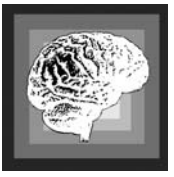
History of Psychiatry, 15(2): 155–175 Copyright © 2004 SAGE Publications (London, Thousand Oaks, CA and New Delhi) www.sagepublications.com [200406] DOI: 10.1177/0957154X04039348



The beer ration in Victorian asylums

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Routine distribution of alcoholic beverages to mental hospital patients would be a fanciful prospect today, yet in the formative decades of lunatic asylums, beer was standard issue. A staple item in the supposedly healthy Victorian asylum diet, beer also served as inducement for patient labour. Around the mid-1880s, this commodity was abolished throughout Britain's mental institutions. This paper explores the factors that combined to condemn the beer barrel to asylum history, and, in particular, how this small comfort for inmates fell foul of the medicalization of the asylum and of the professional project of psychiatry.

Keywords: *alcohol; asylums; Britain; diet; history; psychiatry; temperance; 19th century*

The fuel of the masses

'Good health', that common rendition on raising a glass among friends, is rooted in a traditional notion of beer as a wholesome boost to the constitution. From medieval times beer was the normal beverage with meals; certainly it was consumed in great quantities by the common people, occupying a central role in diet and social life (Burnet, 1999). The mild antiseptic properties of the malted brew were prized in times when water impurities carried risk of disease. Beer provided an energy source at work, giving pleasant relief to arduous toils, and agricultural labourers commonly drank as much as two gallons during a day in the fields (Holter, 2001). Its value was epitomized by the plump figure of John Bull, tankard in hand: a model of manliness (Harrison, 1971: 290–308). Strength was associated with a rotund

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physique. Women drank plentifully, and children were introduced to the habit early.

Thirst for beer increased in the environment created by the industrial revolution. Sprawling conurbations around the expanding heavy industries created a vast market for the brewing trade, and public houses multiplied to satisfy demand. Beer was entrenched in working-class culture. Occupational identity was forged from the camaraderie of hard work and heavy drinking; men drank at all times of day 'to put back sweat' (Thompson, 1980: 347–84). Employers often arranged for labourers' wages to be paid at a local pub, while the truck system remained prevalent in the nineteenth century; asylum staff, for example, were part-paid in beer. Teetotallers were ostracized.

The proletariat serviced a rampant capitalist economy (Victorian Britain was unassailably the richest nation on earth), but their contribution to this wealth brought scant reward. Living conditions were often desperately poor. Impoverished districts had the highest density of pubs, where warmth and conviviality offered an appealing alternative to cold, cramped homes, the ameliorating effect of alcohol blocking out life's miseries (Best, 1979: 169–249). Before the wider availability of alternative expenditure options such as leisure trips, house purchase and consumer durables, beer made a relatively unrivalled claim on family income. Consumption peaked in 1876, at an annual 34.4 gallons per head – around four times today's level.

Productivity and segregation

The rapid transformation of Britain from a pastoral to an urban way of life shattered a long-established social equilibrium. Time-honoured norms and boundaries disintegrated in the anonymous manufacturing towns. The ensuing moral vacuum facilitated an Evangelical revival, which was taken up by the Establishment in its efforts to instil discipline in society. A driving force in Victorian culture was the Protestant work ethic, which asserted a link between work and godliness. Responsibility was placed in the individual rather than society, with personal salvation the goal. Industriousness became the ideal, bringing material gain by the grace of God. Idleness was taboo, and poverty a sin (Oates, 1972). Notwithstanding the growing tide of destitute paupers, public assistance was viewed by *laissez-faire* politicians as too much temptation for the undeserving. After all, work was available: people just had to find it. Yet clearly there were unemployable elements at the margins of society.

Close-knit communities had always looked after their own kind, but economic realities and the breakdown of social ties in the capitalist system left families incapable of supporting vulnerable dependents. Eventually a combination of altruism and a utilitarian quest to supervise the chaotic elements of society raised administrative intervention: bringing help for the helpless, and a use for the useless. Policy-makers projected their anxiety into a rush of institution building, developing a system of segregation for those

failing to earn their existence: cripples, imbeciles, lunatics, and those of idle or immoral tendencies. Deterrence was manifest in the Poor Law Amendment of 1834, which ensured humiliation for welfare recipients, the deliberately austere workhouse acting as depository for all kinds of deviants (Best, 1979: 93–168).

Among the economically impotent, the insane were a target of special concern in the early nineteenth century (Hammond and Hammond, 1939: 174–200). Scandals regarding their treatment led to legislation consolidated by the 1845 Lunacy Act, which made provision of county asylums mandatory. Humanitarian reformers drew inspiration from the York Retreat, where the Quakers offered the mentally stricken a fertile environment for recovery, through the management style of 'moral treatment' (Jones, 1993: 23–40). Patients benefited from a fulfilling lifestyle of fresh air and occupation, in a safe haven where their dignity was retained. The efficacy of this regime was demonstrated by the rapid return to lucidity of even the most furiously mad. Soon progressive county asylums abolished mechanical restraint. Pauper lunatics were entrusted with various types of work according to their erstwhile trades, and were fed and clothed well, compared with the hardships most had left behind at the asylum gates.

Inmate labour served a dual function. Keeping sick minds occupied was a therapeutic goal, but as chronic cases accumulated in asylums, the emphasis shifted to optimizing patients' contribution to the running of the establishment. Exploitation was inevitable as patients were simply moulded into better servants of the institution.

