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# Administrative Psychiatry 1942-1962

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## Introduction

The last twenty years have seen great changes in British administrative psychiatry. Jones (1955, 1960) has described how the mentally ill began to be assembled into special institutions for their own good (and society's protection) some 150 years ago. The humanitarian revolution associated with the names of Pinel and Tuke and the philanthropic enthusiasm of Shaftesbury and the other early Commissioners in Lunacy led to the widespread building of asylums, especially after the Acts of 1845 and 1853. This was a period of great interest in administrative psychiatry, or asylum management, as the writings of Conolly (1847, 1856) and others show. During the latter half of the nineteenth century the enthusiasm was lost and the asylums became custodial. The consolidated Lunacy Acts of 1890 and 1891 fixed a pattern of humane custody scrutinized by Lunacy Commissioners which persisted little changed for 50 years. Custodial decline was also seen in the United States and some causes of it have been discussed by Bockoven (1956) and Ozarin (1954). In the last 20 years, however, and especially since the end of the 1939–45 War, there has been a marked change in the conditions of the mentally ill.

Many factors contributed to this change and differing reasons have been given for its cause. It has been attributed to changing methods of medical treatment of mental illness, to changing public attitudes to mental alienation, to the development of a Welfare State and a National Health Service in Britain, to the spread of knowledge of psychoanalysis and psychotherapy and to changes in the law. To disentangle this web of interlocking cause and effect is the task of the social historian and has been ably tackled by Jones (*v.s.*). The aim of this review is to set out the changes and to indicate salient publications.

The changes will be described under four headings:—

- Administrative Framework;
- Legal Framework;
- Public Opinion;
- Medical Treatment;

and finally the development of ideas in administrative psychiatry itself will be discussed.

A useful base line is provided by the "Report on the British Health Services" compiled by Political and Economic Planning in 1937. This able and authoritative survey covered all the services provided for the sick in Britain at that time and by its statements (and even more its omissions) it gives a picture of the mental health services of that day. In its 430 pages only eight are given to mental illness. Four pages (271–275) consider mental hospitals, but are mostly concerned with the methods of certification and the financial organization; there is no mention of treatment. There are also four pages (351–354) in the chapter on "Other Experimental Services" headed "Psychological Medicine and Mental Health"; the prevalence of shell-shock and psychological invalidism and the efficacy of psychotherapy are discussed, and the clinics of the Institute of Psycho-Analysis, the Tavistock Clinic and the Maudsley Hospital and the increasing development of child guidance clinics are described. The picture given therefore is of a small developing specialty in the treatment of psychoneuroses and a mental hospital service static and divorced from the rest of medicine. This point is inadvertently reinforced by some handsome maps showing "the distribution of hospitals" in the County of London and the County of Norfolk. These maps are dotted with a bewildering variety of coloured symbols to show every kind of hospital, but no psychiatric institutions are shown; not merely are the mental hospitals omitted but even the Maudsley



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Hospital is left out—a fair measure of the position of psychiatry in those days.

### Administrative Framework

Asylums, originally provided by the Justices under the Acts of 1808, 1845 and 1853 were taken over in 1890 by the County and County Borough Councils, who governed them by Committees of Visitors. The Visitors' responsibilities were defined by the very detailed Lunacy Acts of 1890 and 1891, and they were supervised and scrutinized by the Board of Control (before 1913 the Commissioners in Lunacy) who made regular visitations. The Visitors appointed a Medical Superintendent who was personally responsible for all that happened in the hospital. The majority of patients were committed by a magistrate under a Reception Order (i.e. certified), though the Mental Treatment Act of 1930 made it possible for patients to enter the hospital voluntarily.

The National Health Service Act, 1946, cast the whole pattern of British hospital services in a new mould; for the mental hospitals it made changes which altered their internal organization and their relationship to the rest of medicine.

The mental hospitals were removed from the local authorities to become part of the National Health Service. The Minister of Health appointed Regional Hospital Boards to administer, co-ordinate and develop services in 14 (later 15) Regions in England and Wales and 5 in Scotland, and the Regional Hospital Boards appointed Hospital Management Committees to run hospitals or groups of hospitals. In most areas the mental hospitals were large enough to be given Management Committees of their own, many of whose members had served on the previous Committee of Visitors. National rates of pay for all staff were introduced, which meant a marked rise in pay for many mental hospital officers and staff. The Medical Superintendents and senior doctors became Consultant Psychiatrists. The Clerks and Stewards became Hospital Secretaries. Posts of Finance Officer, Hospital Engineer, etc., were created with statutory duties and responsibilities to central Ministry officials.

Since most of the people involved, Management Committee members, Medical Superintendent, Secretary, etc., merely changed their title, the effects of these changes of organization were not at first apparent and personal relationships and methods of operation persisted, as has been described by Sofer (1955). As the years passed, however, shifts of power and responsibility began to occur.

Finance was no longer controlled locally, but centrally. As soon as comparative figures became available the gap between what was considered sufficient for a mental hospital patient and what was regarded as essential for a general hospital patient became apparent and was a cause of dismay, recrimination and debate in Parliament. Funds were gradually made available for upgrading the structure and the life of the mental hospitals. The physical details of the life of the staff and the patients gradually improved and the dreary institutional trappings of the wards—dark green paint, dados, indestructible furniture, bare floor boards, etc., were replaced by pastel colours, prints and modern furniture.

Relationships between the senior officers of the mental hospital gradually changed. The lay senior officers were no longer responsible to the Medical Superintendent, but directly to the Management Committee, and, it gradually became clear, to other officers at Regional Board and Ministry level. The prospect of removal of medical control caused some alarm at first, but the position of the Medical Superintendent as Chief Officer was maintained by a ministerial Statutory Instrument (No. 419, 1948). With the development of the National Service this provision became increasingly anomalous and it was abandoned after the coming into operation of the Mental Health Act 1959. The areas of disputable authority inevitably led to occasional contests of power among senior officers; some of these problems were examined by the Bradbeer Committee on the Internal Administration of Hospitals (1954).

Financial control of hospital operations by Regional, Ministry and Treasury officials gradually tightened over the years. At first all were feeling their way, but a period of economic stringency—1951–53—was managed by close

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central scrutiny of accounting; this has been maintained since by the proliferation of modern business aids and accountants to operate them. This, it was believed, would lead to more efficient use of funds; it certainly led to increased staff in the financial departments and increased central control. The Guillebaud Committee, appointed in 1953 to examine the cost of the National Health Service (1956) did not recommend any changes in the system of financial control; they did however effectively dispel the myth of the "mounting cost of the National Health Service" by showing that the proportion of the national income spent on health (and especially on hospital building) had fallen rather than risen.

Hospital Management Committees found their functions changing. They had little control over finances or planning, they no longer reviewed patients for discharge, they could not alter salaries and they had far less power over staff, senior and junior. They came to have other functions; they were the court of appeal in contests between the senior officers, they took the lead in protests against over-centralization and Ministerial reorganization, they were a link between the hospital and the communities it served and as members of national bodies such as the Association of Hospital Management Committees and the National Association for Mental Health they became powerful instruments of indirect pressure on Ministers, and Members of Parliament. From being paymasters they became independent humane lay bodies alleviating the bureaucratic pressures of an increasingly professionalized and centralized service.

The social structure of the medical staff changed profoundly, though this was only gradually apparent. Until 1948 the Medical Superintendent was personally responsible for everything that happened to every patient, especially treatment and custody. It had not been realized what a crippling effect this responsibility (which is still maintained in the United States) could have on the man in the post, on the institution, and on the treatment of the patients, as the institutions became larger. In the days when the asylum was small and the single medical officer knew all the patients personally and was treating them himself, the system of personal responsibility of the Medical Superintendent had advantages, particularly in keeping the medical aspect of the institution a primary consideration (as opposed to its financial, custodial and penal aspects). But as the institution grew larger and the treatment of patients was carried out by other doctors, the centralization of responsibility crippled medical initiative in treatment and put an over-emphasis on custody, caution and restraint. Even with an outstanding Medical Superintendent in a first-class small institution many decisions had to be delayed until he could make them. With an anxious man or a large institution severe difficulties arose; initiative or experiment were checked, necessary decisions were delayed, junior medical and nursing staff became resentful and disgruntled, and in many hospitals numerous petty tyrannies developed. There was a tendency for the Medical Superintendent to move away from the patients and become interested and expert in non-medical sides of the institution such as pig breeding, dairy management or laundry organization. Crocket (1960) has discusssed some of these difficulties and Osmond and Clancy (1958) have explored some of the pitfalls that beset a doctor who confuses his "sapiential" with his "structural" authority.

