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Dundee Royal Asylum.

Classification of Mental Diseases.

Probably about 1900 when the Lectureship in Mental Diseases was inaugurated in what is now Queen's College.

Dementia Praecox is not mentioned but Acute or Primary Dementia receives a few lines on P4.
Puberty and Adolescence are noted as Physiological Crises on P8.
Katatonia is entered as a separate entity also on P8.

The three main categories are -

Mania.
Mental Paralysis - Stupor & Dementia
Mental Perversion or Partial Insanity-
Melancholia
Monomania
Moral Insanity (Pritchard's term)

DUNDEE ROYAL ASYLUM.

CLASSIFICATION

of

MENTAL DISEASES.

c. 1900.

Insanity or Mental Disease

is an abnormal manifestation of mental phenomena, occurring coincidently with functional disorder or with organic disease of the body, and especially of the nervous system; and which disorder or disease may be either primary or secondary in character, that is—primarily, either due to organic disease, functional derangement, or congenital defective development of the nervous system itself; or, secondarily, the result of functional derangement or organic disease of other organs of the body acting on the nervous system. It is divisible into:—

I. Amentia, non-development of the intellectual processes accompanying imperfect cerebral development.

1. Idiocy, congenital arrest of mental activity and consequent incapacity to acquire knowledge, accompanying malnutrition, disease, arrested or perverted development of the brain before birth or in very young children, and which may or may not be associated with epilepsy. Sub-divided into (Dr Ireland's classification, slightly modified):—

- A. Genetous Idiots, not traceable to any specific cause or disease, and where the mental defect has unmistakably set in before the child was born.
- B. Microcephalic Idiots. Small-headed idiots. Head imperfectly developed.
- C. Eclampsic Idiots. Idiocy following on severe convulsive fits, as during teething.
- D. Epileptic Idiots. Idiocy caused by or associated with epilepsy.
- E. Hydrocephalic Idiocy. Associated with hydrocephalus.
- F. Paralytic Idiocy. Due to paralysis from cerebral hæmorrhage, or the result of tumours, or of inflammatory affections, and often associated with withered, shrunk, or deformed limbs.
- G. Traumatic Idiocy, resulting from injuries, as falls on the head.
- H. Inflammatory Idiocy, from inflammation of the brain, often following on fevers.
- I. Idiots from deprivation, the result of congenital deafness, blindness, or want of touch, or of all combined loss of the senses.

2. Imbecility. Deficiency of mental power and activity, occurring in infancy or in early childhood in a child at first apparently of sound mind, and accompanying disease of, injury to, or imperfect development of, the brain, and which may or may not be associated with epilepsy.

3. Cretinism. Idiocy or Imbecility, accompanied by atrophy, hypertrophy, or functional derangement of the thyroid gland, and either congenital or occurring in early childhood.

4. Moral Deprivation. Idiocy or Imbecility, shown chiefly in imperfect development of the moral powers.

5. Backward Children. Slow mental development or temporary arrest of mental growth occurring in young children.

6. Cranks. Ill-balanced and eccentric forms of individuality from imperfect mental development.

Symptoms.

II. Mental Exaltation or Mania. A morbid mental condition characterised by exaltation, sleeplessness, more or less incoherence, and accelerated activity of the mental processes of perception, imagination, association of ideas, and reproduction of ideas; the emotions and feelings being exalted or variable; the temper irritable; self-control more or less lost; psycho-motor restlessness increased; and the moral and religious sentiments intensified, diminished, or perverted.

1. Mania, Simple. Mental exaltation of a mild character, without incoherence of speech, and chiefly shown by only partial loss of self-control and by great loquacity.

2. Mania, Acute. Intense mental exaltation, sleeplessness, with more or less complete loss of self-control, general incoherence of speech, and sometimes loss of consciousness, and lasting from a few days to 12 months.

3. Mania, Ephemeral or Transitory. Acute mental exaltation suddenly developed, often intense in character, and accompanied by incoherence of speech, loss of self-control, more or less of unconsciousness, sleeplessness, and sometimes homicidal tendencies, and lasting from an hour to a few days.

4. Mania, Chronic. Mental exaltation which has assumed a chronic form often with exacerbations of restlessness, destructiveness, and excitability, and frequently with but little derangement of the general health. May last from 12 months to many years.

5. Mania, Recurrent, divisible into:—

   A. Intermittent Mania. A succession of attacks of mental exaltation of an ague type, with intervals of longer or shorter duration during which the patient seems quite well.

   B. Remittent Mania. A more or less continuous attack of mania with exacerbations and alternate ameliorations, but without complete recovery.

   C. Periodic Mania. Mania accompanying regularly recurring physiological functions, such as the menstrual.

   D. Recurrent Mania Proper—Well developed recurrent attacks of acute mania, with intervals of from months to years duration of complete mental recovery.

6. Mania, Puerperal. Mania occurring during the puerperal state, either during pregnancy, during delivery, or within six weeks thereafter, or during lactation.

7. Mania, Toxic or Pyrexial. Mania resulting from the action of poisons or occurring during the progress of a febrile attack, as in cases of rheumatic fever.

8. Mania, Epileptic. Mania associated with epilepsy.

9. Mania, Hysterical. Mental exaltation of a highly emotional type accompanying or taking the place of hysteria.

10. Mania, Hystero-Epileptic. Hysterical mania of great intensity, accompanied by epileptiform convulsions.

11. Mania à Potu. Mental exaltation arising from the abuse of alcoholic liquors, but where the mental symptoms are those of acute mania and not of delirium tremens or of mere intoxication.

12. Mania, Paralytic. Mental exaltation following upon an attack of paralysis.

13. Mania, Senile. Mental exaltation occurring in the aged.

14. Mania, Religious. Maniacal excitement of an emotional character, and where the religious element strongly predominates.

15. Mania, Acute delirious or Typhomania. A very acute and rapidly developing form of mania approaching delirium in character, accompanied by a febrile condition, rise of temperature, great and rapid exhaustion and prostration, generally terminating in death preceded by deep coma.

III. Mental Paralysis, temporary failure, or permanent decay of mental activity, accompanying temporary or permanent arrest of cerebral function.

1. Stupor. Temporary failure or arrest of mental activity, especially of volition, with impaired cerebral and nervous reaction to external stimuli.

- A. Coma. Complete loss of consciousness, from which the patient cannot be aroused.
- B. Stupor, Anergic. More or less prolonged mental torpor and lethargy, with lowering of general nervous energy and often marked vaso-motor paralysis.
- C. Stupor, Secondary. Stupor following mania, convulsions, or any exhausting nervous discharge, whether motor, sensory, or psychical.
- D. Stupor, Alcoholic or Toxæmic. More or less temporary arrest of mental activity, the result of intemperance, excessive use of bromides, sulphonal, &c., or other agencies affecting the brain.
- E. Stupor, Paralytic. Stupor occurring during the progress of a case of paralysis.
- F. Stupor, Epileptic. The stupor following epileptic fits.
- G. Stupor, Hypnotic. The stupor of the mesmeric and cataleptic states.
- H. Stupor, Senile. The attacks of stupor occurring in the aged, closely resembling, and often passing into, senile dementia.
- I. Stupor, Sexual. Stupor following sexual excess or perversion.

2. Dementia failure of mental activity, accompanying gradual decay or disease of the brain, being an acquired state, that is occurring in a person previously sane and therefore to be distinguished from Amentia.

- A. Dementia, Acute or Primary. A more or less weakened or impaired state of the mental processes occurring as a primary morbid change in a person previously of sane mind.
- B. Dementia, Secondary or Chronic and Progressive. Mental weakness following on some pre-existing acute or prolonged attack of mental derangement, such as mania, melancholia, &c., and generally retaining some of the characteristics of the previous mental illness, in the shape of ill defined hallucinations or delusions.
- C. Dementia, Alcoholic. Dementia the result of excessive and especially prolonged use of alcohol, and involving generally the moral and religious sentiments as well as the general intelligence.
- D. Dementia, Epileptic. The gradual mental decay following on prolonged epilepsy.
- E. Dementia, Organic. Dementia accompanying or supervening upon organic diseases of the brain or brain tumours, meningitis, cerebral hæmorrhage, &c.

f. Dementia of Myxœdema. The mental deterioration generally accompanying this disease.

c. Dementia, Chorcic. The mental deterioration sometimes found accompanying cases of chorea.

s. Dementia, Senile. A synonym of dotage.

IV. Mental Perversion or Partial Insanity. Morbid mental states manifested by more or less partial derangement of the mental processes, and divisible into :—

1. Melancholia. A morbid mental condition, principally characterised by a depressed state of the emotions and feelings, without any or without sufficient cause.

a. Misanthropy. A melancholic state, characterised by hatred or dislike of others, not justified by the circumstances in which the patient is placed.

b. Misogyny. A morbid dislike of the female sex.

c. Nostalgia. A morbidly exaggerated longing for home, its surroundings and associations.

d. Hypochondriasis. A morbid feeling of physical suffering, unjustified by any apparent cause, and accompanied by a tendency to exaggerate and brood over any painful sensations actually experienced.

e. Melancholia, Simple. Morbid mental depression of a mild character, without delusions or suicidal tendency.

f. Melancholia, Agitated or Active. Morbid mental depression where the misery felt by the individual is manifested more or less strongly by language, gestures, or general behaviour.

g. Melancholia, Attonita. Mental depression resembling stupor, but due, not to cerebral functional arrest, but to mental concentration or preoccupation.

h. Melancholia, Resistive or Obstinate. Melancholia, accompanied by obstinate and often senselessly perverse resistance to what is required of the patient.

i. Melancholia, Convulsive. Agitated or active melancholia, accompanied by interrupted convulsive or epileptiform seizures, and often followed by a rise of bodily temperature.

j. Melancholia, Delusional. Morbid mental depression, accompanied by one or more delusions, but without suicidal tendency.

k. Melancholia, Religious. Delusional melancholia, where the delusions are of a marked religious character.

l. Melancholia, Suicidal. Morbid mental depression, accompanied by a fear of, or longing after, self-destruction, whether dependent on delusions or not.

m. Melancholia, Chronic. An attack of melancholia prolonged over 12 months.

n. Melancholia, Recurrent. A recurrence of attacks of morbid mental depression, in which there is an irregular alternation of melancholia and apparent recovery, without maniacal symptoms.

o. Melancholia, Hypochondriacal. Morbid mental depression, in which hypochondriacal symptoms colour the attack without being actual delusions.

