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‘Challenge and Change in a Cinderella Service’: A History of Fulbourn Hospital, Cambridgeshire, 1953 – 1995

Thesis submitted for the degree of Doctor of Philosophy of The Open University, in the Faculty of Health & Social Care

Date of submission: 2009

Abstract

This study of Fulbourn Hospital uses oral history and documentary sources to explore the models of mental illness and the therapeutic practices associated with them in one provincial English psychiatric hospital during the second half of the twentieth century. The appointment in 1953 of a new Medical Superintendent from the Maudsley Hospital, Dr David Clark, set in train a process of change which transformed the hospital through the implementation of a social model of psychiatry. This period was ended by the appointment of the leading biological psychiatrist, Professor Sir Martin Roth, as the University of Cambridge's first Professor of Psychiatry in 1976. The subsequent years saw the appointment of psychiatrists who shared support for a medical model of psychiatry. Attention then turned to the development of care in the community through the establishment of group homes and community mental health teams. The implementation of sectorisation proved to be controversial, as did the increasing role afforded to general managers. It is concluded that many of the elements of the social model introduced by Dr Clark became absorbed into the working practices of the nursing staff, after they had been abandoned by the psychiatrists working in the hospital. This study therefore illustrates the process through which professional boundaries shifted in response to changing models of practice.

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Abbreviations

AWA	Asylum Workers' Association
CPN	Community Psychiatric Nurse
DICT	Deep Insulin Coma Therapy
DPM	Diploma in Psychological Medicine
DSM	Diagnostic & Statistical Manual of Mental Disorders
ECT	Electro-Convulsive Therapy
FRCP	Fellow of the Royal College of Physicians
GNC	General Nursing Council
GP	General Practitioner
GPI	General Paralysis of the Insane
ICD	International Classification of Diseases
LREC	Local Research Ethics Committee
MPA	Medico-Psychological Association
MRCP	Member of the Royal College of Physicians
MRCPsych	Member of the Royal College of Psychiatrists
NAWU	National Asylum Workers' Union
NHS	National Health Service
RMN	Registered Mental Nurse
SRN	State Registered Nurse
WHO	World Health Organisation

Illustrations

Illustrations removed for copyright reasons.

Dedication

To Gwen Adams and Anna Adams.

Acknowledgements

A doctoral study employing oral history as one of its main sources necessarily relies upon the active assistance of many people, but responsibility for any errors, and for the interpretations drawn from source material, remains mine alone.

The initial debt is owed to my colleague Nick Smithson, who first encouraged me to embark on this journey of discovery, putting his own historical resources at my disposal and introducing me to Dr David Clark. This study could not have been undertaken without the assistance of the twenty-six other individuals who agreed to be interviewed. They were unfailingly helpful and hospitable, despite the demands that I was making upon their personal schedules. Librarians and archivists have provided much valuable help and advice. At the Open University, Professor Pam Shakespeare facilitated the transformation of a personal enthusiasm into a project proposal. Dr Sheena Rolph and Professor Dorothy Atkinson supervised the study in a wholly supportive manner, and I am very grateful to them for their judicious balance of critical appraisal and positive encouragement, sustained over the last six years. Professor Joanna Bornat and Dr Tessa Muncey generously agreed to act as critical readers for final drafts of the study. Finally, this thesis is dedicated to my mother and to my wife, who have lived with my enthusiasm for the history of some of the less fashionable corners of the health and social services for over two decades.

Chapter 1: Introduction

This thesis reports a research study which examines the development of treatment regimes in one English provincial psychiatric hospital in the second half of the twentieth century. The initial plans for the study envisaged covering the history of the hospital from its opening in 1858, but the wealth of detailed oral and written sources for the post-Second World War era led to a focus on the period after 1953. This was a time of significant change in both psychiatry and mental health policy.

Now that the era of the large psychiatric hospitals, with their imposing buildings and their many hundreds of patients, has come to an end after an existence of more than a century, it is an opportune time to study their final years. Such large and complex hospitals present many potential themes for the researcher to explore. Several historians have produced detailed administrative studies of similar provincial hospitals, detailing the processes involved as individuals and committees struggled to meet the manifold demands imposed by legislation, budgetary constraints, and professional agendas.[1] Other studies have focussed on the experiences of patients and service-users.[2] While both these factors are inescapable elements in any account of a psychiatric hospital, they do not form the main focus for this study. Instead, it aims to explore the following questions focusing upon the many developments discernable in the recent past:-

[1] For example, R. Hunter & I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973: A Medical and Social History* (London, 1974), J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum – St John's* (London, 1990); P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff, 2003).; S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St Andrew's Hospital, 1810-1998* (Woodbridge, 2003).
[2] For example, D. Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London, 1998); K. Davies, ''Silent and Censured Travellers?': Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine,* 14 (2001), pp. 267-292.

(1) What were the competing discourses in British mental health care in the second half of the twentieth century?

(2) What light can the study of one English hospital shed upon the history of institutional mental health care?

(3) How did the competing medical discourses impact upon nursing practice?

The seeds of my interest in the recent history of Fulbourn Hospital were sown in 1996 by the BBC television documentary, *Unlocking the Asylum*, which was broadcast in a series about the unsung medical pioneers who had worked in parts of the National Health Service which did not usually attract positive media attention.[3] The theme of the programme was the determination of Dr David Clark, its last Medical Superintendent, to ensure that the 'social model' in psychiatry was not forgotten in a heedless scramble to equate mental health problems solely with altered brain physiology, and it created a lasting memory for me. Several articulate psychiatrists and mental health nurses were shown endorsing Clark's arguments, while the defenders of a 'biological model' in psychiatry, led by Professor Sir Martin Roth, appeared rather negative and narrow-minded.

This documentary led me to make further explorations in the hospital history, beginning with Clark's memoir, *The Story of a Mental Hospital: Fulbourn 1858-1983*.[4] In his foreword to the book, the late Roy Porter rightly describes it as 'a rare document, fascinating to read and invaluable as historical evidence'.[5] Clark provides an engagingly modest and wryly humorous account of his struggles to reform the hospital during his tenure as its last Medical Superintendent. However, its overarching theme,

[3] BBC TV Documentary, *Unlocking the Asylum*, first broadcast in 1996.
[4] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996).
[5] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996)., p.x.

like that of the television documentary, could be summarised as *Après mois, le deluge*. The progressive abandonment of the social model in psychiatry in favour of a more biological one, after the election of Professor Roth to the University of Cambridge Chair in Psychiatry, is represented as a retrograde step which will ultimately come to be seen as leading psychiatry up a cul-de-sac. Such evidence of fundamental conflicts over the basis for clinical practice in a vital clinical specialism provided an intriguing subject for further research.

Recreating and analysing the therapeutic regimes and practices to be found in institutions that were by their nature hidden from public view presents considerable challenges. Unlike other medical specialisms which may involve clearly-defined physical interventions, psychiatry is largely an interpersonal process which makes it difficult for the outside observer to appreciate what was involved. Psychiatrists themselves may not be explicit about the model of mental health care that they employ, or the implications for treatment implicit in a particular paradigm. So Fulbourn Hospital as a site for study offers particular attractions for the historian because it was the scene of an unusually visible and sharply defined conflict between psychiatrists who held opposing views on the causation and treatment of mental illness. These conflicts necessarily involved all the other staff, such as nurses, social workers and psychologists, who worked in the hospital, and they also had a major impact upon the treatment regimes experienced by the patients.

A second factor helpful to the historian which makes Fulbourn Hospital unusual amongst former county asylums is the richness of the contemporary material published by many members of staff, and even some patients, in this period. The drive to maximise research and its dissemination was a deliberate policy of the hospital

authorities in this period, in order to make developments at Fulbourn more widely known. The title of this thesis, 'Challenge and Change in a Cinderella Service' is derived from a publication by Fulbourn staff.[6] While these descriptive and analytical studies provide much detail about the hospital and the changes which it underwent, traditional archival resources for the period after 1948 remain sparse. Therefore an oral history study undertaken while most of the main protagonists in the hospital's development were able to take part offered the prospect of accessing first-hand accounts of underlying beliefs and therapeutic practices which would not be available in any other form. The starting date for the study was the appointment of Dr David Clark, as Medical Superintendent at Fulbourn, and the end date provided the distance of a decade from the events being explored

After chapters reviewing the historical literature in this field (Chapter 2), and outlining the methodology used in the study (Chapter 3), there are six chapters outlining the results. These may be summarised as follows:-

Chapter 4: 'The New Superintendent', begins by critically analysing the state of the hospital before the appointment of its reforming Medical Superintendent, Dr David Clark, in 1953. Clark's experiences as an Army doctor during the Second World War partially explain why he felt drawn to the daunting challenge of taking up the post. His early reforms, such as the 'open door' and the 'work for all' policies, are discussed in the context of trends in Anglo-American psychiatry from the 1940s onwards.

