discharged. During their stay, they may be treated for their

'mental illness' which can be administered against their will if deemed necessary. After six months the temporary order may be extended if the person is not considered to be recovered. This process can be repeated up to three times, thus providing for a possible committal of up to two years.

A limited number of safeguards are built into the provisions of the 1945 Act for Temporary patients. The patient must be informed of the nature of the application for committal prior to their removal to the mental hospital, and has a right to the opinion of a second medical practitioner prior to their removal. This second practitioner must be of the same opinion as the first, otherwise the committal does not proceed. The medical officer within the receiving mental hospital must also inform the patient of their various rights once the committal order has been made. This includes the right to know all details relating to the order and the right to make an objection to an order or any subsequent extension to it. Such an objection is made to the Inspector of Mental Hospital or the President of the High Court.

The 1945 Act also provides for admission to a psychiatric hospital of a 'Person of Unsound Mind'. Such an application is made on what is known as a 'white form' and is made in a similar manner as a temporary admission by the spouse or relative of the person being admitted, or a community welfare officer. A medical practitioner must have examined the patient within the previous 24 hours, and if satisfied that the person is of unsound mind, makes a recommendation for the person's admission. The Gárda Síochána may also detain a person if they consider there to be a risk to public safety or the safety of the person in question. Once the person is detained, the Gárda may then apply to a medical practitioner to make a recommendation that the person be admitted to

a psychiatric hospital as a person of unsound mind. If a medical recommendation for committal is made, the patient is then taken to the mental hospital within seven days, which can be with the assistance of the Gárdaí or staff of that institution. The medical officer of the mental hospital must examine the patient and consider the medical certificate. If a committal order is made, the patient may be detained until they are medically discharged. In effect this provides for the possibility of long-term committal if recovery is not medically deemed to have occurred.

The safeguards offered to patients under the 1945 Act provided some protections compared to the 1867 Dangerous Lunatic Act, particularly for voluntary and temporary patients. However, most patients who were resident in asylums prior to 1945 were categorised as 'Persons of Unsound Mind', which essentially provided for their continued long-term residency. For example, in 1949 there were 250 Voluntary Patients resident in District and Auxiliary Mental Hospitals on the 31st of December as compared with 886 Temporary and 17,332 Persons of Unsound Minds (Inspector of Mental Hospital 1949: 46 - Appendix A – Table 2).

As can be observed in Graphs 4 and 6.1, there was an increase in the level and rate of 'mentally ill' persons resident in institutions for a full decade following the passing of the 1945 Act. While there were 19,538 such persons resident in 1945 this steadily increased to a high point of 21,720 in 1956 (Table 17 Appendix 1). This was explained by the inspector as being in light of the new mechanisms that provided for ease of admission:

> The rising trend of reception into district mental hospitals, noticeable since 1947, when the Mental Treatment Act came into operation, continued in 1949. It seems clear therefore that the simpler method of reception and also the provision of facilities for voluntary submission to treatment have encouraged patients to seek

> medical attention in the early stages of mental illness (Inspector of Mental Hospitals 1949: 10).

The proportion of patients admitted as voluntary steadily increased and this category was to become the predominant mode of admission. By 2001 the *Irish Psychiatric Hospital and Units Census* found that "Eighty three percent of resident patients on the census night were voluntary . . . non-voluntary residents decreased from 25% in 1991 to 17% in 2001" (Walsh and Daly 2002: 31).

The 1949 Report of the Inspector of Mental Hospitals is optimistic that the rate of institutional residency would gradually decline as voluntary and temporary admissions increased, these patients having a better recovery rate. This optimism proved to be well founded, as can be observed in Graph 4 and Tables 2 and 5 which show that a pattern of decreased residence was established from 1956 onwards. However the Inspector of Mental Hospitals saw this as a result of early intervention, rather than a trend that was realised through provisions and safeguards against prolonged detention within the 1945 Mental Treatment Act, such as automatic review and new methods of discharge.

> As the number of receptions of voluntary and temporary patients increased each year since 1947 the percentages shown above indicate satisfactory progress over the three years since the Mental Treatment Act came into force. The steady increase in the percentages for these classes of patients shows the good results that may be expected if treatment in the early stage of mental illness is obtained (Inspector of Mental Hospitals 1949: 13).

Hence it would appear that the 1945 Act, while not being the sole factor, was a significant catalyst to the decline of mental hospital usage in Ireland. In practice, this Act shifted the power of admission and discharge from a judicial process to a clinical process, giving medics virtually complete control over Irish mental hospitals. Within an anti-psychiatry thesis, one would expect increased residency to be associated with this

consolidation of medical dominance, "Because psychiatrists were charged with both defining madness and admitting patients to the asylum, they could effectively create the demand for their own services" (Samson 1995: 59)

However, as can be observed in Graph 4 and 6.1, this is not the case. While an initial increase did occur between 1945 and 1956 a pattern of declining asylum residency is established from 1956 onwards (Table 2, Appendix 1). It is interesting to note that this decrease occurred prior to the emergence of the theoretical perspectives provided by Laing (1960), Goffman (1961), Cooper (1967), Foucault (1967, 1973), Illich (1976, 1977) and Szasz (1972), who provided the theoretical basis on which to challenge medical authority, particularly in the field of psychiatry. As such, while the anti-psychiatry movement may have been a factor in sustaining the decline of Irish institutional residency during the later decades of the twentieth century, it was not a catalyst to this declining trend.

As demonstrated in Chapter 4, the medical control over asylum management and inspection coincides with institutional expansion. However, the decline in asylum residency from 1956 onwards occurred at a time when medical control was actually further consolidated within these institutions. While asylum expansion certainly served the self-interest of medics by increasing professional employment, this expansion actually occurred when medical domination was limited by the judicial power over admissions, coupled with a fragmentation between national asylum planning, the medical management of asylums and clinical practice within.

While the 1945 Mental Treatment Act did serve to centralise the power of medics, involuntary admissions were now required to be based on increasingly standardised

medical diagnosis and certification, and was now subject to a mandatory second medical opinion. This provided some safeguards against the spurious admissions that were previously possible under the provisions of the 1838 and 1867 Dangerous Lunatics Acts. Commenting on these changes in *The Health Services of Ireland* Hensey notes that.

> Up to 1945, nineteenth-century definitions, law and procedures still governed the services for the care of the mentally diseased. Patients were 'committed' to mental hospitals on warrants signed by peace commissioners and there was provision for nothing between detention on such warrants and complete freedom, except for a system of 'trail discharge' which did not operate well in practice. Under the Mental Treatment Act of 1945, a more flexible procedure was introduced. Patients are now admitted on 'reception orders' signed by medical practitioners and there are procedures for temporary and voluntary admissions to mental hospitals, the use of which has considerably improved the working of the service. (Hensey, 1959: 22).

In effect the 1945 Act introduced several new dynamics that underpinned the reduction in institutional residency for the 'mentally ill' in Ireland from 1956 onwards. Firstly, the provisions for self discharge for voluntary patients and the system of automatic review for temporary patients provided structured points of reassessment, which instigated systems that encouraged a greater ease of discharge than had previously existed. Secondly, the judicial / medical fragmentation of control over admissions was replaced with consolidated medical control over admissions, which was subject to a second opinion in cases of involuntary detention. Lastly, the 1945 legislation became operational around the same time as the introduction of standardised diagnostic systems by the World Health Organisation (WHO), which served to tighten the criteria on which admissions were based.

International Standardisation of Diagnostic Criteria

As discussed in Chapter 4, the 1838 and 1867 Dangerous Lunatic Acts were utilised during a period of time when diagnostic categories were loosely defined. Classification systems remained inconsistent internationally until the late 1940s when two bodies moved to standardise all diagnostic criteria for psychiatric practice. "WHO took over responsibility for the International Classification of Diseases (ICD), the sixth edition of which was scheduled to be published in 1948. This edition was the first to contain a section on mental disorders" (Healy 2002: 298). In parallel to this the American Psychiatric Association published the first edition of the Diagnostic and Statistical Manual (DSM) in 1952 (Gelder et al 2000: 47).

A number of differences existed between the early editions of these two sets of criteria. Most notably, the DSM included details relating to the level of social, occupational and functional impairment arising from 'mental illness'. However, this was incorporated in the tenth edition of the ICD, with diagnosis being made within reference to clinical signs and symptoms, level of disablement and contextual factors. This made both the DSM and ICD similar in design and operation (Gelder et al 2000: 51).

These diagnostic systems provided for greater standardisation internationally. However, there are significant epistemological limitations to any classification system that makes claim to universality. As such, while the DSM and ICD claim a degree of legitimacy based on the adoption of a scientific process, concepts of 'mental illness' are formulated within a dynamic social process and are influenced by various vested interests and professional agendas. In practice diagnostic criteria have emerged within the context

of the evolution and development of medical practice and in more contemporary times have been influenced by academic and political forces, for example the anti-psychiatry movement or the wider feminist movement (Cleary 1997). As such, diagnostic systems have not only been continuously 'refined', the actual groupings of individuals focused on have also changed at various points in time. For example, whereas homosexuality was once considered to be a mental illnesses, it is no longer conceptualised as such.

> An indication of the political nature of psychiatric diagnosis is inherent in the rapid movement of the categories and criteria for mental illness by the profession. The most well-known example is probably the removal of homosexuality from American psychiatric diagnostics in 1973. This, however, took place only after a very bitter conflict within the APA and between the APA and gay activists in which numerous changes of language to describe homosexuality as a disorder were floated (Samson: 1995: 79)

While the international diagnostic category of homosexuality may have been reformed in 1973, in Ireland professional discourse continued to construct homosexuality as being abnormal and homosexual acts were not illegalised until 1993, with the passing Criminal Law, Sexual offences, Act (Criminal Law [Sexual offences] Act 1993: Section 2). For example in an article in *The Irish Journal of Psychology* published in 1985 Ruth Curtis asserts that:

> While one cannot state categorically that gender disorders in children, if untreated, invariably lead to such adult problems as transsexualism, transvestism and homosexuality, the available evidence points in that direction. Because of the accompanying psychological problems in childhood and the poor outcome of therapy with gender-disturbed adults, it would appear that early intervention is desirable for those children who have been diagnosed as gender-disturbed (Curtis 1985: 50).

Based on these international classification systems, an increasingly standardised diagnostic system was adopted in Irish psychiatric practice from the mid 1950s onwards. Drawing on these classification systems, the current reports of the Mental Health

Commission categorise patients into the following categories "Organic Psychosis, Schizophrenia, Other Psychoses, Depressive Disorders, Mania, Neuroses, Personality Disorders, Alcoholic Disorders, Drug Dependency, Mental Handicap, Diagnosis Unspecified, and Diagnosis not Returned" (Mental Health Commission 2004: 32).

While criteria were internationally standardised, their application in Ireland was utilised inconsistently in different regions, a problem which has remained to date. In practice, there was a reciprocal dynamic between high bed availability, a propensity to diagnose, and high levels of bed utilisation. This has been a contributing factor in the marked differential in the admission rates between the various Health Board areas in Ireland, which was explored in Chapter 3. This fact has come to the attention of the new Inspector of Mental Health Services who notes that: "Admission rates vary from a high of 1,300 per 100,000 over the age of 16 in South Tipperary to a low of 270 per 100,000 population over the age of 16 in the Tallaght service" (Mental Health Commission 2004: 111).

The international standardisation of diagnostic criteria, coupled with the rolling out of the provisions contained in the Mental Treatment Act of 1945, coincides with an overall reduction in the level and rate of institutional residency of the 'mentally ill' in Ireland (Table 2, Appendix 1). In effect from the early 1950s onwards, medics had a narrower set of admission criteria that were applied in a more tightly regulated legal system for admissions based on the 1945 Mental Treatment Act. This would appear to be a contributing factor to the declining trajectory of institutional residency of the 'mentally ill', a development which was subsequently articulated in Irish mental health social policy.

Social Policy and De-Institutionalisation

The social policy developments that underpin the early asylum construction and expansion are examined in detail in Chapter 4. Commencing with the report of the *Select Committee to Consider the State of the Lunatic Poor in Ireland* (1817), this social policy centred on institution building and utilisation, which was based of the principles of categorisation, segregation and moral / medical intervention. This institutional policy approach remained intact throughout the nineteenth century and was continued by the new administration in the Irish Republic after Partition. For example

> In 1925, the Minister for Local Government and Public Health appointed a Commission to consider the relief of the sick and destitute poor, including the insane poor. . . this Commission found overcrowding in many hospitals, and it recommended that excess patients in the mental hospitals and the insane in poor law institutions should be provided for in auxiliary mental hospitals (Commission of Inquiry on Mental Illness 1966:7-8).

In effect, with the exception of the legal changes for admission established through the 1945 Mental Treatment Act, the policy of asylum utilisation articulated in 1817 remained intact until new proposals were published by the *Commission of Inquiry on Mental Illness* in 1966.

Since Partition only five people, all men, have signed off the annual reports as Inspector of Mental Hospitals: Daniel L. Kelly 1924-1937; R. Percy McDonnell 1938; Joseph Kearney 1939-1950; Vincent J. Dolphin 1952-1979 (with a gap in reports for 1962-1977 and 1980-1987) and Dermot Walsh 1988-2001. The passing of the Mental Health Act of 2001 saw the introduction of a new inspectorate 'The Inspector of Mental Health Services' and for the first time since the establishing of the position of Inspector of Lunatic asylums in 1846 the position has been filled by a woman, Dr. Teresa Carey. A

continuous theme within the Inspector of Mental Hospital reports is overcrowding and the poor quality of accommodation in many of these buildings, which became expensive to maintain and in many cases buildings became dilapidated. For example his report for 1952 the Inspector of Mental Hospitals, Vincent J. Dolphin, makes the following observations;

> Ardee: Overcrowding in this institution continued ... Carlow: Accommodation was still generally overcrowded but steps were being taken to deal with the problem ... Cork: All departments of the mental hospital showed overcrowding ... Ennis: There was overcrowding on the male side in this institution ... Enniscorthy: All departments of this hospital were overcrowded ... Grangegorman: Overcrowding was evident in this institution, especially in admission units and infirmaries ... Kilkenny: the female side of this hospital was generally overcrowded ... Killarney: dormitory and day-room accommodation in this institution was inadequate. Some corridors were being used as day-rooms ... Limerick: Overcrowding was evident in a number of divisions and steps to remedy this were being taken ... Monaghan: Overcrowding was evident in patients' dormitory and day-room accommodation and in staff quarters ... Sligo: All departments of this institution were overcrowded ... Waterford: All dormitories and dayrooms were overcrowded (Inspector of Mental Hospitals 1952: 18-29).

As demonstrated in Chapter 3, in 1955 the WHO *Annual Epidemiological and Vital Statistics Reports* (WHO 1958) indicated that, in the international context, Ireland had a disproportionately high level of mental hospital beds in proportion to its population (See Chapter 3 - Table B). Concerns about the extent of Irish mental health service provision resulted in the Irish government establishing a Commission of Inquiry on Mental Illness in 1961. The establishing of this commission was also set within an international legal and political context, particularly the provisions made by the Council of Europe in the *European Convention on Human Rights & Fundamental Freedoms* (Council of Europe 1950). Various provisions in this convention raised questions regarding the adequacy of protections with the 1945 Mental Treatment Act. For

example: Article 5.1 guarantees the 'right to liberty' except in accordance with a procedure defined by law; Article 5.2 calls for the prompt provision of information to the detained person; and Article 5.4 advocates the right to judicial review of the lawfulness of detention (Council of Europe 1950).

The 1961 Commission of Inquiry on Mental Illness had two primary terms of reference. Firstly, it was to examine and report on the extent and state of provisions for mental health and to recommend measures to improve services. Secondly, it was to review the legislative provisions concerning mental illness in Ireland. The report of this Commission was published some five years later, the thrust of which was a recommendation for the relocation of psychiatric residential care from asylums to small units, and the setting up of community services. In effect, this was the first Irish-based national social policy proposal that advocated a process of deinstitutionalisation, a point of separation from the institutional policy first proposed in the early nineteenth century. These recommendations were made in the context of the report expressing concern that mental hospitals continued to be used excessively:

> Statistics in respect of different countries may not be directly comparable, but, even if allowance is made for this, the number of in-patients in Ireland seems to be extremely high – it appears to be the highest in the world. It is hard to explain this (Commission of Inquiry on Mental Illness 1966: 24).

While the recommendations within this report were visionary for their time within the Irish context, similar non-institutional and deinstitutional proposals had been circulating internationally for some years. For example, the United States National Committee for Mental Hygiene was established and in 1930 held its first international congress in Washington. It was "attended by over three thousand participants, brought together delegates from twenty-two countries each of which had developed their own

national committees" (Tudor: 1996: 1). This signalled a new approach to mental illness which questioned the rationale, efficiency and ethics of asylum care:

> After the Second World War . . . The efficacy of the asylum itself came into question in many western countries. This re-evaluation of the dominant mode of mental treatment for over a century eventually led to two important developments, deinstitutionalisation policies, by which thousands of mental patients were released from long stay hospitals, and the allied psychiatric orientation towards social and community care (Samson 1995: 64).

However the 1966 *Report of the Commission* was limited by the lack of detail regarding the administrative framework required for the proposed restructuring and deinstitutionalisation of services, and in practice its recommendations were not implemented nationally. In Ireland residential treatment within the large asylum buildings, now referred to as mental hospitals, continued to be the primary service available for the 'mentally ill'. Alternative community services did develop in an ad-hoc, localised and sporadic fashion. However, they were in effect a small addendum to the primary business of institutional residency.

The actual residence levels of public asylums did decline following the 1966 report. However, this was a continuation of the trend established in 1956 some ten years prior to the Report of the Commission (Graph 15 and Table 17). Hence, social policy planning was subsequent to the actual lived reality of declining asylum usage. A passive interpretation of this is provided by the recently retired Inspector of Mental Hospitals, Dermot Walsh:

> And then, as if following nature, policy acquiesced and the new philosophy was articulated in the 1966 Report of the Commission on Mental Illness (Department of Health, 1966) and re-affirmed in the later policy document Planning for the Future (Department of Health, 1984). Henceforth, the commitment was to de-institutionalisation, turning the nineteenth century on its head (Walsh and Daly 2004: 11).

The core features of the social policy recommendations made in 1966 were to re-emerge in 1984, with the publication of a new policy blue print entitled "*The Psychiatric Services – Planning For the Future*" (Department of Health 1984). Again, this document recommended the setting up of a comprehensive community mental health service and the scaling down of asylum institutions. These services were to include a network of community based psychiatric hostels, clinics, mental health centres and acute psychiatric units within general hospitals:

> The main thrust of our conclusions is that the psychiatric needs of the community should be met by a comprehensive and integrated service made up of a number of treatment components and largely located in the community. A number of changes are necessary if this objective is to be achieved. In particular, there must be a decided shift in the pattern of care from an institutional to a community setting with close links between psychiatry and other community services (Department of Health 1984: viii).

In Ireland, these deinstitutionalisation proposals emerged within a political context of governmental unease with the national balance of payments, which stimulated a drive to reduce health care spending during the 1980s. This national political context was complicated somewhat by a local political concern to maintain employment within mental hospitals during a time of extremely high unemployment. As a means of ensuring its implementation, *Planning for the Future* included clear details regarding the localised administrative and managerial implications of deinstitutionalisation: Chapter 14 addressing *Organisation and Management*; Chapter 15 *Cost Implications*; and Chapter 16 *Planning and Evaluation.* These important details had been absent within the earlier 1966 policy. Most notably *Planning for the Future* stipulated that mental health services should be delivered within distinct geographically demarcated areas and should provide a full spectrum of services, from community clinics to residential services.