F. Melancholia, Puerperal. Melancholia, associated with the puerperal state.

2. Monomania or Delusional Insanity. A perverted state of mental activity, characterised by one or more delusions more or less persistent, sometimes lasting for years or even a lifetime; the rest of the mental processes being comparatively unaffected. Is divisible into :—

A. Demonomania. Delusional insanity in which the patient believes himself to be the subject of demoniacal possession.

B. Monomania of Unseen Agency. The form of delusional insanity, in which patients believe that they are influenced by mysterious, unnatural, and unseen agencies, as spirits, mesmerism, &c.

C. Monomania of Pride and Grandeur. The form of delusional insanity in which patients believe themselves to be in more exalted stations than they occupy, as when persons of ordinary rank believe they are noblemen, kings, princes, or even the Deity himself; or that, while realising their own individuality, they believe they are possessed of extraordinary abilities or attributes, such as great talents, unprecedented beauty, grace, wealth, &c. To be carefully distinguished from the grandiose delusions of the general paralytic.

D. Monomania of Suspicion. The form of delusional insanity, in which the patients suspect that they are the victims of some enemy who entertains evil designs against them. The patients generally submit to their supposed trials without retaliation.

E. Monomania of Persecution. The form of monomania in which the patients believe that they are the subjects of active persecution by persons known or unknown to them. They are generally given to retaliation, and, consequently, often extremely dangerous.

F. Monomania of Self-abasement. The opposite of monomania of pride and grandeur; the patients underrating their position and abilities, and believing themselves to be unworthy of notice or of consideration.

G. Mysophobia or Monomania of Defilement. The form of delusional insanity in which patients believe their bodies, garments, &c., to be covered with filth, and either suppose themselves incapable of being cleansed or are constantly washing themselves to secure this result.

H. Religious Monomania. The form of monomania in which the patient's delusions assume a more or less purely religious character.

I. Monomania of Avarice. The form of monomania characterised chiefly by an inordinate desire of gaining and possessing wealth, also often showing itself in hoarding up all sorts of rubbish.

J. Monomonia of Jealousy. The form of monomania in which this passion is the principal feature.

3. Moral Insanity. A morbid condition of the moral powers, whereby the patient is either unable to distinguish properly between right and wrong; or if able to do so, through a morbid state of his will, is unable to act up to his moral convictions. Moral insanity is therefore shown more by perverted actions and conduct, than by delusions or insane ideas. It is divisible into—

A. Moral Idiocy and Imbecility. Congenital moral defect or undeveloped moral powers from early infancy without marked imperfection of the intellectual processes.

b. Homicidal Insanity or Impulsive Homicidal Monomania. A state of moral degeneration, generally hereditary, manifesting itself in a desire to destroy the life of another, often accompanied by repugnance and horror at the idea of the act, and frequently followed by mental depression and regret should it be accomplished.

c. Suicidal Monomania. A morbid moral degeneration, manifesting itself in an impulsive desire to commit suicide, and unaccompanied by mental depression or delusions.

d. Dipsomania. A morbid moral condition, manifesting itself in an irresistible desire for alcohol, generally of a recurrent character, and during the attack accompanied by great loss of voluntary inhibition, and often followed by anguish, remorse, and apparently normal mental suffering.

e. Kleptomania. A morbid moral degeneration, showing itself in a desire to steal.

f. Pyromania. A morbid moral degeneration, manifesting itself in impulsive acts of fire-raising.

g. Animal or Organic Impulsive Insanity. A morbid moral state, manifesting itself in an uncontrollable desire towards the gratification of the purely animal appetites, instincts, and passions, whether normal or perverted.

h. Destructive Monomania. A morbid moral degeneration, characterized by impulsive and uncontrollable acts of violence and destructiveness.

Mental Diseases classified in accordance with Associated Physiological and Pathological States.

(Regis classification slightly modified.)

I. With Physiological or Developmental Crises.

A. Infancy. B. Puberty. C. Adolescence. D. Appearance of Menses. E. Pregnancy—1. Gestation; 2. Parturition; 3. Lactation. F. Menopause. G. Old Age and Senile Decay.

II. With Pathological States.

A. Febrile and Acute Affections—1. Cholera; 2. Erysipelas; 3. Influenza; 4. Rheumatic Fever; 5. Typhoid Fever; 6. Typhus Fever; 7. Variola.

B. Chronic Affections—1. Ague; 2. Cancer; 3. Gout; 4. Myxœdema; 5. Pellagra; 6. Chronic Rheumatism; 7. Syphilis; 8. Tuberculosis.

C. Diseases of Circulatory System—1. Cardiac Affections; 2. Vascular Disorders.

D. Diseases of Respiratory System—1. Pneumonia; 2. Phthisis.

E. Diseases of Digestive System—1. Digestive Disorders; 2. Hepatic and Biliary Disorders; 3. Constipation; 4. Intestinal Worms.

F. Genito-urinary Disorders—1. Ovarian and Uterine Disorders; 2. Diabetes; 3. Bright's Disease; 4 Diseases of the Bladder.

G. Diseases of the Nervous System—

1 Neuroses—*a* Asthma, *b* Catalepsy, *c* Chorea, *d* Epilepsy, *e* Exophthalmic Goitre, *f* Hysteria, *g* Paralysis Agitans, *h* Somnambulism.

2. Cerebral Diseases—*a* Apoplexy, *b* Cerebeal Sclerosis, *c* Cerebral Softening, *d* Cerebral Tumours, *e* Cerebritis, *f* General Paralysis, *g* Meningitis.

3. Spinal Diseases—*a* Locomotor Ataxia, *b* Multiple Sclerosis.

H. Toxæmic Disorders—1. Alcoholism; 2. Auto-intoxicants; 3. Carbonic Acid; 4. Chloral, Sulphonal, &c.; 5. Cocaine; 6. Ether; 7. Lead, Mercury, &c.; 8. Opium and Morphia.

III. Complex Forms of Mental Disease.

A. Circular Insanity. B. Epileptic Insanity. C. General Paralysis of the Insane. D. Katatonia. E. Paranoia. F. Progressive Systematized Insanity. G. Alcoholic Insanity. H. Syphilitic Insanity.

THE INSANITIES OF THE TIMES OF LIFE.

Enormous differences in the Physiological activities of the brain at different periods,

Type of mental derangement much influenced by the special Physiological activity or decadence of the period.

INSANITY OF PUBERTY.

Rare—Only 2 cases in Royal Edinburgh Asylum at ages of 14 and 15 out of 1800 cases, and only 22 at 16 and 17—Always hereditary—Acute—Remittent—Not dangerous to life—Maniacal—Theories and practices of education at Puberty.

Half the general population are under 20—Only 1·5 per cent. of the insane under 20.

8 per cent. of general population over 60—17 per cent. of the insane.

Prognosis—Good.

Treatment.—Tonics—Fresh air—Baths—Milk and farinaceous diet—Cod liver oil—Bromide of potassium—No opium or chloral.

INSANITY OF ADOLESCENCE.

Meaning of *Adolescence.*

Physiological and Psychological characteristics—Momentous period—Far more so than Puberty.

Novelists the best students and describers of the mental characteristics of Adolescence—Gwendolen Harleth (*Daniel Deronda.*)

Relationship of Adolescence to emotion—Sense of duty—Capacity for work—Sentiment—Religious sense—Courtship—Engagements to marry—Sexual intercourse.

Of 1800 cases 230 uncomplicated between 14 and 25—Of these 49 occurred at the ages of 18, 19, and 20, while 157 occurred from 21 to 25.

Mental Symptoms.—78 per cent. exaltation—Only 22 per cent. depression—Mania, acute, remittent, relapsing in 66 per cent.—Hereditary predisposition very common (45 per cent. ascertained, far more than that in reality.)—Morbid ideas, emotions, speech, and conduct tinctured by erotic, sexual, or adolescent characteristics.

Prognosis.—Good—At least 66 per cent. recover—Remainder mostly become demented and live long, bodily health often being good. *Mortality Small.*—Only 1·8 per cent. died.

Treatment.—Same as for Insanity of Puberty.

Signs and Accompaniments of Recovery.—Perfect development of form and mammæ—Growth of beard and sexual hair—Change of voice—Psychologically they emerge from attack men and women.

CLIMACTERIC INSANITY.

Age—Physiological characteristics of period—Melancholic symptom in half the cases in women between 45 and 50.

Mental Symptoms in a typical case—Loss of keen interest in life—Fits of depression—Capacity for work diminished—Irritability—Suspicion—*Sense of fear and impending danger*—Change of connubial affection—Suicidal longings—Vague melancholic delusions.

Bodily Symptoms.—Sensory neuroses—Vertigo—Pains—Sensations of heat—Vaso-motor neuroses, flushings, etc. *Motor Symptoms.*—Restlessness.

Prognosis.—Fair—60 per cent. of uncomplicated cases recover.

Treatment.—Change of scene—Travel—Change of air and of diet—Iron and Quinine—Sea-bathing—Fresh air—Fattening Diet—The Bromides.

