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Old and mad in Victorian Oxford: a study of patients aged 60 and over admitted to the Warneford and Littlemore Asylums in the nineteenth century

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This is a historical case note analysis of older patients admitted to the Warneford and Littlemore Asylums in nineteenth-century Oxford. Of 1044 admissions to the Warneford, 93 patients were aged over 60 (8.9%). At Littlemore, 998 of a total of 5464 admissions were aged over 60 (18.3%). High levels of psychopathology were found, as in other studies examining patients of all ages, and were similar for the two institutions. The largest difference was in the death rate, which was much higher for Littlemore Asylum. This resulted from the preponderance of patients with organic diagnoses who were admitted to Littlemore, many of whom died shortly afterwards.

Keywords: *diagnosis; history; hospitals; medicine; mental disorders; old age; psychiatry; 19th century*

Introduction

There is now an extensive literature on the history of nineteenth-century asylums. Jones (1955) viewed the process as one of gradual reform and improvement, and Foucault (1967) as a means of social control and repression. Scull (1979, 1993) argued that ambitious but undervalued mad-

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doctors rebranded social deviance into mental illness in order to justify the creation of asylums, which they could then control. Smith (1999) viewed asylums as existing in a complex network of care providers for the insane, and Bartlett (1999) thought that county asylums were firmly rooted within the administrative framework of poor law provision. It has been suggested that asylums were 'dumping grounds for the awkward and inconvenient', yet a number of detailed case note analyses from individual institutions have shown that patients had high levels of serious psychopathology (Beveridge 1995; Doody, Beveridge and Johnstone, 1996; Turner 1992). In these studies, patients of all ages were considered together. Wilkins (1993) examined delusions in children and teenagers admitted to the Bethlem Royal Hospital in the nineteenth century, but there have been no studies of elderly patients.

The history of old age psychiatry is a neglected area (Berrios, 1994). The recognition that older people with mental health problems have social and care needs different from their younger counterparts led to the development in the UK of the subspecialty of psychogeriatrics and the setting up of parallel age appropriate clinical services in the 1970s (Arie, 1989). The purpose of the present study was to examine in detail the sociodemographic and clinical characteristics of patients aged 60 years and over admitted to two Oxford asylums in the nineteenth century. The findings from the two institutions are compared with each other and with those from other studies of Victorian asylums in order to shed light on an important subgroup of the nineteenth-century insane.

Historical background

Oxfordshire in the nineteenth century was an essentially agricultural county. The beginning of the century was a time of financial hardship for the poor; the decline of the weaving trade and increase in enclosures meant that the poor-rate trebled between 1769 and 1809 (Page, 1907). Wages were low, and food prices rose faster than wages; the population increased by 60% over the century to 181,149 in 1901 (Page, 1907). The city of Oxford developed in the latter half of the century into an industrial centre but the 'rural villages slept on, undisturbed in their peaceful seclusion' (Page, 1907). Oxford was seen as having a particular problem with vagrants and beggars, partly as a result of the wealth brought to the city by the University, and partly because of the seasonal nature of local employment which was influenced by University terms and vacations (Crossley, 1979). A workhouse for 200 paupers was built in the city in 1772, and wards for the aged and infirm were provided in the 1790s. Headington Union workhouse for 22 rural and three city parishes opened in 1838, and a hostel was opened in the city by the Anti-Mendicity Society in 1844, which gave relief to 8500 vagrants (Crossley, 1979). The Radcliffe Infirmary was opened by public subscription

in 1771, admission and free treatment of physical ailments being available to those recommended by subscribers or the hospital governors (Parfit, 1987).

Warneford

The origins of the Warneford Hospital date back to 1812 when the governors of the Radcliffe infirmary established a 'committee for the purposes of procuring information on the practicality of erecting a lunatic asylum in the vicinity of Oxford' (Parry-Jones, 1976). Money for the project was raised largely by voluntary charitable subscription, most notably from the Reverend Samuel Warneford whose name later became attached to the asylum. The University provided approximately one-third. The 1808 County Asylums Act permitted county magistrates to develop joint pauper/private asylums, but when the Radcliffe governors approached them in 1813 with this in mind, the magistrates declined and caused much offence into the bargain. Initial plans to build the asylum in the city centre adjacent to the Radcliffe Infirmary were soon abandoned in favour of a green-field site. In 1819 land was purchased in Headington, then a village some 2–3 miles east of Oxford. The foundation stone was laid in 1821 and work was completed in 1826 at a cost of £8246. The philosophy of the institution was to provide '... a temporary retreat to the insane of every condition according to an arrangement by which persons of property would be boarded at a reasonable rate and the poor be maintained almost gratuitously' (Parry-Jones, 1976). A distinction between the deserving poor and pauper cases was made in determining eligibility for admission. The first patients were admitted in July 1826 and paid fees varying from 12 shillings to 2 guineas per week. A 'Fund in Aid of Poor Patients' was established at the instigation of Samuel Warneford in 1828 whereby deserving cases could be admitted or the payments of existing patients supplemented when their means became insufficient. Donations, and the surplus from the payments of wealthier patients, were invested in Government securities and the income utilized for the Fund. In 1840, 20 patients were assisted by the Fund, at rates varying from 3 shillings a week for 3 weeks, to 10 shillings a week for a year, the grants totalling £185 6s 6d (Bowes, 2000). Dr Frederick Wintle served as Resident Apothecary and later Physician Superintendent from 1828 to 1853 in the formative years of the institution. After his death, he was described as:

an officer devoted to every branch of his duty, combining the greatest benevolence with vigilance and firmness, an attention to the minutest details of pecuniary business with the most careful supervision of whatever related to medical dispensation, domestic economy and religious duty (Warneford Hospital Annual Report, 1854).

Thomas Allen – who had impressed the Reverend Vaughan Thomas by his devotion to duty in the Oxford cholera epidemics of 1832 and 1849 – succeeded him. He in turn was followed by Dr John Bywater Ward in 1872

and Dr James Neil in 1897. In 1832 a high boundary wall was built to keep out the prying public, and in 1852 the wings were extended by a further 10 rooms on both sides. There was complete separation of the sexes, and the different classes of patients were also kept largely apart. Patients rose at 5 a.m. and spent the day engaged in a range of activities, sports, outings or work. The hospital fought hard to keep its independence and lobbied (unsuccessfully) against the mandatory inspection of charitable asylums in the 1840s (Bowes, 2000). Patient numbers continued to rise, and John Conolly was invited to visit in 1857 to make recommendations for extending the hospital (Conolly, 1857). Further extensions and purchases of land increased the bed capacity to 100 and the grounds to 126 acres by the end of the century (Parry-Jones, 1976).

