Mechanical Restrains -
and Seclusions -
in the treatment of the insane -
(with Appendix of Cases)

In olden days - in farther back than a
hundreds years ago - mechanical restraint for
lunatics was the rule, and not the exception.
And the only way in which to prevent a
lunatic from injuring others - injury to
himself being regarded, in those less
remote days, as purely his own affair,
and as no way concerning the community - was to chain him up,
is probably an idea of as great antiquity
as that which still holds in the Oriental
Empire, where a madman committing
a capital offence is executed just as
though he were sane; his insanity being
looked upon as an unfortunate accident,
which cannot be held sufficient to
exonerate him from the consequences
of his crime. To evidencing the
existence in very early times of this idea
of the need of close mechanical restraint,
we have the instance recorded in the
New Testament - [Mark \(\frac{5}{7}\) \(3 + 7\) \(\text{cire:} 4.3\)]
of the man of the country of the Galarene
who had his dwelling among the tombs, and
who "had been ofttimes bound with fetters and chains;" this was manifestly an insane man, for both popes, deacons speak of him (after the senses of the unclean spirits into the land of swine) as "sineq[us]
the feet of Jesus]
hungry and in his right "will." The popular traditions (and
invariably some foundation in fact) of
Bedlam always represent the madman as
bound with chains. Burton, in his "Anatomy
"of melancholy," pictures the madman chained
to a rock. In some asylums in this country
there are still preserved specimens of the
instruments of restraint which were formerly
used; such specimens, from the Manchester
Moor Asylum, were exhibited at the Annual
Meeting of the Ladies' Psychological Association
in 1853; from the President of which Association
for that reason the writer learned that when
the Lunatic Hospital in the city of York
was burned down many years ago, it was
commonly believed that the flames had
opportunistically destroyed contumacities and
appliances for the restraint of the inmates
which depended upon means of torture
that their existence would not have
been tolerated in these more humane and
enlightened times.
In our own day, when public opinion is so much more closely brought to bear upon questions affecting the welfare of all who cannot help or protect themselves, and when legislation provides for the protection, not only of the labouring classes, children, and the insane, but even of the lower animals, domesticated and wild, the tendency with regard to mechanical restraint has been to diminish it wherever possible. The Commissioners in Lunacy, in a memorandum addressed to the First Chancellor some eighteen months ago embodying their views on this subject (vide Fortt: Third Report of Commissioners in Lunacy 1889 p. 98) point out that the use of restraint (mechanical and otherwise) was discouraged by the statutes then in force relating to Lunacy — that the statutory provision requiring a record to be kept of all occasions and means of restraint had largely reduced the use of restraint — that the consensus of opinion in this country tends to the most sparing use of restraint, and only under proper restrictions and conditions, but that they could not condemn its employment in every case, as it does to a great extent to the interests of the insane themselves.
"there would always" they consider "be some cases where restraint was necessary." In the Report above referred to, they state (p.99) - "to the foregoing views we adhere, and we think that the statutory prohibition of the employment of mechanical restraint in all but surgical cases, as has been suggested, would be unavoidable." The views thus fully expressed by the Commissioners in Lunacy - whose duties as visitors fall in asylums, hospitals, and licensed houses for the accommodation of the insane give them opportunities for observation on this matter - such as and prepared by no one else - have been practically embodied in the Lunacy Act 1890 (39 & 40: Cap. 5) - where it is enacted (section 40) that "mechanical means of bodily restraint shall not be applied to any lunatic unless the restraint is necessary for purpose of surgical or medical treatment, or to prevent the lunatic from injuring himself or others, and in every case where such restraint is applied, a medical certificate must, as soon as it can be obtained, be signed, describing the mechanical means used, and stating the reasons upon which the certificate is founded.

... A full record of every case of...
restraint by mechanical means must be kept from day to day; and a copy of every
such record and certificate is to be sent
to the commissioners in January at the
out of every quarter. . . . In the application
of this section "mechanical means" shall
be such instruments and appliances as
the commissioners may, by regulations
to be made from time to time, determine.