SENILE INSANITY.

Represents an irregularity in the Physiological decay of the brain—Premature and violent dotage—Relationship to atheroma of arteries, shrinking of brain, and degeneration and atrophy of cells of convolutions.

Out of 1800 cases 95 or 5 per cent. Senile, or over 66—Of these 62 Mania, and 33 Melancholia.

Mental Symptoms.—Loss of memory — Irritability — Excitement — Restlessness.

Prognosis.—Bad—Not hopeless in all cases.

Treatment.—Nursing—Support—Sedatives—Stimulants—Diet.

With Dr Sibbald's compliments

ON THE

PLANS OF MODERN ASYLUMS

FOR THE INSANE POOR.

By JOHN SIBBALD, M.D.,

Commissioner in Lunacy for Scotland.

PRICE ONE SHILLING.

EDINBURGH:

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1897.

Robert Parker
Esq. D.R.H.A.

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THE immediate purpose of the following Paper was to afford information to the authorities of the recently constituted Edinburgh Lunacy District. It has been reprinted because it was suggested that the information it contains might be acceptable to others who are interested in the construction of Asylums.

J. S.

18 GREAT KING STREET,
EDINBURGH, *March* 1897.

ON THE PLANS OF MODERN ASYLUMS FOR THE INSANE POOR.

The construction of an asylum is a more interesting subject of study for the general reader than might be supposed. It is always interesting as well as instructive, to trace the steps by which the operations of public philanthropy have come to embrace a wider field, and to rest on more perfect knowledge than they did at a time, not very remote, when benevolent action of a public character had scarcely a place among the recognised obligations of society. It is one of the most gratifying features of modern social life that the care of the helpless and the relief of the suffering are now regarded as among the most important of public duties, and in no branch of philanthropic work has its domain been more remarkably extended and its efficiency been more conspicuously increased during the present century than in the provision made for those unfortunate persons who suffer from insanity. The history of the construction of asylums is therefore interesting, because we find in the changes that have been effected in the arrangements of these institutions a reflection of the successive stages in the development of one of the most humane phases of modern civilisation.

It is not, however, merely because the subject presents features of general interest that I venture to draw attention to asylum construction in the following pages. My special object is to be useful to those public authorities who may have laid upon them the responsibility of choosing plans for an asylum, but who may not hitherto have had an opportunity of devoting special attention to the subject; and I hope that they will welcome an attempt to furnish them with some information as to the most recent views of

those who have had to study it professionally, and who have had to form opinions as to the best way of solving the problems which present themselves.

For this purpose, it will be useful to refer briefly to the changes of view which have taken place during the present century as to the kind of accommodation that should be provided in institutions for the insane. Those who, from their position as members of public boards, have to deal with the erection of asylums are usually concerned with institutions of the class, known as District Asylums in Scotland and Ireland, and as County and Borough Asylums in England. These institutions are intended for the accommodation of the poorer classes of the insane, and it will therefore be convenient in our brief retrospect to leave out of consideration the accommodation provided for insane persons of large means. It must not, however, be supposed that the insane of the richer classes have not shared in the benefits due to the development of more humane, enlightened, and intelligent views as to the treatment of insanity. A great improvement has taken place in their case also, but their position in former times was never so unsatisfactory as that of the insane poor. The possession of ample means always insures exceptional advantages. The way in which the insane of the richer classes are treated is therefore never a trustworthy indication of the condition of the great mass of the insane. It is also desirable to give special attention to asylums for the poorer class of patients, because it is there that the most difficult problems have had to be solved, and it is by studying the constructional features of such asylums at different times that we can best bring into view the nature of these problems and indicate the principles which have guided the most successful attempts at their solution.

Up to the end of the eighteenth century, the function of an asylum as a hospital for the curative treatment of insanity received little attention. Public asylums of any kind were few in number, and where they did exist they were usually intended to be used

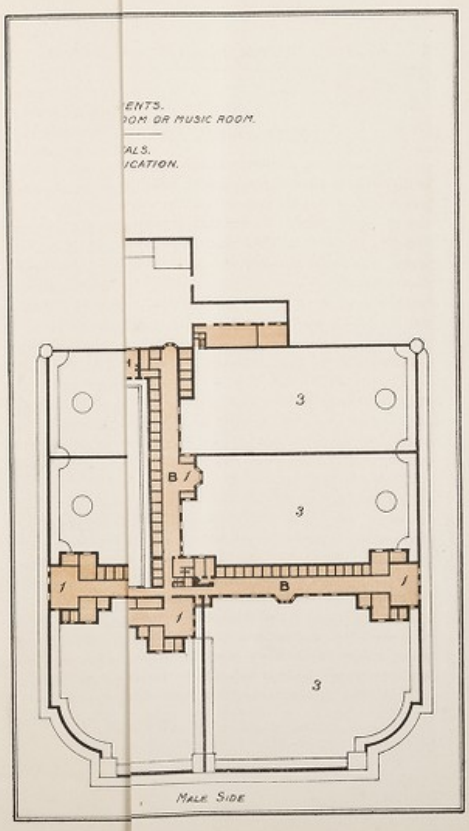
merely as places of safe custody for those of the insane who were regarded as dangerous to the public. Such special provision for the insane as there was consisted usually of a few "cells for the mad people," as they were called, which were attached to hospitals and prisons. Where there was no building specially provided for the insane, those who were regarded as dangerous were usually cast into the nearest jail, where they were often chained or put in irons, and treated worse than criminals.

In Edinburgh, before the opening of the asylum at Morningside in 1813, the only public provision for the insane consisted of twelve cells attached to the Edinburgh Infirmary, and of the wards of the City Bedlam, the latter being a place where the patients lay on loose uncovered straw on a stone floor, in a condition which Dr Andrew Duncan, the founder of the Royal Asylum, described as deplorable and a disgrace to the community. The condition of the insane in other parts of the country, during the earlier years of the present century, was as bad as, and often worse than, in Edinburgh. It is unnecessary, however, for the present purpose to refer in any detail to the character of the buildings which existed previous to the legislation of the year 1845 for England and the year 1857 for Scotland. The passing of the Lunacy Acts of these two years was the culmination of the efforts of philanthropists who, during the first half of the century, had striven to rouse the nation to a sense of its duty to secure for the insane in every part of the country humane treatment in institutions suitably constructed and adequately equipped. The asylums that were erected in consequence of this legislation were therefore intended to be places where the patients would not only cease to be a danger to society, but where they could also be treated in the way most likely to benefit them, either by restoring them to a state of mental soundness, or, where that was impossible, by making their life in an asylum a tolerable and if possible a happy one.

DERBY COUNTY ASYLUM.

It is useful to look back through the intervening forty years to the commencement of what may be called the modern asylum period, and see what the ideas of that time were as to the construction of a good asylum. We find them expressed in the plan of the Derby County Asylum, which was opened in the year 1851. This asylum represented to a great extent the views of Dr Conolly, the most eminent asylum reformer of the day, and it served more or less as a model for several succeeding asylums. In the construction of the building a consistent effort was made to avoid the prison-like arrangements that had been almost universal in asylums previously erected. The annexed plan of the ground floor of the Derby Asylum, although not altogether free from prison-like features, does not indicate such arrangements as the prison-like towers which were then to be found in the asylums at Hanwell and Wakefield, and in others of the best asylums. These towers contained circular staircases which, to quote Dr Conolly's description, were "so guarded with iron palissades as to give the patients looking through them the appearance of persons shut up in tiers of iron cages," * which produced, as Dr Conolly adds, "a very painful impression" on newly admitted patients. The part of the building in which the patients were lodged consisted of two storeys similar in plan, one side being for men and the other for women. The section for each sex was in each storey divided into three divisions, so that there were in each side of the asylum six nearly identical divisions or wards, the main feature of each being a long gallery with windows along the greater part of one side, and about seventeen single bedrooms for patients along the other side. Except for a small room or recess used for meals in each

* *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, by John Conolly, M.D. John Churchill, London, 1847.



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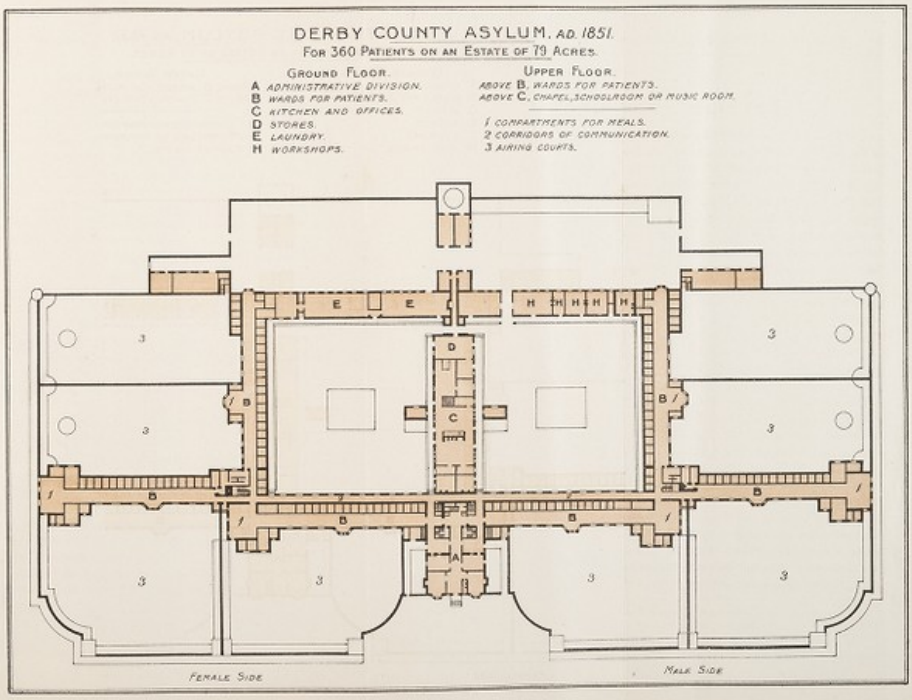
* *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, by John Conolly, M.D. John Churchill, London, 1847.



division, these galleries formed the only day-room space for the patients. A distinctive feature of the institution as compared with more modern asylums was the large proportion, about two-thirds of the whole number of patients, who slept in single rooms. All the doors opened and shut by lock and key. The windows had iron frames, and looked into airing-courts which were surrounded by walls seven feet high. The ideas of the time as to the kind of accommodation suitable for the patients may be understood when we find Dr Conolly recommending that the bedrooms should be floored with "the square Suffolk tile," no great improvement upon the stone floor of the old Bedlam. "Excepting," he says, "in the bedrooms of wards assigned to the cleanest and quietest patients I should not recommend boarded floors." He also speaks with approval of the door of every bedroom at Hanwell being "fitted up with what is called an inspection plate, placed at so convenient a height that it may be looked through if necessary as the attendant passes along the galleries." A general idea may be formed by looking at the plan, with the help of the foregoing description, of what a pauper asylum of the best kind was at the beginning of the present half century.