The proposals set out in *Planning for the Future* need to be placed within the wider discursive context regarding deinstitutionalisation. Internationally, similar policies were proposed and introduced during the late 1960s and 1970s and as such Ireland had the benefit of some hindsight. For example in 1983, the editorial comment in *Hospital and Community Psychiatry* considers deinstitutionalization the USA:

> Is deinstitutionalization working? A careful reading of the evidence that has accumulated over two decades suggests that outcomes have been mixed. On the positive side, a variety of highly successful programs in non-traditional and noninstitutional settings have enhanced the lives of some chronic mental patients (Bachrach: 1983: 105)

However, several concerns relating to the impact of deinstitutionalisation were being raised within professional journals, most notably the risk of homelessness. Here it was noted that people who have been institutionalised and stripped of basic social skills are at risk of becoming homeless if not properly supported within the community. For example in an article in *Hospital and Community Psychiatry* 1984, the Professor of Psychiatry at the University of South California School of Medicine argues that:

> ...homelessness is closely linked with deinstitutionalization in the sense that three decades ago most of the chronically mentally ill had a home in the state hospital. Without deinstitutionalization it is unlikely there would be large numbers of homeless mentally ill (Lamb 1984: 899).

In practice, the 1984 *Planning for the Future* policy document had a much greater impact on service provision than the policy developed in 1966. However, it stopped short of calling for the complete closure and sale of the asylum buildings, and its recommendations were not consistently adopted across the Ireland. As such, while the national rate of asylum utilisation decreased, regional variations continued to exist. As discussed in Chapter 3, this has resulted in an uneven distribution of mental hospital bed availability. This provides for some comparative analysis of the link between the

existence of institutional services and the 'generation' of long-term mentally ill persons. In essence, it appears that the continued physical existence of large asylum buildings is a factor in high localised levels of institutional residency. Essentially it is local supply creating local demand. Commenting on this, the recently appointed Inspector of Mental Health Services observed that:

> The rate of generating new long stay patients varies . . . from a low of under 1 per 100,000 population over the age of 16 to a high of 15.4 in the Waterford catchment. The highest rate was recorded in East Galway at almost 31 per 100,000 population over the age of 16, but this figure is confounded by the practice of West Galway patients continuing to be admitted to St. Brigid's Hospital in Ballinasloe. The rate of generation of new long stay patients is influenced by a number of factors. It is decreased in those areas that are well provided with 24-hour staffed community residences and increased in areas that continue to admit to remaining long stay wards (Inspector of Mental Health Services 2004: 111).

A major limitation of the *Planning for the Future* report was its failure to challenge the power inequality between the perceived mentally ill and those charged with their care. This has led to the establishing of what may be described as multi-locational total institutions. A particular example is the purchasing of multiple buildings along the North Circular Road, Dublin for hostel accommodation that replaced many of the units previously in Grangegorman Mental Hospital, situated about 100 yards away. These community hostels continue to be staffed, administered and managed directly from Grangegorman, which maintains the doctor - nurse - patient power arrangement established during the 19th century.

The recommendations made in the 1966 commission report were reproduced in the 1984 *Planning for the Future* report and appeared once more in the policy document entitled *A Vision for Change, a report of the Expert Group on Mental Health Policy*

(Department of Health and Children 2006). The key recommendations of this report include:

- Mental health services should be organised nationally in catchments areas for populations of between 250,000 and 400,000.
- Well-trained, fully staffed, community-based multidisciplinary CMHTs (Community Mental Health Teams) should be put in place for all mental health services.
- To provide an effective community based service, CMHTs should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families.

(Department of Health and Children: 2006: 9).

While these recommendations distinctly resemble those set out some forty years previously, two further recommendations in this report set it apart from previous reports. Firstly, in relation to the asylum buildings, this report recommends that:

- A plan to bring about the closure of all mental hospitals should be drawn up and implemented. The resources released by these closures should be protected for re-investment in the mental health service.

(Department of Health and Children: 2006: 9).

The trajectory of asylum construction, which began with the 1817 *Report of Select Committee on the Lunatic Poor in Ireland* proposing the construction of asylum buildings, comes full circle with the 2006 *Report of the Expert Group on Mental Health Policy* proposing the closure and sale of these buildings. This proposal, if implemented, will bring to an end these physical sites of social intervention and containment which have endured almost two hundred years.

A second recommendation introduced in the 2006 policy document is the inclusion of service users in service planning.

- Involvement of service users and their carers should be a feature of every aspect of service development and delivery.

(Department of Health and Children: 2006: 9).

This consultation or 'partnership approach' has become a core feature of the process through which the Irish Government has developed social policy planning since the late 1980s. This policy, if successfully implemented in mental health services provision, will be a point of departure from the previous power differential between 'staff' and 'patients', a key feature of the total institution as observed by Goffman (1961), which was a core aspect of Irish asylum life since the early nineteenth century.

While social policy was instrumental in asylum expansion, in reality it had limited impact on the initial trajectory of its demise and eventual closure. As can be observed in Graphs 3 and 6.1, these institutions were in decline from 1956, prior to the development of any social policy which proposed such declining use. In essence a process of de-institutionalisation commenced before it was formally planned and as such social policy did not act as a catalyst to the initial decline. However, it was a factor that consolidated and sustained the trajectory of reduced institutional usage. Hence, while Saris' view of institutional demise is correct in terms of the type of social policy introduced to Ireland, it does not take account of the empirical reality of reduced bed occupancy from 1956 onwards, as demonstrated in Chapter 3.

> The process, widely known as deinstitutionalisation, quickened dramatically in Britain and the United States of America during the 1970's, followed in short order by Italy, then France, and, eventually Ireland (Saris 1997: 218).

The declining level of institutional residency of 'mentally ill' persons in Ireland is significant in terms of its impact on the mental hospital system as a whole, the individual institutions as social entities, and most importantly the lived experience of institutionalised people. As discussed above, central to this change were legislative reform and the standardising of diagnosis and treatment methods, which predated the

actual occurrence of reduced levels of residency. In parallel to this institutional demise came changes to the 'clinical' practice of professional groups who had previously found their occupational security within these institutions.

Professional 'Reform' and the Anti-Psychiatry Movement

As discussed in Chapter 4, a medical monopoly over asylum management was established from the mid nineteenth-century onwards. In Ireland this medical authority over both clinical interventions and mental hospital management remains intact today. The continuation of this administrative structure was dependent on the labour of asylum attendants / psychiatric nurses who carried out the day-to-day running of Irish asylums/mental hospitals. This cohort of staff had a strong administrative hierarchy, which was situated within an overarching hierarchy that was controlled by medics. Essentially the organisation and registration of specialised training for psychiatric nurses from the early twentieth century onwards was informed by the medical model to 'mental illness'. This provided the labour capacity required to enact a continuous reproduction of medical control over 'mental illness'.

The passing of the 1952 Nurses' Act, which established the Nursing Board did little to reform the primary roles and duties of nurses working within mental hospitals, now referred to as 'psychiatric nurses'. In practice, the core roles and responsibilities of psychiatric nurses remained much the same as those set out in the *General Rules for the Governance of all the District Lunatic Asylums in Ireland* (1843). This cohort of staff

continued to diligently enforce mental hospital policies and procedures, while ensuring that medically prescribed treatments and interventions were implemented as instructed.

> A primary feature of the role of Irish psychiatric nurses during the decades of the 1950s and 1960s was, what I have termed, 'institutional agent'. As an agent of the institution, the nurse ensured that patients adhered to the prevailing system of rules and regulations (Sheridan 2005: 178).

At this time institutionalised nursing practice was being challenged, most notably by the *World Health Organisation Expert Committee on Psychiatric Nursing*. This report expressed concern at the continued use of psychiatric institutions and encouraged psychiatric nurses to develop new nursing practices beyond the confines of the institutional base (WHO 1956). This nurse practice reform was being advocated at the same time as the commencement of declining residency in Irish asylums. This context, international policy and the local reality of reduced institutional occupancy would appear to have offered an opportunity for substantial reform within Irish psychiatric nursing. However, such reform was exceptionally slow to materialise and was not embraced within nursing until the closing years of the twentieth century. This is most probably due to the reproductive momentum within the asylums and the reluctance of nursing staff to abandon the institutions that had provided them with a sense of occupational security.

From its commencement, psychiatric nurse education was provided for within schools of nursing that were established in the grounds of asylums. This provided a very strong bond between the institution and the nursing staff. Many of the staff were educated, employed and quite often accommodated within the institution. A host of secondary activities further reinforced institutional loyalties such as membership of hospital social clubs, sporting teams and musical societies. For example an article in the *Official Journal of the Psychiatric Nurses' Association* provides an account of the inter-

hospital centenary seven-a-side hurling tournament complete with photographs of participating teams and referees (Cunningham 1984: 10-11). This article also included photographs of the Grangegorman Hurling Club 1944-1945, Cricket Club 1939-1940 and the Pipeband in 1930. Similarly in the photographical history of the Mental Hospital in Castlebar, *Snapshots in Time* pictures are included of St Mary's Hospital Ladies GAA Football, which was an-Ireland wining team of 1975, and St Mary's Hospital Men's GAA football team – winners of the 1979 All-Ireland Psychiatric Hospitals Championship (Mayo Mental Health Services Arts Committee 2005: 25-27). Such activities provided a deep sense of institutional belonging which encouraged loyalty and diligence amongst staff, a consequence of which was a reluctance to embrace changes that could reform practice in a manner which would undermine the institution.

The asylum based system of psychiatric nurse education was to continue up until 2002. In response to a recommendation made by the Commission on Nursing (1998), all nurse education in Ireland became degree-based and was transferred to third level institutes. This relocation of Irish nurse education was greeted with some enthusiasm, for example an editorial of a leading international nursing journal the *Journal of Advanced Nursing* comments;

> Nurse Education in Ireland: The end of the beginning and the envy of others in Europe. Ireland's decision for the wholesale integration of nurse education into third level/higher education and a graduate registration programme in 2002 is forward thinking and is designed to bring Irish nursing education into line with other countries such as the United States of America (USA) and Australia (Cowman 2001: 219).

The movement of psychiatric nursing education, coupled with the closure of asylum buildings has led to some calls for an integration of psychiatric, general and intellectual disability nurse training. Such a proposal was suggested in the 2006 Report

of the Expert Group on Mental Health Policy *A Vision for Change* which recommended that:

> A common foundation core programme for all student nurses, followed by specialist training up to the point of registration as psychiatric, intellectual disability or general nurses should be given serious consideration. In the interim shortened training should be available for all qualified nurses wishing to register in any of the other nursing disciplines (Department of Health 2006: 192).

While nurses were the largest cohort of employees in the Irish Asylum / Psychiatric system, they did not have positions of influence to the same degree as medics. This appears to continue to be the case. The above Expert Group had only three nursing representatives whereas there were six with medical qualifications (Department of Health 2006: 7).

A significant feature of the professionalisation of Irish asylums was the medical takeover of management and inspection during the 1840s. The basic structures of control established then were to be reproduced and maintained within the mental health services provision up to the present. While other professions including psychiatric nurses, psychologists, occupational therapists and social workers did develop professional practice within these institutions, they did so much later than medics, and as such were situated within a hierarchy controlled by medically qualified personnel. However, the 1984 policy document *Planning for the Future* recommended a multidisciplinary team approach for the assessment, planning and implementation of patient care. These multidisciplinary teams included consultant psychiatrics, junior doctors, psychiatric nurses, community psychiatric nurses, psychologists, occupational therapists, social workers and any other professional who may have an input to make. This multidisciplinary team approach widened the disciplines involved in patient care.

However, overall control and ultimate clinical accountability continues to rest with senior medics, now referred to as consultant psychiatrics. Similarly day-to-day patient care continues to be predominantly undertaken by psychiatric nurses, effectively maintaining the hierarchy established in the Rules for Asylums published in 1843.

Some alternatives to the medical model have been advocated within what can be collectively described as the 'anti-psychiatry' movement. The term 'anti-psychiatry' was used by Cooper (1967) to describe a critical approach to institutional care from within psychiatry. "When the anti-psychiatry movement coalesced into a recognised entity, many of the early treatises were anti-institutional rather than strictly anti-psychiatry" (Bartlett and Wright 1999: 2). However, the term 'anti-psychiatry' is now generally used to describe a critical approach to the analysis of psychiatry itself, most notably in the work of Laing (1960, 1964), Foucault (1967, 1973, 1977), Szasz (1972), and Illich (1976, 1977).

Within the anti-psychiatry approach, the concept of 'mental illness' is disputed from the outset. In particular there is a rejection of the "notion that mental disorder qualifies as illness" (Cockerham 2003: 89). 'Mental illness' is therefore proposed as a form of social control and psychiatric practice is seen as dysfunctional, led by a professional group of people that are eager to justify their occupational security by medicalising a spectrum of social and personal problems. Hence, the actual concept of 'mental illness' is deconstructed and is situated within a dysfunctional power relationship. Within such an anti-psychiatry thesis traditional psychiatric interventions are considered as dangerous and damaging. Intervention within this approach focuses on

the removal of the power assumed by mental health professionals and advocacy for a wider acceptance of the lived reality of human emotion. As such anti-psychiatrists:

> ... did not question *particular* treatments or policies, nor did they *simply* argue for a more humane psychiatry. . . they questioned the vary basis of psychiatry itself: its purpose, its foundational conception of mental illness and the very distinction between madness and sanity itself. . . Moreover, they examined and criticised the social control function which it performs within society (Crossley 1998: 878)

Drawing on the anti-psychiatry perspective, the policy of setting up residential units in general hospitals may be considered as further consolidating and indeed guaranteeing the future of medical dominance in Irish 'mental health' services. In effect, this policy has developed a practice that sees medicine no longer located within psychiatric hospitals. In fact, psychiatric practice is re-located to the focal point of the medical power and practice, the general hospital. This may be considered as a form of liberation from the stigmatised and oppressive asylum buildings. Alternatively, it may be considered as a misjudged attempt to manage an unjust stigma. Hence stigma is not challenged, but reproduced, by promoting a palatable notion of medical ill health, which will be put right through physical interventions.

However the anti-psychiatry movement did not gain momentum internationally until the late 1960s and even when it did so this social movement had little impact in the Irish context. For example, a core strength of the anti-psychiatry movement was the alliance formed between academics, past mental health service users and the voluntary sector, bolstered by the activities of 'radical' psychiatrists such as R.D. Laing. However, as is discussed below, most voluntary bodies working with past 'service users' in Ireland were led by mental health professionals themselves and 'service users' did not collectively develop any platform from which to advocate resistance to psychiatric

practice. There were no significant alliances formed between academics in Ireland, 'radical' psychiatrists and those institutionalised within asylums. Furthermore, the anti-psychiatry thesis does not provide a satisfactory explanation for the declining levels of residency within of Irish mental hospitals from the 1950s onwards, which was in fact a period that saw increased consolidation of medical power within these institutions.

'Modern Clinical Interventions'

> It is high time that we should cease the search for the herb or the salt or metal which in homeopathic or allopathic doses will cure mania, deterioration, delusions, or excitement. It will not be found any sooner than one will find pills that will make a great artist out of an ignorant lout or a well behaved child out of a spoiled child. (Heinrich Neumann (Alienist) 1818 — Cited in Healy 2002: 1)

The biomedical approach to 'mental illness' provided a 'clinical' context that facilitated the utilisation of some bizarre and horrific physical interventions during the nineteenth century. These included bleedings, cold water baths and the use of swinging chairs (Porter 2004, Robins 1986). The development of a more precise scientific process during the late nineteenth century curtailed such physical interventions but others developed. For example, 'surgical bacteriology', which involved extensive abdominal operations, was practised by Dr Henry Cotton in the USA during the fist decades of the twentieth century (Scull 2005). Another example of physical interventions is Electro Convulsive Treatment (ECT). This was developed in 1938 by psychiatrists Cerletti and Bini based on the "idea that the induction of epileptic type seizures might cure schizophrenia" (Newnes 1999: 11). This form of physical intervention continues to be

used in Ireland today. The psychiatric unit within the newest national hospital in the Dublin suburb of Tallaght was fitted with a 'state of the art' ECT suite. The recently appointed Inspector of Mental Health has expressed concern with the use of ECT, particularly the fact that there continues to be a high degree of variation and inconsistency in the usage of this particular treatment:

> There are marked variations in ECT prescription varying from a high of 38.7 patients per 100,000 population over the age of 16 in the South-Eastern Area to a low of 8.4 patients per 100,000 population over the age of 16 in the Southern Area (Mental Health Commission 2004: 111).

Such inconsistencies have received some media attention, for example an *Irish Times* front page headline states "Concern over variations in use of electroshock treatment", and goes on to state that "The findings have raised concern that proper procedures are not being used for a treatment which critics have denounced as barbaric" (O'Brien 2005: 1).

The most significant development in physical methods of intervention to date is the development of symptom-specific pharmacological treatments for 'mental illness' during the 1950s. These drugs, particularly antipsychotic medication such as Haloperidol and Chlorpromazine, were heralded as a clinical breakthrough in the treatment of people who were diagnosed with 'schizophrenia'. "Dealy and Beniker published the first report of the use of chlorpromazine (later sold under the name Largactil) in France in 1952, followed in Canada by Lehmann in 1954" (Newnes 1999: 11). These pharmacological interventions were introduced in Ireland during the late 1950s, a time that saw the commencement of a declining trend of institutional residency of the 'mentally ill'. The use of psychopharmacology now constitutes the principal form of treatment both in residential and community psychiatric services.

> By the middle of the twentieth century, mood altering drugs, pharmacological tranquillizers, psychosurgery and electric shock treatment were available to artificially alter the cognitive processes of patients. The asylum, as a specific site for moral re-socialization, eventually became redundant (Samson 1995 :58).

Essentially these drugs provided a technology that can be employed to 'cure', 'mask' or 'alleviate' the human experience, which continues to be medically diagnosed as 'mental illness'. Such interventions place an emphasis on treatment within the community setting, hence from the late 1950s medical 'excellence' is demonstrated though the use of pharmacology as a means of preventing institutionalisation. As such the career opportunities that diminished with the reduction of institutional residency from 1956 to the present were replaced with new opportunities created within pharmacologically based psychiatry. The psycho pharmacological industry has in turn formed a close alliance with the medical profession, whose cooperation is required for the continued fiscal success of this business. This has generated a close bond between 'clinical' research, psychiatric practice, and the use of psychopharmacology. For example, in their study of discourses within the British Journal of Psychiatry from 1905-2000, Moncrieff and Crawford found:

> ... that there has been a continuous fascination with biological explanations and interventions for psychiatric disorders. Other systems of understanding and methods of treatment such as psychoanalysis and social psychiatry have generally received little attention (Moncrieff and Crawford 2001: 356)

Drawing on the work of Illich (1976) in particular, the anti-psychiatry movement has articulated a critical view of psychopharmacology. According to this view, the development of these medications is located within the context of the profit interests of the pharmacological industry, facilitated by the continued medicalistion of mental hospitals. Hence, drugs are perceived as a central aspect of the problem rather than the

cure. Psychiatric drugs, particularly major anti-psychotic medication, have severe extrapyramidal side effects including drooling, slurred speech, postural problems and twitching. As such the use of these drugs have physical effects which results in individuals displaying symptoms which are publicly stigmatised and ironically read as evidence of mental illness.