That the care held by the commissioners
in January (Report 1897 p 98) as it there
always being cases where restraint
is necessary, is a sound one, must be
evident to any person who has visited one
or two of our large county asylums,
and seen all the restless and demented
cases. In the excitement of general
paralysis - where from the brittleness of
the bones, fracture of the limbs is not
very unusual - the only chance of
obtaining union is to enforce rest of the
limb by mechanical restraint. Some
demented patients will rub or beat
themselves until sores are produced on
the skin, or will pull out the hair of
the scalp, or the beard and whiskers.
Maniacal patients will scratch and
tear at the arms and breast (Clouston:
Clinical lectures on Insanity - instance of "hooking")
or pull out teeth and tear the gums away (Broadmoor Asylum - case of C. A., a maniacal general paralysis - No. 5 in Appendix) or gouge out their eyes (Broadmoor Asylum - case of W. Y., epilepsy-mania - No. 6 in Appendix) - indulgent will tear or bite their skin, and where the existence of corrosive ointments necessitates the application of dressings will tear off and eat the lint and diacrylon plaster (cases seen by the writer in the West Riding Asylum at Wakefield while Resident Clinical Assistant there) - and insane patients of all classes will practice self-abuse persistently (Broadmoor Asylum - E. P. - case 2 in Appendix.) In all these cases mechanical restraint would be beneficial, if carefully and judiciously applied. The mere destruction of clothing can always be used by providing stuff too strong to be torn by ordinary efforts - mechanical restraint should therefore be called into play to check this form of restlessness. As a preventive to efforts of self-destruction, mechanical restraint must always hold a place second to careful supervision, and to conclusion, and these means must also be the chief safeguards against injury to others. At the State Criminal Lunatic Asylum as
Broadmoor, where mechanical restraint has been unknown for the last twenty years (vide Broadmoor Reports - quoted supra), exclusion, with careful and constant supervision of individuals, are the only means employed for the prevention of injury of all kinds, to the lunatic's self or to others; but this asylum is better provided with attendants than any other public asylum in the kingdom (the proportion being about one attendant to every seven inmates) - the percentage of suicides and deaths is not high, such cases being transferred to county asylums whenever tranquil enough - general paralysis is not of frequent occurrence - and the mentally maniacal cases are more disposed to injure others (as might be inferred from the fact of their being drifted into a Criminal Lunatic Asylum) than to do any harm to themselves.

All these reasons combining render the employment of mechanical restraint less necessary than would otherwise be the case. But if it should be noted that the two cases of self-inflicted injury referred to above as having taken place at Broadmoor were both in seclusion and under careful supervision, while the
injuries were such as could have been prevented by mechanical restraint; here it would seem that seclusion and supervision failed where restraint, if applied as a precautionary measure, would have succeeded.

Broadly speaking, mechanical restraint is more suitable for the prevention of injury to the lunatic's self - while seclusion is more effective as a preventative of injury to others. It is manifestly simpler and more effective to remove the excited and threatening lunatic from the company of those whom he might injure than to fasten his arms and legs and leave him among them.

But so very much depends on the judicious selection of cases, and the careful application of means, that a hard and fast rule cannot be laid down. With ample seclusion accommodation and a large staff, as at Broadmoor, restraint is but very seldom required - the restless threatening patient is promptly removed to a room where he can neither hurt himself nor injure or annoy others. Where seclusion accommodation and staff are both limited, restraint will of necessity be much more often employed.
The question as to whether mechanical or manual restraint is preferable is briefly discussed upon by the Commissioners in the above-quoted Report (p. 98) - where they say that a mild form of mechanical restraint, such as gloves, slippers, or the like, are dress, has sometimes, we thought, preferable to, and less irritating than, manual restraint. Further, we expressed our disapproval of a resort to any form of mechanical restraint with a view to economy of attendants, or simply to prevent destruction of staff or bedding, and advocated frequent intermission of the restraint where employed. As the application of manual restraint implies a large staff of attendants, the view set forth in the last quoted paragraph points to the employment of a certain degree of manual restraint, and it is evident, with reference to the more turbulent and excited class of patients, as opposed to the merely restless and destructive, that a mild form of mechanical restraint is recommended. Manual restraint possesses the obvious advantages of being governed by (more or less) intelligence, adaptability, and instant application in removal - mechanical restraint is
manicurate, invariable, and must (in practice) be applied for a given time, nor can it be altered as will to suit a fresh phase of restlessness or a new direction of injurious effort. An important point of difference, moreover, is that in manual restraint the muscular and nervous strain bears heavily upon the attendant concerned—while in the case of mechanical restraint the patient alone suffers from any such strain. The long experience and high ability of Dr. David Hickey, Superintendent of the State Criminal Lunatic Asylum at Broadmoor, entitled his opinion as to the merits of the two forms of restraint to attention. He states in his annual Report for the year 1888 to the Council of Supervision of the Asylum (printed in Report to upon Broadmoor Criminal Lunatic Asylum for 1888—