Littlemore

Until the opening of the County Pauper Lunatic Asylum at Littlemore in 1846, pauper lunatics were confined in workhouses, houses of correction, private licensed madhouses or their own homes (Parry-Jones, 1972). Joseph Henley, local magistrate and later Tory MP, proposed the founding of a county asylum for paupers in 1840, several years before the 1845 Lunacy Act required each county to do so. The fact that his proposals received support suggests a major shift in opinion, as it came only 27 years after the magistrates had so vociferously rejected proposals for an asylum by the governors of the Radcliffe Infirmary. A Committee of Justices was set up, initially to 'inquire into the state of the pauper lunatics of the county' and later to plan the building of the asylum. Initial plans were drawn up for a 120-bed institution, and thirteen acres of land were purchased in 1843 (Bowes, 2000). Even before construction work had finished, however, it had to be extended by adding a second storey. The first physician superintendent, William Ley who had studied under John Conolly at Hanwell Asylum, was appointed and oversaw the final months of construction. The asylum opened in July 1846, and large numbers of patients were immediately transferred from the private licensed houses in Hook Norton and Witney. The hospital was enlarged in 1847 and 1852, and the average number of patients gradually increased from 200 in 1848 to 543 in 1900 (Lobel, 1957). A small number of paying middle-class patients was admitted to the asylum. The governors of the Warneford complained in annual reports and pamphlets that the county asylum was throwing open its doors to private patients and was highly critical of the 'adoption of the practice in Scotland of receiving superior patients of all sorts into public institutions' (Warneford Hospital Annual Report, 1853). In retaliation, William Ley (1856) accused the Committee of Management of the Warneford Asylum of misappropriation and inefficient use of its bequests in a 14-page pamphlet. The Rev. Vaughan Thomas replied in print the following year, defending his conduct in a 'Letter to the Magistrates of the County of Oxford' (Parry-Jones, 1976). The

resonance of this vitriolic rivalry between the hospitals continued through to the 1990s, if attenuated somewhat by twentieth-century sensibilities. William Ley was treasurer of the Association of Medical Officers of Asylums and Hospitals for the Insane (Renvoize, 1991) and continued as physician superintendent over the many years of expansion at Littlemore (Anon., 1869). He was succeeded in 1869 by his long-time assistant, Richard Sankey, who served with a single Assistant Medical Officer to the end of the century. From the time of its opening, Littlemore served an ever-changing population, as the neighbouring counties of Berkshire and Buckinghamshire and various boroughs contracted in and out of agreements with the hospital. At times, patients were boarded out in Worcester, Buckinghamshire or London (Bowes, 2000). Cost-saving reductions were rigorously applied, and the weekly maintenance charge fell continuously between 1848 and 1853 from 11s to 7s 6d (Scull, 1993), though it was still considered cheaper to keep 'harmless' lunatics in workhouses for as long as possible.

Method

The period studied for the Warneford Asylum was from its opening in 1826 to the end of 1899. For Littlemore Asylum the admission registers are missing after 31 December 1890, so the period of study was from the asylum's opening in 1846 until the end of 1890. The admission registers were used to ascertain the total number of admissions (of all ages) and the total number of admissions aged 60 and over during the study period. The study sample comprised every patient aged 60 and over at the Warneford and every fourth patient aged 60 and over at Littlemore. Basic demographic and clinical details were collected from the admissions registers, and further clinical information, details about psychopathology, cause of death, etc., from reception papers, case books, patients' letters and post-mortem books. A 52-item checklist was used to record details for each patient. Background information about the asylums was obtained from annual reports and other contemporary records.

Modern clinical diagnoses were made using ICD-10 psychiatric diagnoses (World Health Organisation, 1992). In cases where there was doubt about the modern diagnosis, the authors discussed the case and reached a consensus. The reliability of these diagnoses was checked by asking five consultant old-age psychiatrists independently to assign modern diagnoses to five case vignettes.

Statistical analysis

Data on the annual number of admissions and from the 52-item checklist were analysed using the Statistical Package for the Social Sciences Version 9.0 (SPSS Inc., 1999). Medians, rather than means, were used to describe age and length of stay as the data were skewed, with a small number of very elderly patients

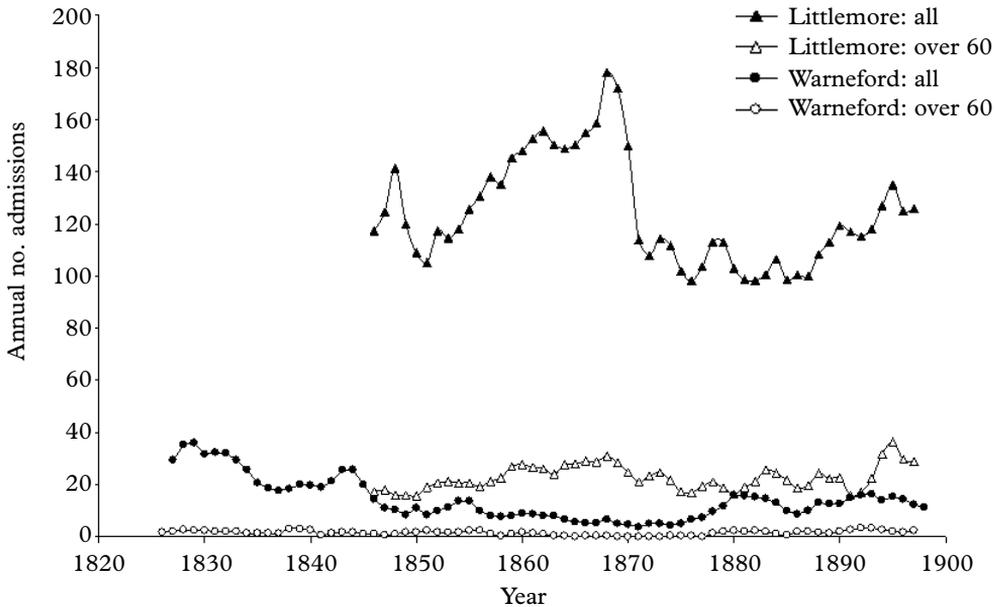


FIG 1. Admissions to Warneford and Littlemore Asylums (3-year rolling averages)

and a few very long admissions. The chi-square test (χ^2), with Yates correction and Fisher exact tests were used to compare findings for male and female patients, patients from the two asylums and different diagnostic groups. The Mann-Whitney U test was used to compare age, duration of illness and length of admission of Warneford and Littlemore patients. Chi-square for trends was used to examine trends, where these were approximately linear.

Results

Number of patients admitted during the study period

Between 1826 and 1900 a total of 1044 patients were admitted to the Warneford, 93 of whom were aged 60 years and over (8.9%). The mean age of all patients on first admission was 39.8 years (range 12–95). Between 1846 and 1890 the Littlemore admission registers recorded a total of 5571 admissions. The patient's age was recorded in 5464 of these, of which 998 (18.3%) were aged 60 years and over. The study sample comprised 250 patients. Figure 1 shows the annual number of admissions to both asylums expressed as 3-year rolling averages, as yearly admission numbers showed significant fluctuation (data for numbers of Littlemore admissions between 1891 and 1899 were obtained from the asylum's annual reports). The number of admissions to

Littlemore rose progressively until 1870 when the Moulsoford Asylum for Berkshire patients was opened. The proportion of elderly admissions remained fairly constant between 1846 and 1899 (χ^2 for trends showed no significant increase in the proportion of elderly Littlemore admissions during this period).

