CHAPTER 4

Psychiatry and the State in Britain

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The focus of this paper is on the relationship between the British state and the mentally ill, primarily in the second half of the twentieth century. To a large extent, this is the story of the National Health Service – the NHS. This relationship with the state has inevitably involved politics – but generally not party politics, along the usual left-right dimension.

Origins

Until the 1940s, the British state did not acknowledge responsibility for providing general health care to the population. In the early modern period, the functions of the national government, embodied in the Sovereign, were very few. Everything else was a local responsibility, controlled by the lay magistrates in each county and major borough, who represented the elite of each area. They were both the judicial and the executive authorities. The counties were divided into parishes, which formed the basic organisation of the established Church of England. It was only in the 1880s that elected local government began in the counties. In the later nineteenth century, the responsibilities of the national government did enlarge gradually, but not yet to the extent of supplying health or welfare services directly.

In 1601, almost at the end of the reign of Elizabeth I, a comprehensive Poor Law was enacted. It was economic difficulties at the end of the sixteenth century, including substantial unemployment, that are said to have been largely responsible for this Elizabethan Poor Law. The unemployment was a fairly new phenomenon, and it produced the category of indigents known then as 'sturdy beggars'. These people – mostly men – were mentally and physically capable of work, but had no employment. Through the Poor Law, they could then be given relief from local funds, but only in their 'parish of settlement'. The parish could also support local people who were not capable of working, whether for bodily or mental reasons. The geographical responsibility for a local population that was then given to the parishes is a theme that will run through much of the subsequent story. It was, in fact, a form of 'community care'.

In the eighteenth century, the expansion of Britain's trade and wealth led to the evolution of a bourgeois, civil society which was largely independent of aristocratic patronage. This new society, much influenced by evangelical and Dissenting religious groups such as the Quakers and Unitarians, took up a number of humanitarian causes. One of these was to establish charitable general hospitals, which were constructed in practically every large provincial town. The primary clientele of these institutions were people who were physically ill, but in many cases, a 'lunatick ward' or annexe for the mentally ill was added to the hospital. At Manchester Royal Infirmary – where I was both a student and a house surgeon – the annexe grew to be almost as large as the main hospital. There were also three charitable hospitals wholly for the mentally ill – Bethlem and St Luke's in London and St Patrick's in Dublin.

But for reasons which so far remain unexplained, all these psychiatric additions to voluntary general hospitals had ceased to exist by the early nineteenth century.[1] It may have been that the particular problems of caring for the mentally ill were simply too different from what the hospitals saw as their primary task – caring for medical and surgical cases. Hardly any of their doctors specialised in the care of mental illness. Had this closing of psychiatric annexes not happened, the whole subsequent history of mental health care in Britain would have been quite different.

All this took place purely on a charitable basis, without any involvement of the state or of local government. But about the same time, another development was happening, though for commercial reasons – what William Parry-Jones called 'The trade in lunacy'.[2] These private madhouses were run for profit, and varied in size from a few people taken into the home of a doctor or clergyman to quite a large institution.

It was this development, in fact, which first provoked the active intervention of the state as a regulator of mental health care. Where money was involved, abuses were likely – particularly in the largely ungoverned world of the eighteenth century. As a result, Parliament passed several Acts to try and prevent the exploitation of the mentally ill by these entrepreneurs.[3] These laws had very little effect, though, because the administrative structure needed to enforce them simply didn't exist then. But on the basis of the general humanitarian concern of that period, the care of the mentally ill had become acceptable as a legitimate subject for the involvement of the state. This feeling was increased by the psychotic illnesses of King George III, which were a threat to the whole stability of the government. For the same reasons, treatment of the mentally disordered by deliberate cruelty had ceased to be an acceptable practice by this time, largely through general cultural and intellectual changes associated with the Enlightenment.

It would be wrong, though, to omit from the Georgian period a description of its most important voluntary initiative – the establishment by the Quakers of their mental hospital known as The Retreat at York.[4] In an unpublished lecture,

Leon Eisenberg has pointed out that every therapeutic use in psychiatry of the milieu in the subsequent two centuries has really been a rediscovery of the 'Moral Treatment' that was developed at The Retreat. This principle – which was the opposite of much previous practice – was to provide a quiet, supportive and encouraging environment in which natural recovery could occur. Moral Treatment was the inspiration for the non-restraint movement in early nineteenth century English mental hospitals, and even for the Therapeutic Community of the 1940s. The Retreat's methods were based on a shared religious ideology between staff and patients – a principle which Michel Foucault notably failed to understand.[5]

The first hesitant step towards publicly provided – rather than charitable – mental health care was an Act of Parliament of 1808. This was a permissive law, which allowed counties to establish asylums through their local property taxes, known as 'rates'. The Act did not actually require them to do *anything*, though, and most of them did nothing, in some cases claiming that there were 'no lunatics' within their boundaries. The real importance of this legislation was in establishing the principle that public funds could be used to provide a form of health care in hospitals.

The mid-nineteenth century, though, is the crucial period in this account. One of the changes of that time may seem at first to have nothing to do directly with the care of the mentally ill. The Elizabethan Poor Law had provided relief mainly in the form of money given to destitute people at home. But with a rapidly growing and more urbanised population, these payments caused a steadily increasing burden on the local rates. Since that growth of local taxation alarmed the wealthier classes, in 1834, the Poor Law Amendment Act tried to control this cost by providing relief only in institutions – the workhouses.

A workhouse was built for each group of parishes, known as a 'Union', and the geographical responsibility for a population that began with the Elizabethan Poor Law still continued. The capital investment that constructed workhouses in every part of the British Isles in the mid-nineteenth century now seems enormous, particularly as it was all done from local funds. Compared with the lack of hospital building a century later, the contrast is striking.

The Amendment Act was a utilitarian solution to the need that was felt for reducing the costs of poor relief. Conditions in workhouses were required to be 'less eligible' – which means worse – than those which a poorly paid labourer would experience outside. But the people who flooded into the workhouses were not 'sturdy beggars', who should have been working. They were mostly orphaned children, abandoned mothers, frail old people, and the sick and disabled of every kind – including the mentally ill. They could not be deterred from entering by bad conditions.