Chapter 5: 'Winds of Change', highlights the role played by physical therapies at the hospital from the 1950s onwards. While deep insulin coma therapy and leucotomy proved to be short-lived innovations, electro-convulsive therapy and psychopharmacology continued to have a major impact upon treatment regimes. The

[6] C. Harries, D.H. Clark & D. Towell, 'Challenge and Change in the Cinderella Services' in D. Towell & C. Harries (eds.), *Innovation in Patient Care* (London, 1979), pp.22-38.

theory developed by the historian Edward Shorter is employed to explain the apparent conflicts between physical and psychological paradigms that their use appeared to represent.

Chapter 6: ‘Hereward House and Westerlands: The Creation of a ‘Therapeutic Community Proper”, demonstrates that soon after his appointment, David Clark, under the influence of pioneers such as Maxwell Jones, set in train plans to establish therapeutic community units at the hospital. A sabbatical year in California, meeting some of the leading humanistic psychologists, only strengthened his commitment to the ‘social model’ in psychiatry. The experience gained in running Hereward House is analysed using social scientist Robert Rapoport’s framework.

Chapter 7: ‘Social Therapy in Practice’, documents the extension of the philosophy of the therapeutic community to all the admission wards of the hospital. Each consultant psychiatrist had their own particular approach to issues of therapeutic practice. Using the evidence from sociologist David Towell’s researches, together with oral history sources, the implications of the therapeutic community philosophy for nursing practices are analysed.

Chapter 8: ‘Nursing Reforms at Fulbourn’, highlights the need to improve the so-called ‘back wards’, which cared for rehabilitation, long-stay, and older patients. The hospital was not embroiled in the scandals that afflicted several similar hospitals in the 1960s, but it was widely recognised that standards needed to be improved in these neglected areas. As the role of the nurse was crucial in these areas, the reform of nurse education had a vital role to play.

Chapter 9: ‘The Critics of the Fulbourn Regime’, analyses the views of those who opposed some or all elements of David Clark’s philosophy of ‘social therapy’ delivered through the medium of the therapeutic community. While Clark himself has tended to portray this criticism as coming principally from the biological psychiatrist Professor

Sir Martin Roth, other evidence suggests a more nuanced reaction from critics who were opposed only to certain aspects of the regime. The impact of the 'anti-psychiatry' movement helped to sharpen this conflict in the short term, but a developing consensus in the wider psychiatric profession in favour of a more 'medical model' had an inevitable longer-term influence on the direction taken by the hospital. It is argued that Shorter's identification of a period he calls 'the Second Biological Psychiatry' can be fruitfully applied to developments at the hospital.

Chapter 10: 'Reaching Out from the Institution' charts the increasing links between the hospital and mental health services provided in the wider community of Cambridgeshire. Ultimately, the community care agenda led to the establishment of new resources there, with the parallel reduction of service provision on the main hospital site. Disputes over models of mental health care were replaced by shared support for a more 'medical model', and conflict shifted to other areas, such as general management and sectorisation.

Chapter 11: 'Conclusion' summarises the arguments put forward in the previous chapters.

A Note on Terminology

As a psychiatric diagnosis continues to carry considerable stigma for anyone thus labelled, there is an understandable sensitivity about the use of language in this area. While some historians of psychiatry have chosen to reject any such constraints on their choice of terminology, it is recognised here that these concerns are legitimate. At the same time, historical writing needs to reflect the language used in the period of the past under discussion. This study therefore does not use terms such as 'mad', 'madness', 'crazy', or 'insane', but does employ some of the language used almost universally by

the staff and service-users who agreed to be interviewed. Such terms when used in the text are enclosed in single quotation marks.

Another issue of terminology concerns the name of the institution. When it was opened in 1858, it was called, 'The Cambridgeshire and Isle of Ely Pauper Lunatic Asylum', but it soon became known by the name of the nearby village of Fulbourn. After 1930, it was known as 'Fulbourn Hospital', but local custom has been followed in this thesis by also using the single word 'Fulbourn' to refer to the hospital.

The referencing style in this thesis conforms to the *Conventions for the presentation of essays, dissertations and theses,* published by the Board of the Faculty of History, University of Oxford, 2007.

Chapter 2: The History of Mental Health Care: A Review of the Literature

Introduction

This chapter aims to provide a critical analysis of key themes in the literature on the history of mental health care. The provision of that treatment thought appropriate at the time, and the on-going care for people with enduring mental health problems, requires complex responses from society. It raises issues of nosology, legal control, service organisation, and institutional maintenance, and requires the services of psychiatrists, psychologists, nurses, therapists, lawyers, and others. Given the complexity of this background, historians have generally chosen to focus upon one aspect in order to provide a sense of clarity to their narratives. Therefore this chapter provides a critical appraisal of the literature related to the four key debates relevant to this study:

(1) The competing discourses in the history of mental health care

(2) The history of mental symptoms and their treatment

(3) The history of institutional mental health care in Britain

(4) The history of mental health nursing

The Competing Discourses in the History of Mental Health Care

The nature of mental health problems, and the usefulness of the wide array of treatments which have been proposed in order to treat it, have been controversial in the past and remain so in the present day. In fact, the only approach to the history of the subject which seems to be agreed upon by all as inappropriate is a ‘Whig’ interpretation which

sees the past as the inevitable precursor of the successful and triumphant present.[1] This is partly because the present state of care for people with a mental health problem looks very far from triumphant.[2] Psychiatry can point to few dramatic breakthroughs of the kind that have so revolutionised other fields of medicine, such as surgery or cardiology. The confident assertion that the closure of the asylums and the introduction of 'community care' heralded a decisive break with the problems of the past is regarded far more sceptically today. So while there is little scope for depicting this branch of history as a graph of progress moving inexorably upwards, there is one aspect of the Whig interpretation of history which many historians seem to find impossible to discard. That is the tendency to study 'the past with reference to the present'.[3] Few historians of the mental health services in Britain or abroad seem to be able to avoid this temptation. This is partly because many of its practitioners have a professional background in psychiatry, nursing or social work, but this does not explain the same tendency in those historians who have never worked with people experiencing mental health problems. So when reviewing publications in the field, it is often necessary to consider both the historical study and the views on contemporary practice which underpin it.

The Swiss historian Erwin Ackerknecht's *Short History of Psychiatry* first appeared in 1959, and a second edition in 1968. Acknerknecht was medically qualified, but worked as an academic in several fields of the history of medicine. His book emphasises the role of 'great men' in psychiatry, with a focus on the contributions of Pinel, Esquirol,

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[1] E. Ackerknecht, *A Short History of Psychiatry* (New York, 1968), p.viii; A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, 1993), p.xvii.. For a more detailed outline of the 'Whig interpretation', see Chapter 3.
[2] A. Scull, 'A Quarter of a Century of the History of Psychiatry', *Journal of the History of the Behavioral Sciences*, 35 (1999), p.243.
[3] H. Butterfield, *The Whig Interpretation of History* (1951), p11.

Kraepelin and Freud.[4] Yet Ackerknecht himself emphasised that he did not advocate this approach to the study and writing of history, and saw it as a necessary reflection of the scarcity of specialist research in the field. The introduction to the second edition of his book also gave him the opportunity to defend himself against those critics who had claimed that only psychiatrists could write the history of psychiatry. In a comment that continues to have relevance, he wrote:

> So far the efforts of psychiatrists-turned-historians have not been altogether successful, and since when must one be a politician or a soldier to write political or military history, a creative artist to write the history of art or literature?[5]

If the psychiatric profession was affronted by the efforts of a medically qualified historian to write what in retrospect appears to be a rather traditional history of their field, that was as nothing compared to the shock in store for them.

