

MODERNITY, RACE AND MENTAL HEALTH CARE IN JAMAICA, c. 1918-1944

Henrice Altink
henrice.altink@york.ac.uk

Department of History, University of York, Heslington, York, United Kingdom

Revisionist histories of colonialism have presented Empire as a modernising, benevolent and non-discriminatory force. While recent scholarship on Caribbean health and medicine has done much to contest the idea of a modernising and benevolent Empire, it has thus far done little to challenge the claim that there was no institutionalised discrimination in the Empire. By exploring conditions in Jamaica's mental hospital from 1918 till 1944, this article tries to fill this gap in the scholarship. Based on amongst others official correspondence and newspaper reports, it examines the extent to which dominant ideas of race informed the treatment meted out on the overwhelmingly black patients and staff and explores the colonial government's response to demands made by black politicians to improve patient care and enhance the promotion opportunities of local staff. Informed by Critical Race Theory, this study argues that not only the colonial government helped to uphold the island's racial and class status quo by bypassing local staff for promotion and protecting incompetent white senior officers but also black politicians as they failed to call this racial discrimination and worked more to enhance the promotion opportunities and working conditions of local doctors and nurses than improve the care of the patients, who tended to be a lower class and darker shade.

Keywords: Jamaica, mental health, Crown Colony government, racial discrimination, social stratification.

Introduction

Revisionist histories of colonialism have presented Empire as a modernising and benevolent force, as exemplified by Niall Ferguson's *Empire: How Britain made the Modern World* (2003). Yet there is a growing scholarship on colonial medicine that strongly contests this claim, in particular works on colonial psychiatry (e.g. Vaughan 1991; Sadowsky 1999; Keller 2001; Ernst 2002). Also the more recent work on health and medicine in the Caribbean has done much to challenge the idea of Empire as a modernizing and benevolent force (e.g. De Barros and Stilwell 2003; De Barros, Palmer and Wright 2009).

But while the recent histories on Caribbean health have done much to question the claim that Empire was not a modernising and benevolent force, they have thus far not fully engaged with a second claim made by revisionist histories of colonialism, namely that racial discrimination was not a central force in the exercise of colonial rule. Ronald Hyam, for instance, has argued in his *Britain's Declining Empire: The Road to Decolonisation* (2006) that 'a sense of racial difference certainly permeated many aspects of colonial practice' but that there was no 'institutionalised discrimination' (Hyam 2006: 38-9). This article will challenge Hyam's conclusion and lend further support to the argument that Empire was not a modernising and benevolent force by exploring the treatment meted out on the

overwhelmingly blackⁱ patients and staff in Jamaica's mental hospital from the end of the First World War until 1944. An increase in patients in the immediate post-war period led to overcrowding which did much to raise public concern about the hospital, as did the reports in the *Gleaner*, the leading newspaper in the island, that local staff was bypassed for promotion. Public concern reached a climax in 1944, when the *Gleaner* published the condemning report of a commission (hereafter, the 1942-43 commission) appointed by the governor in 1942 to 'enquire into and make recommendations concerning the administration' of the hospital.

Jamaica's mental hospital provides a useful case study to test the claim that Empire was a modernising, benevolent and non-discriminatory force not only because it was set up in the 1860s as part of the so-called 'civilising mission' – i.e. attempts by the government and local elites to bring African Jamaicans in line with metropolitan norms and values (Moore and Johnson 2004: xiii) – but also because it was a microcosm of Jamaican society. The following will show that both staff and patients in the hospital largely mirrored the island's peculiar system of social stratification, in which class and colour were closely entwined. The bottom of the social ladder was occupied by mostly dark-skinned men and women engaged in unskilled or semi-skilled work. The middle rung was made up of predominantly light-skinned Jamaicans and included small planters, teachers, ministers, policemen, postmasters and clerks but also some businessmen and professionals, including doctors. The less than two per cent whites constituted the top and consisted of the very wealthy, such as sugar planters, as well as colonial officials, missionaries, owners and managers of small firms and plantation bookkeepers.

This is not the first study, however, to address conditions in Jamaica's mental hospital. Margaret Jones (2008) has examined the founding of the hospital in the late nineteenth century, while Leonard Smith (2010) has taken her work further and explored the administration of the hospital in the period up to the onset of the First World War. And more recently, Darcy Hughes Heuring (2011) has moved the discussion of the mental hospital into the interwar years. She has examined the contest – mainly between the government and the elected members of the Legislative Council (LegCo) – over who should take financial and moral responsibility for the hospital's patients. Yet like many other historians working on the interwar Caribbean she has paid scant attention to race. Not only has she failed to set out the role that race played in this particular contest but she has also not indicated that racial ideas underpinned patient care and the promotion opportunities of staff.

Based on amongst others Colonial Office correspondence, the hospital's annual reports, and verbatim reports of Legislative Council sessions in the *Gleaner*,ⁱⁱ this study of conditions in the mental hospital in Jamaica will provide ample evidence that although it was modelled on an English county asylum by 1918 it lagged far behind its metropolitan counterparts, failed to benefit the majority of the population, and discriminated against its predominantly black staff. But this study is not just concerned with the extent to which dominant ideas of race informed the treatment meted out on patients and promotion opportunities of staff but also with the colonial government's response to demands made by black members of the Legislative Council (LegCo) to improve patient care and even more so to enhance the promotion opportunities of black staff.

During the period under discussion, African Jamaicans formed the majority of the fourteen elected members of the LegCo. Black politicians used the treatment of patients and staff in the mental hospital not only to rally political support but also to illustrate the shortcomings of Crown Colony government, which had been instituted in the island following the 1865

Morant Bay rebellion. Yet few of them condemned the poor standard of patient care and the bypassing of black doctors and nurses for senior posts as racial discrimination. By engaging with Critical Race Theory (CRT) – a body of work that started in American law schools in the 1980s and examines the ways in which white supremacy is upheld in the post-civil rights era (Delegado and Stefanic 2001) – this study will argue that by remaining silent about racial issues or presenting them as being about something else, black politicians helped the colonial government to uphold the afore-mentioned system of social stratification. In doing so, it raises an issue which many Caribbean historians have thus far shied away from, namely the complicity of African-Caribbean people in a system that helped to uphold white superiority (Brereton 2006).

It needs to be stressed, however, that the power of black elected members of the LegCo to affect change on behalf of patients and staff was limited. Firstly, because ex-officio and nominated members of the LegCo were expected to support the government. Hence motions proposed by elected members were easily lost. Secondly, elected members were excluded from the Privy Council – the executive body –, which the governor had to consult. And thirdly, elected members could not propose financial bills. They did, however, have the right to overturn financial matters proposed by the government if nine of them voted against (Lewis 2004: 92-7; Wrong 1923: 123-35). As this study will show, this right was one of the main methods they used to express their discontent with government policies that discriminated against African Jamaicans.