The close alliance between the drug industry and the medical profession together with the potential dangers of psychiatric medication is the primary focus of Peter Breggin's *Toxic Psychiatry: Drugs and Electroconvulsive Therapy: The Truth and the Better Alternatives* in which he argues that

> The drug companies provide the backbone of financial support for the APA and for most of organized psychiatry. The psychiatric newspapers and journals, including those published by APA, are largely paid for by drug company advertising (Breggin: 1993: 426).

This type of advertisement is very common across psychiatric professional journals. For example, an advertisement placed by the drugs company Roche in the *Journal of The America Psychosomatic Society* in 1970 shows a picture of a "freely" moving cat, which has "electrodes permanently implanted in the brain" and is receiving the drug Librium in low doses. Based on such experiments the advertisement goes on to state that;

> Today, Librium (chlordiazepoxide HCI) is well known as a dependable calming agent when anxiety is a significant component of the clinical profile. Although clinical performance cannot be extrapolated from experimental procedures and results, animal studies on Librium indicate a selective action on the limbic system may help to explain the characteristic "Librium effect" in therapy (Roche Laboratories: 1970 1-2).

Other approaches to 'mental illness' developed during the twentieth century provided an alternative to both the use of institutional confinement and physical

interventions: for example, psychological interventions, including psychoanalysis (particularly drawing of the work of Sigmund Freud), cognitive approaches and behaviourism which emerged in the early 1900s. However these were not employed nationally within the Irish psychiatric services until the 1980s and even today they continue to a be small addendum to psycho pharmacology. Commenting on these approacheds Bartlett and Wright note that:

> The adoption of Freudian psychoanalysis, though less influential in Britain and Ireland than in the United States, further challenged the institution as the most appropriate and efficacious locus of medical treatment (Bartlett and Wright 1999: 15).

As explored in Chapter 3, asylum management in Ireland had limited connection with religious administration. However, in the context of modalities of treatment the Catholic Church did have some influence. Firstly, there was limited experimentation with eugenics in Irish asylums which contrasts with the international experience. Only one branch of the Eugenics Education Society was established in Ireland and this was located in Belfast (Finnane 1981). Secondly, the Catholic Church asserted some influence on the education of medics and psychologists within Irish universities. This was most notable in the context of reproductive health issues. Trinity College, which was predominately outside the influence of the Catholic Church, was criticised for its perceived liberal approach to contraception. In a similar way philosophies that underpinned psychological approaches to mental illness also generated some comment. The Irish Catholic Church had some reservations with the development of psychological interventions, particularly the behaviourist movement.

> Church attitudes to psychoanalysis had softened in Ireland by the 1960s, in great part owing to the influence of Fehin O'Doherty, who was later Professor of Psychology in University College Dublin (UCD/Catholic). A marked hostility to

> behaviourism, however, remained until the mid 1970s. Students seeking advice on a career in psychology as late as 1973 were liable to be informed by Dr O'Doherty that the behaviourist approach, as embodied in the Trinity College (Protestant) psychology course, produced a pagan and materialistic psychology. In contrast, while flirting with the depth psychologies, the UCD psychology course remained centred on metaphysics until well into the 1970s (Healy 1996: 279).

In addition to pharmacological and psychological interventions, there has been increased professional interest in what has been described as 'mental health promotion'. The professional groups who had previously found occupational security within asylums began to gravitate to this area of practice during the 1980s, which was the latter period of declining institutional residency in Ireland, illustrated in Graph 6.1. As such, this movement of professional practice was more a result that a cause of deinstitutionalisation.

There are varying perceptions of what comes within the scope of mental health promotion practice and opposing views of what professional groups and organisations are well placed to engage in this activity. In Ireland, the organisations and professionals purporting to engage in 'mental health promotion' are primarily concerned with two very different projects. Firstly, a concern to improve conditions with psychiatric hospitals, and secondly, the pursuit of positive mental health within society (Brennan 2000). Hodgson provides a succinct description of the theory of mental health promotion practice, locating it within a community context and proposing that it is a practice that transcends the limited activity of preventing mental illness.

> Mental health promotion is the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences (Hodgson 1996: 2).

Hodgson's description fits well with the 1946 constitution of the World Health Organisation, which defined the general concept of health as "a state of complete

physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO 1946: 3). This statement signalled a break from the perception of health as a human condition that is the consequence of the absences of illness. A notable feature of the W.H.O. definition is the integration of physical well-being, mental well-being and social well-being. In practice this advocated the reintegration of areas of human existence which had been demarcated and separated, both conceptually and in practice, through a process of occupational closure, scientific positivism and clinical specialisation, particularly in the medical field.

In Ireland mental health promotion activities are primarily resourced through and delivered by the professional groups that are responsible for the provision of psychiatric services. This is often done in conjunction with various voluntary groups that are formed as support agencies for people who have been diagnosed with particular psychiatric illness. These groups are loosely affiliated under the Alliance for Mental Health, an umbrella organisation that incorporates groups such as Schizophrenia Ireland, The Irish Mental Health Organisation, The Alzheimer Society, Bodyways (a group concerned with eating disorders) and the Out and About Association. However, many of these groups are led by psychiatric professionals. For example, the largest such group, the Irish Mental Organisation, is staffed by psychiatric nurses who are paid by and seconded from the public psychiatric services.

This blurring of the boundaries between mental health promotion and psychiatric service provision is not localised to the Irish context. For example the World Federation of Mental Health, formed in 1948, became an internationally influential agency within the field of mental health policy promotion during the late twentieth century. However,

an analysis of the discourses within the book of abstracts published as part of its 1995 World Congress demonstrates the prevalence of psychiatric professionals within this field. Four hundred abstracts are listed, each outlining the context of a lecture, workshop or presentation of some type. Almost all of these presentations exclusively address mental illness, psychiatric disorders and psychiatric service provision and most are presented by individuals employed within the psychiatric field (World Federation for Mental Health 1995).

Hence some significant changes in practice concerned with 'mental illness' have occurred during the period of declining institutional residency. The impact of the demise of these institutions as locations for professional occupation security has been offset by the development of new forms of intervention, most notably increased specialisation in psychopharmacology, but also the development of psychological interventions along with the migration of professional practice into the field of mental health promotion. Hence, the professional groups involved in the direct provision of interventions to the 'mentally ill, have found new forms of practice that transcend the walls of the institutions. This migration of practice is quite evident in a study conducted by Cowman, Farrelly and Gilheany who found that:

> that Irish Psychiatric Nurses have adapted well to changing health policy and in doing so they have been innovative and initiated many new services in response to emerging needs. These include for example, day services, substance abuse programmes and behavioural cognitive and complementary therapies. The study suggests that the educative role of psychiatric nurses has also expanded, particularly in relation to medications and aspects of mental health and rehabilitation in local communities and in society, generally... The extent to which elements of this role are within the remit of professional psychiatric nursing practice has yet to be evaluated and this is suggested as an area for further study. (Cowman, Farrelly and Gilheany 2001: 752)

However, the declining level of institutional residency of the 'mentally ill' dislodged a second cohort of asylum staff. While these staff had no direct involvement in the treatment of the 'mentally ill', they had found employment within asylums in Ireland. These included those employed in construction, maintenance, cooking and gardening etc. The demise of the institution removed such employment opportunities and these staff needed to find occupational security elsewhere.

Employment Beyond the Institution

Irish asylum institutions endured as major physical and social structures within communities for almost two hundred years. In many cases these institutions became the largest buildings in the towns in which they existed and in some cases were the largest single site of residency. For example, the national census in 1951 recorded the town of Ballinasloe as having a population of 5,596 persons of whom "2,078 were patients in the mental hospital, which the asylum had now become, and 439 were full-time employees of the hospital" (Walsh 1997: 127).

As discussed in Chapter 4 these buildings provided many latent functions, most notably a source for local employment, particularly in rural parts of Ireland. Such employment provided individuals with the opportunity to avoid emigration, an enduring feature of Irish social life after independence, particularly along the western sea board. The wages from asylum employment was also strategically important to the communities in which they were situated. An economic dynamic existed where local employment was

generated through mental hospital bed availability and utilisation, the stability of which is dependent on a steady 'supply of patients'.

As explored above, national social policy that advocated alternatives to asylum usage was slow to materialise and was only proposed subsequent to the reality of declining levels and rates of asylum residency. The 1966 report of the *Commission of Inquiry on Mental Illness* was not implemented in practice and the implementation of the 1984 *Planning for the Future* policy was inhibited by the local political dynamics, particularly concerning matters of employment. The scaling down of psychiatric hospitals during the mid 1980s was proposed at a period of exceptionally high unemployment and was an affront to the public desire to protect local employment. This was of major concern to the elected members of the Irish Parliament (TDs). These politicians could not afford to endorse policies that were perceived to be a threat to the permanent employment provided within psychiatric hospitals. Any Minister of Health proposing such closure also ran the risk of being politically isolated by local TDs. This situation was complicated further by the fact that elected politicians were also members of their local Health Boards, the support of which was required to implement the policies set out in *Planning for the Future*. Commenting on this Walsh, the then incoming Inspector of Mental Hospitals, notes that:

> The wish of the Minister for change, without securing the backing of the Health Boards, exposes the weakness of the system. The Health Boards recognise the importance of the psychiatric hospitals as major employers in relatively poor rural areas (Walsh 1987: 114).

Even with virtual full employment in Ireland, coupled with the fact that psychiatric hospitals were almost empty by 2006, the Minister for Health and Children was concerned to reassure the public regarding the issue of employment when launching

A vision for Change: Report of the expert group on Mental Health Policy (2006), which finally announced the sale of the asylum buildings. Eithne Donnellan quotes the Minister of Health and Children Mary Harney as stating:

> ... their closure may cause controversy in some areas, but the move was in the best interest of patients, the vast majority of whom would be better out of an institutional environment. Anyone who suggests that closure of the hospitals would effect local employment was mistaken . . . as multidisciplinary teams are to be put in place in each area to support patients moving to the community (Eithne Donnellan, 2006: 11).

In spite of a decline in usage, which was belatedly endorsed by social policy, the vast majority of the actual physical buildings that were constructed as asylums continued to function up until 2006. At this stage many of these buildings were virtually vacant with only 3,192 persons resident in public mental hospitals and units in 2003 (including persons resident in new psychiatric units in general hospitals) compared with 20,063 residents in mental hospitals in 1956 (Table 17, Appendix 1). It would appear that this declining usage weakened the various latent functions of these buildings and provided the political context required for the unopposed announcement of a policy for their closure and sale.

As mentioned in Chapter 3, there are several economic dynamics between asylums and local communities, one of which was the latent function of these institutions as locations for institutionalising individuals who are socially constructed as unemployable or of no economic utility to their communities. Ironically, once resident within these institutions, many of these 'unemployable' individuals were put to work under the auspices of 'industrial therapy'. The Irish economic boom, which commenced in early the 1990s, reversed the competitive market for local employment. Where once individuals competed with one another for employment, industry now competed to secure

the services of employees. Hence, many individuals once considered unsuitable for employment, were now sought after as a valuable source of labour. However, declining levels of institutional residency predated this development, and as such the virtual full employment achieved during the 1990s was not a catalyst to the process of deinstitutionalisation. However it would appear to be a factor which further facilitated the final closure and sale of these institutions.

With declining usage, the primary policy focus concerning Irish asylum buildings became their equity and real-estate value, particularly their architectural potential for private sector apartment style residential housing, hotels and educational institutions. This has led to some tasteless headlines, for example, a Sunday Times property article was entitled "Mad for it: Why developers are taking over the asylum in Ireland" (Coyle 2003: 6-7).

Hence, by the late 1990s a new political context existed in which Irish asylum buildings could be closed, sold and reopened to perform new functions. It is interesting that the stigma once attached to these buildings quickly disappeared during this process. An example of this seamless destigmatising transition is the District Asylum in Sligo. This institution dominates the skyline of one side of Sligo Town, a stigmatised establishment once feared by families as a shamed location of detention, while simultaneously being relied on by the community for their economic wellbeing. This asylum was closed and immediately converted into a luxury hotel. An institution once feared and stigmatised is now a location for expensive and sophisticated weddings, conferences and holiday breaks.

Irish Family Dynamics and the Demise of the Asylum

The role of the family within the admission process, particularly within the context of the Dangerous Lunatics Acts during the nineteenth century, is explored in Chapter 4. Scheper-Hughes (1977) examined family dynamics during the twentieth century, particularly how family structure influenced the trajectory of asylum usage during the 1970s. This anthropological study considered the relationship between changing rural family life and asylum admission, with particular reference to depopulation, emigration, sexuality and sexual activity, urban/rural ideological conflict, and spirituality / religious dynamics. Scheper-Hughes's study focused on communities in West Kerry, which she argued mistrust outsiders, are intensely familistic and conceptualise land as a form of 'holy geography'. Unusually for an anthropologist, she is dismissive of traditional understandings and beliefs surrounding insanity, referring to local myths as 'irrational', which would appear to contradict the anthropological tradition.

At the time of first publication in 1977 Scheper-Hughes observed foundational threats to the form and meaning of village social life in Kerry. She suggested that such threats are encountered through the disintegration of families, the devaluation of farming and rural trades as an acceptable way of life, and the growing acceptance by the young of the ethos of urban capitalism and secularisation. She also observed a pattern of rural depopulation in Kerry, particularly in the case of young women, which created a situation where young men had limited opportunity to form family units that were strictly conceptualised as lifelong and heterosexual unions. She suggests that a combination of

these factors provided a context for psychological distress, regularly classified as psychiatric illness. This was compounded by the familiarity and counter reliance between communities and the local asylum, which provided for an ease of committal, a lack of resistance, and a general fatalistic acceptance by young men of the logic of their admission to the asylum.

While the changes to family life explored by Scheper-Hughes during the 1970s were certainly profound, the empirical data illustrated in Graphs 4 and 6.1 demonstrate that these changes occurred at a time when Irish asylum utilisation was actually in decline. Hence, it would appear that the challenges to, and conflicts within, rural family life during the 1970s did not provide the context for high levels of asylum admission, as asylum utilisation was declining at this time.

A number of factors would appear to be at play which served to decouple the impact of family dynamics on asylum usage. Firstly, while Irish society continued to be challenged by chronic unemployment and emigration, there was a sustained increase in urbanisation during the 1960s and 1970s. This served to fragment and undermine the previously powerful paternal family dynamic, which had been underpinned and maintained by systems of inheritance, particularly in the context of land ownership. During the 1960s and 1970s education replaced land ownership as the most valuable source for economic security, and mobility was required both to gain and utilise such educational attainment. This undermined the power and status previously held by elder family members. Secondly, the development of internationally standardised diagnostic criteria made it difficult to obtain an ad hoc admission of a family member whose behaviour was considered to be unruly. Lastly, while family members continued to be

part of the process of involuntary asylum admissions, the 1945 Mental Treatment Act made such admissions subject to the endorsement of a general practitioner and the second opinion of another medic within the admitting institution. This served as a safeguard against asylum admission, or the threat of it, being utilised as a weapon within family disputes.

It would appear therefore that a factor contributing to asylum expansion during the mid to late nineteenth century is the manner in which families committed relatives using legal structures that lacked safeguards against abuse. Likewise, the fragmentation of paternal control, coupled with the tightening of legal and medical provisions for mental hospital admission appear to be factors in the decline in institutional residency from 1956 onwards. These safeguards have been consolidated further with the introduction of the provisions of the 2001 Mental Health Act. This legislation provides a system of automatic, independent advocacy for any person admitted to a mental hospital against their will. Essentially this will diminish any threat of mental hospital admission being used within family disputes.

Contemporary Legislative Provisions

The 1945 Mental Treatment Act was replaced by the Mental Health Act of 2001. This Act was passed following a protracted legal and political process, which included the drafting of a Green Paper on Mental Health in (1992), a White Paper on Mental Health in (1995) and a Mental Health Bill in (1999). The passing of the 2001 Act was situated within an international legal and political context, particularly Ireland's

obligations under the *Council of Europe Recommendations for the Legal Protection for Persons Suffering from Mental Disorders Placed as Involuntary Patients* (Council of Europe 1983) and the *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (United Nations General Assembly 1991). These recommendations and principles advocated the passing of legislation at the national level that would ensure a spectrum of protections including: a right to best care, protection from exploitation, and the guarantee of access to a process through which one can exercise one's human rights. The Irish Government was very aware of the shortcomings of the 1945 legislation. For example the White Papers on Mental Health noted that:

> ... the criteria for detention did not conform to those required by this country's international commitments, principally the European convention for the protection of Human Rights and Fundamental Freedoms of 1950 to which Ireland is a signatory (Department of Health, 1995: Section 7).

Some fifty years after signing this European Convention, the 2001 Act provided for the setting up of the Mental Health Commission and the establishing of new regulations for admission and discharge to mental hospitals and units. While this is a welcome development, it has occurred within the reality of a low residency level having already being established as can be observed in Graph 6.1 and Appendix 1, Table 2. However, while the implementation of this legislation is imminent, admissions and discharges continue to be administered under the provisions of the 1945 Mental Treatment Act.

Under the 2001 Mental Health Act, involuntary admission may be made within the following contexts:

> Because of the illness, dementia or disability: there is a serious likelihood of the person concerned causing immediate & serious harm to himself or herself or other persons.
> Or
> Because of the illness, dementia or disability: The judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration of his or her condition or would prevent the administration of appropriate treatment and reception, detention and treatment of the person is likely to benefit or alleviate the condition of that person to a material extent" (Mental Health Commission 2005: Section 2.2: 1)

The process of admission under the 2001 Mental Health Act is similar to that of the 1945 Mental Treatment Act. Forms are completed by a relative or other suitable person, a medical practitioner and a consultant psychiatrist from the admitting institute and the patient must be made aware of their rights at the time of admission. However, the 2001 Act provides much stricter criteria and safeguards than the 1945 legalisation. Involuntary admission is made for only 21 days in the first instance, with the possibility for renewal not exceeding three months on first renewal, six months on the second, and twelve months thereafter.

A copy of all admission or renewal orders must be sent to the Mental Health Commission who refer the matter to a Mental Health Tribunal comprising a practicing barrister or solicitor, a consultant psychiatrist, and a person other than a barrister, solicitor, consultant psychiatrist, registered medical practitioner or registered nurse. The Mental Health Commission also assigns a legal representative to the patient and directs that a consultant chosen from their panel of consultants carry out an examination and interview so as to determine if the admitted person has a mental disorder. All documentation relevant to the case is sent to a Mental Health Tribunal which either affirms or revokes the admission or renewal order. If revoked an order is given that the patient be discharged.

The provisions of the 2001 Act, particularly the existence of the Mental Health Tribunals, provide a level of protection against wrongful detention in psychiatric facilities that has not previously existed in Ireland. However, this legislation is being implemented at a time when the actual level of institutional residency is at its lowest point in over one hundred and fifty years. Hence the 2001 Mental Treatment Act did not cause deinstitutionalisation. Nevertheless, it does provide the legal mechanism to copperfasten the declining trend of institutional residence of 'mentally ill' persons that was established from 1956 onwards.