In 1962, Michel Foucault published his influential book, *Folie et Déraison: histoire de la folie á l'âge classique*, arguing that eighteenth and nineteenth century approaches to mental illness were motivated by a desire to confine socially deviant people rather than to promote therapeutic advance.[6] This work may be said to have inspired a new interest in the early history of psychiatry on both sides of the Atlantic, and in particular in the claims of psychiatric reformers to be implementing benign and humane systems of care. The historical study of British psychiatry in the nineteenth and early twentieth century is currently dominated by the work of the American sociologist-turned-historian, Andrew Scull. A quotation from Foucault appears on the opening page of Scull's influential first

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[4] E. Ackerknecht, *A Short History of Psychiatry* (New York, 1968)
[5] Ibid, p.vii.
[6] G. Gutting, 'Foucault and the history of medicine', in G. Gutting (ed.) *The Cambridge Companion to Foucault* (Cambridge, 1994). pp.47-70.

book, *Museums of Madness*, and it is clear that Foucault's ideas provided a major inspiration for the book. Scull maintained that:

> It is time to transfer our attention away from the rhetoric of intentions [of the 'reformers'] and to consider instead the actual facts about the establishment and operation of the new apparatus for the social control of the mad.[7]

The leading British historian of psychiatry was the charismatic and highly productive scholar Roy Porter.[8] He focused his researches on the eighteenth and early nineteenth centuries, and like Scull, he was highly critical of the progressive and reformist rhetoric adopted by psychiatrists of that period.[9] In a later essay surveying the development of British psychiatry in the twentieth century, significantly titled 'Two cheers for psychiatry!', Porter concluded a not unsympathetic review by asserting that widespread public awareness of developments in psychiatry and psychology had been accompanied by a growing crisis of public confidence in the effectiveness of the therapeutic interventions these professions have developed.[10]

This spirit of peaceful co-existence between historians and psychiatrists has not been fostered by the historical work of a retired psychiatrist from the Institute of Psychiatry in London, John Crammer.[11] His institutional history of St John's Hospital, Stone, Buckinghamshire, began with a raking broadside directed against 'a posse of non-medical sociologists and social historians'. These miscreants, who were identified as

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[7] A. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London, 1979), p.15.
[8] J. Forrester, 'Obituary: Professor Roy Porter' *The Independent* 5 March (2002).
[9] R. Porter, *Mind-Forg'd Manacles: A History of Madness in England From the Restoration to the Regency* (London, 1990).
[10] R. Porter, 'Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain', in H. Freeman and G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), pp.383-406.
[11] J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum – St John's* (London, 1990).

including Andrew Scull and Roy Porter, were charged with promoting the doctrine that, 'in a new, fairer society, madness would simply disappear as a kind of human behaviour requiring attention', and they are said to be guilty of promulgating 'anti-psychiatric views'.[12] In place of such positions, Crammer advocated a reading of history based on an understanding of, 'who gives the orders, and what orders they give to the staff, and how the staff interact among themselves in obeying, [which determines] the outcomes [of treatment]'.[13]

Scull's criticisms of the psychiatric profession also attracted an attack from the Canadian psychiatrist and historian Harold Merskey.[14] The crux of Merskey's argument was that Scull's negative depiction of a range of physical treatments, including malarial therapy, electro-convulsive therapy, and psychotropic medication, was based on a flawed combination of hindsight and exaggeration. According to Merskey, psychiatrists used these treatments as indicated by the research-based evidence that was available to them at the time. As might be expected, Scull responded to Crammer and Merskey with vigour, describing them as 'angry men' whose 'fury has led to some remarkable misreadings of what I actually said' and also to 'display their own ignorance and historical naiveté'.[15] The journal's editor then gave Merskey the opportunity for a brief reply, and finally declared the debate closed.[16]

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[12] J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum – St John's* (London, 1990), p.x.
[13] Ibid, p.x.
[14] H. Merskey, 'Somatic Treatments, Ignorance, and the Historiography of Psychiatry', *History of Psychiatry*, 5 (1994), pp.387-394.
[15] A. Scull, 'Psychiatrists and historical 'facts': Part One: The Historiography of Somatic Treatments', *History of Psychiatry*, 6 (1995), pp.225-240.
[16] H. Merskey, 'H. Merskey replies to Scull' *History of Psychiatry*, 6 (1995), pp.240-241.

Despite the claims and counter-claims generated by this debate, it seems clear that the point at issue is not a failure of historical scholarship, but a clash of views about how the history of psychiatry should be characterised. Crammer, Merskey, and other psychiatrists, had an essentially positive view of the history of their profession, despite acknowledging its many missteps, while Scull regarded any attempt to construct a triumphalist account of modern psychiatry with complete hostility.

While psychiatrists have bridled at Scull's provocative jibes about their discipline, such as the remark that, 'psychiatry needed only to develop a plausible esoteric theory, and a course of training to transmit it, in order to persuade the public of its expertise and thus to secure its independence from outside scrutiny and interference', such comments do not present a complete picture of his views.[17] Scull himself has complained that a recent book on early nineteenth century asylums simplifies and caricatures the position of 'revisionist historians' like himself.[18] It is certainly true that Scull was not responsible for setting an idealised picture of 'community care' against a grim account of asylums. As he argued, 'one can – indeed I think must – be deeply sceptical about claims made on the mental hospital's behalf: yet one must not fall prey to equally groundless fantasies and illusions about the available alternatives'.[19] Similarly, although he mentions the work of the leading figure in the 'anti-psychiatry' movement, Thomas Szasz, it is only to argue that Szasz's conclusions, 'grossly ... oversimplify and distort what happened'.[20]

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[17] A. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London, 1979), p.258.
[18] A. Scull, 'Book review: 'Cure, Comfort and Safe Custody': Public Lunatic Asylums in Early Nineteenth Century England', *Bulletin of the History of Medicine*, 76 (2002), pp.607-608.
[19] A. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London, 1979), p.262.
[20] Ibid, p.256.

In his most recent book, Scull returned to the attack against the profession of psychiatry with a study of the horrifying career of Henry Cotton, the promoter of the concept of 'focal sepsis' as the cause of mental illness.[21] Cotton was the Medical Superintendent of Trenton Hospital, New Jersey, in the first quarter of the twentieth century, and became convinced that radical surgery to remove supposed sources of infection in the gut and other internal organs would cure mental illness. As a result, Cotton and his followers, like the British psychiatrist Thomas Chivers Graves, were responsible for killing and maiming thousands of patients.[22]

One of the first British scholars to review the history of the provision of mental health care in Britain was Kathleen Jones, the Professor of Social Administration at the University of York. She was working in a tradition of British historiography which reaches back to the work of Sidney and Beatrice Webb. They believed that any aspect of contemporary welfare provision could be illuminated by a rigorous examination of the Acts of Parliament and official reports which had shaped it in the past.[23] Accordingly, Jones' book is structured around statutes ranging from the Vagrancy Act, 1597, to the Mental Health Act, 1959.[24] This approach provides a valuable corrective to simplistic accounts which assume that psychiatrists and administrators had complete freedom to treat or care for people with mental health problems in any way that they chose, but Jones goes further in identifying lawyers as the most powerful influence on the way services developed before 1890.[25] In doing so, she has highlighted the importance of a

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[21] A. Scull, *Madhouse: A Tragic Tale of Megalomania and Modern Medicine* (New Haven, 2007).
[22] Ibid, pp.292-293. Graves was Medical Superintendent of Rubery Hill Hospital, Birmingham, but his influence on his profession was far greater than this position suggests. He retired from the hospital in 1940, and in that year was elected President of the Royal Medico-Psychological Association (which in 1971 became the Royal College of Psychiatrists).
[23] S. Webb & B. Webb, *English Poor Law History: Part II: The Last Hundred Years,* volume 1 (Reprint: London, 1963) pp.v-ix.
[24] K. Jones, *A History of the Mental Health Services* (London, 1972).
[25] Ibid, p.153.

professional group largely ignored by other historians both before and after her book appeared. In fact, the only exception to this criticism seems to be the more recent work of Peter Bartlett, which explicitly considers the legal influences on service provision.[26]

However, Jones' approach, based as it was on the succeeding administrative responses to the challenges posed by mental health problems seemed to more recent historians to exemplify a complacent acceptance of the 'status quo' promoted by professionals working in the field. The radical critiques of contemporary service provision formulated by the 'anti-psychiatry movement' had no place for the complexities of administrative change, so Jones' painstaking work seemed outdated even as it appeared. When Jones came to write her most recent history of mental health care in Britain, she was well aware that her approach and views had become a standard target for 'revisionist' historians like Scull.[27] Far from surrendering her position for the more fashionable line advanced by the 'revisionists', Jones extended her critique of legislators and lawyers to identify a 'new legalism' enshrined in the Mental Health Act, 1983.[28] Jones also raised an issue which receives little attention from other historians: that of terminology. A psychiatric diagnosis remains highly stigmatising, even within the NHS itself, so it is understandable that sensitivities about the use of language remain acute. Jones reports a conversation with a revisionist historian who expressed no concern that the use of terms like 'madness' may cause distress to contemporary patients or their relatives. Jones disagreed vehemently, and settled on the term 'mental illness', but while being

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[26] P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London, 1999).
[27] K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), pp.2-4. Scull called Jones, 'a marginal figure', in A. Scull, 'A Quarter of a Century of the History of Psychiatry', *Journal of the History of the Behavioral Sciences*, 35 (1999), p.240.
[28] K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993, chapter 12.

relatively neutral in the current context, it does carry the disadvantage of implying uncritical agreement with those psychiatrists who support a 'biological or medical model' of mental illness.

