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Article

Liberty and the individual: the colony asylum in Scotland and England

Gillian Allmond

Queen's University Belfast

Corresponding author:

Gillian Allmond, School of Natural and Built Environment, Queen's University Belfast,
Belfast BT7 1NN, UK.

Email: gallmond01@qub.ac.uk

Abstract

This paper analyses the buildings, spaces and interiors of Bangour Village public asylum for the insane, near Edinburgh, and compares these with an English asylum, Whalley, near Preston, of similar early-twentieth-century date. The village asylum, which developed from a European tradition of rendering the poor productive through 'colonisation', was more enthusiastically and completely adopted in Scotland than in England, perhaps due to differences in asylum culture within the two jurisdictions. 'Liberty' and 'individuality', in particular, were highly valued within Scottish asylum discourses, arguably shaping material provision for the insane poor from the scale of the buildings to the quality of the furnishings. The English example shows, by contrast, a greater concern with security and hygiene. These two differing interpretations show a degree of flexibility within the internationalized asylum model which is seldom recognized in the literature.

Keywords

Asylum buildings, Bangour Village Asylum, colony, individuality, England, liberty, Scotland, 20th century

Introduction

The 'village asylum' – also known as the 'villa colony' or 'segregate' system – is a little-studied asylum type, adopted in a number of locations across the world in the late-nineteenth and early-twentieth centuries. A typical village asylum comprised patient accommodation dispersed into separate 'villas' set out on an extended agricultural site, in contrast with the more common layout consisting of large pavilions connected by corridors. The 'villa system' was prevalent by the end of the nineteenth century in Germany and the Austrian Empire, and 'colony asylums' were built in Brazil (1898), Argentina (1901), Norway (1904), Italy (1908), New Zealand (1912) and Tokyo (1919), as well as in Scotland and England. The 'segregate system' also attained 'high status' in the USA following the opening of the first US asylum to include 'cottages' at Kankakee, Illinois, in 1878 (Eraso, 2010; Hashimoto, 2013; Skålevåg, 2002; Topp, Moran and Andrews, 2007; Yanni, 2003).

This paper explores the European context for the establishment of the village asylum ideal, and its particular manifestation in Scotland. A comparison of two asylum blocks, one north (Bangour Village, Edinburgh) and one south (Whalley Asylum, Lancashire) of the border, suggests that there were sometimes stark differences in what was considered acceptable accommodation for 'chronic' patients in Scotland, where the colony layout was widely adopted, and in England and Wales, where it was only peripherally accepted. Some explanations for these differences are offered, leading finally to a consideration of deeper cultural tendencies. It is argued that, among other factors, distinct conceptions of liberty and the individual prevailed in Scottish asylum culture, contributing to the receptive conditions that allowed village asylums to become more firmly established north of the border. This paper builds on recent unpublished work by Darragh (2011), Halliday (2003) and Ross (2014), who have offered valuable (although non-comparative) analyses of Scottish asylums, as buildings and spaces, and of the ideologies that informed their construction.

In broader terms, this paper challenges the prevailing historiographical orthodoxy which suggests that, by the end of the nineteenth century, an initial therapeutic optimism had evaporated and asylums were being constructed as 'warehouses' to sequester the unwanted (Scull, 2015: 223; Waddington, 2011: 326). This implies a detachment from the asylum project not supported by close analysis of buildings and primary sources, which reveals both deliberate attention to the therapeutic effect of buildings and spaces and a less conscious embedding of material practices within their local cultural contexts. This paper advances the work of asylum historians who have focused on the therapeutic significance of asylum buildings and environments, both from an architectural perspective (Andrews et al., 1997; Malcolm, 2009; Markus, 1993; Richardson, 1998; Rutherford, 2003; Stevenson, 2000; Taylor, 1991; Topp, 2007; Yanni, 2007) and addressing the materiality of asylum spaces, interiors and exteriors (Fennelly, 2014; Hamlett, 2015; Hickman, 2013; Philo, 1989). The present paper approaches asylum materiality as illustrative of trends beyond the discursive constructions of mental illness and provides a detailed analysis of external forms, interior spaces and furnishings, drawing out connections between materiality and broader social currents. It is axiomatic for this study that materiality, and buildings in particular, are a form of (currently under-used) historical evidence. While buildings differ from written sources in that they are functional as well as representational, they

may be a better guide to the value system of a society than words, precisely because they are more costly and time-consuming to produce: 'What people say they care about ... is one kind of evidence ... but a better guide to what they really believe is to look at how they act' (Ballantyne, 2006: 37).