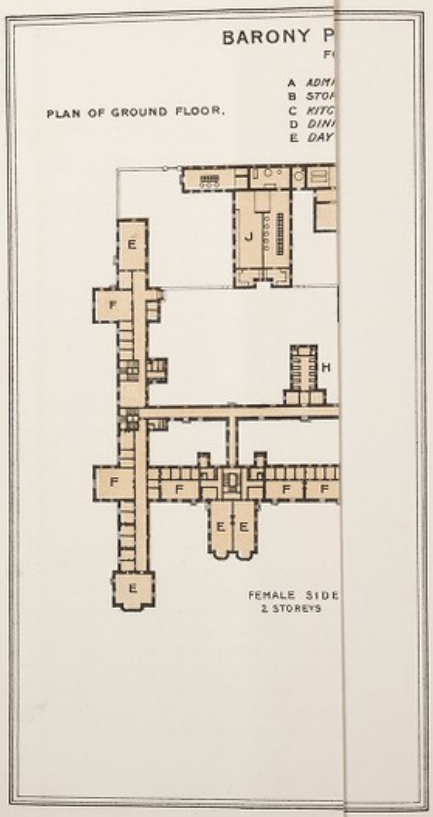
1851 to 1875.

It may be useful now to devote a few words to a notice of the development of opinion among constructors of asylums during the quarter of a century which followed the erection of the Derby Asylum.

When the care of the insane passed out of the hands of those who regarded themselves as mere gaolers charged with the custody of persons who were sources of public danger, into the hands of men who had chiefly in view the cure and alleviation of the condition of patients committed to their care, it was soon recognised that though the most objectionable of the methods of coercion that had previously been the predominant characteristic of the treatment of the insane were abandoned, there was room for

further progress in the same direction. With the more enlightened study of the different phases of insanity, it had been ascertained that much of the terror with which the insane were regarded was groundless. Iron manacles, fetters, and chains had been discarded, and mechanical restraint either discontinued or, in exceptional cases, applied in the milder form of the strait waistcoat, and patients who had for years been kept in solitary confinement in their cells mixed freely and harmlessly with their fellows. The knowledge acquired from a study of the insane under the new conditions showed that it was desirable to do much more than had previously been thought necessary to supply the inmates of asylums with objects of interest, and otherwise to lead their thoughts into healthy and tranquillizing channels.

Although substantial progress had been made in the amelioration of the condition of the insane and in the improvement of asylums at the time the Derby Asylum was erected, the structural features of that institution must in the light of subsequent experience be regarded as imperfect and unsatisfactory in several respects. It was only by a gradual process that it became evident how much more could be done with safety and with benefit to the insane in the direction of removing restrictions in the management of the patients, and in bringing the arrangements of the buildings more into harmony with those of ordinary dwellings. It was therefore to be expected that further progress would be made in such directions between the years of 1851 and 1875. Probably no asylum could be selected from among those that existed in 1875 which would embody all the improvements that had been introduced at that time. Some asylum constructors had realized the advantages of certain changes, and other constructors had adopted other desirable modifications. The plan of the Barony Parochial Asylum, at Lenzie, near Glasgow, may, however, be taken as illustrative of some of the most important improvements.



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Barony Parochial Asylum.

Woodilée, Lenzie.

ONY ASYLUM.

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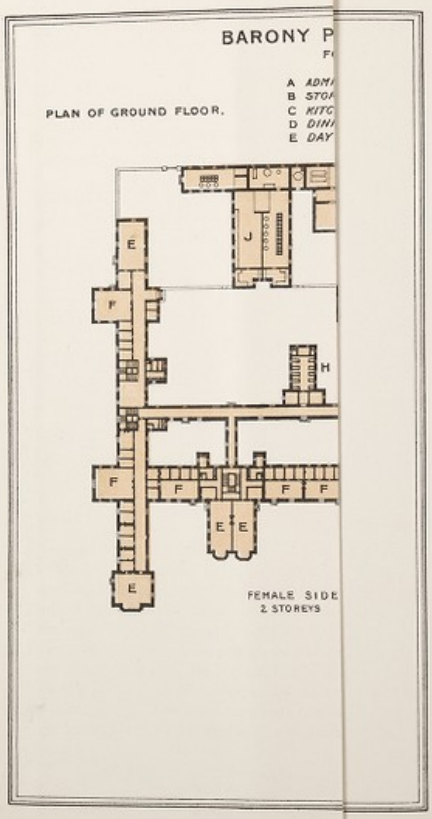


THE BARONY ASYLUM.

The Barony Asylum was opened for the reception of patients in the year 1875. The following are among the features which distinguish it from an asylum of the Derby type:—

(1) The sections of the building in which the patients reside are not identical in plan, the wings used as hospital and special observation wards presenting marked features of their own.

(2) The dayrooms are all upon the ground floor, the whole of the upper storey being devoted to sleeping accommodation.

(3) The day accommodation for patients consists almost entirely of rooms shaped like those usual in private dwellings, instead of consisting chiefly of long narrow galleries, as in the Derby Asylum.

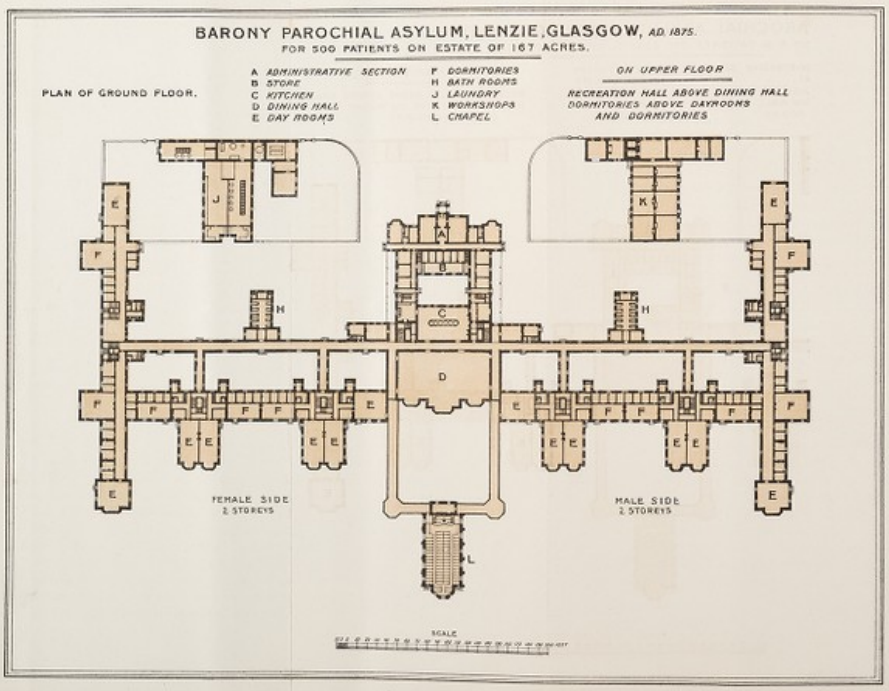
(4) The southern front of the building is entirely devoted to accommodation for patients, and there is easy access for the patients from the day-rooms to the grounds on the south side.

(5) The entrance to the asylum for the public is on the north front, and the grounds to the south are thus free from interference by traffic or strangers.

(6) There are no walled airing courts.

(7) There is a large central dining hall adjacent to the kitchen.

Most of these features will be evident on looking at the annexed plan. There were other features of the building, however, which distinguished it from the Derby type, but which cannot be shown on a plan of the ground floor of the asylum. The character of the fittings were everywhere made more like what is usual in private dwellings. The windows had ordinary wooden sashes. The floors were of pitch pine, waxed and polished, tiles being only used in the kitchen, the lavatories, and similar places. There were no inspection plates in the doors of single bedrooms. The doors opening into the day-rooms and elsewhere were fitted with ordinary handles, and an



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effort was made by furniture, decorations, and otherwise, to obviate everything of a prison-like character. It will be understood that arrangements such as these did not appear for the first time in the Barony Asylum. Most of them had been introduced into many asylums before the erection of that asylum, in accordance with views which had been gaining in favour for several years. The Barony institution is merely given as a good illustration of the best views of the time.