By comparison with the Littlemore, the total numbers of admissions and the numbers and proportion of elderly admissions to the Warneford were much smaller. The total number of admissions to the Warneford fell following the opening of the Littlemore Asylum in 1846. There was no increase in the proportion of elderly admissions to the Warneford during the study period.

All the following information relates only to those patients aged 60 years and over.

Sociodemographic details (see Table 1)

Gender and age Of the Warneford patients, 53 (57.0%) were male and 40 (43.0%) female. Of the 250 Littlemore patients in the study sample, 114 (45.6%) were male and 136 (54.4%) female. The median age at first admission was very similar for both asylums: Warneford males, 65 years (range 60–81), Littlemore males, 68 years (60–86); Warneford females, 64 years (60–95), Littlemore females, 66 years (60–83).

Domicile The Warneford patients came mostly from Oxfordshire (57.0%) and the surrounding counties and London (34.4%). Few patients from the colonies or abroad were attracted, only a single elderly man from the Virgin Islands falling into this category. Over the whole study period the majority of Littlemore's patients (70.4%) were Oxfordshire residents. Berkshire residents were admitted to the Littlemore Asylum from 1846 until the opening of the Moulsoford Asylum (in Berkshire) in 1870 and comprised 39% of older admissions during this period. After 1871 the proportion of older Berkshire residents admitted to the Littlemore Asylum fell to 15%. The Littlemore admission register records a single admission of an older patient from outside these counties (London).

Occupation An occupational history was not as consistently recorded for the over-60 age group as for younger patients. The majority of Warneford male patients were from the professional, farming and trading classes. No labourers or unskilled workers were admitted. Occupations included a professor of music, a curator of botanical gardens and a billiard hall proprietor. Five elderly clergymen were admitted, several 'gentlemen' and four 'college servants'. One patient was described as 'Lord Churchill's shepherd'. Of the Warneford male patients for whom an occupation is recorded, 11.3% were described as retired. Female occupations were poorly recorded at the Warneford and generally described in terms such as 'farmer's wife', 'tailor's wife', 'farmer's daughter', etc. In 12.5% the woman's own occupation was recorded as, for example, college servant, nurse and artist. Three Warneford women were described as 'receiving an annuity'.

TABLE 1. *Sociodemographic characteristics of Warneford and Littlemore Asylum admissions (percentages are given in brackets)*

	Warneford patients		Littlemore patients	
	Males (N = 53)	Females (N = 40)	Males (N = 114)	Females (N = 136)
Age on admission (years):				
median	65	64	68	66
range	60–81	60–95	60–86	60–83
Age band (years):				
60–69	41 (77.4)	31 (77.5)	66 (57.9)	91 (66.9)
70–79	11 (20.8)	7 (17.5)	40 (35.1)	41 (30.1)
80+	1 (1.8)	2 (5.0)	8 (7.0)	4 (2.9)
Marital status:				
single	10 (18.9)	12 (30.0)	13 (11.4)	20 (14.7)
married	25 (47.2)	8 (20.0)	62 (54.4)	61 (44.9)
widowed	18 (34.0)	20 (50.0)	39 (34.2)	54 (39.7)
not known	–	–	–	1 (0.7)
Domicile:				
Oxfordshire	32 (60.4)	21 (52.5)	80 (70.2)	96 (70.6)
Berkshire	4 (7.5)	6 (15.0)	32 (28.1)	38 (27.9)
elsewhere	12 (22.6)	11 (27.5)	–	1 (0.7)
not known	5 (9.4)	2 (5.0)	2 (1.7)	1 (0.7)
Occupation:				
professional	11	1	2	–
farming	5	–	27	3
trades/craftsman	13	1	39	25
labourer/unskilled	–	–	39	17
wife of professional	–	6	–	1
wife of farmer	–	3	–	9
wife of trade/craftsman	–	7	–	12
wife of labourer	–	–	–	16
domestic servant or nurse	4	2	–	13
retired	6	1	3	–
housewife	–	–	–	8
pauper	–	–	1	4
no occupation	–	3	–	18
not known	14	16	3	10

TABLE 2. *Details of index admission to Warneford and Littlemore Asylums: numbers and (in brackets) percentages*

	Warneford patients		Littlemore patients	
	Males (N = 53)	Females (N = 40)	Males (N = 114)	Females (N = 136)
History of admissions to other asylums	14 (26.4)	11 (27.5)	15 (13.2)	25 (18.4)
History of previous admission to any asylum (includes previous admissions to index asylum)	14 (26.4)	11 (27.5)	29(25.4)	50 (36.8)
Direct transfer from another asylum	3 (5.7)	2 (5.0)	11 (9.6)	14 (10.3)
Outcome of admission:				
discharged recovered	11 (20.8)	12 (30.0)	24(21.1)	26 (19.1)
discharged relieved	13 (24.5)	5 (12.5)	6 (5.3)	7 (5.1)
discharged not improved	8 (15.1)	3 (7.5)	5 (4.4)	8 (5.9)
discharged – state unknown	–	–	1 (0.9)	–
dead	16 (30.2)	17 (42.5)	78(68.4)	92 (67.6)
outcome not known	5 (9.4)	3 (7.5)	–	3 (2.2)
Duration of admission in months:				
median	6	8.3	6	12
range	1–204	0.5–280	0.5–181	0.2–184
Patients readmitted	8 (15.1)	3 (7.5)	8 (7.0)	8 (5.9)

At Littlemore, occupation was recorded for most (94.8%) admissions. For men, the largest occupational groups were trades and crafts (34.2%) and labourers (34.2%), followed by farmers and agricultural workers (23.7%). Only two male patients were of professional occupation, a rector and a librarian. For females the largest occupational group was trades and crafts (18.4%), and 9.5% were domestic servants or nurses. In 27.9% of cases, female patients were recorded as being the wife of a man with an occupation. No females were from the professional class but one was described as the wife of a professional, a librarian. No males were recorded as being of no occupation, although 13.2% of females were. Three patients, all males, were described as retired. Only four patients were recorded as being paupers. One patient was described as 'a tramp of the gypsy tribe'.

Admission details (see Table 2)

Previous admissions At the Warneford 26.9% of patients were recorded as having had admissions to other asylums. Direct transfers from other

institutions accounted for 5.4% of admissions. The variety and geographical spread of the institutions to which patients had been admitted was greater for the Warneford patients. A single patient transferred from the Warneford's rival Oxford Asylum occasioned a rare mistake in the spelling of 'Littlemoor'.

Of the Littlemore patients, 31.6% had had previous admissions, approximately half to Littlemore itself and half to other asylums. Direct transfers from other asylums accounted for 10.0% of admissions.

