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THE DEMISE OF THE ASYLUM IN LATE TWENTIETH-CENTURY BRITAIN: A PERSONAL HISTORY*

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ABSTRACT. Mental health care in Britain was revolutionised in the late twentieth century, as a public asylum system dating back to the 1850s was replaced by a community-based psychiatric service. This paper examines this transformation through the lens of an individual asylum closure. In the late 1980s, I spent several months in Friern mental hospital in north-east London. Friern was the former Colney Hatch Asylum, one of the largest and most notorious of the great Victorian 'museums of the mad'. It closed in 1993. The paper gives a detailed account of the hospital's closure, in tandem with my personal memories of life in Friern during its twilight days. Friern's demise occurred in an ideological climate increasingly hostile to welfare dependency. The transfer of mental health care from institution to community was accompanied by a new 'recovery model' for the mentally ill which emphasised economic independence and personal autonomy. Drawing on the Friern experience, the paper concludes by raising questions about the validity of this model and its implications for mental healthcare provision in twenty-first century Britain.

Historians of the recent past often witness its remnants disintegrating around them; sometimes they even participate in the process. This happened to me in the late 1980s, when I was a patient in Friern mental hospital, in north-east London. In 1988 and 1989 I had three stints in Friern, totalling some eight months. The hospital closed four years later. Today it is a luxury apartment complex inhabited mostly by

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City employees (the nearby train station is on a direct line to London's financial district).

Friern was not just any loony bin. Entering it for the first time in July 1988, I found myself in what was once England's largest and most advanced mental institution: the Middlesex County Pauper Lunatic Asylum at Colney Hatch, or 'Colney Hatch' as it was universally known until the mid-twentieth century. A few days after my admission, my friend the historian Raphael Samuel came to visit me. He looked around the vast drab ward with undisguised fascination and embraced me. 'Darling Barbara! What a privilege for you, as a historian, to be present at the demise of one of the last great Victorian institutions!' I was annoyed and amused, but he was right of course – and I dedicate this paper to him.

The closure of Friern, along with the rest of Britain's great asylums, was first intimated in 1961, by the then minister of health, Enoch Powell, in his famous 'Water Tower' speech. 'There they stand', Powell told his audience at the annual conference of National Association for Mental Health (now MIND): 'Isolated, majestic, imperious, brooded over by [the] gigantic water-tower[s] ... the asylums which our forefathers built with such immense solidity to express the notions of their day.' But this day had passed: 'For the great majority of these establishments there is no appropriate future use.'[1] Later that year the MP for Finchley and Friern Barnet, one Margaret Thatcher, spoke at a nurses' prize-giving ceremony at Friern. The young MP praised the state of mental health services in the UK. 'We lead Europe in our approach to mental health', she declared, 'and it is delightful with the coming of the Common Market that this is something for which Europe was coming to Britain.' If a chill wind blew down the hospital corridors as she spoke, no one recorded it.[2]

In 1962, Powell issued his Hospital Plan which provided for the replacement of the mental hospitals by acute-care psychiatric wards in general hospitals and community-based services for non-acute and

[1] The full text of Powell's speech is available on www.studymore.org.uk/xpowell.htm. Powell's decision to close the asylums was strongly influenced by a 1961 study forecasting a steady fall in the need for psychiatric beds (Trevor Turner, 'The History of Deinstitutionalisation and Reinstitutionalisation', *Psychiatry*, 3, 9 (2004), 1). In fact, the proportion of the population admitted to inpatient psychiatric institutions grew steadily between 1945 and 1990; what declined was the average length of these admissions, which decreased rapidly from the mid-1950s (James Raftery, 'Decline of Asylum or Poverty of Concept?', in *Asylum in the Community*, ed. Dylan Tomlinson and John Carrier (1996), 18–30; Peter Barham, *Closing the Asylum: The Mental Patient in Modern Society* (1997), 11–12, 158). The admission rate to Friern Hospital increased by 40 per cent between 1956 and 1961, but with an accelerating shift toward short-stay patients (letter from Friern Hospital Group Medical Advisory Committee, to group secretary, 4 July 1962: London Metropolitan Archives (LMA), H/12/CH/A/30/1).

[2] Margaret Thatcher, 'Speech at Friern Hospital', 9 Oct. 1961: www.margaretthatcher/org/speeches/displaydocument.asp?docid=101111.

after-care. But it was to be another two decades before Friern's closure was formally announced, and a decade more before the hospital shut its doors for the last time.[3] By then, most of the old asylums had closed and the number of psychiatric beds in England had fallen from its 1954 high of 152,000 to 43,000, a drop of 72 per cent.[4] Today these great 'museums of the mad',[5] once such a familiar sight on the outskirts of cities and towns across the UK, have either vanished or metamorphosed into business parks, leisure centres or – as in the case of Friern – up-market housing developments.[6] Their former residents are back with their families, or living in group homes or social housing; or they have vanished into the netherworld of the urban homeless.

Why did the asylums die, and what died with them? The question is controversial. From the 1960s, when Michel Foucault's jeremiad against the 'Great Confinement' of European lunatics lent intellectual muscle to the anti-psychiatry movement, historians of the Asylum Age have divided between critics who regard the asylums as primarily instruments of social control and defenders who stress the humanitarian motives of the asylum founders while acknowledging – insufficiently, critics contend – the abuses and suffering that went on in them.[7] Their demise has also been contentious, with some historians portraying 'deinstitutionalisation' as a progressive policy response to the failings of hospital care, facilitated by the development of new drug therapies,[8] while others emphasise

[3] Friern's closure is described in Elaine C. Stewart, 'Community Care in the London Borough of London Borough of Islington for Former Short Stay and Long Stay Patients Following the Decision to Close Friern Hospital' (Ph.D. thesis, University of London, 1999).

[4] Sarah Payne, 'Outside the Walls of the Asylum? Psychiatric Treatment in the 1980s and 1990s', in *Outside the Walls of the Asylum: The History of Care in the Community, 1750–2000*, ed. P. Bartlett and D. Wright (1999), 247. In 1960, there were 130 mental hospitals in England; by the time Friern closed, there were 41 (Joan Busfield, 'Restructuring Mental Health Services in Twentieth Century Britain', in *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, ed. Marijke Gijswift-Hofstra and Roy Porter (Amsterdam, 1998), 22).

[5] Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (New York, 1979); enlarged and revised as *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900* (1993).

[6] For the fate of the old asylums, see Anna Lowin, Martin Knapp and Jennifer Beecham, 'Uses of Old Long-Stay Hospital Buildings', *Psychiatric Bulletin*, 22 (1998), 129–30; SAVE, *Mind over Matter: A Study of the Country's Threatened Mental Asylums*, SAVE Britain's Heritage (1995).

[7] Michel Foucault, *The History of Madness*, trans. Jonathan Murphy and Jean Khalfa (2006). The most influential spokesman for the social control thesis has been the American sociologist Andrew Scull: see *Most Solitary of Afflictions*, 376–81, for his sophisticated version of the argument. For a nuanced defence of the asylum system, see Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services from the Early Eighteenth Century to the 1990s* (1993).

[8] As studies from Britain and elsewhere show, the introduction of new drug therapies did not cause deinstitutionalisation, which was already well underway before the new medications came into use, but it fuelled optimism and played an important role in shaping

'the attractiveness of community care to policy-makers concerned about ever-rising costs of health care within a capitalist welfare system'.[9] The arguments are fiercer for having been strongly politicised, as historians find themselves caught up in the policy battles raging around welfare provision over the last half century.

