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The Functions of Asylum*

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Many of the functions of large psychiatric hospitals were those of asylum. As the structure of services has changed and the role of the large hospital has diminished, the necessity to continue to cover their functions has tended to be forgotten, partly because it has been thought that, even at best, they were purely protective. Such a point of view cannot be sustained. The functions of asylum have always been both refuge and recuperation. 'Community care' will come to deserve the odium now attached to the worst practices of former times if the tradition of asylum practised in the best of the large hospitals is not (with appropriate modification) acknowledged, properly placed in the psychiatric curriculum, and given high priority in service planning.

When Mr Enoch Powell, then Minister of Health, made his famous speech to the National Association of Mental Health in 1961 he made the following central point:

> "Building hospitals is not like building pyramids, the erection" of memorials to endure to a remote posterity. We have to get into our heads that a hospital is like a shell, a framework to contain certain processes, and when the processes are superseded, the shell must, most probably, be scrapped and the framework dismantled." (Powell, 1961)

This serves as text for a commentary on community care in the 1990s, but for 'framework and process' I will substitute 'structure and function'.

The functions that were being superseded were those of bad institutions – authoritarian, custodial and deadening. They were the reason for the reaction against the idea of institutions more generally. However, as Titmuss (1959) had earlier pointed out:

> "No such swing of opinion away from the *good* institution can be discerned: the effective general hospital for the acutely ill, the public school and other socially approved forms of institutional care. But these have been experienced and remembered only by a minority; for most people institutional life has spelt little besides ugliness, cheapness and restricted liberties."

The Oxford English Dictionary (OED) definition of 'asylum' actually conjures up quite a warm and humanitarian image: "inviolable protection"; "a secure place of refuge, shelter or retreat". One of the illustrations given is a quote from 1728: "A port, where his ships might find an azylum". The functions of asylum are those of a haven: to provide a calm and peaceful environment, protection from violence outside, and a base for repair and reprovision. These functions may be carried out in "a benevolent institution . . . for some class of the afflicted, the unfortunate or destitute". The OED gives several examples of such classes, but adds a rider to that of the lunatic asylum, to the effect that the term 'asylum' is sometimes popularly restricted to this one type.

The labels we give to our concepts should be no more than a shorthand for a more extended description that others can check against their own observations. However, in everyday usage some words tend to take on a connotation that owes more to emotion than to reason. 'Asylum' is one of these. It is often popularly restricted in meaning, if not to an 18th-century madhouse, then to a 'total institution' as pictured by Goffman (1961) – Asylum with an upper case 'A'. The 'community', on the other hand, tends to be seen as a cohesive and caring neighbourhood, although there are very few such in industrialised societies. 'Asylum' then becomes a convenient Aunt Sally, while being in the 'community', by a process of tautology, becomes an administrative goal in itself. I propose to adopt the OED definitions, which allow an impartial examination of the extent to which asylum (lower case 'a') functions are being carried out, whatever the nature of the setting.

'Asylum' in the 18th and 19th centuries

When William Tuke, in 1792, set up an establishment for the 'moral treatment' of the insane he did not wish to call it either an asylum or a hospital. "York already possessed an asylum, operating under conditions which made the use of the term a mockery, and the Retreat was not a hospital." William Tuke had a strong distrust of the medical profession and its methods. Daniel Hack Tuke states that 'The Retreat' was suggested by his grandmother, William's daughter-in-law, "to convey the idea of what such

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an institution should be, namely . . . a quiet haven in which the shattered bark might find the means of reparation or of safety" (Jones, 1972, p. 47). The functions of asylum that Samuel Tuke described in his *Description of the Retreat*, published in 1813, were very similar to those put forward by Pinel in his *Traité Médico-Philosophique sur l'Aliénation Mentale* of 1801 (Pinel, 1806). Both regarded the functions as twofold – refuge and recuperation.