Frugality was paramount in the ethos of pauper institutions. A disincentive for authorities in developing facilities for lunatics was the enormous cost, asylums being roughly four times as expensive per head as the workhouse. In 1844 only 4000 of the registered 16,000 lunatics were in specialized accommodation; 9000 remained in workhouses (Hammond and Hammond, 1939: 174–200), either mixed with the sane or in special lunatic wards. Even by the beginning of the twentieth century, a quarter of lunatic accommodation was provided by workhouses, where inmates were less remote, and free from certification. Workhouse lunatics were often chronic, harmless cases, who could largely be put to gainful employment. Asylums, meanwhile, became receptacles for the least desirable types of people: the floridly mad who were disruptive to workhouse management, and the senile. Large numbers were incapable of work; for example, only half of Leicester Asylum's patients were employed in 1860 (Bartlett, 1999: 421–32).

Beer provision in asylums

Patient labour served a crucial role in the asylum economy. Accordingly, once their acute mental disturbance had subsided, all able-bodied lunatics were employed on the asylum farm, in the various workshops, or on ward

TABLE 1. *Rations at selected county and borough asylums, 1880*

Asylum (and date of report)	Ordinary diet (pints)	Extra for workers (pints)
Berkshire (1881)	1/2 at dinner	1/2 at 10 a.m. and 4 p.m
Bristol (1881)	1/2 at dinner	1/2 at 11 a.m. and 4 p.m. for men; 1/2 for women at 11 a.m.
Dorset (1881)	1/2 at dinner	1/2 at 11 a.m. and 4 p.m. for men; 1/2 for women at 11 a.m.
Essex (1881)	1/2 at dinner	1/2 at 11 a.m. and 4 p.m.
Hereford (1881)	3/4 for men; 1/2 for women at dinner	1/2 at 11 a.m. and 4 p.m.
Lancashire (Prestwich, 1880)	1/2 at dinner	additional 1/2 at dinner
Newcastle (1880)	1/2 at dinner and supper	1/2 at lunch
Nottingham (1880)	1/2 at dinner	1/2 at 11 a.m. and 4 p.m
Wiltshire (1881)	1/2 for men; 1/3 for women at dinner	1/2 at lunch
Worcester (1880)	1/2 at dinner	1/2 at 11 a.m. and 4 p.m

chores. Self-sufficiency was an objective requiring appreciable goodwill between officers, staff and patients. In keeping with inmates' social class background, beer was used as a convenient reward for labour.

It was uniform issue at mealtimes, as well as during work breaks. Little water was drunk at asylums, beer and tea providing patients' fluid intake. Until 1853, male inmates at Stafford Asylum (1854) drank fourteen pints per week as ordinary diet alone. A survey of asylums in 1864, which excluded extra quantities earned by workers, revealed an average weekly dietary provision of five pints, ranging from nil at Durham Asylum to ten and a half pints at Stafford (Anonymous, 1864).

By the 1870s variation in rations between asylums had levelled off. The conventional supply was a half pint at the midday meal, with workers receiving an additional mid-morning ration alongside bread and cheese (this repast was called lunch). A further half pint in the afternoon break was given at certain asylums. Additional beer (or cider in West Country asylums) lubricated the workforce during harvesting. Male workers tended to receive more than their female counterparts: at Sussex Asylum (1870) men received an extra half pint in the afternoon, but the laundry women got tea instead; Buckinghamshire Asylum (1866) allowed males a half pint in both work intervals, but women had just a quarter pint in the morning and tea in the afternoon. Table 1 shows the rations at some asylums in 1880.

Most original county asylums produced their own beer; indeed, a brewhouse was as fundamental in architects' plans as a bakehouse. The brewer, aided by

a couple of patients, received wages equivalent to those of the head attendant (e.g., Salop & Montgomery Asylum, 1882). Vast quantities were produced: 58,044 gallons were brewed at Prestwich Asylum in 1878 (see 1879 *Report*).

Beer is produced by the fermentation of an infusion of barley malt and hops, aided by yeast. Fortified brews such as stout were up to nine per cent in alcoholic strength, but the general issue for lunatics was quite innocuous, akin to table beer at one or two per cent. Scant details exist on the quality of the staple beverage. Fortunately, a standard item in reports from the Lunacy Commissioners' statutory annual inspections was the standard of meals served during their presence. They occasionally entered observations on the asylum brew: 'We were present at dinner in the wards, tasted the soup, beer, and bread, and found them to be of good quality' (Hereford Asylum, 1874); 'The beer was sound but rather light: however, no patient complained of it' (Warwick Asylum, 1877); 'We have tasted the beer about which there has been much complaint and some improvement in the quality is desirable' (Devon Asylum, 1878). Medical superintendent Marriott Cooke (1895) described the benign properties of Worcester's offering: 'The proportion of alcohol contained in our beer, a very wholesome beverage brewed on the asylum premises, is small – something like two-thirds of an ounce to the pint'.

Authors of the 1864 survey (Anonymous, 1864) voiced scepticism about the beer at Devizes: 'As Wilts, in other respects, is not remarkable for over-feeding its inmates, it is a matter of curiosity to us to know the strength of the malt supplied'. Dr Skae described the Ayr Asylum brew as 'feeble' (Tuke, 1885).