However, it is now no longer true that an interest in promoting a biological model of mental illness is just confined to members of the psychiatric profession, such as Crammer and Merskey. In his *History of Psychiatry*, the American historian Edward Shorter, who teaches at the University of Toronto, has produced a polemical work which celebrates what he called, 'the renewed triumph of views stressing the primacy of the brain', and its publication marked a new departure for scholarship in the field.[29] He charted the rise and fall of psychoanalysis, and the later 'antics' of feminists and Vietnam veterans in attempting to derail biological psychiatrists' enlightened attempts to 'let science point the way'.[30] Shorter described himself as a 'neoapologist' who is 'not unabashedly apologetic but rather semiapologetic'.[31] The account that he has created of the development of psychiatry is divided into a number of key phases.

Following the development of asylums throughout the western world in the early- to mid-nineteenth century, Shorter identified a period he calls 'the first biological psychiatry' in which German researchers led the world in the systematic study of mental illness. The pioneer in this approach was Wilhelm Griesinger, who held the Chair of Psychiatry and Neurology at the University of Berlin from 1865 to 1868. As well as conducting his own neurological research, Griesinger organised his department so that medical students received regular teaching, and doctoral and post-doctoral students

[29] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p.viii; E. Harari, 'On the History of Psychiatry: A Special Review', *Australian & New Zealand Journal of Psychiatry*, 33 (1999), pp.448-455.
[30] Ibid, p.305.
[31] Ibid, pp.viii, ix.

were supervised in their researches, which could then be published in the scientific journal he founded, the *Archive for Psychiatry and Nervous Diseases*. Shorter dated the end of this period to 1904, with the death of Carl Wernicke. At the beginning of his career, Wernicke had the good fortune to examine a patient whose stroke prevented him from understanding speech and which resulted in the production of incomprehensible sounds. This localised area of the brain became known as 'Wernicke's area', and he also gave his name to the aphasia which damage to it caused. Following this breakthrough, Wernicke spent the rest of his career attempting to relate mental symptoms of all kinds to specific areas of the brain. However, further discoveries of this kind remained elusive, so the next generation of German psychiatrists turned to other approaches. The dominant figure was Emil Kraepelin, who began to study the outcomes of the various forms of mental illness that he encountered in clinical practice. Two of the major categories that he described, manic-depressive psychosis and dementia praecox, were to remain highly influential in psychiatry up to the present day, although the latter was renamed 'schizophrenia' by Kraepelin's pupil Eugen Bleuler.[32]

According to Shorter, these promising developments in biological psychiatry were eventually disregarded in the profession's enthusiasm to embrace the psychoanalytic theories of Sigmund Freud. Shorter claimed that the attempts to localise mental symptoms in particular areas of the brain led to the temporary triumph of neurology over psychiatry, so psychiatrists, particularly in the United States, cast around for new intellectual territory to control, and Freud's theories provided the ideal basis for their practice. As a result, American psychiatry entered what he calls 'the Freudian hiatus', in which the profession largely ignored the vast state mental hospitals that were full of

[32] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), Ch. 3.

patients with florid mental symptoms, in favour of lucrative private psychoanalytic practice with neurotic patients from the wealthier strata of society.

For those psychiatrists still concerned with treating patients in the asylums, Shorter described a period from the First World War to the 1950s, in which a range of dramatic physical treatments were tried in an attempt to ameliorate the conditions affecting such patients. He used the term, 'Alternatives' to encompass treatments including deep insulin coma therapy (DICT), electroconvulsive therapy (ECT), and lobotomy. Finally, from the 1970s onwards, Shorter claimed that, 'biological psychiatry came roaring back on stage, displacing psychoanalysis as the dominant paradigm and returning psychiatry to the fold of the other medical specialties'.[33] The catalyst for this period which he labelled, 'the Second Biological Psychiatry', was the discovery of effective drugs to treat mental symptoms. While American psychiatrists still retained a degree of enthusiasm for psychoanalytical therapies, their power to prescribe from an expanding pharmacopoeia added potent new weapons to their armoury. So Prozac came to displace Freud from his central place in psychiatry. Shorter therefore had very little to say about the role of the so-called 'social model' in the post-War period in American psychiatry. The aim of the 'social model' is to said to be to, 'help the individual to take up an acceptable role again, not to correct a biochemical disturbance'.[34] This aim is promoted through a focus on the impact of the social environment on mental health.[35] The 'social

[33] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p.239.
[34] P. Tyrer & D. Steinberg, *Models of Mental Disorder: Conceptual Models in Psychiatry* 4th edn. (London, 2005), p.110.
[35] T. Thompson & P. Mathias, *Lyttle's Mental Health and Disorder* 3rd edn. (London, 2000), pp.11-12.

model' was evidently much more prominent in many British hospitals, and particularly at Fulbourn.[36]

In adopting such a deliberately provocative stance, Shorter has succeeded in reigniting the debate amongst historians about the nature of mental health problems, and the response of psychiatrists to them. The American historian Gerald Grob characterised the book as, 'a significant (if flawed) work'.[37] Edwin Harari, an Australian psychiatrist with an evident sympathy for psychoanalysis, has argued that, 'Shorter's good guys are today's biological psychiatrists, and the bad guys are psychoanalysts, while the social psychiatrists are well-meaning but ineffectual', and that this represents no more than a caricature of a complex process of evolution involving all strands of psychiatric thinking.[38] As might be expected, Scull had no sympathy for Shorter's enthusiastic promotion of a biological model of psychiatry. In an essay significantly titled, 'Blinded by biology', Scull delivered a blistering critique of the book, ending with the observation that,

> The very shrillness and one-sidedness of Shorter's account may guarantee it a welcome of sorts among the more uncritical exponents of modern biological psychiatry. But those whose taste in historical writing is for something other than crude ideological tracts would do well to look elsewhere for intellectual sustenance.[39]

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[36] R.D. Hinshelwood, *What Happens in Groups: Psychoanalysis, the Individual and the Community* (London, 1987), pp.168-169; D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996); D.H. Clark, *Social Therapy in Psychiatry* (Harmondsworth, 1974).
[37] G. Grob, 'Book review: A History of Psychiatry', *Bulletin of the History of Medicine*, 72 (1998), pp.153-155.
[38] E. Harari, 'On the History of Psychiatry: A Special Review', *Australian & New Zealand Journal of Psychiatry*, 33 (1999), pp.448-455.
[39] A. Scull, *The Insanity of Place/The Place of Insanity: Essays on the History of Psychiatry* (London, 2006), p.91.

The impact Shorter's book made on historians working in the field of psychiatry has been equalled by that of Jack Pressman's account of psychosurgery to cure mental illness.[40] In an era in which contemporary health care professionals place so much stress on the importance of undertaking research in order to establish 'evidence-based practice', Pressman's case study provides a useful corrective to some of the more simplistic arguments for supporting such an approach. Far from being an example of psychiatrists' tendency to resort to barbaric interventions for want of any real knowledge of mental health issues, Pressman shows that psychosurgery was the 'evidence-based practice' of its time. The lessons he draws from the controversial history of psychosurgery are that:

> the success of a research venture in medicine is never a safe bet; the evaluation of therapeutic success is not an absolute measure, but is relative to time and place; and the standard of what constitutes valid medical science is itself never fixed, but evolving.[41]

In Pressman's account, the development of psychosurgery helped to bring American psychiatry back into the mainstream of American medicine, and laid the foundations for the future development of the experimental method.