But not only the black elected members, also government officials, including the white, English superintendents and matrons of the hospital, were silent about race. We shall see, for instance, that they never invoked race to deny the promotion of black doctors or nurses or the hospital's lack of modern methods of treatment. Yet their frequent references to the sexuality and intelligence of the mostly black patients and staff – which were and still are major markers of racial inferiority (Collins 2005) – more than suggest that racial ideas shaped as much the government's responses to demands from black politicians to enlarge and modernise the hospital and promote black staff as the island's finances and other more practical factors.

Patient care

In 1776, a public hospital was set up in Kingston, which included a 'lunatic asylum'. In 1843, funds were set aside for the construction of a modern asylum. For various reasons, the new asylum was not completed until 1862. In the same year, an act was passed that set out new rules and regulations for the management and supervision of the asylum (Jones 2008: 302; Carley 1943: 2-3). The superintendents of this new hospital tried to implement the regime that was common in English county asylums but soon failed to do so because of a rapid increase in patients (from 212 in 1870 to 1,000 in 1904), a shortage of staff the lack of a classification system of patients, defective buildings, and various other problems (Smith 2010: 11). Like its metropolitan counterparts, the hospital followed periods of severe overcrowding with building expansions but little else was done to improve patient care in the period leading up the First World War.

From the late 1920s, the term 'mental hospital' was increasingly used to refer to the asylum but it was not until 1938 before this name was formally adopted.ⁱⁱⁱ The adoption of the name 'mental hospital' suggests that by the 1920s various improvements had been affected and that the hospital had become less a place of confinement and more one of treatment. After the

War, the hospital did become, like its metropolitan counterparts, a more open community with patients spending less time in the wards. But common modes of treatment used in English county asylums in the interwar years were largely absent in the Jamaican mental hospital. By the early 1940s, some doctors experimented with electro-convulsive therapy but the hospital's facilities were such that it was very difficult for them to use modern methods of treatment. There were only a few clinical rooms where they could examine and treat patients, which were small and lacked such basic things as a proper examination table. And although the hospital accommodated more than 2000 patients on the eve of the Second World War, it had only two small, poorly equipped operating theatres (*Gleaner*, 14 October and 16 November 1944).

In addition to shock therapy, metropolitan mental hospitals also used occupational therapy to treat early cases of insanity in the interwar years (Jones 1991). The annual reports of the Jamaican mental hospital mention that patients were taking part in 'occupational therapy'. This work, however, far from resembled the occupational therapy of the English county asylums at the time, which was devised by a properly trained occupational therapist, consisted of rug making and various other arts and crafts that valued the creativity of the activity, and served more as a therapeutic agent than a means of rehabilitation (Bennett 1996: 194-6). In Jamaica, patients who were deemed fit to leave the wards were 'occupied' in light work around the hospital. Men were usually employed around the hospital's farm, gardens, courts and workshops, while women sewed and did kitchen and laundry work (*Gleaner*, 30 December 1933). This 'occupational therapy' served less as a means of treatment than as a way to create a self-sustaining hospital (*Gleaner*, 9 October 1944).

And the lack of a system of classification of patients also clearly illustrates that the hospital prioritised confinement. There were no separate buildings for recoverable and chronic cases and patients sentenced by the courts were not segregated. Hence old and weak patients often suffered physical injury and the progress of the recoverable cases was hindered by violent outbursts of the more acute cases of insanity (*Gleaner*, 4 November 1944). Furthermore, the small proportion of patients who managed to recover was not provided with after-care. As a result, many discharged patients failed to get a job, relapsed and soon returned to the hospital (*Gleaner*, 14 November 1944).

But the patient/staff ratio and the amount of money that the government spent on the mental hospital suggest more than anything that the adoption of the term 'mental hospital' in the late 1920s was largely a matter of window dressing. During the period under discussion the number of patients doubled from 1,200 to 2,400 (*Gleaner*, 3 November 1922 and 14 October 1944). The superintendents and government officials argued that this did not reflect an increase in insanity per se but suggested that it was the result of rapid population growth, the increasing ease with which courts sent criminals to the hospital, and the reluctance of African Jamaicans to care for the mentally ill in their family (e.g. *Annual Report* 1928; Board of Visitors, 1931 and 1934; Denham, 1934). Of course by investing little in public health, housing and education, the colonial government was largely to blame for this 50 per cent increase as many patients admitted suffered from insanity that was the result of diseases brought about by poor housing and sanitation and lack of instruction in hygiene (Riley 2005, 76-77 and 101-5), a fact conveniently ignored by the superintendent and government officials.

Although the number of patients doubled during the period under discussion, government expenditure on the hospital rose only by 10 per cent. The fact that the patients did not, and

probably never would, contribute to the island’s economy largely explains why the hospital did not witness the same increase in government funding as the public hospitals. It did not differ in this regard from metropolitan mental hospitals which were also less generously funded than general public hospitals. Yet it could be argued that the funding for the hospital was also informed by racial and class prejudices and did much to uphold the afore-mentioned social structure, as the less than 10 per cent increase in funding benefitted staff more than patients. For instance, the wages of the nurses were re-graded and new accommodation was built for the doctors. Although most of the nurses did not have a school certificate that placed them, like the doctors, in the middle rung of the afore-mentioned social ladder, they too occupied a higher social status than the patients. Annual reports suggest that most of the patients had been ‘labourers’, ‘cultivators’, and ‘domestic servants’ prior to admission (e.g. *Annual Report* 1920). In other words, the patients came from the lowest tier of the social ladder.

Table 1: staffing at the mental hospital

1920	1926	1938
1 superintendent	1 superintendent	1 superintendent
2 doctors	3 doctors	4 doctors
0 matron	1 matron	1 matron
1 head nurse (female wards)	1 head nurse (female wards)	1 head nurse (female wards)
1 chief attendant (male wards)	1 chief attendant (male wards)	1 chief attendant (male wards)
120 male and female nurses	120 male and female nurses	214 male and female nurses
1 dispenser	1 dispenser	1 dispenser
		1 deputy chief attendant

Source: *Annual Report* 1920; *Gleaner*, 7 April 1926; Memorandum asylum staff 1938.

As table 1 illustrates, the number of staff increased over time. But because the number of nurses and doctors did not increase as rapidly as the number of patients, there was a high patient/staff ratio, which was nearly three times that in metropolitan mental hospital. In the early 1940s, for instance, there was 1 nurse on every 11 patients during the day and 1 nurse in 57 patients during the night and only one doctor on every 600 patients (*Gleaner*, 21 October 1944). But not only the quantity also the quality of staff made it difficult for the hospital to be more than a place of confinement. The doctors, most of whom had obtained their medical degree from a university in North America, had gained practical experience in mental health but did not have a diploma in psychiatric medicine. The African-Jamaican doctor Uriah Murray, for example, had done two internships in English mental hospitals but never obtained a diploma in psychiatric medicine (*Gleaner*, 16 November 1944). And with the exception of the matron and head nurse, nursing positions in the hospital did not require a nursing certificate or even an accepted standard of education, such as the Cambridge Junior Examination. From 1927 onwards, nurses could take lectures in mental health and first aid, followed by a junior and a final examination. This lecture course was cancelled by Superintendent Dr Donald Cameron in 1940 on the grounds of ‘reduced enthusiasm’. That nurses became less enthusiastic about these lectures over time is not surprising, however, because, as the next section will illustrate, Dr Cameron withheld the promotion of nurses who had successfully passed the examinations (*Gleaner*, 16 October and 22 November 1944).