Ten years later, an even more important step was the Lunacy Act of 1845, passed through the initiative of the great reformer, Lord Shaftesbury. This

required every county or group of counties to provide an asylum for the insane from its own locally raised funds. Every asylum had to have a medical officer, and this was the beginning of the psychiatric profession, though they were really general practitioners then. Except for a few private patients, all residents of asylums were classified as 'paupers'. In this way, the Poor Law system and the asylum system were closely involved with each other. The procedures for admission to an asylum were regulated by law, and a national inspectorate was set up for these institutions, as it was for the Poor Law. These two inspectorates were the first examples of direct government intervention in local responsibilities. Paradoxically, the asylums followed a humanitarian agenda, while the workhouses had a primarily utilitarian, financial purpose, so that the two could sometimes be at cross-purposes. There is no evidence to support the Marxist view that the purpose of the asylums was simply to remove unproductive people from society.[6] It is clear that the patients admitted were severely ill and that their relatives had done as much as they could.

Once the asylums existed, mentally ill residents of workhouses were supposed to be transferred to hospital care. But the Guardians of the Poor had to pay more for a patient in an asylum than for a resident of a workhouse. As a result, the Poor Law authorities resisted making these transfers. The consequent mix-up between the mentally ill, needing medical care, and the indigent, who needed social care, was not resolved until a century later; since then, that problem has re-occurred.

In the workhouses, the proportion of residents who were ill or decrepit grew so large that these institutions were becoming like hospitals. Poor Law Guardians responded to this situation by building their own hospitals, known as Union Infirmaries. This development began in the 1860s and continued so that, eventually, these infirmaries were provided in every major centre of population. The particular relevance of this development to the present theme is that when the NHS began in 1948, the largest proportion of hospital beds that it took over then were in the former Poor Law infirmaries.

Also, because a proportion of admissions to the infirmaries were mentally ill, most of these institutions included a special observation unit for these cases. If such individuals settled down quickly, they would be discharged, but otherwise, they would be transferred to an asylum. Sometimes, though, neither of these disposals happened, and the patients simply remained in what was called the 'mental block'. From the 1950s, many of these facilities developed into general hospital psychiatric units.

While all this was going on under the Poor Law, the asylum system was extending throughout the British Isles, and the mental institutions were becoming much larger. Admission rates, though, didn't change much, allowing for the growth in population. Why the resident numbers in asylums increased so much is an important question in itself. Torrey & Miller have argued that schizophre-

nia was a new disease in the early nineteenth century, and that its frequency in the population then increased steadily.[7] What is certain is that a high proportion of the patients in asylums were also physically ill – from disease, malnutrition, or alcohol. Much of the mental illness there had an organic basis, particularly tertiary syphilis, so that the medical work in asylums was still largely general practice. At the same time, there were many mentally ill paupers still in workhouses, who had not been transferred to asylums for financial reasons; this factor complicates estimates of the total numbers of people suffering from severe mental illness.

The organisation and culture of the mental hospitals – similar to that in other industrialised countries – then existed largely unchanged for almost a century. But one innovation which was very significant for the future occurred in 1874. The national government decided to pay counties a small weekly subsidy for every pauper patient in their asylums. This was the first time that any payment had been made from central taxation for any health or welfare purpose. Just why this happened has not so far been well explained.

Political considerations became important again in 1890, when another Lunacy Act made it more difficult for patients to be admitted to asylums. The new law required the agreement of a magistrate, except in emergencies; it was the result of a long campaign by pressure groups, who alleged that sane people were being illegally confined in asylums. There was little evidence for this view, and they were mainly playing on atavistic fears in the public's mind. Asylums were now required to observe a mass of legal restrictions, which were a major barrier to progress. Though the medical superintendent had a powerful role within the institution, individuals outside decided who should be admitted, and the budget was controlled by local politicians in the county or city.

In the twentieth century, the highest ever recorded rate of mental hospitalisation in relation to population was in 1915. World War I then produced a huge number of psychiatric casualties, described as suffering from 'shellshock'.[8] This phenomenon upset psychiatric orthodoxy, by discrediting theories of 'degeneration' as the cause of mental illness. It also encouraged some acceptance of Freudian theory, but the long-term effects of the war on mental health care in Britain were in fact surprisingly small. Within a few years, mental hospitals were functioning much the same as before 1914, though malarial treatment for tertiary syphilis and continuous narcosis were introduced as the first specific therapies. An *exposé* by one medical officer of poor conditions in a mental hospital in Manchester attracted some attention, but political and public interest in the subject was only brief.[9] Outside the public system, a few small institutions such as the Cassel Hospital and Tavistock Clinic provided psychotherapy on a charitable basis, but the numbers of patients involved in this were very few. The Ministry of Pensions established some patient clinics for veterans with psychiatric disabilities, which offered a form of psychotherapy; little has been recorded about these

facilities, and they did not last for more than a few years. Some voluntary hospitals in cities established a psychiatric outpatient clinic, usually staffed by psychiatrists in private practice, who were few in number nationally. The number of patients seen must have been very small, though there are few reliable records of these activities.

The general point made above that political differences did not follow party lines was not entirely true. The brief Labour government of 1924 set up a Royal Commission to examine the law on mental illness. Its report was very progressive, but nothing happened then until 1930, when the second Labour government passed the Mental Treatment Act. This had two important provisions – it provided for voluntary admission to mental hospitals, and it allowed their medical staff to see psychiatric outpatients at other hospitals. This indicated the beginning of a retreat from the custodial and authoritarian principles that had governed both the asylums and the Poor Law during the previous century. This government also abolished the Poor Law and brought its functions under the control of local government – a symbolically important step in reducing stigma.

My examination of government records from the 1930s about these new outpatient clinics has not revealed very much as to what went on in them.[10] There is little doubt, though, that this outpatient work was all on a very modest scale. Compared with the USA at that time, psychiatry in British general hospitals hardly existed at all. In the few years before the war began in 1939, new physical treatments were just beginning to be introduced, and refugee psychiatrists from Europe played a very useful part in this.[11] Academic psychiatry was also in its infancy, and virtually nothing would have happened but for the practical support of the Rockefeller Foundation.[12]

'Social Psychiatry' in this period was no more than a few small voluntary initiatives, again owing much to American help. The first Child Guidance Clinics were established, and the first psychiatric social workers (PSWS) were trained, in very small numbers; in both cases, the theoretical orientation of their work was derived from psycho-analysis. A few psycho-analysts were in private practice – almost all in London. The Mental After-Care Association provided some convalescent homes, and there was also one for ex-servicemen. Local government was responsible for the care of the mentally retarded, helped by some voluntary societies. Just before World War II, a number of voluntary welfare bodies combined to form the National Association for Mental Health (NAMH), which provided casework and educational services. All this took place in almost complete isolation from the mental hospitals.