A similar argument was developed by another American psychiatrist-turned-historian, Joel Braslow, who was greatly influenced by Pressman's earlier doctoral thesis. Braslow regarded physical means of treatment, such as malarial therapy, electroconvulsive therapy, and lobotomy, as laying the scientific foundations for the later development of psychotropic medication, through a focus on physical remedies for

[40] J. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge, 1998).
[41] Ibid, p.16.

mental illnesses.[42] Scull, however, as might be expected, has no time for such defenders of the concept of eventual progress in psychiatry despite frequent setbacks. While acknowledging Pressman's qualities as an historian, Scull argues that lobotomy should never have been undertaken, as even in the 1940s it was criticised by, 'a number of informed and perspicacious critics'.[43] However, this phrase only serves to confirm Scull's persistent unwillingness to engage with the complexities of clinical evidence. Pressman has shown that psychiatrists have to practise in a context of conflicting research findings, and it is usually only in retrospect that it is possible to distinguish the 'informed and perspicacious' from the rest.

While vigorous debates continue about the role of the psychiatric profession in society over the last three centuries, similar controversy surrounds the nature of the disorders which they sought to treat, and the appropriateness of that treatment.

The History of Mental Symptoms and Their Treatment

The Cambridge psychiatrist German Berrios has pioneered the study of historical nosology, through focusing on the classification of psychiatric conditions over time. While denying that the rapidly developing science of genetics has the ability to anchor definitively mental disorders in biology, he does suggest that it is worth pursuing a quest for 'invariants', that is the unchanging elements of such disorders.[44] In an earlier version of this line of argument in favour of historical epidemiology in the field of psychiatry, Berrios developed an image drawn from electronic engineering: that of

[42] J. Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley, 1997).
[43] A. Scull, *Madhouse: A Tragic Tale of Megalomania and Modern Medicine* (New Haven, 2007), p.285.
[44] G. Berrios, 'Classifications in Psychiatry: A Conceptual History', *Australian and New Zealand Journal of Psychiatry*, 33 (1999), pp.145-160.

distinguishing the biological 'signal' in past descriptions of mental illness from the background 'noise' of its socially-determined expression. In a more recent paper, James Moran has tested this approach through an examination of civil court records dealing with mental illness in New Jersey between 1790 and 1867.[45] He concluded that, 'the 'signal' of mental illness that may be identifiable in the descriptive symptomatology is 'inevitably context bound', so he argues that 'noise' should not be regarded as 'background interference, but rather as a determinant of the historical epidemiology of mental illness to be appreciated alongside and in relation to the 'signal''.[46]

Berrios has also collaborated with Roy Porter in the production of an innovative book which aimed to combine the expertise of clinicians and historians.[47] It makes the bold claim that clinicians' '*knowledge by acquaintance* is essential to the writing of good clinical history'[48] However, most of the clinicians who have made contributions to the volume confine their material to the early diagnostic literature, and it is difficult to see what their personal experience of clinical practice has added. Nevertheless, this substantial volume continues to provide a useful guide to the complexities of the history of terminology, and its underlying clinical implications, in psychiatry, as illustrated by such terms as hebephrenia, katatonia, and dementia praecox, for the condition which is now called schizophrenia.[49] The language used by psychiatrists and their patients to describe mental processes has clearly changed over time and is strongly influenced by local factors. The issue of religious and cultural factors in the conceptualisation of

[45] J.E. Moran, 'The Signal and the Noise: The Historical Epidemiology of Insanity in Ante-Bellum New Jersey' *History of Psychiatry*, 14 (2003), pp.281-301.
[46] Ibid, p.298.
[47] G. Berrios & R. Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995).
[48] Ibid, p.vi, authors' emphasis.
[49] J. Hoenig, 'Schizophrenia', in G. Berrios & R. Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995), pp.336-348.

mental distress and its symptoms amongst Jewish immigrants in East London has been studied by Carole Anne Reeves.[50] She has traced the effects of psychosocial stress caused by the pogroms in Eastern Europe and Tsarist Russia, and flight to a foreign country, on the presentation of mental distress as recorded in contemporary medical records. A further dimension of her study was provided by a comparative analysis of mental diagnoses, and the language used about them, in men and in women. Over time, the Jewish community gradually developed a range of charitable initiatives in order to ameliorate the hardship of such patients. So the existence of national policy directives should not obscure examples of other localised responses to mental distress.

In another recent study, Rosaline Delargy has analysed an innovative scheme developed in late-Victorian Ireland, which was inspired by the ancient settlement of Gheel in Belgium, where people experiencing mental distress had been boarded in private houses since the Middle Ages.[51] The Belfast Asylum authorities began transferring patients to Purdysburn, a country estate outside the city, in 1896. Throughout the Edwardian period several substantial buildings, each holding fifty patients, were built in the grounds. It was intended that these would demonstrate 'high architectural character without undue extravagance', and that patients would derive therapeutic benefit from these 'comfortable and homely' surroundings.[52] The 'villa colony system' was to exert a long-lasting influence on the design of both psychiatric hospitals, and later provision for people with learning disabilities, but it did not achieve its fundamental goal of 'normalising' the experience of mental distress. Far from being integrated into the wider

[50] C.A. Reeves, 'Insanity and Nervous Diseases amongst Jewish Immigrants to the East End of London, 1880-1920' (London Univ. Ph.D. thesis, 2001).
[51] R. Delargy, 'The History of the Belfast District Lunatic Asylum, 1829 – 1921' (Ulster Univ. Ph.D. thesis, 2002).
[52] Ibid, pp.220-221.

society, the 'villa colony' system simply perpetuated institutional isolation behind the high walls of the asylum.[53]

William Jones, an emeritus consultant psychiatrist at Mapperley Hospital, Nottingham, based his history of physical treatments in psychiatry around the metaphor of 'continuous refinement'.[54] This enabled him to regard discredited early physical treatments, not as evidence of the poverty of psychiatrists' claims to understand mental illness, but as the necessary precursors of a 'narrowed down' therapy based almost entirely on pharmaceutical products. However, it was not made clear how an enthusiasm for cold water douches led to the development of more sophisticated interventions, such as psychotropic medication. In fact, most historians of drug treatments for mental illness reject such a model of progress in the story of their development. Sheldon Gelman, an American professor of law, in his study of drug treatments for schizophrenia, rejected both the 'progress' and 'cyclical' models of psychiatry, and chose to emphasise instead the elements of chance and unpredictability that he regarded as characterising their development and use.[55]

The leading figure in the study of psychopharmacology in Britain is the psychiatrist, David Healy. He was secretary of the British Association for Psychopharmacology in the 1980s, but he is not the uncritical enthusiast for biological psychiatry and drug interventions that this position might suggest. In his historical study of antidepressant medication, he maintained a position of 'universal scepticism' about the claims and

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[53] T. Butler, *Changing Mental Health Services: The Politics and Policy* (London, 1993), pp.19-23; D. Mitchell & A.M. Rafferty, "I Don't Think They Ever Really Wanted To Know Anything About Us': Oral History Interviews With Learning Disability Nurses', *Oral History* 33 (2005), p.80.
[54] W.L. Jones, *Ministering to Minds Diseased: A History of Psychiatric Treatment* (London, 1983), p.130.
[55] S. Gelman, *Medicating Schizophrenia: A History* (New Brunswick, 1999). pp.1-20.

actions of pharmacotherapists and drug companies, but equally about those of psychotherapists.[56]

While drug treatments for an expanding range of mental ills continue to dominate contemporary clinical regimes, social aspects of treatment have tended to be sidelined and much knowledge and experience risks being lost. Kerry Davies, in a wide-ranging review of the current state of historical scholarship on the experience of mental distress since 1948, has called for further work to 'examine the interrelationship between patient and staff experiences and understandings of group therapy, therapeutic communities and present-day ward meetings'.[57]

The limited accounts that have been published on these developments are dominated by the voices of psychiatrists with a continuing commitment to a 'social model' in psychiatry, such as Stuart Whiteley, Malcolm Pines, and David Millard. Whiteley, was Medical Director of the Henderson Hospital, and a founder member of the Association of Therapeutic Communities, of which he was secretary from 1971 to 1978. His historical account of the therapeutic community movement was dominated by a wry awareness of the many mistakes and dead ends that the initial enthusiasm of its founders, such as Maxwell Jones and David Clark, had embraced. These included Clark's view, eventually put into practice at Fulbourn, that the approach, 'could be universally applied across the field of psychiatric treatment'.[58] Pines, who was a Consultant Psychotherapist at both the Cassel and Maudsley Hospitals, described with approval the way in which therapeutic community methods had been adopted at a

[56] D. Healy, *The Antidepressant Era* (Cambridge Mass., 1997), p.3.
[57] K. Davies, ''Silent and Censured Travellers?': Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine*, 14 (2001), p.287, n.77.
[58] S. Whiteley, 'Progress and Reflection' in R.D. Hinshelwood & N. Manning, (eds.), *Therapeutic Communities: Reflections and Progress* (London 1979), p.17.

succession of teaching hospitals across Britain. He saw this as a concerted attempt to capture the commanding heights of British psychiatry, and so to embed the philosophy in the training of future generations of medical students and psychiatrists. In retrospect, it is ironic that Clark's links with the teaching hospital (Addenbrooke's) in Cambridge were highlighted by Pines at precisely the time, in 1979, when Clark's influence was in steep decline.[59] Lastly, Millard, an Oxford University lecturer and Honorary Consultant Psychiatrist at Warneford Hosptal, has traced the influence of war-time developments on the later evolution of the therapeutic community.[60] While these accounts have continuing value to the historian, their authors' partisan approach tends to isolate the development of therapeutic communities from wider currents in the psychiatry of the period.