Considering the high patient/staff ratio, the nurses’ lack of training and their excessively long working hours – 10 hours per day and 65 hours per week –, the less than modern methods of

treatment and overcrowding, which will be discussed further on, it is not surprising that the hospital had a much lower recovery rate than its metropolitan counterparts, which in the early 1930s was less than 20 per cent of all admitted patients (*Annual Report* 1931). Many white superintendents tried to justify this low rate by presenting mental illness in African Jamaicans largely as a chronic condition. They claimed that most patients had inherited a predisposition to insanity and suffered from 'chronic mania' (e.g. *Annual Report* 1921). Yet some superintendents and Directors of Medical Services^{iv} (DMS) saw insanity in African Jamaicans less as an inherent and more as an acquired condition. They, however, did not hold the 'civilizing mission' or other features of colonialism responsible for insanity but lower-class African-Jamaican culture. For instance, acting DMS Gifford saw 'religious excitement' as an important cause of insanity, while superintendent Hewson largely blamed it on the 'consanguinity of the parents', i.e. the sexual mores of lower-class African Jamaicans (*Annual Report* 1918 and 1928). In fact, even black doctors located insanity largely in African-Jamaican culture. The afore-mentioned Uriah Murray, for instance, mentioned in an article published in 1935 that 'our idiots and imbeciles are the result of thoughtless mating' (*Gleaner*, 14 February 1935). In doing so, he reinforced one of the main stereotypes of people of African descent: hyper-sexuality. But black Jamaicans were not only seen to be more prone to insanity than whites because of their biology or culture, their insanity was also deemed to be of a different kind. Governor Denham, for example, explained the low recovery rate in terms of the fact that 'borderline cases of insanity that account for such a high record of cures in English institutions are rarely considered fit for admission in Jamaica' (Denham 1938).

Also in terms of its death rate the mental hospital compared unfavourably with its metropolitan counterparts. In the early 1920s, it had a crude death rate of 106.9 per 1,000 patients. As the island-wide crude death rate was 24.8 per 1,000 of the population (Roberts 1957: 185), this rate more than questions the claim that the mental hospital was a benevolent institution. Superintendents tried of course to excuse this high rate of mortality, which was mainly concentrated in the age group 20 to 50. Dr D. T. Williams, for example, argued that it was largely due to 'the admission of an unfavourable class of patients, some of whom were moribund on arrival' (*Annual Report* 1920). Yet not only did the hospital admit mainly patients under 35 but most of the deaths were caused by diseases triggered or exacerbated by the hospital's poor diet, overcrowding and lack of sanitation, such as TB, dysentery and pellagra (e.g. annual reports 1920 and 1926). In the early 1940s, patients were usually given a pint of 'bush tea' and a loaf of unbuttered bread for breakfast and supper and for their midday meal, two green bananas and a piece of mackerel, which even the matron had to admit, led many 'to go hungry' (*Gleaner*, 7 November 1944). As for the wards, they were so overcrowded that many patients had to sleep on the floor. They also lacked washing basins, had only a few showers and about 1 toilet per 30 patients (*Gleaner*, 14 October, 2 and 4 November 1944). Further facilitating the spread of disease was a lack of clothing and linen. Patients were given two changes of clothing but which were interchangeable between patients and they were not issued with towels but had to dry themselves with rags (*Gleaner*, 7 November 1944).

Although more than 25% of patients died of pulmonary tuberculosis during the period under discussion, little was done to isolate tuberculosis sufferers. A tuberculosis block was set up in the 1930s but there was not enough space to accommodate all tuberculosis patients and it also lacked the most basic facilities to lower the incidence of tuberculosis, such as antiseptic and brushes for staff to scrub their hands (*Gleaner*, 4 November 1944). But patients not only suffered from tuberculosis, they were also used as objects of research into tuberculosis. From

1931 till 1942, the mental hospital took part in a tuberculosis project funded by the Rockefeller Foundation. This project aimed first of all to shed light on the epidemiology of tuberculosis, in particular the question whether 'Negroes' were more susceptible to the disease and suffered higher mortality rates than 'whites' (e.g. Putnam, Saward and Opie 1941). And second, it aimed to establish the efficacy of a vaccine of heat-killed tubercle bacilli. This was not the first time, however, that Jamaica was used by American scientists as a 'laboratory', nor did it stand out in this regard from other parts of the region (e.g. Altink 2007; Stepan 1991).

As part of the tuberculosis project, new patients were tested for tuberculosis upon arrival and an X-ray was made of patients who showed a positive reaction to the tuberculin test. Those who tested negative were divided into two groups. One group was given weekly injections with the vaccine, while the others constituted the control group (*Annual Report* 1932 and 1933). Each group was regularly given tuberculin tests and by the end of the trial, the Rockefeller tuberculosis commission concluded that the vaccinated group suffered lower attack and death rates of tuberculosis than the control group. About 14% of the vaccinated group developed tuberculosis compared to 22% of the control group. And the death rate of those who developed tuberculosis was 11% for the vaccinated group and 18% for the control group. This favourable outcome led it to conduct an island-wide vaccinated-control group study, involving some 4000 people in Kingston and 8000 in rural parishes (Zwerling 1945, 201-4).

Like in wider society, the high incidence of tuberculosis in the mental hospital was closely associated with overcrowding.^v Just before the outbreak of the First World War, government decided to erect a new ward that would accommodate 100 patients (*Gleaner*, 20 September 1920). In anticipation of this new ward, the Public Works Department (PWD) pulled down an existing ward but the outbreak of the War prevented it from building the new ward. After the War, the government did not instruct the PDW to work on the new ward, which along with a rapid increase in patients in the immediate post-war period, including many veterans, quickly resulted in overcrowding (*Annual Report* 1919 and 1920). In the early 1920s, proposals were regularly made by both white and black elected members of the LegCo to extend the hospital or build a new and more modern one outside of Kingston. The government usually responded to such demands with the claim that there were at present 'no funds available' (e.g. *Gleaner*, 21 March 1924). Yet at the same time it allocated large sums to the PWD to build roads and other overhead capital, such as a central sugar factory, that benefitted the island's economic elite far more than the people. The sums allocated to the PWD for road works, for instance, served to extend and improve existing main roads so that they could carry motor lorry traffic (mainly from plantations to the ports) rather than build new roads that would open up the interior lands and thus allow more African Jamaicans to become small cultivators (*Gleaner*, 6 March 1924).