Length of admission The median length of first admission was 6 months for Warneford males, and 8.3 months for Warneford females. This time sometimes included periods of leave with family and friends. The median length of first admission to Littlemore Asylum for male patients was 6 months and for females 12 months. There was no significant difference in the duration of first admissions between the two asylums or between the genders. Of the Warneford patients, 6.5% died within three months of admission, while the corresponding figure for Littlemore patients was much higher at 20.0%. For those patients who died in the asylum, the median duration of admission was much longer for Warneford than for Littlemore patients (43.5 months vs. 12.0 months; Mann-Whitney $Z = -2.97$, $p < 0.005$).

Re-admissions Second or subsequent admission to the Warneford were recorded for 15.1% of male patients and 7.5% of females. The median time to re-admission was 8 months for both sexes and the median length of admission was 12 months (range 2.5–96). Only 7.0% of males and 5.9% of females had subsequent admissions to Littlemore Asylum. The median time to re-admission was 9 months (1–91). The median length of the second or subsequent admission was 9 months (0.5–158). There was no significant difference in the re-admission rate between the two asylums.

Clinical features

Previous attacks of insanity This was explicitly stated in 55.9% of the Warneford patients. Of these 40.4% had no previous attacks, 46.1% had between 1 and 3 previous attacks and 13.5% had more than three. The greatest number recorded was 11 previous attacks. Vague terminology such as 'not first attack' was common. For the Littlemore patients, whether or not they had had previous attacks of insanity was recorded for 84.0%. Of these, 62.4% had not been ill before, 13.8% had had between 1 and 3 attacks and 0.5% more than three. A substantial number of patients (23.3%) were described as having had several previous attacks but the exact number was not specified. The median age at first attack was 63.5 years (range 23–86).

Duration of illness prior to admission This was recorded for 64.5% of the Warneford patients. Of these, the duration was less than one month in 18.3%, 1–12 months in a further 40.0% and more than 12 months in 41.7%. The longest duration of illness prior to admission was 40 years and the

shortest a single day. Unclear statements such as 'ill for two weeks though coming on for 4–5 years', or 'first insane 35 years ago, ill for one year' were common. Duration of illness was recorded for 89.6% of Littlemore patients. Of these, the duration was less than a month in 37.9%, 1–12 months in 46.9% and more than 12 months in 15.2%. Duration of illness prior to admission was significantly longer for Warneford than for Littlemore patients (Mann-Whitney $Z = -7.22$, $p < 0.0001$).

Perceptual abnormalities Clear descriptions of perceptual abnormalities occurred in 11.3% of the Warneford male patients and 17.5% of the Littlemore males, and in 25.0% of the Warneford female patients and 14.0% of the Littlemore females. Auditory hallucinations (of noises or voices) were the commonest, occurring in 14.0% of the Warneford patients and 10.4% of the Littlemore patients. They included the sounds of pumps working or the voices of wives, torturers and people outside the window. A female patient heard 'friends calling her downstairs to lie with them'. Visual hallucinations occurred in 8.6% of the Warneford patients (6 cases), for example, 'sees regiments of soldiers and boys which walk about the ward'. Three cases of olfactory hallucinations were described at the Warneford. Visual and olfactory hallucinations were uncommon in the Littlemore patients (5.6% and 0.8%, respectively).

Delusions Thirty (75.0%) of the Warneford female patients had clear descriptions of delusions and 24 (45.3%) of the males. There was great variety in the content of the delusions, but the commonest themes were: persecution (22 cases); grandeur (9), for example, 'fancies himself heir to many persons'; poverty (8); guilt (7); religion (5); and unworthiness (2), for example, 'afraid she will hurt other people and be helpless of pardon'. Nihilistic delusions were present in 4 cases, including a woman who 'believed she died and was buried yesterday'. Delusions of misidentification were recognizable in 4 cases. Depressive delusions included those of a 66-year-old insurance agent who believed that his heart only beat once a week and that he had no pulse, and a 63-year-old manager of a grocery business who believed the front part of his body was gone. More unusual themes included delusions of sexual interference, as in a woman who believed the 'assistant M.O. was at her all night'. Some delusions were difficult to categorize, as in the case of a 77-year-old wheelwright who was 'convinced his neighbour's privy was discharging itself across his garden'.

In the Littlemore case notes, the mental state descriptions were generally briefer with less detail. Delusions were documented for 42.1% of males and 44.1% of females. The commonest themes were: persecutory 13.6%, depressive 10.8%, grandiose 7.2%, religious 4.8%.

Aggression Acts of physical aggression prior to admission were recorded for 5 (9.8%) of the Warneford male patients and 2 (5.0%) of the females.

Violence during the Warneford admissions was uncommon, occurring in only 7 patients (2 men and 5 women). Occasional descriptions of verbal aggression and threats of aggression are also recorded. For the Littlemore patients, an act of aggression prior to admission was recorded in 71 out of 219 cases (32.4%). Males were more likely to have been aggressive than females (41.6% vs. 24.6%, $\chi^2 = 6.43$, $p < 0.05$). In common with the Warneford, surprisingly few of the Littlemore patients (6.1% of males and 5.9% of females) were recorded as being aggressive during the course of their admission.

Physical injuries sustained during the admission Being a victim of aggression from co-patients was uncommon at the Warneford, only a single instance being recorded. The consequences, however, were grave for the individual concerned, a 70-year-old man admitted to the Warneford 10 years previously. Suffering with 'mania', he had been 'effusively friendly' and intermittently aggressive to staff for many years. He eventually entered a depressed phase during which he was stabbed in the face by a young man (later sent to Oxford Gaol) and he died the following day from his wounds. At Littlemore, nine patients, three male and six female, were recorded as being physically injured during the course of their admission. This was usually because of aggression on the part of other patients. For example, 'AH pushed her over and her leg was broken'. However, sometimes the cause of the injury was not clear, e.g., 'HJ was found with a broken clavicle', and sometimes the attendants were involved, 'RB broke his leg in a scuffle with the attendant'.

Suicidal behaviour References to suicidal thoughts prior to admission were present in 15.1% of the Warneford male patients and to suicide attempts in 7.5%. Of the Warneford female patients, 10.0% had suicidal thoughts but only 2 cases (5.0%) attempted suicide prior to admission. Of the Littlemore patients, 26.0% of men attempted suicide prior to admission and a further 10.6% had suicidal ideation. Of the Littlemore females, 17.2% attempted suicide and 7.3% had suicidal ideation prior to admission. There were no statistically significant differences between the genders or asylums. Once admitted there are few references to suicidal ideation: it is recorded in only 4 (4.3%) of the Warneford cases. Two of these attempted self-harm: a woman tried to throw herself into a fire and jump from a window and a man repeatedly tried to strangle himself with cords and neckties. At Littlemore only 2.8% of patients were recorded as having suicidal ideation and only two, both female, attempted suicide during admission.