To John Conolly (1830) the lunatic asylums and madhouses with which he was acquainted were not fit for the care of the insane, whether acutely disturbed or convalescent: "so long as one lunatic associates with another lunatic, supposing the cases to be incurable, so long must the chances of restoration to sanity be very materially diminished." But in view of the squalour, disease and misery endured by the sane in larger towns, what was the alternative? Scull (1989) quotes MacGill, writing in 1810: ". . . the circumstances of the great body of mankind are of such a nature as to render every attempt to recover insane persons in their own houses extremely difficult, and generally hopeless."

Scull argues: "To improve the living conditions of lunatics living in the community would have entailed supplying relatively generous pension or welfare benefits to provide for their support, implying that the living standards of families with an insane member would have been raised above those of the working class generally . . . something approximating a modern social welfare system, while their brethren were subjected to the rigours of a Poor Law based on the principle of less eligibility." This has a familiar ring to it.

Conolly's antipathy to asylums was restricted to their use for curable cases ("two-thirds, or I might say four-fifths of the cases of reception"), and he was particularly concerned about those "who have been accustomed to refined society" (Conolly, 1830). When he introduced the principle of non-restraint to the large asylum at Hanwell, following Gardiner Hill's demonstration at Lincoln, he seemed tacitly to accept that his earlier estimate of prognosis had been optimistic. Conolly's success at Hanwell provided an acceptable alternative both to the madhouses and to the community neglect of the time, and gave a much needed gloss to the public image of the asylum. In this way he contributed to the growth and systematisation of the asylum system during the next 100 years.

I am not here concerned with the merits and demerits of that system, except to point out that the structure within which the functions of asylum are carried out must, as Scull suggested, always be judged within the context of the social conditions of the time. I would add the context of medical and social knowledge to that. There must always be a balance between the protective and the rehabilitative functions. The reason for beginning with this brief historical sketch is to set the scene for the changes that have occurred since the 1920s, interrupted and then accelerated by World War II.

'Asylum' after World War II

During the late 1940s and the 1950s the foundations of the welfare state were laid in legislation that included every aspect of social life – pensions, family allowances, education, unemployment and sickness benefits, a complex of personal social services, a national health service and provisions for the disabled and the destitute. The 'community' that had looked so threatening and brutalising, especially for vulnerable people, during the earlier stages of the industrial revolution, now seemed more welcoming. Parallel changes, which Alexander Walk called "back to moral treatment", were made in the mental hospitals.

All the techniques of rehabilitation and resettlement now accepted as good psychiatric practice were introduced or reintroduced in hospitals like Glenside, Netherne and Warlingham well before the introduction of reserpine and chlorpromazine. The same is true of admission policies like that at Mapperley, where the emphasis on care outside hospital originated before the war when Duncan Macmillan was medical officer of mental health for Nottingham, as well as superintendent of the mental hospital. However, the success of the new medications, the first really effective physical treatments to be introduced, reinforced the optimism of the time and made it inevitable that the structure of the mental health service must change. Perhaps the most obvious reason for this was that the acute symptoms of psychosis often abated within a few weeks of admission, and, if patients wanted to leave hospital, it was their right to do so. What became known, often disparagingly, as "the early discharge policy" leading to the 'revolving door' system of care, was at many hospitals not a policy at all but an acceptance of the inevitable.

Two theory-driven studies of the clinical and social practice at Netherne, Mapperley and Severalls hospitals, carried out during the 1960s, illustrate the variation in standards at the time. One compared the quality of the care provided in the three hospitals for long-stay women under the age of 60 with a diagnosis of schizophrenia, in order to test the assumption that there would be an association with disability. In 1960, the environment at Netherne

was socially rich in most respects, particularly by comparison with Severalls. One of the central factors seemed to be length of time doing nothing, which was strongly associated with severity of negative symptoms, and was least prominent at Netherne. As the environment of Severalls Hospital improved in this respect during the subsequent eight years so did the level of disability of many of the residents who had been admitted in 1960 (Wing & Brown, 1970).