At the root of much of the debate about the ways in which mental health services have been organised over the past two centuries is a fundamental divergence of view about the possibility of progress. As might be expected, most historians with professional qualifications in psychiatry have shared an assumption that, despite some setbacks, mental health services have improved over that period. Richard Hunter and Ida Macalpine were confident that their study of Friern Hospital, in north London, showed that, 'the history of the hospital reflects social, medical and psychiatric progress'[61] Similarly, the American psychiatrist and historian Gerald Grob has stated that, 'to call into question the exaggerated promise of future omniscience is not to deny the

[59] M. Pines, 'Therapeutic Communities in Teaching Hospitals', in R.D. Hinshelwood & N. Manning, (eds.), *Therapeutic Communities: Reflections and Progress* (London 1979), pp.23-30.
[60] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman & G.E. Berrios, (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), pp.581-604.
[61] R. Hunter & I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973: A Medical and Social History* (London, 1974), p.11.

possibility of progress'.[62] Scull described Grob as the psychiatric profession's 'favourite historian of psychiatry', which was clearly not intended as a compliment.[63]

Scull himself typifies the opposite viewpoint in this debate, resolutely resisting any temptation to lapse into what he regards as a Whiggish tendency to detect progress in psychiatric treatments. Scull's account of modern psychiatry is an unrelieved tale of the folly, self-deception, and occasional deranged abuse, foisted upon defenceless patients by the profession which consistently claimed to possess the knowledge that would heal them.[64]

While Scull's career has been devoted to the history of Anglo-American psychiatry, wider currents in historical scholarship have begun to challenge some of his fundamental assumptions. David Wootton, a professor of intellectual history at York University, has questioned the wholesale rejection of the idea of progress by historians of medicine and surgery.[65] In these fields, Wootton highlighted the complex relationship between medical knowledge, technological development, and medical practice. He castigated the medical profession for its dogged adherence to the outmoded medical doctrines of Hippocrates and Galen right up until the mid-nineteenth century, despite earlier scientific findings which should have confined them to the status of antiquarian curiosities. However, Wootton does not succumb to the temptation to equate technological developments with inevitable progress in medical practice. He pointed out

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[62] G. Grob, 'Psychiatry's Holy Grail: The Search for the Mechanisms of Mental Diseases', *Bulletin of the History of Medicine*, 72 (1998), p.217.
[63] A. Scull, 'Psychiatrists and historical 'facts': Part One: The Historiography of Somatic Treatments', *History of Psychiatry*, 6 (1995), p.227.
[64] In a recent book, Scull has confirmed that this fundamental intellectual stance remains unchanged. A. Scull, *The Insanity of Place/The Place of Insanity: Essays on the History of Psychiatry* (Abingdon, 2006), p.13.
[65] D. Wootton, *Bad Medicine: Doctors Doing Harm Since Hippocrates* (Oxford, 2007).

that the invention of the stethoscope by Laennec in 1816 did not lead to immediate advances in understanding, say, the operation of the heart. Instead, its rapid acceptance by the medical profession was due in large part to its ability to spare physicians the embarrassing procedure of placing their ear in close proximity to the chests of female patients. For Wootton, Lister's adoption of antiseptic surgical techniques in 1865 was the beginning of an entirely new era of medical progress, unhindered by its past. It is difficult to quarrel with his assertion that surgery has advanced immeasurably in the last one hundred and fifty years. While he does not deal with psychiatry in his recent book, it is possible to discern a future direction for historiography in this field which gives due place to errors and dead ends, but also finds room for occasional modest advances.

The History of Institutional Mental Health Care

While Kathleen Jones has attracted much critical fire from revisionist historians over the years, it is at first sight surprising that the work of the two psychiatrist-historians, Ida Macalpine and Richard Hunter, a mother and son, generally receives respectful attention.[66] However, this can probably be explained by their consistent use of contemporary publications and archival sources in their ground-breaking studies. Their short history of Friern Hospital in north London, where both of them had worked, was based on the selection of brief excerpts from the hospital records and it had many historical and contemporary illustrations.[67] While their account nominally covered the period from 1851 to 1973, there was only very limited material on the post-Second World War era of the hospital's history.

[66] A. Scull, 'A Quarter of a Century of the History of Psychiatry', *Journal of the History of the Behavioral Sciences*, 35 (1999), p.240.
[67] R. Hunter & I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973: A Medical and Social History* (London, 1974).

On the book's cover, both authors gave their qualifications as 'MD FRCP' and while Hunter was described as 'consultant psychiatrist to Friern Hospital', his other post was as, 'physician in psychological medicine to the National Hospital, Queen Square'. Their implied repudiation of the standard qualification in psychiatry, the Diploma in Psychological Medicine (DPM), in favour of the much more prestigious Fellowship of the Royal College of Physicians, certainly indicates a view that psychiatry is the proper province of the physician, albeit of a specialist one. This indication of their orientation as advocates of biological psychiatry was fully confirmed in their forthright statements in their history of Friern that, 'psychiatry is foremost a branch of medicine and subject to its discipline', and that, 'patients suffer from mental symptoms which like bodily symptoms are caused by disease'.[68]

A similar stance was taken by John Crammer in his history of St John's Hospital, Buckinghamshire. On the cover of his book, he was described as Reader Emeritus in Biological Psychiatry at the Maudsley Hospital, so it was not a surprise to find his forthright statement that mental illness, 'is a disorder of function in the mind/brain'.[69] However, this ideological position as a biological psychiatrist had little impact on his history of the institution, which was dominated by the endless administrative struggles involved in attempting to maintain an acceptable level of functioning for the hospital, despite consistently inadequate staffing levels and all other resources. In the independent hospital sector, lack of resources did not prove to be such a constraint.

[68] R. Hunter & I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973: A Medical and Social History* (London, 1974), p.12.
[69] J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum – St John's* (London, 1990), p.11.

Kerith Trick, a psychiatrist, has written a history of the charitable foundation, St Andrew's Hospital, Northampton. [70] Although it was a substantial work, it did not rise above the level of chronicling positive developments. It lacked any detailed consideration of diagnoses or treatments, and made no references to the work of other historians. As such, it forms an extended promotional publication for the hospital, rather than a serious historical study.[71]

An example of a Welsh institutional history which engaged with current scholarship in a more sophisticated fashion, and was soundly based on archival sources, was Pamela Michael's study of the Denbigh Hospital.[72] While demonstrating an awareness of the work of Foucault, Scull, and other historians of mental health provision, Michael maintained that she took a broadly positive view of the hospital's mission, while leaving the reader sufficient scope to, 'make of this history whatever they want'.[73] An added dimension to this study was the linguistic division between English and Welsh speakers in the hospital's catchment area. Not only was there a sizable proportion of monoglot Welsh-speakers in the locality until the 1930s, but a far greater proportion continued to regard Welsh as their first language. As persistent efforts to recruit Welsh-speaking psychiatrists over many decades proved to have only very limited success, monoglot English-speakers continued to dominate the hospital's medical services. English was also the language of official communications and clinical notes, and yet many patients expressed their mental distress through the medium of Welsh.