A formal pattern of medical gradings within the National Health Service was established in 1948; a "consultant" was defined as being in full control of and personally responsible for the treatment of his patients. On the other hand, the Lunacy Acts of 1890–91 made the "Medical Officer of the Asylum" (i.e. the Medical Superintendent) personally responsible for the detention of certified patients. This anomalous position was gradually clarified. In many hospitals the consultant psychiatrists were given full freedom to treat their patients as they saw fit, but in a number, older Medical Superintendents insisted on retaining excessive control and restraint over these senior doctors.

This resentment gradually came to a head; Tetlow (1957) published the results of a questionnaire to consultant psychiatrists showing widespread dissatisfaction with the medical administration of their hospitals; there was much correspondence in the *Lancet* in 1958 and 1959

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during the passage of the Mental Health Bill; a "Group for the Advancement of the Views of Clinical Psychiatrists" was formed. The Mental Health Act 1959 cleared the situation. The Responsible Medical Officer (usually a consultant psychiatrist) now has personal responsibility for detention and discharge of the patient. The Medical Superintendent is not mentioned in the Act. This change has improved the situation within the hospitals.

The relationships among the senior doctors remain an important aspect of the social organization of the mental hospital and problems can arise in this area. Before 1948 the Medical Superintendent was paid more than the other doctors; from 1948 all consultants were paid the same, so that the post of Medical Superintendent appeared less attractive and was often obtained by younger men; following the report of the Royal Commission on Doctors and Dentists Remuneration (1960) Medical Superintendents were paid a small additional sum. A number of experiments in senior medical organization are at present going forward in different hospitals.

Shifts have also occurred since 1948 amongst the other senior officers. The Bradbeer Committee rejected a submission that mental hospitals should have a similar organization to general hospitals with a lay secretary as Chief Officer. In general, however, there has been a tendency for much administrative activity which before 1948 was performed by the Medical Superintendent to be passed on to the lay officers and it is rare nowadays to find a Medical Superintendent concerning himself with the day to day running of the farm or the laundry or drawing up the hospital estimates. In most hospitals however he still acts as the main adviser to the Hospital Management Committee on medical and nursing matters, handles relations with Regional Board and Ministry officials, deals with planning and organization of hospital and the co-ordination of the therapeutic activities and he often acts as the leader and public figurehead of the hospital.

One of the hopes expressed in setting up the National Health Service was that rational planning would take the place of the haphazard and uneven growth of the past, and the Regional Hospitals Boards were especially charged with planning; however, progress here has been disappointingly slow. In the early years of the Service, administrators were appalled at the uneven state of the hospitals and the backwardness of many of them and most time and money went on up-grading. There was very little building of new hospitals and change usually seemed to be forced on the surprised planners by developments in medical treatment; when the successful chemotherapy of tuberculosis emptied the sanatoria other uses for the buildings had to be devised piecemeal. The planning of the National Health Service was discussed in a series of pamphlets published by the Acton Trust between 1955 and 1959; these contain a description of the methods of control, references to all relevant reports and debates on the organization of the National Health Service and some vigorous but constructive criticisms.

During 1961 a plan for the Hospital Service for the next 15 years was worked out, and the Minister of Health laid it before Parliament in 1962. This was particularly important for psychiatry. The number of psychiatric in-patients in the country had been falling since 1954 and a statistical prediction showed that this fall might continue until by 1975 only 1·8 beds per 1,000 catchment population would be required (Tooth and Brooke, 1961). The Plan therefore states the intention to develop short-stay psychiatric units attached to general hospitals and forecasts that in this new pattern there will be no place for many of the existing mental hospitals. "Some can probably continue if reduced in size and improved, but a large number will in course of time be abandoned."

Relationships of Local Authorities to the psychiatric services have seen a number of surges of feeling and commitment during the period of review. For a century the provision of mental hospitals had been the prerogative of the City, Borough and County authorities. Some authorities such as the London County Council had done a great deal, and there was a good deal of bitterness when they lost all their mental hospitals in 1948 to the newly created Regional Hospital Boards. For a time there was a mutual withdrawal. The mental



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hospital doctors, eager to claim kinship with their general hospital colleagues, tended to forget the public health doctors who had worked with them for so long. Many local health authorities contented themselves with designating their Relieving Officers as Duly Authorized Officers in 1948 and did little more for the mentally ill in the community, though services for the mentally defective—training centres, schools for the educationally subnormal, sheltered workshops, etc.—were often developed. Most developments of domiciliary care came from the mental hospitals and the psychiatric patient in need of community support appeared to be suffering directly from the bipartite division of the National Health Service.

The Royal Commission on the Law relating to Mental Illness and Mental Deficiency (1957) whose Report will be discussed in the next chapter was also charged to inquire regarding the "Absence on trial or licence, discharge and supervision of persons who are or are alleged to be suffering from mental illness or mental defect". They declared firmly that care and after-care must be the responsibility of the local authorities and that this should be greatly developed. The Minister of Health has since brought pressure on local authorities and much is being done. Many administrative psychiatrists have been involved in these developments and this will probably be a major growing point in coming years. A few excellent services already existed, as in Nottingham (Macmillan, 1956) and York (Bowen and Crane, 1957) and others are now being developed. The liaison between the hospital psychiatrist and the public health doctor presents some difficulties. They have different trainings, one in psychiatry with its emphasis on individual understanding and passivity and the other in preventive medicine with its emphasis on general considerations and vigorous authoritative action. They have had different experiences, one in hospital, with its firmly defined roles, the other in public life with many ill-defined boundaries. They work for different public bodies who pay them different salary scales. To overcome these differences of attitude and experience and rôle conception is not easy and makes considerable demands on the psychiatrist (Caplan, 1959).

### Legal Framework

Most doctors have little contact with the law; they are even exempted from jury service. The psychiatrist, and especially the administrative psychiatrist, must be well informed legally, for the law touches his work frequently. One function of the law is to regulate the dealings between society and its deviant members; many of these are the psychiatrist's patients. It has been said that the law is codified public opinion; the Lunacy Laws certainly demonstrate the swings of public opinion over the last two centuries. Jones's two books (1955, 1960) are an excellent study of this process and essential background reading. At any time the laws then in force set limits to what psychiatrists could do for their patients and also defined the use and functions of the institutions for psychiatric patients.

The nineteenth century contained most of the important English Lunacy legislation. Wynn's Act (1808) allowed the founding of the first county asylums, and the Asylums Acts of 1845 and 1853 made it obligatory on county and borough authorities to construct asylums; there were some sixteen other Acts regarding Lunacy during the century. The Lunacy (Consolidation) Acts of 1890 and 1891 drew together all the legislation of the previous century and they remained in force, little altered, for the next 70 years. They reflected the resigned acceptance of public opinion at the time they were passed; during the period of this review these Acts became a steadily greater irritant and an outdated check on therapeutic development. Their main aim was to obtain secure and reasonable humane custody of those who were undoubtedly insane and to prevent the improper detention of those who were not insane. Admission was by a magistrate's order based on medical certificates —one for a "pauper" (the great majority), two for a "private" patient. The medical officer of the asylum (the Medical Superintendent) was personally responsible for the custody and the care of all the lunatics and for the government of the asylum. Lunacy Commissioners (later the Board of Control) were charged with regular inspection of the asylum, the patients, the records of seclusion and restraint, and many other details.

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These Acts certainly secured humane treatment of the mentally ill in English mental hospitals for many years, and this is perhaps the best that could have been achieved in the first quarter of the twentieth century. But the pattern they set of fault-finding authority and insistence on security may well have been quite damaging.

The only Acts in the next half century were the Mental Deficiency Acts of 1913 and 1927 which allowed for the establishment of separate institutions for the mentally defective and the Mental Treatment Act of 1930 which allowed for voluntary admissions and for the temporary admission, without magistrates' orders, of so-called "non-volitional" cases. These were the fruits respectively of the Royal Commission on the Care of the Feeble Minded (1908) and the Royal Commission on Lunacy and Mental Disorder (1926).