Restraint and seclusion Seclusion is recorded as being used on only two men at the Warneford. A Warneford female patient was 'held' and a 'restraining jacket' used on a further three individuals. For those who resisted restraint the consequences could be serious as in the case of 60-year-old manufacturer's

daughter who had suffered smallpox at the age of six with consequent learning disability and impaired vision and hearing. She sustained a fractured humerus after resisting the 'strong dress'. Forced feeding was used on two Warneford male patients and five Warneford females, generally in cases of melancholia. This too could cause problems, as in the case of a 63-year-old epileptic and melancholic man who had a fit during one attempt to force feed him. At Littlemore Asylum very few instances of physical restraint or seclusion were documented in the clinical notes. Two patients were secluded, two were put in a restraining jacket, one had a belt around the waist to prevent injury, three were put in a padded room and one had protective gloves used.

Physical morbidity At the time of admission to Littlemore 59.6% of patients were recorded as having at least one physical health problem or abnormality on physical examination. The commonest findings were: fever 26.8%, paralysis 16.4%, epilepsy 10.0%, chest disease 5.6%. There were no gender differences in the frequency of physical health problems, except males were more likely to have paralysis (21.9% vs. 11.8%, $\chi^2 = 3.96$, $p < 0.05$) and chest disease than females (9.6% vs. 2.2%, $\chi^2 = 5.17$, $p < 0.05$). Physical health problems on admission were recorded much less frequently for Warneford patients (Warneford 21.5% vs. Littlemore 59.6%, $\chi^2 = 14.5$, $p < 0.0005$). The commonest findings were neurological abnormalities 7.5%, epilepsy 5.4% and dropsy 2.2%.

Supposed cause

The presence or absence of a family history of mental illness was recorded in only 33.3% of the Warneford patients; it was positive in 35.5% of these. The family history often referred to other patients who had been admitted to Oxford asylums or other institutions. For others the information was less specific, for example, 'an uncle is said to have been odd'. Family history was less rigorously collected at Littlemore, but insanity was said to be hereditary in 10.0% of cases.

A supposed cause was recorded for 54.8% of Warneford patients and 48.2% of Littlemore patients. What might now be termed an organic aetiology was recorded in 20.4% of the Warneford and 17.7% of Littlemore patients. These included 'softening of the brain', 'apoplexy', 'accident to the head', 'Bright's disease' and 'sunstroke'. Psychological causes were attributed to 36.6% of the Warneford patients but only 9.6% of the Littlemore patients. These included bereavement, business anxieties, 'pecuniary loss' and 'domestic trouble'. One of the commonest causes was 'old age', which was applied to 7.6% of the Littlemore cases but none of the Warneford cases. Intemperance and delirium tremens accounted for 5 cases (all men) at the Warneford and 13 cases at Littlemore. Less common causes included 'living too free', 'marrying too young a wife', 'religious excitement', a general election and

'inactive and tedious employment'. 'Fright' was given as the cause of insanity for two females and 'thunder and lightning' and 'hysteria' as the cause in a single case each. Multiple causes were often given, for example, a 68-year-old retired farmer was described as 'latterly a total abstainer but at times he is said to have drunk freely and [to have] lived in concubinage with a woman previously to his marriage'. No cases of masturbation insanity were recorded and few references to the subject were made. Occasionally the cause was still recorded as 'unknown' even when the clinical history gave a number of possible causative factors. For example, a 60-year-old clergyman at the Warneford presented with 'obscene language' and 'filthy habits' and 'uncertain memory for recent events'. He 'had been a drunkard and had delirium tremens several times'; he had also received a blow to his head four months prior to admission and had focal neurological signs.

Diagnosis (see Table 3)

Contemporary diagnosis At the Littlemore, dementia (45.2%) was the most frequent contemporary diagnosis, followed by mania (32.8%) and melancholia (16.4%). Few patients were described as imbeciles (4.8%). At the Warneford a much wider range of clinical diagnoses was assigned to patients including delusional insanity, mental weakness, folie circulaire and mental perversion.

Modern diagnosis There was insufficient clinical information documented for a firm ICD-10 diagnosis to be made in 26.9% of the Warneford patients and 25.6% of the Littlemore patients. The majority of indefinite diagnoses at the Warneford occurred prior to 1845, when the case notes were less detailed, and from the early years at Littlemore. Regarding modern diagnoses, the largest diagnostic groups were organic (Warneford 29.0%, Littlemore 45.6%) and affective disorders (Warneford 36.6%, Littlemore 25.2%). Only a single patient at the Warneford was found with a neurotic or stress-related disorder and none at Littlemore. There was only one Littlemore patient who appeared to have no signs of mental illness, a man who had attempted to stab a man while drunk. He was discharged from the asylum after three months. There was also a single male patient at the Warneford who manifested no sign of mental illness. He was discharged home after two months of observation during which he 'conducted himself well'. One Littlemore patient appeared to have learning disabilities. There were no significant gender differences in contemporary or modern diagnoses. However, there were significant differences when the genders from each asylum were compared. Among females, a greater proportion at the Littlemore patients had organic illness than at the Warneford (42.6% vs. 15.0%, $\chi^2 = 9.05$, $p < 0.005$), while affective disorder was more common among Warneford females (47.5% vs. 26.5%, $\chi^2 = 5.42$, $p < 0.05$). For males there were no significant differences between the two asylums.

TABLE 3. *Diagnostic details of admissions to Warneford and Littlemore Asylums: numbers and (in brackets) percentages*

	Warneford patients		Littlemore patients	
	Males (N = 53)	Females (N = 40)	Males (N = 114)	Females (N = 136)
Contemporary diagnosis:				
Melancholia	8 (15.1)	7 (17.5)	19 (16.7)	22 (16.2)
Mania	3 (5.7)	6 (15.0)	32 (28.1)	50 (36.8)
Dementia	2 (3.8)	1 (2.5)	55 (48.2)	58 (42.6)
Imbecile	1 (1.9)	1 (2.5)	7 (6.1)	5 (3.7)
Melancholia and mania	–	–	1 (0.9)	1 (0.7)
Delusional insanity	4 (7.5)	2 (5.0)	–	–
Mental weakness	4 (7.5)	–	–	–
Despondence	4 (7.5)	1 (2.5)	–	–
Folie circulaire	2 (3.8)	–	–	–
Senile insanity	1 (1.9)	1 (2.5)	–	–
Senile imbecility	1 (1.9)	1 (2.5)	–	–
Mental perversion	1 (1.9)	–	–	–
GPI	1 (1.9)	–	–	–
Deranged	1 (1.9)	–	–	–
Excitement	–	1 (2.5)	–	–
Not stated	5 (9.4)	1 (2.5)	–	–
Modern diagnosis:				
Organic (including alcohol)	21 (39.6)	6 (15.0)	56 (49.1)	58 (42.6)
Schizophrenia and related psychoses	2 (3.8)	3 (7.5)	1 (0.9)	6 (4.4)
Affective disorders	15 (28.3)	19 (47.5)	27 (23.7)	36 (26.5)
Neurotic and stress-related	1 (1.9)	–	–	–
Learning disability	–	–	1 (0.9)	–
No mental illness	1 (1.9)	–	1 (0.9)	–
Insufficient information for diagnosis	13 (24.5)	12 (30.0)	28 (24.6)	36 (26.5)