"The legitimate or justifiable use of mechanical restraint is one thing; the authorized abuse of it is another. The sanction of modern times in this country is clearly against the use of mechanical restraint, and very properly so, in recollection of the extent to which it was carried in days gone by. The existing practice is, as a matter of fact, in
accordance with this sanction; and the
exceptions, where this form of restraint
is used for other than surgical reasons,
are sufficiently few to afford the best
depth of the rule. Besides sanction and
practice, an element of sentiment has
crept into the matter, which would fail
make use of mechanical restraint at all,
unless perhaps in surgical cases.
Mechanical restraint is practically
unknown at Broadmoor. It was, I
believe, used on a few occasions in the
early days, but for over twenty years
it has been found possible to do
without it. The comparatively numerous
staff of attendants at this asylum
endeavours to exceptional strength to be
brought to bear when occasion requires
it, but my own feeling in the matter
is that in a case of continuous and
long-sustained maniacal violence
with an activity amounting and
determinedly homicidal, it is possible
to carry the non-restraint principle
(so-called) far and as long as a
crew. Few people who have not been
engaged with are able to estimate
the devil and the devil's father and heart

which a struggle with a desperate lunatic of this sort means to the attendants, apart from the risk of positive injury, either to patient or warder. And when this struggle has not only to be anticipated, but be engaged in several times a day for a long term period, the justifiability and humanity of simple restrictive and safer mechanical restraints become apparent. If even it should be my lot to be a lunatic, such as the one whose treatment is here in question, I suppose my good friends the Superintendents who have in charge will not be too scrupulous about recent traditional usage, but will see that I am checked by the minimum and necessary amounts of mechanical restraint to ensure my own safety and that of others. On the one hand, I do not wish to think that under any circumstances I should be the means of inflicting injury upon my attendants. On the other hand, I would infinitely prefer mechanical restraint to the long-continued manipulations, however painful and friendly, of four or more attendants leaped together upon my prostrate form. I have thought it right to dwell some length on this subject, as public
"reference was made to Broadmoor practice in the correspondence that took place."
[on the question of the employment of mechanical restraint in asylums - 1888].
"I have no intention of breaking my long record by the introduction of mechanical restraint if I can possibly help it. If I should be compelled to have recourse to it in any case it will be because I regard it as the kindest, the most humane, and the least harmful mode of treatment under the particular circumstances. The evil is feared with regard to the employment of mechanical restraint is lest its legitimate use should lead to its authorised abuse. This could never happen if, in every case, the medical Superintendent himself were to order its use, and that only after careful and complete personal investigation.
When the restraint is applied by underling and its use afterwards sanctioned by the responsible officers, we have the authorised abuse which is altogether wrong and reprehensible." A brief comparison between such a case of continuous and long-standing maniacal influence, with an activity, aroused and determined, homicidal, as it were, has arisen, and a case of maniacal
or uncease restless - where the actions have none of the purposiveness and determination seen in the former instance, but are aimless and incoherent, and harmful only from their interference with the comfort or minor wellbeing of the patient or those around him - will serve to point to the desirability of judiciously restricted mechanical restraint for the violent patient, and careful manual restraint for the neurotically restless one. The writer has before him two illustrative examples, both of which came under his notice during his tenure of the post of Senior Assistant Medical Officer of the State Criminal Lunatic Asylum at Broadmoor. The first - (J.S.) - both as a patient and as a man in his prime, accustomed to hard labour as an iron-worker, and with a very frame most easily shaken and worn by repeated severe storms of mania - passed into a condition of acute mania while under the care of the writer - whose duty it was, during the six or eight months for which the attack lasted, to see that he was duly fed and kept warm. It was necessary,