At the beginning of the period of review therefore the law was as it had been for many years. Most patients were admitted under certificate; in the majority of cases a Relieving Officer called a magistrate who took a doctor with him to see the patient and committed him under a Summary Reception Order. In many areas, however, increasing use was made of Sections 20 and 21 of the 1890 Act; these were originally designed to speed the admission to a workhouse observation ward of a person found wandering, but by an extension of their application, especially after 1948, they were employed to get patients into hospital quickly without too much formality. In some areas Urgency Orders, allowing a week's detention on a medical certificate were preferred as a means of securing rapid admission. For private patients a Reception Order on Petition with two medical certificates was needed. Occasionally there was a Judicial Inquisition. The provisions of the 1930 Act for "Temporary" treatment were little used.

From 1930 voluntary admission was steadily extended. At first it was only used most cautiously; in some areas patients had to sign a formidable undertaking, and the Board of Control's regulations laid down that every clinical note made on a voluntary patient should include a statement that he was fit to remain as such. During the 1940's, however, voluntary admission became widespread and the presence of a group of legally free patients, perceptive and critical, began to modify some of the more obsolete asylum practices. By the 1950's the majority of admissions were voluntary, and by special permission of the Board of Control certain selected hospitals had outlying units "de-designated" (i.e. removed from the jurisdiction of the Lunacy Acts) and began admitting patients on a "non-statutory" basis.

The increasing inadequacy of the ancient laws finally led the Government to set up in 1954 a Royal Commission "on the Law relating to Mental Illness and Mental Deficiency" in England and Wales. The Commission took evidence from all concerned, including a number of patients who had experienced certification, and in 1957 produced a very full report, including far-reaching recommendations for revising the law. The Government acted with commendable speed and produced a Bill in the following year which became law as the Mental Health Act, 1959. Though a few provisions, such as "informal admission", became effective in the same year, most of them had to be worked out in detail and came into effect on 1 November, 1960.

The Act runs to 154 Sections and repeals nearly all previous lunacy and mental deficiency legislation back to the *Statuta de Praerogativa Regis* of the fourteenth century. Only the main provisions which affect administrative psychiatry will be dealt with here. For details, the Report of the Royal Commission (1957), the parliamentary debates (Hansard, 1959), the Act itself (1959), the Ministry's explanatory memorandum (1960), and Edwards' handbook (1961) should be consulted.

The Act removes all legal distinctions between psychiatric and other hospitals; it also abolishes all legal formalities for the admission of psychiatric patients to any hospital, provided no compulsion is used. This is interpreted as applying to any patient who does not positively object to admission.

Where compulsory admission is necessary, that is, where a patient's objection must be overruled "in the interests of his own health and safety or for the protection of others", this is

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now arranged without the use of a "magistrate's order"—a safeguard which had proved of little value in the past. Instead, the Act provides for what is intended to be a more efficient safeguard by giving a detained patient a right of appeal, at stated intervals, to a special "Mental Health Review Tribunal".

The actual admission procedure consists essentially in an application by the nearest relative or by a Mental Welfare Officer of a local authority, supported by two medical recommendations. Under Section 25, a patient can be detained for up to 28 days "for observation"; in an emergency, Section 29 allows a patient to be taken to hospital and held for up to three days on one recommendation only, the second recommendation being furnished during that time.

At the end of the 28 days period, if compulsion is still necessary, Section 26 provides for detention "for treatment" for up to one year, renewable under certain formalities for further periods. Under this procedure the medical recommendations must state the reasons why detention appears necessary, and why alternative methods of dealing with the case are not appropriate,

In all these cases one of the recommendations must be given by a doctor who has been "approved as having special experience" in mental disorder (Section 28), and one should, if practicable, be given by a doctor who was previously acquainted with the patient.

Provision for mentally disordered persons who are charged with criminal offences is made in Sections 60 and 65. If convicted, such persons can be made the subject of a "Hospital Order", and, if the offence is serious enough to warrant this, a judge in the High Court may order that the patient shall not be discharged without the Home Secretary's consent.

Apart from these "restricted" Court cases, all other detained patients can be discharged by order of their nearest relative (unless dangerous to themselves or others) or by the "responsible medical officer", i.e. the senior doctor in charge of the case; previously no doctor possessed the power of discharge, which rested with the Hospital Committee or Visiting Justices, usually on the recommendation of the Medical Superintendent. Under the new Act, if a patient is refused his discharge by his relatives and his doctor, or by the Committee, he can appeal to a Mental Health Review Tribunal at specified intervals throughout his detention. These Tribunals have been set up in each Region (Section 8) with a mixed medical, legal and lay membership, and have the power to discharge a patient if, after enquiry, they find his detention no longer necessary.

By Section 2 of the Act, the Board of Control for England and Wales was dissolved, thus bringing to an end a tradition dating back to the appointment of the first Metropolitan Commissioners in 1828. It was held that since the hospitals were now part of the National Health Service and controlled by the Ministry of Health through the Regional Boards there was no place for supervision or inspection by an independent Authority.

A Mental Health Act for Scotland was placed on the Statute Book in 1960. Although it has many features in common with the English Act, it differs on two important points, the difference reflecting the fact that there had been in Scotland less dissatisfaction with the previously existing law. Firstly, the Scottish General Board of Control has been replaced by a Mental Welfare Commission, charged with protective functions, particularly as regards possible "ill-treatment, deficiency of care or treatment or improper detention". Secondly, applications and medical recommendations for compulsory admission must still be approved after due enquiry by the Sheriff, and the Sheriff is also entrusted with the duty of hearing appeals by detained patients.

Northern Ireland brought its Mental Health legislation up to date on similar lines by an Act passed in 1961.

It is too early to assess all the effects of these new laws, but certain of them are already clear in England and Wales. "Informal" admission has succeeded voluntary admission as the commonest way of entering hospital—in 80 to 90 per cent. of admissions. Most of those brought to hospital compulsorily settle down within the 28 days and then become "informal". The majority of the long-stay patients have been regraded as "informal" and this has caused no

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difficulties. Every hospital has a small group of patients under long-term detention under Sections 26, 60 and 65. There have been difficulties with the Courts about the application of Section 65, which are still being worked out. There has been far less work for the Mental Health Review Tribunals than was expected. The House of Lords debated the application of the Mental Health Act on 4 July, 1962 (Hansard, 1962); there was general satisfaction, but some doubt about the widespread use of Section 29.

Administrative psychiatrists have had to concern themselves greatly with legal matters during this transition period, but perhaps legal knowledge will be less important to them in the future, and they will no longer have to spend long hours waiting to testify in Courts. Any Responsible Medical Officer who wishes can make a specialty of medico-legal work. The administrative psychiatrist, no longer the legal custodian of all the detained patients, can develop further his therapeutic interests.

### Public Opinion

Public opinion is a limiting factor in administrative psychiatry, and the doctor active in this field must constantly consider it. It sets the limits to what he can provide for his patients, and determines what facilities (and especially finances) he will get for them. He can change public opinion positively—by taking part in mental health programmes, by popular lectures, by press interviews—or negatively—by churlish behaviour to the Press, maladroit management of unavoidable crises of public confidence or unimpressive behaviour in law courts.

In the years immediately after the war, there was not a great deal of public interest in psychiatric administration. Psychiatric evidence at notorious murder trials, especially those of Heath and Haigh, and the incident of Straffen (the mentally defective murderer who escaped from psychiatric custody to repeat his crime), contributed to the public image of the psychiatrist as one who would condone any crime, however abominable, by attributing it to an unfortunate childhood; "psychiatry" has been a frequent scapegoat of the perfervid floggers and hangers in the intermittent public debates that have marked the gradual abandonment of corporal and capital punishment in Britain during the last two decades.

Some public interest and disfavour focused on the operation of leucotomy which was stigmatized as "the operation on the soul" and its use was discussed by theologians and psychoanalytic purists in pejorative terms.

When the National Health Service began, interest centred on the general hospitals, but in the early 1950's attention moved to the lamentable state of the mental hospitals. There were questions in Parliament, and in 1953 the Minister of Health, Mr. Iain Macleod, announced that a "mental million" (pounds sterling) was to be spent on upgrading of mental hospitals.