Asylum employees also received daily rations of beer. Lunatic asylums did not offer attractive conditions of employment, and there were chronic problems in recruiting and retaining staff. Like the patients, most were of the working class. Beer was included in the remuneration, and must have been one of the few pleasures of the occupation. Dr Lockhart Robertson (1860) at Sussex noted: 'the home-brewed beer of the attendants is the best I've ever tasted in an asylum'. At the Somerset Asylum (1867) male attendants and servants received ten and a half pints of porter per week; females received seven pints. Buckinghamshire Asylum (1866) allowed two pints of ale each day to male attendants; female attendants had one pint daily. Asylums taken over by the London County Council in 1889 had been providing a generous ration of fourteen pints a week to male attendants, and ten and a half pints for women (Bell, 1939). Until its removal by Dr Hood in 1851, a hydraulic beer machine existed at the Bethlem Hospital in London (Russell, 1997), which was constantly accessible to attendants, and which apparently contributed to 'making the fat and formidable keepers look more satisfied than cheerful.'

The temperance movement

As dust settled from the industrial revolution, drinking habits emerged as an issue of serious social concern. Across the grim landscape of manufacturing

areas, immense amounts were spent by the common people on the temporary comfort of intoxicating liquor, money which might have gone towards their betterment. Alcoholic excess exacerbated poverty, reducing many families to destitution, while drunkenness brought violence and crime. Unruliness in the masses threatened the nation's progress, necessitating costly interventions such as the creation of police forces.

It was in this century of record alcohol consumption that the temperance movement was born. Originally the focus of concern was distilled spirits, the drinking of which had risen sharply in the 1820s following excise relaxation (Curgenven, 1883). The 1830 Beer Act, which encouraged the widespread availability of beer and cider, was actually viewed as a temperance measure (Burnett, 1999), as it diverted people from stronger liquor. Taxation on beer was repealed, partly as a response to pressure from employers, who sought cheaper goods for workers in order to maintain low wages – just as they had brought down the Corn Laws (Monckton, 1966). Beer consumption subsequently escalated.

Amid mounting evidence of the harm caused by 'demon drink', temperance groups grew in strength. The British & Foreign Temperance Society, founded in 1831, received patronage from Queen Victoria on her accession to the throne in 1837 (Weeks, 1925*a*). The National Temperance Society had 52,241 members by 1849 (Harrison, 1971: 316). The cause was taken up wholeheartedly by the clergy (Weeks, 1925*a*), the Church of England playing a major role (Dalby, 1883). Religious tracts, a propaganda vehicle widely distributed among the masses for putting down vice, reinforced the temperance message. Despite its hold on the middle class, however, Christianity had less influence in the lower orders (Best, 1979: 169–249), where it was perceived as patronizing dogma offering no practical assistance against the daily struggle. So engrained was beer in working-class culture that converting people to teetotalism, or even moderate drinking, was a mammoth task.

The temperance movement channelled its energy into forcing legislative change, to limit the availability of alcohol. Tighter control was in accord with the Establishment's desire to instil order in the masses, and by the mid-nineteenth century Sunday Observance and other restrictions on public house opening times were imposed (Best, 1979: 169–249). Yet the government pursued regulation tentatively. Overzealous taxation would ultimately threaten revenue, while restrictive legislation might incur the wrath of the electorate. In 1872 Gladstone's government passed a fairly moderate licensing act, yet this was fruitful campaigning material for the Tories, who accused the Liberals of depriving working men of their hard-earned beer (Harrison, 1971: 290–308). Despite temperance pressure, tax on beer did not reappear until 1880 (Monckton, 1966).

The temperance movement succeeded in persuading Victorian society that alcohol endangered civilized life. Underlying the mission was a subtle

recruitment to bourgeois values. Within the working class a growing element strove for respectability (Best, 1979: 169–249), disassociating themselves from those immersed in drunken squalor. Honest working people, having experienced at close hand the ruinous effects of liquor, steered clear of the disreputable pub. Although ultimately the campaign was undermined by fanaticism, cultural attitudes towards drinking changed markedly, and as a legacy of temperance success there are few countries today where alcoholic drinks are dearer than in Britain.

Medical views on alcohol

A major obstacle for temperance reformers was the medical profession. The Victorian pharmacopoeia was sparse, and alcohol was a popular remedy for a plethora of conditions. General hospitals liberally dispensed fortifying beverages for the aged and feeble, spending more on alcohol than on bread (Cope, 1954), while in asylums brandy and stout served as stimulants for melancholics (Parker, Dutta, Barnes and Fleet, 1993). The confidence placed in alcohol by the respected profession of medicine frustrated the temperance movement, as it seriously undermined their message that the substance was inherently destructive.

Medical practitioners were not unanimously in favour of this widespread use of liquor. Temperance campaigners realized the importance of support from the medical profession, and publicized any favourable movements in this direction. A small but vociferous anti-alcohol lobby gained momentum within the profession (Weeks, 1925*a*), advancing its case in a series of declarations. A first 'medical manifesto' signed by 79 members of the profession in 1839, began:

> An opinion handed down from rude and ignorant times, and imbibed by Englishmen from their youth, has become very general, that the habitual use of some portion of alcoholic drink is beneficial to health, and even necessary to those who are subjected to manual labour. Anatomy, physiology, and the experience of all ages and countries, when properly examined, must satisfy every mind well informed in medical science, that the above opinion is altogether erroneous. (quoted in Williams, 1889: 5)

In 1847 a second petition asserted that alcohol was the root of 'human misery' (quoted in Williams, 1889: 7), advocating total abstinence. Doctors were well aware of the effects of excessive drinking from their clinical experience, and many were sympathetic to the temperance cause. The National Temperance League began publishing the *Medical Temperance Journal* in 1869, when their first annual breakfast meeting with the British Medical Association was held (Weeks, 1925*a*). In 1871 a third declaration was issued by 269 physicians and surgeons, which described the drinking of intoxicating beverages by the working class as 'one of the greatest evils of the day', and a

threat to 'the great industrial prosperity which Providence has placed within the reach of this nation' (*Medical declaration* …, 1872). It urged greater caution by doctors in the prescribing of liquor:

> As it is believed that the inconsiderate prescription of large quantities of alcoholic liquids by medical men for their patients has given rise, in many instances, to the formation of intemperate habits, the undersigned, while unable to abandon the use of alcohol in the treatment of certain cases of disease, are yet of the opinion that no medical practitioner should prescribe it without a sense of grave responsibility.