The life of patients living in buildings of this kind was necessarily very different from what the life of patients in a building such as the Derby Asylum in 1851 could have been. There was less of the feeling of imprisonment among the patients, when they were able to go in and out of a day-room by opening the door with an ordinary handle instead of having it opened by an attendant with the obnoxious key. It was more like life in the outer world when they could go out into the extensive grounds of the institution for their walks instead of being turned out to take monotonous exercise in a walled airing court. The absence of prison-like restrictions was necessarily accompanied by a change in the relations between the patients and those in charge of them. The removal of mechanical restrictions was the result of finding that most patients could be induced to submit to control when it was accompanied by efforts to gain their confidence by the exhibition of kindly sympathy and a desire to promote their comfort. It was found that the resistance of the patients to detention was, in most cases, diminished, if not removed, when it was made evident to them that those under whose charge they were placed were anxious to help and benefit them; and experience showed that the introduction of additional arrangements obviously intended for the advantage of the patients, combined with the removal of irksome restrictions, had the effect of still further tranquillizing the patients and promoting their contentment. The absence of locked doors and of similar inhibitive expedients of a structural or mechanical kind was attended with other advantages, and not the least

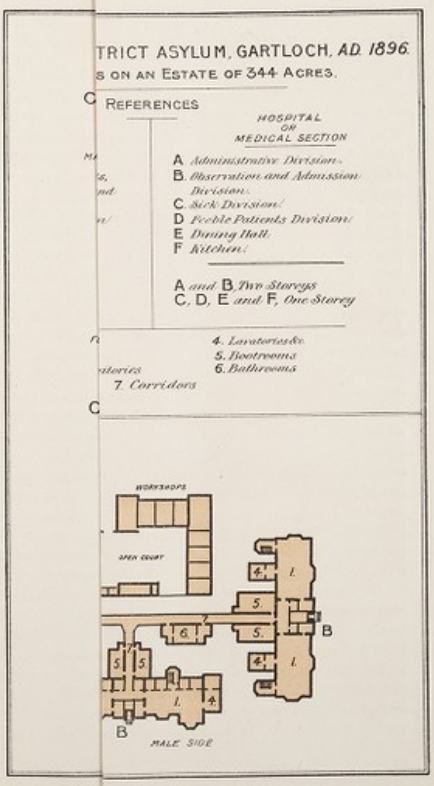
of these was its effect on the attendants. It obliged them, when they could not wholly rely on walls and bolts and bars for the detention of the patients, to give more individual and constant attention to them, to engage them in congenial occupation, and, otherwise, to guide their thoughts into channels likely to foster contentment and happiness. Thus the abolition of mechanical restrictions acted both directly and indirectly in promoting the welfare of the patients, and in making the asylum more truly a place for the cure of the insane and the amelioration of their condition.

THE CITY OF GLASGOW DISTRICT ASYLUM.

The plans of asylums erected since the year 1875 show that the efforts of asylum constructors, to make these institutions as efficient as possible, have not been relaxed in more recent years. As might be expected, the improvements have taken various directions, according to the views of different asylum authorities, but it may be said with confidence that every asylum that has been recently erected gives evidence of being the outcome of enlightened consideration and liberal views, and that each asylum presents in one feature or another an advance on its predecessors. It would occupy too much space to do more than describe illustrative examples. Some of the English County Asylums, such as the Middlesex Asylum, at Claybury, for 2500 patients—an unwieldy number, and the West Riding Asylum, at Menston, for 1000 patients, are, from certain points of view, among the most admirable of the newer asylums; but it will serve my present purpose best to describe the City of Glasgow District Asylum, at Gartloch, for 600 patients. I select the Gartloch Asylum, not that it is in every respect the best, but partly because it is of moderate size, and partly because it illustrates among other things common to the plans of many of the newer asylums, a principle of construction

that, as will be shown further on, had been previously adopted in some German and American asylums, and which has recently been growing in favour among asylum authorities in Scotland. What has been called the pavilion system, has been adopted more or less in most of the new asylums. This consists of erecting several separate blocks containing day-rooms, dormitories, and their accessories, each complete in itself, and appropriated to a special group of patients. It has the advantage of making it easy to give abundance of light and air to all the apartments. It also defines in an effective manner the responsibilities of every attendant in charge of a group of patients, each block providing accommodation, both night and day, for all his or her patients. It permits likewise of each block being constructed with special reference to the requirements of the class of patients it is intended to receive, free from the hampering influence of architectural or other considerations dependent on its forming part of one great building. It lends itself to the adoption of the simpler kind of structural arrangements usual in private houses; and it gives to each group of patients a feeling of having a home not of inordinate size. These separate blocks have hitherto, with few exceptions, been connected with one another, and with the central administrative and commissariat block, by covered corridors. This pavilion system is illustrated in the annexed plan of the Gartloch Asylum, and it also shows a division of the asylum into two quite separate sections, an arrangement, which has been adopted in American and German asylums, and in some of the newer Scottish asylums.

The division of the institution into two more or less independent sections is due to the recognition of the fact that the inmates of an asylum are of two classes, one of which consists of patients requiring constant medical attention and nursing, and the other of patients not requiring constant medical attention, in the more restricted sense of the words. One of the sections is therefore devoted to the patients requiring constant medical attention, and is named the hospital. In this section are contained all the newly



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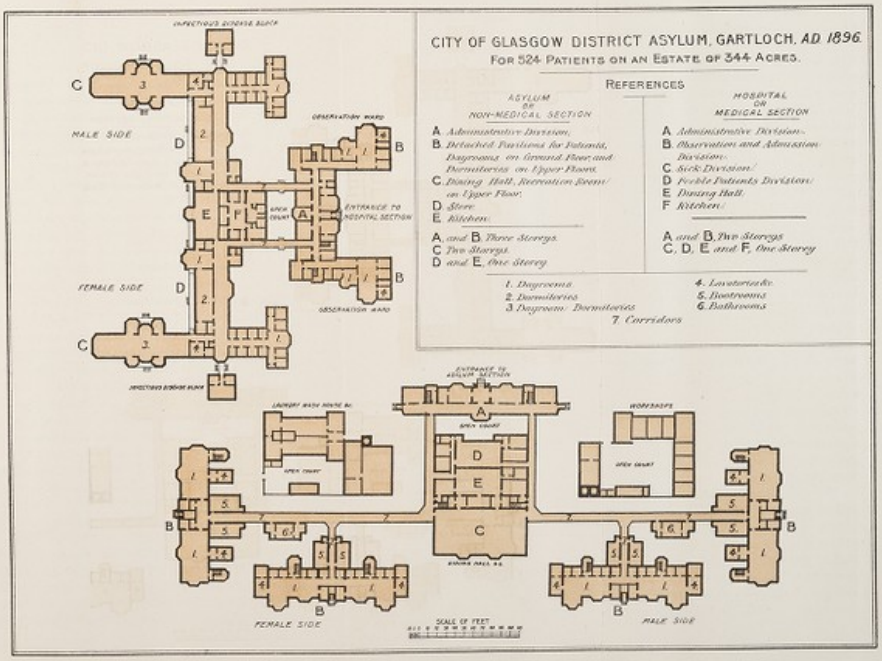


admitted patients, all requiring special attention owing to suicidal tendencies or for any similar reason, all patients requiring ordinary hospital treatment on account of either bodily or mental illness, and also those patients who require special nursing on account of general feebleness, wet or dirty habits, or other peculiarities which require nursing or other treatment of a special kind. It is found that in an ordinary district asylum, the number of patients who thus require accommodation in the hospital section amounts to from about one third to one half of the total number. The hospital consists almost entirely of buildings of a single storey, and is divided into sub-divisions, adapted to the requirements of the several classes of patients just enumerated. It has in the centre a kitchen, dining hall, and administrative block of its own. The rest of the asylum, which accommodates the remaining patients, contains those, chiefly chronic cases, who do not require or have ceased at least for a time to require special medical treatment. It gives accommodation to the more easily managed patients and to the working patients, and its organisation is, in its main features, that of an industrial community. The central building of the section consists of a block containing the general store, the kitchen, the dining-hall, the amusement-room, and the chief administrative offices for the whole institution. The accommodation for the patients consists of separate pavilions, connected with the centre by corridors. They are of three storeys each, and are of simpler construction than is necessary in the hospital section.

The advantages claimed for this division of an asylum into two partially independent sections are that it permits of more complete provision being made in the hospital section for the medical treatment of those patients who specially require it, and it gives facilities for making more effective arrangements in the other section for making the daily life of its inmates more like that of a sane community. It is claimed that, when there is a section of the institution where the medical treatment of the patients is the predominant aim, the duties, both of the medical officers and of the

attendants in that section, will be performed more thoroughly and successfully than when their attention has to be directed at the same time to administrative or other duties not directly medical in their object. The attendants will, to a large extent, be selected from among persons with ordinary hospital experience, and will enter on their duties in the spirit of the trained nurse, and all the arrangements of the section will be made with a dominant view to the cure or relief of persons suffering from disease. It is represented, in regard to the other and larger section of the institution where the patients do not require special medical attention, that, not only can it be of simpler and less costly construction than ordinary asylum wards, but that all the patients requiring exceptional treatment having been eliminated from it, the administration can be carried on more economically and more effectively. The arrangements for engaging the patients in useful occupation and for giving interest in other ways to their daily life can be made in a more satisfactory manner in this section, and much that is regarded as characteristic of asylum life can be dispensed with.