I do not intend to adjudicate these disagreements (although I have more to say about them further on). I am not a historian of mental health policy and anyway my own concerns are rather different. I am interested neither in loading more opprobrium on the defunct hospitals, nor in defending them (although my experience revealed some things that warrant defending); rather, I want to explore the ideals behind the asylum, and what has become of them in recent times. The birth of the asylum witnessed the emergence of a paradigm conflict still evident in mental health circles. This conflict maps loosely onto the historic opposition between psychological and biomedical models of madness, but terms such as near versus far, interactive versus passive, subject versus object, probably tell us more about it. How close to madness does one need to get to treat it effectively? One paradigm shows us madness practitioners proffering remedies to madness sufferers across a gulf of professional expertise and objectivity; the other shows sufferer and healer drawn together in a therapeutic partnership which, in the strongest versions of this tradition, directly implicates the healer's own psyche in the treatment process (an approach recently described by the leading forensic psychotherapist, Dr Gwen Adshead, as 'mak[ing] your mind available to somebody else, to help them recover').[10] The pioneers of the Asylum Age initiated the second tradition, creating an up-close therapeutic regimen based on personal rapport, moral example and the utilisation of other-regarding emotions ('social affections' in the vocabulary of the day) as remedial agents. This psycho-relational paradigm was known as 'moral treatment', and was strongly resisted by many mad-doctors at the time, accustomed to dispensing biophysical remedies – blood-letting, purging, drugs, psychosurgery, etc. – from a professional distance.[11] The demise of the asylum, I argue below, has reconfigured this conflict without

community-care policy (Jed Boardman, *New Services for Old – an Overview of Mental Health Policy*, Sainsbury Centre for Mental Health (2005), 29).

[9] John Welshman, 'Rhetoric and Reality: Community Care in England and Wales, 1948–74', in *Outside the Walls*, ed. Bartlett and Wright, 205. As John Raftery and others note, the deinstitutionalisation of mental health care also needs to understood as part of a long-term government drive to curtail public health expenditure by shifting provision toward the private and voluntary sectors: Raftery, 'Decline of Asylum', 20; Turner, 'History of Deinstitutionalisation', 3–4.

[10] 'Desert Island Discs', BBC Radio 4, 16 July 2010.

[11] See below, pp. 202–7, for a more detailed discussion of this.

diminishing it, and it continues to reverberate throughout mental health services.

Here in the UK, asylumdom entered its terminal phase with the foundation of the National Health Service. The decision to incorporate mental health services into the NHS, thereby drawing them into the medical mainstream, effectively signed the execution warrant for the old 'bins'.[12] But socialised medicine was not the sole or even the main factor behind deinstitutionalisation. The transfer of mental health care from asylum to community was a general western phenomenon, occurring more or less simultaneously in countries with medical systems as diverse as those of Britain, Italy and the USA. From the 1960s onward, asylums across Europe and North America faced a host of enemies: anti-psychiatrists who damned them as 'total institutions' and 'carceral cities'; public purseholders keen to reduce health costs; welfare reformers and campaigning journalists shocked by conditions in the infamous 'back wards'; and, increasingly, patients themselves, organised into a growing 'consumer' movement.[13] The most radical of these opponents (in the UK, R. D. Laing and his followers) regarded themselves as psychiatric insurgents, but the times favoured them.[14] Asylum populations were changing: voluntary patients had been admitted since 1930, and in the wake of the 1959 Mental Health Act (which abolished the distinction between psychiatric and general hospitals) the ratio of voluntary to detained patients rose dramatically: a transformation that made the custodial regimen of the old asylums appear gratuitously oppressive as well as out-dated.[15] Outpatient psychiatric services had expanded throughout the 1950s and 1960s, as new drug treatments made it possible to treat increasing numbers of people in their homes. By the early 1970s, asylums everywhere were recording a steady shrinkage in their resident numbers.[16] Moreover, many of the buildings housing these old

[12] Jones, *Asylums*, 146–8; Douglas Bennett, 'The Drive towards the Community', in *150 Years of British Psychiatry, 1841–1991*, ed. G. Berrios and Hugh Freeman (1991), 326–7; Elaine Murphy, *After the Asylums: Community Care for People with Mental Illness* (1991), 10–11, 13. The provision of social welfare benefits and public housing was also crucial in enabling the unwaged mentally ill to live outside asylums, although generally in very straitened circumstances.

[13] For the deinstitutionalisation of mental health services internationally, see *International Journal of Mental Health*, 11, 4 (1982/3) (entire issue); Walid Fakhoury and Stefan Priebe, 'Deinstitutionalisation and Reinstitutionalisation: Major Changes in the Provision of Mental Health Care', *Psychiatry*, 6, 8 (2007), 313–16.

[14] R. Boyers and R. Orrill, eds., *Psychiatry and Anti-Psychiatry* (Harmondsworth, 1972); Peter Sedgwick, *Psycho Politics* (1982).

[15] Bennett, 'Drive towards Community', 327.

[16] Admission rates (including repeated admissions: the notorious 'revolving-door' syndrome) were higher than ever by the end of the 1960s, but these admissions were increasingly short term (see n. 1 for references).

hospitals were crumbling. Refurbishing them would be hugely costly: an unwelcome prospect to governments, especially during the fiscal crisis of the seventies. And then there were the scandals. In the UK, there were a series of these in the 1960s and 1970s – several involving Friern hospital – which gave the *coup de grâce* to the Asylum Age. Who could defend institutions that handled people like 'human trash'? as one journalist demanded in the wake of a major exposé of the treatment of the demented elderly at Friern in the late 1960s.[17]

This constellation of anti-asylum forces could be found, with variations, in most western nations. But deinstitutionalisation also had a deeper root, in resurgent free-market ideology and the correlative attack on welfare 'dependency'. The last quarter of the twentieth century saw the post-war welfare settlement coming under sustained assault from free-marketeers, with a commensurate growth in hostility toward people reliant on state support. The opprobrium was initially directed against those traditional bogeys of the liberal (now 'neoliberal') imagination – the idle, the shiftless, the 'undeserving poor' – but quickly expanded to include new categories such as single mothers and, inevitably, the chronically mad:

> The punitive sentiments directed against those who must feed from the public trough extend only too easily to embrace those who suffer from the most severe forms of psychiatric misery … those incapacitated by psychiatric disability all too often find themselves the targets of those who would abolish social programs because they consider any social dependency immoral.[18]

Today the discourse of mental health 'providers' is all about autonomy and independence. The language of dependency is almost entirely negative. Its primary referents are to drug and alcohol addiction, but the pejorative connotations extend across most varieties of neediness, including for basic care and support. To need other people on a day-to-day basis (unless you are very young, very old or very disabled) is seen as inherently pathological; independence is a *sina qua non* of mental health.[19] The motives behind this philosophy are, in many respects, honourable: to treat mentally ill people as full adults, capable of making valid life decisions; to prevent emotional exploitation; to promote self-confidence and reduce stigmatisation. But the ideal of personal autonomy driving the agenda is, Elizabeth Bott has argued in a classic study of hospital care,

[17] Barbara Robb, *Sans Everything: A Case to Answer* (1967). Robb's book caused a furor. An independent committee of inquiry was established to investigate her allegations of abuse and neglect; for its findings (which many commentators at the time decried as a 'whitewash'), see www.sochealth.co.uk/history/Friern.htm.

[18] Andrew Scull, 'Historical Reflections on Asylums, Communities, and the Mentally Ill', *Mentalities*, 11, 2 (1997), 14–15.

