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### **Lessons from a lost world: messages from the mental hospital era**

- Who are the famous figures of mental health nursing?
- How does the past inform the future of mental health care?

Pertinent questions, you might think. Yet in my experience, as a nurse educator and extracurricular historian of mental health nursing, they are not readily answerable by qualified or budding practitioners. The first would expose a remarkable lack of celebrated figures in our field. General nursing has its heroine in Florence Nightingale, but asking students to name pioneers of psychiatric nursing draws a blank stare. The second question relates to the transformation from institutional to community-based care. Perceptions of the asylum are often polarised between a dark age of oppression and a pastoral idyll. For nurses trained in this millennium, however, such debate seems scantily relevant, and the older colleague who reminisces about the ‘good old days’ at a defunct hospital has a fleeting audience. Collective memory of the institutional era is fading. But if we don’t know where we are coming from, how can we know where we are going?

By neglecting the history of their discipline, mental health nurses allow others to write it for them. Historical accounts by psychiatrists tend to portray nurses as mere accessories to a medical enterprise, while postmodern revisionists fit the story around an ideological bent. This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jan.13467  
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Accepted Article

Myths are perpetuated in societal discourse: the asylums were built to keep the mentally ill ‘out of sight, out of mind’; women were simply sent there for the shame of an illegitimate birth; when the mental hospitals eventually closed it was to cut costs, leaving the patients homeless. Such assumptions present a narrow version of truth, and sweeping statements are made without reference to those who managed the wards, day and night. Nurses were not merely passive pawns of a rigid hierarchy: they had agency, and exercised this in their continual contact with patients. As senior healthcare managers know, policies and procedures cannot run a hospital: cultural dynamics must be understood as the medium between organisational purpose and delivery.

My historical interest in the asylums began many moons ago, when I applied for a post at Claybury Hospital on the edge of London. The map sent for the interview seemed to depict a whole town, circuted by sweeping avenues, with a large nurses’ home near the perimeter. Deterred by a sense of the ‘total institution’ described by Erving Goffman (1961), I did not pursue my application, but two years later I visited with a nurse of recent Claybury employ. Ascending the main drive, we passed ghostly blocks with boarded windows. This awesome Victorian behemoth was retreating to its core, but the wide corridors in the main block were busy, with motorised carts heading to or from the laundry or kitchens. My colleague showed me the rehabilitation ward where she had worked: a high-ceilinged hollow of overpowering institutional odour. Chronic schizophrenic patients ‘caged’ cigarettes, sidestepped by nurses performing their daily routine. Despite a sense of timelessness within those walls, the writing was on the wall. Admissions had ceased years ago, and every month another ward was closed.

The large psychiatric institutions like Claybury have gone for ever, but they left a mark on me. Although most of my practice was in community settings, I worked with numerous nurses who had spent much of their career in the mental hospitals of Surrey: Netherne, Brookwood, Banstead, Cane Hill, and the Epsom Cluster (where five institutions were built on the same estate, including Horton, Long Grove and West Park). Fascinated by colleagues' experiences, I realised that an important chapter of our social history was coming to an end. Beginning locally, I embarked on a photographic tour of the country, catching images of these sombre yet solid structures before they were erased from the landscape. This great legacy of Victorian philanthropy was being bulldozed by stealth, although in later closures much of the redundant buildings were saved for conversion to private housing.

A cherished item of my printed ephemera is a brochure produced by the Claybury Hospital Management Committee in 1958. A remarkably candid account of the work of the hospital, it's worth reviewing here. For all the stark contrasts between then and now, we can yet observe that the more things change, the more they stay the same. A linear trajectory from the unenlightened past to the progressive present is a common but naïve idea, termed the 'Whiggish interpretation of history' by Herbert Butterfield (1931). Social history should be seen as a dialectical process of constancy and change (rather like the political balance in Western democracies of liberals and conservatives): both are essential to the narrative.

The most obvious difference is the loss of space. Opened by the London County Council in 1893, Claybury was one of several asylums serving the metropolis. An elevated site was chosen for fresh air; the ward blocks were designed to maximise sunlight; the surrounding farmland of over a hundred acres was crucial to the livelihood of the institution. Agriculture had a dual purpose, keeping patients occupied while maintaining a self-sufficient community.

Six decades later, the chairman of the board lamented the decision by government bean-counters to close the hospital farms. The cattle herd had gone, but bacon and eggs continued to be garnered from the chicken coops and 350 pigs, and turkey and goose were fattened for Christmas dinner. According to the management committee, the farm provided useful work experience for patients of rural background, although this was becoming harder to justify in the Home Counties. Eventually the fields were sold, as the expanding suburbs crept nearer. In 1965 the hospital was brought within the boundary of Greater London.