The division of an asylum into a medical and a non-medical section is not identical with the separation of the curable from the incurable patients, as the medical section will always contain a certain number of incurable, and the non-medical always a certain number of curable patients. That idea—the separation of the establishments for the curative treatment of the insane from those where the chronic and incurable might be lodged—is by no means new. It was, many years ago, given effect to in Germany, where an attempt was made to create two separate kinds of asylums, the *Heil-anstalten* and the *Pflege-anstalten*. It was also given expression to in the English Metropolitan Poor Act of 1867, under which a set of asylums were brought into existence in the London district for the accommodation of chronic and easily managed lunatics, the County Asylums being left with the curable and those requiring special treatment. But in these and other cases that might be mentioned, where the chronic and easily managed patients were separately provided for, such as the lunatic wards of poorhouses in Scotland, there is an important respect in which they differ from the arrangement illustrated by the Gartloch Asylum. The two sets of institutions are in the former case placed under entirely independent authorities, the authorities of what we may call the medical institutions having no control over the admission and discharge of patients in the non-medical institutions, and having no share in their management. The consequence of this has been, that it has been found impossible to keep the two sets of institutions in the London district entirely restricted to their proper functions, the medical institutions having always a large number of patients not requiring special medical care, and the others having a large proportion requiring special medical care. In the Gartloch and similar asylums this difficulty does not arise. The patients there being all under one superintendent are transferred from the medical to the non-medical section, whenever occasion arises, those ceasing to require medical care being at once transferred to the non-medical section, and those in the non-medical section being at once transferred to the medical section whenever their condition makes it desirable, however temporary the necessity for transference may be.

I have dwelt at some length on this division of the asylum into two great sections, because it is regarded by those who have adopted it as an important improvement in asylum construction, and it deserves to be very favourably considered by those who may have to decide on the plans of new asylums.

ASYLUM FARMS.

Few things have impressed themselves more strongly on the minds of the administrators of District Asylums in Scotland and of similar institutions elsewhere than the advantage of having a farm of considerable size attached to an asylum. Many of the District Lunacy Boards which had only small farms attached to their

asylums at first, have subsequently become either the proprietors or tenants of neighbouring farms, and all the most recently erected asylums have farms of considerable size attached to them. One of the most recent of these, the Lanark District Asylum, has 600 acres of land attached to it. The Barony Asylum which began with 167 acres has now 459 acres.

The chief advantage of an asylum farm is the opportunity it affords of giving occupation to the male patients. Occupation of a suitable kind is of more importance than anything else in the treatment of a large number of the inmates of an asylum. It benefits them by promoting their health both of body and of mind; but it is necessary for this purpose that the work provided for them should be in itself healthy, interesting, and of various kinds. When there is nothing in the bodily condition of a male patient to render him unfit for it, out-door work, such as is afforded by a garden or a farm, is the most favourable to his health. Such work is also of a kind that seldom fails to interest all the patients of the asylum whether they engage in it or not; and to those who can engage in farm work it offers sufficient variety to suit patients of different kinds and degrees of capacity. And it has the advantage of commending itself to every one by its obvious usefulness, not the least of its merits being that the results of such work are continually in view of those engaged in it. Experience shows, indeed, that work in which a patient takes no interest, not only fails to benefit him, but is positively injurious by producing irritation and discontent.

The existence of a farm in connection with an asylum is important from another point of view. It makes an asylum less like a prison than it is where there is no farm. This becomes at once apparent if one has the opportunity of contrasting an asylum with a farm with one without a farm. The farm gives the institution many of the features of ordinary life among the sane, and makes the life of the patients more like that of an industrial community. It thus tends to make the patients both think and act more sanely,

and must therefore exercise no inconsiderable curative influence.

It should not be left out of account that it provides to some extent healthy and active work for women as well as men; and there is a difficulty in most asylums in finding sufficient work for women that is not of a sedentary kind such as needlework, which has an injurious effect in many cases.

Another circumstance that should not been lost sight of, is that it has generally been found that an asylum farm is remunerative and lessens the cost of maintenance of the patients

THE SEGREGATED OR VILLAGE TYPE OF ASYLUM.

I have now only one other type of asylum to describe, but it is one which illustrates a very important and instructive development. The institution which I select to illustrate this type of asylum is that of Alt-Scherbitz, near Halle in Prussia. Before describing this institution, it will however be useful to devote a few words to a consideration of the way in which this type of asylum came into existence.

At an early date, in what may be called the modern asylum epoch, small groups of the more trustworthy patients were placed in houses quite separate from the main asylum buildings. In most instances, such groups consisted of a few patients who lived at the farm steading attached to the asylum, and were engaged in the work of the farm. For the last thirty years this practice had been adopted in a large number of asylums, not only in this, but also in foreign countries; and the system has gradually assumed larger proportions. At the Barony Asylum, for example, there have been for many years three such groups,—one of 50 men, who live at the chief farm steading; one of 15 men, who live at a small outlying farm steading; and one of 8 women who reside in a small cottage on the grounds. The houses used for the accommodation of such groups of patients are sometimes buildings which have been

erected for the purpose, and sometimes buildings which have been previously used as private dwellings, and which have undergone only slight alterations to make them suitable for being occupied by patients. In several places, especially on the continent, the buildings erected in connection with the farm steadings are of considerable size, and in France and Germany they are called agricultural colonies. The experience gained in the detached buildings, such as those just mentioned, has contributed to strengthen a conviction that has been growing in the minds of many persons acquainted with lunacy administration, that a large number of the inmates of these institutions require little more than kindly care and guidance to induce them to conduct themselves in an orderly and inoffensive manner; and it is becoming more and more recognised that, the nearer the conditions of asylum life are made to resemble those of a sane community, the more contented do the patients become, and the more successfully is their restoration to a really sound state of mind promoted and secured. These views have found very complete expression in the plan of the asylum at Alt-Scherbitz, which will now be described.

THE ALT-SCHERBITZ ASYLUM.

The asylum of Alt-Scherbitz combines two ideas—(1) The division of the institution into two great sections, corresponding to what has been already described as the hospital or medical section and the non-medical section; and (2) the approximation of the buildings as far as possible to the character of ordinary private dwellings, as regards their size, their style of architecture, their internal arrangements, and their grouping. The asylum thus consists of two congeries of houses,—one called the central establishment, corresponding to the medical section; and the other called the colony, corresponding to the non-medical section.

The erection of the asylum was begun in the year 1876. It was completed for the reception of 800 patients in 1885, and shortly afterwards on the completion of the William Augusta Foundation it was able to receive 960 patients. It contains, besides the pauper inmates, a certain number of private patients, but none paying high rates of board. The estate extends to 750 acres, and it included at the time it was bought by the asylum authorities a mansion, a farm steading, and a hamlet, in close proximity to one another. The houses forming the hamlet were not included in the purchase, but most of them have since been acquired for the asylum, and, before long, they will all be acquired. The mansion and farm steading and the greater part of the hamlet form part of the asylum as it now is. The annexed plan shows the disposition of these and of the buildings that have been erected by the asylum authorities. It will be seen that the public road from Halle to Leipzic passes from north-west to south-east through the middle of the institution. The buildings to the north form the so-called central establishment, and those to the south form the colony. An addition to the buildings on the north was made in 1885 by the erection of what is called the Emperor William Augusta Foundation, in commemoration of the late Emperor William's golden wedding. This consists of a building for 80 lunatics of each sex suffering from bodily infirmity, and it is practically an extension of the central establishment. The whole of the buildings on the north furnish accommodation for 550 patients, and the buildings on the south for 410. In order to give an intelligible description of the organisation of the asylum, it will be necessary to go somewhat into detail.

I.—The Central Establishment.

It will be seen in the plan that, if the William Augusta Foundation is left out of consideration, the central establishment consists of two symmetrical halves,—one for men and the other for women. In the centre in front is the house (numbered 1 on the

plan), containing the administrative offices, and behind it is the hospital, using the word in its most restricted sense. This hospital (10 on plan), which is appropriated to patients suffering from the more serious bodily diseases, is for 18 patients of each sex, and is the only building in which there are patients of both sexes. On each side of the middle line are five houses for patients, identical in arrangement. The following is a description of those on the west side, allocated to women :—

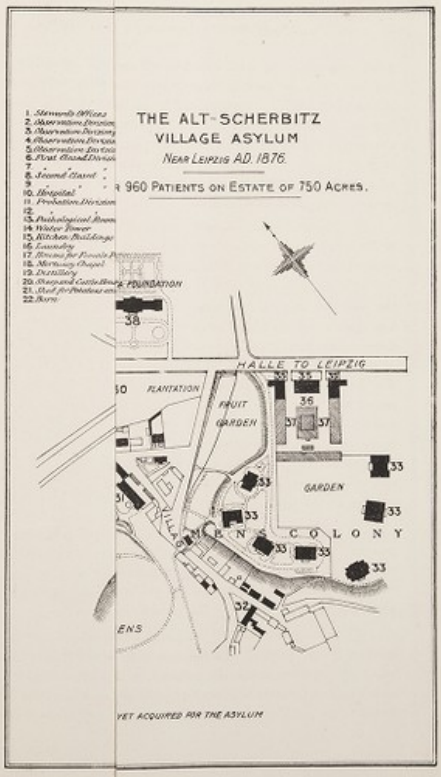
(1) Observation Division (4 on plan), for 22 patients. This is for newly admitted patients and those who require special supervision on account of their mental condition.

(2) First Closed Division (6 on plan), for 51 patients. This and the next division are the only houses constantly under lock and key during day time and containing seclusion rooms. In these divisions the patients are kept who are untrustworthy, on account of tendencies to escape or to be violent in their conduct. This first division is for the more easily managed and least restless of the class, and it also contains recently admitted patients who would be unsuitable for the observation division from being likely to disturb the other inmates.

(3) Second Closed Division (8 on plan), for 36 patients. In this division are placed the untrustworthy patients of the most refractory kind and those with obnoxious and anti-social habits.

(4) Probation Division (11 on plan), for 37 patients. The patients in this division are those who are regarded as fit, or on the way to become fit, for being transferred to the colony, but whom it is not thought expedient as yet to entrust with such complete liberty as is enjoyed by the patients in the colony.