Meanwhile, scientific evidence amassed against the therapeutic efficacy of alcohol. Frenchmen Lallemand and Perrin published research in 1860 refuting the belief that alcohol raised body temperature; in fact, it did the reverse (Harrison, 1971: 290–308). Alcohol was described by Willshire in the *Lancet* in 1862 as a nervine toxic agent (Weeks, 1925*a*). A leading medical opponent in the 1870s and 1880s was Benjamin Ward Richardson, who later became president of the British Medical Temperance Society (Curgenven, 1883). His studies (Cope, 1954) demonstrated that, while a state of alertness tends rapidly to follow ingestion of alcohol, the lasting action is soporific. Further scientific inquiry (Power, 1909) revealed that 'sham stimulation' occurs because alcohol is really a narcotic, its ingestion causing neural paralysis, depriving the tone of the nervous system and thus quickening the action of the heart. Alcoholic beverages were also charged with retarding growth, lowering resistance and prolonging illness (Dalby, 1883). Medical temperance supporters presented a basic dichotomy: alcohol must either be beneficial or poisonous. Clearly demonstrating it as the latter, they urged its deletion from the formulary.

However, the profession resisted this radical position and avoided any curtailing of clinical freedom. Teetotallers like Richardson did not speak for the majority; indeed, temperance doctors were persecuted in their profession (Harrison, 1971: 290–308). The virtues of alcohol continued to be extolled by many physicians, such intransigence incurring the wrath of the anti-alcohol camp.

> If the medical profession cannot afford to give that support to the Temperance cause which it so greatly merits from them and every Christian man, we may expect at least that they should be silent, and not oppose the movement and thus seem to place their own prosperity before the public good. (Dalby, 1883: 6)

A dearth of alternatives meant that doctors continued to default to the palliative properties of alcohol. Richardson himself continued to advocate alcohol as an antispasmodic, antiseptic, febrifuge and styptic, and for cases of shock, neuralgia, hysteria, nervous indigestion, painful menstruation and high blood pressure (Cope, 1954). As late as 1907 a pro-alcohol manifesto by 16 doctors in *The Lancet* asserted its efficacy as a 'good anti-nitrogenous

wasting agent' (Power, 1909). Retaining their place in the medicinal arsenal well into the twentieth century, ales and port continued to be termed 'stimulants' in hospital accounts (Cope, 1954). The profession procrastinated until the First World War before making an official pronouncement against the medicinal use of alcohol. By then, most doctors acknowledged its limited pharmacological value, and those who continued to prescribe it did so in diminishing quantities (Wilson, 1940).

In the context of revised attitudes towards drink both within medicine and society as a whole, the efficacy of routinely supplying beer to asylum patients became increasingly questionable. From the late 1870s, medical superintendents such as the outspoken Hearder at Carmarthen (Anonymous, 1881*a*) took the first steps in what became known as 'the beer movement'. The abolition of alcohol as a beverage for inmates, while undoubtedly influenced by external temperance pressures, arose through particular dynamics within the world of the asylum. As will be seen, withdrawal of beer rations was grounded in a mixture of medical, moral and economic themes.

Medicalization of lunacy

Practising a dubious branch of medicine, the work of alienists was not highly esteemed. Moral treatment lay too close to common sense, precluding the development of a body of wisdom in treating lunacy. Isolation and constant exposure to lunacy brought doctors a share of the inmates' stigma and alienation (Scull, 1979). Medical superintendents occupied the highest rank in the asylum hierarchy, with attractive remuneration, but their movements were greatly restricted by their lay employers. Asylum committees issued directives on all aspects of running the institution, with power to dismiss uncooperative medical personnel instantly. Meanwhile the rising tide of lunacy saturated asylums, stifling any curative pursuits. Clinical efforts were largely unfruitful: the cure rate had dropped to 8% by 1875 (Scull, 1980). The profession could hardly improve its standing with such abject failure; somehow goals had to change.

The infant field of psychiatry became the subject of a professional project which would transform the administration of mental disorder. In 1841 the Association of Medical Officers of Asylums & Hospitals for the Insane was created. This professional organization introduced *The Asylum Journal* (later *Journal of Mental Science*) in 1853, a medium promoting a more scientific ethos among asylum doctors (Jones, 1993: 93–111). The focus changed from social factors to individual pathology; from moral management to locating and treating lesions in the brain. Insanity was transformed from a vague cultural notion to a definitive medical diagnosis (Scull, 1979). In their quest for supremacy, the profession redefined every aspect of madness in a medical paradigm, placing it beyond the competence of lay administrators. Empowered by an accumulating expertise, doctors began to wrest control from the hands

of their employing committees. The nature of this power shift is revealed in the approach towards beer rations.