During the later nineteen-fifties increasing public interest fell on the mental health services. B.B.C. television showed a series, "The Hurt Mind", in January 1957 which gave a balanced and informed picture of the services at that time. The "Lifeline" series on B.B.C. television over the years presented a number of aspects of psychiatry and psychiatric treatment to the public. Books, films and articles about psychiatric hospitals appeared, some hostile and critical, but all evidence of a general public interest.

The most important organization forming public opinion during this period was the National Association of Mental Health. Formed in 1945 by the fusion of the main voluntary mental welfare associations, the Association has grown greatly. It runs hostels, training courses and an information service, it co-ordinates, supports and extends local associations, and one of its major activities has been public education. It has produced a number of excellent pamphlets for the lay reader on mental health subjects and every year since 1952 it has organized a conference, attended by Royalty and Cabinet Ministers, which has become a major forum for the discussion of important issues of mental health and psychiatric administration.

The formation of Associations of Friends of Mental Hospitals is another measure of changing public attitudes. In 1950 there were only three; in 1962 there were 77. Two societies of patients

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pledged to mutual help, Alcoholics Anonymous and Neurotics Nomine have done a good deal by meetings, discussion and persuasion to change attitudes.

The Royal Commission Report (1957), the debates in Parliament (1958) and the Mental Health Act 1959 all gained a good deal of attention and mostly favourable comment. 1960 was designated Mental Health Year and many organizations had demonstrations, exhibitions, film shows, lecture tours. In most areas of Britain the local psychiatrists responded to this interest by giving lectures to civic bodies, serving on Voluntary Committees, arranging Open Days for the public to view the hospitals and organizing Mental Health Exhibitions.

There is no doubt that public opinion in Britain has in the last decade become steadily more tolerant of the psychiatric patient, the psychiatric institution and those who work there. Whether this is due to the educational activity, or the improved treatment, or some cultural shift, no one can say for certain. At British hospitals where an active public education programme, with articles in the local Press, lectures, etc., has been followed by a change of attitude, the psychiatrists are convinced that these activities have been valuable. But perhaps it is easy for us in Britain as we swim with the tide. The problem is more difficult in the United States, as the report of the Joint Commission on Mental Illness and Health (1961) makes clear. The public image of the State Hospital there is still clearly linked with violence, homicide and the penal system. The Cummings (1957) have described some of the difficulties in forcing mental health education on a community. Much more study is required of how public opinion changes towards the mentally ill and those who look after them.

## Psychiatric Treatment

Psychiatric treatment has changed greatly in the last quarter century; this study is not directly concerned with these changes. Since psychiatric administration is partly concerned, however, with what Crocket (1960) has called "supportive administration"—that is organizing the resources to enable doctors to treat patients—an account must be given of these changes. They can be summarized thus:—

| | Discovered | General adoption |
|---|---|---|
| Insulin coma therapy .. | 1935 | 1945 |
| Electroplexy .. .. | 1939 | 1943 |
| Leucotomy .. .. | 1939 | 1944 |
| Tranquillizers .. .. | 1952 | 1956 |
| Antidepressants .. | 1958 | 1961 |

The administrative side-effects of their introduction were complex and fascinating.

In the days when mental hospitals provided only humane custody little skilled medical or general nursing care was needed and the staff was organized for this. The occasional stitching of a scalp or splinting of a broken bone, the nursing of the dying elderly and the general practice care of the physical illnesses and infectious diseases of the population were the medical recreation of the asylum physicians. Almost the only treatment calling for skilled physical techniques was the malaria treatment of G.P.I. and this was often removed to special centres with selected staff.

The needs of the physical treatments made a change. An Insulin Coma Unit required highly trained staff, medical and nursing, to meet the daily crises of this dramatic and dangerous treatment. The brightest and liveliest nurses and doctors volunteered for the work and built up nuclei of high morale, therapeutic endeavour and hope that often invigorated the rest of the hospital. Convulsive therapy with cardiazol and electricity called for special arrangements, but little reorientation. The practice of modifying the convulsion with relaxants, however, with its associated anaesthetic dangers, made necessary the organization of special treatment teams with a high level of efficiency and the employment of consultant anaesthetists. The wave of leucotomies (1944–54) brought neurosurgeons into the mental hospitals and entailed the development of neurosurgical nursing techniques.

All these developments made demands on the nursing and medical staff of the hospital. They forced staff to learn new skills and understand new dangers, thus creating some insecurity. But they had a far more important tonic effect in breaking up pessimistic static regimes and

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reviving the prospects of cure for the most severely ill patients.

In the nineteen forties, during and immediately after the war, there was an increasing demand from the public and the general practitioners for the provision of adequate psychiatric services. This required out-patient clinics, at first for diagnosis and follow-up. It was found possible to carry out physical treatments at these clinics, and their numbers grew. Senior psychiatrists began to spend more of their time outside the hospital walls and found they were seeing new groups of patients. A rising admission rate became the mark of a go-ahead hospital.

The entry of comparatively well-oriented persons, of all social classes, into the mental hospital wards brought repercussions. Their comments often brought about modifications in the security regulations and oppressive stripping practices of the institution. Often an "admission villa culture" developed, with its own life of dances, parties and outings, quite separate from the "main building" life of the long-term psychotics who continued to live out their drab, regimented, anonymous life.

During 1955 the use of the "tranquillizers"—principally chlorpromazine (Largactil) from France and reserpine (Serpasil) from U.S.A. spread through Britain. They appeared to have a striking effect on long-term psychoses and began to be prescribed in such vast quantities as to cause unprecedented drug bills in the mental hospitals. Every post brought accounts of new drugs which were enthusiastically tried out in "double blind" trials. The violence of the hospitals diminished and nursing became less dangerous; a certain number of long-stay patients left hospital. On the other hand toxic reactions were seen and deaths from agranulocytosis occurred. Nurses and doctors had to learn to recognize toxic signs and symptoms and their treatment.

In 1959 antidepressant drugs such as imipramine (Tofranil), phenelzine (Nardil) and variants became available. They reduced the amount of electroplexy required in the hospital.

There were new developments in treatment—out-patient clinics, day hospitals, night hospitals, sheltered workshops, etc. For each of these new arrangements had to be made, cutting across older patterns. To arrange this called for considerable skill in "supportive administration" in explaining developing medical experiments to finance committees and financial considerations to eager doctors.

## STAFF

### *Medical*

The changing professional position of psychiatry has been reflected in the training and recruitment of doctors to the specialty. Before the war, with the exception of the Scottish Universities, the teaching of psychiatry to medical students was inadequate and only a few doctors went to work in the mental hospitals. The pay was low, but the perquisites—free house, garden produce, patients as servants, etc.—were pleasant for those who liked a rural life. Gradually departments of psychiatry and adequate training programmes have been established. In 1948 most senior positions in mental hospitals were graded at consultant level and since then new positions have been created until "mental health" is one of the largest specialty groups in the National Health Service. Recruitment has increased, and psychiatric hospitals found themselves becoming training institutions. After a period of confusion immediately after the war when numerous experimental diplomas with differing qualifying conditions were started and then stopped, the Diploma in Psychological Medicine of the Conjoint Board of the Royal Colleges of Physicians and Surgeons became the generally accepted professional qualification; this required two years' psychiatric experience. In the competition for consultant posts, higher medical qualifications were esteemed, and many aspiring psychiatrists joined the ranks of those attempting again and again the London M.R.C.P. examination. The need to do "research work" toward an M.D. thesis increased the output of publications from mental hospitals, with also, fortunately, some improvement in their quality.

Recruitment has varied. Distant provincial mental hospitals, or those with a poor reputation have found it difficult to get staff, and in recent years, like provincial general hospitals, have had to rely largely on overseas doctors for

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junior staff. In some areas a good postgraduate training programme based on a University department attracts and trains sound recruits.

The psychiatric administrator must in many hospitals plan not on a settled unambitious medical staff, as was common before the war but a continual flow of active energetic inexperienced ambitious young men whose passage through the hospital may be either unsettling or stimulating, depending on their personal qualities. Many senior nursing staff speak of this as the biggest social change that has come over the life of the mental hospital in the period under review.