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[70] A. Foss & K. Trick, *St Andrew's Hospital, Northampton: The First 150 Years (1838-1988)* (Cambridge, 1989).
[71] It was remarkable that even at this late date, sociological critiques of institutional mental health care had apparently had no impact: for example, E. Goffman, *Asylums* (Harmondsworth, 1968).
[72] P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff, 2003).
[73] Ibid, p.2.

In recent years, oral history techniques have been used by some historians of psychiatric institutions in order to uncover hidden aspects of the recent past. The term 'oral history' encompasses a wide range of overlapping yet distinct approaches to the collection of primary sources and their transformation into written narratives. At one end of this spectrum of approaches, oral sources do little more than illustrate discreet features of historical accounts based largely on written records. One example of this technique from the field of mental health care was Steven Cherry's history of St Andrew's Hospital, the former Norfolk Lunatic Asylum, commissioned by the health authority that ran it.[74] The initial two thirds of this book were devoted to an account of the hospital before 1920, and hence before the availability of oral testimony. The final third makes some use of interviews with twenty-three members of staff and two former patients, but these can only be said to supplement the main direction of the narrative which derives from administrative records and other written sources. Cherry states that he has deliberately rejected the path of 'offering intimate details of hospital life or glimpses of patients when considered essentially as people rather than as cases'. Instead, he has created a 'strong institutional 'storyline'' to chart the 'rise and fall of the asylum/psychiatric hospital'.[75]

At the other end of the spectrum could be placed Diana Gittins' study of Severalls Hospital in Essex.[76] In this study, oral testimony from both staff and patients formed the core of the book and while many documentary sources were used, they supplemented rather than shaped the account. While there was plenty of material to satisfy the most trenchant critic of asylums, there was also a balanced recognition that

[74] S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St Andrew's Hospital, 1810-1998* (Woodbridge, 2003).
[75] Ibid, p.305.
[76] D. Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London, 1998).

many of her interviewees had positive things to say. At least one reviewer was so disconcerted by the suggestion that there was *anything* positive to be said about such a place, that she fell back on ascribing those elements in the book to a desire to relieve an 'unremittingly depressing account of asylum life', or even to an undeclared 'personal agenda' on the part of Gittins (the dedication reads, 'in memory of my mother Lloyd Pierce Butler (1922 – 1984) who died in Severalls').[77] Gittins' innovative approach in making personal testimony the core of the narrative has yet to impact fully upon the writing of individual hospital histories.

Andrew Stevens' study of the Royal Eastern Counties Institution represents an example of the burgeoning interest in the history of what is now called learning disability, which was increasingly treated separately from mental health problems as the twentieth century went on.[78] Stevens' motive for using oral history interviews with both patients and staff was that most of the written records of the institution had either been lost or deliberately destroyed.[79] He was successful in reconstructing many aspects of the internal operations of the institution that might otherwise have been lost.

A failure to preserve some or all of the written records of psychiatric hospitals is a commonly-encountered issue, but where such records still exist, oral history can have an important role to play in adding fresh dimensions, insights and challenges to the archives. However, the most recent study of a mental hospital through the medium of oral history serves to illustrate some of the challenges of this method.

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[77] A. Rogers, 'Book review: Diana Gittins, 'Madness in its Place'', *Sociology*, 33 (1999), pp. 650-652.
[78] A.R.A. Stevens, 'The Institutional Care and Treatment of People Categorised as Mentally Defective Before and After the Second World War: The Royal Eastern Counties Institution' (Essex Univ. Ph.D. thesis, 1999).
[79] He interviewed 14 former patients and staff members. Ibid, p.13.

Rodney Griffin's doctoral study aimed to explore the concept of 'community' as it was experienced at St Crispin Hospital, Northampton.[80] Griffin set out to recruit subjects who had been either patients or staff at the hospital, in order to produce an oral history of a specialised form of community. In the event, recruitment proved to be so difficult that he was forced to modify his research plan. He re-used six interviews with retired nurses that he had recorded for an earlier study, even though only three of them had actually worked in Northampton. He was then able to recruit five more subjects who had worked in the hospital in various capacities, and to these he added an interview with a publican's daughter who had lived near Rainhill Hospital in Liverpool. Griffin found it impossible to recruit former patients of St Crispin Hospital, as only two responded to his advertisements, and both subsequently withdrew their consent. The key issues seemed to be a fear that recording oral history might re-awaken harmful memories, and the daunting nature of the NHS information and consent forms. Griffin therefore used instead eight interviews from the National Sound Archive, with former psychiatric hospital patients from several hospitals. [81]
None of these had any connection with Northampton.[82]

So while several histories of mental hospitals have been written in recent years, and there is a burgeoning 'survivor' literature, there remains a need for an account which focuses in detail on the therapeutic regime in such an institution during the second half

[80] R.J. Griffin, 'Concepts of Community in Mental Health, 1935 to 1965: A Modified Grounded Theory Approach used with Oral History and Other Sources' (De Montfort Univ. Ph.D. thesis, 2005).
[81] The Mental Health Testimony Archive of the British Library (C905) (a collaborative project with Mental Health Media) holds fifty life story video interviews with mental health service users. Interview No. 50, with Peter Campbell, includes coverage of his brief admission to Fulbourn in the 1960s, with positive comments about the regime under David Clark.
[82] R.J. Griffin, 'Concepts of Community in Mental Health, 1935 to 1965: A Modified Grounded Theory Approach used with Oral History and Other Sources' (De Montfort Univ. Ph.D. thesis, 2005), p.117.

of the twentieth century.[83] Therefore this thesis attempts to address this gap through its focus on the use made of competing theoretical concepts in psychiatry, and their impact upon staff and patients, in this period.

The History of Mental Health Nursing

The historiography of mental health services remains dominated by accounts of psychiatry and its practitioners, and coverage of other staff roles remains sparse. Yet in all historical periods, asylum attendants, and later, mental health nurses, are likely to have been the staff members who spent most time with patients. One key exception was the pioneering study of the history of mental health nursing in Britain by Peter Nolan.[84] In it he traces the tortuous process of development of the profession. As county asylums were established across the country in the middle of the nineteenth century, an army of asylum attendants had to be recruited in order to staff them. In 1860, Florence Nightingale founded the first School of Nursing at St Thomas' Hospital in London, but it was intended for the training of general hospital nurses only. Nightingale was not opposed to the use of her newly trained nurses in the sick wards of asylums, but she had no concept of a unified nursing profession which would include asylum workers.[85] Therefore the benefits that her revolution brought to general nursing, in terms of training, improved accommodation, a concern for welfare, and greatly improved social status, did not reach the asylum.[86]

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[83] A social enterprise called Chipmunka Publishing specialises in 'survivor' narratives: http://www.chipmunkapublishing.co.uk

[84] P. Nolan, *A History of Mental Health Nursing* (London, 1993); P. Nolan, 'Celebrating Our History of Care', *Journal of Psychiatric and Mental Health Nursing* 10 (2003), pp.637-639.

[85] B. Abel-Smith, *A History of the Nursing Profession* (London, 1960); M. Baly, *Florence Nightingale and the Nursing Legacy* 2nd edn. (London, 1997).

[86] N.R. Brimblecombe, 'Asylum Nursing as a Career in the United Kingdom, 1890-1910' *Journal of Advanced Nursing* 55 (2006), pp.770-777.

In a study of the attendants at the Wiltshire County Asylum in the late Victorian and Edwardian periods, David Russell paints a picture of low pay, rigid discipline, accommodation on hospital wards, and food shared with patients. It was not surprising that recruitment proved to be difficult and that staff turnover rates remained high.[87] As might be expected, such poor working conditions encouraged the growth of trade unionism amongst attendants. The early attempts at organisation proved to be abortive, but they caused considerable alarm to Medical Superintendents. To counter this perceived threat, two Medical Officers from Northampton County Asylum founded a 'company union' in 1895 – the Asylum Workers' Association (AWA) – which soon became a national organisation, thanks to the enthusiastic support of Superintendents in other asylums.[88] In 1911, a counter-organisation run by workers themselves, the National Asylum Workers' Union (NAWU), was founded, and it steadily encroached upon the support of the AWA until the latter closed in 1919. Claire Chatterton has drawn attention to the prominent role that women came to play in the NAWU.[89] The NAWU eventually became the Confederation of Health Service Employees (COHSE), and played a major role in the national political developments surrounding the NHS in the period covered by this study.[90]

While the growth of trade unionism in mental hospitals promoted the view that attendants were 'workers' with a job, rather than 'professionals' with a vocation, educational developments also tended to separate asylum and general hospital staff.[91]

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[87] D. Russell, 'Roundhay, Wiltshire County Asylum Attendants and Nurses, 1881-1905: A Window onto Victorian Sobriety', *International History of Nursing Journal* 5 (2000), pp.14-21.
[88] M. Arton, 'The Rise and Fall of the Asylum Workers' Association: The History of a 'Company Union', *International History of Nursing Journal* 7 (2003), pp.41-49.
[89] C. Chatterton, 'Women in Mental Health Nursing: Angels or Custodians?' *International History of Nursing Journal* 5 (2000), pp.11-19.
[90] C. Webster, *The Health Services Since the War: Volume 1: Problems of Health Care: The National Health Service Before 1957* (London, 1988), pp.335-337.
[91] B. Abel-Smith, *A History of the Nursing Profession* (London, 1960), Ch. 9.