However, by far the most significant event in this whole story was the establishment of the National Health Service in 1948. Attempts to reorganise general health care in Britain between the two World Wars had achieved relatively little, partly as a result of the world economic Depression, and partly because the political and cultural climate was strongly conservative.

Once war began, though, the whole political atmosphere changed, particularly after Churchill formed his coalition government with Labour in 1940. To cope with wartime needs, an Emergency Medical Service had been set up, financed by the central government, which was an addition to the existing hospitals. Its experience showed that medical services could be run by the state, and not just by the existing local governments or by voluntary (charitable) hospitals. The general idea of a national health service was accepted in principle as early as 1942, and lengthy discussions about it went on behind closed doors. These were held between representatives of the doctors – mainly the British Medical Association (BMA) – and staff of the Ministry of Health. There was no attempt to consult the public about this.

This whole situation was enlivened in late 1942 by the appearance of the Beveridge Report on social security, which set out the basic structure of a post-war welfare state. Going far beyond his terms of reference, Sir William Beveridge created a vision of a better society, in which free and comprehensive health care would be one of the fundamental rights of its citizens. His big failure, though, was calculating the financial projections for this development in a completely wrong way; that mistake had an unfortunate influence for many years to come. What he clearly understood, though, was that the different aspects of health and welfare services were closely related to each other; they couldn't be developed in isolation. People had often gone into mental hospitals for social reasons, rather than for medical and nursing care. But these needs could now be provided outside the hospitals by other services which were more appropriate. The Beveridge Report stirred up enormous public interest, as a result of which the government was obliged to respond to it in a generally favourable way.

Early plans for the NHS left out the mental hospitals. The rationale for this omission was that the administrative and legal arrangements of mental institutions were so different from those of general hospitals that the two couldn't be fitted within a single system.[13] To change these peculiar arrangements of the mental hospitals would have needed legislation, and this was impossible in wartime.

However, the BMA argued strongly against this separation. From long experience, they were opposed to any hospitals being run by local government, as the mental hospitals were then. The BMA wanted all hospitals to be independent of local government, with its political influences, and their arguments were successful. This was a critical point, because a continued separation between the

two kinds of hospitals would almost certainly have prevented much of the progress that occurred in later years. A separate mental hospital system from the NHS general hospitals would inevitably have been an inferior one – as experience world-wide has shown. It would have inhibited the growth of psychiatry in general hospitals and would have made it difficult for staff to operate between different parts of the mental health service.

By the end of the war, both main parties were publicly committed to the principle of the NHS, but the Conservatives had a much more modest idea of what it should be like. What happened next would depend on the result of the 1945 general election. This was won by Labour, and the new Minister of Health was Aneurin Bevan, a major political figure on the left of the party. His responsibilities also included housing and local government, so that he played an important role in the Cabinet, and in the evolution of the Welfare State.

In spite of all the wartime discussions, plans to set up the NHS remained extremely vague in 1945 and 1946, apart from the decision to include the mental hospitals. Bevan described the separation of mental from physical care as 'a source of endless cruelty and neglect'.[14] The principles of the NHS were to be very important for the future management of psychiatric disorders, providing care that was free and comprehensive for all patients.

Bevan made a bold decision to nationalise all the hospitals in the UK, apart from a few small private ones. This provoked relatively little argument in the end, compared with the arrangements for general practice, where bitter disputes were settled only just before the NHS was due to start. All referrals to specialists were now to go through GPs, and patients were not to go directly to hospitals, except in emergencies. This was a 'filter', which had the effect of reducing the pressure on specialist services, including psychiatry.[15] Of all the hospital beds in the country, nearly half – 44 per cent – were in mental illness or mental retardation hospitals in 1948. A high proportion of their patients were then chronic or long-stay.

In NHS general hospitals, medical superintendents, where they existed, were now abolished. Instead, the arrangements of the voluntary teaching hospitals were introduced everywhere. All the medical consultants formed a committee, which decided the hospital's medical policy collectively. Its practical implementation, as well as that of the policy of the nursing staff, was then the responsibility of the Hospital Secretary or Administrator. There was thus a tripartite arrangement, rather than a hierarchical one. Before 1948, the voluntary hospital consultants were not paid for their hospital work, deriving their income from private practice, but now they received a salary – usually on a part-time basis.

The Ministry of Health controlled the NHS through 14 Regional Hospital Boards (RHB), each related to a university with a medical school. In turn, the RHB supervised groups of hospitals, each under a Hospital Management Committee (HMC). Mental hospitals, though, were not part of a group, like the rest,

but each had its own HMC. Mental hospitals were mostly much larger than general hospital groups, and this was one of the ways in which the psychiatric institutions still remained different.

Although hospital medical directors in general hospitals were abolished, the law still required every mental hospital to have a medical superintendent. However, some senior doctors in mental hospitals were also designated now as consultant psychiatrists, and under the NHS, they were supposed to be completely autonomous clinically, like consultants in general hospitals. How this impasse of responsibility was resolved depended on the influence of local personalities in each hospital. But as time went on, consultant psychiatrists became increasingly rebellious about the role of the medical superintendent.

After the end of the war, the demand for admission to mental hospitals grew rapidly, and in most cases, people came in as voluntary patients. Over the next 20 years, total admissions increased nearly ten times, and first admissions trebled in number.[16] The growth in admissions was seen then as a positive trend, since it was believed to be better for patients to be admitted at an earlier stage of their illness. From about the mid-1950s, though, this view of hospitalisation was completely reversed, and *reducing* admissions was seen – not always logically – to be the main criterion of success.