Conclusion

> Hence, from the late 1950s, sociological forces not fully understood have operated in moving against the institutional containment of the mentally ill. (Walsh 1997: 137)

No single social force created the decline of institutional residency for the 'mentally ill' in Ireland. Rather it was the combined impact of interconnected social forces. Core features of this conjuncture were the international standardisation of diagnostic criteria, the rolling out of the provisions contained in the Mental Treatment Act of 1945, and the introduction of new psychopharmacological interventions. These features had a combined impact that resulted in an interruption of the tendency to institutionalise that emerged in the mid nineteenth century which was reproduced relatively unaltered until 1956. In particular, the judicial / medical fragmentation of control over admission that characterised asylum expansion was replaced by consolidated medical control. In practice, medics had a narrower set of admission criteria that were applied to a more tightly regulated legal system for admissions from 1945 onwards. The

1945 Mental Treatment Act provided for routine and regular points of review of patients, and hence the possibility of long-term institutionalisation became increasingly problematic. The introduction of new clinical interventions such as psychopharmacology and ECT provided forms of intervention that were perceived to be medically 'advanced', and as such there was professional pressure to demonstrate clinical expertise in the utilisation of such interventions as an alternative to long-term institutional care.

The reduced level of residency that commenced in 1956 was belatedly endorsed by social policy, originally in the 1966 *Report of the Commission of Inquiry on Mental Illness* and with greater effect in the 1984 *Planning for the Future* policy document. While these documents were not driven by legislation, in practice they had an impact on the structure, administration and practices relating to mental hospitals. However, in spite of the decline in usage, the actual built environment of mental hospitals continued to function up until the 1990s, essentially until their latent functionality and strategic economic usefulness became redundant.

Today we have a new conjuncture, formed by the 2001 Mental Health Act; new social, political and economic contexts; new systems of inspection; and most importantly the social policy set out in the *A Vision for Change* (Department of Health and Children 2006). This new point of conjuncture is currently bringing about the closure and sale of the asylum buildings that had endured as a feature of Irish social life since 1817. As with the rise of institutional residency for the 'mentally ill' in Ireland, the demise of this national system of institutions is a complex and multi-layered social process.

The combined social forces that instigated the decline of institutional residency for the 'mentally ill' in Ireland are set out in Illustration 5 below. This draws from

Ritzer's framework of four major levels of social analysis, which is explored in Chapter 2. These social forces are graphically presented in Illustration 6 which situates this point of conjuncture within the data contained in Chapter 3.

Illustration 5: A Slow Process of De-Institutionalisation – Established Through a Conjuncture of Social Forces 1945-1950's

Macroscopic

Objective	**I. Macro-Objective** • 1945 Mental Treatment Act • Political concern regarding Ireland's comparatively high level of institutionalisation • 1950 European Convention on Human Rights & Fundamental Freedoms • Admission controlled by the internationally standardised of classification systems • Belated social policy for deinstitutionalisation (1966/1984)	**II. Macro-Subjective** • Continued experience of high unemployment and emigration. • Public confidence in the advance of medical science and psychiatry • Urbanisation and rural decline • Increasing impact of industrialisation and capitalism on family life • Change in family dynamics (eroding of lifelong parental control over children)
	III. Micro-Objective • Continued local economic and social dependency on asylums • Medical consolidation of admission process – subject to second opinion • Use of ECT; psychological interventions and psychopharmacology • Development of limited community based psychiatric practice	**IV. Micro-Subjective** • Continued stigmatisation of patients • Continued pride and loyalty of mental hospital staff • Reduced but continued institutionalisation of the 'mentally ill' / loss of self esteem / loss of contact with outside world / and acceptance of ones role as a mental patient

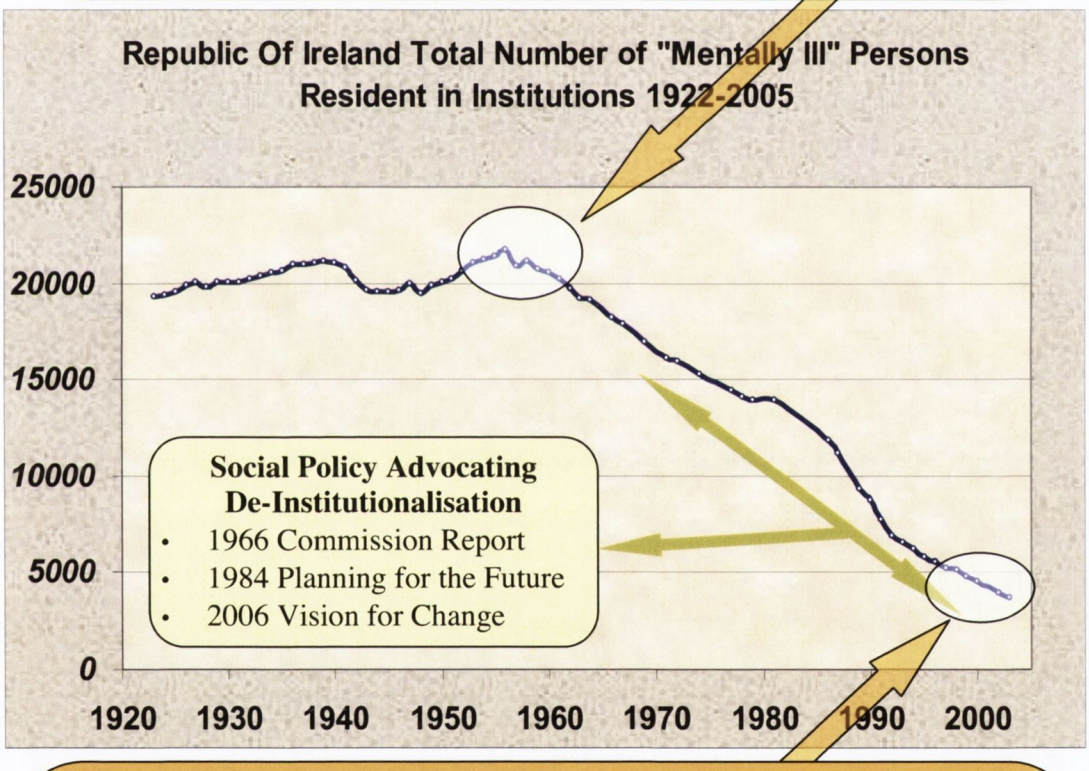
Subjective

Microscopic

Illustration 6: Conjuncture: The Interruption and Ending of Institutions for the 'Mentally ill' in Ireland

Conjuncture and the Interruption of Institutionalisation of the 'Mentally ill'

- 1945 Mental Treatment Act
- Development Psychopharmacology / ECT and Psychological Interventions
- International Standardisation of Classification Systems
- European Convention on Human Rights & Fundamental Freedoms (1950)
- Gradual Fragmentation of Traditional Family & Parental Control



Conjuncture and the End of Institutionalisation of the 'Mentally ill'

- 2001 Mental Health Act
- UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)
- Renewed System of Inspection / Mandatory Legal Advocacy
- End of Local Economic Dependency of Asylums - Celtic Tiger and Full Employment
- Re-orientation of Practice Towards Mental Health Promotion
- Sale of Asylum Buildings

Chapter 6

Conclusion:

Irish Asylum Utilisation – A Question of Conjuncture?

Introduction

> I would be among the first to declare that the long-run purpose of all empirical research is construction of sound theories - which are no more than verifiable generalizations about the world we live in. But, this said, it is important to keep before us constantly the fact that social change, where it can be unchallengeably said to exist, is always change of some element or structure of human behaviour in society. There is no way, I decided long ago in my own teaching, to confront the beginning student with the nature of social change except by doing this in terms of empirical manifestations of change (Nisbet 1972: vi).

During the early phases conducting this dissertation it became apparent that no single factor could explain the particular trajectory of institutional residency for the 'mentally ill' in Ireland. In light of this a methodological framework was sought that would provide for a multicausal exploration of the factors that have underpinned institutional use in Ireland. This methodological framework is set out in Chapter 2 where it is proposed that the critical and interpretive traditions within historical sociology are particularly suitable for considering this field of study. Drawing on this methodological approach and research agenda, an overarching understanding of the multicausal features of the trajectory of institutional confinement for the 'mentally ill' in Ireland was sought.

Chapters 3, 4 and 5 reveal that the establishment, expansion and demise of this institutional residency can indeed be understood as a complex and multilayered social

process that is underpinned by a wide range of social forces and enabled through the human action of individuals and groups. As such, these chapters confirm and demonstrate the initial tentative observations that were made at the commencement of this research process and also further validate critical-interpretive historical sociology as a relevant and useful methodological approach. However, during the conduct of this research process another finding began to emerge. It became increasingly clear that there were identifiable points of conjuncture that punctuate the major phases of change in Irish asylum/mental hospital utilisation.

Conjuncture, Tendency and Social Change

The insights gleaned from this dissertation suggest that social life can become ordered through identifiable points of conjuncture. This draws from the understanding of conjuncture as a "particular combination of structural causes and events, in a particular time and place" (Paige 1999: 782). These points of conjuncture have an effect on macro and micro systems and structures that shape the social action of individuals and groups through time. In the case of this dissertation the actions in question refer to the construction of institutional confinement. Once formed these social actions can develop into tendencies that are reproduced and repeated relatively uninterrupted until a new point of conjuncture occurs.

Three points of conjuncture are identified in this dissertation as being of enduring importance to Irish institutional residency for the 'mentally ill'. The first of these occurred during the mid-nineteenth century and served to shape and order a tendency to institutionalise that was enacted and experienced by individuals, families and professional groups. The various themes explored in Chapter 4 and set out in Ritzer's framework in Illustration 3 suggest that this point of conjecture was multicausal and constituted a confluence of wide scale social forces along with the action of individuals. The macroscopic aspect of this conjuncture includes features such as the centralisation of colonial administrative systems, legislative provisions, and the fragmentation of local planning, payment and utilisation of asylums. The microscopic features integral to this conjuncture include the activities of the first Inspector of Asylums, Francis White, internal family dynamics and the personal experiences of those institutionalised.

The tendency to institutionalise became embedded at both the personal and societal level, which underpinned the sustained rise in the rate of institutional residency up until the late 1950s. What is most notable is the enduring nature of this tendency. Once formed this tendency is reproduced until a new point of conjuncture occurs. This once again entailed multiple objective and subjective changes at both the macroscopic and microscopic level. This is not to suggest that no change occurred from the mid-nineteenth to early twentieth century. As discussed in Chapters 3 and 4 there was in fact substantive change. However, no new point of conjuncture was formed during this time that was powerful enough to reshape the structures, systems and human behaviours enabling institutionalisation.

For example, as observed in Chapter 4, "Under an Act of 1898, a new administrative system was set up and it became the duty of County Councils to provide accommodation for the lunatic poor and manage the asylum for the county" (Commission of Inquiry on Mental Illness 1966: 9). This development provided for a greater level of localised cohesiveness between asylum planning, administration, funding and utilisation. In theory this created a bureaucratic context in which excessive institutional usage could be curtailed. However, a reduction in the rate of institutional usage did not materialise at this time. The legal provision set out in the Dangerous Lunatic Acts of 1868 and 1867 continued to be utilised for admission. Asylum rules and diagnostic criteria did not substantively change. Asylums/mental hospitals continued to be depended on for social intervention and local employment, and there continued to be an overall societal acceptance of the logic of institutional utilisation. Similarly, while wide and profound changes were underway in Irish society, for example political unrest, partition and civil war, the 'tendency' to institutionalise remained until a new point of conjuncture occurred.

It was not until the mid-twentieth century that a confluence of objective and subjective changes emerged at both the macroscopic and microscopic level that was powerful enough to disrupt and reshape the social practice of institutional utilisation. The core features of this second point of conjuncture are set out within Ritzer's framework in Illustration 5 in Chapter 5. Again substantive change was identified at each of the four levels of analysis. However, it is interesting to note that while there is a confluence of change, there was not complete change. For example up until the late 1980s there was a continued local dependency on mental hospitals in terms of local employment

opportunity and the individuals admitted to these institutions continued to be stigmatised and marginalised by Irish communities.

As such, while major change occurred in the mid twentieth century, several factors continued to militate against a reduction in institutional usage. A tension therefore existed between the reproductive momentum within these institutions and the conjuncture of social forces that stimulated change during this time. The resulting decline in institutional utilisation was therefore a slow process that spanned some 50 years - from 1956 to the present. Hence, while the tendency to institutionalise was interrupted and reshaped, particular societal and organisational resistance to change remained, which served to prevent a radical emptying of these institutions.

As observed in Chapter 5, during the declining phase in Irish utilisation a migration of practice occurred, particularly within the professions of psychiatry and psychiatric nursing. This has included the development of psychological innovations; community based approaches, the opening of psychiatric units in general hospitals and the emergence of 'mental health promotion'. These new forms of intervention have effectively ensured that the professional power structures that were established within the asylum system of the nineteenth century are maintained beyond the institutional setting.

While there was significant change during the mid twentieth century, it was not until the commencement of the twenty-first century, almost two hundred years after the initial foundation of the Irish asylum system, that asylum buildings were finally closed and put up for sale. This closure was made possible through a new point of conjuncture, which again is characterised by substantive change at all four levels of analysis suggested by Ritzer. This is set out in Illustration 7 below.

Illustration 7: The End of Irish Institutions for the 'Mentally ill' in Ireland – A Contemporary Conjuncture of Social Forces

Macroscopic

	I. Macro-Objective • 2001 Mental Health Act • UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) • Industrialisation / Celtic tiger economy • Rapid urbanisation • Social policy endorsing sale of asylum buildings	**II. Macro-Subjective** • Medical authority is brought into question (hepatitis tribunal / organ retention scandal) • Crises in trust of institutions – public investigation of industrial schools / Magdalene laundries / nursing homes • Growth in advocacy • High profile (celebrity) role models who utilise 'mental health services'
Objective	**III. Micro-Objective** • Asylums are recognised as valuable real-estate • Establishing of mental health tribunals • No local economic and social dependency on asylums	**IV. Micro-Subjective** • Mental health / mental illness are increasingly recognised as part of personal health • De-stigmatising of 'mental illness' • Personal empowerment to resist institutionalisation

Subjective

Microscopic

Conclusion

> ... 'history of the present' may be loosely characterised by its use of historical resources to reflect upon the contingency, singularity, interconnections, and potentialities of the diverse trajectories of those elements which compose present social arrangements and experience (Dean 1994: 21).

This dissertation provides an insight into how particular points of conjecture were formed by objective and subjective changes at both the macroscopic and microscopic levels, thus creating and reshaping a social tendency to institutionalise the 'mentally ill'

in Ireland. It would appear that once this tendency was established it became robustly embedded within social life and was repeatedly enacted until a new point of conjuncture occurred.

Illustration 1, set out in the Introduction of this dissertation, shows the overall trajectory of institutional usage in Ireland, along with a diagrammatic presentation of the three particular points of conjuncture that have punctuated the major changes of this trajectory. This illustration provides a synthesis of the empirical, historical and sociological insights gleaned from this study, demonstrating both the reproduction of a social tendency (institutionalisation) and the impact of points of conjuncture in reshaping this tendency.

> ... change is *not* constant and universal; not if we keep our eye rigorously on some given structure or trait ... Social interaction is to be found in social fixity and persistence as well as in social change. That is why, if we are to answer the question of causation in change, we are obliged to deal with, first, *the nature of social persistence* and, then, *with variables, not constants*, when we turn to the matter of what causes the observed change in structure, trait or idea (Nisbet 1972: 5).

Epilogue

The act of institutionalisation has a profound dehumanising effect, most notably on the institutionalised person, but also on both those who directly enact institutionalisation and the wider society that is lessened by the rejection of its own. In Ireland this act of institutionalisation was widely utilised against people socially constructed as being 'mentally ill' and medically diagnosed as such. This constituted an extensive programme of institutional confinement that was publicly funded and administered. To date a substantive public inquiry into this programme of institutionalisation has not taken place. Such an inquiry would appear timely.

Appendix 1
Tables of Data

Abbreviations used in Tables:

Inspector of Lunatic Asylums Ireland	(ILI)
Central Statistics Agency	(CSO)
Inspector of Mental Hospitals	(IMH)
Inspectors-General	(IG)
Irish Psychiatric and Units Census	(IPH & U Cen)
Statistical Abstract of Ireland	(SAI)

Note: Source years for the Inspector of Mental Hospital (IMH) reports indicate the year referred to in the title of each report. The actual year of publication along with the full title of each report is indicated in the bibliography.

Total Number (and Gender) of "Mentally ill" Persons Resident in Institutions

Table 1

Island of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Institutions 1829-1921						
Year End	**Source**	**Date of Count**	**Male**	**Female**	**Gender Not Given**	**Total**
1829	IG 1830				2,097	2,097
1843	IG 1844 (Report for 1843)	Jan 1st 1844	1,100	1,012	1,386	3,498
1844	IG 1845 (Report for 1844)	Jan 1st 1845	2,362	2,276		4,638
1845	ILI 1846 (Report for 1845)	Jan 1st 1846	2,626	2,953		5,579
1846	ILI 1847 (Report for 1847)	Dec 31st 1846	2,951	3,153		6,104
1847						
1848	ILI 1949 (Report for 1848)	Dec 31st 1848	2,718	2,960		5,678
1849						
1850						
1851	ILI 1851 (5th Report)	Mar 31st 1851	2,666	3,129		5,795
1852						
1853						
1854						
1855	ILI 1855 (7th Report)	Mar 31st 1855	2,891	3,372		6,263
1856	ILI 1857 (8th Report)	Mar 31st 1856	2,914	3,238		6,152
1857	ILI 1857 (8th Report)	Mar 31st 1857				
1858	ILI 1859 (9th Report)	Mar 31st 1858				
1859	ILI 1859 (9th Report)	Mar 31st 1859				
1860	ILI 1861 (10th Report)	Mar 31st 1860	3,628	4,002		7,630
1861	ILI 1862 (11th Report)	Dec 31st 1861	3,820	4,235		8,055

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1862	ILI 1863 (12th Report)	Dec 31st 1862	3,809	4,053		7,862
1863	ILI 1864 (13th Report)	Dec 31st 1863	4,030	4,169	73	8,272
1864	ILI 1865 (14th Report)	Dec 31st 1864	4,179	4,238	68	8,485
1865	ILI 1866 (15th Report)	Dec 31st 1865	4,344	4,425	64	8,833
1866	ILI 1867 (16th Report)	Dec 31st 1866	4,351	4,551	62	8,964
1867	ILI 1868 (17th Report)	Dec 31st 1867	4,475	4,560	51	9,086
1868	ILI 1869 (18th Report)	Dec 31st 1868	4,703	4,703	49	9,455
1869	ILI 1870 (19th Report)	Dec 31st 1869	4,973	5,064	45	10,082
1870	ILI 1871 (20th Report)	Dec 31st 1870	5,120	5,095	43	10,258
1871	ILI 1872 (21st Report)	Dec 31st 1871	5,365	5,367	35	10,767
1872	ILI 1873 (22nd Report)	Dec 31st 1872	5,520	5,408	30	10,958
1873	ILI 1875 (23rd Report)	Dec 31st 1873	5,671	5,632	25	11,328
1874	ILI 1875 (24th Report)	Dec 31st 1874	5,761	5,797	25	11,583
1875	ILI 1876 (25th Report)	Dec 31st 1875	5,840	5,937		11,777
1876	ILI 1877 (26th Report)	Dec 31st 1876	6,001	6,122		12,123
1877	ILI 1878 (27th Reoprt)	Dec 31st 1877	6,047	6,333		12,380
1878	ILI 1879 (28th Report)	Dec 31st 1878	6,271	6,314		12,585
1879	ILI 1880 (29th Report)	Jan 1st 1980	6,359	6,460		12,819
1880	ILI 1881 (30th Report)	Dec 31st 1880	6,510	6,529	19	13,058
1881	ILI 1882 (31st Report)	Dec 31st 1881	6,677	6,749	18	13,444
1882	ILI 1883 (32nd Report)	Jan 1st 1883	6,862	6,943	16	13,821
1883	ILI 1884 (33rd Report)	Jan 1st 1884	7,073	7,015		14,088
1884	ILI 1885 (34th Report)	Dec 31st 1884	7,231	7,048		14,279
1885	ILI 1886 (35th Report)	Dec 31st 1895	7,292	7,127		14,419
1886	ILI 1887 (36th Report)	Dec 31st 1886	7,401	7,301		14,702