[19] For examples of this policy language see Department of Health, *Independence, Well-Being and Choice* (2005); Department of Health, *From Segregation to Inclusion: Commissioning Guidance on Day Services for People with Mental Health Problems* (2006).

illusory: 'autonomous is just what most mental . . . patients are not. Either they are social isolates, or they are locked in dependent but conflict-ridden relationships with relatives'.[20]

If Bott is right about this – and I suspect most people with mental disorders, or people who work with people with mental disorders, would endorse her description – what are the care implications? Today, in Britain, 'choice' is the watchword in mental health services, as it is throughout the NHS. In 2006, the Department of Health initiated a website, 'Our Choices in Mental Health'. Launching the site, a DoH spokesperson declared that 'patients should know that they now have the powers to choose their own path through services and keep control of their lives. They have the preference to choose how, when, where or what treatments they receive.'[21] (The following year the government introduced Community Treatment Orders, which compel previously detained patients to take their medication under threat of re-hospitalisation if they refuse.) This 'logic of choice' is the focus of a recent book by the Dutch philosopher Annemarie Mol, who contrasts it to a 'logic of care'. 'Choice', Mol shows, interpellates the patient as an autonomous consumer selecting from an array of treatment options, while the 'logic of care' sees patient and carer interacting for the patient's benefit. Mol illustrates the difference between the two logics with an anecdote about a man in a mental hospital who refuses to leave his bed. A group of ethicists and psychiatrists meet to discuss how the man should be treated. The ethicists argue for non-intervention: the patient, they say, is harming no one by staying in bed; it's his choice to be there; he should be left alone. A discussion of what choice means for someone with severe mental illness ensues; eventually a psychotherapist cuts across it. The question, he says, cannot be decided outside its institutional context. Does the hospital have plenty of staff? If so, a nurse should be assigned to sit by the patient's bed and find out *why* he doesn't want to get up.

> 'Maybe his wife is not coming for a visit that afternoon, maybe he feels awful and fears he will never be released from hospital. Take time for him, let him talk.' Someone who does not want to get up, says the psychotherapist, needs care. Offering him the choice of staying in bed is as much a way of neglecting him as is forcing him to get up.[22]

[20] Elizabeth Bott, 'Hospital and Society', *British Journal of Medical Psychology*, 49 (1976), 126. Bott's classic essay is more than three decades old, but problems of social isolation and family conflict among people with serious mental illness appear to be ongoing: see Brendan D. Kelly, 'Structural Violence and Schizophrenia', *Social Science and Medicine*, 61 (2005), 721–30; J. Boydell, K. McKenzie, J. Van Os and R. M. Murray, 'The Social Causes of Schizophrenia', *Schizophrenia Research*, 53 (Suppl.) (2002), 264; J. Leary, E. C. Johnstone and D. C. Owens, 'Social Outcome', *British Journal of Psychiatry*, 159 (Suppl. 13) (1991), 13–20.

[21] For the announcement of the website launch see www.e-health-insider.com/news/itemcfm?ID = 2246. The website www.mhchoice.org.uk appears to be defunct.

[22] Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (2008), x–xi.

'Choice' in mental health care is usually contrasted to force: 'is care a soft form of force', Mol asks, 'or might it be something different?'[23] The view of psychiatric care as a 'soft form of force' was popular in libertarian circles in the 1960s and 1970s, and still has many proponents. But what was once an anti-Establishment stance has now leached into official policy. Alongside choice, mental health policy-makers today are increasingly preoccupied by risk: a concern that focuses primarily on safety risks to the public from aggressive patients,[24] but which runs too in the opposite direction: toward the potential risks to patient autonomy from carers and care institutions. Minimising these latter risks is a core aim of the 'recovery model', a healthcare approach which means living with a chronic illness as if one doesn't have it.[25] Services everywhere are becoming geared to this model, which requires patients (service users as they are now known) to pass through the system as quickly as possible; open-ended care – whether on an outpatient or inpatient basis – is a no-no.[26] Even

[23] *Ibid.*, xii.

[24] Risk leapt to the forefront of UK government mental health policy after the widely publicised murder of Jonathan Zito by the schizophrenic Christopher Clunis in 1992. The public inquiry that followed revealed care failures that were deemed to necessitate a more risk-oriented policy approach. 'Risk minimisation' became the must-do, dominating day-to-day decision-making, albeit in ways that sat very uneasily alongside the 'choice' agenda. As John Wilkinson, a former manager of mental health services in East London, writes: 'The very people who stalk the nightmares of tabloid editors and Heath Ministers and who must be policed in thought and act, at one and the same time are Consumers, who must exercise Choice and must assess the Performance of those providing them with services. The very people who must be subject to community orders and who must demonstrate Compliance – with treatment, with care plans – must grasp those opportunities made available to them through the new Recovery perspective!' (John Wilkinson, 'The Politics of Risk and Trust in Mental Health', *Critical Quarterly*, 46, 3 (2004), 83).

[25] The recovery model is a complex policy initiative. It has received strong impetus from the service-users movement, which sees in it a rejection of psychiatric paternalism in favour of a service that treats its users as persons rather than patients, and affords them a greater voice over their treatments and care. Critics however – which includes both users and practitioners – argue that the model has been 'hijacked' by mental health managers as a way of legitimating service cuts. For a government statement of the model see Mental Health Division Department of Health, *New Horizons: A Shared Vision for Mental Health* (HMSO, 2009); for service-users' perspectives see www.psychminded.co.uk, and a host of other internet sources. For a detailed discussion of the model see Geoff Shepherd, Jed Boardman and Mike Slade, *Making Recovery a Reality*, Sainsbury Centre for Mental Health (2008).

[26] Most inpatient admissions are now strictly time-limited; getting a patient 'off the books' – if only by shunting him or her onto another part of the service – is the goal. Outpatient services which do not fit into the new recovery model, such as rehabilitation programmes and day centres, are disappearing everywhere. For the decline in rehabilitation services see Debbie Mountain, Helen Gillaspy and Frank Holloway, 'Mental Health Rehabilitation Services in the UK in 2007', *Psychiatric Bulletin*, 33 (2009), 215–18. For day centre closures, see www.communitycare.co.uk, and scores of internet-based protests against local day centre closures.

NHS psychological treatments like cognitive behaviour therapy are time-limited in order to encourage 'client self-management' and to mitigate 'dependency issues'.[27] The ideal of the autonomous self underpinning these policies is so radically individuated that it begins to approximate to Melanie Klein's account of psychotic aloneness, although in this case the anxieties driving the fantasy belong to the professionals rather than the mad.[28] It is as if the terrible loneliness of madness, which Klein describes so well, has flooded the entire mental health establishment. Cognitive behaviour therapy, for example, can now be done on the NHS without any human contact at all, sitting alone at one's computer with an online CBT package – and this despite the fact that a host of studies have shown that it is the quality of the relationship with the therapist that determines the outcome of CBT, as it does all therapeutic encounters.[29]

I interviewed a number of mental health managers for this lecture. All, with one exception, repeated the anti-dependency mantra; all, *without* exception, spoke passionately about the need for emotional rapport between care-workers and users, and – in the spirit of Mol's psychotherapist – gave examples of up-close, sympathetic care relationships as instances of best practice. These contradictions, a London psychiatrist explained to me, are not incidental but endemic to a system

[27] The British Association for Behavioural and Cognitive Therapies describes the therapeutic relationship in CBT as a 'partnership' that aims to promote client independence: 'The approach ... relies on the therapist and client developing a shared view of the individual's problem. This then leads to identification of personalised, usually time limited therapy goals and strategies which are continually monitored and evaluated. The treatments are inherently empowering in nature, the outcome being to focus on specific psychological and practical skills ... aimed at enabling the client to tackle their problems by harnessing their own resources ... Thus the overall aim is for the individual to attribute improvement to their own efforts, in collaboration with the psychotherapist' (Katy Grazebrook, Anne Garland and the Board of BABCP, *What are Cognitive and/or Behavioural Psychotherapies?* (2005)). For the need to time-limit CBT in order to avoid 'dependency issues', see Ceri Evans, 'Cognitive Behavioural Therapy with Older People', *Advances in Psychiatric Treatment*, 13 (2007), 111–18.