It was not until the late 1920s and largely resulting from pressure exerted by a new superintendent before government finally set funds aside for building works. A few months after his arrival in 1926, the English-born superintendent Dr Dale Hewson stated that he had not expected 'to find conditions in general so far behind *modern* mental hospital practice' and concluded that the hospital was more 'a place of incarceration rather than a place for treatment of disease' (*Annual Report* 1926). A year later, he submitted a report, which highlighted the overcrowding, insanitary conditions, and lack of competent staff. Following a visit to the hospital, which confirmed Hewson's observations, Governor Stubbs ordered an investigation into improvements in the hospital which estimated that implementation of

Hewson's recommendations with regards to staffing and buildings would cost £19,000. Because of financial constraints, it was decided to carry these recommendations out in instalments. In 1927, the government proposed and the LegCo voted in favour of £3,000 for improvements in the buildings. The government expected that the elected members would approve additional funds for improvements in following years (Heuring 2011). Yet they approved only small sums. This should not only be seen in light of the fact that because of their limited powers, their role was largely reduced to that of opposition but also their belief that the insane were unproductive members of society, who competed with others for scarce resources. Or as some black elected members argued, the insane were 'economically dead' and money 'could be better used elsewhere' (*Gleaner*, 18 April 1929 and 25 March 1931).

In fact, black elected members were generally less concerned about patients than staff. We shall see further on that they made demands for the promotion of local doctors and vehemently protested against the treatment of nurses. This is not surprising, however, as they stood as independents until the emergence of a party political system in 1938. This necessitated a focus on the interests of the small number of taxpayers in their parish.^{vi}^{vii}Hence, black elected members were more inclined to ask for roads, schools, irrigation works etc. than to enlarge a hospital that benefitted not just the whole island but also mostly non-voters. And the fact that it was mainly the sons and daughters of their voters, who became doctors and nurses in the hospital helps to explain why the few times that they raised conditions at the mental hospital it was mainly the working conditions of staff rather than the level of patient care. As doctors and nurses were of a higher social status than the patients, it could be argued that by working more towards the benefit of staff rather than patients, black elected members did little to challenge the existing social structure.

The improvements affected in the late 1920s and early 1930s reveal that it was not just race but also class and gender prejudices that influenced the government's attitude towards the mental hospital. The first group to benefit from improvements were private and thus upper- or middle-class and mostly white or light-skinned patients. In 1927, a new ward was built for them and they were also given access to a tennis court. In following years, three further private wards were set up, which far exceeded the normal wards in terms of space and sanitation. And although the gender ratio of the patients was roughly equal and superintendents stressed that there was 'serious overcrowding' on the female side, the first new normal ward that was built was a male ward and in total four male wards were erected compared to only two for women (*Annual Report 1926*; *Gleaner*, 12 April 1937, 24 July 1930 and 21 July 1931).

The world-wide economic depression did much to halt the building work. In 1930, the DMS submitted a request to spend £ 10,600 on new buildings and sanitation works. Initially the government approved his request but eventually asked the LegCo to vote in favour of only £1,000 for an additional ward and £2,000 for sanitation works (Colonial Secretary's Office overcrowding 1933; *Gleaner* 4 December 1930). Four years later, Colonial Secretary Jelf visited the hospital and was so 'appalled at the overcrowding' that he suggested 'to provide immediately the accommodation for which the superintendent asks' (Jelf 1934). Governor Denham thereupon ordered an investigation into the possibility of moving the hospital to another site. Based on commercial considerations rather than a concern for the welfare of the patients – the hospital's land was valuable as residential property and the investigation recommended a new hospital. The costs involved led the governor to reject this recommendation and order instead improvements that would reduce overcrowding in "the cheapest way possible" (Heuring 2011). As a result, by 1944 the mental hospital had nine

male and eight female wards, each made up of various buildings, scattered across some 120 acres and connected by two miles of dirt road. The majority of the buildings were constructed of brick but the ones added since the late 1920s were made of reinforced concrete. Not only were wards – enclosed units where patients slept, dined, were examined and had their recreation – seriously overcrowded, they also suffered from leaking roofs and flooding during rainy weather because of a lack of a proper drainage system. Most wards also lacked dining sheds so that patients had to eat on the verandas or under trees (*Gleaner*, 2 November 1944).

The mental hospital, then, was grossly underfunded in the interwar years. The government allocated sums for building work but this did little to counteract overcrowding which was positively correlated to the high mortality rate. And while the government met Dr Hewson's demand for more staff, the patient/staff ratio along with the quality of staff and their long working hours as well as the superintendents' lack of interest in modern methods of treatment resulted in a low standard of patient care. As mentioned, the government's claim that there were 'no funds' available for substantial improvements was largely an excuse, as it did make funds available for projects that benefited the mostly white business elite. Although it never openly discriminated against patients and staff, the following section, which focuses on the white senior staff of the hospital in particular their relationship with the mostly locally-born doctors and nurses, also suggests that the government's attitude towards the mental hospital was influenced more by its racial biases than economics.

Staffing

Throughout the period under discussion, the superintendent and matron were 'imported' from Britain, while the doctors, the head nurse and other nurses were recruited locally and thus invariably black. Black head nurses were never considered for the post of matron. In 1913, Matron Annie Douglas took up a new post at the public hospital in Kingston. It took until 1926 before the government finally decided to appoint a new matron, which provides another illustration that treatment was not a priority. It did not, however, consider head nurse Munroe, who had acted as matron for more than ten years, but advertised abroad (*Gleaner*, 3 March 1926). And when the 'imported' matron – Harriet Tyler – resigned in August 1938, the post was again advertised abroad because the head nurse had the required ten years of experience but not the necessary certificate in mental nursing (Richards 1938a).

Local doctors were also not considered for promotion to the most senior rank. In 1924, the post of superintendent became vacant. Dr Hugh Bond, an African Jamaican who was engaged in private practice in London but had acted as superintendent and also held a diploma in psychiatric medicine, enquired at the Colonial Office about the vacancy. He was told that the post was already under offer to another candidate. This, however, was a mere excuse. As in the case of other African-Jamaicans doctors whose applications for senior posts in- or outside Jamaica were rejected, skin colour was the deciding factor. A summary of the Colonial Office's interview with Bond concluded with the words that 'although perhaps not a fully blooded negro he is not far short of it' (Notes Senior assistant medical officer).

The person eventually appointed to the post of superintendent was Dr Birch, an Englishman who had previously worked in the hospital. He resigned, however, within a year because the government did not want to implement his suggestions to modernise the hospital (*Gleaner*, 7 July 1925). He was succeeded by Dr Dale Hewson. When Hewson died in 1937, hope was expressed that a local doctor would be appointed, especially after the *Gleaner* reported that Dr Hugh Bond had once more applied (*Gleaner*, 2 March 1937). Yet in October 1937, Dr

Aslett, who lacked experience in tropical medicine, arrived from England. Like Dr Birch, he compared the hospital to its metropolitan counterparts, found it lacking, and resigned within a month (Notes interview with Dr Aslett, 1938).