*Nursing*

From the earliest days those who attempted to treat the mentally ill in institutions were concerned about the quality of staff available and their instruction. Pinel (1801), Tuke (1813), Browne (1837), Conolly (1847-56) all discuss this. The R.M.P.A. certificate was the first national certificate for nurses. Walk (1961) gives details of the history of mental nursing. It was for long one of the strengths of British mental hospitals that they had a body of staff trained and qualified in psychiatric nursing and did not have to rely on a mixed group of general trained registered nurses and untrained underpaid attendants as in the United States.

By the 1930's mental nursing was in a reasonably satisfactory but static position. Most of the recruits came from rural or industrial depressed areas—Wales, Ireland, the Scottish Highlands and Tyneside—but there were enough of them and after completing their training most of them settled down and worked until they drew their pension. The work was hard, the hours long and the pay low, but the pension was good, the house rent for the married men was low and the sports facilities often excellent.

The 1939-45 War upset all this; many of the men went into the Forces and the women into war industries. There were no recruits. Standards of care in the hospitals inevitably fell as a dwindling band of ageing staff attempted to look after increasing numbers of patients. After the war the men returned, but the women did not, and the post-war decade was marked by many expedients to help the staffing position—cadet schemes, employment of nursing assistants and the importation of girls from other countries—France, Spain, Germany, Italy, Nigeria, Jamaica. The National Health Service raised pay and there were numbers of conferences and committees of enquiry. During the nineteen fifties pay was raised on several occasions and the working week was shortened, but the shortage continued. Abel Smith (1960) has shown that despite the many other careers open to women, nursing continued to attract a constant quota, but that the number of nursing positions was expanding faster than the number of entrants. His book however does not deal with mental nursing. One reform much advocated was to improve the status of the student nurses and the quality of their training. In 1948 the financing of nurse training was removed from the general Health Service Budget and administered by Area Nurse Training Committees.

These constant shortages forced a healthy state of self-scrutiny on those in power and in 1957 the General Nursing Council for England and Wales agreed to a new experimental syllabus of training for psychiatric nurses which drew on advanced educational practice. It advocated teaching by group discussion rather than by didactic lecture and brought teaching much more actively into the wards.

The Nurses Acts, 1943 and 1949 protected the legal position of the nurse. The Royal Medico-Psychological Association gave up its separate examination to the General Nursing Councils. As psychiatry developed in general hospitals there was an increased desire to bring psychiatric and general nursing together, without abandoning all the advantages that psychiatric nursing had gained from having its own professional body. Inevitably administrative psychiatrists have been very much involved in all these discussions.

At present, more general nurses are spending a period in psychiatric hospitals, either on secondment as a portion of their general training or as postgraduate students, and many psychiatric nurses are taking a general qualification. The wider development of comprehensive training schemes seems likely in the future.

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Standards vary, and John (1961) found poor standards and low morale in four Scottish mental hospitals, but by 1961 most psychiatric hospitals had adequate *numbers* of staff. They were however a very mixed body of people, and each hospital tended to have its own patterns of ethnic and professional sub-groups. All this forced a greater flexibility and readiness to experiment with different staffing patterns in nursing administration, nursing tutors, and psychiatric administrators. Experiments in therapeutic community work cut across traditional concepts of nursing and training, producing a number of strains. The first report of the expert committee on psychiatric nursing of the World Health Organization (1956) explores many of the problems of the developing rôle.

*Other Professional Groups*

Before the war, the mental hospital contained patients, nurses, and doctors; nearly everyone could be allotted to one of these groups. Since the war other professional groups have become essential members of the psychiatric treatment team; clinical psychologists, psychiatric social workers and occupational therapists are to be found in all hospitals and in some, more recondite professionals are to be found—social anthropologists, non-medical biochemists, statisticians, lay psychotherapists, music therapists, etc.

The establishment of each new group raises problems for the administrative psychiatrist, as well as for the unfortunate forerunner. Space has to be found for him to work, secretarial assistance, library facilities, car parking facilities, etc. Each department finds this new man puzzling ". . . Just what is he, doctor?" and there is an initiation phase of mutual exploration. If the new man is sensible and adaptable this may pass off soon, but if he is sensitive or truculent or unable to resist the temptation to play parental figures off against one another he may be the centre of great storms and interdepartmental battles.

## Administrative Psychiatry

The major psychiatric writings of the first half of the nineteenth century concerned themselves constantly with administration, or "moral management" as they called it. Pinel (1801, 1809), Tuke (1813) and Browne (1837) wrote at length on the subject, as did Conolly (1847, 1856). Walk (1954) and Rees (1957) have pointed out that their writings are still valuable and inspiring today. As asylums became custodial, publications became fewer. Burdett (1891) surveyed the hospitals and asylums of the world in four vast volumes and Mercier (1894) wrote on their management. The only text in the first fifty years of the twentieth century was Bryan's (1937) work *Administrative Psychiatry*.

Towards the end of the nineteen thirties interest in group therapy began to develop; this has been well reviewed by Kräupl Taylor (1958), who should be consulted for details. During the war these ideas were further applied, and a social psychological approach to administrative psychiatry began to develop.

Bion and Rickman (1943) described an attempt to resuscitate the morale of a dispirited Army neurosis unit by management and reorganization. Foulkes (1948) in a book devoted chiefly to group-analytic psychotherapy, describes administrative action undertaken at the same neurosis unit (Northfield Hospital) rather later in the war with the same aim of producing therapeutic change in a group of dispirited demoralized men awaiting discharge on psychiatric grounds. In an issue of the *Bulletin of the Menninger Clinic* in 1946 the British group therapists expressed their developing ideas, and in the article on "The hospital as a therapeutic institution" Main commented on the damage which the traditional medical organization did to the psychoneurotic in making him dependent—"the fine traditional mixture of charity and discipline which they receive is a practised technique for removing their initiative as human beings and making them patients."

The group therapists returned from war service to their clinics and hospitals and began to apply these ideas. Group therapy was developed at the Tavistock Clinic; T. F. Main became Director of the Cassel Hospital; S. H. Foulkes started group-analytic psychotherapy at the Maudsley Hospital; publications were mostly brief, but Taylor's (1958) review, is most valuable.

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Maxwell Jones had developed his methods of group therapy initially at a cardiac neurosis unit at Mill Hill at the beginning of the War (1942); the ideas were transferred to returning ex-prisoners of war (1946) and then to the famous unit at Belmont Hospital, which started with men unable to work and developed into the pioneer unit for the treatment of psychopathic individuals by community methods. These three communities were described in his book *Social Psychiatry* (1952) (published in America as *The Therapeutic Community*).

The Belmont unit was studied during the following years by a group of social scientists who after publishing various briefer studies gathered their material into a book *Community as Doctor* (Rapoport, 1960). In this they described the unit and its functioning; they analysed the ideology of the unit, the patients accepted and their reactions. They carried out a follow-up and finally analysed the process of milieu therapy, the use of it in the unit and some of the weaknesses and strengths of the method.

During these years, contributions came from another group, the social anthropologists. Just before the war, Rowland (1938, 1939) had made some striking comment on the bizarre life of the State Mental Hospital. Bateman and Dunham (1948) recorded some further sociological comments on the "attendant culture" of the State hospital, showing the value of the anthropological approach. The material of this study appeared later in a book by Dunham and Weinberg (1960). Schwartz, a social psychologist, and Stanton, a psychiatrist (1949*a*, 1949*b*, 1949*c*, 1950), published a series of exciting articles in the journal *Psychiatry* from Chestnut Lodge Sanitarium, Maryland. They analysed the life in a locked ward for deeply disturbed schizophrenic women who were all undergoing intensive psychoanalysis. They described in particular a "triangular conflict" in which a disturbed patient with a histrionic personality became the focus of a covert staff disagreement on management which intensified as the two chief protagonists (doctors or nurses) withdrew from each other while the rest of the staff took sides, until the situation burst in an incident when the isolated staff member rejected the patient, became very disturbed personally and soon after left the hospital—while the patient's condition settled. They also analysed staff reactions to patients' demands and incontinence as a social psychological phenomena. All this material was later gathered into a book *The Mental Hospital* (1954).