[28] Melanie Klein, 'On the Sense of Loneliness', in her *Envy and Gratitude and Other Works, 1946–1963* (1988), 300–13.

[29] M. Lambert and D. E. Barley, 'Research Summary on the Therapeutic Relationship and Psychotherapy Outcome', *Psychotherapy*, 38, 4 (2001), 357–61; Paul Gilbert and Robert L. Leahy, eds., *The Therapeutic Relationship in Cognitive Behavioural Therapies* (Hove, 2007). In 1962, Denis Martin, the physician superintendent of Claybury Hospital in Essex, criticised psychiatric institutions for failing to develop strong relationships between patients and practitioners: 'Lack of channels of communication seems to be the fundamental barrier to constructive change and fosters a very ... superficial kind of personal relationship [between practitioner and patient]' (Denis Martin, *Adventures in Psychiatry* (Oxford, 1962), 15, quoted in Barham, *Closing the Asylum*, 7). Today this is a failing which many service managers – keen to avoid 'dependency-generative relationships' – seem to regard as a strength, while mental health staff who continue to emphasise the value of the therapeutic relationship are 'dismissed as self-serving and mystifying' (Wilkinson, 'Politics of Risk', 95).

that requires mental health professionals to respond empathically to patient suffering while simultaneously defending themselves against this suffering lest it draw them into care relationships that violate the anti-dependency imperative. These emotional defences are also meant to keep the craziness on the patient's side, well away from professional sanity . . . although this isn't always so easy. Mental health workers must get close enough to their clients' misery to comprehend it; keeping too far away, as one service manager complained to me, makes them callous. 'So how do you stay sane?' I asked a long-time psychiatrist. 'I don't always', he told me. 'I don't think I should.'

These paradoxes are stark today, but they are not new: the underlying issues stretch back to the beginnings of the asylum age. 'I used to be astonished', the leading Victorian psychiatrist John Conolly wrote in 1856, 'to see humane physicians going daily round the wards of asylums, mere spectators of every form of distressing coercion, without a word of sympathy, or any order for its mitigation.'[30] But now, Conolly claimed, things were changing. In the 1840s, Conolly had been the superintendent of Hanwell Asylum in Middlesex, an institution whose medical officer was 'really intimate with the insane'. 'He is constantly with the patients', Conolly wrote of this practitioner: 'their characters are intimately known to him; he watches the effects of all the means of cure to which he resorts; and his own character gives the tone to the whole house'.[31] As a result, 'wherever they [inmates] go they meet kind people and hear kind words; they are never passed without some recognition, and the face of every officer is the face of a friend'.[32]

The sympathetic relationships described by Conolly were the linchpin of moral treatment, the foundational regimen of the public asylum system. Moral treatment, which was pioneered at the end of the eighteenth century by Phillipe Pinel in France and the Tuke family in England, was a portmanteau term for therapeutics directed at the minds and emotions of lunatics (their 'moral' characteristics) rather than any supposed organic cause of insanity.[33] At a minimum, moral treatment meant managing

[30] John Conolly, MD, *The Treatment of the Insane without Mechanical Restraints* (1856; 1973), 13.

[31] John Conolly, MD, *A Letter to Benjamin Rotch Esq . . . on the Plan and Government of the Additional Lunatic Asylum for the County of Middlesex, About to be Erected at Colney Hatch* (1847), 20.

[32] Conolly, *Treatment of the Insane*, 58.

[33] For moral treatment at the York Retreat see Charles L. Cherry, *A Quiet Haven: Quakers, Moral Treatment and Asylum Reform* (Rutherford, NJ, 1989); Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796–1914* (Cambridge, 1985); Louis C. Charland, 'Benevolent Theory: Moral Treatment at the York Retreat', *History of Psychiatry*, 18, 1 (2007), 61–79; Samuel Tuke, *Description of the Retreat: An Institution near York, for Insane Persons of the Society of Friends* (1813; Milton Keynes, 2010). For Pinel see Philippe Pinel, *A Treatise on Insanity* (1806); Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Chicago, 2001); Dora B. Weiner, '*La Geste de Pinel*: the History of a Psychiatric Myth', in *Discovering the History of Psychiatry*, ed. Mark Micale and Roy Porter (Oxford, 1994), 232–49.

lunatics without recourse to 'mechanical restraints' such as chains or manacles, or to the ineffectual and often brutal physical remedies favoured by mad-doctors of the period. In its stronger versions, it was a psycho-therapeutic that utilised the asylum environment and staff/inmate relationships as healing agents. Phillipe Pinel was physician-in-chief at the Salpêtrière asylum from 1795. There he engaged his patients in 'repeated, probing, personal conversations', taking detailed notes as they spoke.[34] Pathological ideas and emotions (the 'secrets of the heart') were identified and, where possible, gently challenged.[35] Pinel and the Tukes were passionate believers in the efficacy of *douceur*, 'judicious kindness' in Samuel Tuke's phrase,[36] and their curative optimism was very strong. Prior to the eighteenth century, lunacy had been anathematised as a debased, reprobate or even bestial state. Enlightened opinion in the eighteenth century reconceived it as an ailment to which any person – even a king, as in the case of George III – might succumb. Now moral therapists insisted that the disease was only partial, that lunatics retained intellectual and moral powers which, if properly acted upon in a supportive environment, would replace 'morbid feelings . . . [with] healthy trains of thought'.[37] Ordinary life, especially family life, was full of travails and 'excitements' that wracked the fragile mind.[38] A well-conducted asylum was a sanctum where demented minds could be soothed into sanity:

> calmness will come; hope will revive; satisfaction will prevail. Some unmanageable tempers, some violent or sullen patients, there must always be; but much of the violence, much of the ill-humour, almost all the disposition to meditate mischievous or fatal revenge, or self-destruction will disappear . . . .and despair itself will sometimes be found to give place to cheerfulness or secure tranquility. [The asylum is] where humanity, if anywhere on earth, shall reign supreme.[39]

At the York Retreat – the Quaker asylum founded in 1796 by the philanthropist William Tuke and made famous by his grandson Samuel in his 1813 *Description of the Retreat* – there were no high walls or window bars. Inmates were treated as members of the Quaker 'family' and

[34] Weiner, '*La Geste de Pinel*', 235.

[35] Goldstein, *Console and Classify*, 88.

[36] Tuke, *Description of the Retreat*, 168.

[37] Scull, 'Historical Reflections', 3. See also Tuke, *Description of the Retreat*, 133–4.

[38] Arguing for the institutional confinement of the insane, some early champions of the asylum system claimed that removal from family life was, for many lunatics, a prerequisite to recovery (Scull, 'Historical Reflections', 3). Historians have tended to dismiss such arguments as self-serving, but it seems very likely, as Elizabeth Bott suggests, that for some inmates the asylum served as a refuge from miserable homes. Bott tells the story of one female patient who, during a period of turmoil in her hospital, remarked to Bott: 'There are so many changes and upsets here now that I might as well go home' ('Hospital and Society', 128).