After Aslett left, Uriah Murray became acting superintendent. Although Aslett had recommended him for the post of superintendent, Acting Governor Woolley decided to appoint someone from abroad because Murray lacked the 'necessary qualifications'. As it would be difficult to find a doctor from abroad with both the relevant qualification and experience in tropical medicine on a salary of only £750 a year, Woolley proposed in the discussion of the budget for 1938-39 to increase the salary to £850. The black elected members fiercely opposed this and argued that whatever Murray lacked in qualifications, he more than made up in experience. Although they could not prevent Woolley from appointing a superintendent from abroad, they showed their discontent by voting against his proposal. Because at least nine voted against, the government was forced to withdraw its proposal and was thus only able to appoint a superintendent from abroad on a salary of £750 (*Gleaner*, 18 May 1938).

It needs to be stressed that the black elected members used the appointment of a new superintendent also more generally to express their discontent with the bypassing of African Jamaicans for senior posts in government service. Or as member Little argued, there is a 'feeling that wherever there is a position that calls for something like a decent salary, every effort is made to leave out the *local* talent' (*Gleaner*, 18 May 1938). Other black elected members equally avoided the words race or colour in their support for Murray and used instead such neutral terms as 'locals', 'natives' or 'Jamaicans'. As more than 95 per cent of the population was of African descent, it could be argued that they did not have to bring up race in their attacks on the government's practice to keep the top of the government service white, as the government would have known implicitly that they were talking about discrimination against non-whites. Yet another explanation why they did not invoke race or colour is that it was not deemed respectable in middle-class Jamaican society to raise 'the colour question' (Richards 2002: 351-7). Some black elected members may have embraced this norm, like other white, middle-class, norms and values, in an attempt to gain acceptance from the white elite. Others, however, may have done so to avoid the vilification meted out on Marcus Garvey and others who preached a race-first ideology. But for whatever reason, by not calling the bypassing of Murray racial discrimination, black elected members did little to challenge the racial hierarchy.

The high turn-over in superintendents may have negatively affected patient care as nurses and doctors constantly had to adjust to new personalities. But what affected patient care even more was the quality of the 'imported' superintendents. Except for Birch, none of the superintendents during the period under consideration had experience in tropical medicine and most were unwilling to gain knowledge of 'native psychology' and local conditions possibly because of their metropolitan orientation and/or racial prejudice. For instance, Dr Donald Cameron, who succeeded Dr Aslett, tried to avoid as much as possible interaction with the predominantly lower-class and dark-skinned patients. He never visited the wards and ordered treatment solely on the basis of case sheets provided by the doctors (*Gleaner*, 10 and 16 November 1944). His racial prejudices also led Cameron to prevent patients from leaving the hospital after they had been recommended for discharge by one of the doctors. When asked by the 1942-43 commission about this, he claimed that the patients concerned had not yet completed a course of anti-syphilitic treatment. As syphilis was not a prevalent disease in the hospital, it is likely that he never ordered such treatment and that he merely kept these

patients out of spite and mobilised the stereotype of black promiscuity – syphilis is a sexually transmitted infection – to justify his action (*Gleaner*, 2 November 1944).

But even Dr Hewson, who recommended building works and an increase in staff, was not free from racial prejudices. In 1935, the white Canadian Guy Armstrong was put on trial for murder. He was found guilty but on evidence supplied by Hewson was declared ‘insane’ and committed to the mental hospital. He was released within a year on evidence again provided by Hewson. Yet Hewson did not support the release of black convicts in the hospital, who had committed far lesser crimes than Armstrong (*Gleaner*, 5 February 1936 and 20 February 1937, Denham 1937).

And the white matrons too discriminated against the overwhelmingly dark-skinned, patients. For example, Matron Doris White, the successor to Matron Tyler, gave patients castor oil for ‘no better reason than they curse her’. And she also issued excessive punishments for minor offences. She, for instance, deprived patients who had ‘picked up ripe fruit’ of their bed or took away their private belongings or withheld from them such privileges as playing cricket (*Gleaner*, 14 November 1944). And Matron White also acted out of mere spite when she ordered the removal of discarded pieces of canvas that the locally-born head nurse had given to patients who were forced to sleep on the concrete floor because of a lack of beds (*Gleaner*, 10 November 1944).

But the ‘imported’ superintendents and matrons were not just prejudiced against patients. Triggered by the black elected member J. A. G. Smith and following a long series of complaints by nurses, a commission chaired by attorney-general Camacho was set up in 1936 to enquire into the dismissal of several nurses for sleeping on a four-week night shift and more generally the discipline in the institution. The Camacho commission concluded that the dismissal was justified on the basis of the rules in place at the time but that there was no justification for the ‘rough and sometimes insulting manner in which they are spoken to and treated by the superintendent and matron’. It furthermore noted that shifts were too long; that staff had insufficient annual leave and lacked sanitary facilities; and that the patient/staff ratio was too high. The commission was especially critical of the behaviour of Matron Harriet Tyler. It argued that in many cases Dr Dale Hewson had been inclined to leniency but that she had ‘insisted on punishments being meted out or sentences increased in severity’ (*Gleaner*, 15 January 1937).

Although the Camacho commission severely criticised Matron Harriet Tyler, it did not recommend her dismissal. In fact, the DMS fully supported her. He told the colonial secretary not to attach too much weight to the commission’s report because ‘all matrons have acid tongues and few efficient matrons are liked by their staff’ (Hallinan 1936). Also attempts by black elected members to reduce the matron’s salary as a means of punishment for her behaviour came to nothing and she was even given an MBE (*Gleaner*, 30 April 1936 and 10 June 1938). Yet at the same time, some of the nurses who had testified before the Camacho commission were dismissed. And in spite of demands made by black elected members, the nurses who had been dismissed for sleeping were not reinstated, even though the four-week night shift had been repealed (*Gleaner*, 2 February and 5 May 1937).

The 1942-43 commission was even more outspoken in its criticism of the superintendent (Dr Donald Cameron) and matron (Miss Doris White) than the Camacho commission, which is not surprising considering its make-up. While the Camacho commission consisted of the attorney-general, the commander of the troops and a retired senior civil servant, the 1942-43

commission was made up of George Seymour, the locally-born white custos of St Andrew; Dr Oswald E. Anderson, a black doctor and elected member, who had resigned as Mayor of Kingston in 1938 following his public accusation that there was racial discrimination within the medical department; and nominated member Robert Barker. The commission was set up in response to numerous, publicly-made complaints by staff that recommendations made by the Camacho commission and accepted by the government had not been implemented and that the new superintendent Dr Cameron issued 'severe penalties' for minor offences and was extremely condescending towards them (e.g. *Gleaner*, 2 September and 12 November 1938: Memorandum asylum staff). As a result, the 1942-43 commission's remit was much wider than the Camacho's: 'to enquire into and make recommendations concerning the administration of the Jamaica mental hospital'.