Back in 1958, the hospital was thriving, with 2300 patients and hundreds of resident staff. The brochure boasts of modern methods of treatment: insulin coma therapy, prefrontal leucotomy operations and the recent arrival of tranquillising drugs. Social methods too were emphasised. A highlight was the weekly dance, although this would have been a stilted waltz. According to average attendance figures, fewer male patients were trusted, numbering 78 of the 280 present. Of the 218 from 'disturbed wards' at main hall cinema shows, 160 were female (Claybury Hospital Management Committee, 1958).

The therapeutic community model, for which Claybury became famous, had been introduced on some wards. Patients and staff had daily meetings to discuss and plan the running of the ward, taking democratic votes on proposals. This radically liberating approach was later expanded throughout the hospital by Denis Martin, after his promotion to physician superintendent. In 1958 the model had novelty value, and was 'producing encouraging results', but in reality there was great difficulty in persuading nurses to relinquish control. Martin, fortunately, had the indispensable help of matron Vera Darley (1972). His predecessor was evidently a proponent of behaviourist methods, with several wards assigned to 'habit-training'. Few of my current students have heard of the therapeutic community: treatment has become more individualised – and medicalised.

Like today, mental nursing suffered from recruitment problems. Claybury struggled to attract local people, and the great Irish human import was insufficient to fill the gaps. The brochure acknowledges that ‘more are always needed, and as in other walks of life the larger the list of applicants the finer the selection’, but declares (somewhat contradictorily) that ‘mental nursing is a privilege’ (Claybury Hospital Management Committee, 1958: 37). In the 1950s NHS hospitals began to tap into Britain’s colonial legacy, bringing thousands of young men and women from distant shores to these ‘ports on the hill’. Photographs in the brochure show the vanguard of demographic change at Claybury; by the 1970s, as much as half of the nursing staff in London mental hospitals was from overseas. In my recent book *Echoes from the Corridors*, written with Peter Nolan (2016), a whole chapter is devoted to the experiences of foreign nurses, who arrived long before the emergence of a multicultural society.

All healthcare organisations present an upbeat message in their publicity material. The Claybury brochure promotes a modern hospital unrecognisable from its past status as a lunatic asylum, and makes every effort to rebut stigma towards mental illness. Evidence of progress is in the proportion of voluntary admissions: 70% and steadily rising. The reader is not told that hundreds of chronic cases remain under the strictures of the 1890 Lunacy Act. But a liberalising trend had gained momentum, and within a few years of the Mental Health Act 1959, over 90% of patients in mental hospitals in England and Wales had informal status. Compare that with present acute psychiatric wards, where patients who are not ‘sectioned’ are the exception. In the 1950s Claybury was steadily unlocking its wards; now, it is back to safety first.

The history of mental health care has lessons we would do well to heed. In the 1950s the mental hospital was more a social than a medical environment, but inpatient units today lack the social, occupational and recreational facilities that can nurture recovery. Acute wards now are pressurised settings, with high threshold for admission, rapid turnover and little time for therapeutic engagement. Treatment is predominantly pharmacological. Furthermore, admission is regarded as a last resort: an anomaly in a brave new world. Concerned by the dichotomy of community good, hospital bad, Thornicroft and Tansella (2004) emphasised that there are 'no compelling arguments that support hospital services alone or community services alone'.

I write as a proponent of care in the community, not as a defender of the institutional past. Sadly, patients were prone to abuse in the back wards of remote hospitals, unlike the transparency expected now. But a vital element of the old system has been lost: the original concept of asylum. Some patients need more than a brief period of containment and tranquillising medication. As argued before in this journal (McCrae & Hendy, 2016), ideology has driven policy-makers and practitioners to place all their eggs in the community basket, while a well-intended but uncritical campaign against stigma has led to denial of the dangerousness of people with paranoid psychosis or severe personality disorder. The number of homicides involving psychiatric patients has increased lately, and inevitably this will lead to growing concern that the system is failing. Perhaps we are nearing 'peak community care'.

The mental hospitals served a purpose (admittedly not always well) as sanctuary. Claybury was a colossus of care and control: twenty years after the demise of such institutions, there are losses and gains for mental health patients and for society. Nurses should look back as well as forward, and appreciate that the development of services is as much cyclical as it is

linear. The wheel does not need reinventing, but it will surely revolve.

### Note

*The Story of Nursing in British Mental Hospitals: Echoes from the Corridors*, by Niall McCrae and Peter Nolan, is now available in paperback. <https://www.routledge.com/The-Story-of-Nursing-in-British-Mental-Hospitals-Echoes-from-the-Corridors/McCrae-Nolan/p/book/9781138556829>

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