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1887	ILI 1888 (37th Report)	Dec 31st 1887	7,682	7,581		15,263
1888	ILI 1889 (38th Report)	Jan 1st 1889	7,923	7,762		15,685
1889	ILI 1890 (39th Report)	Jan 1st 1890	8,115	8,044		16,159
1890	ILI 1891 (40th Report)	Jan 1st 1891	8,165	8,086		16,251
1891	ILI 1892 (41st Report)	Jan 1st 1892	8,405	8,284		16,689
1892	ILI 1893 (42nd Report)	Jan 1st 1893	8,705	8,419		17,124
1893	ILI 1894 (43rd Report)	Jan 1st 1894	8,947	8,329		17,276
1894	ILI 1895 (44th Report)	Jan 1st 1895	9,121	8,534		17,655
1895	ILI 1896 (45th Report)	Jan 1st 1896	9,504	8,853		18,357
1896	ILI 1897 (46th Report)	Jan 1st 1897	9,824	9,142		18,966
1897	ILI 1898 (47th Report)	Jan 1st 1898	10,127	9,463		19,590
1898	ILI 1899 (48th Report)	Jan 1st 1899	10,522	9,782		20,304
1899	ILI 1990 (49th Report)	Jan 1st 1900	10,756	10,107		20,863
1900	ILI 1901 (50th Report)	Jan 1st 1901	11,014	10,155		21,169
1901	ILI 1902 (51st Report)	Jan 1st 1902	11,217	10,413		21,630
1902	ILI 1903 (52nd Report)	Jan 1st 1903	11,503	10,635		22,138
1903	ILI 1904 (53rd Report)	Jan 1st 1904	11,803	10,991		22,794
1904	ILI 1905 (54th Report)	Jan 1st 1905	11,900	11,096		22,996
1905	ILI 1906 (55th Report)	Jan 1st 1906	12,184	11,181		23,365
1906	ILI 1907 (56th Report)	Jan 1st 1907	12,254	11,300		23,554
1907	ILI 1908 (57th Report)	Jan 1st 1908	12,274	11,444		23,718
1908	ILI 1909 (58th Report)	Jan 1st 1909	12,355	11,576		23,931
1909	ILI 1910 (59th Report)	Jan 1st 1910	12,562	11,582		24,144
1910	ILI 1911 (60th Report)	Jan 1st 1911	12,704	11,690		24,394
1911	ILI 1912 (61st Report)	Jan 1st 1912	12,868	11,787		24,655

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1912	ILI 1913 (62nd Report)	Jan 1st 1913	12,962	11,877		24,839
1913	ILI 1914 (63rd Report)	Jan 1st 1914	13,030	11,979		25,009
1914	ILI 1915 (64th Report)	Jan 1st 1815	13,187	11,993		25,180
1915	ILI 1917 (65th Report)	Dec 31st 1915	13,070	12,033		25,103
1916	ILI 1918 (66th Report)	Dec 31st 1916	13,044	11,722		24,766
1917	ILI 1919 (67th Report)	Dec 31st 1917	12,426	11,466		23,892
1918	ILI 1919 (68th Report)	Dec 31st 1918	11,819	11,049		22,868
1919	ILI 1921 (69th Report)	Dec 31st 1919	11,690	10,888		22,578
1920						
1921						

Table 2

Republic of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Institutions 1922-2000					
Year	**Source**	**Male**	**Female**	**Gender Not Given**	**Total**
1922	IMH 1924				
1923	IMH 1924				
1924	IMH 1924	10,125	9,273		19,398
1925	IMH 1926	8,989	7,649	2,924	19,562
1926	IMH 1926	10,387	9,522		19,909
1927	IMH 1927	10,423	9,641		20,064
1928	IMH 1928	10,303	9,470		19,773
1929	IMH 1929	10,470	9,596		20,066
1930	IMH 1930	10,486	9,598		20,084
1931	IMH 1931	10,556	9,527		20,083
1932	IMH 1932	10,564	9,623		20,187
1933	IMH 1933	10,651	9,776		20,427
1934	IMH 1934	10,733	9,798		20,531
1935	IMH 1935	10,751	9,907		20,658
1936	IMH 1936	10,890	10,066		20,956
1937	IMH 1937	10,865	10,080		20,945
1938	IMH 1938	10,903	10,135		21,038
1939	IMH 1939	10,952	10,173		21,125
1940	IMH 1940	10,876	10,205		21,081
1941	IMH 1941	10,748	10,078		20,826
1942	IMH 1942	10,401	9,703		20,104
1943	IMH 1943	10,059	9,593		19,652
1944	IMH 1944-1946	9,960	9,551		19,511
1945	IMH 1944-1946	9,963	9,575		19,538
1946	IMH 1944-1946	9,984	9,622		19,606
1947	SAI 1949	10,161	9,798		19,959
1948	IMH 1949	9,887	9,587		19,474
1949	IMH 1949	10,182	9,742		19,924
1950	IMH 1950	10,229	9,850		20,079
1951	IMH 1951	10,293	9,948		20,241
1952	IMH 1952	10,578	10,065		20,643
1953	IMH 1953	10,748	10,319		21,067
1954	IMH 1954	10,843	10,399		21,242

Year	Source	Male	Female	Gender Not Given	Total
1955	IMH 1955	10,997	10,355		21,352
1956	IMH 1956	11,207	10,513		21,720
1957	IMH 1957	11,015	9,848		20,863
1958	IMH 1958	11,204	9,946		21,150
1959	IMH 1959	11,078	9,615		20,693
1960	IMH 1960	11,022	9,572		20,594
1961	IMH 1961-62	10,788	9,403		20,191
1962	IMH 1961-62	10,584	9,160		19,744
1963	IMH 1977-1979			19,247	19,247
1964	IMH 1977-79 & Central Mental Hospital (Archive - Night Reports)	89	12	18,989	19,090
1965					
1966	IMH 1977-79 & Central Mental Hospital (Archive - Night Reports)	88	16	18,084	18,188
1967	IMH 1977-79 & Central Mental Hospital (Archive - Night Reports)	93	19	17,787	17,899
1968					17,224
1969	IMH 1977-79 & Central Mental Hospital (Archive - Night Reports)	90	25	16,802	16,917
1970					
1971	IMH 1977-79 & Central Mental Hospital (Archive - Night Reports)	85	28	15,961	16,074
1972	IMH 1977-79 & Central Mental Hospital (Archive - Night Reports)	93	20	15,856	15,969
1973					
1974	IMH 1977-79 & Central Mental Hospital (Archive - Night Reports)	92	14	15,156	15,262
1975					
1976					
1977	IMH 1977-1979			14,462	14,462
1978	IMH 1977-1979			14,067	14,067
1979	IMH 1977-1979			13,947	13,947
1980				90	90
1981	IPH & U Census 1981			13,920	13,920
1982					
1983					
1984					

Year	Source	Male	Female	Gender Not Given	Total
1985					
1986	IMH 1988-89 & Central Mental Hospital (Archive - Night Reports)			11,823	11,823
1987	IMH 1988-89 & Central Mental Hospital (Archive - Night Reports)			11,122	11,122
1988					
1989	IMH 1988-89	76	9	9,250	9,335
1990	IMH 1990	74	6	8,636	8,716
1991	IMH 1991	81	10	7,633	7,724
1992	IMH 1992			6,866	6,866
1993	IMH 1993			6,511	6,511
1994	IMH 1994			6,181	6,181
1995	IMH 1995			5,830	5,830
1996	IMH 1996			5,552	5,552
1997	IMH 1997			5,192	5,192
1998	IMH 1998			5,101	5,101
1999	IMH 1999 & Central Mental Hospital (Archive - Night Reports)	81	5	4,709	4,795
2000	IMH 2001			4,522	4,522

Table 3

Northern Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Institutions 1926-1991				
Year	**Source**	**Male**	**Female**	**Total**
1926	Pauline M. Prior (2001)	2,215	1,948	4,163
1930	Pauline M. Prior Personal Correspondence	2,446	2,078	4,524
1935	Pauline M. Prior Personal Correspondence	2,788	2,337	5,125
1937	Pauline M. Prior (2001)	2,856	2,375	5,231
1951	Pauline M. Prior (2001)	2,798	2,522	5,320
1971	Pauline M. Prior (2001)	2,457	2,487	4,944
1981	Pauline M. Prior (2001)	1,473	1,681	3,154
1991	Pauline M. Prior (2001)	1,625	1,712	3,337

Number of "Mentally ill" Persons Resident in Institutions Per 100,000 of Population 1850-2000

Table 4

Island of Ireland: Number of "Mentally ill" Persons Resident in Institutions (and Gender) Per 100,000 of Population 1851-1911			
Year	Male	Female	Total Rate Per 100,000
1851	83.57	93.08	88.44
1861	134.63	143.00	138.90
1871	203.24	193.57	198.93
1881	263.57	255.49	259.80
1891	362.45	347.22	354.73
1901	509.85	461.01	485.11
1911	587.03	536.22	561.59

Table 5

Republic Of Ireland: Number of "Mentally ill" Persons Resident in Institutions (and Gender) Per 100,000 of Population 1922-2000			
Year	Male	Female	Total Rate Per 100,000
1922			
1923			
1924			
1925			655.34
1926	689.30	649.92	669.89
1927			678.53
1928			670.50
1929			683.21
1930			686.16
1931			684.73
1932			686.87
1933			689.64
1934			691.05
1935			695.32
1936	716.23	695.18	705.96
1937			711.45
1938			716.31
1939			720.01
1940			712.68
1941			696.52
1942			678.50
1943			667.07
1944			662.74
1945			654.98
1946	667.88	658.94	663.46
1947			671.57
1948			652.40
1949			668.37
1950	677.42	675.12	676.29
1951	683.20	684.18	683.68
1952	704.78	693.18	699.08
1953	717.54	711.12	714.38
1954	726.26	718.06	722.22

Year	Male	Female	Total Rate Per 100,000
1955	743.49	718.20	731.01
1956	765.98	732.41	749.35
1957	756.47	689.06	723.08
1958	778.65	703.49	741.40
1959	772.20	681.43	727.19
1960	772.34	681.28	727.16
1961	761.57	670.78	716.41
1962	743.89	650.89	697.64
1963			675.33
1964			666.60
1965			648.55
1966			630.65
1967			617.27
1968			591.44
1969			578.32
1970			555.95
1971			539.71
1972			528.01
1973			503.45
1974			488.56
1975			471.91
1976			448.37
1977			442.01
1978			424.47
1979			414.08
1980			
1981			
1982			
1983			
1984			
1985			
1986			333.92
1987			313.60
1988			
1989			265.98
1990			248.61
1991			219.08
1992			193.16
1993			182.17

Year	Male	Female	Total Rate Per 100,000
1994			172.37
1995			161.89
1996			153.11
1997			141.69
1998			137.75
1999			128.15
2000			119.33

Table 6

Northern Ireland: Number of "Mentally ill" Persons Resident in Institutions (and Gender) Per 100,000 of Population 1926-1991			
Year	**Male**	**Female**	**Total Rate Per 100,000**
1926	364.26	300.40	331.30
1937	458.31	361.72	408.75
1951	418.98	358.70	388.06
1971	325.57	318.28	321.86
1981	194.69	213.79	204.42
1991	211.29	211.68	211.49

Island of Ireland 1800-1921: Detailed Breakdown of "Mentally ill Persons Resident in Institutions

Table 7

Island of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Public Asylums 1837-1921						
Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1843	IG 1844 (Report for 1843)	Jan 1st 1844	1,100	1,012		2,112
1844	IG 1845 (Report for 1844)	Jan 1st 1845	1,101	1,035		2,136
1845	ILI 1846 (Report for 1845)	Jan 1st 1846	1,311	1,244		2,555
1846	ILI 1847 (Report for 1847)	Dec 31st 1846	1,346	1,264		2,610
1847						
1848	ILI 1949 (Report for 1848)	Dec 31st 1848	1,348	1,255		2,603
1849	ILI 1851 (5th Report)	Mar 31st 1849	1,314	1,258		2,572
1850	ILI 1851 (5th Report)	Mar 31st 1850	1,302	1,259		2,561
1851	ILI 1851 (5th Report)	Mar 31st 1851	1,301	1,283		2,584
1852	ILI 1853 (6th Report)	Mar 31st 1852	1,376	1,346		2,722
1853	ILI 1853 (6th Report)	Mar 31st 1853	1,447	1,423		2,870
1854						
1855	ILI 1855 (7th Report)	Mar 31st 1855	1,720	1,802		3,522
1856	ILI 1857 (8th Report)	Mar 31st 1856	1,825	1,813		3,638
1857	ILI 1857 (8th Report)	Mar 31st 1857	1,969	1,887		3,856
1858	ILI 1859 (9th Report)	Mar 31st 1858	2,035	1,930		3,965
1859	ILI 1859 (9th Report)	Mar 31st 1859	2,087	2,003		4,090
1860	ILI 1861 (10th Report)	Mar 31st 1860	2,131	2,044		4,175
1861	ILI 1862 (11th Report)	Dec 31st 1861	2,216	2,172		4,388
1862	ILI 1863 (12th Report)	Dec 31st 1862	2,319	2,187		4,506
1863	ILI 1864 (13th Report)	Dec 31st 1863	2,439	2,233		4,672

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1864	ILI 1865 (14th Report)	Dec 31st 1864	2,465	2,264		4,729
1865	ILI 1866 (15th Report)	Dec 31st 1865	2,529	2,306		4,835
1866	ILI 1867 (16th Report)	Dec 31st 1866	2,661	2,409		5,070
1867	ILI 1868 (17th Report)	Dec 31st 1867	2,748	2,464		5,212
1868	ILI 1869 (18th Report)	Dec 31st 1868	3,131	2,685		5,816
1869	ILI 1870 (19th Report)	Dec 31st 1869	3,382	2,934		6,316
1870	ILI 1871 (20th Report)	Dec 31st 1870	3,574	3,081		6,655
1871	ILI 1872 (21st Report)	Dec 31st 1871	3,760	3,232		6,992
1872	ILI 1873 (22nd Report)	Dec 31st 1872	3,905	3,235		7,140
1873	ILI 1875 (23rd Report)	Dec 31st 1873	3,967	3,380		7,347
1874	ILI 1875 (24th Report)	Dec 31st 1874	4,072	3,513		7,585
1875	ILI 1876 (25th Report)	Dec 31st 1875	4,142	3,599		7,741
1876	ILI 1877 (26th Report)	Dec 31st 1876	4,340	3,733		8,073
1877	ILI 1878 (27th Reoprt)	Dec 31st 1877	4,393	3,790		8,183
1878	ILI 1879 (28th Report)	Dec 31st 1878	4,550	3,857		8,407
1879	ILI 1880 (29th Report)	Jan 1st 1980	4,577	3,913		8,490
1880	ILI 1881 (30th Report)	Dec 31st 1880	4,685	3,982		8,667
1881	ILI 1882 (31st Report)	Dec 31st 1881	4,860	4,118		8,978
1882	ILI 1883 (32nd Report)	Jan 1st 1883	5,022	4,249		9,271
1883	ILI 1884 (33rd Report)	Jan 1st 1884	5,196	4,346		9,542
1884	ILI 1885 (34th Report)	Dec 31st 1884	5,322	4,365		9,687
1885	ILI 1886 (35th Report)	Dec 31st 1895	5,402	4,470		9,872
1886	ILI 1887 (36th Report)	Dec 31st 1886	5,493	4,584		10,077
1887	ILI 1888 (37th Report)	Dec 31st 1887	5,734	4,765		10,499
1888	ILI 1889 (38th Report)	Jan 1st 1889	5,888	4,937		10,825

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1889	ILI 1890 (39th Report)	Jan 1st 1890	6,037	5,143		11,180
1890	ILI 1891 (40th Report)	Jan 1st 1891	6,194	5,294		11,488
1891	ILI 1892 (41st Report)	Jan 1st 1892	6,359	5,375		11,734
1892	ILI 1893 (42nd Report)	Jan 1st 1893	6,601	5,532		12,133
1893	ILI 1994 (43rd Report)	Jan 1st 1894	6,818	5,616		12,434
1894	ILI 1895 (44th Report)	Jan 1st 1895	7,002	5,769		12,771
1895	ILI 1896 (45th Report)	Jan 1st 1896	7,287	6,045		13,332
1896	ILI 1897 (46th Report)	Jan 1st 1897	7,680	6,361		14,041
1897	ILI 1898 (47th Report)	Jan 1st 1898	7,945	6,653		14,598
1898	ILI 1899 (48th Report)	Jan 1st 1899	8,323	6,966		15,289
1899	ILI 1990 (49th Report)	Jan 1st 1900	8,607	7,302		15,909
1900	ILI 1901 (50th Report)	Jan 1st 1901	8,912	7,492		16,404
1901	ILI 1902 (51st Report)	Jan 1st 1902	9,133	7,747		16,880
1902	ILI 1903 (52rd Report)	Jan 1st 1903	9,508	8,072		17,580
1903	ILI 1904 (53rd Report)	Jan 1st 1904	9,791	8,303		18,094
1904	ILI 1905 (54th Report)	Jan 1st 1905	10,089	8,526		18,615
1905	ILI 1906 (55th Report)	Jan 1st 1906	10,341	8,716		19,057
1906	ILI 1907 (56th Report)	Jan 1st 1907	10,452	8,854		19,306
1907	ILI 1908 (57th Report)	Jan 1st 1908	10,509	9,002		19,511
1908	ILI 1909 (58th Report)	Jan 1st 1909	10,753	9,285		20,038
1909	ILI 1910 (59th Report)	Jan 1st 1910	10,937	9,333		20,270
1910	ILI 1911 (60th Report)	Jan 1st 1911	11,099	9,504		20,603
1911	ILI 1912 (61st Report)	Jan 1st 1912	11,276	9,604		20,880
1912	ILI 1913 (62nd Report)	Jan 1st 1913	11,425	9,733		21,158
1913	ILI 1914 (63rd Report)	Jan 1st 1914	11,480	9,834		21,314

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1914	ILI 1915 (64th Report)	Jan 1st 1815	11,626	9,901		21,527
1915	ILI 1917 (65th Report)	Dec 31st 1915	11,576	9,954		21,530
1916	ILI 1918 (66th Report)	Dec 31st 1916	11,531	9,753		21,284
1917	ILI 1919 (67th Report)	Dec 31st 1917	10,956	9,567		20,523
1918	ILI 1919 (68th Report)	Dec 31st 1918	10,438	9,304		19,742
1919	ILI 1921 (69th Report)	Dec 31st 1919	10,359	9,130		19,489
1920						
1921						