The commission produced a majority report written by Seymour and Anderson and a minority report by Barker. The majority report listed some 90 recommendations. Amongst them were various suggestions to increase the quality of staff, which offered opportunities for social mobility, such as providing doctors and the head nurse with opportunities to pursue degrees that would enable them to occupy the most senior posts in the hospital and a three-year nursing training (*Gleaner*, 7 October 1944). But the majority report also included various proposals that tried more directly to improve patient care, such as adding new buildings, the purchase of specialised equipment, the appointment of a dietician, etc. But its most controversial recommendation and which led Barker to produce his minority report was the dismissal of Dr Cameron and Matron White because they had a 'lack of sympathetic understanding' of the staff (*Gleaner*, 11 October 1944). The majority report stated that the matron held an unhealthy sway over the superintendent. It mentioned various instances in which Matron White had tried to influence Dr Cameron and also stated that Dr Cameron usually took her words against that of the doctors and that he also ignored the doctors' complaints about Matron White's inappropriate behaviour towards them (*Gleaner*, 21 November 1944). It is likely that Matron White would not have shown such condescending behaviour towards doctors in a metropolitan mental hospital as they ranked much higher than her.

Yet Seymour and Anderson reserved most of their criticism for Dr Cameron. They stressed in their report that he antagonised staff, in particular the doctors and the head nurse; was not impartial in the exercise of discipline; did not follow just procedure when issuing penalties for offences; and failed to take circumstances into consideration that had caused staff to commit offences in the first place (*Gleaner*, 18 October and 21 November 1944). For example, he dismissed nurses when a patient under their care escaped. Yet because of a lack of staff and the numerous opportunities for patients to escape, including 'occupational therapy', there was little nurses could do to prevent escape. Furthermore nurses who were accused of such serious offences as the escape of a patient were rarely asked to appear before Dr Cameron. Instead, he usually sent them a note listing the offence and after their reply, issued another note stating that they were dismissed (*Gleaner*, 8 October 1944). And nurses he did not like, he 'perpetually watched and brought up for any error, however trivial', while others could commit similar or even more serious offences but 'were not even reprimanded' (*Gleaner*, 18 October 1944).

Seymour and Anderson also stressed that Dr Cameron was not impartial when it came to promotions and increments. Various nurses who had attended lecturers, taken the exams and had a clean record were not given increments, while nurses far junior who did not meet these standards were promoted (*Gleaner*, 22 October 1944). As it was not deemed respectable to

raise 'the colour question', it is not surprising that Seymour and Anderson did not state that it was 'shadism' – a preference for a lighter skin – that underpinned Cameron's partiality with regards to punishment and promotion, as it was for many of his predecessors (e.g. Lysaigt 1937). The majority report, however, does provide evidence that Cameron held negative and stereotypical ideas of people of African descent, including the idea that they were less intelligent than whites. For instance, he told the commission that there was much 'dead wood' amongst the nurses, which should be 'trimmed off by retirement or dismissals in order to improve the efficiency of the nursing staff', a fact much disputed by the doctors, who claimed that about two thirds of the nurses were 'of fair intelligence and capable of absorbing technical training in general and mental nursing' (*Gleaner*, 16 October 1944). But Cameron not only questioned the intelligence of the nurses, he also repeatedly told the commission that the doctors lacked certificates in psychiatric medicine and did not 'know their work' (e.g. *Gleaner*, 21 November 1944).

While Robert Barker agreed with Seymour and Anderson that the relationship between the senior and subordinate staff was fraught with friction, he was convinced that the superintendent and matron alone were not to blame for this state of affairs. He stated for instance in his report that the superintendent could not be held responsible for 'conditions that were complained of before the he took up office'. Yet he did not completely excuse the superintendent by adding that it was 'clear that he has not remedied them [conditions]' (*Gleaner*, 11 October and 10 November 1944). Barker's attempt to excuse the superintendent is not surprising, however, as he was a nominated member of the LegCo and thus expected to support the government. The government had already made attempts to protect Dr Cameron before the commission had completed its work. When the commission discovered in February 1943 that Cameron did not follow just procedure in the case of dismissal, such as refusing nurses to call witnesses, it submitted an interim report to the governor asking him to retry some recent cases of dismissal. Governor Richards not only declined this request but also stated that 'there is nothing to show that the discretion of the senior medical officer has been at fault' (*Gleaner*, 17 October 1944).

After the commission had completed its work, the government continued to protect Dr Cameron. The two reports were submitted to the Privy Council in May 1944. As even Barker's report raised questions about Dr Cameron's performance, the Privy Council asked to interview both Dr Cameron and the DMS. Dr Cameron tried to exonerate himself first by arguing that the three doctors who had testified before the commission were 'the only ones he did not get on with' and that the commission had refused to honour his request to call other witnesses, and second by stressing that 'conditions at the institution had affected adversely the work of the medical officers, nurses and subordinate staff'. Dr Cameron also tried hard to excuse Matron White, whom he argued 'was highly efficient and the best-informed matron with whom he had worked'. The DMS furthermore convinced the Privy Council that the governor should tell the LegCo that the government did not support the majority report's recommendation to dismiss the superintendent and matron. He stated that there 'was no doubts as to the efficiency of the matron' and that Dr Cameron had submitted requests to him for improvements but that he had to refuse them because of the financial situation of the colony and the war (Privy Council 1944).

The governor accepted the Privy Councils' advice and told the LegCo that while the government was willing to implement many of the recommendations made in the majority report, including the appointment of a dietician and occupation officer, the institution of an after-care system and greater opportunities for staff training, it would not take steps to

remove the superintendent and matron. And it also argued that 'lack of funds' and the war made it impossible to adopt an eight-hour work day and the appointment of more nurses to achieve a nurse/patient ratio of one in eight – other key recommendations made in the majority report (*Gleaner*, 1 November 1944). In other words, the government failed to endorse those recommendations that impacted most on patient care and the relationship between senior and subordinate staff.