[39] Conolly, quoted in Scull, 'Historical Reflections', 4.

encouraged to participate in the religious life of the community.[40] Whipping and manacling were banned, although milder forms of restraint were permitted as a last resort. Bleeding, purging, drugging and other popular medical treatments were mostly eschewed in favour of rational conversation (to wean patients away from mad ideas) and appeals to the patient's moral sensibility. Like Pinel, the Tukes were agnostic about whether madness had a biophysical component but, as William Tuke testified to the 1815 Select Committee on lunacy, experience had demonstrated that treatments directed at the body had 'very little effect' in 'cases of mental derangement'.[41]

Mad-doctors, pushed onto the back foot, were generally hostile.[42] But lay reformers and legislators were more persuadable, and by the mid-nineteenth century a dilute version of moral treatment, combining non-restraint with some traditional medical remedies, had become public policy.[43] In 1845, the government made it mandatory for local authorities across England and Wales to provide institutional care for pauper lunatics, then mostly languishing in workhouses. A Lunacy Commission was created to regulate all institutions catering to the insane. In 1847, the commissioners reported very favourably on the 'substitution of mild and gentle treatment in place of the old method of mechanical coercion', and by 1854, twenty-seven of the thirty county asylums in England and Wales had abandoned mechanical restraints.[44] Visitors to the Hanwell Asylum, where Conolly had pioneered non-restraint in the 1840s, were delighted to witness the inmates gardening, attending chapel and even dancing at a Christmas party without 'a single circumstance occurring to mar [their] happiness'.[45]

These happy times did not last long, as we shall see. But how happy were they? Like other aspects of asylum history, the moral treatment tradition has been contentious. Critics have raised questions about the continued use of physical restraints, the quality of nursing staff, the uneasy balance between care and custodialism.[46] The psycho-relational method pioneered in the moral-treatment asylums has also come in for criticism – most famously from Michel Foucault, who in an excoriating attack on the

[40] Digby, *Madness*, 37–50.

[41] Scull, *Most Solitary*, 192.

[42] *Ibid.*, 190–3.

[43] Leonard Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth Century England* (Leicester, 1999), 275–6.

[44] John Walton, 'Pauper Lunatics in Victorian England', in *Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia, 1981), 168.

[45] Harriet Martineau, *A History of the Peace* (1858), book 3, 304; *London Illustrated News*, Jan. 1848.

[46] See Walton, 'Pauper Lunatics', 182–92, for a detailed account of these concerns as they arose in relation to conditions in Lancaster Asylum between 1816 and 1870.

up-close therapeutics practised by Pinel and the Tukes, charged them with fostering a malign complicity between the madman and the practitioner who 'begin to form a strange sort of couple, an undivided unity . . . the root cell of madness'.[47] This therapeutic coupling, Foucault went on to argue, paved the way to Freudian psychoanalysis, in which 'all the structures integrated by Pinel and Tuke into confinement' became 'concentrated' in the analytic relationship. 'All the powers that had been shared out in the collective existence of the asylum' were 'appropriated' by the analyst, Foucault fulminated, in a 'gigantic moral imprisonment'. Freud thereby 'freed the patient from . . . asylum existence' only to bring the spirit of the asylum into the 'psychoanalytic situation': a paradox that Foucault clearly relished even as he decried it.[48] In fact, the differences between moral treatment and psychoanalysis were manifold, but Foucault was right to draw a connection.[49] I want now to look at this in more detail.

Foucault's critique of moral treatment, in the penultimate chapter of the *History of Madness*, took him far beyond asylum history, or even madness history as it is generally conceived, into a set of profound meditations on the vicissitudes of human subjectivity. The chapter brought to a head all the paradoxes and inversions that made this extraordinary book such a treasure trove for contrarians. In an anticipation of what he would later describe as subjectification, Foucault denounced Pinellian *douceur* as psychological authoritarianism. But the authority that moral therapists imposed on the lunatic, Foucault argued, was not external but internal; it was the lunatic's own psyche 'in thrall to the pedagogy of good sense, truth and morality'.[50] What moral treatment inflicted on the madman, via his relationship with his would-be healer (which, in the case of moral-treatment asylums, was more often a lay attendant than a medical physician), was a new agony of self-awareness about his mental state and its impact on others. For William Tuke, Foucault wrote

> the liberation of the alienated, the abolition of constraints . . . were mere justifications . . . In fact, Tuke created an asylum where he substituted the stifling anguish of responsibility for the free terror of madness; the fear was no longer of what lay on the other side of the prison door, but what raged instead beneath the seals of conscience.[51]

[47] Foucault, *History of Madness*, 507.

[48] *Ibid.*, 510–11.

[49] For a brief discussion of these differences in relation to therapeutic practices at the York Retreat, see Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (1987), 225–6. As Porter says, the Tukes were not concerned with exploring the unconscious minds of their patients but in 'making them want to be good'. However, like most historians of moral treatment Porter underestimated the innovativeness of the Tukes' emphasis on the therapeutic relationship as a curative agent.

[50] Foucault, *History of Madness*, 483.

[51] *Ibid.*, 484–5.

Here Foucault arraigned Tuke's Quaker convictions, but the argument was not about religious guilt but about self-judgement in general, the 'mind-forg'd manacles' of conscience. Within the lunatic/attendant couple, where the madman's subjectivity became lodged, shackles gave way to self-restraint, surveillance and coercion to self-policing. The inmates of the York Retreat were continuously observed and monitored, but under Tuke's moral ministrations this external gaze became an inward gaze, until these lunatics could not 'fail to see themselves for what they were'.[52]

There is much more to Foucault's critique of moral treatment than this, a good deal of which is historically inaccurate.[53] But his emphasis on the therapeutic relationship as the locus of what Andrew Scull calls the 'curative utopianism' of moral treatment is surely right, although Foucault missed the intellectual roots of this optimism. Pinel and Tuke's faith in the healing power of the patient/practitioner interaction was an Enlightenment product, an offshoot of enlightened moral sentimentalism. Moral sentimentalists – who included such luminaries as David Hume, Adam Smith and Jean-Jacques Rousseau – posited a natural sympathy between human beings, an innate fellow-feeling variously dubbed 'sensibility', 'benevolence', or 'social affection'.[54] Pinel and Tuke, and Conolly after them, believed that even the most demented mind retained 'unextinguished remains' of such 'valuable feelings',[55] which they sought to reignite through a combination of moral example and the exercise of their own sympathetic capabilities.[56] Pinel revered Rousseau and was an enthusiastic reader of Adam Smith's *Theory of Moral Sentiments*, a bible of enlightened sentimentalism.[57] The Tukes were devout believers in the healing powers of Christian love, combining this with Pinellian *douceur* and enlightened sentimentalism to produce a model of individualised care delivered in an atmosphere of quasi-familial intimacy.[58] Their success rate was said to be high, demonstrating, Samuel Tuke claimed, 'the almost infinite power of judicious kindness and sympathy on disordered minds'.[59]

This power could be coercive. Some madmen evinced no social feeling, Pinel conceded, and in such cases 'it is necessary to subjugate first,

[52] *Ibid.*, 499.

[53] Porter, *Mind-Forg'd Manacles*, 5–9; Andrew Scull, *Insanity of Place/the Place of Insanity* (Abingdon, 2006), 42.

[54] Adam Phillips and Barbara Taylor, *On Kindness* (2009), 26–38.

[55] Conolly, *Treatment of the Insane*, 115.

[56] According to Samuel Tuke, one of the most important qualifications for an asylum manager was 'a ready sympathy with man, and a habit of conscientious control of the selfish feelings and passions' (quoted in Digby, *Madness*, 27).

[57] Goldstein, *Console and Classify*, 97; Aubrey Lewis, 'Philippe Pinel and the English', *Proceedings of the Royal Society of Medicine*, 48, 8 (1955), 584.

[58] Digby, *Madness*, 37, 51, 58–61.