Table 8

Island of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Private Asylums 1843-1921						
Year End	**Source**	**Date of Count**	**Male**	**Female**	**Gender Not Given**	**Total**
1843	IG 1844 (Report for 1843)	Jan 1st 1844			283	283
1844	IG 1845 (Report for 1844)	Jan 1st 1845	184	115		299
1845	ILI 1846 (Report for 1845)	Jan 1st 1846	155	96		251
1846	ILI 1847 (Report for 1847)	Dec 31st 1846	238	180		418
1847						
1848	ILI 1949 (Report for 1848)	Dec 31st 1848	245	187		432
1849	ILI 1851 (5th Report)	Mar 31st 1849				
1850	ILI 1851 (5th Report)	Mar 31st 1850	245	187		432
1851	ILI 1851 (5th Report)	Mar 31st 1851	251	195		446
1852	ILI 1853 (6th Report)	Mar 31st 1852				
1853	ILI 1853 (6th Report)	Mar 31st 1853	245	176		421
1854						
1855	ILI 1855 (7th Report)	Mar 31st 1855	252	207		459
1856	ILI 1857 (8th Report)	Mar 31st 1856	250	210		460
1857	ILI 1857 (8th Report)	Mar 31st 1857	252	211		463
1858	ILI 1859 (9th Report)	Mar 31st 1858	254	213		467
1859						
1860	ILI 1861 (10th Report)	Mar 31st 1860	259	239		498
1861	ILI 1862 (11th Report)	Dec 31st 1861	265	250		515
1862	ILI 1863 (12th Report)	Dec 31st 1862	284	262		546
1863	ILI 1864 (13th Report)	Dec 31st 1863	285	271		556
1864	ILI 1865 (14th Report)	Dec 31st 1864	272	281		553
1865	ILI 1866 (15th Report)	Dec 31st 1865	288	295		583

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1866	ILI 1867 (16th Report)	Dec 31st 1866	293	320		613
1867	ILI 1868 (17th Report)	Dec 31st 1867	290	336		626
1868	ILI 1869 (18th Report)	Dec 31st 1868	294	338		632
1869	ILI 1870 (19th Report)	Dec 31st 1869	294	345		639
1870	ILI 1871 (20th Report)	Dec 31st 1870	299	339		638
1871	ILI 1872 (21st Report)	Dec 31st 1871	310	342		652
1872	ILI 1873 (22nd Report)	Dec 31st 1872	295	352		647
1873	ILI 1875 (23rd Report)	Dec 31st 1873	305	359		664
1874	ILI 1875 (24th Report)	Dec 31st 1874	296	376		672
1875	ILI 1876 (25th Report)	Dec 31st 1875	271	382		653
1876	ILI 1877 (26th Report)	Dec 31st 1876	257	387		644
1877	ILI 1878 (27th Reoprt)	Dec 31st 1877	249	387		636
1878	ILI 1879 (28th Report)	Dec 31st 1878	257	385		642
1879	ILI 1880 (29th Report)	Jan 1st 1980	248	382		630
1880	ILI 1881 (30th Report)	Dec 31st 1880	236	386		622
1881	ILI 1882 (31st Report)	Dec 31st 1881	238	397		635
1882	ILI 1883 (32nd Report)	Jan 1st 1883	254	396		650
1883	ILI 1884 (33rd Report)	Jan 1st 1884	247	389		636
1884	ILI 1845 (34th Report)	Dec 31st 1884	245	394		639
1885	ILI 1886 (35th Report)	Dec 31st 1895	243	389		632
1886	ILI 1887 (36th Report)	Dec 31st 1886	233	369		602
1887	ILI 1888 (37th Report)	Dec 31st 1887	239	386		625
1888	ILI 1889 (38th Report)	Jan 1st 1889	240	361		601
1889	ILI 1890 (39th Report)	Jan 1st 1890	260	377		637
1890	ILI 1891 (40th Report)	Jan 1st 1891	253	368		621

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1891	ILI 1892 (41st Report)	Jan 1st 1892	266	366		632
1892	ILI 1893 (42nd Report)	Jan 1st 1893	275	369		644
1893	ILI 1994 (43rd Report)	Jan 1st 1894	281	361		642
1894	ILI 1895 (44th Report)	Jan 1st 1895	293	353		646
1895	ILI 1896 (45th Report)	Jan 1st 1896	305	358		663
1896	ILI 1897 (46th Report)	Jan 1st 1897	318	358		676
1897	ILI 1898 (47th Report)	Jan 1st 1898	325	366		691
1898	ILI 1899 (48th Report)	Jan 1st 1899	327	387		714
1899	ILI 1990 (49th Report)	Jan 1st 1900	318	381		699
1900	ILI 1901 (50th Report)	Jan 1st 1901	325	384		709
1901	ILI 1902 (51st Report)	Jan 1st 1902	323	409		732
1902	ILI 1903 (52rd Report)	Jan 1st 1903	335	410		745
1903	ILI 1904 (53rd Report)	Jan 1st 1904	341	432		773
1904	ILI 1905 (54th Report)	Jan 1st 1905	351	443		794
1905	ILI 1906 (55th Report)	Jan 1st 1906	379	439		818
1906	ILI 1907 (56th Report)	Jan 1st 1907	390	455		845
1907	ILI 1908 (57th Report)	Jan 1st 1908	394	476		870
1908	ILI 1909 (58th Report)	Jan 1st 1909	386	477		863
1909	ILI 1910 (59th Report)	Jan 1st 1910	387	514		901
1910	ILI 1911 (60th Report)	Jan 1st 1911	409	500		909
1911	ILI 1912 (61st Report)	Jan 1st 1912	401	505		906
1912	ILI 1913 (62nd Report)	Jan 1st 1913	388	492		880
1913	ILI 1914 (63rd Report)	Jan 1st 1914	385	501		886
1914	ILI 1915 (64th Report)	Jan 1st 1815	394	511		905
1915	ILI 1917 (65th Report)	Dec 31st 1915	408	529		937

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1916	ILI 1918 (66th Report)	Dec 31st 1916	420	503		923
1917	ILI 1919 (67th Report)	Dec 31st 1917	435	509		944
1918	ILI 1919 (68th Report)	Dec 31st 1918	439	522		961
1919	ILI 1921 (69th Report)	Dec 31st 1919	426	543		969
1920						
1921						

Table 9

Island of Ireland: Total Number (and Gender) of "Mentally ill" Resident in the Central Mental Hospital 1848-1921					
Year End	Source	Date of Count	Male	Female	Total
1850					
1851	ILI 1851 (5th Report)	Mar 31st 1851	59	33	92
1852					
1853					
1854					
1855	ILI 1855 (7th Report)	Mar 31st 1855	84	42	126
1856	ILI 1857 (8th Report)	Mar 31st 1856	80	43	123
1857	ILI 1857 (8th Report)	Mar 31st 1857	84	42	126
1858	ILI 1859 (9th Report)	Mar 31st 1858	84	42	126
1859	ILI 1859 (9th Report)	Mar 31st 1859	85	43	128
1860	ILI 1861 (10th Report)	Mar 31st 1860	89	41	130
1861	ILI 1862 (11th Report)	Dec 31st 1861	90	41	131
1862	ILI 1863 (12th Report)	Dec 31st 1862	90	38	128
1863	ILI 1864 (13th Report)	Dec 31st 1863	86	41	127
1864	ILI 1865 (14th Report)	Dec 31st 1864	83	37	120
1865	ILI 1866 (15th Report)	Dec 31st 1865	84	41	125
1866	ILI 1867 (16th Report)	Dec 31st 1866	87	45	132
1867	ILI 1868 (17th Report)	Dec 31st 1867	109	49	158
1868	ILI 1869 (18th Report)	Dec 31st 1868	107	56	163
1869	ILI 1870 (19th Report)	Dec 31st 1869	116	54	170
1870	ILI 1871 (20th Report)	Dec 31st 1870	117	50	167
1871	ILI 1872 (21st Report)	Dec 31st 1871	122	50	172
1872	ILI 1873 (22nd Report)	Dec 31st 1872	126	49	175
1873	ILI 1875 (23rd Report)	Dec 31st 1873	121	39	160
1874	ILI 1875 (24th Report)	Dec 31st 1874	123	35	158
1875	ILI 1876 (25th Report)	Dec 31st 1875	134	38	172
1876	ILI 1877 (26th Report)	Dec 31st 1876	132	34	166
1877	ILI 1878 (27th Report)	Dec 31st 1877	133	34	167
1878	ILI 1879 (28th Report)	Dec 31st 1878	140	37	177
1879	ILI 1880 (29th Report)	Jan 1st 1980	149	38	187
1880	ILI 1881 (30th Report)	Dec 31st 1880	140	37	177
1881	ILI 1882 (31st Report)	Dec 31st 1881	144	29	173
1882	ILI 1883 (32nd Report)	Jan 1st 1883	144	29	173
1883	ILI 1884 (33rd Report)	Jan 1st 1884	139	33	172
1884	ILI 1885 (34th Report)	Dec 31st 1884	146	32	178

Year End	Source	Date of Count	Male	Female	Total
1885	ILI 1886 (35th Report)	Dec 31st 1895	144	29	173
1886	ILI 1887 (36th Report)	Dec 31st 1886	139	33	172
1887	ILI 1888 (37th Report)	Dec 31st 1887	140	29	169
1888	ILI 1889 (38th Report)	Jan 1st 1889	140	28	168
1889	ILI 1890 (39th Report)	Jan 1st 1890	146	30	176
1890	ILI 1891 (40th Report)	Jan 1st 1891	150	29	179
1891	ILI 1892 (41st Report)	Jan 1st 1892	124	19	143
1892	ILI 1893 (42nd Report)	Jan 1st 1893	128	21	149
1893	ILI 1994 (43rd Report)	Jan 1st 1894	130	26	156
1894	ILI 1895 (44th Report)	Jan 1st 1895	140	21	161
1895	ILI 1896 (45th Report)	Jan 1st 1896	140	23	163
1896	ILI 1897 (46th Report)	Jan 1st 1897	145	20	165
1897	ILI 1898 (47th Report)	Jan 1st 1898	150	20	170
1898	ILI 1899 (48th Report)	Jan 1st 1899	148	21	169
1899	ILI 1990 (49th Report)	Jan 1st 1900	141	21	162
1900	ILI 1901 (50th Report)	Jan 1st 1901	140	22	162
1901	ILI 1902 (51st Report)	Jan 1st 1902	146	24	170
1902	ILI 1903 (52nd Report)	Jan 1st 1903	149	20	169
1903	ILI 1904 (53rd Report)	Jan 1st 1904	133	20	153
1904	ILI 1905 (54th Report)	Jan 1st 1905	139	20	159
1905	ILI 1906 (55th Report)	Jan 1st 1906	137	23	160
1906	ILI 1907 (56th Report)	Jan 1st 1907	140	22	162
1907	ILI 1908 (57th Report)	Jan 1st 1908	136	22	158
1908	ILI 1909 (58th Report)	Jan 1st 1909	144	24	168
1909	ILI 1910 (59th Report)	Jan 1st 1910	151	23	174
1910	ILI 1911 (60th Report)	Jan 1st 1911	148	20	168
1911	ILI 1912 (61st Report)	Jan 1st 1912	147	21	168
1912	ILI 1913 (62nd Report)	Jan 1st 1913	141	21	162
1913	ILI 1914 (63rd Report)	Jan 1st 1914	143	23	166
1914	ILI 1915 (64th Report)	Jan 1st 1815	146	22	168
1915	ILI 1917 (65th Report)	Dec 31st 1915	145	20	165
1916	ILI 1918 (66th Report)	Dec 31st 1916	141	16	157
1917	ILI 1919 (67th Report)	Dec 31st 1917	148	19	167
1918	ILI 1919 (68th Report)	Dec 31st 1918	142	23	165
1919	ILI 1921 (69th Report)	Dec 31st 1919	138	20	158
1920					
1921					

Table 10

Island of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Union Work Houses / Work Houses/ Poor-Houses 1844-1921

Year End	Source	Date of Count	Male	Female	Total
1844	IG 1845 (Report for 1844)	Jan 1st 1845	480	477	957
1845	ILI 1846 (Report for 1845)	Jan 1st 1846	754	1,167	1,921
1846	ILI 1847 (Report for 1847)	Dec 31st 1846	943	1,295	2,238
1847					
1848	ILI 1949 (Report for 1848)	Dec 31st 1848	778	1,162	1,940
1849					
1850					
1851	ILI 1851 (5th Report)	Mar 31st 1851	898	1,495	2,393
1852					
1853					
1854					
1855	ILI 1855 (7th Report)	Mar 31st 1855	734	1,266	2,000
1856	ILI 1857 (8th Report)	Mar 31st 1856	679	1,120	1,799
1857					
1858					
1859	ILI 1859 (9th Report)	Mar 31st 1859	722	1,324	2,046
1860	ILI 1861 (10th Report)	Mar 31st 1860	965	1,569	2,534
1861	ILI 1862 (11th Report)	Dec 31st 1861	1,008	1,584	2,592
1862	ILI 1863 (12th Report)	Dec 31st 1862	849	1,376	2,225
1863	ILI 1864 (13th Report)	Dec 31st 1863	954	1,501	2,455
1864	ILI 1865 (14th Report)	Dec 31st 1864	1,056	1,507	2,563
1865	ILI 1866 (15th Report)	Dec 31st 1865	1,100	1,633	2,733
1866	ILI 1867 (16th Report)	Dec 31st 1866	1,087	1,661	2,748
1867	ILI 1868 (17th Report)	Dec 31st 1867	1,104	1,601	2,705
1868	ILI 1869 (18th Report)	Dec 31st 1868	1,139	1,603	2,742
1869	ILI 1870 (19th Report)	Dec 31st 1869	1,177	1,730	2,907
1870	ILI 1871 (20th Report)	Dec 31st 1870	1,130	1,624	2,754
1871	ILI 1872 (21st Report)	Dec 31st 1871	1,173	1,741	2,914
1872	ILI 1873 (22nd Report)	Dec 31st 1872	1,194	1,772	2,966
1873	ILI 1875 (23rd Report)	Dec 31st 1873	1,277	1,853	3,130
1874	ILI 1875 (24th Report)	Dec 31st 1874	1,270	1,871	3,141
1875	ILI 1876 (25th Report)	Dec 31st 1875	1,275	1,904	3,179
1876	ILI 1877 (26th Report)	Dec 31st 1876	1,268	1,948	3,216

Year End	Source	Date of Count	Male	Female	Total
1877	ILI 1878 (27th Report)	Dec 31st 1877	1,268	2,104	3,372
1878	ILI 1879 (28th Report)	Dec 31st 1878	1,320	2,017	3,337
1879	ILI 1880 (29th Report)	Jan 1st 1980	1,382	2,109	3,491
1880	ILI 1881 (30th Report)	Dec 31st 1880	1,449	2,124	3,573
1881	ILI 1882 (31st Report)	Dec 31st 1881	1,435	2,205	3,640
1882	ILI 1883 (32nd Report)	Jan 1st 1883	1,442	2,269	3,711
1883	ILI 1884 (33rd Report)	Jan 1st 1884	1,488	2,238	3,726
1884	ILI 1885 (34th Report)	Dec 31st 1884	1,518	2,257	3,775
1885	ILI 1886 (35th Report)	Dec 31st 1895	1,500	2,233	3,733
1886	ILI 1887 (36th Report)	Dec 31st 1886	1,532	2,309	3,841
1887	ILI 1888 (37th Report)	Dec 31st 1887	1,565	2,396	3,961
1888	ILI 1889 (38th Report)	Jan 1st 1889	1,652	2,431	4,083
1889	ILI 1890 (39th Report)	Jan 1st 1890	1,671	2,494	4,165
1890	ILI 1891 (40th Report)	Jan 1st 1891	1,566	2,395	3,961
1891	ILI 1892 (41st Report)	Jan 1st 1892	1,656	2,524	4,180
1892	ILI 1893 (42nd Report)	Jan 1st 1893	1,701	2,497	4,198
1893	ILI 1994 (43rd Report)	Jan 1st 1894	1,718	2,326	4,044
1894	ILI 1895 (44th Report)	Jan 1st 1895	1,686	2,390	4,076
1895	ILI 1896 (45th Report)	Jan 1st 1896	1,724	2,388	4,112
1896	ILI 1897 (46th Report)	Jan 1st 1897	1,636	2,356	3,992
1897	ILI 1898 (47th Report)	Jan 1st 1898	1,657	2,373	4,030
1898	ILI 1899 (48th Report)	Jan 1st 1899	1,674	2,365	4,039
1899	ILI 1990 (49th Report)	Jan 1st 1900	1,634	2,355	3,989
1900	ILI 1901 (50th Report)	Jan 1st 1901	1,590	2,215	3,805
1901	ILI 1902 (51st Report)	Jan 1st 1902	1,560	2,186	3,746
1902	ILI 1903 (52nd Report)	Jan 1st 1903	1,458	2,081	3,539
1903	ILI 1904 (53rd Report)	Jan 1st 1904	1,479	2,181	3,660
1904	ILI 1905 (54th Report)	Jan 1st 1905	1,267	2,053	3,320
1905	ILI 1906 (55th Report)	Jan 1st 1906	1,264	1,951	3,215
1906	ILI 1907 (56th Report)	Jan 1st 1907	1,210	1,918	3,128
1907	ILI 1908 (57th Report)	Jan 1st 1908	1,167	1,886	3,053
1908	ILI 1909 (58th Report)	Jan 1st 1909	999	1,724	2,723
1909	ILI 1910 (59th Report)	Jan 1st 1910	1,014	1,641	2,655
1910	ILI 1911 (60th Report)	Jan 1st 1911	975	1,596	2,571
1911	ILI 1912 (61st Report)	Jan 1st 1912	972	1,585	2,557
1912	ILI 1913 (62nd Report)	Jan 1st 1913	934	1,559	2,493
1913	ILI 1914 (63rd Report)	Jan 1st 1914	952	1,542	2,494
1914	ILI 1915 (64th Report)	Jan 1st 1815	956	1,484	2,440
1915	ILI 1917 (65th Report)	Dec 31st 1915	885	1,447	2,332

Year End	Source	Date of Count	Male	Female	Total
1916	ILI 1918 (66th Report)	Dec 31st 1916	893	1,365	2,258
1917	ILI 1919 (67th Report)	Dec 31st 1917	826	1,287	2,113
1918	ILI 1919 (68th Report)	Dec 31st 1918	738	1,114	1,852
1919	ILI 1921 (69th Report)	Dec 31st 1919	710	1,111	1,821
1920					
1921					