As the majority report incriminated not only senior government officials for conditions in the mental hospital but also the government itself by stressing that between 1900 and 1942 expenditure on the hospital as a percentage of total expenditure increased from only 1.7 to 1.9 per cent (*Gleaner*, 30 November 1944), the government tried to ensure that the LegCo had as little opportunity as possible to discuss the majority report. Hence it simply informed the LegCo on 31 October 1944 of the recommendations made in the majority report that it was willing to implement. Yet it could not completely avoid discussion of the report. On 9 November, the LegCo discussed the proposal to ask for a grant under the Colonial Development and Welfare Act to set up various 'temporary structures' at the hospital with a view to building a complete new and modern hospital in the future. Although it was tabled as the last item of the day, black elected members used this opportunity to raise their concerns about the government's handling of the commission's findings. They argued that the main problem with the mental hospital was not 'buildings but administration' and that by keeping the two main officers in place, both staff and patients would continue to suffer ill-treatment. They were not surprised, however, by the government's refusal to endorse the proposal to dismiss the superintendent and matron. For instance, Anderson said that he knew that 'friendship existed between officers of the government and the administration of this institution' and that 'friends must protect friends' while 'sick people must go to ruin and employees must take their chance so that friends might be maintained' He also indirectly accused the government of discriminating against African Jamaicans by comparing the government's treatment of this white English superintendent with the way it treated locally-born and thus invariably black doctors in charge of the public hospitals in rural parishes. He mentioned, for instance, that the doctor 'in charge of the cattle barn which is the Morant Bay hospital is expected to be up-to-date. If he did not conduct that hospital properly he would have been fired long ago'. And although the other black elected members did not state things as bluntly as Anderson, they too used the discussion about the proposed grant application to show their discontent with the practice of appointing only whites to senior posts in government service. A. B. Lowe, for example, stated that he did not object to white men occupying senior posts in the medical service per se as he realised that many were more qualified than locals but he did not want those 'with poor mentality' only those 'who are friends' (*Gleaner*, 10 November 1944).

Not only was the government not persuaded by these arguments to allow for a greater discussion of the majority report, it also accused black elected members of dealing with 'the matter in an electioneering spirit' – the first election under universal suffrage was only a few weeks away. Yet we have seen that this was not the first time that elected members complained about the administration of the mental hospital. While the government may have granted a commission to investigate conditions at the hospital in order to stem the discontent of elected members with the system of Crown Colony government, by suppressing a full and open discussion of the majority report, which highlighted the shortcomings of not just the senior white officers but also Crown Colony government itself, it in fact did much to fuel this discontent. In particular, by not dismissing the two white senior officers that were at the

centre of the investigation the government conveyed to black elected members its commitment to uphold the racial status quo.

Conclusion

This case study of conditions in the Jamaican mental hospital in the decades leading up to the first election under universal suffrage has provided evidence to contest the claim that Empire was a modernising, benevolent and non-discriminatory force. Although patients spent more time outside the wards, the hospital remained throughout the period under discussion a place of confinement rather than treatment. For instance, it did not, like its metropolitan counterparts, employ an occupational officer. And shock therapy was only used on an experimental basis and administered by the doctors because the superintendent had no interest in employing such modern methods of treatment. Because of this lack of modernisation, the hospital failed to benefit the majority of its patients, who were poor and mostly dark-skinned. When the government finally agreed to enlarge the hospital, it was not these patients but the small number of private, i.e. middle-class, patients, who were the first to benefit. Although more normal wards were added in the late 1920s and early 1930s, building work failed to keep step with the increase in patients so that normal wards were heavily overcrowded. This largely explains the hospital's high mortality rate, which above all contests the idea of Empire as a benevolent force.

Underinvestment in mental health care was a phenomenon not unique to Jamaica. Also in the metropole, mental hospitals received less funding than general public hospitals because patients were not 'normal', i.e. not contributing to the economy. Yet in Jamaica as in African colonies (Vaughan 1991), the colonial governments underinvested in mental health care because the patients were doubly abnormal – insane and black. Although they never openly discriminated against patients, racial biases did influence the government's and the white senior officers' attitudes towards them, as is clearly illustrated by Matron White's decision to take away privileges from patients for such things as 'picking up ripe fruit' and Dr Cameron's refusal to discharge certain patients.

And racial prejudices also underpinned the government's and white senior officers' attitudes towards the local and thus invariably black staff. By turning down requests for promotion on the grounds of 'lack of qualifications' and appointing white men and women who lacked 'the necessary experience' to senior posts and also by withholding opportunities for local staff to get promoted, such as study leave for doctors and lecture courses for nurses, the government and white senior officers helped to uphold the island's peculiar system of social stratification. But to sustain this system, the government also had to protect the white senior officers against attacks by the black elected members of the LegCo. Hence it ensured that there were yes-men on the two commissions that investigated conditions in the hospital. And when these commissions found incriminating evidence against the white senior officers, the government went out of its way to keep them in post. It, for instance, rejected the recommendation to dismiss Superintendent Cameron and Matron White on the grounds that:

. . . it has been impossible, owing to the war, to remedy the unsatisfactory conditions that have obtained at the mental hospital for some years which are due mainly to overcrowding and inadequacy of personnel and equipment, concerning which several representations have been made by the Director of Medical Services, and the Senior Medical Officer, it is considered that the latter Officer and Matron cannot be held sufficiently responsible for these conditions to justify the acceptance of this recommendation (*Gleaner*, 1 November 1944).

Yet the sheer fact that black elected members managed to get a commission of investigation in spite of their limited powers illustrates that they were considered by the government as a force to be reckoned with. And their attempts to openly discuss the findings of the two commissions and even more so their attempts to mete out some form of punishment on the white senior officers, indicate the black members' commitment to replace Crown Colony government with representative or even fully responsible government. But as they were more concerned with the promotion opportunities of staff than patient care, black elected members themselves also worked to uphold the peculiar system of social stratification. And they did so too by not condemning as racial discrimination the bypassing of Murray for the post of superintendent or Dr Cameron's decision to withhold increments from certain nurses.

This case study, then, has revealed some uncomfortable truths. It has shown not only that Empire was marked by institutional racism but also the complicity of the colonised in their own submission. Although these truths are not surprising, it is important for scholars to bring them out in the open because, as Stephen Steinberg has argued with regards to the study of American racism, 'failing to recognize and condemn oppression, or calling it by its right name, allows oppression to go unchallenged' (Steinberg 2007: 84).

Author bio: Henrice Altink is a Senior Lecturer in Modern History at the University of York (U.K). She was an executive member of the Society for Caribbean Studies from 2005 till 2012 and is the author of *Representations of Slave Women in Discourses on Slavery and Abolition, 1780-1838* (Routledge, 2007) and *Destined for a Life of Service: Defining African-Jamaican Womanhood, 1865-1939* (Manchester University Press, 2011). This article is part of a larger project on racial discrimination in Jamaica in the era of decolonisation.

REFERENCES:

Altink, H. 2007. An American race laboratory: Jamaica, 1865-1945. *Wadabagei* 10 (3): 53-83.

Bennett, D. 1996. Work and occupation for the mentally ill. In H. Freeman and G. E. Berrios, eds. *150 Years of British Psychiatry, vol. II*. London: Athlone.

Board of Visitors. 1931. [Minutes] special meeting. 20 May. 1b/5/77. Spanish Town. Jamaica Archives (JA).