Developments, influences and comparisons

Following the passing of legislation in 1857, 18 district asylums were built in Scotland before World War I. After c.1880, an earlier monolithic style of asylum construction, where all accommodation and services were contained within a single building, began to break down and a number of segregative trends arose, including the construction of separate asylum and hospital buildings.¹ The royal (charitable) asylums started to build or adapt separate houses in suburban areas for their private patients (Aberdeen, Dundee, Edinburgh), usually on the scale of a hotel or large mansion house, and villas resembling middle-class dwelling houses were added to asylum sites at Dumfries, Perth, Montrose, Argyll, Ayrshire, and Haddington. Three asylums were built on a pavilion plan in the mid-1890s, with patient accommodation separated into blocks connected by corridors: namely, Lanark, City of Glasgow and Govan (Darragh, 2011). The 'village system', as it was often known in Scotland, constituted the fullest flowering of this trend, not only segregating patient accommodation but dispersing it around a rural site. The only complete asylums built after 1900 in Scotland followed this plan, which provided the majority of patient accommodation in bourgeois-style villas, laid out in the manner of a village or suburban settlement within a substantial rural acreage. The village layout was adopted for Crichton Royal Asylum's 'Third House' (commenced in 1898) and for the three district asylums constructed in the period 1900–14 at Kingseat (Aberdeen), Dykebar (Renfrew) and Bangour (Edinburgh) (Easterbrook, 1940).² Shortly after the opening of Kingseat, near Aberdeen, John Macpherson, Lunacy Commissioner, commented that '[t]he village type of asylum ... *combines the advantages of the home and of the labour colony*' (Macpherson, 1905: 490, emphasis added).

Village asylums in Scotland were directly inspired by the most influential German example of a purpose-built colony for the insane, Alt-Scherbitz, near Leipzig; by the 1890s this was 'a standard stop on asylum research trip itineraries' (Richardson, 1991; Topp, 2007: 736). Alt-Scherbitz was only one among a wide range of attempts to 'colonize' the poor as part of an improvement ethic, which sought to render productive

a sector of the population seen as both morally lacking and socially threatening (Sonntag, 1993). Attempts to marry agricultural work and family-style institutional provision for the poor began with the 'farm school' system which originated in Switzerland in the 1770s. By the mid-nineteenth century, such schools were widespread across Europe and influenced the development of 'cottage homes' for pauper children in England in the 1870s. This pedagogical, reformatory trend was accompanied by a growing interest in the 'colonization' of unemployed adults, which may be traced initially to experiments in utopian reform such as the 'villages of unity and mutual co-operation' suggested by the socialist Robert Owen, as well as at the Dutch pauper colonies of Frederiksoord and Willemsoord. All these projects aimed to make the poor self-supporting through working on the land, an occupation which was seen as 'morally superior' to manufacturing work (Harrison, 1969).

From 1837, these experiments were extended to the insane, and a French agricultural colony for the insane at Fitz-James was established as an annexe to the main asylum at Clermont (Labitte, 1861). In the same year, Scottish alienist W.A.F. Browne put forward his influential utopian asylum vision, advocating farms for agricultural work in the open air and 'separate houses, in which the patients are distributed according to their dispositions and the features and stage of their disease' (Browne, 1837: 185). Interest was also being revived in the Belgian colony for the insane at Gheel, following reforms by the Belgian authorities. At Gheel, patients were accommodated with local residents in a village community in pre-existing cottage dwellings, paralleling the Scottish practice of boarding-out (Andrews, 1998). In the following decades the focus of attention shifted markedly from France, Belgium and the Netherlands to Germany: *Ackerbaucolonien*, agricultural colonies for the insane, were established across Germany in the 1860s, following the example of Fitz-James. Alt-Scherbitz was a departure from the *Ackerbaucolonien* because the amount of land was much extended, to about 0.6 ha (or 1.5 acres) per patient, and all patients were accommodated on a single site, with the vast majority (it was claimed 90%) engaged in useful work, largely outdoors (Besser, 1881; Letchworth, 1889; Sonntag, 1993).