Table 11

Island of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Prisons 1843-1899

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1843	IG 1844 (Report for 1843)	Jan 1st 1844			228	228
1844	IG 1845 (Report for 1844)	Jan 1st 1845	182	107		289
1845	ILI 1846 (Report for 1845)	Jan 1st 1846	177	113		290
1846	ILI 1847 (Report for 1847)	Dec 31st 1846	294	188		482
1847						
1848	ILI 1949 (Report for 1848)	Dec 31st 1848	196	142		338
1849	ILI 1851 (5th Report)	Mar 31st 1849				
1850	ILI 1851 (5th Report)	Mar 31st 1850	196	142		338
1851	ILI 1851 (5th Report)	Mar 31st 1851	157	123		280
1852	ILI 1853 (6th Report)	Mar 31st 1852	157	123		280
1853	ILI 1853 (6th Report)	Mar 31st 1853	101	74		175
1854						
1855	ILI 1855 (7th Report)	Mar 31st 1855	101	55		156
1856	ILI 1857 (8th Report)	Mar 31st 1856	79	50		129
1857	ILI 1857 (8th Report)	Mar 31st 1857	99	76		175
1858	ILI 1859 (9th Report)	Mar 31st 1858	88	91		179
1859	ILI 1859 (9th Report)	Mar 31st 1859	122	108		230
1860	ILI 1861 (10th Report)	Mar 31st 1860	184	109		293
1861	ILI 1862 (11th Report)	Dec 31st 1861	213	126		339
1862	ILI 1863 (12th Report)	Dec 31st 1862	247	131		378
1863	ILI 1864 (13th Report)	Dec 31st 1863	266	123		389
1864	ILI 1865 (14th Report)	Dec 31st 1864	303	149		452
1865	ILI 1866 (15th Report)	Dec 31st 1865	343	150		493
1866	ILI 1867 (16th Report)	Dec 31st 1866	223	116		339
1867	ILI 1868 (17th Report)	Dec 31st 1867	224	110		334
1868	ILI 1869 (18th Report)	Dec 31st 1868	32	21		53
1869	ILI 1870 (19th Report)	Dec 31st 1869	4	1		5
1870	ILI 1871 (20th Report)	Dec 31st 1870	0	1		1
1871	ILI 1872 (21st Report)	Dec 31st 1871	0	2		2
1872	ILI 1873 (22nd Report)	Dec 31st 1872	0	0		0
1873	ILI 1875 (23rd Report)	Dec 31st 1873	1	1		2
1874	ILI 1875 (24th Report)	Dec 31st 1874		2		2

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1875	ILI 1876 (25th Report)	Dec 31st 1875	1	2		3
1885	ILI 1886 (35th Report)	Dec 31st 1895	3	6		9
1886	ILI 1887 (36th Report)	Dec 31st 1886	1	0		1
1887	ILI 1888 (37th Report)	Dec 31st 1887	1	0		1
1888	ILI 1889 (38th Report)	Jan 1st 1889	0	0		0
1889	ILI 1890 (39th Report)	Jan 1st 1890	1	0		1
1890	ILI 1891 (40th Report)	Jan 1st 1891	2	0		2
1891						
1892						
1893	ILI 1994 (43rd Report)	Jan 1st 1894	0	0		0
1894	ILI 1895 (44th Report)	Jan 1st 1895	0	1		1
1895	ILI 1896 (45th Report)	Jan 1st 1896	1	0		1
1896	ILI 1897 (46th Report)	Jan 1st 1897	0	0		0
1897	ILI 1898 (47th Report)	Jan 1st 1898	1	2		3
1898	ILI 1899 (48th Report)	Jan 1st 1899	2	0		2
1899	ILI 1990 (49th Report)	Jan 1st 1900	1	0		1

Table 12

Island of Ireland: Total Number (and Gender) of "Mentally ill " Persons Resident in Convict Prisons with a Sentence of Imprisonment or Transportation, who became Insane in Prison 1856-1862						
Year End	**Source**	**Date of Count**	**Male**	**Female**	**Gender Not Given**	**Total**
1856	ILI 1857 (8th Report)	Mar 31st 1856	1	2		3
1857	ILI 1857 (8th Report)	Mar 31st 1857	3	0		3
1858	ILI 1859 (9th Report)	Mar 31st 1858				
1859	ILI 1859 (9th Report)	Mar 31st 1859				
1860	ILI 1861 (10th Report)	Mar 31st 1860				
1861	ILI 1862 (11th Report)	Dec 31st 1861	10	0		10
1862	ILI 1863 (12th Report)	Dec 31st 1862	2	0		2

Table 13

Island of Ireland: Total Number (and Gender) of "Mentally ill " Persons Resident in Island Bridge and Hardwich Cells / House of Industry Patients in Hardwich Cell / Local Asylums 1843-1853

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1843	IG 1844 (Report for 1843)	Jan 1st 1844			875	875
1844	IG 1845 (Report for 1844)	Jan 1st 1845	415	542		957
1845	ILI 1846 (Report for 1845)	Jan 1st 1846	229	333		562
1846	ILI 1847 (Report for 1847)	Dec 31st 1846	130	226		356
1847						
1848	ILI 1949 (Report for 1848)	Dec 31st 1848	151	214		365
1849	ILI 1851 (5th Report)	Mar 31st 1849				
1850	ILI 1851 (5th Report)	Mar 31st 1850				
1851	ILI 1851 (5th Report)	Mar 31st 1851				
1852	ILI 1853 (6th Report)	Mar 31st 1852	122	175		297
1853	ILI 1853 (6th Report)	Mar 31st 1853	117	176		293

Table 14

Island of Ireland: Total Number (and Gender) of " Mentally ill " Persons Resident in Lucan Spa and Houses of Industry Supported by Government 1861-1874						
Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1861	ILI 1862 (11th Report)	Dec 31st 1861	18	62		80
1862	ILI 1863 (12th Report)	Dec 31st 1862	18	59		77
1863	ILI 1864 (13th Report)	Dec 31st 1863			73	73
1864	ILI 1865 (14th Report)	Dec 31st 1864			68	68
1865	ILI 1866 (15th Report)	Dec 31st 1865			64	64
1866	ILI 1867 (16th Report)	Dec 31st 1866			62	62
1867	ILI 1868 (17th Report)	Dec 31st 1867			51	51
1868	ILI 1869 (18th Report)	Dec 31st 1868			49	49
1869	ILI 1870 (19th Report)	Dec 31st 1869			45	45
1870	ILI 1871 (20th Report)	Dec 31st 1870			43	43
1871	ILI 1872 (21st Report)	Dec 31st 1871			35	35
1872	ILI 1873 (22nd Report)	Dec 31st 1872			30	30
1873	ILI 1875 (23rd Report)	Dec 31st 1873			25	25
1874	ILI 1875 (24th Report)	Dec 31st 1874			25	25

Table 15

Island of Ireland: Total Number (and Gender) of "Mentally ill Persons Resident in Stewarts Institution 1875-1888						
Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1875	ILI 1876 (25th Report)	Dec 31st 1875	17	12		29
1876	ILI 1877 (26th Report)	Dec 31st 1876	4	20		24
1877	ILI 1878 (27th Report)	Dec 31st 1877	4	18		22
1878	ILI 1879 (28th Report)	Dec 31st 1878	4	18		22
1879	ILI 1880 (29th Report)	Jan 1st 1980	3	18		21
1880	ILI 1881 (30th Report)	Dec 31st 1880			19	19
1881	ILI 1882 (31st Report)	Dec 31st 1881			18	18
1882	ILI 1883 (32nd Report)	Jan 1st 1883			16	16
1883	ILI 1884 (33rd Report)	Jan 1st 1884	3	9		12
1884						
1885						
1886	ILI 1887 (36th Report)	Dec 31st 1886	3	6		9
1887	ILI 1888 (37th Report)	Dec 31st 1887	3	5		8
1888	ILI 1889 (38th Report)	Jan 1st 1889	3	5		8

Table 16

Island of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Single Chancery and Unlicensed Houses 1895-1921

Year End	Source	Date of Count	Male	Female	Total
1895	ILI 1896 (45th Report)	Jan 1st 1896	47	39	86
1896	ILI 1897 (46th Report)	Jan 1st 1897	45	47	92
1897	ILI 1898 (47th Report)	Jan 1st 1898	49	49	98
1898	ILI 1899 (48th Report)	Jan 1st 1899	48	43	91
1899	ILI 1990 (49th Report)	Jan 1st 1900	55	48	103
1900	ILI 1901 (50th Report)	Jan 1st 1901	47	42	89
1901	ILI 1902 (51st Report)	Jan 1st 1902	55	47	102
1902	ILI 1903 (52rd Report)	Jan 1st 1903	53	52	105
1903	ILI 1904 (53rd Report)	Jan 1st 1904	59	55	114
1904	ILI 1905 (54th Report)	Jan 1st 1905	54	54	108
1905	ILI 1906 (55th Report)	Jan 1st 1906	63	52	115
1906	ILI 1907 (56th Report)	Jan 1st 1907	62	51	113
1907	ILI 1908 (57th Report)	Jan 1st 1908	68	58	126
1908	ILI 1909 (58th Report)	Jan 1st 1909	73	66	139
1909	ILI 1910 (59th Report)	Jan 1st 1910	73	71	144
1910	ILI 1911 (60th Report)	Jan 1st 1911	73	70	143
1911	ILI 1912 (61st Report)	Jan 1st 1912	72	72	144
1912	ILI 1913 (62nd Report)	Jan 1st 1913	74	72	146
1913	ILI 1914 (63rd Report)	Jan 1st 1914	70	79	149
1914	ILI 1915 (64th Report)	Jan 1st 1815	65	75	140
1915	ILI 1917 (65th Report)	Dec 31st 1915	56	83	139
1916	ILI 1918 (66th Report)	Dec 31st 1916	59	85	144
1917	ILI 1919 (67th Report)	Dec 31st 1917	61	84	145
1918	ILI 1919 (68th Report)	Dec 31st 1918	62	86	148
1919	ILI 1921 (69th Report)	Dec 31st 1919	57	84	141
1920					
1921					

Republic of Ireland 1922-2000: Detailed Breakdown of "Mentally ill Persons Resident in Institutions

Table 17

Republic Of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Public Mental Hospitals 1922-2003						
Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1922						
1923	IMH 1924	Dec 31st	8,698	7,408		16,106
1924	IMH 1924	Dec 31st	8,749	7,549		16,298
1925	IMH 1926	Dec 31st	8,874	7,630		16,504
1926	IMH 1926	Dec 31st	8,966	7,742		16,708
1927	IMH 1927	Dec 31st	8,990	7,844		16,834
1928	IMH 1928	Dec 31st	9,143	7,944		17,087
1929	IMH 1929	Dec 31st	9,255	8,124		17,379
1930	IMH 1930	Dec 31st	9,291	8,163		17,454
1931	IMH 1931	Dec 31st	9,400	8,184		17,584
1932	IMH 1932	Dec 31st	9,516	8,312		17,828
1933	IMH 1933	Dec 31st	9,704	8,531		18,235
1934	IMH 1934	Dec 31st	9,826	8,599		18,425
1935	IMH 1935	Dec 31st	9,848	8,658		18,506
1936	IMH 1936	Dec 31st	9,935	8,806		18,741
1937	IMH 1937	Dec 31st	9,878	8,794		18,672
1938	IMH 1938	Dec 31st	9,998	8,949		18,947
1939	IMH 1939	Dec 31st	10,018	9,024		19,042
1940	IMH 1940	Dec 31st	10,057	9,077		19,134
1941	IMH 1941	Dec 31st	9,809	8,937		18,746
1942	IMH 1942	Dec 31st	9,477	8,654		18,131
1943	IMH 1943	Dec 31st	9,176	8,555		17,731
1944	IMH 1944-1946	Dec 31st	9,090	8,516		17,606
1945	IMH 1944-1946	Dec 31st	9,136	8,572		17,708
1946	IMH 1944-1946	Dec 31st	9,143	8,648		17,791
1947	SAI 1949	Dec 31st	9,022	8,613		17,635
1948	IMH 1949	Dec 31st	9,178	8,816		17,994
1949	IMH 1949	Dec 31st	9,491	8,986		18,477
1950	IMH 1950	Dec 31st	9,580	9,097		18,677
1951	IMH 1951	Dec 31st	9,644	9,153		18,797

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1952	IMH 1952	Dec 31st	9,817	9,250		19,067
1953	IMH 1953	Dec 31st	10,033	9,439		19,472
1954	IMH 1954	Dec 31st	10,189	9,545		19,734
1955	IMH 1955	Dec 31st	10,309	9,501		19,810
1956	IMH 1956	Dec 31st	10,457	9,606		20,063
1957	IMH 1957	Dec 31st	10,512	9,296		19,808
1958	IMH 1958	Dec 31st	10,683	9,353		20,036
1959	IMH 1959	Dec 31st	10,574	9,016		19,590
1960	IMH 1960	Dec 31st	10,494	8,948		19,442
1961	IMH 1961-62	Dec 31st	10,279	8,798		19,077
1962	IMH 1961-62	Dec 31st	10,095	8,548		18,643
1963	IMH 1977-79	Dec 31st			18,234	18,234
1964	IMH 1977-79	Dec 31st			17,929	17,929
1965	IMH 1977-79	Dec 31st			17,594	17,594
1966	IMH 1977-79	Dec 31st			17,059	17,059
1967	IMH 1977-79	Dec 31st			16,767	16,767
1968	IMH 1977-79	Dec 31st			16,173	16,173
1969	IMH 1977-79	Dec 31st			15,775	15,775
1970	IMH 1977-79	Dec 31st			15,392	15,392
1971	IMH 1977-79	Dec 31st			14,922	14,922
1972	IMH 1977-79	Dec 31st			14,818	14,818
1973	IMH 1977-79	Dec 31st			14,449	14,449
1974	IMH 1977-79	Dec 31st			14,082	14,082
1975	IMH 1977-79	Dec 31st			13,896	13,896
1976	IMH 1977-79	Dec 31st			13,408	13,408
1977	IMH 1977-79	Dec 31st			13,288	13,288
1978	IMH 1977-79	Dec 31st			12,875	12,875
1979	IMH 1977-79	Dec 31st			12,693	12,693
1980						
1981	IPH & U Census 1981	Dec 31st			12,837	12,837
1982						
1983	IMH 1988-89	Dec 31st			11,876	11,876
1984	IMH 1988-89	Dec 31st			11,613	11,613
1985	IMH 1988-89	Dec 31st			11,179	11,179
1986	IMH 1988-89	Dec 31st			10,840	10,840
1987	IMH 1988-89	Dec 31st			10,052	10,052
1988	IMH 1988-89	Dec 31st			9,138	9,138
1989	IMH 1988-89	Dec 31st			8,354	8,354
1990	IMH 1990	Dec 31st			7,787	7,787

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1991	IMH 1991	Dec 31st			6,797	6,797
1992	IMH 1992	Dec 31st			6,048	6,048
1993	IMH 1993	Dec 31st			5,684	5,684
1994	IMH 1994	Dec 31st			5,501	5,501
1995	IMH 1995	Dec 31st			5,256	5,256
1996	IMH 1996	Dec 31st			4,977	4,977
1997	IMH 1997	Dec 31st			4,615	4,615
1998	IMH 1998	Dec 31st			4,529	4,529
1999	IMH 1999	Dec 31st			4,288	4,288
2000	IMH 2001	Dec 31st			4,060	4,060
2001	IMH 2001	Dec 31st			4,734	4,734
2002	IMH 2002	Dec 31st			3,451	3,451
2003	IMH 2002	Dec 31st			3,192	3,192

Table 18

Republic Of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Private Asylums 1922-2003

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1922						
1923	IMH 1924	Dec 31st			943	943
1924	IMH 1924	Dec 31st	393	517		910
1925	IMH 1926	Dec 31st			917	917
1926	IMH 1926	Dec 31st	397	533		930
1927	IMH 1927	Dec 31st	310	497		807
1928	IMH 1928	Dec 31st	321	502		823
1929	IMH 1929	Dec 31st	333	508		841
1930	IMH 1930	Dec 31st	339	504		843
1931	IMH 1931	Dec 31st	328	485		813
1932	IMH 1932	Dec 31st	319	484		803
1933	IMH 1933	Dec 31st	308	483		791
1934	IMH 1934	Dec 31st	308	471		779
1935	IMH 1935	Dec 31st	292	472		764
1936	IMH 1936	Dec 31st	293	491		784
1937	IMH 1937	Dec 31st	288	475		763
1938	IMH 1938	Dec 31st	285	446		731
1939	IMH 1939	Dec 31st	279	439		718
1940	IMH 1940	Dec 31st	278	411		689
1941	IMH 1941	Dec 31st	261	391		652
1942	IMH 1942	Dec 31st	267	375		642
1943	IMH 1943	Dec 31st	248	391		639
1944	IMH 1944-1946	Dec 31st	239	375		614
1945	IMH 1944-1946	Dec 31st	238	359		597
1946	IMH 1944-1946	Dec 31st	231	330		561
1947	SAI 1949	Dec 31st	395	525		920
1948	IMH 1949	Dec 31st	390	488		878
1949	IMH 1949	Dec 31st	372	509		881
1950	IMH 1950	Dec 31st	381	510		891
1951	IMH 1951	Dec 31st	370	511		881
1952	IMH 1952	Dec 31st	389	486		875
1953	IMH 1953	Dec 31st	408	546		954
1954	IMH 1954	Dec 31st	367	558		925

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1955	IMH 1955	Dec 31st	392	536		928
1956	IMH 1956	Dec 31st	409	571		980
1957	IMH 1957	Dec 31st	428	544		972
1958	IMH 1958	Dec 31st	444	585		1029
1959	IMH 1959	Dec 31st	426	593		1019
1960	IMH 1960	Dec 31st	447	617		1064
1961	IMH 1961-62	Dec 31st	425	597		1022
1962	IMH 1961-62	Dec 31st	411	602		1013
1963	IMH 1977-79	Dec 31st			1013	1013
1964	IMH 1977-79	Dec 31st			1060	1060
1965	IMH 1977-79	Dec 31st			1057	1057
1966	IMH 1977-79	Dec 31st			1025	1025
1967	IMH 1977-79	Dec 31st			1020	1020
1968	IMH 1977-79	Dec 31st			1051	1051
1969	IMH 1977-79	Dec 31st			1027	1027
1970	IMH 1977-79	Dec 31st			1008	1008
1971	IMH 1977-79	Dec 31st			1039	1039
1972	IMH 1977-79	Dec 31st			1038	1038
1973	IMH 1977-79	Dec 31st			1022	1022
1974	IMH 1977-79	Dec 31st			1074	1074
1975	IMH 1977-79	Dec 31st			1098	1098
1976	IMH 1977-79	Dec 31st			1065	1065
1977	IMH 1977-79	Dec 31st			1064	1064
1978	IMH 1977-79	Dec 31st			1093	1093
1979	IMH 1977-79	Dec 31st			1145	1145
1980						
1981	IPH & U Census 1981	Dec 31st			986	986
1982						
1983						
1984						
1985						
1986	IMH 1988-89	Dec 31st			903	903
1987	IMH 1988-89	Dec 31st			992	992
1988	IMH 1988-89	Dec 31st			937	937
1989	IMH 1988-89	Dec 31st			896	896
1990	IMH 1990	Dec 31st			849	849
1991	IMH 1991	Dec 31st			836	836
1992	IMH 1992	Dec 31st			736	736
1993	IMH 1993	Dec 31st			750	750

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1994	IMH 1994	Dec 31st			600	600
1995	IMH 1995	Dec 31st			503	503
1996	IMH 1996	Dec 31st			497	497
1997	IMH 1997	Dec 31st			494	494
1998	IMH 1998	Dec 31st			488	488
1999	IMH 1999	Dec 31st			421	421
2000	IMH 2001	Dec 31st			383	383
2001	IMH 2001	Dec 31st			439	439
2002	IMH 2002	Dec 31st			441	441
2003	IMH 2002	Dec 31st			435	435