Intemperance and insanity

A prominent issue in asylum circles was the extent to which madness was actually caused by alcohol abuse. Lord Shaftesbury, Chairman of the Lunacy Commissioners, reckoned this applied to at least half the nation's pool of registered lunatics (Gardner, 1999: 177–93). Dr Hearder saw excessive drinking as 'the most potent cause of insanity' (Anonymous, 1881*a*). The battery of statistics uniformly presented in Victorian asylum reports featured summaries of the ascribed cause of mental breakdown. Identified causes were categorized as moral (such as domestic trouble, anxiety or worry, fright, religious excitement, love affairs), and physical (including intemperance, alongside hereditary influence, childbirth, venereal disease, masturbation, sunstroke, old age). The alleged causative relationship was not obviously reflected by the actual figures for intemperance recorded by asylum doctors. As a typical example, Newcastle Asylum admitted 625 patients from 1879 to 1885, of which only 67 cases were attributed to alcohol abuse (Newcastle Asylum, 1880–1886).

Contradictory evidence was offered on this issue, but the prevailing opinion of asylum doctors was that intemperance was a contributory factor rather than a direct cause. Medical superintendent Harrington Douty of Berkshire Asylum (1892) voiced disquiet over the tendency of an ignorant public to apportion a sweeping blame on patients for overindulgence in drink, calculating that 'as a rule 90 per cent of our cases have no connection whatever with alcohol'. In practice, assigning a true value to alcohol in the aetiology of madness was difficult. Topers were not always identified as such on admission, making annual tables an underestimate. Nonetheless, over the country as a whole the aggregate was significant enough, and rising. In 1880 there were 3319 lunatics received into public asylums via intemperate habits: 20% of the total admissions (Curgenven, 1883).

Although intemperance by itself was not sufficient for certification under lunacy law, it was claimed as a unique disease entity, and framed in medical terminology such as 'dipsomania' and 'alcoholism' (Barrows and Room, 1991). However, no specialist treatments developed, and inebriates continued to be housed in the conventional county asylum. Their presence jeopardized the viability of beer rations. Asylum doctors were wary of being overly associated with teetotalism, but clearly it was injudicious to make alcohol so accessible to those with deficient self-control. A regimen of total abstinence was vital in the treatment of inebriates to break their ruinous habit. Otherwise, on regaining liberty their continual urge would hasten their return to the asylum. Withholding beer from patients on the grounds of drinking history, however, entailed an arbitrary distinction between the intemperate

and those of more sober appetite, those in the former category being assigned the status of a 'marked man' (Tuke, 1885).

There were other categories of patient contraindicated for beer rations. Epileptics, with their propensity to fits and violence, were particularly awkward to manage before the advent of anticonvulsant drugs; exciting beverages were thus withheld. Beer was often omitted for criminals, whose troublesome presence in county asylums irritated medical superintendents. At Bristol Asylum (1885), superintendent George Thomson excluded beer from '160 idiots, imbeciles and paralytics'. Dr Strange of Salop Asylum, an advocate of beer rations, affirmed 'I see no reason for giving beer to a lot of idle imbeciles and dements' (Tuke, 1885).

A widening net of exclusions from beer rations broke uniformity in the dietary provision. An important aspect of asylum administration could no longer be decided by lay committee alone. Alcohol was a hazardous substance, and whether used as medication or ingredient of the relatively innocuous asylum beer, its dispensation fell into medical territory. For doctors, experience had shown how alcoholic beverages worsened the behaviour of certain types of patient, but in practice selectively barring beer was problematic, and eventually must have made a blanket ban appealing. Although rations were well within the recommended safe daily intake of alcohol, it was increasingly apparent that asylums were setting a poor example in routinely providing intoxicating beverages to patients. Many inmates, particularly women, who were previously unaccustomed to regular doses of alcohol, acquired such a taste in the asylum that their return to the community was accompanied by a craving (Anonymous, 1883*a*). The doctor's role was incompatible with generating this dependency.

Order and discipline

Overcrowding made the original tenets of moral treatment unfeasible, as asylums deteriorated into vast human warehouses. Housing in excess of a thousand lunatics, with an inadequate legion of attendants, these lumbering institutions required steering by a competent helmsman. Occupying a moral pedestal in the asylum community, medical superintendents exercised a guiding role, imposing standards of behaviour compatible with their own superior background. Those of weaker moral disposition had to be protected from indulgence by maintaining puritan control. The beer allowance was a discretionary privilege which, properly administered, encouraged desirable behaviour in both staff and patients. However, its availability had the potential to detract from, as well as enhance, discipline.

Beer was prone to misappropriation. Dr Lindsay at Derby found it was frequently 'given away to or taken by other patients of gluttonous and intemperate habits', and among Somerset inmates, rations were bartered to those with a craving (Anonymous, 1883*a*). Some patients, probably those

accustomed to high levels of drinking prior to admission, inevitably exceeded their allotted quantity. A steward observed an unremitting thirst among the men: 'It is extraordinary what dodges and schemes there are to get at the beer barrel' (Anonymous, 1883*a*). Officers at Monmouth faced perpetual pleas for extra beer (Anonymous, 1883*a*), while patients at Bristol Asylum (1884) and Essex (Nightingale, 1990: 19–23) threatened industrial action, refusing to work until they were given more beer. Such insurrection had to be quashed. Dr Wade at Somerset was scornful of a system which encouraged patients to believe they actually required beer to perform their work (Anonymous, 1883*a*). Once patients were accustomed to a certain amount, they took it for granted. Dr Wade also noted that attendants supervising labour tended to bribe able patients with extra beer, at the expense of the less productive, causing much squabbling. Evidently, beer had become counter-productive.