It was these studies more than any others which brought home to psychiatrists how much valuable information social scientists could give about the workings of their wards and hospitals. They showed that a social scientist using the techniques of the social psychologist (questionnaires, sociograms, interaction scales) or the more general descriptive approach of the social anthropologist could elucidate and analyse the social processes at work in the hospital. As the studies multiplied it became clear that some of these social processes had quite powerful effects on the patient's behaviour, their illnesses, and their chances of recovery. If they could be understood and effectively manipulated there was a chance of developing an administrative psychiatry based on scientific verified knowledge and theory rather than the hunches and self-evident propositions of the nineteenth century moral treatment reformers. During the next decade the theoretical explorations of the social scientists and the practical experiments of the social psychiatrists are so interlocked that the developments cannot be related separately.

Caudhill (1952), a social anthropologist, contributed a valuable study by entering a neurosis unit as a patient. He described how the other patients instructed a new entrant on the patients' "role" and taught him what sort of things to do and to say, and what sort of material the various doctors appreciated at their psychotherapeutic interviews. He discussed in another paper (1953) the anthropologist's contribution to medical studies. Later he returned to the hospital and carried out further studies, particularly into the social components in a collective disturbance and published these in a book *The Psychiatric Hospital as a Small Society* (1958).

Belknap (1956), a sociologist, carried out a study of a State mental hospital. He pointed out that this institution had been "cleaned up" and had subsequently slipped back four times in 85 years; he set out to discover why. He analysed

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the grades of staff and their turnover; he found that doctors and administrative nurses seldom stayed long in the hospital, and that many of the attendants turned over quickly, but that there was a hard core of senior long-stay attendants who spent all their working lives in the service of the hospital. He examined their beliefs about mental illness and showed that these were simple, humane, moralistic, custodial and essentially pessimistic. He then examined the social structure of a typical back ward and showed that it was a rigidly stratified hierarchy in which he distinguished six social classes—the executive (doctor), the supervisors (charge attendant and deputies), foremen (attendants), the privileged patients (ward workers), the limited privilege patients and the patients without privileges. He described how these classes each had their privileges and their duties and the firm social barriers that stood against any penetration by the group below. A new patient entered the bottom category; by learning to conform he might slowly graduate to the fifth or fourth categories. Discharge from hospital was scarcely considered; there were no facilities, such as a social work department, for bringing it about, and as an aim it was discouraged ("You'll only have to come back"). Belknap thus illustrated in detail what Dunham had earlier pointed out, that the enduring backbone of the American State Hospital was the "attendant culture"; that this provided, from meagre financial, intellectual and social resources, moderately humane custodial care for the committed mentally ill, but that its effect was to produce a permanent resident, a fairly quiet "asylum patient" and that any recoveries or discharges were almost accidental. Although some aspects of this study applied only to American hospitals, its general lessons were clearly applicable to any custodial mental hospital. A contemporary publication, an autobiography of an alcoholic who cured himself by working as an attendant (Maine, 1947) effectively if garishly illuminates the life, beliefs and practices of the attendants.

In 1956 the National Institute of Mental Health sponsored a Research Conference on Socio-Environmental Aspects of Patient Care in Mental Hospital in Boston, to which most of the authors cited above were invited, and altogether 50 active workers in the field. They all contributed papers and discussions and from this a book emerged which is probably the most important source book for the administrative psychiatrist (Greenblatt *et al.*, 1957). There are a number of descriptions of actual experiments but, more important, several valuable theoretical papers. The Cummings (p. 50) described a method of producing an attitude change in a mental hospital by finding "culture carriers" among the staff, teaching them and thus bringing the others over. Greenblatt (p. 317) in an article "The Psychiatrist as a Social System Clinician" put forward ideas later developed as "administrative therapy". Jones and Rapoport (p 248) described the process of acculturation of new doctors joining the Belmont unit.

A symposium on Preventive and Social Psychiatry a year later at the Walter Reed Army Institute of Research also produced a volume of essays of considerable value (1958). This contained an important article by E. Goffman (p. 43) on "The Characteristics of Total Institutions" in which he points out that the mental hospital shares certain characteristics with prisons, monasteries, boarding schools or battleships, such as a "modification system" for new entrants, by which they are stripped of all that gives them individuality and put in the lowest status rôle, a "privilege system" of bizarre rules and punishments, a "fraternalization process", etc. He describes five main reactions to the pressures of the total institution —situational withdrawal, the rebellious line, colonization, conversion, and "playing it cool". Also in this volume is an account by Sivadon (p. 457) of his principles of Sociotherapy and a discussion by Hamburg (p. 479) of the construction of therapeutic hospital environments.

All these theoretical studies have thrown considerable light on the social structure of psychiatric hospitals; they have shown that the traditional organization with centralized fault-finding authority, a rigid hierarchy, and a traditional pattern of medical and nursing relationships tended to produce a state of social crippling and deprivation in long-stay patients which prevented their rehabilitation and discharge even when their psychoses had remitted.

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The studies provided the theoretical background for the practical experiments described in the next section.

### The Mental Hospital Changes

Study of the history of mental hospitals shows that methods of organization of the patients' lives have risen and fallen in popularity (Bockoven, 1956; Rees, 1957).

One method, the organization of a full life of fruitful activity, had been advocated very forcibly by Simon (1927, 1929), of Gütersloh in Germany; these ideas had been taken up in Holland and partially in Britain, where the Board of Control (1933) warmly advocated the development of occupational therapy in mental hospitals.

In the post-war period these ideas were revived and a report published by the World Health Organization (1953) set out clearly some of the desirable characteristics of the "community mental hospital". This report was compiled by a committee of whom the leading members were Kraus of Sandpoort, Holland, Rees of Warlingham Park, England, and Sivadon of Neuilly-sur-Marne, France. They stated firmly that a hospital should be a "therapeutic community" and listed important components of a therapeutic atmosphere—the preservation of the patient's individuality, the assumption that patients are trustworthy, the encouragement of good behaviour, freedom, responsibility, chances for the patients to show initiative, and a full programme of activity. These principles were gradually applied in a number of hospitals in Britain and in America during the coming years, different aspects being stressed in each hospital.

At the beginning of the period of review mental hospitals had most of their ward doors locked; keys were immensely important, elaborate systems of mastering and checking were maintained and staff spent much time letting patients in and out of doors and counting them. There had been experiments in opening hospital doors in the past but they had not spread. At the Fife and Kinross asylum in the 1870's and at Woodilee asylum in 1881 all or nearly all doors were open (Scottish Board of Control Reports, 1881, 1882); at a conference in 1923 the Board of Control called for more open doors; in later generations the idea had cropped up again (Good, 1930), but in 1942 most psychiatrists and mental nurses were firmly convinced that locked doors were an essential if regrettable part of institutional psychiatry. In the period after the war the open door idea started once again, but this time did not fade away.

In 1949 Dingleton Hospital, Melrose, opened all its doors (Bell, 1955). In 1953 Mapperley Hospital, Nottingham, opened all its doors. By 1956 the Ministry of Health (1957) were able to report that seven hospitals in England were fully open door, and 23 (out of a total of 106) mental hospitals had less than four locked units. There was, of course, considerable controversy. As doors were opened tension diminished, violence decreased, escapes became fewer; the nursing and medical staff came to prefer the new way. But there were always those that expressed grave doubts or inveighed against the change. Ratcliff (1962) analysed with careful statistics the results of 10 years' experience of open doors at Dingleton Hospital; he showed that suicides, escapes and police charges were fewer and voluntary admissions and discharges were higher than they had been before the open door and better than expectancy figures based on all the other Scottish mental hospitals.

The position in 1962 is that most English mental hospitals have most of their ward doors open. Most hospitals have one or two locked wards on either side; a growing number have all their ward doors open. Most hospitals in England no longer have padded rooms. In the United States change is coming slower; a few hospitals are open (Snow, 1959, 1961) but there is still considerable hesitation; the use of methods of coercion—camisoles, cuffs and wet packs—has decreased markedly but they are still actively employed in many hospitals.

A number of hospitals have developed programmes of work, and in particular industrial contract work. Following a study of Dutch and other methods of industrial occupation by Carstairs *et al.* (1955) an industrial unit was started at Banstead Hospital which gave good

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results (Carstairs *et al.*, 1956; Baker, 1956). Factories with facilities for patients were developed at Cheadle Royal Hospital (Wadsworth, 1958) and at Glenside Hospital (Early, 1960). Patients were sent to work at an Industrial Rehabilitation Unit (Wing, 1959) and responded well to the incentive and social stimulation. Many English mental hospitals now have small industrial workshops.