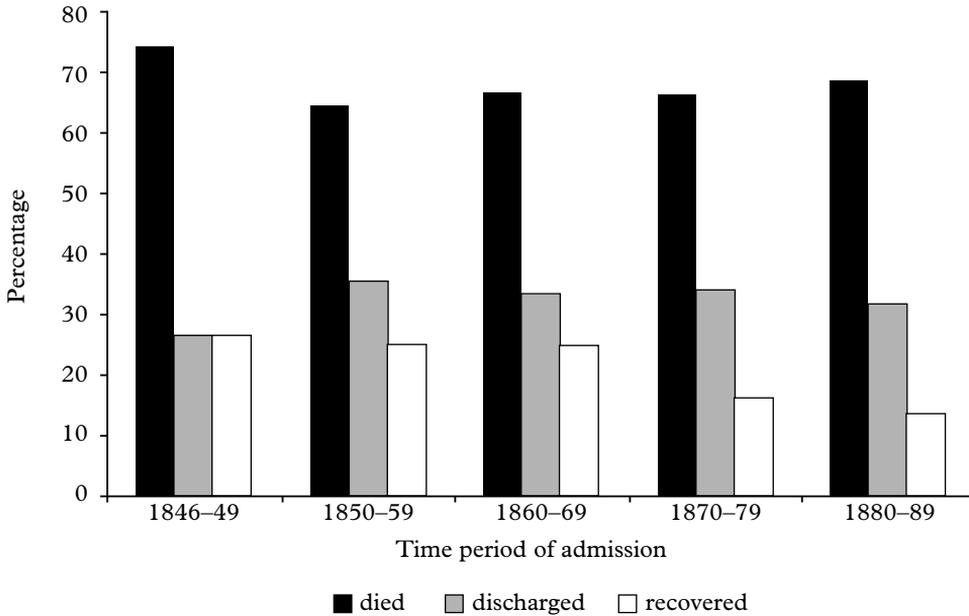


FIG 2. Outcome of Littlemore admissions over 10-year admission time periods

Agreement over assignment of modern diagnoses There was 92% concordance in the assignment of modern diagnoses to the case vignettes by 5 consultant old-age psychiatrists. The inter-rater agreement between GY and CH was 100%.

Outcome

Outcome of admissions Both Littlemore males and females were more likely to die in the asylum than their counterparts at the Warneford (Littlemore males 68.4% vs. Warneford males 30.2%, $\chi^2 = 20.0$, $p < 0.00001$; Littlemore females 67.6% vs. Warneford females 42.5%, $\chi^2 = 7.26$, $p < 0.01$). However, there were no significant differences for males or females at the two asylums in the proportion of patients who were discharged 'recovered'.

Overall, 35.5% of patients died at the Warneford, whereas at the Littlemore the death rate was 68.0% (see Table 2). Of the rest, 24.7% of Warneford and 20% of Littlemore patients were 'discharged recovered', 19.4% of Warneford and 5.2% of Littlemore patients were 'discharged relieved', and 11.8% of Warneford and 5.2% of Littlemore patients were 'discharged not improved'. A single patient at the Warneford was described as 'worse' on discharge.

Figure 2 shows the outcome of Littlemore admissions during five time

TABLE 4. *Warneford and Littlemore patients: outcome and duration of index admission by modern diagnosis*

Modern ICD-10 diagnosis	No. with known outcome	Died (%)	Discharged (%)	Recovered (%)	Median duration of admission in months (range)
Organic F00-09	140	77.1	20.7	8.6	4.0 (0.2-199)
Schizophrenia F20-29	11	36.4	54.5	18.2	35.5 (3-204)
Affective disorder F30-39	97	41.2	56.7	40.2	9.5 (0.5-281)
Neurotic F40-48	1	0	100	100	36.0
Learning disability F70-79	1	100	0	0	181.0
No mental illness	2	0	100	100	2.8 (2.5-3)
Diagnosis unclear	89	56.2	39.3	19.1	12.0 (0.5-173)

periods between 1846 and 1889. The percentage of patients who died in the asylum showed no change but, over time, the percentage that were discharged recovered fell from 26.3% to 13.7%. This fall in recovery rate was not statistically significant (using χ^2 for trends) but the number of patients involved was relatively small.

Discharge destination Of the 32 Warneford male patients who were discharged, it is recorded that three went to another asylum, three went to live with their families and seven to friends. Of the 20 Warneford females who were discharged, 4 went to family and one to 'the house of industry by desire of the parish officers'. No information was given for the majority, and no information was recorded about the discharge destination for Littlemore patients.

Outcome of admission by modern diagnosis Table 4 shows combined data from both asylums concerning the outcome of admission according to modern ICD-10 diagnosis. The following significant differences were found for patients of different diagnostic groups: the mortality rate was significantly greater for patients with an organic diagnosis than for those with affective disorder (77.1% vs. 41.2%, $\chi^2 = 30.0$, $p < 0.00001$). The mortality rate was greater for patients with an organic illness than for those with schizophrenia (77.1% vs. 36.4%, Fisher exact 2-tailed $p < 0.01$). Patients with affective

disorders had a significantly higher recovery rate than those with organic diagnoses (40.2% vs. 8.5%, $\chi^2 = 32.1$, $p < 0.00001$). Patients with schizophrenia had longer admissions than those with organic disorders (Mann-Whitney $Z = -2.48$, $p < 0.05$). Those with affective disorders also had longer admissions than those with organic disorders (Mann-Whitney $Z = -2.18$, $p < 0.05$).

Cause of death For the 33 (35.5%) Warneford patients and 170 (68.0%) Littlemore patients who died, a cause of death was given 128 cases (63.3%). A post-mortem was recorded as having been performed in 4 (12.5%) of the Warneford and 70 (66.7%) of the Littlemore cases. The commonest causes of death given at Littlemore were senile decay (31.4%), bronchitis or pneumonia (20.0%) and paralysis or hemiplegia (14.3%). Females were more likely than males to die of senile or gradual decay (44.3% vs. 13.6%, $\chi^2 = 9.75$, $p < 0.005$).

Discussion

Modern diagnosis

The nine Warneford case books containing the handwritten clinical notes of the physician superintendents (and later in the century of their assistants) form a continuous and complete record of patients admitted to the asylum from its opening in 1826. The average number of admissions to the Warneford Asylum was small (14 per year) in comparison to Littlemore (129 per year). The clinical material in the admission and progress notes at the Warneford is much more detailed than in the equivalent records of the Littlemore, although note-keeping at the Littlemore improved later in the century. Despite this, it was possible to make modern diagnoses in the majority of patients at both institutions. Most other published case note analyses include data only from the latter half of the nineteenth century, as note-keeping improved, so the Warneford data from 1826 to 1850 are particularly valuable and deserve more study.