Sometimes, opportunities existed for procuring beer externally. At the Buckinghamshire Asylum the medical superintendent had no objection to patients working in the front garden enjoying a half pint in the pub opposite (Crammer, 1990: 41–53). Walking parties ventured out on country lanes, and occasionally, albeit unofficially, pit stops were made at nearby hostelries. Inevitably liberties were abused. On one occasion at the Essex Asylum nine patients and their escorting attendant returned intoxicated (Nightingale, 1990: 9–14).

Attendants were expected to be sound role models throughout their long working hours. In superintendent George Thomson's view, beer noticeably worsened the conduct of attendants at Bristol Asylum (1885). Asylum reports of the period show drunkenness as the most common disciplinary problem, with male staff particularly susceptible to the temptations of the beer barrel. Undoubtedly many supplemented their allowance with that intended for patients. Swift dismissal was the usual fate for wayward employees. Despite these problems, staff rations continued, as distributing beer to patients but not to their supervising staff was clearly untenable.

Beer as nutriment

For inmates of institutions, as in working class life generally, beer was an important source of calories. However, its dietary role became increasingly dubious under a weight of scientific evidence contradicting the notion that beer supplied fuel and warmth. Metabolized as carbohydrate, alcoholic beverages merely provide a transient energy boost; increased activity causing a temporarily rise in body temperature. Certainly, asylum beer would have provided some beneficial effects as a foodstuff, but the true calorific value of beer was found to be disappointing. On analysis, a pint of beer contains 337 calories, but only around 120 are nutrient, whereas with milk all 397 calories are of value. Despite some healthful ingredients, the finished product of beer

is nutritionally weak, comprising 90% water, 4% alcohol, 4% sugar, plus traces of vitamins (Mearns, 1963). Medical superintendents soon found more than adequate substitutes in alternative beverages such as skimmed milk, tea or lemonade. Meanwhile, asylum water quality was improving, as extension of the municipal system allowed contaminated wells to be abandoned. By 1881 editorial comment in the asylum doctors' professional journal assured that beer was 'quite unnecessary in county asylums' (Anonymous, 1881*a*).

Expense

Relationships between medical superintendents and lay administrators were often uneasy. Dismal cure rates meant that medical superintendents went cap in hand for further resources with little promise of visible return on such investment. In appeasing rate-payers, magistrates were reluctant to throw good money after bad at the accumulating mass of incurable lunatics (Scull, 1979). Doctors presented hypothetical arguments that improved treatment facilities would eventually reduce the burden incurred by insanity, but concrete savings were always preferred by frugal visiting committees. Swollen asylums were immersed in regimes of cheeseparing custodial care, their efficiency earnestly measured by comparing costs per head with fellow institutions.

The unabated flood of patients submerged medical superintendents in administrative matters, as their focus was diverted from medical care to bureaucratic matters. Budgetary control was tight, new items of expenditure often paid for by savings elsewhere. The dubious efficacy of beer made it an extravagance in the context of an institution's hard-pressed finances. Brewing on asylum premises was cheaper than bringing in beer from outside, but still entailed purchase of malt and hops, and not insignificant production costs. Asylum accounts show the extent of potential savings to be made by abandoning beer rations. In the 1880s at Stafford Asylum (1885–1889), for example, around £1000 was spent annually on malt, hops, ale and beer – almost a third of the total cost of wages and salaries.

While appreciating the potential financial benefits in withdrawing beer, doctors glossed over such rationale (Anonymous, 1883*a*), manoeuvring to present the case as a medico-moral issue. For doctors, patients' health and the good order of the institution were the principal concerns in removing this pleasurable commodity, while asylum committees were tacitly portrayed as giving priority to saving money (Tuke, 1885). Indeed, the purse strings were held tighter still with the new local government structures introduced in 1889. Subsequently, committees were dominated by businessmen. One of the first decisions of the new Buckinghamshire County Council was to reduce the asylum maintenance charge; withdrawal of beer allowed a reduction in total dietary expenditure from £5185 in 1889 to £3451 in 1892

(Crammer, 1990: 103–15). Optimal savings were reaped where substitute beverages were deemed unnecessary.

The process of withdrawal

When the Cumberland & Westmoreland Asylum opened in 1862 (Campbell, 1881), patients received no beer in their diet. Superintendent Dr Clouston was initially unsure about this experiment: 'I confess I thought it a mistake that no beer was given to the patients as a part of their ordinary dietary; but I was perfectly willing to give the system I found in operation a fair trial' (Anonymous, 1870). It appears that, in England and Wales at least, no other establishment followed suit until well into the next decade. Apprehension about the potential consequences of ceasing regular beer supply caused trepidation among medical superintendents. While temperance supporters referred to prisons as evidence that alcohol could be abruptly withdrawn (Power, 1909), asylum doctors might have expected adverse reactions in patients, behavioural or physiological.