(5) Private Division (2 on plan), for 26 patients. In this division those private patients are kept who require special supervision or treatment, the patients in the other houses being either pauper patients or private patients paying the lowest rate of board.



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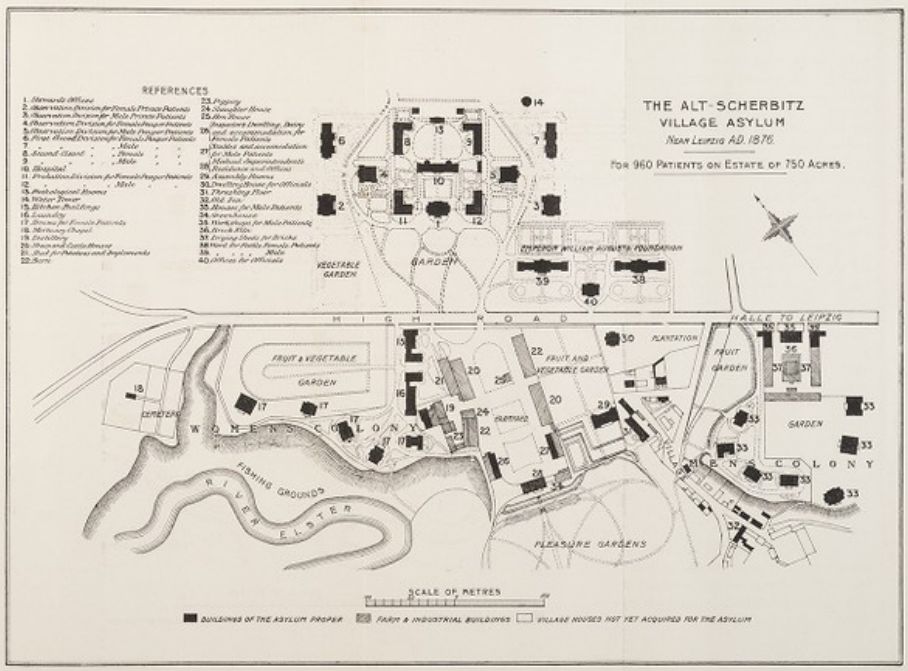
(3) Second Closed Division (8 on plan), for 36 patients. In this division are placed the untrustworthy patients of the most refractory kind and those with obnoxious and anti-social habits.

(4) Probation Division (11 on plan), for 37 patients. The patients in this division are those who are regarded as fit, or on the way to become fit, for being transferred to the colony, but whom it is not thought expedient as yet to entrust with such complete liberty as is enjoyed by the patients in the colony.

(5) Private Division (2 on plan), for 26 patients. In this division those private patients are kept who require special supervision or treatment, the patients in the other houses being either pauper patients or private patients paying the lowest rate of board.



These five houses for women and the corresponding houses for men, together with the little hospital building, and the William Augusta Foundation, constitute the whole of the accommodation for patients on the north side of the Leipzic and Halle road, and, taken together, they provide for 550 patients. This includes all the patients who are regarded as requiring special medical treatment or special supervision, and leaves 410 patients, or less than half the total number, to be provided for in the southern section of the institution, called the colony.

II.—The Colony.

The colony has in its centre the old mansion house of Alt-Scherbitz, now the medical superintendent's residence (28 on plan), and the old farm steading. It also includes the old hamlet or village, which will be seen on the plan towards the south-east between the figures 31 and 32. The accommodation for patients consists of six houses on each side of the centre buildings, built specially for patients (17 and 33 on plan), of accommodation connected with the stables, laundry, and dairy, and of village houses which have been converted into accommodation for patients. The whole of the accommodation for men lies to the east of the middle line, and the whole of the accommodation for women to the west. Two of the houses on each side, built specially for patients, are for the private patients paying the higher rates of board. These contain from 11 to 20 patients each. The other four on each side contain from 26 to 42 patients each. The kitchen (15 on plan), the laundry (16 on plan), and the farm buildings, are grouped round the centre of the colony. The assembly rooms (29 on plan), for dances, concerts, entertainments, and, pending the erection of a church, for religious services, is situated to the east of the central buildings. The male workshops (35 on plan) face the Leipzic and Halle road. Other houses consist chiefly of the residences of officials and servants.

III.—Of the Asylum as a whole.

It will be seen from the foregoing description of the institution at Alt-Scherbitz that the accommodation for patients, excluding the houses for those paying higher rates of board, consists almost entirely of houses containing from 25 to 50 patients each. These buildings are all, as regards their outward appearance, undistinguishable from private houses, and, with the exception of the four closed divisions and the William Augusta Foundation, their internal arrangements are also similar to those of private houses. There is no wall encircling either the central establishment or the colony. The roads which lead to the different houses are branches of the public road which passes through the middle of the asylum. The only enclosed spaces are the gardens connected with the houses in the central establishment, and these, even in the case of the closed divisions, are undistinguishable from ordinary well-kept villa gardens. They are surrounded by wooden palings, covered with shrubs, trained *en espalier*. The palings round the closed divisions are higher than the palings round the other villas, and are the only palings intended to remain permanently, the others are being gradually replaced by hedges, and, before long, they will have ceased to exist. It is an instructive fact that all these gardens were at first enclosed by walls, and that the walls have all been removed, as they seemed to Dr Paetz, the present distinguished medical superintendent, notwithstanding the way in which the gardens lie open to the public road, to be "at least superfluous, and probably injurious."* The architecture of the houses, both in the central institution and in the colony, is of the simplest character. There is nothing grand or imposing about any of them, but they are all pleasant to look at, and many of them are picturesque. No attempt has been made to secure uniformity of design, on the contrary, uniformity seems to have been avoided. The interior arrangements of the closed divisions are very similar to ordinary asylum arrangements. In the houses of the colony, the ground floor usually consists of three day-rooms, one of which is used as a dining-room, and of a scullery, a lavatory and bath-room, a dressing-room, a store-room, and water closets. The upper floor is occupied by sleeping accommodation. The style of architecture of both sections of the institution is generally that of the plain villa with over-hanging eaves, or of the Swiss *chalet*. Simple balconies and verandahs are frequent, and the walls are, in all cases, more or less adorned with climbing plants. The whole area occupied by buildings is freely decorated with shrubs and trees, planted either singly or in clumps, and these are so placed that a view of only a few houses can be obtained at a time. One result of this is that, although there are upwards of 1100 persons in the institution, no inmate can be oppressed, as an inmate of an institution consisting of one huge pile of buildings often is, with the feeling that he has lost his individuality, and is only an insignificant unit in a great aggregation. The incorporation of the old village within the institution tends greatly to make one forget that it is an asylum for the insane, the houses occupied by the patients having lost nothing of their original domestic appearance, except that they are less out of repair than the cottages of villagers often are. One of these houses is the old inn, and it might still be taken for a village hostelry if it were not that the sign board has been removed.

Another feature of the asylum, which helps to bring its arrangements into accordance with those of private houses, is that there is no general heating apparatus by which the heat is transmitted from a common centre to the different sections of the institution. Every house has its own heating, and stoves are used everywhere for this purpose, except in the single rooms, where the heating is by steam of low pressure. The water supply and the electricity for lighting are of course distributed from central

* *Die Colonisirung der Geisteskranken*, von Dr Albrecht Paetz. Julius Springer, Berlin, 1893.

sources. A curious feature of the institution is the existence of a small distillery (19 on plan). It existed when the estate was purchased, and it is still in operation. The proceeds are sold; none of the liquor is consumed in the institution.

To one accustomed to what is usual in asylums where the different sections are in close contiguity, the absence of a general dining-hall attracts attention. This is, however, a necessary consequence of the segregated or dispersed situation of the houses; and it is right to keep in mind that the administrators of what may be called the aggregated asylums are not unanimous in their approval of general dining-halls. There are disadvantages as well as advantages connected with them; and some of the best superintendents of aggregated asylums prefer that each ward should have its own dining-room. Dr Paetz expresses no regret at the absence of a general dining-hall, and finds no difficulty in distributing the food in a quite satisfactory manner to the various houses. It is conveyed from the kitchen in a large food waggon divided into a large number of small compartments, carefully lined with material which is a non-conductor of heat. The food for each house is packed in the kitchen in a zinc case which fits the compartment appropriated to the house, and the waggon, which is drawn by two horses, makes the round of the houses, and delivers each case with substantially no loss of heat to the several houses. Two journeys of the waggon taking not more than a quarter of an hour each suffice to go round the whole institution, and those in charge of each house know almost to a minute when they may expect its arrival. I saw the process carried out on the occasion of my visit to Alt-Scherbitz, and found that it was entirely successful in its operation.

The building containing the assembly rooms, which takes the place of the recreation hall usual in asylums, stands by itself as a village hall might be expected to do. The hall is used at present for religious services as well as for entertainments; but it is proposed to erect before long a separate church. There is an advantage

in having the church and the hall separate from the rest of the buildings, as it makes the occasions on which they are used more like what occurs in ordinary life. It helps to make the patients feel on such occasions that they are for the time out of the asylum, and it makes the break in the ordinary routine of their existence more complete and more enjoyable. A billiard room for the men is attached to the assembly rooms.