...some two months to feed him by the stomach tube; to effect his removal from the single room (vulgarly - cell, omnibule) which he occupied to the table on which he was laid, and to ensure his retention thereon while the liquid food was passed into his stomach, the service of five or when possible, six picked attendants were requisite - one to manage each limb, one to secure his head, and one to hold the gag in position while the medical officer passed the tube down the oesophagus and administered the ultimatum. To seize securely so powerful and active a man, carry him out of his room, fighting and struggling, lay him on the table close at hand, hold him securely for the few or six minutes needed for the feeding, carry him back to his room, and release him from custody, and lock his door without allowing him an opportunity of injuring any of the attendants, and without inflicting any injury on him, was anything but an easy task. He was a skilful wrestler, and would now and again manage to take one of his younger attendants...
unaware while being brought in or out of his room, and would give him a "fall" in a manner which drew irresistible, if inopportune, comments from the senior attendants present, a Cumberland man. So determinedly fierce and hostile was he, that when taken into his room by three strong attendants, he would rush after them as they retired, after releasing him, and if one time it was found necessary for the attendants to blindfold him with a stocking, take him into his room, turn him round twice or thrice (if this was not done he would rush, blindfold, to the door, knowing its direction) and then hastily leave the room — by the time that he had torn off the stocking and looked round they had locked the door. This was undoubtedly a form of mechanical restraint — it was perfectly harmless, and saved many a dangerous struggle between attendant and patient. When such a struggle as has been briefly sketched above had to be gone through three times every day for five or six weeks, the waste of energy and nerve power to all concerned became serious,
and the question whether mechanical restraint would not be much less risky and much more humane pressed itself on the mind. The
most case was that of a young lunatic (J.G.B. - no. 1 in Appendix) who would indulge for hours in incoherent and aimless movements
of his body and limbs - progressing bodily by a series of little jumps, striking benches, walls, or railings with his hands,
or (striking) kicking them with his feet, buttoning and unbuttoning his clothes, and at times masturbating openly. He could always be checked by
a little precarious manual restraint - an attendant walking beside him, or sitting by his side, could control his movements sufficiently to prevent
his annoying others, or injuring them or himself; and it would have been unnecessary hardship to have
condemned him to wear gloves, sleeves, or a side arm dress for the
restraint of his movements.
Again, the moral aspect of the application of mechanical restraint is
not one to be neglected. The moral
element in the treatment of the insane
is a highly important one, and every aid should be given to the ill-balanced mind recovering from a maniacal or melancholic attack. It is said that the regaining of self-respect and self-reliance in the patient's own surroundings, and to the way in which they are treated by friends in authority over them, than is usually supposed; hence it arises that a patient who is emerging from the mental turmoil and confusion of an acute attack of mania may feel most keenly the implicit degradation of having been while acutely ill put into a strait jacket, or forced to wear strapped-down gloves or sleeves. Such patients frequently retain a vivid recollection of what occurred when their attack was at its height—(cases of H. S. - W. S. 1 in Appendix; and K. T. W. - B. F. 2 in Appendix)—and, likely, to add to the sense of pain, due to the knowledge that Reason has actually suffered on her throne, the feeling of humiliation inseparable from the recollection of having been (practically) bankrupted or strapped down, is an unhappiness to be avoided if at all possible. The usage of Broadmoor...
For over twenty years—the reports upon Broadmoor for the years 1886–96—has there been found possible to dispense with it. This has been accomplished by the maintenance of an abundant staff of attendants, and by their careful training in the matter of applying manual restraint—the staff being constantly kept before them that while manual restraint is to be applied when absolutely necessary, its application in no way excuses any injury to the patient to whom it is applied, and that the secret of safely applying manual restraint is to apply it when enough and in sufficient quantity to preclude any prolonged struggle or ineffectual use of force. Practically, the Broadmoor attendants are educated to freeze the need for manual restraint, to apply it, if needed, in good time, and to apply it thoroughly, so that the remedy is not used to deal with a maniacal outburst of violence as a. strong and wise Government would deal with a rebellion of the subjects in one of its provinces—and hence mechanical restraint is as seldom needed in
Broadmoor as the proclamation martial law would be in the realm of such a government. For the careful enunciation and steady application of these principles, as for many other wise and humane regulations, the Regius's indebted manum is to the last Superintendent, Sir William Orange, C.B.