The other study was a five-year follow-up of patients with schizophrenia admitted to the same three hospitals in 1956 (Brown *et al*, 1966). Here the hypothesis was that shorter hospital stay and greater contact with community services in Nottingham would be associated with a more favourable clinical course and less family burden. Unlike the in-patient study, however, no significant differences could be demonstrated. This was partly due to refusals by patients or families to accept follow-up visits, partly because there were not enough agencies to undertake long-term domestic and industrial rehabilitation, and partly because the most severely disabled people did not necessarily receive the most community contact. Such problems were not solved in any of the three areas. In fact, the average amount of time spent doing nothing by patients who were unemployed was higher than that of long-term in-patients in the first study.

A feature of both studies was that the general trends in the results could, with hindsight, have been predicted from a knowledge of the personalities of the medical superintendents of the three hospitals.

The functions of asylum can be specified in some detail from comparative research into the practice, at that time, of the best hospitals and of the new facilities set up outside to supplement their services. The first function (refuge, shelter, retreat, sanctuary) included protection from: cruelty; exploitation; intolerable stress; competition (e.g. if unable to compete for housing or work on the open market, or unable to use ordinary amenities for recreation); pauperism (insufficiency of food, light, heat, clothing and basic personal possessions); social and intellectual poverty and isolation; and harming self or others, whether by self-neglect or violence. The second function, reparation, included: identification of the causes of social disablement, by skilled diagnosis and psychosocial assessment; treatment, within the limits of contemporary medical knowledge, of the physical and mental disorders responsible for admission; and provision, within the limits of local social attitudes and facilities, of the means of rehabilitation and resettlement. In addition, a place was usually rapidly available at times of emergency, however difficult the problem, and all services were provided free.

The most typical structure within which these functions were being carried out, sometimes very well by the standards of the time but often not well enough, was the mental hospital estate, with its limited apparatus of outreach into the community and links to the medical and welfare departments, now abolished, of local authorities. Early in the history of Sunnyside Royal Hospital, near Montrose, a superintendent who gave thought to the question of how much land was needed, suggested four acres per patient. When I attended its 200th anniversary, Sunnyside looked not much more suitable for people trying to recuperate from severe mental disorders than the factory buildings that form the present 'state of the art' district general hospitals. Nevertheless, when working well, the system did have the substantial advantages listed above, as well as two more that tend to be forgotten. There was a relatively limited and identifiable line of responsibility to a physician superintendent at the top, and there were the appreciable benefits of space, trees and grass.

The disadvantages were mainly those of size, cheapness and overprotection: having wards the size of aircraft hangars; the necessity of conforming to timetabled routines because of low supervisory staff ratios; the restriction of individual choice; and the distance (in some cases) from centres of ordinary social activity. Stigma was also attached to the buildings and perhaps amplified the odium that is always accorded to deviant behaviour, whatever the setting. Scandals were not uncommon, usually in some part of the hospital that had become isolated from the rest and was not under vigilant supervision.

How far these advantages and disadvantages were specific to large institutions was a matter for intense debate then as it is now. Two compilations of papers provide a good account of the arguments (Freeman & Farndale, 1963; Freeman, 1965). Since the functions carried out by mental hospitals had changed so radically, Enoch Powell's point about the need to dismantle the structure seemed apposite. He did not say, however, what structure should be put in its place (Powell, 1989).

Several major problems were foreseen. Many long-stay patients lacked the motivation and the skills to achieve their own resettlement. On the hospital estate, or within reach of it, all the steps and landings on the three stairways of residential, occupational and social rehabilitation (Wing, 1986) *could* be provided. The staff, who were needed to help people mount at their own pace or (just as important) descend without falling precipitously to the bottom, *could* be in easy communication with each other.