However, because of the greater acceptability of mental hospitals to the public at this time, serious overcrowding resulted. There had been no new building or redevelopment of hospitals during the war, and even repairs had been neglected. Living conditions for patients were generally poor, and there were serious shortages of staff. Full employment nationally then meant that it was relatively easy for mental nurses to earn more in other jobs. Psychiatrists were also in short supply, but on the positive side, ECT had come into general use and many schizophrenic patients were being treated with insulin coma. Though this latter treatment was eventually found to have no specific therapeutic effect, it encouraged a more active and optimistic regime in mental hospitals.[17]

Overcrowding in mental hospital wards now became a big problem for the Ministry of Health, which had taken over these hospitals from local governments. For about ten years after the end of the war, there continued to be practically no building of new hospitals. Public housing and schools were given the greatest priority for capital spending, while total investment was limited by the country's critical economic situation and by the effects of the Korean war. But why hospital building in Britain should have been so minimal for so long is a political question that is still unanswered.

One medical event of the late 1940s which was surprisingly important here was the treatment of tuberculosis. Between the wars, special sanatoria and clinics for this condition had developed in the UK on quite a large scale, mostly run by local governments. But there were never enough beds available in them, and just after the war, waiting lists of tuberculous patients for admission to sanatoria

represented a major health problem. In 1948, though, streptomycin was discovered in America, and within a surprisingly short time, the need for hospital beds for tuberculosis got rapidly less. Far from building new accommodation for these patients, the Ministry of Health was now reducing beds and then closing them down.

In my research on the subject, I found that the example of tuberculosis made a big impression on senior medical figures in the Ministry.[18] I believe that it affected their view of the very large number of beds then occupied by patients with mental illness – 154,000 in 1954. Yet in spite of the size of inpatient provision, direct public expenditure on mental health amounted to less than 0.2 per cent of the Gross National Product, because the cost of each inpatient was relatively low.[19] Outpatient services, which did not need much accommodation, grew rapidly, and the treatment of outpatients with ECT made a big contribution to the care of major depression. Patients also began to be visited at home by both psychiatrists and social workers; PSWs were appointed to the staff of mental hospitals, though the number trained each year remained small for some years.

However, politics cannot be forgotten for long. Bevan had been outstandingly successful in establishing the NHS, in spite of the enormous upheaval involved. Within the government, though, his political position was diverging strongly from that of the central figures – Clement Attlee, Ernest Bevin, and Herbert Morrison. In 1950, he was moved to a lesser position – Minister of Labour – and responsibility for housing and local government was separated from the Ministry of Health. The new Minister of Health was not in the Cabinet, and so the NHS moved sharply downwards in the political agenda. Another consequence was that the new Ministry, which was quite small, would be avoided by the more able and ambitious civil servants – which would also reduce its influence in the competition for resources.

Meanwhile, the very misleading financial estimate made earlier by Beveridge, with the prediction that the cost of the NHS would actually *fall* after a few years, began to have unfortunate effects. When the cost of health care proved to be much more than had been budgeted, and when it increased year by year, instead of falling, there was panic in the government. This was quite irrational, since the total cost was actually quite low, compared with similar industrialised countries, and from the administrative point of view, the NHS was extremely cheap. But thinking in the Treasury didn't change much over the next 50 years. They went on insisting that 'demand' for health care was too high and that the only real problem was the public's 'perception' of what needed to be provided. In fact, it was the Treasury whose perception was wrong, and they confused 'demand' with need.

At this time, one of the ways in which the UK differed from both Continental Europe and the USA was the almost complete failure of academic psychiatry to take root. There was one university chair in London, and one in Edinburgh, but

hardly anything at other medical schools. The London chair was based at the Maudsley Hospital, which had opened in 1925 as a psychiatric unit outside the restrictions of the Lunacy Acts. Systematic teaching was developed there, as well as some research, while the same developments occurred, on a smaller scale, at the Royal Edinburgh Hospital. Why there should have been such a difference from, say, Munich or Paris or Baltimore has never been well explained. In the Netherlands, a much smaller country than the UK, there were six chairs of psychiatry at this time. Most doctors working in British psychiatry simply picked up their working knowledge in mental hospitals on the old apprenticeship system. There was a Diploma in Psychiatry, but it was considered very inferior to the higher qualifications in medicine or surgery.

An organisation of doctors working in mental hospitals had been started in 1841, but a century later, when it had become the Royal Medico-Psychological Association, it was still quite small and had little influence. The two most powerful bodies in British specialist medicine – the Royal Colleges of Physicians and of Surgeons in London – were opposed to the growth of new specialist organisations. The Physicians believed that in so far as psychiatry had any right to be represented to the government, this should be done through their College.

Frankly speaking, the standard of doctors working in mental hospitals then was generally low, though it had been improved by the arrival of refugee psychiatrists from Europe and by others who had been rapidly trained by the Army during World War II. These two categories of specialists had not grown up professionally within the culture of mental hospitals and were more resistant to its authoritarian habits. Whereas the NHS had a surplus of trained physicians and surgeons for the available consultant posts, it was desperately short of competent psychiatrists as well as of other specialists such as anaesthetists and pathologists. At the end of 1949, there were only 405 consultant psychiatrists in England and Wales, whereas the planned number – still very modest – was 670.[20]

One very positive factor, though, from the medical point of view was that through the NHS, the psychiatric profession remained united. In many countries, particularly the USA, most trained psychiatrists worked exclusively in private practice, leaving the public mental hospitals with few competent doctors. In Britain, hardly any specialists stayed completely outside the NHS. In fact, a part-time appointment as a hospital consultant was virtually a *sine qua non* for a doctor to be recognised as a specialist. So Bevan's compromise, leaving consultants with a large degree of freedom, prevented a split between those working in the public hospitals and specialists seeing only private patients. Had this not been the case, the development of a significant psychiatric profession within the NHS would hardly have been possible.

Changes of the 1950s

For about ten years after the end of World War II, there was little sign of significant change in mental health care. Outpatient ECT, offered mostly at general hospitals, was the first effective treatment that did not require admission to hospital, and a few experimental day hospitals showed the possibility of a more flexible kind of care.[21] Practically all psychiatric accommodation then dated from before 1910. The total number of patients resident in mental hospitals increased every year up to 1954. But from then on, it reduced year by year, as it did in the USA, though not in other countries. There was no change in national policy on health at this time, but there was a change in the *zeitgeist* of society, with large institutions becoming less desirable as a response to society's problems.[22] This suggests that the steady reduction in the role of mental hospitals within the general provision of psychiatric care, occurring over the next four decades, had a primarily ideological basis. It included an explosion of new ideas – broadly described as 'social psychiatry' – which originated to a major extent in the UK.