Although the Alt-Scherbitz model was readily accepted in Scotland, colony asylums did not find equivalent favour in England, notwithstanding calls from English lunacy experts for greater segregation of patient accommodation, using detached blocks or houses, and early experiments in this vein such as a separate house and disjoint

convalescents' 'branch asylum' used at the Devon County Asylum in the 1850s (Philo, 1987, 1989). Instead, across England and Wales the pavilion plan, inspired by hospital design, was elaborated in a greater variety of ways after 1870 (Taylor, 1991). Pavilions were distributed in linear or semi-circular forms and in echelon, but by 1900 a single design had emerged as the favourite: the 'compact arrow',³ first constructed at Claybury in Essex to designs by George T. Hine; of the c.30 English public asylums built between 1890 and 1910, 28 were built according to this plan. The first English asylum with three detached 'villas' (so-named) on site as part of the design, rather than as an addition to a pre-existing asylum, was at Bexley (by Hine, opened 1898). Four subsequent compact arrow asylums (three by Hine) provided villa accommodation for between 5% and 20% of patients, likely to have been those able to work: at Horton (1902), Long Grove (1907), East Sussex (1903) and Essex and Colchester (1913). A handful of English asylums for epileptics and/or the cognitively impaired were also built on the colony model over the period 1888–1914; they were largely charitable enterprises or constructed under the Poor Law by Boards of Guardians, while Ewell epileptic colony near Epsom (1903) was the sole example built by an asylum authority. Despite accommodating a minority of patients in detached buildings of various kinds, the explicit dispersal of asylum buildings into village layouts did not occur in England as it did in Scotland, and no English county or borough asylum for the full range of patient categories was built on the colony model before World War I.⁴ After 1900, therefore, the model for English asylums consisted of closely spaced pavilions connected by corridors, often with some detached villas, while Scottish asylums were laid out as fully dispersed detached villa colonies.

Bangour Village Asylum

Bangour Village Asylum was constructed between 1903 and 1908, the site having been purchased in 1897 by the Edinburgh District Lunacy Board (EDLB) following increasing pressure of numbers within existing provision. The asylum was announced with moderate fanfare in the medical and architectural press as 'the first asylum of the village type in Great Britain' which would mark 'a new departure as far as this country is concerned' (Anon., 1898). It was the largest of the three village asylums in Scotland, housing 766 patients initially, with communal buildings allowing for the potential to expand to 1,000.⁵

The EDLB had visited Alt-Scherbitz in 1897 noting that:

[T]he most striking feature of the place is the *absence of the appearance of an institution* ... the separate dwellings, the home-like surroundings, the freedom from restraint, the substitution of gardens for airing yards, bedrooms for dormitories, sitting rooms for halls, and roads for corridors, cannot fail to have a soothing and beneficial effect on the patients requiring treatment in an asylum. (EDLB, 1897: 27, original italics)

The asylum was praised for 'having none of that dead uniformity of design which produces monotony ... Monotonous uniformity has been avoided, whether it be in the design of the villas or the pattern of the teacups,' and the authors recognized Alt-Scherbitz as the 'logical development of the "open door" system' (p. 27). The following year a competition was held to design the new asylum for Edinburgh, architects being instructed to frame their design 'on the principle of segregation' practised at Alt-Scherbitz (Blanc, 1908: 310). The contract was won, from a field of nine entrants, by Hippolyte J. Blanc of Edinburgh, who subsequently also visited Alt-Scherbitz, before preparing working drawings (EDLB Minutes, 18 Feb. 1901).

Hine, the foremost asylum architect of his day, commended Blanc on being one of the first to design an asylum on the colony system and admitted that England was moving 'at a less rapid pace' (quoted in Blanc, 1908: 324), having only experimented with a few detached villas in the grounds of traditional asylums. He nonetheless thought that not enough was known about the working of the villa system in practice, warning that 'in a few years the promoters of this scheme in Edinburgh might probably think they had gone a little too far' (p. 324). Hine's architectural colleagues were more forceful in their condemnation, foreseeing difficulties with supervising and administering the village asylum, and criticizing its sanitary arrangements. It was vilified as a 'backward' step, one critic going so far as to position the Scottish Lunacy Commissioners as subalterns, claiming that they were less intelligent than those in England for having passed such a scheme (Blanc, 1908: 325). A source of contention in Scotland was the building cost, perceived to be high at £387 per patient (Keay, 1911: 411), putting Bangour in the top 16% when compared with English and Welsh asylums built 1893–1909, with the average cost per patient south of the border at £306 (ELC, 1910: 258–65). The high cost of Bangour threatened to erupt into a wider controversy when the former prime-minister, Lord Rosebery, at the formal opening in 1906, complained that the villas were 'sumptuous homes for the insane ... laid out as daintily

as they could be for the blood royal', and asked rhetorically 'why do all this for the intellectually dead?' (Anon., 1906a: 1162). Rosebery's words were widely reported in the national and medical press, prompting debate on the importance or otherwise of environment in the treatment and care of the insane.