During 1955 and 1956 the *Lancet* published ten articles on aspects of the life of the chronic patients which aroused such interest that they were later issued as a booklet "In the Mental Hospital" (*Lancet*, 1956).

Martin (1955) described "institutionalization"—the state of crippled dependence produced by long years of life in the mental hospital, and in a vivid booklet some years later R. Barton (1959) illustrated the same syndrome under the name "Institutional Neurosis". Summer and Osmond (1961) also give a useful account of some of the effects of long stay in hospital, with a number of key references.

A most important publication appeared at this time in America—*From Custodial to Therapeutic Patient Care in Mental Hospitals* by Greenblatt, York and Brown (1955). They discussed three hospitals in the Boston area —the Boston Psychopathic Hospital, the Bedford Veterans' Administration Hospital, and Metropolitan State Hospital—a small teaching hospital, a large quiet veterans' hospital, and a typically neglected state hospital. They described how these hospitals had had custodial régimes with wards full of neglected, apathetic patients and then gave a detailed description of how all this had been changed, with illustrations of the effects. The section devoted to the Boston Psychopathic Hospital, by Greenblatt, which occupies half the book, is most valuable. There is a graphic description of the repression, squalor and confusion of the admitting ward in 1941 and then an account of how this changed over the next decade as a result of attention to the social climate and a differing administrative policy. The gradual introduction of measures such as adequate amenities, staff education, activities, games and outings, and patient government gradually transformed the hospital. This book is a valuable mine of ideas for anyone starting to change a custodial institution.

During the nineteen fifties many British hospitals were changing and applying one or other of these social methods to revolutionize the lives of their patients. Numerous journal articles have illuminated aspects of this process (Annesley, 1961; Baker and Freudenberg, 1957; Bastoe, 1960; Bennett and Robertson, 1955; Bennett, 1961; Bickford and Miller, 1959; Bickford, 1954; Cameron *et al.*, 1955; Glatt *et al.*, 1957; Mandelbrote, 1958; Martin *et al.*, 1954; Martin, 1959; May, 1956, 1957; Shoenberg and Morgan, 1958; Stern, 1957, 1959). The list includes many of the British publications, but is certainly incomplete. Many valuable American articles have also appeared but are not listed as all these are accounts of small portions of programmes, bright ideas that worked dramatically well in moving a hospital a further step "away from the custodial régime". Dax (1961) has given an account of the transformation of the services for the mentally ill in Victoria, Australia, from a state of lamentable neglect.

Special mention should be made of the paper given to the Zurich International Psychiatric Congress by Freudenberg and his colleagues at Netherne Hospital (Freudenberg, 1957) in which they summarized the very important community work that they had been doing for a number of years at this hospital and compared its results with those of the physical treatments. Martin (1962) has given a most valuable account of how Claybury Hospital has gradually changed from a custodial régime to a therapeutic community of free communication and problem sharing.

The relationship of the hospital as a whole to the outside community was an important aspect of these changes. Many custodial attitudes were a reflection of general public feelings; these changed gradually, as indicated in an earlier chapter, but the process was speeded up by Open Days, Volunteer programmes, Press publicity, etc. These are discussed in both of Greenblatt's books and touched on in many other articles.

A major problem was found to be the rehabilitation to useful social life of the patient

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who had been many years in the mental hospital. Maxwell Jones carried out a review of facilities throughout the world on behalf of the World Health Organization (1952) which describes many of the earlier facilities. Charlotte Schwartz (1953) reviewed all earlier work on this subject, and Greenblatt and Simon (1959) published the papers contributed to a Symposium held in 1957. In these articles the need for realistic work, proper rewards, and a gradual return to community life are stressed. Some of these techniques are detailed in another collection of articles on "Remotivating the Mental Patient" by von Mering and King (1957). Brooks and his co-workers in Vermont have contributed a number of valuable studies arising from their well-established rehabilitation unit (Chittick *et al.*, 1961). A valuable development has been the halfway house, in which patients could stay for a time before emerging into the community. Huseth surveyed American (1958) and British (1960) halfway houses, and various authors have described them (Brooks, 1959; Clark and Cooper, 1960; Landy, 1960). Developments in this area have been well reviewed in another valuable Boston symposium *Mental Patients in Transition* by Greenblatt, Levinson and Klerman (1961).

The first step as the asylums emerged from isolation was to set up diagnostic out-patient clinics, but many variants on this have now been developed; the general theme in all is to carry out treatment, even of major psychoses, without removing the patient entirely from his home. These have a considerable vogue and there is no doubt that many patients do much better, though the cynical have suggested that Ministry enthusiasm for such projects may be due not so much to their therapeutic value as their much lower cost. Carse (1958), in the much publicized Worthing scheme, switched the treatment of less severely ill patients from in-patient care to a day hospital; Sainsbury (Morrissey and Sainsbury, 1959) and his co-workers have studied some of the advantages and problems this raises for the patients and their families. Another project has been developed in Oldham (Freeman, 1960). A comprehensive psychiatric treatment programme based on an out-patient clinic and therapeutic club supported intensively by local women's voluntary associations has been developed in Bromley (Morgan and Tylden, 1957; Tylden, 1956, 1961). Bierer (1951), the pioneer in this work, continues to develop activities based on the Marlborough Day Hospital. Freeman (1959) reviewed some of these day hospitals; Farndale (1961) reviewed all day hospitals in Great Britain with very full details of the administrative arrangements.

There have been a few attempts to measure the effects of these changes, but they run up against many difficulties. Clark and Hoy (1957) measured and assessed a programme on the male side of their hospital and cited a number of references. Wing and Brown (1961) compared three mental hospitals with different régimes, and showed that some of the patients' regressive symptoms were considerably less in the less custodial hospital.

There is an urgent need for many more detailed studies of the effects which all these varied measures have on patients. At present it can only be said that by applying a variety of social and administrative measures a number of psychiatric hospitals have been transformed from dreary custodial institutions to lively, optimistic and therapeutic establishments where the staff morale is high, and where patients, especially the long-stay patients, have a greatly improved prospect of discharge.

This review is far from complete. Many valuable small articles appear in out of the way journals describing experiments and developments, especially in the United States where the Federal Funds of the National Institute of Mental Health are promoting many valuable plans. For every published project there are others going quietly ahead, moving out patients locked up for years and improving the life of those still in the hospitals.

### The Therapeutic Community

This phrase has different meanings. In the W.H.O. report (1953) it is applied to the whole hospital. Following Maxwell Jones's book (1952) it has gradually been restricted to the small psychiatric unit where face to face relationships between all patients and staff are possible; this is often a ward within a mental hospital. Such

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units have been the spearhead of the developments discussed in this article. Martin in a handbook given to new staff at Claybury Hospital says—"A therapeutic community is one in which a deliberate effort is made to use to the fullest possible extent in a comprehensive treatment plan the contributions of all staff and patients." Characteristics of a therapeutic community are regular (often daily) meetings of all staff and patients, staff consultative meetings, the examination of community happenings to help understanding and recovery, and constant attention to communications, authority patterns and rôle relationships of staff and patients; there is usually a well-developed programme of work, social activities and small group meetings.

This work began in the Northfield experiment (Foulkes, 1948) and Maxwell Jones's early units (Jones, 1952*a*). Taylor's review (Taylor, 1958) covers this earlier work. Since the war a small group of pioneers, all in fairly close touch with one another, have been working out these methods and occasional books and papers have documented the development of their ideas. Rapoport's book (1960) describes the Belmont Unit up to 1957. Main, whose original paper (1946) was a starting point, detailed some of the findings at the Cassel Hospital in a report (1958). Wilmer (1958) in an important book *Social Psychiatry in Action* described the application of the ideas of Maxwell Jones (with whom he had worked) to a U.S. Navy Admission and Diagnosis ward at Oakland, California. This unit had a function very like an English "observation ward"; it took in acutely disturbed psychotics from all over the Pacific, held them for about 10 days and then passed them on for treatment. It had relied mostly on seclusion, sedation and observation to control the men; Wilmer reorganized it as a therapeutic community with daily ward and staff meetings and transformed the unit. Seclusion ceased, sedation dropped, violence largely disappeared, and many of the men were set well on the road to recovery. This work was very fully recorded on films and tape; Wilmer had a year's leave to produce his book; more recently a film with professional actors has been made about the unit.