A rabbit, if secured, though tenderly strapped down and left for some hours, dies (Professor W. Rutherford - lectures on Physiology.) The effect of long continued mechanical restraint, though not likely the fatal, cannot but be injurious, both morally and physically, to an insane patient - a point manifest no doubt to the minds of the Commissioners in Lunacy when they recommended frequent intermission of mechanical restraint where employed (vide Commissioners' Report year 1889 - p. 99.) and the forming the Register of Mechanical Restrains: prescribed by the Commissioners under the provisions of the Lunacy Act 1890, where not only the means of restraint employed, and the duration thereof in hours must be stated, points to the contemplated temporary nature of such treatment, as well as to its very cautious application.
The necessity for providing mechanical restraint for purposes of surgical or medical treatment in many cases is self-evident, and needs no discussion. Simultaneous combination of medical treatment and mechanical restraint is in vogue at Bethlehem Hospital. The patient is placed in a warm bath, provided with a cover which is locked down, so that only the head of the patient is outside of the bath casing, and in this position the patient is kept for four or five hours. This treatment is said to be an effective sedative in some cases of acute mania!

It would appear then, that—

I.- Mechanical Restraint is not only permissible, but very advisable in some (a minority of) cases.

II.- Such cases will be for the most part those of acute excitement—setting apart cases where surgical considerations enter.

III.- The Mechanical Restraint should be applied as openly, as possible, and only under skilled supervision—never by substitutes under standing orders—never for the sake of economy—always, because of its endless restlessness or destructiveness—never without frequent interruption.

IV.- Mechanical Restraint is more applicable—better—paribus to the prevention of self-injury than to the prevention of injury to others.
Seclusion.

The old idea— that inmates were only fit to be kept together and kept from the ears of the community no longer obtains, happily for the insane; and though they might formerly be largely thrown into association in the institutions where they are under treatment, still the advantages, not to say the necessity, of separating many cases from among the crowd is now on all sides admitted. This is, indeed, a natural and necessary consequence of the classification of the insane as in treatment— one of the first steps in which direction it is to remove from amongst the greater majority of the inmates from asylums those who are restless, noisy, destructive, dirty, dangerous, or unreliable as to violent conduct.

And upon the care with which this is carried out will depend to a large extent the degree of discipline maintained among the inmates.

The more manicured and dangerous patients having been sifted out, a proportion of them may with safety be accommodated in association, given work and constant supervision. But those will remain a residuum, who cannot be treated in company—
and fortune. Declination is requisite. The week in our parlour, denotes Delirium tremens during its waking hours. Oftentimes a patient is suffering from acute mania, with all its restless excitement and noise, from melancholia with its deep depression, excessive irritation, and consequent fear, and dislike of company, from strong fixed delusions, accompanied by hallucinations of sight and hearing (one of the most dangerous forms of madness) — Declination is always the safest, usually the most humane, and often the only rational treatment.

Broadmoor Asylum — conspicuous for its lack of the application of mechanical restraint — is the asylum where the method of declination is most largely enforced. Here, indeed, declination has been reduced to a system, and is very carefully through largely applied. Nothing of the methods as in use at Broadmoor, will therefore be a guide to a thorough understanding of the merits of the system.

The enforcement of declination at Broadmoor Asylum is entirely in the hands of the Superintendents and Medical Staff. The Principal Attendants in charge of each block of buildings, has it in mind, discretionary,
power to place any patient in exclusion if an emergency arise, but he must at once report the act to the medical officer on duty, and shew to the responsibility of the exclusion when reported. As a matter of experience, it is seldom or never found that this power is almost exclusively the Principal Attendant, who more often than not the Medical Officer that exclusion appears necessary, than enforce it and then report the enforcement. Each Medical Officer, on visiting the portion of the Asylum under his charge, first before they return for the day, the names of all patients in exclusion, the duration, and the cause of the exclusion. which return he ratifies with his signature. Once a week these returns are laid before the Superintendent, instead of before the Junior Officers — and a daily abstract is forwarded to him. Returns of exclusion are also made daily to the Central Office, where the Medical Officers fill up the cause of the exclusion. This every case of exclusion comes twice daily under the notice of the Medical Officer in charge. The cases of exclusion are divided into three classes — voluntary exclusion — exclusion for medical causes — and exclusion for safety.
Voluntary seclusion accounts for a large proportion of the total amount. Many of the inmates avail themselves of the rule that a patient may occupy his room for the part of the day. provided the door be locked, and the freedom from intrusion so guaranteed is much appreciated by some. Under seclusion for medical causes come all the cases of bodily illness in single rooms, and all cases of mania, melancholia, and general paralysis, which are of short duration, and destructive to association. Seclusion for safety includes all patients deemed to be likely to do any injury to others — naturally. In a somewhat large proportion of criminal asylums — for safe custody cases occurring of serious cases among the criminal class who swell the Broadmoor population. Where a patient can only be held to be in safe custody if impractically, better under lock and key.