The beer movement gathered pace in English and Welsh asylums in the early 1880s, after a handful of pioneers survived the change without undue hardship. Dr Hearder ventured forth to remove beer from the ordinary diet at Carmarthen in 1879 (Anonymous, 1881*a*), and in the same year at Norfolk Asylum Dr Hills restricted allowances to just 30 patients 'who do hard labour, and who seem the better for some stimulant and encouragement' (Anonymous, 1881*b*). Uniform rations in the dining hall were usually withdrawn first, whereas the reward system for workers was maintained – productivity remained a priority. At Essex Asylum, for example, working patients' allowances continued for ten years after the omission of beer from the general diet in 1882 (Nightingale, 1990: 19–23). An incremental replacement of beer by 'skim milk' was executed at Macclesfield (Anonymous, 1883*b*), as at Hereford Asylum (1883), where superintendent Algernon Chapman achieved complete replacement within two years: the only alcohol remaining in circulation being dilute cider for male workers 'from hay to corn harvest'. At Wakefield the female side was deprived of beer first (Anonymous, 1883*a*).

Successes elsewhere gave the authorities greater confidence, and a clean sweep was made of beer in several institutions. In 1883 the visiting justices of Devon Asylum (Eager, 1945) imposed immediate withdrawal, with any future use of alcohol confined to doctor's orders. George Thomson did likewise at Bristol Asylum (1884) on the grounds of its 'deleterious effect, moral and physical'. The situation had become a *fait accompli* by the mid-1880s, illustrated by absence of any discussion in annual reports; for example Newcastle Asylum provides no explanation for the disappearance of beer from the dietary table. Meanwhile new institutions opening around this time, such as Birmingham Borough (Anonymous, 1883*a*) were dry from the outset. In 1884 the editor of the *Journal of Mental Science*, Daniel Hack

Tuke, conducted a survey of all 129 public mental institutions in Great Britain and Ireland (Tuke, 1885). Fifty of the 100 respondents had eliminated alcohol except for medicinal purposes. Disproportionately, half of the dry asylums were in Scotland and Ireland, where perhaps prohibitive measures were more culturally acceptable.

Substitute beverages included arrowroot, beef-tea, gingerade, cocoa and oatmeal water. Generally, institutions spent more on milk as the alcohol budget fell. All savings went to improving the diet and rewards for workers at Worcester Asylum (1895), where Dr Marriott Cooke (1895) reported industrious labour from patients partaking of 'stokos', a home-produced drink consisting of lemon, oatmeal and sugar. At other asylums such as Somerset (Anonymous, 1883*a*) the belief was that patients' nutritional intake would be unaffected by the omission of beer, indicating no need for substitutes.

Consideration then turned to the staff. Around 10% of attendants' pay was given in the form of liquor. Some employees, particularly females (Bristol Asylum, 1884), declined their beer allowance, and there had been many requests over time to receive money in lieu. However, it was considered a mistake to allow this while beer remained in circulation (Tuke, 1885). Following termination of patients' rations, staff were usually offered a choice of retaining their beer allowance or accepting equivalent amounts in cash. The latter was overwhelmingly preferred; for example, at Somerset the outcome was unanimous. Some asylums offered a uniform. At Glamorgan Asylum the head attendants were instructed to enquire into the preferences of their complement of 65 staff: only two wished to retain beer (Tuke, 1885).

In defence of beer

Patients, as certified lunatics, were unlikely to be consulted on the issue of discontinuing beer. Countering arguments, to be taken seriously, required voices of sufficient status and authority. A handful of superintendents offered resistance to the beer movement. Rooke Ley argued:

> Patients do not find an asylum a pleasant place to live in, and it will not add to their contentment to cut off their beer and tobacco. I should like to hear from some superintendent who indulges in beer what harm he thinks the asylum beer will do his patients. (Tuke, 1885)

Dr Spence at Stafford agreed: 'happily I am supported by my Committee in adhering to the good old plan of giving the patients one of their very few pleasures, a glass of beer' (Tuke, 1885). Dr Strange at Salop & Montgomery Asylum (1883) challenged the demonizing of this weak beverage: 'It is simply in my opinion absurd to suppose that it can work an evil'. Tuke himself, although convinced of beer's 'inutility', sympathized with the idea that it was 'hard lines to cut off a poor man's beer who has been accustomed to it all his life' (Tuke, 1885: 550).

The dietary scale of asylums had followed guidelines set by the Lunacy Commissioners. Exercising their role of patient guardians, the Commissioners expressed dissatisfaction on their visits to asylums that had discarded beer. When the new London County Council determined that beer would no longer be supplied at its adopted asylums, the Commissioners wrote:

> Having regard to the fact that the vast majority will never leave the Asylum, and that all these were brought here against their own will, and that but a certain proportion of those brought here ... have been insane through excess of drink, it does seem hard that the many should suffer for the sake of the few' (Middlesex Lunatic Asylum ..., 1893).

At Buckinghamshire Asylum (1893), the absence of beer made the Commissioners 'sorry to find the diet worse'.

In agricultural society, untouched by temperance campaigns, the tradition of 'harvest beer' lingered (Harrison, 1971: 290–308). Some rural county asylums such as Wiltshire (1901), Berkshire (1896) and Sussex (Gardner, 1999: 209–33) displayed reticence in abandoning beer for their legions of farmhands, who understandably expected similar rewards to those toiling on neighbouring fields. Into the 1890s Marriott Cooke defended the continuation of beer at Worcester Asylum (1892): 'The half pint which the working patients have with their dinner is much enjoyed by them, and does them good'. At Hereford Mental Hospitals (1942), cider returned to the dietary scale, where it remained until the Second World War.