One important feature of the institution is the absence of any corridors of communication. Every house has its own front door, and stands quite separate from any of its neighbours. This is an important feature for several reasons. It is important, because corridors of communication add greatly to the expense of building. In some asylums the cost has been enormous. Another very important consideration is, that the distribution of the buildings is injuriously affected when it is made subservient to the requirement that the different parts of the asylum are to be connected by corridors. And a weighty reason for avoiding their use is, that it is impossible to introduce them largely into a building without giving it somewhat of a prison character. It is not to be denied, on the other hand, that there are advantages in having them. They enable the patients and the officials to pass from one part of the asylum to another without being exposed to cold and wind and rain. When the patients have to go to a central dining-hall for their meals or to an entertainment, they can be more easily supervised and conducted. And there are other ways in which they are found to be convenient. One consideration that is perhaps of greater weight than any other is, that they afford an opportunity to the architect to construct in their basement a passage for heating and lighting apparatus and water pipes. But, notwithstanding these admitted advantages, the opinion of Dr Paetz is strongly against them. Indeed, he insists on the absence of corridors as one of the chief advantages of the Alt-Scherbitz plan. One important advantage that he claims for it is, that it leads to the rooms occupied by patients being arranged in a way that makes the con-

stant supervision of the patients easier than it can be in an asylum built in the corridor system.*

Dr Paetz attaches great importance also to the extensive adoption of what is known as the open door system, a system which was first adopted in Scotland as a prominent feature of asylum management. It consists in having every door in a large part of the asylum unlocked during the day time, so that a patient can open it with an ordinary handle. The William Augusta Foundation and the houses in the colony are all worked on the open door system. The central establishment is partly locked and partly open. The closed divisions are always locked; the other houses are sometimes locked and at other times open, according to the condition of the inmates and other circumstances. Counting the whole of the central establishment as locked and the rest of the institution as open, there are 33 per cent. of the patients in locked houses and 67 per cent. in open houses.

The staff of attendants is 103 persons, which gives an average of one attendant to nine patients. The total number of sane persons employed in the institution is about 160, a proportion of about one sane person to every six insane.

In every modification of asylum management which has been attended with the removal of restrictions the question of how far it is consistent with the safety of the public and of the patients has always demanded careful consideration, and it is right that the results obtained under the conditions which exist at Alt-Scherbitz should be looked at from this point of view. It is desirable therefore to see how the record of that institution stands as compared with other asylums in regard to the number of escapes, suicides, and other untoward occurrences. With reference to escapes, Dr Paetz makes the following statement.—"For a long time the annual number of escapes has not been more than 1 to 1½ per cent. of the total number of patients;" and he adds that "it was only

* *Colonisirung der Geisteskranken*, p. 72.

rarely that an escape was due to the want of locked doors and high walls, and was almost invariably due to gross carelessness on the part of the attendants, or to errors of judgment by the medical officers." This proportion of escapes which he records does not compare unfavourably with other asylums, as may be seen by a comparison with the asylums of Scotland where the proportion of escapes appears from the Annual Reports of the General Board of Lunacy to be over 2 per cent, per annum. In regard to suicides we find that the number of such cases since the opening of Alt-Scherbitz gives an annual proportion to the number of patients under treatment of 0·72 per thousand, and it is sufficient to know that this is somewhat below the average for the whole of the Prussian asylums, which is given in the Official Statistics for 1877 to 1885 as 0·86 per thousand. It is also satisfactory as well as important to find that no untoward sexual incident has ever occured among the patients at Alt-Scherbitz. These facts are sufficient to show that no special danger attends the adoption of the Village type of asylum.

IV.—The Cost of the Asylum.

A full statement of the cost of the land and the buildings at Alt-Scherbitz is given by Dr Paetz.* The land cost about £50,000, and the buildings, inclusive of the installation of the electric light, about £86,000, which together amount to £136,000. This gives for 960 patients an average of about £90 for building for each patient, and about £52 for land for each patient,—a total of £142. Compared with the cost of recent German asylums built on the corridor system the cost of the buildings is moderate; the buildings at the Berlin Asylum at Dalldorf having cost £198 for each patient, and the West Prussian Asylum at Neustadt having cost £190 for each patient, in each case being more than double the cost of the buildings at Alt-Scherbitz. Recently erected corridor asylums in this country have cost much larger sums.

* *Colonisirung der Geisteskranken* p. 206-7.

In regard to the annual cost of management of Alt-Scherbitz, I found it impossible to ascertain from published documents such data as would enable me to compare it with the cost of management of other German asylums. Dr Paetz has, however, been so kind as to supply me with information on this subject. The following is a translation of part of a letter which I have recently received from him:—

"I have already dealt with the cost of maintenance of third class patients in this asylum in my book, *Die Colonisirung der Geisteskranken*, pages 192-193. The cost of board (Beköstigung) since then has remained substantially without change, and amounts to 230 Marks (£11, 10s.) *per annum*, or about 60 Pfennige (7d.) *per diem* for each patient. The cost of management (allgemeinen Kosten) has somewhat diminished, and amounts on the average to 270 Marks (£13, 10s.), the total cost for maintenance and management being thus about 500 Marks (£25) *per annum* for each patient.*

"In regard to this, it must be kept in view—

"1. That the calculation of the cost of management is a quite arbitrary one, as I have already stated on page 193, and cannot be satisfactorily compared with the figures of other asylums, as the cost of management is almost everywhere calulated on different principles.

"2. That the cost of management for this asylum appears greater than it really is, because it includes several building expenses and outlays on stock properly belonging to the original cost of erecting and providing the institution, which are being gradually paid off out of the revenue for current management.

"3. That the profits from our estate management are not included in our figures, as the estate and the asylum have quite separate sets of accounts. The capital sunk in the purchase of the property bears interest, independently, from 5 to 7 per cent.

* Under "Beköstigung" Dr Paetz includes only food and clothing; under "allgemeinen Kosten" he includes salaries to officials, cost of administration, repairs to buildings, and other miscellaneous expenses.

"These circumstances being taken into consideration, that is to say, if the surplus of income be deducted from the total sum charged to maintenance, there can be no doubt that the cost is much lower than in other German asylums. A calculation made some years since for a large number of asylums, showed that only a few were cheaper, and these were exclusively second-class institutions for chronic patients (Pflegeanstalten), with defective equipment and inferior alimentation, which could not be compared with this asylum, and which, now that their condition has been improved, appear to be conducted at greater expense than this asylum.

"It may thus be confidently stated that this institution, although one of the best of German asylums, is, as I have shown in my book (pages 205-7), one of the cheapest, not only in regard to the cost of building, but also in regard to the cost of maintenance."

THE INCREASING FAVOUR WITH WHICH THE VILLAGE TYPE OF ASYLUM IS REGARDED.

I have described the Alt-Scherbitz Asylum in considerable detail, because it may be taken as the type of a class of asylums that has found favour especially in Germany and America, and because it seems to me to be the type of asylum that conforms most completely to the most modern and the best idea of what an asylum ought to be. It carries further than any other type the idea of making asylum arrangements similar to those of ordinary life, and every development in asylum construction which has stood the test of experience has been made in this direction.

The favour with which the Alt-Scherbitz type of asylum is regarded is steadily increasing in Germany. Several new asylums are being erected of this type, one of the most recent being the asylum at Lichtenberg for the Berlin district. In the United States of America it is also gaining in favour. In a notice of the

Eastern Hospital for the insane at Kankakee in Illinois, the late Dr Hack Tuke,* says:—"This institution has been in operation sufficiently long to test the wisdom of the plan adopted of a central building with a large number of entirely distinct pavilions. We are able to give the opinion of a high authority who has watched the experiment from the beginning to the present time with great interest." The authority to whom Dr Hack Tuke refers is Mr Frederick Wines, who says:—"Kankakee has already accomplished all that the originators expected from it. It shattered at a single blow the superstitious veneration formerly felt for the old fashioned type of hospital construction. The ideas embodied in the Kankakee Asylum have been more or less carried out in three other institutions, namely at Toledo (Ohio), at Richmond (Indiana), and another at Dakota. A new asylum for pauper insane on Long Island (New York) resembles it, although it owes its inspiration not so much to Kankakee as to Alt-Scherbitz." In regard to the Willard Asylum (New York) Dr Hack Tuke, says:—"The guiding principle in the building has been the segregation of patients according to their mental condition, the buildings being so placed that they would admit of economical enlargement of the asylum by the erection of similar blocks. It has been found that this plan has materially reduced the cost of construction, favoured a good classification, and increased the health and happiness of the patients." The buildings for the patients in the Willard Asylum have been erected at a cost of £50 per bed. I shall only quote further a statement by Professor Cabred, who recently made an extended tour in this country and on the Continent, on behalf of the Argentine Government, for the purpose of deciding on the best type of asylum to be adopted for a new asylum at Buenos Ayres. He says,† in regard to the asylum of Alt-Scherbitz, that:—"It is the asylum to be recommended as the model most

* *Journal of Mental Science*, July 1891.

† Letter to *La Prensa* (Buenos Ayres) in the number of that newspaper for 31st August 1896.

worthy to be imitated everywhere, having regard both to the requirements of medical treatment and to the complete realisation of philanthropic aims."

Though there is no asylum in Great Britain or Ireland precisely of the Alt-Scherbitz type, there are among the asylums for private patients some which make a near approach to it. But there are so many important differences between the arrangements for pauper patients and those for patients at the higher rates of board, that the experience gained at these establishments is not regarded as altogether safe guidance when the erection of a pauper asylum is in question. The erection of villas of the Alt-Scherbitz type, as adjuncts to corridor asylums of the District Asylum or County Asylum class, is, however, not uncommon, and some of these are excellent examples of the kind of houses that would be suitable for an asylum of the Alt-Scherbitz type in this country. Two villas recently erected at the Perth District Asylum at Murthly might be accepted as examples of what the houses should be in the section of the institution corresponding to that which is called "The Colony" at Alt-Scherbitz.

In the foregoing pages I have endeavoured to indicate the principal questions which arise for consideration when deciding on the kind of plan that should be adopted in any new asylum for pauper patients. I have indicated a preference for the Village type; but I have tried at the same time to furnish information that will help the reader to judge for himself of the comparative merits of different kinds of plan, and if I have succeeded in this attempt my chief purpose will have been attained.