A typical case of this class is that of J. S. — No. 1 in Appendix — briefly described above, line 14. This class is the only one where seclusion is imposed against his will on a patient who is not suffering from illness and under medical treatment.
and taking into consideration the lawless and turbulent character of a large proportion of the inmates, the number in this class has not of recent years been large. In unmonths ending on 24th June 1886, there had been 26 in this class, only one male and six females, and an average number resident of four males and one hundred and forty-five females - or one in forty men, and one in twenty-four women. The apparently large amount of seclusion among the female patients diminishes very greatly when it is stated that the two men were secluded in 1223 instances, and for a total duration of 93,441 hours, while the six women were secluded only in 20 instances and for 92 hours - (Broadmoor Reports - 1884-5). It is thus very evident that the male cases requiring seclusion during the period referred to were cases of long continued excitement, restlessness, and destructiveness, or cases well known to be of dangerous brothers that continued seclusion was an essential safeguard - while the female cases were transient outbreaks of excitement or violent tendencies - speedily subsiding to such degree as only to require close
supervision and occasional manual restraint in place of seclusion. It may appear that this seclusion for safety, being entirely at the discretion of the medical staff, is liable to abuse and that a noisy troublesome, but harmless, patient may be locked up to save the medical officer trouble. But experience shows that the safeguards provided are sufficient — these consist in the Superintendent’s supervision, and the fact that all seclusion must be recorded and reported upon, and also in the right of unrestricted complaint to the Home Secretary possessed by all the inmates of Broadmoor. As a matter of fact, complaints of unjust compulsory seclusion have been unknown there for the last five years and all events.

The rooms in which patients are secluded at Broadmoor deserve a word of mention. Padded rooms are unknown there — but almost every block there is a number of strong rooms, with asphalted floor, cemented walls, iron covered doors and window shutters. The latter glazed with half-inch glass strongly set in the wooden frames, and practically unbreakable; these rooms have no
Inspection from behind on the interior surface, and all angles are rounded off— they are lighted by gas in the corridor outside, shining through a small window high up in the wall, and are furnished with an inspection window about three feet long by two inches wide, through which the inmates can be seen even when the room is in total darkness, by the light of a hand lamp being thrown in at the lower part of the window, while the eye is applied to the upper part. The writer has carefully questioned a patient—wt. no. 1 in Appendix—in his saner moments, who was subject to severe and recurrent maniacal attacks, of the details of which he afterwards retained a very good recollection, and during which he would rush and dance wildly and furiously round and round his single room for hours at a time, as to whether he ever hurt himself in any way on the walls of the room, and has been told by him that he never did injure himself and did not think it was possible to do so accidentally, or hurt himself intentionally against the walls, an action by no means to dwell indulged in as is sometimes supposed.
If, then, as stated above p. 23, line 12, seclusion be the safest, the most humane, and often the only rational treatment, why is it not more frequently and extensively carried out in public and private asylums?

In private asylums, seclusion can only be resorted to in the most extreme cases, and instead is usually anticipated by the use of restraint, manual or mechanical, which savours less, on the whole, of oppression and injustice than the locking up in a room, possibly darkened by shutters, lest the window be frequented by the prisoner. That the discipline of private asylums, and, inevitably, the comfort and welfare of the inmates, may occasionally suffer from the non-application of seclusion is probable. A patient - Dr. M. - No. 4 in Appendix - a member of the Indian Civil Service, subject to very frequent and severe attacks of recurrent mania, was sent back to Brookwood (where he had been for a few months in 1880) in 1885 from a private asylum - in which establishment it was found impossible to keep him, from his violent, noisy, and restless actions during his acute attacks.
Such restraint, almost entirely manual as was applied, was used as very great risk of injury to him and to the attendant, as he was a strong man. In Broadmoor, where he was under the writer's immediate charge for four years, he was invariably placed in seclusion as soon as an acute attack developed (he once had twelve in twelve months) and was only visited and the ever-committed was to kick on the leg, a way more terrible than savage, an attendant who was holding him. In seclusion he was most happy, restless, and utterly restlessly, in act as well as in speech, but the ever-injured injured himself, nor hurt any one, from absence of opportunity and of the exciting influence of association.