Aftermath

The immediate outcome of beer abolition was remarkably uneventful. No ill effects were experienced when rations ended at Worcester, according to Marriott Cooke (1895): 'the very little notice that has been taken of the change has greatly surprised me'. Dr Lindsay at Derby noted that 'in carrying out the entire disuse of beer, I was prepared to encounter some difficulties, but in reality I have met with none' (Anonymous, 1883*a*). Similar results were found around the country. 'Discontent was trifling' according to Hereford superintendent Algernon Chapman (Hereford Asylum, 1883), adding: 'those who appeared to regret the change and who yet were temperate people worthy of consideration in the matter were only some three or four'. Superintendents probably disregarded any dissatisfaction among patients with an alcoholic history in their evaluation. Dr Pritchard Davies of Kent Asylum (Tuke, 1885) acknowledged that some drinkers experienced hardship until their urge subsided. Just one British asylum in Tuke's survey experienced serious turmoil. Dr Claye Shaw's trial at Banstead Asylum was postponed; 'we tried the discontinuance of beer in one of the wards on each side for a few days, but we very nearly had a riot in consequence' (Tuke, 1885).

Of course, medical superintendents anticipated lasting benefits from

imposing an alcohol-free environment, such as improvements in household discipline. Removal of beer relieved officers of greedy demands, and working patients wasted less time quarrelling (Bell, 1939). Wards were noticeably quieter, with less excitement and violence, and more contented patients (Anonymous, 1883*a*). Other asylums experienced little difference in inmates' demeanour, a phenomenon explained by Dr Mitchell of the West Riding Asylum at Wadsley: 'The beer formerly given was of too weak alcoholic strength to have any effect in any way upon the patients' (Tuke, 1885).

Claims of health gains varied between establishments. At the very least, doctors could no longer be accused of feeding addiction, and sobriety could only be a virtuous step. Reduced mortality was reported, but a causative link was tentative (Anonymous, 1883*a*). Dr Wade believed that the change, while proving beneficial to patients' well-being, coincided with other factors such as better drainage (Anonymous, 1883*a*). Patients ate more (Anonymous, 1881*b*) and gained weight, as observed by Dr Pritchard Davies of Kent Asylum:

> When we gave beer, the first thing a large majority of the patients did, when they sat down to dinner, was to drink all the beer. After that they had not good appetites, and the consequence was that a great quantity of the food supplied was wasted and went to the farm for the pigs. (Tuke, 1885)

Some superintendents witnessed marked improvement in the conduct of attendants (Anonymous, 1883*a*; Bristol Asylum, 1884), Dr Wade at Somerset boasting 'in two years I have not had a single case of drunkenness in nearly 100 attendants' (Tuke, 1885). Interestingly, Dr Pringle at Glamorgan devoted the savings from inmates' rations to improving the conditions for attendants (Tuke, 1885).

Pharmacological advances

Excessive reliance by alienists on the stalwarts opium and alcohol illustrated a therapeutic vacuum in treating mental disease. The exhortations of scientific psychiatry led to a plethora of drug experimentation on asylum inmates, from which some useful treatments emerged. Bromium was a significant boost to the asylum pharmacopoeia from the 1860s, followed by the sedative chloral around 1870 and paraldehyde in 1882 (Crammer, 1990: 116–28). Yet medicinal use of alcoholic beverages persisted. All 33 asylums listed in a 1900 survey (Weeks, 1925*b*) were continuing to dispense alcohol in the form of wines, spirits or malt liquor; in that year Bucks and Preston asylums each spent over £1000 on beer. Stout was used for melancholia, and as a fortifying supplement for the accumulating aged and feeble patients.

Conclusion

The 'beer movement' in asylums occurred in the context of a Victorian

society that had clearly suffered from the evils of alcohol. Drinking habits reached a turning point, as the persuasion of the temperance campaign and prohibitive legislation caused the descent of drunkenness from norm to vice. Pillars of society demonized alcohol. Treatment of public water supplies and the emergence of tea and coffee as alternative beverages loosened the grip of beer on the lower orders of British society. Meanwhile, working-class lifestyles were improving thanks to social reforms, encouraging alternatives to drunken apathy.

The temperance message filtered very slowly through the solid walls of the lunatic asylum, where regulated consumption barred the potential for alcoholic excess. Indeed, malt liquor had served the authorities well in its nutritional and motivational functions. Eventually, a combination of practical, economic and professional concerns converged to serve notice on this popular commodity. As asylum administrators struggled to contain a relentless accumulation of lunatics, unnecessary luxuries were soon quashed. However, the motives for withdrawing beer went beyond the appeasement of ratepayers. The beer movement was a pawn in a power shift in the administration of lunacy. As the tenets of moral treatment were forgotten in vast, impersonal institutions, alienists sought to improve their lot by embarking on a professional project that colonized madness as a medical specialty. Mundane matters regarding the daily lives of inmates were distanced from the competence of laymen, as asylums evolved into hospitals.

Daily provision of beer by a medically managed establishment was increasingly incompatible with societal attitudes towards alcohol. However, even the strongest critics of alcohol among asylum doctors were keen to disassociate themselves from teetotalism. In managing lunatics, doctors did not want to be guided either by zealots or by the financial interests of visiting justices. The medical profession ascertained alcohol as a potent substance, its supply to patients thus becoming a matter for clinical judgement. After beer rations were abolished, alcohol remained in use medicinally until the development of more refined medication. Noting the current pharmacological dominance of psychiatry, one senses irony that, as evidence of the iatrogenicity of psychotropic drugs accumulates (Livingston, 2001), recent research (van der Gaag *et al.*, 2000) shows that a daily pint may, after all, be good for you.

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