Following the passing of the Lunacy (Scotland) Act of 1857 and the start of large-scale institutionalization of the insane, discourses of freedom around the insane developed in Scotland, with some evident effects on how the pauper insane were cared for within and outside Scottish public asylums. An antipathy to aggregating large numbers of patients within institutions appears to have originated at an early stage, partly fuelled by the comparison with English asylums. In 1857, W. Lauder Lindsay, Medical Superintendent of Murray Royal Asylum at Perth, advised that '[w]e must have no Colney Hatches in Scotland, huge, overgrown, unmanageable establishments, whose interior rivals the gloom and monotony of a prison' (Lindsay, 1857: 114). He objected to 'isolated, single, symmetrical masses of building', preferring:

... a series of buildings studded over the grounds, resembling in general character and appearance a large English homestead, or some large industrial community; we look forward to the time when a pauper asylum will partake of the character of a farming or industrial colony; when we shall have a large proportion of its inmates living in cottages under the charge of intelligent and kind attendants ... (Lindsay, 1857: 115; also McCandless, 1979)

The practice of boarding-out harmless, chronically insane patients was formally initiated in 1858 and accounted for up to 25% of patients in Scotland in the period up to 1913, both pauper and private, providing an innovative model for the rest of Europe and beyond (Sturdy and Parry-Jones, 1999).⁶ Frequent comparisons were made with Gheel, the Belgian colony for the insane, although there the patients were largely concentrated into a central location, where a closed asylum was also provided for more intractable cases, and a much wider range of mental illness and disability was catered for than in Scotland. Scottish 'Gheels of the North' appear to have been exaggerated, but the ideal that Gheel represented, in terms of liberty and access to family life, was an ongoing interest for many Scottish asylum-doctors (Philo, 1989; Sibbald, 1861). The idea of an asylum that addressed the unavoidable aggregation of patients unsuitable for boarding-out – breaking down the ensuing accumulation to a more home-like scale –

remained attractive, but no realistic model applicable to the public asylum system appeared until Alt-Scherbitz came to wider attention in the 1880s.

Despite the lead set by English alienists in the early-nineteenth century, a quantitative comparison of the Reports of the Commissioners in Lunacy (England and Wales) (ELC) and the Reports of the General Board of Commissioners in Lunacy for Scotland (SLC) suggests that discourses of liberty and freedom relating to asylum patients were more fully developed in Scotland by the end of the century. On average, the SLC reports refer to 'liberty' or 'freedom' eight times as often as the ELC reports in the period 1880–1910. A qualitative assessment suggests that Scottish Commissioners pushed forward an agenda where patient freedom was prioritized, with almost all references to freedom/liberty occurring when offering praise for asylums giving greater freedom to patients. The English Commissioners, although making a handful of approving references, more commonly referenced patient freedom in relation to suicide (where a patient had taken advantage of an implicitly excessive freedom to harm themselves), lunacy legislation (the protection for individuals against wrongful incarceration) and, most commonly, the characteristics of a well-run asylum (freedom from odours, disease, excitement and complaints). This emphasis may have reflected the legalistic concerns of the ELC visiting panel, three of six being practising barristers, in contrast to the SLC, whose legal members did not take part in visiting asylums (Report of Royal Commission, 1908: 210). Andrews (1998: 63) suggests that the SLC enjoyed a better relationship with medical superintendents and among themselves than did the ELC, and were not criticized, as were the ELC, for their resistance to 'new treatments'.

The SLC firmly positioned itself as an advocate of non-restraint in its 23rd annual report: 'it is now held wrong, not only to use any form of mechanical restraint of the person, but even to put restriction of any other kind on the liberty of a patient, which cannot be shown to be necessary either for his own welfare or the safety of the public' (SLC, 1881: xxxi; also Ross, 2014). Modifications to asylums at this stage were intended to remove their prison character and to 'assimilate them to the arrangements of private houses'. It was stated that fenced or walled 'airing courts' had disappeared at most public asylums, and that the practice of locking ward doors had given way to an 'open door' system reliant on the supervision of attendants to exercise control over patients (pp. xxxi–xxxv). The open-door system was thought to diminish the patient's desire to

escape, in the same way that removing shackles and chains had been thought by early advocates of non-restraint to induce calm. Another strand in allowing liberty for patients was a more extensive use of parole, by which some patients were permitted to walk or work in or beyond the grounds of the asylum. Previous scholarship has questioned the real extent of these changes (Halliday, 2003: 130), pointing to how an apparent liberty served other, more subtle forms of control (Ross, 2014: 238–9).