In public asylum the number of single rooms is as a rule barely sufficient for the due accommodation at night of the patients who need such separate lodgment - and there are none to spare for seclusion during the daytime; for it must be remembered that the single seclusion rooms must be well ventilated and kept empty for some
hours in the evening, to be fit for night's occupation. Moreover, the enforcement of seclusion requires a larger and better trained staff than most county conditions can afford to employ—otherwise the frequent shifting of patients from room to room, and the carrying off of a delicate case now and then to seclusion, is exceedingly apt to cause struggles and injuries to the patients. Then in public and private opinions—as distinguished from Criminal lunatic asylums—the liberty of the subject still remains a somewhat indefinite quantity, and therefore not to be encroached upon without excessive caution. While in the Criminal Lunatic Asylum the inmates have all forfeited their liberty, primarily through breach of the law, secondarily through the influence of insanity, and hold a much more clearly defined position in regard to the nature and extent of their personal liberty. In short, the support which the Medical Staff at Broadmoor obtains from official authority is such as to enable them to maintain a higher standard of discipline.
than is possible in county or private asylum—albeit that the authorisation of such discipline is fully justified when the dangerous characters of a considerable proportion of the inmates is borne in mind.

The administrative tendency at Broadmoor is to towards seclusion of sections of the community, as well as of individuals. The inmates of each block, and in some instances among the more dangerous classes, those of each ward, are not permitted to mix with those of another block or another ward at meals, exercise, or examination. This close adherence to the integrity of the administrative unit lightens the labours of supervision, and removes a fruitful source of quarrels, ill-feeling, and plots to escape. Just as the individual who is secluded in his own room is much more easily controllable than if he were in association with twenty others in a ward, or the wards or the block is much more manageable by itself than if free intercourse with other parts of the asylum were permitted.

Isolation, then, may be regarded

as——
I. Necessary at times, and in a small proportion of cases, where mechanical restraint would be insufficient or unsuitable.

II. Beneficial not only to the other patients, but also to the subject himself, as securing to him freedom from noise, bustle and interference.

III. Like mechanical restraint, rarer to be applied save by the direction of competent authority — and never as a standing means of treatment, but only for so long as the patient's state may call for it — only to be used where the resistance, novice, or violence (attempted or threatened) of the patient demand it.

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1890.
Appendix -
Cases referred to -

1. J. D. F. - Reg. No. 93 - Offence - Wounding with intent to murder (his wife) - Recurrent Mania - admitted to Broadmoor 15 April 1864 - died 4 Sept. 1865, from pneumonia and congestion of lungs. When the maniacal attacks occurred he was restless, incoherent, declamatory, dirty in habits, obscene and abusive in language - would spend hours in walking or running round and round his cell, shouting and yelling all the time. In his lucid intervals he retained a clear recollection of what had occurred during the period of犯ment.


on admission, when he was in a reduced state of health and was to receive careful treatment in the beginning of the case and to be restored on him than he had ever after a most lively recollection.

J.S. - Reg: No. 1154 - Offence - unlawfully wounding - Acute Mania - Admitted to Broadmoor 16 April 1883. Very violent and threatening in language and demeanour - frequently said he would kill some of the attendant if he could, and certainly failed through no means of force. Would fight, kick, struggle and bite when restrained. He saw delusion of safely over eighteen months at Broadmoor.

E.R. - Reg: No. 1253 - Offence - Attempting to set fire to farm building - General Paralysis - Admitted to Broadmoor 18 July 1883 - died 28 Oct. 1888, from General Paralysis. During amanual attack he pulled out several of his teeth and tore away the skin from above with his fingernails.


On 1st August, 1889, forged under his eye, with his fingers and thumb, stating when questioned that "they had been on his face trying to get at his eye, when he stopped them."

J.J. M. - Reg: No. 12440 - Offence: Murder.
Reconvicted: Attest at Broadmoor in Feb., 1885. Recurrent attacks very frequent, very severe, and at first very sudden in, bolted and recovery - the patient, from fairly rational condition, becoming acutely maniacal within two days, and recovering his rational state after about ten days, as quickly. Laterly, however, the attacks were longer, less acute, and not so (quickly) completely recovered from.
Thesis for
Graduation as M.D.
B. E. Patterson - M.B., Chir.
1890