[59] *Ibid.*, 105.

and encourage them afterward'. For '[w]hat good could come of ... *douceur*' with lunatics who 'regarded other men as particles of dust?'[60] Like previous generations of mad-doctors, Pinel was proud of his ability to gain emotional sway over his patients, while insisting that such domination must be 'exempt from feelings of animosity or anger'.[61] The Tukes similarly aimed to 'domineer for good purposes', using techniques of punishment and reward adapted from Quaker childrearing practices (although Samuel Tuke also warned against treating lunatics 'in a childish manner').[62] So Foucault's diatribe against moral treatment contains a kernel of truth, encased in a Dionysian fantasy of madness as untamed libido and psychotherapy as inherently carceral – a 'confinement without confinement' as Derrida later described psychoanalysis.[63] But one does not need to be mad, or to be a card-carrying Freudian, to know that madness is at bottom a self-incarceration. The therapeutic relationship that Foucault excoriates may not be as gentle or ethically unambiguous as the moral therapists imagined (or as transcendently illuminating as some psychoanalytic enthusiasts fondly believe), but the guilt and pain that it releases are the patient's own; what Foucault derides as the 'miracle cure' of the disclosed self has nothing miraculous about it.[64] 'To know the worst about oneself', the psychoanalyst Marion Milner once wrote, '[is] like the breaking down of a prison wall'.[65]

The moral treatment phase of British asylum history was shortlived. In the second half of the nineteenth century, asylum populations rose rapidly, as pauper lunatics crowded in from the workhouses, and the wards 'silted up' with the 'chronically crazy'.[66] Moral therapy collapsed under the combined pressures of overcrowding, 'cheeseparing economies, overworked medical superintendents ... untrained, undersupervised nursing staff'.[67] By the late 1860s, most asylums had reintroduced straitjacketing and other physical restraints.[68] By the end of the nineteenth century, the curative optimism of the asylum pioneers had vanished entirely, to be replaced by a hereditarian determinism as gloomy as the decaying buildings housing the 'degenerates' and 'defectives' that lunatics had now become.[69] Care collapsed into custodialism, as the mad were

[60] Goldstein, *Console and Classify*, 86.

[61] *Ibid.*, 86, 99. See also Patrick Vandermeersch, '"*Les Mythes d'Origine*" in the History of Psychiatry', in *Discovering the History of Psychiatry*, ed. Micale and Porter, 222.

[62] Digby, *Madness*, 61; Tuke, *Description of the Retreat*, 59.

[63] Joel Whitebook, 'Against Interiority: Foucault's Struggle with Psychoanalysis', in *The Cambridge Companion to Foucault*, ed. Gary Cutting, 2nd edn (2005), 323.

[64] Foucault, *History of Madness*, 506–11.

[65] Joanna Field [Marion Milner], *On Not Being Able to Paint* (Los Angeles, 1957), 92.

[66] Scull, *Insanity of Place*, 82.

[67] Walton, 'Pauper Lunatics', 91.

[68] Murphy, *After the Asylums*, 37.

[69] Scull, *Insanity of Place*, 82.

pronounced irredeemable, 'tainted persons', and the asylums became their prisons.[70]

The fate of Colney Hatch asylum – *my* asylum, as I cannot help thinking of it – illustrates well this sad collapse of vision. Even before construction began on Colney Hatch, John Conolly was warning the Middlesex officials that the asylum's projected size of 1,000 inmates would militate against the 'close and intimate' care that lunatics required. Wards would be unvisited, patients neglected and 'many good principles ... hopelessly given up'.[71] In 1849, the foundation stone was laid in a flurry of moral-treatment propaganda. No hand or foot would be bound at Colney Hatch, the chairman of the Middlesex magistrates declared at the ceremony, for here was no mere gaol but 'a *curative* institution, and ... we anticipate that, with the advantages which this asylum can command, it will soon acquire a European reputation'.[72] The asylum opened in 1851, the year of the Great Exhibition. People coming to London for the Exhibition were urged to visit, to admire the asylum's lovely grounds and elaborate Italianate frontage, to peer down its endless corridors (the main corridor was a third of a mile, the longest in Europe) and to witness at first hand the happy condition of its inmates, labouring peaceably in the communal farms, gardens and craft workshops.[73] A decade later, such visitors could, if they wished, attend a 'lunatic ball' (fifteen of these were held in 1868 alone, along with magic lantern exhibitions, concerts, lectures and plays) or the ever-popular summer fête. So idyllic did all this seem that it left more than one early visitor convinced that Colney Hatch was a model environment for the sane as well as the insane. The only anxiety was that patients enjoying a steady diet of such delights would never want to leave.[74]

Yet almost as soon as Colney Hatch opened, the Lunacy Commission was expressing concern about overcrowding and insanitation, its dark prison-like wards and poor structural condition. By 1865, the asylum's population had doubled, mechanical restraints were in use, and the overall atmosphere, especially in the 'refractory wards', was so oppressive that the commissioners were moved to declare that '[i]t would be difficult to instance more perfect examples of what the wards of an asylum ... should not be, than are presented here'.[75] The downward spiral continued relentlessly through the rest of the century and into the next, through two world wars and the foundation of the NHS. The arrival of the NHS put

[70] Barham, *Closing the Asylum*, 75–7; Murphy, *After the Asylums*, 36–41.

[71] Conolly, *Letter to Benjamin Rotch*, 21, 14, 12.

[72] Richard Hunter and Ida Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973* (1974), 24.

[73] *Ibid.*, 25–9.

[74] *Ibid.*, 44–5.

[75] *Ibid.*, 86; Barham, *Closing the Asylum*, 2.

the medical staff of the asylum – now renamed Friern Mental Hospital – on an equal footing with doctors and nurses in general hospitals, but otherwise effected few changes.[76] The mid-1950s saw admissions into UK mental hospitals reach a new high, including admissions into Friern which were running at three times the pre-war rate.[77] The succeeding decade saw some improvements to the hospital, including the introduction of psychotherapeutic treatments;[78] but in 1966, Friern was hit by a major scandal when Barbara Robb, a campaigner for the elderly, revealed serious abuses in the care of the demented elderly there. Robb's report, and the publicity and government inquiry that followed, led to calls for closure, although no official action was taken until over a decade later.[79]

Not all mental hospitals were faring so badly. In the 1950s and 1960s, a wave of innovative energy swept throughout the asylum system, with the introduction of new treatments and rehabilitation programmes, the unlocking of wards and a revitalisation of moral therapy, especially among psychiatrists with a psychodynamic bent.[80] David Clark, the psychoanalytically trained medical superintendent of Fulbourne Mental Hospital, was a leader in this moral-treatment renaissance, introducing psychosocial therapies that soon became very influential under the banner of the 'therapeutic community' movement.[81] In his memoir of Fulbourne, Clark recalled the transition from custodialism to the therapeutic-community regimen: 'It was more satisfying to intelligent and sensitive staff and was more humane and dignified. However, it did require more staff and it was perplexing and exhausting work. To open oneself fully to the tortured feelings of the deeply mentally ill is very disturbing.'[82]

[76] *Ibid.*, 84. Despite its integration into the NHS, patient costs at Friern for the remaining decades of its existence were kept well below levels at general hospitals (Stewart, 'Community Care', 308).

[77] Bott, 'Hospital and Society', 97, 102, 103, 106; Stewart, 'Community Care', 27.

[78] In 1969, the Head of Nursing Services at Friern noted proudly that 'all treatments available in the psychiatric field' were currently at use in the hospital, including individual and group psychotherapy (but not psychoanalysis, which was judged 'too expensive of time to be a viable proposition') (*Nursing Mirror*, Oct. 1969). The psychotherapeutic treatments were mostly delivered in Halliwick House, a small inpatient unit located in a separate building on the Friern grounds. Unlike the vast majority of Friern inmates, Halliwick patients tended to be drawn from the professional middle class.

[79] Robb, *Sans Everything*; Stewart, 'Community Care', 279–80. The uncatalogued files from Friern deposited in the Royal Free Hospital Archives Centre at the time of the hospital's closure include files pertaining to the Robb scandal.

[80] Peter Barham, 'From the Asylum to the Community: The Mental Patient in Postwar Britain', in *Cultures of Psychiatry*, ed. Gijswift-Hofstra and Porter, 224–6.

[81] David H. Clark, *Social Therapy* (1974); David H. Clark, *The Story of a Mental Hospital: Fulbourn 1858–1983* (1996).