This is not to say that they were, only that the structure allowed such functions. If services became geographically fragmented, and responsibility diffused between different statutory, voluntary and commercial organisations, integration into a well planned and interconnected whole could be difficult. Co-ordination between dispersed day and residential units would be particularly problematic. Further problems concerned the extent to which professionals would and could be replaced by informal carers (Abrams, 1978) and how far professionals would wish to continue to serve the most disabled patients if a wider choice of work were on offer (Wooff *et al*, 1986).

In order to judge the success of any structure, it is not sufficient only to improve on the standards of an isolated and poverty-stricken 2000-bed Victorian hospital with a chronic staff shortage, poor facilities and a reputation for scandals and neglect. The standard by which to judge any new structure should be fourfold: (a) whether the functions of asylum are being carried out at least as successfully as in the *best* hospital-based services of the past; (b) whether any disadvantages thought to be inherent in the old structure were being avoided; (c) whether problems specific to the new service were being introduced; (d) whether extra advantages were being derived by people who might once have become long-term residents because of an increased interaction with their families and with the general public. Chief of these latter might be enhanced enabling functions that would provide greater choice to handicapped people than could have been provided in hospital and thus lead to a better quality of life.

Very few such studies on new structures have been published. The most comprehensive attempt to provide a full and integrated structure that would allow the catchment hospital to be closed was the Worcester Development Project (WDP). Substantial central resources were put into the area in order to make the demonstration. In particular, new day services were provided in generous measure along with two new acute psychiatric hospital units. The proceedings of the conference called to mark the final closure of Powick are now published (Hall & Brockington, 1990) – the financial, administrative and clinical statements made there will be examined carefully.

There were critical comments at the conference about health authorities that were proposing to close hospitals even though no alternative structure based on the WDP model had been established. However, very few districts in fact have such a range of services. Even if there were, Worcester and Kidderminster are substantially more socially advantaged than the average across the country, and it would be unwise to generalise from them to average or below-average districts. That not all the problems had been solved even in the WDP area was indicated by a story on the front page of the *Malvern Courier*, published during the conference. It began: "Care agencies in Malvern have expressed fears about the lack of support for people who have been discharged into the community from mental institutions." Scandals featured in the press now occur in the 'community' rather than in the hospitals. Torrey (1988) has described experiences of people discharged from American hospitals to an uncaring and hostile 'community' that are as harrowing as any described two centuries ago. Scandals may not be typical of the general level of care but that was also true of the hospital cases featured in the 1960s. Torrey is complimentary about the safety net provided by our own health and social services, but we have no reason for complacency.

Who needs asylum?

Most of the patients who used to accumulate in the large psychiatric hospitals even though their need for long-term high-dependency care had ceased, have now left. Very few new admissions lead to such long-term care. Many of the functions of asylum can be served by a variety of geographically and administratively separated agencies, as long as all the units are in place and there is co-ordination and co-operation to ensure smooth movement and sharing of functions between them. On the other hand, a fragmentation of functions and lack of a strong overall management policy, particularly when added to a scarcity of resources, must lead to disasters. The Commons' Social Services Committee report (1985) and Griffiths' proposals (1988) were designed to prevent this, but it is not clear how the procedures recommended in the White Paper on community care will promote continuity and provide the tough leadership, on a defined geographical basis, that is required.

Whether the functions of asylum can be completely fulfilled without an 'Asylum' as one component of a district service is as hotly debated now as it was 25 years ago. The word itself has been devalued but there is a measure of agreement that, at the bottom of the three stairways that should form the main framework of a comprehensive district structure for people with high-dependency needs associated with long-term mental disabilities, there should be a strong foundation on which the rest of the edifice rests; a haven of needed refuge but also a harbour from which to set out again. The name 'community', in the sense of a small group of people sharing common

aims and needs, is much more appropriate to a place that continues the tradition of Tuke's Retreat than to the modern localities that are usually given the name (Abrams & McCulloch, 1976).