In 1952, however, there was an important therapeutic development – the discovery in France of the first neuroleptic, chlorpromazine. Since then, opinions have been divided as to how much the neuroleptics contributed to the steady decline in the numbers of mental hospital residents. Writers hostile to conventional psychiatry have claimed that the drugs made little difference, but this seems quite illogical. Together with outpatient ECT, the neuroleptics made it possible, for the first time, to treat severe psychiatric disorders in a wide variety of settings: outpatient clinics, day hospitals, hostels and general practice. That must inevitably have reduced the numbers in hospital. Another factor operating in the same direction was the steady growth of treatment and care on a day basis, for those who did not need full-time medical and nursing provision. By 1959, there were 65 such units in the UK, mostly for the adult mentally ill.[23]

In 1954, the Conservative Prime Minister appointed a second Royal Commission to examine the law on mental illness and mental deficiency. It is not at all clear, though, why the government decided to take this step at that particular time. The Ministry of Health had been having some trouble over the compulsory detention of a few people diagnosed as 'mentally deficient', and this may possibly have been the provoking factor.

It was also in the mid-1950s that official reports on the mental hospitals in the NHS began to change their language. References to overcrowding disappeared, and the possibility of alternative ways of managing psychiatric disorders began to be mentioned. Within a few years, the phrase 'community care' was to be seen for the first time. When new hospital building was being considered again, the Ministry made it clear to the regions that they would not agree to the construction of any new mental hospital. Yet even though mental hospitals had then been the foundation of mental health care for over a century, this reversal of

policy was never announced publicly. I have been unable to find any document in the government archives stating that such a decision had ever been made.

In 1959, the government was truly conservative in having very little legislation in mind. They filled the gap by embodying the report of the second Royal Commission in a Mental Health Act. This swept away a whole jungle of legislation on lunacy, some of it going back for centuries. People could now go into any hospital for psychiatric treatment, with or without compulsion. Magistrates were removed from the compulsory admission process, which was now to be undertaken only by doctors, assisted by social workers. Voluntary admission was abolished and psychiatric patients would be managed legally in exactly the same way as medical or surgical cases – described as 'informally'.

The results were dramatic in that within a year or so, the proportion of psychiatric patients who were compulsorily resident in hospital had fallen to only 7 per cent. Before 1930 it had been 100 per cent. It has often been said that the 1959 Mental Health Act legislated a policy of community care, but in fact this was not so. The Royal Commission had recommended that local health authorities – counties and cities – should be given a positive duty to provide community care services, and that they should receive specific government grants for doing so. But the Treasury fought successfully against these proposals, and it managed to delay special community care funds for 30 years. The Mental Health Act did in fact remove any legal barriers to community care, and it expressed general approval of a non-institutional approach. But that was all. The local health authorities had had their hospitals removed from their ownership by the NHS in 1948, but they were still responsible for employing mental health social workers, who were mostly untrained then.

While all this was happening, an important development was going on in Lancashire, in the north-west of England.[24] A group of influential specialists in Manchester – none of whom had previously been involved in psychiatry – decided that the mental hospitals in the region had become obsolete. With the very small amounts of money available for developments, they created a number of local services for medium-sized towns which had autonomous local governments. Each was headed then by only one consultant psychiatrist and was based in the 'mental block' of a former Poor Law infirmary. One of the units had as many as 220 beds, but these were mostly filled by patients with chronic psychoses.[25] The population served by each unit was 200,000 – 250,000.

The new district consultants were given access to beds in the nearest mental hospital, but to everyone's surprise, they made practically no use of these facilities. By close co-operation with the local health authority and the general practitioners, they were able to run an efficient service for their catchment population. The administrative autonomy of consultants in the NHS allowed for such experiments in the provision of services, provided that many new resources were not needed. The service provided was, of course, a fairly basic one, but it did respond

to the needs of the most serious cases – particularly of schizophrenia. Though not many people recognised it at the time, this was the basic model on which future mental health policy would be based.

Developments of the 1960s

In 1961, I became a consultant for the city of Salford, next to Manchester.[26] Here, circumstances were rather different from the other cities because the 'mental block' of the former Poor Law infirmary had been completely destroyed by a bomb in 1940. Only a few beds could be obtained for psychiatry in the two general hospitals, and so most of the inpatient accommodation had to be in the nearest mental hospital. However, an autonomous unit was developed there, and its work was integrated with that of the general hospitals and community services. The fundamental principle was to make all staff involved feel part of a single organisation, wherever they were based. In this way, the wasteful and often hostile processes of negotiation and bargaining over matters such as admission to hospital could be largely eliminated. The individual patient still remained the responsibility of the same team, wherever this person was. An important principle of these developments was that the hospital unit was part of the comprehensive service.

On the political side, following the Conservatives' return to office in 1951, there had been six successive Ministers of Health in the subsequent nine years. None of them made much impression until Enoch Powell came into office in 1960. Like Bevan, Powell was a highly intelligent and articulate politician, though at the opposite end of the political spectrum. He saw an analysis of total mental hospital patients for the five years following the peak total in 1954. This showed a steady downward slope in resident numbers, and if that was projected onwards, it theoretically reached nil in 1975.[27] He concluded that the size of mental hospitals would have to be drastically reduced. This was not a value judgement; it was simply a response to what seemed an inevitable trend.[28]

Powell also produced the first national plan for general hospitals.[29] From the psychiatric point of view, the most important part of this plan was that it included psychiatry as one of the basic specialties of the district general hospital (DGH). So as the mental hospitals would be declining, a new network of general hospital psychiatric units would be evolving. For the first time, day care was given a specific role in the planning of psychiatric services. It has been argued that the biggest motive for this change was financial – that the cost of bringing the mental hospitals up to date would have been prohibitive. My research has been unable to find any evidence for this view. In any case, the cost of building a new system of psychiatric units could hardly have been less than that of modernising the mental hospitals. One of the biggest problems of the mental hospitals was that, a century

or so after their foundation, most were in the wrong place to act as the centre of a district psychiatric service. In London, they were mainly in the outer suburbs, far from the population they served. The 1962 Hospital Plan also assumed that psychiatry ought to be in the district general hospital, so that it could co-operate with the other major specialties. At the time, this was still a fairly revolutionary concept, however, there was still very little capital for building new hospitals.