[82] Clark, *Story of a Mental Hospital*, 180.

Similar developments were occurring in other UK mental hospitals, and the sector was gripped by a resurgent curative optimism.[83] It was at this point that the government, in the person of Enoch Powell, announced its intention to close the hospitals – a timing later described by Roy Porter as a 'rich irony': 'our age, which has seen the agitation for the closing of traditional asylums come to fruition, has also been the time when many of them have been, at long last, most therapeutically innovative and successful'.[84]

By the late 1970s, asylums everywhere were running down, with wards closing and their former inhabitants out on the street. By the mid-1980s, the hospital population had declined by two-thirds: a truly astonishing rate of reduction when one realises that it was achieved, as Peter Sedgwick wrote at the time, 'through the creation of a rhetoric of "community care facilities" whose influence over policy in hospital admission and discharge has been particularly remarkable when one considers that they do not, in the actual world, exist'.[85] Opposition MPs declared community care a 'catastrophe': a judgement later endorsed by a leading figure in UK mental health politics, Baroness Elaine Murphy, who titled her account of community care between 1962 and 1990, 'The Disaster Years'.[86]

Friern's closure was announced in the midst of this debacle. In July 1983, the hospital learned its fate from a televised news announcement.[87] Staff were very shocked. Significant improvements had been made to the hospital in the wake of the Robb scandal, and doctors and nurses had no inkling of any closure plans.[88] In 1980, the Hospital Management Team had even issued a glossy brochure, *Friern 2000*, celebrating the hospital's achievements and looking forward to the next millennium.[89] But the North East Thames Regional Health Authority had done its feasibility studies and added up its sums, and Friern faced the axe. The decade that followed was a wretched one for the staff, some of whom mounted a robust anti-closure campaign but were soon outgunned by their opponents.[90]

[83] Bott, 'Hospital and Society', 104–5.

[84] Roy Porter, 'Introduction', in Clark, *Story of a Mental Hospital*, x.

[85] Sedgwick, *Psycho Politics*, 192–3. Sedgwick's assessment of the situation was endorsed by a Parliamentary Select Committee, which reported in 1985 that 'the pace of removal of hospital facilities for mental illness has far outrun the provision of services in the community to replace them' (cited in Barham, *Closing the Asylum*, xii). 'Any fool can close a long-stay hospital', the Committee went on to comment, but 'it takes more time and trouble to do it properly and compassionately'.

[86] Murphy, *After the Asylums*, 60–85.

[87] Stewart, 'Community Care', 291.

[88] *Ibid.*, 293.

[89] LMA, H/12/CH/A/30/6.

[90] Writing about the situation in Friern in 1985, the Chair of its Medical Committee, Rosalind Furlong, described plummeting staff morale: 'When such staff are already working under pressure in adverse conditions, this can have a profound effect' (Rosalind C. Furlong,

'We were quite a militant group', Doris Hollander, a consultant on my ward who led the campaign, later recalled: '[but] [t]here were other powerful organisations saying "It has got to happen now" . . . There was no shortage of people who could point to all the terrible things in the old hospitals and disregard their positive side.'[91] Hollander's views were aired in parliament, where in July 1990, the Labour MP for Islington North, Jeremy Corbyn, described a state of 'panic' among patients at Friern, and demanded assurance that the hospital's closure would not proceed unless adequate accommodation for its inmates could be guaranteed.[92] A few of these patients and former patients made their voices heard, attending meetings with Friern managers where they expressed support for the hospital's closure mixed, however, with strong concern about post-closure provision.[93] Even the local vicar got in on the act, collecting fifty signatures on an anti-closure petition.[94]

Meanwhile, in 1985, a team of researchers moved into Friern, under the aegis of a government-funded study into the impact of the hospital's closure on its former residents. The Team for the Assessment of Psychiatric Services (TAPS) researchers followed the progress of inmates into staffed group homes over a five-year period and reported, for the most part positively, on their lives there.[95] The people being studied, however, had been selected for their capability while many others, more disabled and harder to place, remained in hospital; some were still there on the night before Friern closed.[96] Moreover – and more important for the long-term consequences of the hospital's closure – over a third of the

'Closure of Large Mental Hospitals – Practicable or Desirable?', *Bulletin of the Royal College of Psychiatrists*, 9 (1985), 130–4).

[91] 'In Conversation with Doris Hollander', *Psychiatric Bulletin*, 28 (2004), 18; Stewart, 'Community Care', 294.

[92] House of Commons Debates, 6 July 1990, 1.15pm (www.theyworkforyou.com/debates).

[93] No one involved in the hospital's closure seems to have made any systematic effort to ascertain the patients' views. Those patients who met with management wanted to see the hospital shut down, but were very anxious about what would become of ex-inmates; some, like the service-user activist and academic Diana Rose, became actively involved in supporting patients through the transition into community care (Dr Diana Rose, personal communication).

[94] Dylan Tomlinson, *Utopia, Community Care and the Retreat from the Asylums* (Milton Keynes, 1991), 135.

[95] Tomlinson, *Utopia*; Julian Leff, ed., *Care in the Community: Illusion or Reality?* (Chichester, 1997); Julian Leff, 'Why is Care in the Community Perceived as a Failure?', *British Journal of Psychiatry*, 179 (2001), 381–3; Dylan Tomlinson and John Carrier, eds., *Asylum in the Community* (1996); Christine McCourt Perring, *The Experience of Psychiatric Hospital Closure* (Avebury, Aldershot, 1993); Barham, *Closing the Asylum*, 21–4.

[96] 'Friern Hospital Decommissioning Report', Royal Free Hospital Archives Centre (uncatalogued papers relating to Friern Hospital's closure).

decanted patients required readmission during the five-year follow-up.[97] Alternative inpatient provision was radically insufficient, and seriously ill patients entering the hospital in its twilight days faced an accelerating crisis of resources. Many of these 'new long-stay' patients, as they were awkwardly dubbed, did not qualify for the new community facilities: what was to become of them, when Friern's doors closed for the last time?[98]

In 1989, I was a likely candidate for 'new long stay' status, or at least that was certainly how I saw myself when I entered Friern for the third time and remained there for over six months. My stints in Friern came midway through the closure process, and the evidence of this was everywhere. Most of the ward nurses had left and been replaced by agency staff.[99] The ward across the stairwell from mine was empty, having been burned out in a major fire shortly before I arrived. Corridors were sealed off, therapy rooms locked up, the old apple orchard was choked with weeds. The kiln in the pottery workroom broke down and was not repaired; a little pot that I left in the firing queue was thrown away.

Yet for me Friern was truly an asylum. I entered it on my knees: I could no longer do ordinary life, and giving up the struggle was an incalculable relief. My home in the hospital was a locked acute ward with a deservedly violent reputation: a Dickensian barrack of crumbled brickwork and peeling walls, reeking with fag smoke and teeming with ghosts; but for me it was a sanctuary. I settled in quickly, got to know people, acquired a lot of new survival skills (some of which have proven surprisingly useful since, especially in university committees). I was very wretched most of the time, and often frightened, but I felt safe from what I feared the most: myself. This was a huge plus, and I wanted to stay forever.

People like me who end up in the bin – that is, educated, middle-class people – if they write about the experience later on, often sound a bit like tourists on an alien planet. But I was no tourist. By the end of the 1980s, I was deeply embedded in the world of the chronically mentally ill. I had lost my home, and was living in a psychiatric hostel. When I was not in Friern, I was at the Whittington day hospital (later made notorious by Clare Allen in her bestselling novel *Poppy Shakespeare*) or at the Pine Street Day Centre in Finsbury. I still had friends and connections from earlier days, but I spent most of my time with other mental health users with whom I often felt more comfortable than with old chums (although

[97] Julian Leff, 'The TAPS Project: A Report on 13 Years of Research, 1985–1998', *Psychiatric Bulletin*, 24 (2000), 165.