The main differences between the modern diagnoses of patients admitted to the two Oxford asylums, is the preponderance of organic cases at Littlemore and the excess of women with affective disorders (mainly depression) at the Warneford. Although the number of cases is small (12), the case-notes also contain clear descriptions of patients' psychopathology that would result in a modern diagnosis of schizophrenia. The presence of schizophrenia in elderly patients in the early years of the nineteenth century is important. Hare (1988) suggested schizophrenia was extremely rare before 1800, and Torrey and Miller (2002) have developed further the notion that an epidemic of mental illness began around 1750. The Warneford casebooks are extremely valuable in that they provide detailed descriptions of psychopathology in patients requiring hospitalization as early as 1826. For those cases in which it was not possible to make a diagnosis, it was usually clear

that there was considerable behavioural disturbance, and that some sort of psychiatric illness was almost certainly present, but the information was insufficient to categorize further. Some cases that appeared on the admission register in the early years at Littlemore had no clinical records in the casebooks.

Age

The age of sixty was chosen as a cut-off for inclusion in the study as it is the age at which organic psycho-syndromes, particularly dementia, start to become more common. Most modern old-age psychiatry services use 65 as a cut-off, though there is often flexibility. Until the mid-nineteenth century people were perceived as being old when they ceased to be economically and physically independent and this varied with the individual. A fixed retirement age of 65 for civil servants was set in the Northcote-Trevelyan Report of 1857 based on the observation that this was the age at which 'bodily and mental vigour begin to decline' (Thane, 1978). It took some time for the concept of a fixed retirement age to spread to other occupations and the age varied between 60 and 65. Workers in heavy manual jobs traditionally retired earlier. When a non-contributory pension was introduced in Britain in 1908, it was paid at 70 to lower the cost to the Treasury, and it was not until 1925 that a contributory pension scheme paid at 65 was introduced.

Although the average age of patients admitted to the Warneford Asylum increased slightly throughout the century, it remained within the 38–42 range. This is comparable to other asylums, both private such as Ticehurst House in Kent (Turner, 1992) and pauper such as the Fife and Kinross Asylum (Doody *et al.*, 1996). The average age of admissions to the Littlemore Asylum was more variable with a large increase at the end of the century. The proportion of admissions to the Littlemore over the age of 60 was more than double (18.3%) that of the Warneford (8.9%). A number of possibilities could account for this: greater poverty of the elderly, disinclination to admit untreatable cases of dementia, reluctance to admit cases which might disturb the ambiance of the institution (for example demented patients with behavioural disturbance or incontinence).

The percentage of the population of England and Wales aged over 60 remained fairly stable between 1841 and 1901 at 7.4%, and was probably similar in the pre-industrial era (Laslett, 1977). Although the numbers of elderly patients admitted rose towards the end of the century, the proportion of patients over 60 being admitted to both asylums, did not rise significantly over the period of study. Several studies have shown an increase in the numbers of elderly patents admitted to asylums in Ireland and the USA (Finnane, 1981; Grob, 1983; Malcolm, 1989). Berrios and Freeman (1991) have suggested a similar increase took place from 1890 onwards in Britain. Evidence supporting this comes from Davis (1995), who found a significant increase in elderly admissions to the Glasgow Royal Asylum in the first 20

years of the twentieth century. Thomas Clouston, President of the Medico-Psychological Association and Physician Superintendent of the Royal Edinburgh Asylum, repeatedly complained in annual reports that increasing numbers of elderly patients were being sent to the asylum (Beveridge, 1995). Yet Clouston's own analysis shows only a slight increase in average age from 39.5 to 42.1 over the period 1874 to 1907. Crammer (1990) in his study of the Buckinghamshire pauper asylum showed no increase in the overall proportion of elderly patients being admitted to the hospital between 1861 and 1911. The data from the current study do not support the view that there was a sizeable increase in the proportion of elderly admissions to asylums over the course of the nineteenth century. The study was not able to address the question of whether the proportion of elderly patients already in the asylums increased over the century, as these statistics were not recorded for either hospital. Davis (1995) found that the increase in the proportion of elderly admissions to the Glasgow Royal Asylum between 1890 and 1920 was exceeded by the increase in the proportion of elderly patients already in the hospital which rose from 18% in 1890 to 31% in 1920.

Domicile

The majority of patients admitted to the Warneford Asylum lived locally prior to admission. This contrasts with Beveridge's (1995) study which showed a higher proportion of patients in the private East House of the Royal Edinburgh Asylum came from outwith the immediate locality. The ability to attract more distant patients may have been a reflection of the greater prestige of the Edinburgh institution and its physician superintendent. The Warneford had not yet attracted such a reputation and in Oxfordshire and the surrounding counties there were a number of private madhouses offering greater choice of more local facilities than was available in Scotland (Andrews & Smith, 1996; Parry-Jones, 1972).

Occupation

The majority of male patients were employed despite their age. Similar high levels of regular employment have been found in other studies (Doody *et al.*, 1996; Walton, 1985). Attitudes to retirement changed significantly throughout the nineteenth century, partly in response to changes in poor law provision and partly to changes in life expectancy (Thomson, 1991). The lower rate of recording of occupation for the elderly at the Warneford may reflect a lower expectation by society of the elderly having an occupation. Although the Warneford endeavoured to attract 'the better class' of patients, specifically excluding paupers, and often commented on this in its annual reports, it is apparent from the Littlemore Pauper Asylum records that this institution was also able to attract a small number of patients from the professional classes, though it is not clear from the records whether they contributed to their care.

Previous admissions

The difference in the proportion of patients transferred from other institutions is striking: 10.0% for Littlemore and 5.4% for the Warneford. This probably reflected the Warneford's prerogative of turning away chronic or incurable patients, the failures of other asylums, which would have lowered the institution's cure rate. However, a bias exists in the Littlemore data, as in the early years of the asylum large numbers of patients were transferred from private licensed madhouses.

Supposed cause

The supposed cause of insanity reflected current thinking in aetiology in contemporary texts. Psychiatric problems associated with alcohol abuse were well known in the nineteenth century (Maudsley, 1867). Some private asylums such as Ticehurst House sought to exclude patients with alcohol dependence (Turner, 1992) while alcoholic insanity was a common reason for admission to others, accounting for 20% of male admissions to the North Riding Asylum, Yorkshire, between 1880 and 1884 (Renvoize & Beveridge, 1989). Until recently it was believed that alcohol problems were uncommon in the elderly, but there is increasing recognition that this is not so (Atkinson, 1994). The substantial number of elderly patients admitted to the two Oxford asylums as a result of alcohol abuse in the nineteenth century is evidence that such problems are not new. The description of a general election as a cause of insanity is interesting: Thomas Clouston believed that politics was rarely a cause of insanity (Beveridge, 1991) and to this day there are few case descriptions of psychopathology being influenced by political matters (Bohlken and Priebe 1991; Markowitz 1996; Yorston, 1997).

There is a marked difference in the attribution of the cause of insanity in elderly patients between the two hospitals. At the Warneford 36.6% of patients had a psychological cause compared with only 9.6% at Littlemore. It is not clear whether this is due simply to different training and conceptualization of mental illness by the physician superintendents, and therefore an entirely local phenomenon, or a reflection of wider beliefs about how psychological stressors affected the different classes. Some diagnoses in the nineteenth and early twentieth centuries came in and out of fashion, the best example of this being neurasthenia which changed from an illness of the superior overworked upper classes to an illness of the indolent working classes (Abbey and Garfinkel, 1991). Unlike the Warneford patients, many of the Littlemore patients were admitted in a physically deteriorated condition from workhouses and it is likely that this would also have contributed to the differences in ascribed causation.