Bangour Village Asylum was laid out on a south-facing, sloping site and was divided into two parts: the medical section, with hospital, admission wards and villas for all patients requiring medical supervision; and the ‘industrial’ section comprising villas for ‘chronic’ and convalescent patients (Figure 1, top). There was no gate lodge at the entrance to the site, and the asylum presented no centralized structure, the administration building being a two-storey structure of unimposing character and relatively distant from the entrance, with the hospital removed to the back of the site. The asylum itself ‘disappears’, as in the Alt-Scherbitz model. With no surrounding wall and buildings ‘distributed without formality or attempt at regularity’ (Anon., 1906b: 544), the site mimicked an unplanned development that had grown up organically. Curving roadways connected the buildings in a series of continuous irregular loops, totalling nearly four miles, in place of the lengthy corridors of a pavilion layout.

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The buildings varied in building forms and orientations, thereby to ‘destroy all appearance of official residence’, and interest was imparted by the ‘variety of external treatment in exposed stone, harling, tiled and green slated roofs’ (p. 545). Each villa was orientated slightly differently and positioned irregularly around the site, deriving variety from their aspect and environment. The villas also ranged in size so that more difficult patients were accommodated in smaller dwellings for closer supervision, with acute villas housing 32 patients, whereas chronic villas housed 46–50. The absence of corridors, walls and fences meant that patients leaving the villas and moving between buildings enjoyed the open grounds. Difficulties in managing patients outdoors were addressed either by vesting more trust in the patients or by increasing attendant supervision, rather than relying on the built environment. Ratios of staff to patients

were on average 1 to 11 by day and 1 to 46 by night, which was considered a high staff/patient ratio for the period, and indeed the colony system was often criticized for its high staffing requirements (Steen, 1900).

Villa 18 for 46 females with chronic mental illness, exhibited a number of domestic features: canted bays on either side of the main elevation: a verandah spanning the middle three bays; wall-head dormers, a characteristic feature of Scottish domestic architecture; grouped windows; and angled chimney stacks. The variation in roof line, heights and surface articulation subtly undermined the building's uniformity as an institutional space. The main elevation bore comparison with Edinburgh's stone tenements, often three and four storeys high, but the interior was laid out as a single, unified domestic villa with living accommodation on the ground floor and sleeping and bathroom facilities on the upper floors. The ground floor patient dayrooms were positioned to take advantage of the sunny, south-east-facing main elevation. Unlike a domestic house, however, the main living areas did not open off a central hallway but rather into each other, rendering the control and observation of patients easier. The L-shaped day room allowed the room to be cross-ventilated and to receive light from two different directions, although this made patient supervision more difficult because not all corners of the room could be seen from one point. A contemporary photograph (Figure 2) shows that the room was sparsely but comfortably furnished in a restrained domestic style with a relatively elaborate egg-and-dart moulding along the cornice, suggestive of a bourgeois domestic interior despite the expense and potential to trap dust and dirt. On the first and second floors, the sleeping accommodation was divided into five dormitories of between six and twelve beds, the small size of which meant that cross-ventilation was not always achieved. This villa and the other 'industrial' villas all practised the open-door system, with doors kept open during the day and locked at night.

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Sixth Lancashire Asylum

In August 1898 the Lancashire Asylums Board (LAB), perceiving the need for a sixth asylum for the county, appointed a committee to investigate what form the new asylum should take.⁷ Village asylums had their champion here in the form of John Milson

Rhodes, a GP and prolific writer influential in the field of Poor Law reform. He had visited Alt-Scherbitz, and had published approvingly on it in 1897 (Rhodes and McDougall, 1897). At Rhodes' instigation, the LAB narrowly voted in favour of sending a deputation, including a Scot, David Mackay Cassidy, the Superintendent of Lancaster Asylum, to asylums in Britain and abroad to investigate their suitability as models (LAB Minutes, 25 Aug. 1898). The deputation was 'very favourably impressed' with Alt-Scherbitz, and asserted that the smaller numbers in each villa led to the preservation of the individuality noted as a key requirement for sanity: 'Individuality is lost in a crowd, and the increasing loss of the sense of individuality in a lunatic goes *pari passu* with a loss of initiative and of mental energy, in short of mind' (LAB, 1900: 64). Designs for a villa colony asylum for 2000 on a site in Whalley were produced in 1904, including 24 villas for 40–45 patients each (LAB Minutes, 23 Sep. 1904), but in August 1906, six years after the initial decision, the LAB decided not to go ahead with the villa colony design because it 'would cost probably between £15 to £30 a bed more' (LAB Minutes, 30 Aug. 1906). The LAB decided that 'for certain classes of curable cases the more home-like surroundings of a villa may result in a greater probability of a cure to the patients than treatment in a large ward', but there was no 'clear proof' that more cures would result or that 'the general condition of the patients would be substantially improved' (LAB Minutes, 30 Aug. 1906).