Two groups of people, with relatively well defined dependency needs, those with severe mental handicap or dementia, will not be considered here. A third, more heterogeneous group is represented by people with a variety of mental disorders who still, in spite of everything that is done (deliberately or by default) to prevent it, accumulate as long-stay hospital patients. There are many like them who do not acquire this status, but are to be found at home with their families, in bedsits or lodgings, in National Health Service (NHS) or local authority or charitable hostels or homes, in Salvation Army shelters, or in prison on remand or sleeping rough on the streets. It seems much more difficult, therefore, to estimate numbers or to assess their current status than it was in the 1960s. A much larger part of the prevalence is invisible. As the large hospitals run down further, and the small ones focus only on acute episodes, this element of uncertainty will seem to grow.

However, because there has been no major breakthrough in treatment or in methods of rehabilitation since Robertson (1981) made some projections based on trends in hospital statistics up to 1981, his figures do still provide a reasonable estimate of the numbers of people on behalf of whom many (in some cases all) of the functions of asylum still need to be exercised. Because of differing levels of social deprivation across health and local authority districts, no single formula can be applied, but the average for England works out at about 50 per 100 000 population. The kinds of psychiatric and social problems experienced by the people concerned are discussed elsewhere (Wing, 1986; Wing & Furlong, 1986).

So vociferous has been the condemnation of Asylums, and so universal the identification of Enoch Powell's out-of-date structure with the functions that it served, that very little attention, and virtually no experiment, has been devoted to the alternative structures that might serve the functions of asylum. It is a classic case of the baby and the bath water.

Such new structures might take two forms, depending on the availability of sites. Where a large hospital estate is conveniently situated in relation to the population it serves, a section could be reserved for a sheltered community, organised on the core and cluster model, with close connections to other parts of the service. The rest of the estate should be used imaginatively, with sectors devoted to housing, shops and leisure and business facilities that would become part of the neighbourhood as well as being available to patients. Most of the former hospital functions could be served from buildings that merged into the new complex without being specially identified. In this way, the 'community' would be brought on to a site where a mental hospital had stood for a century or more and where local people were familiar with its presence. John Burrell has worked out the architectural basis of the idea in substantial detail (Burrell, 1986).

Another possibility is the free-standing core and cluster model, although this might be at greater risk of becoming isolated from the rest of the district services and from the locality as well. One health region (South East Regional Health Authority, SETRHA, 1988) has adopted the name 'haven' but equated it with the more limited hospital-hostel concept (Hyde *et al*, 1987). At the Maudsley this is developing into a core and cluster arrangement with the central house and most day care on the hospital site and other houses off it (Wykes, 1982; Garety *et al*, 1988). Comparative research has not been undertaken into the merits and demerits of more extensive contemporary forms of sheltered community. But whatever structure is found to be most effective, a comprehensive and integrated district service requires co-ordinated planning, management and finance and a clear-cut policy for caring for the most persistently disabled people. It is essential to understand that such havens must be an integral part of such a district service. If the rest of the system is not in place and working, the name is inappropriate and should not be used (Wing, 1990).

Conclusion

Parry-Jones (1988) is generally sympathetic to the aims and practice of asylum with a small 'a', and sensitive to the swing of the pendulum during the 19th century from neglect to reform to neglect again – and then back during this century as far as reform. On the basis of his analysis, he could have added that the pendulum could still be swinging towards further neglect. If so, a way to stop it is to insist that the functions of asylum be fully incorporated into all the new structures, and tested for their efficacy, as we dismantle the old ones. Although these functions have been elaborated and systematised, they remain much the same as in the time of Tuke and Pinel. We have more effective medical treatments at our disposal which make the task of rehabilitation and settlement easier, and there is beginning to be a respectable body of knowledge about how to help and sustain families. Our social security system, whatever its faults, is immeasurably better than in the time of the Poor Law. However, the needs of severely and chronically disabled people still have a

low priority and there is little sign that 'the district' has any therapeutic function in itself.

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