[98] G. Thornicroft, O. Margolius and D. Jones, 'The TAPS Project 6: New Long-Stay Psychiatric Patients and Social Deprivation', *British Journal of Psychiatry*, 161 (1992), 621–4; Rosalind Furlong, 'Haven Within or Without the Hospital Gate: A Reappraisal of Asylum Provision in Theory and Practice', in *Asylum*, ed. Tomlinson and Carrier, 158–62.

[99] Stewart, 'Community Care', 294–7.

I should add here that old chums were wonderfully kind and supportive). It wasn't a good life, but it was a do-able life: and in its best moments it yielded feelings of care and belonging which were new to me. 'I think it will be good for you to stay here for a while', my Friern psychiatrist told me in the summer of 1989, 'you will discover that you can be looked after, and that will be important to you.' She was right on both counts.

Mental hospitals like Friern were places of horror for many. Recorded testimony from former Friern inmates speaks of coercion and neglect: of nurses punishing awkward patients with violent drug injections; of beatings; of psychiatrists ignoring or deriding patients.[100] I witnessed abuses like these, especially of 'sectioned' patients (those legally detained under the terms of the 1983 Mental Health Act). My voluntary status and, even more, my middle classness protected me from the worst of such cruelties, although I too was briefly targeted by a sadistic nurse who made my life hell for a time. No one who has ever been subjected to such behaviours is likely to wax nostalgic about the asylum system, or to mourn its demise – and I do not.

And yet: I also received a lot of very effective looking-after during my years as a mental patient. Living in the bin was tough, but it gave me some shelter from my darkest self and, very importantly, the friendship of other patients, which made my days tolerable. My psychiatrist, who was psychoanalytically oriented, was intelligent and kind. During the three plus years I was under her care, I was also seeing a psychoanalyst five times a week. Like many severely ill people in psychoanalysis, I became abjectly dependent on my analyst. This dependence, and the painful therapeutic dialogues to which it gave rise, were the means by which I learned the sources of my misery, and gradually made my peace with them.

In 1990, this therapeutic education went through a crisis which proved to be a turning-point. The following year, I left my last day centre, and in 1992, I was discharged from the UK mental health system.

Friern closed in April 1993. Two years later it reopened as Princess Park Manor, 'a supremely elegant' residence of some 200 apartments. The gorgeous asylum frontage and part of the grounds were retained, but otherwise all traces of the old asylum were obliterated – bar the original commemorative plaque, which now overlooks the glossy reception area outside the Manor's gym.

In 1996, a group of film-makers came to Princess Park Manor to interview the first batch of apartment owners.[101] They brought with them a few former patients, including one whom I knew slightly – a bright, pugnacious Mind activist. The film that resulted is riveting. As the

[100] 'Testimony: Inside Stories of Mental Health Care', British Sound Library Archive.

[101] The film, *Asylum*, directed by Rebecca Frayn for Cutting Edge, was screened by Channel 4 in March 1999.

two groups of inhabitants chatter to camera, a slow movement toward each other occurs. The patients are thoughtful, humorous, fluent. One, a former theatre-worker, describes the hospital as having been 'hell on earth'. Finding himself in the gutted main hall, he abruptly opens his mouth and sings his heart out. 'I can go now', he tells the camera. 'I'm not frightened any more.' Another, an elderly man, looks wistfully at the carcase of his ward, my 'second home', and reminisces about his time on the Friern football team. Meanwhile, a feng shui consultant is busy tapping for energy sources in the walls. 'Phew!' she cries, knocking hard, 'Something sure was going on here!' Are they afraid of ghosts? the film-makers ask the new residents. None will admit to this, but all emphasise their sympathy for the mentally ill. 'My friends say I should have been in an institution like this long ago', one man chortles. Quizzed about their reasons for choosing the Manor, some become remarkably self-revealing, one retired man describing the 'mad' world beyond its gates as too stressful for him, while a divorcée admits that she hopes such a self-contained housing development – with its fancy leisure facilities, café and private bus service to the train station and shops – will bring her new friends and romances. She had been feeling pretty suicidal before she moved in, she confides. How ironic, my Mind acquaintance comments to the camera, that people are now willing to pay large sums of money to live in a place that advertises itself as somewhere that you 'never need to leave'. With its manned security gate, high tech locking systems and omnipresent surveillance cameras, Princess Park Manor aims to keep out what Friern was meant to keep in: but not all the devils that beset individuals are so easily contained. Yet it is good to be reminded, as this lovely film does, of the miseries and frailties common to all humankind, whether hopefully mad or hopelessly sane.[102]

I was fortunate not to need an asylum by the time Friern closed. I would not like to have been left to the tender mercies of 'the community'. Reading mental health policy documents today – with their warm talk of 'connected communities' and 'shared visions'[103] – it would be easy to imagine that the up-close therapeutic regimen pioneered by Pinel and the Tukes, and revived by the therapeutic-community movement in the 1950s, was once again in the ascendant. In fact, nothing could be further from the truth. In the quick-fix, drug-based culture of present-day psychiatry, the community, in Peter Barham words, 'possesses null value':[104] it is not a site of belonging and support; it is just where people go when they are sufficiently 'recovered' to negotiate daily life without posing a

[102] An earlier version of this account of the filming of Princess Park Manor appeared in the *London Review of Books*, 8 May 2003 (under the pseudonym 'Eve Blake').

[103] Mental Health Division Department of Health, *New Horizons* (see n. 25).

[104] Barham, *Closing the Asylum*, 13.

danger to themselves or others. The notion that decanting people from institutions automatically improves their lives is a convenient myth. 'There is an assumption', the TAPS researchers wrote in the run-up to Friern's closure, 'that the quality of life for those who are relatively independent in the community is by definition greater than the quality of life for those . . . in asylum-type settings. This assumption is not easily supported.'[105]

In the UK today, community mental health services are delivered to their recipients as 'care packages'. Care is individuated and disconnected from any communal body; the enforced sociality of the asylum has been replaced by the insularity of the healthcare consumer. Sociability among service users is not encouraged: day centres of the kind that I attended, and where I made some very close friends, are now mostly closed.[106] Service users are meant to integrate into the community, which for people with serious mental disorders can be a cruelly daunting ambition. The much-touted independence of the community-based user thus often equals a life of lonely isolation, with a television for companionship.[107] It is an extraordinary fact that – in a modern world acknowledged by all to be fragmented, anomic, and psychologically demanding of even the most capable – mentally ill people are increasingly expected to thrive (to achieve 'wellness' in another buzzword) with a minimum of day-to-day support. Most people in twenty-first century Britain spend most of their lives in institutions of one sort or another – schools, offices, factories, universities – and few of us could manage emotionally without the sense of belonging that these institutions provide. The old mental hospitals had plenty wrong with them – horribly wrong, in many cases – but they nurtured communities of their own whose disappearance has been painful for many. People, with or without mental disorders, depend on other people to lead a decent life: we do not really need history to tell us this, but history can show what happens when we forget it. The asylum story is not a good one, but if the demise of the asylum means the death of effective and humane mental health care, then this will be more than a bad ending to the story: it will be a tragedy.

[105] D. W. Jones, D. Tomlinson and J. Anderson, 'Community and Asylum Care: *plus ça change*', *Journal of the Royal Society of Medicine*, 84 (May 1991), 253.

[106] See n. 26.

[107] On the television as a 'friend', see Tomlinson, *Utopia*, 165–6. One ex-inmate, who spent his days alone in his flat in front of the television, told a researcher that it was just like living in a hospital ward 'but with nobody else there' (Dr Felicity Callard, personal communication).