Board of Visitors. 1934. [Minutes] meeting. 17 January. 1b/5/77. Spanish Town. JA.

Brereton, B. 2006. Recent developments in the historiography of the post-emancipation Anglophone Caribbean. In J. De Barros, A. Diptee and D. V. Trotman, Eds. *Beyond Fragmentation: Perspectives on Caribbean History*. Princeton: Markus Wiener Publishing, pp. 187-209.

Carley Manning, M. 1943. *Medical Services in Jamaica*. Kingston: Institute of Jamaica.
Collins Hill, P. (2005). *Black Sexual Politics: African Americans, Gender and the New Racism*. New York: Routledge.

Colonial Secretary's Office. 1933. [Notes] overcrowding lunatic asylum. 1b/5/77. Spanish Town. JA.

- DeBarros, J., S. Palmer and D. Wright, eds 2009. *Health and Medicine in the Circum-Caribbean, 1800-1968*. New York: Routledge.
- _____. And S. Stilwell, Eds. 2003, 'Colonialism and health in the tropics'. Special issue of *Caribbean Quarterly* vol. 49, no. 4.
- Delgado, R. and J. Stefanic. 2001. *Critical Race Theory: An Introduction*. New York: New York University Press.
- Denham, E. 1934. [Letter] to Colonial Secretary, 5 December. 1b/5/77. Spanish Town. JA.
- Denham, E. 1937. [Letter] to Secretary of State, 29 March. CO 137/819/10. London. The National Archives (TNA).
- Denham, E. 1938. [Letter] to Secretary of State, 5 April. CO 137/826/6. London. TNA. Gleaner (1918-1944).
- Ernst, W. 2002. 'Colonial policies, racial policies and the development of psychiatric institutions in early nineteenth-century India', in *Race, Science and Medicine, 1700-1960*, eds., W. Ernst and B Harris. London: Routledge.
- Gleaner, 1918-1944.
- Hallinan, T. J. 1936. [Letter] to Colonial Secretary, 21 December. CO 137/826/6, London. TNA.
- Heuring Hughes, D. 2011. "In the cheapest way possible": responsibility and the failure of improvement at the Kingston lunatic asylum, 1914-1945. *Journal of Colonialism and Colonial History*, [online]. Available at: http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/journal_of_colonialism_and_colonial_history/v012/12.3.heuring.html (accessed 20 March 2012).
- Hyam, R. 2006. *Britain's Declining Empire: The Road to Decolonisation*. Cambridge: Cambridge University Press.
- Jamaica. 1930-1938. Annual Report of the Medical Department. Kingston.
- Jelf, A. S. 1934. [Letter] to Governor, 24 November. 1b/5/77. Spanish Town. JA.
- Jones, K. 1991. The culture of the mental hospital. In G. E. Berrios and H. Freeman, eds. *150 Years of British Psychiatry, 1841-1991* vol. I. London: Gaskell, pp. 17-28.
- Jones, M. 2008. The most cruel and revolting crimes: the treatment of the mentally ill in mid-nineteenth century Jamaica. *Journal of Caribbean History*, 42 (2): 290-309.
- Keller, R. 2001. Madness and colonialism: psychiatry and the British and French empires, 1800-1962. *Journal of Social History*, 35: 295-326.
- Lewis. G. K. 2004, *The Growth of the Modern West Indies*. New York: Monthly Review Press, 1968. Reprint, Kingston: Ian Randle Publishers.

Lysaigh, R. L. 1937. [Letter] to Governor Denham, 15 July. 1b/5/777. Spanish Town. JA.
[Memorandum] asylum staff. 1938. CO 950/270. London. TNA.

Moore, B. L. and M. A. Johnson 2004. *Neither Led nor Driven: Contesting British Cultural Imperialism in Jamaica, 1865-1920*. Kingston: University of the West Indies Press.

[Notes] Senior assistant medical officer lunatic asylum. 1924. CO 136/766. London. TNA.

[Notes] Interview Dr Aslett. 1938. CO 137/819/11. London. TNA.

Privy Council. 1944. [Minutes]. 1b/5/3. Spanish Town. JA.

Putnam, P., E. J. Saward and E. L. Opie. 1941. *Studies on Tuberculosis*. Baltimore: Johns Hopkins University Press.

Richards, G. 2002. Race, class and labour politics in colonial Jamaica, 1900-1934. In K. E.A. Monteith and G. Richards, eds. *Jamaica in Slavery and Freedom: History, Heritage and Culture*. Kingston: University of the West Indies Press, pp. 340-62.

Richards, A. 1938a. [Letter] to Secretary of State, 18 November. CO 137/830/17. London. TNA.

Richards, A. 1938b. [Letter] to Secretary of State, 16 November. CO 318/435/2. London. TNA.

Roberts, G. W. 1957. *The Population of Jamaica*. Cambridge: Cambridge University Press.

Riley, J. C. 2005. *Poverty and Life Expectancy: The Jamaica Paradox*. Cambridge: Cambridge University Press.

Sadoswky, J. 1999. *Imperial Bedlam: Institutions of Madness in Colonial South West Nigeria*. Berkeley: University of California Press.

Smith, L. 2010. *Caribbean bedlam: The development of the lunatic asylum system in Britain's West Indian Colonies, 1838-191*. *Journal of Caribbean History*, 44 (1): 1-47.

Steinberg, S. 2007. *Race Relations: A Critique*. Stanford: Stanford University Press.

Stepan, N. L. 1991. *The Hour of Eugenics: Race, Gender and Nation in Latin America*. Cornell: Cornell University Press.

Vaughan, M. 1991. *Curing their Ills: Colonial Power and African Illness*. Stanford: Stanford University Press.

Wrong, H. 1923. *Government of the West Indies*. Oxford: Oxford University Press.

Zwerling, R. 1945. *Vaccination against tuberculosis*. *Millbank Quarterly*, 23 (2): 201-04.

ⁱ The term 'black' is used here to denote Jamaicans of African descent

ⁱⁱ The paper was paid £600 a year by the government for its Council reporters in order to economise on the costs of Hansard reporters.

ⁱⁱⁱ This happened with the passing of the Mental Hospital Amendment Act, which was based on the 1930 metropolitan Mental Treatment Act that turned 'lunatic asylums' in Britain officially into mental hospitals.

^{iv} Until the early 1930s, the term Superintending Medical Officer was used for the head of the medical department. The term DMS, however, is used throughout this study to refer to this person

^v As pulmonary tuberculosis, the most common case of tuberculosis in interwar Jamaica, is a bacterial disease transmitted from person to person through droplets coughed, sneezed, or spit by people with an active case of the disease, it spreads easily in overcrowded residential areas and also in institutions that are marked by overcrowding, such as prisons and hospitals (Riley 2005: 97-8).

^{vi} In the interwar years, no more than 10 per cent of the population paid enough taxes on property or had a sufficient high income to qualify for the vote (Wrong 1923: 130).