The sixth Lancashire asylum at Whalley was instead built as a 'dual pavilion', with two rows of pavilions for men and women on each side, and administration and communal buildings placed down the central spine (Figure 1, bottom). As a local newspaper report implied, it was a somewhat conservative design in comparison with the compact array then more usual in England at this period (Anon., 1907). The main entrance for patients, staff and visitors was through a formalized gate-screen of railings, piers and arches associated with a substantial lodge, and it is likely that the majority of the estate perimeter was fenced (Cornwell, 2010: 19). The site was almost entirely rectilinear in design, the visitor being led along a largely straight avenue to an open square dominated by the main administration building. Building designs were classical and symmetrical, a repeating theme being the deeply corniced pediment with central cartouche, evoking many generations of institutional building from barrack to hospital. Accommodation for men and women was arranged in symmetrical rows, one pavilion behind another, so that the views from dayrooms were on to other institutional

buildings. The pavilions were connected by covered walkways running parallel to the main buildings which were open from above waist level, allowing air to circulate freely, but were roofed to keep out the worst of the weather.

Accommodation pavilions faced south-south-west to obtain the benefits of sunlight, and each was enclosed by a rectangular grassed airing court with a railing over six feet high, hooped at the top for safety reasons, through which the wider grounds were visible but unreachable. There was no apparent intention to practise an open-door system at Whalley, and the main doors to the pavilions were probably meant to remain locked. The chronic blocks were without significant features on the main elevation, but a full-height canted bay at the western end of each pavilion provided an architectural flourish that also increased sunlight to the interior at the end of the day. The interior accommodation did not echo the layout of a domestic house, being organized identically on the first two floors, each comprising a large dayroom with western-facing bay, a dormitory of 29 beds, sanitary facilities and a ward scullery. The second floor was laid out as two huge dormitories of 36 and 54 beds, the main rooms organized on the typical plan of a Nightingale ward with tall windows opposite each other, allowing for cross-ventilation and natural light from two directions. WCs and bathrooms were isolated, hospital-style, from the rest of the building in a separate sanitary annexe. The wards were rectangular, allowing easy observation of all parts of the room, with one main entrance into the ward from the covered way and all rooms opening off a central corridor, suggesting that wards and dayrooms may have been habitually locked as the corridor would otherwise have been a weak point in attempts to control patient movements. A contemporary image of a chronic ward in use by soldiers shows extremely high ceilings, possibly as much as the 15 feet recommended by Nightingale to give patients healthful amounts of air, and the effect of sunlight pouring into the ward from all sides (Cornwell, 2010: 62). The walls had rounded arrises, thought to assist air circulation and aid cleaning, but – despite plain dado and picture rails – no panelling or cornicing of the domestic kind seen at Bangour was evident, suggesting that such finishes were seen as unnecessary or dirt traps.

Conclusion

The foregoing comparison has established clear differences between the accommodation offered to chronic patients at Bangour and at Whalley. At Bangour, an

environment was created that resembled, if imperfectly, a bourgeois domestic house in its furnishing and layout, while the division into relatively small rooms emulated the individualized spaces of a domestic interior. The Bangour villa dispensed with visible emblems of patient control such as corridors and airing courts, and the interior was arranged to facilitate patient supervision without the need for locking rooms. The Whalley pavilion was three times as large and the interior layout grouped patients together in huge dormitories and dayrooms, exceeding the scale of hospital wards and perhaps suggestive of army barracks. The aspiration to be 'home-like' was here subordinated to the hygienic requirements of the hospital, with wards designed to maximize cross-ventilation and natural lighting, and sanitary facilities withdrawn into separate annexes. The Whalley pavilion was designed to enable patients to be controlled with the minimum of attendant supervision, with corridor connections between buildings, fenced airing courts and huge rectangular rooms all making for easy surveillance.