While this was going on in the UK, there were big developments in the USA, where the national plan for comprehensive community mental health centres was inaugurated in 1963. But 'community mental health', as it was understood there, was very different from 'community psychiatry', as it was developing in Britain. The former was a very broad concept which assumed that early intervention in the crises of individual lives would prevent the later development of mental illness. The British approach was to provide an integrated service for identified psychiatric disorders, related to local communities. Freeman & Bennett described it as an 'eclectic, non-ideological, and largely atheoretical discipline [...] open to and capable of absorbing ideas or data from any school, provided that these are found pragmatically to be capable of reducing disease, distress, or disability'.[30] I believe it is true to say that the British model has stood the test of time much better than the American one. Yet the official commitment in Britain to 'community care' of psychiatric disorders, which gradually emerged, was not supported by the necessary central funds.

In the 1960s, the *practical* question of *where* a patient should be cared for at any particular time began to be changed by anti-psychiatry into a *moral* question. All hospital care was then labelled as 'oppressive', and reducing admissions rather than providing the most appropriate care for a person at any particular time became a principal objective. In fact, through the 'Cultural Revolution' of the 1960s, the psychiatric profession in Britain then faced attacks on the whole legitimacy of its discipline. The most prominent figure in this confrontation was R.D. Laing, a psychiatrist himself.[31] Though he was for some time the most famous psychiatrist in the world, this did not last, and his long-term influence on provision for mental health turned out to be small. The *événements* of the 1960s, though, made it clear that the power of the mass media was a new factor that professionals would have to be aware of.

Two other critical questions emerged in Britain over the course of time. Firstly, could *all* the functions of the mental hospital – including the care of chronically ill patients – be reproduced by a 'dispersed institution'? This would have to include management of the small proportion of psychiatric patients who showed severely disturbed behaviour. Secondly, would there ever be enough money to provide effective community-based services throughout the country?

Logically, the mental hospitals should have been starved of resources, to help pay for new services. Yet in fact, the 25 years from 1960 were the best period they ever had in Britain. Following a series of public scandals – most of which con-

cerned psycho-geriatric or mentally retarded patients – successive governments became very sensitive about conditions in these institutions. As total numbers fell, the living conditions of patients were enormously improved, staffing ratios increased, the quality of the psychiatric profession was enhanced, and a whole series of psychiatric sub-specialties developed services of their own.

These sub-specialties were: psycho-geriatrics, forensic psychiatry, rehabilitation, liaison psychiatry, child and adolescent psychiatry, and substance abuse. Without the accommodation and space that mental hospitals could provide, it is very unlikely that these developments could have occurred. As well as psychiatrists, nurses, social workers and psychologists also developed similar specialist skills. The most important of these groups were community psychiatric nurses (CPNs); their profession constituted a particularly British contribution to psychiatric care. In a typically British way, this innovation was never planned but grew out of informal experiments at several hospitals in the late 1960s. Formal training in community work for registered mental nurses developed during the next decade. In 1985, there was a ratio of about one CPN to 24,000 of the population, but with wide regional variations.[32] By the 1990s, CPNs had become an essential element in community-based psychiatric services, taking over much of the supervisory work that social workers had undertaken with patients at home. This was because a 'generic' unification of social workers in 1971 largely destroyed the skills developed by specialised groups such as PSWs and the Mental Welfare Officers of local authority health departments. Where these staff had been integrated into mental health services, the integration often came to an end. As Kathleen Jones pointed out, the 'integration' of social work meant the *dis*integration of mental health services.[33]

Social Psychiatry

At this point, it is worth considering the place of 'social psychiatry' in the evolution of British mental health services up to the 1960s. There have been varying definitions of this phrase – as there have been of 'community psychiatry' – but such semantic arguments are best avoided. In the UK, the views taken of the subject were essentially practical, induced mainly from clinical experience, rather than deduced from some theoretical principle. In this, professionals in the mental health field were largely following a tradition that had long been influential in British politics and administration.

First of all, it came to be accepted that social factors were very important both in the evolution of psychiatric disorders and in their management. Such views were then unusual in the rest of medicine, except for public health, but that specialty had gone into decline as infectious diseases became less important. Child guidance (which evolved into child and adolescent psychiatry) was the first aspect

of the psychiatric discipline to focus on family and environmental influences.[34] Its initial Freudian orientation, however, was modified in the UK by a more clinical approach, which would later give birth to scientific child psychiatry. In adult psychiatry, the importance of housing conditions began to be recognised even before World War II; when the NHS began, home visits by both psychiatrists and social workers (then mostly untrained) made mental health staff constantly aware of the influences of everyday life.[35] In this, they were following the tradition of British general practice, which was heavily focused on domiciliary work. The fact that Britain in the mid-twentieth century was the most urbanised country in the world may well have been relevant to this tradition. From the late 1950s, research into the family environment of schizophrenic patients, begun by Morris Carstairs and George Brown at the Maudsley Hospital, was to lead over more than 30 years to important scientific and clinical developments.

Secondly – and probably more important in the long run – was the emergence of a whole range of clinical initiatives, which first modified and then eliminated the previously monolithic structure of mental hospital practice. As mentioned earlier, it began in 1930 with voluntary admission and outpatient consultations. After World War II, the process continued with extramural ECT and rapidly growing outpatient consultations, which began to extend into general hospitals. By the early 1950s, 'part-time hospitalisation' had emerged in the form of the first day hospitals. During the War, military hospitals had been the setting for the early development of 'therapeutic communities', and their principles influenced institutions of all kinds, particularly mental hospitals.[36]

There, attention to the social environment and to institutional habits led to a climate of liberalisation, in which patients were encouraged to make the most of their capacities for normal living. A leader in this development was Dr D.H. Clark at Cambridge, who described it as 'Administrative Psychiatry' because all the resources of the hospital were co-ordinated in the process of rehabilitation.[37] Weekend leave became common, family visiting was encouraged, and patients increasingly went outside hospital for recreation or even work. As a result, many long-stay patients were found not to need the permanent medical and nursing care of a hospital, though they were not yet ready for independent life outside. To fill this gap, a variety of forms of 'sheltered accommodation' were developed – staffed hostels, unstaffed group homes, supervised lodgings in private homes, and individual apartments with visiting staff. For some time, it was assumed that these residents would eventually graduate to independent living, but as experience accumulated, it became clear that a significant number would need some degree of shelter permanently. That lesson was not popular with administrators and funders.