Table 19

Republic Of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in the Central Mental Hospital: 1922-2006						
Year End	**Source**	**Date of Count**	**Male**	**Female**	**Gender Not Given**	**Total**
1922						
1923	IMH 1924	Dec 31st	122	21		143
1924	IMH 1924	Dec 31st	110	20		130
1925	IMH 1926	Dec 31st	115	19		134
1926	IMH 1926	Dec 31st	118	21		139
1927	IMH 1927	Dec 31st	117	20		137
1928	IMH 1928	Dec 31st	114	22		136
1929	IMH 1929	Dec 31st	109	22		131
1930	IMH 1930	Dec 31st	97	18		115
1931	IMH 1931	Dec 31st	103	18		121
1932	IMH 1932	Dec 31st	99	17		116
1933	IMH 1933	Dec 31st	99	17		116
1934	IMH 1934	Dec 31st	96	15		111
1935	IMH 1935	Dec 31st	95	13		108
1936	IMH 1936	Dec 31st	100	12		112
1937	IMH 1937	Dec 31st	103	13		116
1938	IMH 1938	Dec 31st	95	13		108
1939	IMH 1939	Dec 31st	96	13		109
1940	IMH 1940	Dec 31st	95	11		106
1941	IMH 1941	Dec 31st	94	11		105
1942	IMH 1942	Dec 31st	96	10		106
1943	IMH 1943	Dec 31st	99	11		110
1944	IMH 1944-1946	Dec 31st	101	11		112
1945	IMH 1944-1946	Dec 31st	101	12		113
1946	IMH 1944-1946	Dec 31st	98	11		109
1947	SAI 1949	Dec 31st	97	11		108
1948	IMH 1949	Dec 31st	91	17		108
1949	IMH 1949	Dec 31st	91	13		104
1950	IMH 1950	Dec 31st	85	12		97
1951	IMH 1951	Dec 31st	81	12		93
1952	IMH 1952	Dec 31st	81	13		94
1953	IMH 1953	Dec 31st	81	14		95
1954	IMH 1954	Dec 31st	81	14		95

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1955	IMH 1955	Dec 31st	78	11		89
1956	IMH 1956	Dec 31st	78	11		89
1957	IMH 1957	Dec 31st	75	8		83
1958	IMH 1958	Dec 31st	77	8		85
1959	IMH 1959	Dec 31st	78	6		84
1960	IMH 1960	Dec 31st	81	7		88
1961	IMH 1961-62	Dec 31st	84	8		92
1962	IMH 1961-62	Dec 31st	78	10		88
1963						
1964	Central Mental Hospital (Archive - Night Reports)	Dec 31st	89	12		101
1965						
1966	Central Mental Hospital (Archive - Night Reports)	Dec 31st	88	16		104
1967	Central Mental Hospital (Archive - Night Reports)	Dec 31st	93	19		112
1968						
1969	Central Mental Hospital (Archive - Night Reports)	Dec 31st	90	25		115
1970						
1971	Central Mental Hospital (Archive - Night Reports)	Dec 31st	85	28		113
1972	Central Mental Hospital (Archive - Night Reports	Dec 31st	93	20		113
1973						
1974	Central Mental Hospital (Archive - Night Reports)	Jan 17th	92	14		106
1975						
1976						
1977	IMH 1977-80	Dec 31st			110	110
1978	IMH 1977-80	Dec 31st			99	99
1979	IMH 1977-81	Dec 31st			109	109
1980	Central Mental Hospital (Archive - Night Reports)	Dec 31st			90	90
1981	IPH & U Cen 1981	Dec 31st			97	97
1982	Central Mental Hospital (Archive - Night Reports)	Dec 31st			81	81
1983	Central Mental Hospital (Archive - Night Reports)	Dec 31st			85	85
1984						
1985	Central Mental Hospital (Archive - Night Reports)	Dec 31st			84	84
1986	Central Mental Hospital (Archive - Night Reports)	Dec 31st			80	80

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1987	Central Mental Hospital (Archive - Night Reports)	Dec 31st			78	78
1988						
1989	IMH 1988-89	Aug 22nd	76	9		85
1990	IMH 1990	July 19th	74	6		80
1991	IMH 1991	June 21st	81	10		91
1992	IMH 1992	Mar 12th			82	82
1993	IMH 1993	Dec 31st			77	77
1994	IMH 1994	Dec 31st			80	80
1995	IMH 1995	Dec 31st			71	71
1996	IMH 1996	Dec 31st			78	78
1997	IMH 1997	Dec 31st			83	83
1998	IMH 1998	Dec 31st			84	84
1999	Central Mental Hospital (Archive - Night Reports)	Dec 31st	81	5		86
2000	IMH 2001	Dec 31st			79	79
2001	IMH 2001	Dec 31st	81	6		87
2002	IMH 2002	Dec 31st			74	74
2003	IMH 2002	Dec 31st			74	74
2004	Central Mental Hospital (Archive - Night Reports)	Dec 31st	67	6		73
2005						
2006	Personal Contact With Director	Jan 19th	66	6		72

Table 20

Republic Of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Poor Law Institutions / Public Assistance Institutions / Health Institutions 1922-1956

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1922						
1923	IMH 1924	Dec 31st			1,973	1,973
1924	IMH 1924	Dec 31st	816	1,118		1,934
1925	IMH 1926	Dec 31st			1,872	1,872
1926	IMH 1926	Dec 31st	842	1,152		1,994
1927	IMH 1927	Dec 31st	783	1,051		1,834
1928	IMH 1928	Dec 31st	641	922		1,563
1929	IMH 1929	Dec 31st	690	861		1,551
1930	IMH 1930	Dec 31st	680	825		1,505
1931	IMH 1931	Dec 31st	643	756		1,399
1932	IMH 1932	Dec 31st	533	723		1,256
1933	IMH 1933	Dec 31st	456	651		1,107
1934	IMH 1934	Dec 31st	412	608		1,020
1935	IMH 1935	Dec 31st	419	663		1,082
1936	IMH 1936	Dec 31st	455	654		1,109
1937	IMH 1937	Dec 31st	474	696		1,170
1938	IMH 1938	Dec 31st	408	601		1,009
1939	IMH 1939	Dec 31st	425	577		1,002
1940	IMH 1940	Dec 31st	336	579		915
1941	IMH 1941	Dec 31st	447	610		1,057
1942	IMH 1942	Dec 31st	438	539		977
1943	IMH 1943	Dec 31st	405	514		919
1944	IMH 1944-1946	Dec 31st	400	529		929
1945	IMH 1944-1946	Dec 31st	361	511		872
1946	IMH 1944-1946	Dec 31st	387	512		899
1947	SAI 1949	Dec 31st	523	545		1,068
1948	IMH 1949	Dec 31st	108	167		275
1949	IMH 1949	Dec 31st	103	150		253
1950	IMH 1950	Dec 31st	76	151		227
1951	IMH 1951	Dec 31st	82	192		274
1952	IMH 1952	Dec 31st	181	236		417
1953	IMH 1953	Dec 31st	125	239		364

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1954	IMH 1954	Dec 31st	104	211		315
1955	IMH 1955	Dec 31st	122	233		355
1956	IMH 1956	Dec 31st	172	261		433

Table 21

Republic Of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Single Care in Unlicensed Houses / in Court Care in Unregistered Houses 1922-1956

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1922	IMH 1924	Dec 31st				
1923	IMH 1924	Dec 31st			106	106
1924	IMH 1924	Dec 31st	57	69		126
1925	IMH 1926	Dec 31st			135	135
1926	IMH 1926	Dec 31st	64	74		138
1927	IMH 1927	Dec 31st	76	80		156
1928	IMH 1928	Dec 31st	84	80		164
1929	IMH 1929	Dec 31st	83	81		164
1930	IMH 1930	Dec 31st	79	88		167
1931	IMH 1931	Dec 31st	82	84		166
1932	IMH 1932	Dec 31st	97	87		184
1933	IMH 1933	Dec 31st	84	94		178
1934	IMH 1934	Dec 31st	91	105		196
1935	IMH 1935	Dec 31st	97	101		198
1936	IMH 1936	Dec 31st	107	103		210
1937	IMH 1937	Dec 31st	122	102		224
1938	IMH 1938	Dec 31st	117	126		243
1939	IMH 1939	Dec 31st	134	120		254
1940	IMH 1940	Dec 31st	110	127		237
1941	IMH 1941	Dec 31st	137	129		266
1942	IMH 1942	Dec 31st	123	125		248
1943	IMH 1943	Dec 31st	131	122		253
1944	IMH 1944-1946	Dec 31st	130	120		250
1945	IMH 1944-1946	Dec 31st	127	121		248
1946	IMH 1944-1946	Dec 31st	125	121		246
1947	SAI 1949	Dec 31st	124	104		228
1948	IMH 1949	Dec 31st	120	99		219
1949	IMH 1949	Dec 31st	125	84		209
1950	IMH 1950	Dec 31st	107	80		187
1951	IMH 1951	Dec 31st	116	80		196
1952	IMH 1952	Dec 31st	110	80		190
1953	IMH 1953	Dec 31st	101	81		182

Year End	Source	Date of Count	Male	Female	Gender Not Given	Total
1954	IMH 1954	Dec 31st	102	71		173
1955	IMH 1955	Dec 31st	96	74		170
1956	IMH 1956	Dec 31st	91	64		155

Table 22

Republic Of Ireland: Total Number (and Gender) of "Mentally ill" Persons Resident in Institutions for Mental Defectives (only in the 1927 Report)					
Year End	**Source**	**Date of Count**	**Male**	**Female**	**Total**
1927	IMH 1927	Dec 31st	147	149	296

Table 23

Republic Of Ireland: Total Number (and Gender) of "Mentally Handicapped / Intellectually Disabled and Geriatric Patients / Older Persons in De-Designated Facilities" 1989-2003					
Year End	**Source**	**Date of Count**	**"Mentally Handicap"**	**Geriatric**	**Total**
1989	IMH 1988-89	Dec 31st	282	315	597
1990	IMH 1990	Dec 31st	332	205	537
1991	IMH 1991	Dec 31st	327	448	775
1992	IMH 1992	Dec 31st	294	578	872
1993	IMH 1993	Dec 31st	284	542	826
1994	IMH 1994	Dec 31st	278	412	690
1995	IMH 1995	Dec 31st	247	407	654
1996	IMH 1996	Dec 31st	190	258	448
1997	IMH 1997	Dec 31st	169	252	421
1998	IMH 1998	Dec 31st	196	297	493
1999	IMH 1999	Dec 31st	182	231	413
2000					
2001	IMH 2001	Dec 31st	251	139	390
2002	IMH 2002	Dec 31st	217	160	377
2003	IMH 2002	Dec 31st	169	176	345

Note: Post 1989, These people are not included as part of the total of "Mentally ill" persons resident in institutions

Demographic Data

Table 24

Island of Ireland: Population 1821-1911				
Year	**Source**	**Male**	**Female**	**Total**
1821	Vaughan (1978)	3,341,926	3,459,901	6,801,827
1831	Vaughan (1978)	3,794,880	3,972,521	7,767,401
1841	Vaughan (1978)	4,019,576	4,155,548	8,175,124
1851	Vaughan (1978)	3,190,630	3,361,755	6,552,385
1861	Vaughan (1978)	2,837,370	2,961,597	5,798,967
1871	Vaughan (1978)	2,639,753	2,772,624	5,412,377
1881	Vaughan (1978)	2,533,277	2,641,559	5,174,836
1891	Vaughan (1978)	2,318,953	2,385,797	4,704,750
1901	Vaughan (1978)	2,200,040	2,258,735	4,458,775
1911	Vaughan (1978)	2,192,048	2,198,171	4,390,219

Table 25

Republic Of Ireland: Population 1922-2005

Year	Source	Male	Female	Gender Not Given	Total
1922					
1923					
1924					
1925	CSO (2006)			2,985,000	2,985,000
1926	CSO (2006)	1,506,889	1,465,103		2,971,992
1927	CSO (2006)			2,957,000	2,957,000
1928	CSO (2006)			2,949,000	2,949,000
1929	CSO (2006)			2,937,000	2,937,000
1930	CSO (2006)			2,927,000	2,927,000
1931	CSO (2006)			2,933,000	2,933,000
1932	CSO (2006)			2,939,000	2,939,000
1933	CSO (2006)			2,962,000	2,962,000
1934	CSO (2006)			2,971,000	2,971,000
1935	CSO (2006)			2,971,000	2,971,000
1936	CSO (2006)	1,520,454	1,447,966		2,968,420
1937	CSO (2006)			2,944,000	2,944,000
1938	CSO (2006)			2,937,000	2,937,000
1939	CSO (2006)			2,934,000	2,934,000
1940	CSO (2006)			2,958,000	2,958,000
1941	CSO (2006)			2,990,000	2,990,000
1942	CSO (2006)			2,963,000	2,963,000
1943	CSO (2006)			2,946,000	2,946,000
1944	CSO (2006)			2,944,000	2,944,000
1945	CSO (2006)			2,983,000	2,983,000
1946	CSO (2006)	1,494,877	1,460,230		2,955,107
1947	CSO (2006)			2,972,000	2,972,000
1948	CSO (2006)			2,985,000	2,985,000
1949	CSO (2006)			2,981,000	2,981,000
1950	CSO (2006)	1,510,000	1,459,000		2,969,000
1951	CSO (2006)	1,506,597	1,453,999		2,960,596
1952	CSO (2006)	1,500,900	1,452,000		2,952,900
1953	CSO (2006)	1,497,900	1,451,100		2,949,000
1954	CSO (2006)	1,493,000	1,448,200		2,941,200

Year	Source	Male	Female	Gender Not Given	Total
1955	CSO (2006)	1,479,100	1,441,800		2,920,900
1956	CSO (2006)	1,463,100	1,435,400		2,898,500
1957	CSO (2006)	1,456,100	1,429,200		2,885,300
1958	CSO (2006)	1,438,900	1,413,800		2,852,700
1959	CSO (2006)	1,434,600	1,411,000		2,845,600
1960	CSO (2006)	1,427,100	1,405,000		2,832,100
1961	CSO (2006)	1,416,549	1,401,792		2,818,341
1962	CSO (2006)	1,422,800	1,407,300		2,830,100
1963	CSO (2006)	1,432,700	1,417,300		2,850,000
1964	CSO (2006)	1,439,800	1,424,000		2,863,800
1965	CSO (2006)	1,445,800	1,430,000		2,875,800
1966	CSO (2006)	1,449,000	1,435,000		2,884,000
1967	CSO (2006)	1,457,000	1,442,700		2,899,700
1968	CSO (2006)	1,463,500	1,448,700		2,912,200
1969	CSO (2006)	1,470,000	1,455,200		2,925,200
1970	CSO (2006)	1,481,900	1,468,000		2,949,900
1971	CSO (2006)	1,495,760	1,482,488		2,978,248
1972	CSO (2006)	1,519,100	1,505,300		3,024,400
1973	CSO (2006)	1,543,700	1,529,300		3,073,000
1974	CSO (2006)	1,569,500	1,554,400		3,123,900
1975	CSO (2006)	1,597,000	1,580,300		3,177,300
1976	CSO (2006)	1,622,900	1,605,000		3,227,900
1977	CSO (2006)	1,645,000	1,626,900		3,271,900
1978	CSO (2006)	1,666,000	1,648,000		3,314,000
1979	CSO (2006)	1,693,300	1,674,900		3,368,200
1980	CSO (2006)	1,709,000	1,692,000		3,401,000
1981	CSO (2006)	1,729,354	1,714,051		3,443,405
1982	CSO (2006)	1,746,000	1,734,000		3,480,000
1983	CSO (2006)	1,756,300	1,747,700		3,504,000
1984	CSO (2006)	1,767,000	1,762,000		3,529,000
1985	CSO (2006)	1,771,000	1,769,000		3,540,000
1986	CSO (2006)	1,769,700	1,771,000		3,540,700
1987	CSO (2006)	1,770,300	1,776,200		3,546,500
1988	CSO (2006)	1,758,800	1,771,900		3,530,700
1989	CSO (2006)	1,744,100	1,765,500		3,509,600
1990	CSO (2006)	1,742,800	1,763,100		3,505,900
1991	CSO (2006)	1,753,418	1,772,301		3,525,719
1992	CSO (2006)	1,768,400	1,786,100		3,554,500
1993	CSO (2006)	1,778,000	1,796,100		3,574,100

Year	Source	Male	Female	Gender Not Given	Total
1994	CSO (2006)	1,783,300	1,802,600		3,585,900
1995	CSO (2006)	1,788,400	1,812,900		3,601,300
1996	CSO (2006)	1,800,232	1,825,855		3,626,087
1997	CSO (2006)	1,819,400	1,844,900		3,664,300
1998	CSO (2006)	1,838,900	1,864,200		3,703,100
1999	CSO (2006)	1,858,600	1,883,000		3,741,600
2000	CSO (2006)	1,882,900	1,906,600		3,789,500
2001	CSO (2006)	1,913,100	1,934,100		3,847,200
2002	CSO (2006)	1,946,164	1,971,039		3,917,203
2003	CSO (2006)	1,977,200	2,001,700		3,978,900
2004	CSO (2006)	2,011,200	2,032,600		4,043,800
2005	CSO (2006)	2,059,000	2,071,800		4,130,800

Table 26

Northern Ireland: Population

Year	Source	Male	Female	Total
1926	Vaughan (1978)	608,088	648,473	1,256,561
1936	Northern Ireland Statistics and Research Agency (2006)	631,000	663,000	1,294,000
1937	Vaughan (1978)	623,154	656,591	1,279,745
1946	Northern Ireland Statistics and Research Agency (2006)	638,000	675,800	1,313,800
1951	Vaughan (1978)	667,819	703,102	1,370,921
1961	Vaughan (1978)	694,224	730,818	1,425,042
1966	Vaughan (1978)	723,884	760,891	1,484,775
1971	Vaughan (1978)	754,676	781,389	1,536,065
1981	Northern Ireland Statistics and Research Agency (2006)	756,600	786,300	1,542,900
1986	Northern Ireland Statistics and Research Agency (2006)	768,400	805,100	1,573,500
1991	Northern Ireland Statistics and Research Agency (2006)	769,071	808,765	1,577,836
2001	Northern Ireland Statistics and Research Agency (2006)	824,400	864,900	1,689,300

Prisons

Table 27

Republic Of Ireland: Daily Average Number of Persons In Prisons Sourced from: O'Donnell I., O'Sullivan E., and Healy D. (2005) *Crime and Punishment in Ireland 1992 to 2003: A Statistical Sourcebook* Dublin: Institute of Public Administration	
Year	Total in Custody
1922	674
1923	767
1924	1,030
1925	922
1926	862
1927	801
1928	729
1929	695
1930	643
1931	657
1932	627
1933	575
1934	631
1935	617
1936	592
1937	591
1938	517
1939	500
1940	493
1941	579
1942	772
1943	766
1944	724
1945	733
1946	683
1947	583
1948	589

Year	Total in Custody
1949	580
1950	521
1951	488
1952	479
1953	458
1954	449
1955	396
1956	401
1957	396
1958	369
1959	426
1960	461
1961	447
1962	490
1963	534
1964	573
1965	561
1966	561
1967	611
1968	615
1969	656
1970	749
1971	927
1972	1,035
1973	963
1974	960
1975	1,017
1976	1,049
1977	1,029
1978	1,179
1979	1,140
1980	1,215
1981	1,196
1982	1,236
1983	1,450
1984	1,594
1985	1,863
1986	1,869
1987	1,943

Year	Total in Custody
1988	1,962
1989	2,067
1990	2,108
1991	2,141
1992	2,185
1993	2,171
1994	2,133
1995	2,121
1996	2,191
1997	2,422
1998	2,610
1999	2,871
2000	2,948
2001	3,112
2002	3,165
2003	3,176

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Note: * Denotes Inspector of Mental Hospitals Reports with no publication date indicated other than the date provided in the title of that report.

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