The material practices of both asylums may be seen as illustrative of regionally specific attitudes to the insane poor and their care. Bangour speaks of a Scottish medical culture which arguably placed a high value on patient freedom and individuality, while imposing a paternalistic standard of bourgeois domestic living intended to elevate patient conduct and to induce calm and order. The spatial organization of the village asylum promoted individuality and mental health by maintaining small patient groups, as well as by replicating the character of individualizing domestic spaces. A concern with individuality extended even to the choice of furniture: armchairs were chosen which would render each patient 'comfortable and isolated,' in contrast to benches which would seat five or six together 'increasing their irritability and excitement' (ADLB Minutes, 28 July 1903). Individuality was to be encouraged both by the preservation of domestic scale and by environmental variety. The diversity of the village asylum, with variation in siting and surroundings, architectural styles and materials, alongside the lack of regularity of the buildings' disposition on a site, were frequently identified as implicitly individualizing and antithetical to the usual homogenizing asylum architecture and layout.

Conversely, the architecture and layout of the Whalley pavilion suggests that patient individuality was minimized here, and that the needs of the hierarchy to manage 'unitized' patient bodies, or to keep the hospital environment free from disease, were

prioritized over the provision of idealized 'home-like' surroundings. Medical discourses were often critical of what were termed 'barracks' asylums, built on a huge scale with large rooms and long corridors; indeed, 'barrack-like' became a kind of shorthand for the very antithesis of the domestic in asylum planning. The Scottish Lunacy Commissioners declared in their 56th report that Bangour Village was 'an advance on the old "barrack" type of institution and an approximation towards the normal mode of life of human beings' (SLC, 1914: xxviii), permitting better classification, greater freedom and greater facilities for work and exercise in the open air. The barrack asylum system was also criticized by Lindsay, the Murray Royal Superintendent, who held that 'the practical tendency of the age [is] to *diffuse, not to mass*, the sick and dependent' (Lindsay, 1871 (original italics), quoted in Sturdy, 1996: 11). The barracks reference was intended to convey regularity, monotony, symmetry and the crowding together of large numbers of patients, who were positioned by the architecture and layouts as passive, mentally dull, identical units to be brought under a unifying discipline. Burdett (1891: 103) describes one such barrack asylum, Leavesden near London, as 'well arranged for the storage (we use the word advisedly) of imbeciles'. It is nonetheless possible that 'medicalized' asylum buildings were, in fact, viewed by the Lancashire (and other) asylum authorities as more advanced than domestic-style surroundings which might trap dirt and be insufficiently lit and ventilated. Whalley may be seen as the fulfilment of a late-nineteenth-century trend towards hospitalization of asylum architecture and interiors, sometimes at odds with the desire to provide more 'home-like' surroundings (Hamlett, 2015: 25).

Bangour can clearly be taken as an exemplar of its type and period in Scotland, but the status of Whalley as exemplary in relation to asylum construction at this period is much less certain. Among the *c.*30 asylums built in England and Wales between 1890 and 1910, its dual pavilion layout would have seemed rather old-fashioned, but the use of pavilions was nonetheless universal among English/Welsh asylums at this period. Although a strong link can be drawn between Scottish medical discourses and local architectural practices in relation to asylums, the same cannot be said of England and Wales, where detailed analyses of asylum materiality are, as yet, lacking. Liberty and individuality have been identified, through the analysis of contemporary discourses, as possible factors influencing the character of asylum provision in Britain, although other factors must be considered as contributory, including legal philosophies and varying

enthusiasm for asylum 'medicalization'. Driver (2004) has argued that 'individualization' with the aim of moral improvement was an important goal in breaking up the 'barrack' designs of prisons, reformatories, workhouses, schools and asylums during the second half of the nineteenth century, and this tendency can be set within Foucault's concept of 'descending individualisation' within disciplinary regimes, wherein the least powerful in society are the most subject to individualizing mechanisms, classification and tabulation (Foucault, 1977: 193).