These different forms of accommodation could be seen as a 'ladder', which people moved up towards independence, as they improved. But equally important was the question of occupation. Occupational therapy had arrived in the UK

from Germany, via the Netherlands, in the 1920s; it only ever served a minority of mental hospital patients, though. After the War, the idea arose that actual work was more therapeutic than mere occupation; it also allowed patients to earn some money. Although there was a national system of rehabilitation units and sheltered workshops, these overwhelmingly served the physically handicapped. Within psychiatry, therefore, a new movement of 'industrial therapy' brought workshops into the hospitals, mainly undertaking sub-contract work for industry. The leading figure in this was Dr Donal Early of Bristol.[38] He emphasized that a second 'ladder' of work was needed, in collaboration with that for accommodation. This consisted of a series of increasingly complex tasks; patients would move on to a more difficult one, as their condition improved. Until the mid-1970s, the volume of economic activity in the UK allowed many people with psychiatric problems to be usefully employed.

One further aspect of the social approach was public education. As in other countries, prejudice, ignorance and feelings of rejection towards the mentally ill were common in the UK. The NAMH and other voluntary bodies did their best to combat this antagonism, emphasising how much had changed in the mental health services. These efforts had only modest success, though in the late 1950s, there were some useful television programmes. In the next decade, however, things were to get much worse with the emergence of anti-psychiatry, often linked with political extremism. The film 'Family Life' was a notable expression of these views; it made a big impression on the British public, encouraging the view that parents and 'capitalism' were the causes of schizophrenia.

From today's standpoint, it may seem surprising that all these 'social' approaches were conceived and introduced on an entirely intra-professional basis, with psychiatrists taking the leading roles. As with the negotiations leading to the NHS, there was virtually no involvement with other influential groups. Voluntary organisations and most politicians saw it as their role to support the professionals, not to undermine them. Yet the psychiatrists who achieved all these changes would soon be denounced as 'reactionary' and practising 'social control'. In Britain and other West European countries, Marxism became dominant in both the universities and the media, establishing a form of academic totalitarianism. This particularly affected the training of social workers, whose numbers were growing rapidly. Amongst other developments, the word 'social' would become hijacked to suit a Marxist paradigm. This involved a denial of the reality of mental illness and its treatment that has remained influential.

A Mental Health Policy?

At various points, one could have asked the question – is there a national mental health policy? – and the answer would have been uncertain. But in 1975, an

official white paper was published which clearly set out such a policy.[39] Preparation of it had been started several years before, under a Conservative government, but by the time it was actually published, Labour was again in office. At this period, differences between the two main parties on health policy were relatively small, and for all its faults and deficiencies, the NHS was enormously popular with the public. This national mental health policy laid down a provision of inpatient beds at the rate of 0.5 per 1,000 of the population; most psychiatrists regarded this as too low, but with the passage of time, political and financial pressures were to reduce it further.

During this period, there had been very considerable growth in the numbers and quality of the psychiatric profession. The inauguration of the Royal College of Psychiatrists in 1971 symbolised that the specialty had come of age.[40] Medical superintendents were finally abolished in mental hospitals, though 20 or 30 years later, the role was to be reinvented in a changed NHS. Academic psychiatry finally expanded to serve every medical school, and research activity increased enormously.[41]

The run-down of mental hospital numbers up to then had been relatively easy. Only the least ill or disabled long-stay patients were resettled outside – in hostels, group homes or even independent accommodation. Their medical care was transferred to local GPs, and they were reviewed periodically in psychiatric outpatient clinics, with occasional visits from a CPN. Their financial support came from Social Security. By 1981, the number of occupied psychiatric beds had fallen from a peak of 3.4 per thousand in 1954 to 1.58 per thousand.[42]

But as this process went on, the level of morbidity among the remaining patients in mental hospitals steadily increased. At the same time, the new general hospital services were having to be paid for, and there were managerial complaints that as long as the mental hospitals still existed, very little money could be saved. It was said that although 80 per cent of the patients were in the community, 80 per cent of the money was being spent on hospitals. Yet the question I raised above – could *all* the functions of the mental hospital be reproduced in other ways? – was still largely unanswered. While British psychiatry had by now grown into a fairly large and well trained profession, the best one could say of community services was that they were patchy, though quite good in some places.

The answer to the second question was that although the rhetoric of community care had been officially spoken then for about 20 years, the money that it required had never existed in the budgets of the local authorities who were mainly responsible for it. It would have been reasonable to say that, up to then, 'community care' as a comprehensive national system was never much more than a shared myth.[43]

'No Such Thing as Society'

However, worse was to come. The year 1979 was a political watershed, with the return to office of the Conservatives under Mrs Thatcher. Their monetarist ideology, with the slogan that 'There is no such thing as society', was to cause profound economic, social and cultural changes. Whereas doctors had always been by far the most influential group in the planning and delivery of health services, they were quickly replaced by managers, some of whom had little knowledge of hospitals or health care. The multi-disciplinary management that had existed since the beginning of the NHS was now abolished and was replaced by a hierarchical system, directed by a Chief Executive. Both managers and politicians were very unwilling to face the reality of severe, chronic mental illness, because of the alarming cost implications of caring for these people in an acceptable way over a very long time. Two experiments to care for groups of them in a domestic environment – 'hospital hostels' – were very successful, but they were eventually closed down by managers, because of the cost of the trained staff they required.[44] This was one of the very few examples of a form of service provision being tested empirically, yet the clear results were ignored in the prevailing political climate.

In both the UK and the USA, there had been big falls in the mental hospital population, but that in the USA had been much more rapid and had been largely driven by financial motives. In the UK, it had always been accepted officially that mental hospital accommodation should not be closed until an adequate alternative was in place. But in the early 1980s, the Government made it clear that they wanted the process to be speeded up, so that mental hospitals could actually be closed and their buildings and land sold. At the same time, all hospitals were having their numbers of beds reduced because of financial pressures.

By 1982, the number of psychiatric hospitals with over 1,000 beds had fallen to 23, compared with 65 in 1972.[45] Total psychiatric beds in the UK were then 120,678, of which just over 11,000 were in general hospital units; compared with other West European countries, the provision of beds was lower, in relation to population, but that of qualified psychiatric nurses was the highest.