Psychopathology

Florid psychopathological symptoms such as delusions and hallucinations are

common in elderly patients with both functional and organic psychiatric illness referred to modern psychiatric services (Katona & Levy, 1992). The frequency of severe symptomatology was no less in the elderly patients admitted to the Oxford asylums. The subject matter of the delusions suffered by these patients is similar in content to that found in other studies (Eagles, 1983; Robinson, 1988), although the numbers are too small to permit meaningful statistical comparisons with other institutions or patients of different ages.

Contemporary diagnosis

At the Warneford Asylum the terms *dementia* and *delirium* were rarely used; patients were more likely to be described as suffering from *senile mania*, *senile melancholia*, *mental weakness* or *senile insanity*. The Littlemore medical staff used *dementia* more frequently, but from the descriptions of the onset and progression of clinical symptoms at both hospitals, the assignment of modern diagnostic categories was reasonably straightforward. At the Littlemore a smaller range of diagnostic terms was used probably because the time frame of the Littlemore data is smaller. The concept of dementia changed significantly over the course of the nineteenth century, the 'cognitive paradigm' eventually becoming dominant by the century's end (Berrios, 1990).

Violence and restraint

Serious violence committed by the elderly is rare (Yorston, 1999). Verbal and minor physical aggression, however, is extremely common in modern old-age psychiatry, particularly in patients suffering from dementia (Freyne and Wrigley, 1996). Historical studies have commented on the frequency of aggression in several asylums, although it has proved difficult to quantify rates. Turner (1992) suggests that approximately 25% of patients exhibited violence at Ticehurst Asylum, but he does not define the term further. Restraint and seclusion records, where present, can allow a clearer analysis of the cases that required such treatment. Turner found 16 cases where restraint was used from a total of 515 (3.1%) admissions. The rate of seclusion and restraint used on elderly patients at the Warneford (6.4%), though not at Littlemore (2.8%), appears rather high in comparison. The difference may be genuine, suggesting that the disinhibited behaviour of dementia was poorly tolerated and attendants were expected to intervene to prevent it, or that the detailed note-keeping at the Warneford more accurately portrays the extent of restraint and seclusion.

Length of admission

The median length of admission for older patients in Oxford is much shorter than figures for patients of all age groups in similar studies: in the Fife pauper asylum the figures are 28 months and 39 months, respectively

(Doody *et al.*, 1996). Turner (1992) found an association with increased length of stay and younger age on admission and a modern diagnosis of schizophrenia. The latter finding is mirrored in the current study where a modern diagnosis of schizophrenia is associated with a longer stay (although numbers in this category are small). The length of admission of elderly patients did not rise significantly for either asylum over the study period. This provides some evidence to counter the suggestion that asylums silted up with ever-increasing numbers of long-stay patients (Scully, 1979). The difference almost certainly results from the admission of patients with organic psychiatric problems secondary to physical ill health who died shortly after admission.

Interval to re-admission for second and subsequent admissions

Many other studies have used data from first admissions only. The inclusion of second and subsequent admissions in the data analysis provided some information on this group of patients. It is clear from this study that the elderly were not simply dumped in the asylum by families and forgotten about. As in modern practice, patients spent a period of months, or years, in hospital and were then discharged, often after a period of trial leave, to be certain the symptoms of mental illness or behavioural disturbance did not return. When the patient was back in a home setting the physician superintendent of the Warneford would often visit before making the final discharge arrangements. Although the number of re-admissions is small, it emphasizes the fact that even patients with relapsing illnesses were able to return home during periods of clinical improvement.

Outcome

Outcome data need to be interpreted with caution. Governors of asylums were keen to portray their institutions in the best possible light, and statistics were needed to support claims of good recovery rates. At times, 'discharged recovered' appears to bear no relationship to the case as described in the case-notes. The data may be distorted for other less obvious reasons, as in the case of a 65-year-old widow of a minister who was recorded as 'discharged relieved' although the physician superintendent thought her cured. The reason for the discrepancy was her daughters' reluctance to pay for the medical certificate that would support such a designation. Recovery rates for the Warneford and Littlemore are similar to those stated for other asylums for patients of all ages. This may seem surprising, given that many elderly patients were admitted with dementia and were cared for until death with no prospect of recovery. This is reflected in contemporary medical writing on dementia which emphasizes therapeutic pessimism (Porter, 1995). Occasional patients, however, were sent home with advanced dementia to be cared for by their families or discharged to other institutions. The female patient transferred to the workhouse is evidence that the Lunatics Law Amendment

Act 1862 was used. Such transfers, almost always motivated by reasons of economy, were heavily criticized by the Commissioners in Lunacy (Myers, 1998). Possible explanations for the unexpectedly high recovery rate include the fact that a higher proportion of elderly admissions for acute episodes of delirium secondary to physical illness resolved quickly with an equally rapid resolution of the insanity; also, patients with schizophrenia with a low recovery rate were more likely to be admitted earlier in life, in their third or fourth decades. The Warneford mortality rates for older patients of 30.2% for men and 42.5% for women are surprisingly low, being not dissimilar to the figures for all age groups at the Fife Pauper Asylum (Doody *et al.* 1996) and only slightly higher than the figures for the Royal Edinburgh Asylum (Beveridge, 1995). This may reflect better conditions at the Warneford which, being able to exclude the poorest classes, was presumably not as prone to epidemics of tuberculosis and other infectious diseases. Littlemore had a fearful mortality rate of 68.4% for its older men and 67.6% for its female patients, but some managed to survive many years: a 71-year-old female patient lived in the asylum for 20 years until her death. Nevertheless, echoes of its grim reputation survived into the 1990s when it was common for elderly patients to express extreme reluctance at proposed admission to the hospital, a reluctance that was not as obvious for other hospitals in Oxford.

Conclusion

The methodology used for case-note analysis of patients of all ages in nineteenth-century institutions is equally applicable to the examination of age-specific sub-groups of patients. This study has shed light on a hitherto neglected but important section of the Victorian asylum population. Modern diagnoses can be made for the majority of elderly patients admitted at times of adequate note-keeping. Other studies have shown high levels of psychiatric morbidity in asylum patients with florid and instantly recognizable psychopathology. Elderly patients at the Warneford and Littlemore Asylums were no different in this respect. For only two patients in this study was it possible to say with confidence that no psychiatric illness was present. Neither the proportion of elderly patients nor their average length of stay increased significantly over the study period. The Warneford Asylum was a charitable hospital which was able to control the type of patients admitted in a way that was not possible in pauper asylums. The fact that similar findings emerge from the admission data of the Littlemore Pauper Asylum argue against there being a universal increase in elderly admissions to asylums at the end of the nineteenth century.

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