Another important U.S. Services research group was in the Walter Reed Army Hospital. Here Artiss (1959) and others worked intensively with a small group of schizophrenics for several years, repeating some of Sullivan's (1931*a*, 1931*b*) classic work on an intensive treatment programme provided by male attendants for male schizophrenics. Here again the daily ward meeting was the centre of the whole project.

In Glasgow a psychoanalyst, Freeman, who had also worked with Maxwell Jones, set up a small intensive treatment unit ("the rumpus room") for chronic female disturbed schizophrenics based on close interpersonal relationships and a permissive atmosphere. This was described in an article (Cameron *et al.*, 1955) and a book (Freeman *et al.*, 1958) in which a theoretical basis for some of the results achieved was advanced in terms of ego strengthening.

Among the various Boston compendia are a number of descriptions of therapeutic communities. Denber (1960) in publishing the contributions to a New York Conference in 1959 has collected a valuable series of descriptions of therapeutic communities operating at that time in the United States. One of the most interesting of these is an account of the opening of a ward door in Boston Psychopathic Hospital, by Greenblatt and Levinson; this door was opened by fiat in 1954 and the staff forced its closure; ward meetings and consultations were developed and two years later in 1956 it was opened by the staff themselves, though a follow-up in 1959 showed that it had taken many months to work fully through the change. A number of psychiatric units in the U.S.A., especially in general hospitals, are applying the therapeutic community approach most vigorously, notably in Kansas City, San Mateo (California), Salem (Oregon), Wisconsin, Boston and St. Louis, although few of these experiments have yet been described.

In England, therapeutic communities have been actively developed in a number of mental hospitals, including Claybury, Napsbury and Fulbourn hospitals and in some general hospital units. Clark *et al.* (1962) have described the development of a therapeutic community in a women's rehabilitation ward and some of the repercussions in the hospital. Martin (1962) has

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just brought out a most important book describing the experiences at Claybury. He describes the pattern of the therapeutic community clearly, the advantages it produces and the strains on the staff. Their first therapeutic community was in an in-patient neurosis unit, but they have since developed them in an acute admitting unit and in long-stay wards. In each there was an initial period of confusion and readjustment, followed by a great increase in therapeutic effectiveness.

In each project communications have been opened, so that the psychiatrists for the first time share the anxieties of the nurses and enter into the daily life of the ward. The régime has been modified and the needs and feelings of the patients have become the prime consideration. Every incident has been fully analysed with the emphasis on understanding what has happened in emotional and interpersonal terms, as a basis for social learning both for the community and for the patient himself. All these units have had discussions and conflicts over authority, the use of medical treatments and drugs, oscillations of permissiveness and rôle conflicts of different professional groups.

The immediate results are soon seen. There is a decline in the use of methods of constraint, and of physical treatments; a greatly increased understanding of the problems of the individual patient; involvement of all staff in the treatment process; active social learning and improvement of a number of patients. Although there are more currents of feeling, acute episodes of violence, homicide and suicide become fewer. The Staff, nursing and medical, find the method far more rewarding. But there is much still to be understood.

The therapeutic community method of treatment is still developing and its full field of application is not yet determined. It has been applied to various groups of patients—cardiac neuroses, returned prisoners of war, psychopathic personalities, acute psychotic admissions, chronic neurotics, long-stay psychotics, convalescent patients, prisoners, mental defectives.

It is not yet clear what its limitations are, and which are its most effective fields of application. The approach has already modified considerably the practice of administrative psychiatry and it seems likely to affect it further in the coming years.

### Administrative Therapy

The practice of administrative psychiatry has changed in the period under review. As the old hierarchical paramountcy of the medical superintendent has passed, many clinical psychiatrists have been finding themselves more involved in "administrative measures" in the attempt to develop social psychiatric aid to their patients. There have been some attempts to study the skills and techniques required for this.

In the concluding chapter of *From Custodial to Therapeutic Care in Mental Hospitals* the authors (1955) call for physicians to serve the social treatment units and to provide leadership and support; they say sadly, "at the present time it is impossible to obtain physicians who can generally fulfil this rôle" . . . because of shortage of numbers and because their training conditions lead them "to see themselves almost exclusively as individual and direct therapists". In another volume Greenblatt (1957) says that the psychiatrist must become "a social system clinician". He develops the need to study the communication pattern and to modify the social system; he stresses the importance of administrative leadership and discusses "concepts and practices that retard or arrest institutional progress".

The Cummings (1956) discussed ways in which the social system of a hospital could be modified. They referred to the way in which a hospital resists change proposed by bright outsiders (cf. Belknap); they identified "culture carriers"—selected by vote amongst the nurses—taught them new methods and let them implement these. Hooper (1960) in a comparative study concluded that imposing change on a psychiatric ward by administrative fiat, though it made the place look more attractive, made little difference to the interpersonal relations or the patients' chances of recovery; allowing change to evolve and allowing the therapeutic team to restructure their rôles, however, led to a more effective change and better treatment results. Mandelbrote (1958), on the other hand, favoured the rapid conversion of a hospital by central direction.

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Ewalt (1956) discussed various aspects of psychiatric administration. Barton (1957) in an amusing paper comments on some aspects of the life of a medical superintendent. Linn (1955) discusses all aspects of the work of the doctor in a psychiatric hospital, but also examines certain aspects of his rôle in the Therapeutic Community. The American Psychiatric Association journal *Mental Hospitals* frequently prints articles on aspects of administration and gathered a number of these together in a booklet in 1957. Some of these are concerned with finance, architecture and legal problems but a few discuss the tasks that the doctor must take on. Dolgoff and Sheffel (1958) emphasized certain aspects of misunderstanding in communications and Osmond and Clancy (1958) countered with an examination of the authority aspects of orders and requests. The Group for the Advancement of Psychiatry (1960) in one of their reports discuss the Administration of the Public Psychiatric Hospital; this lively report is full of stimulating ideas. Sheffel (1951) and Sheffel and Dolgoff (1954) discuss some of the advantages and disadvantages of a psychiatrist's training in preparing for administration; they point to his skill in listening but regret his tendency to see too much of his colleagues' motivations.

W. E. Barton (1962) has just published a monumental book on "Administration in Psychiatry", the first since Bryan, 25 years earlier. It arrived too late to be noticed adequately in this review but will obviously become a major work of reference.

Clark has developed the term "administrative therapy" which he defines as "the art of treating psychiatric patients in an institution by administrative action". He first examined (1958) the demands which the rôle of medical superintendent makes on the clinical psychiatrist but later (1960) set out some of the principles that should govern the administrative actions of any psychiatrist. Crocket (1960) has criticized some of these statements, contending that much "supportive administration" can well be done by a layman, but he also examines the administrative activities necessarily initiated by the psychiatrist. In a recent study of the development of a therapeutic community Clark *et al.* (1962) discussed and contrasted the administrative therapy activities of the ward doctor and the medical superintendent.

There is need to examine the work of the administrative psychiatrist to see what he must do and how he must do it. Few of the men practising administrative psychiatry have been formally trained for it. Most of the leading administrators admit that they came to it by accident and have developed their skills empirically. Maxwell Jones (1962) has recently discussed training for social psychiatry and has said that the only way to learn is to work in a therapeutic community.

The sub-specialty of administrative psychiatry is living through an interesting and exciting period, as this review has attempted to show. The whole background is changing—society's attitudes and laws for the mentally ill, and the buildings provided. The medical treatment of the major psychoses is changing. But most important, the actual methods of dealing with patients and staff in a psychiatric hospital is also changing. After rediscovering the methods of moral treatment, after making our patients active, and then free, we are now beginning to study the applied social psychology of hospital administration and beginning to construct communities where the express purpose is rehabilitation and the social structure consciously engineered toward this.

The psychiatrist who interests himself in administration will today find it a fascinating and kaleidoscopically shifting specialty in which he will have many opportunities for developing effective social psychiatric help for his patients and will experience many frustrations. In the United States he will be hampered by too much responsibility for too many minutiae and the hugeness of the hospitals, in Britain by the complexities of the centralized organization. In both he suffers the low public esteem of the specialty, the ancient fears of madness and the ancient and squalid facilities provided; in both he can have the satisfaction of working in a deeply rewarding field and serving a group of sick and neglected people.

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