A long and detailed research study by the Medical Research Council of two mental hospitals in outer London showed that when there was plenty of time and money, most of the residual long-stay patients could be resettled outside. Most of them did well there and were happier than in hospital. But there was still nearly a fifth who had to be transferred to other hospitals, and government plans took no account of this group, known as the 'Difficult to Place' patients. Nor did the re-provision of beds allow for the new long-stay patients who would continue to accumulate indefinitely, in small numbers.[46] Furthermore, in most parts of the country, there was neither plenty of time nor plenty of money for the resettlement process, as there had been in this London scheme.

In 1983, with a new Mental Health Act, the lawyers had their revenge for the previous Act of 1959. More legal restrictions and bureaucracy were imposed in relation to compulsory admission or treatment, making the work of health professionals more difficult, and often having bad effects on patients. Once again, a vocal lobby had been successful, through an unholy political alliance of elements from both Left and Right.

What happened next was a return to the 'Trade in Lunacy' of 200 years earlier. Without any public discussion or even a public announcement, the NHS withdrew from providing long-term care, for either physically or mentally disabled patients. Instead, the social security system began to pay for these people to go into privately run nursing homes. In the case of patients with chronic mental illness, they were transferred into units that were similar to the hostels that had formerly been provided by local authority social services. In response to this unannounced change of policy, an enormous number of private institutions commenced business, mostly in large old houses.

Correspondingly, the long-stay accommodation in hospitals which was part of psychiatric and geriatric services was steadily reduced, so that the closure of mental hospitals became easier. Local authority social services had the responsibility of inspecting these new private homes regularly, but they often lacked the resources to do this effectively. If they wanted to close a home because the conditions were bad, there was nowhere that the residents could go: the hospital beds they came from had ceased to exist. Now, the question was raised whether these smaller units were simply re-creating the asylum in a new form. The Government claimed that the number of places for the mentally ill was no less than before, but a high proportion of these were now in small, private facilities which had no trained staff. This presented a much greater problem than before of monitoring their standards of care because of the vastly increased number of places in which patients were resident.

Nonetheless, in the decade between 1976 and 1986, the number of consultant psychiatrists increased by over one-third in England to a level of 3.1 per 100,000, although this was still much lower than in some other European countries.[47] However, the work of psychiatrists was now much more dispersed than it had been with the mental hospital system.

In 1993, local authority social services ceased to be providers of old people's homes or psychiatric hostels, and became simply the funders for private or charitable operators. For local authorities, it was a partial return to the situation before the Poor Law Amendment Act of 1834, when they simply subsidised poor people in the community. Psycho-geriatric services which had integrated hospital facilities with social services accommodation often found their arrangements disintegrating.

Even acute psychiatry, which was supposed to remain entirely within the NHS, was unable to function fully, because managers had closed down so many

beds. By the end of 1993, 89 of the 130 mental hospitals that were open in England in 1953 had closed, and the total number of psychiatric beds had fallen to a little over 50,000.[48] This was to keep within unreal financial targets. In the five years from 1996, nearly 10 per cent of all acute psychiatric beds were closed – nearly always against psychiatric advice. As a consequence, private beds often had to be used – at enormous cost to the NHS; this was particularly true for patients requiring secure accommodation.

One of the strengths of the NHS had been that it did not have to collect money or charge for transactions between different units within it. This advantage was thrown away, and a huge accounting system set up by the Conservative 'Internal market'. The cost of this and of endless administrative changes was enormous, but this financial burden was concealed from the public, and the full amount is still not known. Yet this and the endless bureaucracy it created was described as 'reform'. The NHS had succeeded to a significant extent because of the idealism and commitment of those who worked in it, most of whom were badly paid. Now, the change in culture and habits of thought that percolated down from the government included a contempt for these feelings, for the ideal of public service, and for the expertise of health professionals. The only thing that mattered now was money.

With the great reduction in psychiatric beds, there was a decentralisation of the mental health services. Many of these now operated from small centres, which had no accommodation for inpatients. This made them more accessible geographically for patients and often more acceptable than a large institution. On the other hand, it partly removed psychiatrists and other staff from the district general hospital, which is the focus of all other specialist health care. Yet the move of psychiatric inpatient work into general hospitals, which had seemed to be such a sign of progress, was now raising serious doubts. Acute psychiatric wards in general hospitals were often proving unable to provide the therapeutic milieu which was supposed to be their main purpose. Accommodation was unsatisfactory, staffing was inadequate, and a high proportion of beds tended to be occupied by patients who really needed either more secure accommodation or its opposite – a more domestic setting. General social changes – which included widespread drug abuse, extreme cultural diversity, and a loss of respect for health professionals – added to the problems of general hospital units, particularly in inner cities.

In a return to the 1940s and 1950s, overcrowding re-emerged as a regular feature of psychiatric units. It was partly due to ill-considered reductions in beds by managers and partly to the presence of patients waiting to go to other accommodation that would have been more suitable for them, such as a secure unit. In London particularly, wards occupancy levels of 120 per cent were regularly recorded. Deteriorating morale was seen in 14 per cent of posts for consultant psychiatrists being unfilled in England, though this situation was better in

Scotland. The recently introduced European Directive which restricts the working hours of junior doctors is likely to make the staffing of general hospital units increasingly difficult.

At the fiftieth anniversary of the NHS in 1998, a Labour government was again in office, but one so committed to financial orthodoxy that it was unwilling for some years to deal with the large gap between Britain and other West European countries in spending on health. More than anything, the NHS needed a period of quiet and consolidation, but it was about to be put through yet another enormous administrative upheaval in 2002, for uncertain reasons. The main unit of administration for health services, with the budgetary power to commission services, was now the Primary Care Trust, consisting mainly of representative general practitioners. Hospitals and some community services had become independent NHS Trusts, having to obtain their funds from the new PCTS which are more numerous (and so more costly) than the former District Health Authorities. Regional Health Authorities had first been abolished and then re-created as Strategic Authorities. It was all more confusing than ever, and the costs of reorganisation were again immense (though unpublished).

When the NHS began, there was full employment, addiction to dangerous drugs was unknown, serious crime was uncommon, there was relative cultural homogeneity, and health professionals received general respect from the public. In the succeeding 50 years, every one of these conditions changed totally. Psychiatry has had to accommodate to this changed world as well as it can. Whether it can succeed in today's economic and social climate remains to be seen.

Notes

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