It can further be argued that Enlightenment concepts such as liberty and individuality have been subject to local inflection, which may help to explain variations in material evidence between Scotland and England/Wales. Dalglish (2001) analyses changes in nineteenth-century rural Scotland shaped by an ideology of agricultural 'Improvement', noting that a fundamental element of Improvement was the emphasis on both the individual and private property, a structuring disposition which replaced an earlier emphasis on community. Pre-Improvement domestic space was characterized by unpartitioned dwellings focused on a shared central hearth, while Improved dwellings were increasingly divided. Everyday activities became segregated and associated with different spaces, making the 'ideology of the individual knowable' (Dalglish, 2001: 23). Key to the success of Improvement ideology was a conception, with its roots in the Scottish Enlightenment, specifying stages of development through which society is carried by the initiative of the individual: 'There is ... in man a disposition and capacity for improving his condition, by the exercise of which, he is carried from one degree of advancement to another' (Millar, 1771, quoted in Dalglish, 2001: 19). The success of Scottish capitalism has been attributed to refashioning the 'habits, attributes and attitudes' of a backward workforce through Improvement, while the European-wide advance of capitalism was inflected in Scotland by features of Calvinism lending individual conscience an elevated position and resulting in 'constant self-criticism and a need to do better' (Whatley, 2000: 98-9). Calvinism 'envisaged a social order that radiated outward from the self-disciplined individual' and which, regardless of individual adherences, produced a cultural climate north of the border that placed high value on individual identity and striving (Gibson, 2006: 35). The increasing division of domestic space within the rural dwellings of the poor, as identified by Dalglish (2001), suggests that material practices were seen as directly formative of desired attributes, leading to increased wealth production and capitalist accumulation.

An analysis of the architecture, spaces and discourses of Scottish asylums of the early-twentieth century suggests that the emphasis on the individual was not only a feature of the historical development of Scottish capitalism, but had thoroughly permeated discourses of poverty and insanity. The ethic of Improvement was discernible in the attitude to the poor insane in Scotland, seen less as a problem of contagion, to be contained, and more as one of inefficiency: of unproductive persons whose latent initiative was to be promoted through addressing their individuality. Individuality, in the sense of personal initiative, had become a quality – associated with productive work – to cultivate in the poor as a means of lifting them out of the related problems of poverty and mental disease. Even in chronic patients who were not expected to recover, a strong cultural imperative existed to raise them up from the drab homogeneity thought to be the corollary of insanity. This attitude led to material changes in how the poor were accommodated and treated in asylums. The planned variety of environments and spaces afforded by the village asylum system, together with the spatial separation of patients into small groups, reflected the seeming will of Scottish asylum culture to engage the individuality of patients. This will derived from a long tradition of Calvinist-inspired Improvement directed towards the majority, arguably a distinctive driver in the development of Scottish modernity, and it found ideal material expression in Continental European-inspired village schemes for the colonization of the poor.

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Notes

1. Several asylums built separate hospital blocks for ‘acute’ patients, believed to be curable, in the late nineteenth century/early twentieth century period, leaving the asylum proper for ‘chronic’ long-stay patients (Aberdeen Royal, Montrose Royal,

- Ayrshire, City of Glasgow, Govan, Melrose and Stirling); Darragh, 2011; Halliday, 2003; Ross, 2014.
2. Until at least the 1960s, the colony plan remained the dominant form in Scotland, the asylums listed above being followed by three colonies for 'mental defectives' constructed in the 1920s and 1930s; Darragh, 2011; Richardson, 1988. The timeline offered by Darragh (2011: 52) conflates the sequence of changes in asylum design, because some asylums (e.g. Lanark) are listed by the date of opening and others by the date the site was purchased, usually several years before. In fact, the first colony asylum, Kingseat (1904), opened seven years *after* the last pavilion asylum, City of Glasgow (1897), implying a clear sequential shift in material practices.
 3. The terms 'compact arrow' and 'dual pavilion' derive from an unpublished 2004 study by Cracknell, summarized in Roberts, 2016.
 4. Three mental hospitals were built on a colony plan in the mid- to late-1930s (Barrow, Shenley, Runwell) and colonies for the 'mentally defective' and tubercular were also constructed in the inter-war period.
 5. Aberdeen was built to accommodate 500 patients and Renfrew 300 patients.
 6. Boarding-out did take place in England and Wales, at about half the rate of Scotland, but did not come under the control of the Lunacy Commissioners; Sturdy, 1996.
 7. Initially the committee was confined to looking at accommodation for 'imbeciles and epileptics', but later widened its remit to the full range of insane poor; LAB Minutes, 25 Aug. 1898.

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[captions]

Figure 1. *top*: Layout of Bangour Village, from *The Builder*, 1906 (© The British Library Board, HIU.LD85, 10th November 1906, p.545); *bottom*: Layout of Whalley Asylum (Calderstones Institution) (Ordnance Survey, 1932 edn).

Figure 2. Bangour Village Villa 18 interior, c.1906 (courtesy of Lothian Health Services Archive, Edinburgh University Library).