While training for general nurses began to develop from 1860 onwards, formal training, instituted by the Medico-Psychological Association (MPA), did not begin in asylums until 1890. When State Registration for nurses was introduced in 1919, the MPA Certificate was accepted by the General Nursing Council (GNC) for admission to the supplementary part of the Register. The GNC subsequently demanded that the MPA relinquish its role in the education of mental nurses, but a stalemate marked by vituperative exchanges between the two bodies set in.[92] The MPA (which gained the prefix 'Royal' in 1925) maintained its separate examination system for mental nurses until 1951, at which point the GNC became the sole examining body.[93] So training was another factor tending to perpetuate 'difference' between the two branches of nursing.[94]

The more recent history of mental health nursing has received comparatively little attention, with Nolan one of the few scholars to examine it in detail. In a paper co-authored with Hopper, he used oral history sources for an overview of the societal and organisational forces which shaped mental health nursing in the 1950s and 1960s.[95] Their study revealed the extent to which mental nurses in this period were influenced by the increasing depiction of mental health problems in popular culture during this period. This has helped to correct the common view that nurses' attitudes were formed solely by the content of their training, and their subsequent clinical experience. David Russell, a former Director of Nursing Services at the Maudsley Hospital, has used oral history to investigate the recent history of the hospital, as a companion piece to his documentary

[92] R. Dingwall, A.M. Rafferty & C. Webster, *An Introduction to the Social History of Nursing* (London, 1991), pp.123-137.
[93] Learning disability nursing shares this history: D. Mitchell, 'The Origins of Learning Disability Nursing', *International History of Nursing Journal* 4 (1998), pp.10-16.
[94] N.R. Brimblecombe, 'The Changing Relationship Between Mental Health Nurses and Psychiatrists in the United Kingdom', *Journal of Advanced Nursing* 49 (2005), pp.344-353; D. Mitchell, 'All Our Yesterdays', *Learning Disability Practice* 11 (2008), pp.36-38.
[95] P. Nolan & B. Hopper, 'Mental Health Nursing in the 1950s and 1960s Revisited', *Journal of Psychiatric and Mental Health Nursing* 4 (1997), pp.333-338.

history of its early years, from its days as 'Bedlam'.[96] He used the interview schedule developed by Nolan, together with discussion of predetermined topics such as treatments, ethnicity, gender and violence. He concluded that his subjects had a tendency to minimise controversial issues, such as racial prejudice and aggression towards patients, but that sensitive interviewing and careful examination of the transcripts could sometimes shed light on concealed areas of hospital life, in the hints and asides that were easy to disregard.

P.M. Godin has studied the impact of the move to care in the community on nurses, as hospital-based staff took on new roles as community psychiatric nurses (CPNs).[97] One of the key tensions that became apparent as these roles developed was that between a clinical role largely devoted to the delivery of depot injections of psychotropic medication, and a wider one founded upon concepts of psychosocial nursing.[98] Against this background of limited research in the modern period, this study aims to break new ground by a detailed examination of nursing issues in the post-War period in one English hospital.

Conclusion

While an awareness of the polarised discourses that characterise the writing of the history of mental health is an essential foundation for a new study, it is important that they are not adopted in an uncritical manner prior to its commencement. It is all too easy to fall into an unexamined espousal of either Trick's unfailingly optimistic Whig approach of unimpeded progress in one hospital's development, or Scull's Foucault-

[96] D. Russell, 'An Oral History Project in Mental Health Nursing', *Journal of Advanced Nursing* 26 (1997), pp.489-495.
[97] P.M. Godin, *Doing the Frontline Work: A Historical Sociology of Community Psychiatric Nursing in Britain* (Essex Univ. Ph.D. thesis, 2002).
[98] Ibid, Chapter 4.

inspired negativity about psychiatrists and all their works. At the same time, the historian producing a local study has a responsibility to place that account in its wider context, perhaps, in Finberg's classic phrase, causing national and international histories, 'to be revised at many points'.[99] So for example, an historical study of Fulbourn Hospital provides the opportunity to examine the extent to which the broad sweep of Shorter's periodisation of psychiatry in a largely North American context can be applied to developments in Britain. At the outset, it is clear that one aspect of Shorter's scheme which does not apply to Fulbourn is his brief dismissal of the 'social model' in American psychiatry, as it played a major part in the hospital's development under Dr David Clark and will be examined in detail in this study. However, Shorter's depiction of the eventual triumph of a more biological model of mental illness does seem to reflect changes at Fulbourn in subsequent years.

A second strand of this study analyses the ways in which particular discourses in psychiatry were related to the therapeutic regimes practised in the hospital. In particular, physical treatments such as electro-convulsive therapy (ECT), deep insulin coma therapy (DICT), and leucotomy are reviewed in the context of their time. This study also seeks to answer Davies' call for more work to be done on the history of therapeutic communities. As there is currently a lack of detailed historical research on the role of nurses in therapeutic communities, the study of Fulbourn in the second half of the twentieth century fills a gap in the literature. The tide of opinion in psychiatry is currently running strongly in directions that are profoundly influenced by models of mental illness that focus upon biological factors, so it is timely to examine the

[99] H.P.R. Finberg, *The Local Historian and His Theme* (Leicester, 1952), p.10.

philosophy and practice of therapeutic communities through the medium of oral history, while such material remains recoverable.

This study's focus on the therapeutic regimes employed in the hospital in the second half of the twentieth century also breaks new ground. Previous mental hospital histories have tended to focus on either the managerial dimensions of the institution, or on some aspect of the patient experience. While both of these elements are important, studying them in isolation from the intellectual basis on which the institution claimed to function risks ignoring the fundamental rationale for its other dimensions of operation. These were all founded upon some degree of shared understanding of the cause of mental distress and its treatment. As that understanding changed over time, it had a profound impact upon all aspects of the hospital's life.

The final strand of this study analyses the implications for mental health nursing practice of the various models of mental health that were current at Fulbourn over this period. It aims to supplement the pioneering scholarly studies of the profession by presenting a local case study of nursing practice issues in one hospital.

In Chapter 3, the methodological issues raised in the research are critically analysed.

Chapter 3: Research Methodology

Introduction

In Chapter 2, the literature concerning the history of mental health care over the last century was analysed, emphasising the contested nature of that history. It was argued that the complexity of provision for people with mental health problems requires the historian to combine consideration of the differing views on the causal and therapeutic models of mental illness that were used in the past, with evaluation of issues relating to hospital organisation, professional agendas and boundaries, and legal frameworks. The complexity of social organisation present in a mental hospital requires that its history needs to be approached via a strategy of accessing evidence from its multiple layers and dimensions.[1] So it must not be studied in isolation from national and international influences.[2] The operation of Fulbourn Hospital was shaped by national directives in the form of mental health legislation, managerial policies from the national and regional layers of the National Health Service bureaucracy, and the requirements of professional bodies, such as the Royal Medico-Psychological Association (which later became the Royal College of Psychiatrists) and the General Nursing Council. It was also shaped by international forces, principally developments in American psychiatry.

However, against this backdrop of influence from the outside, individual clinicians had considerable scope to shape the ethos within the hospital, so personal career trajectories need to be analysed in the context of these institutional constraints. It would also be a mistake to regard those careers as shaped by purely individual imperatives. The review of the literature outlined in Chapter 2 has demonstrated that the concept of

[1] S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St Andrew's Hospital, 1810-1998* (Woodbridge, 2003).
[2] U.H. Peters, 'The Emigration of German Psychiatrists to Britain', in H. Freeman & G.E. Berrios, (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), pp.565-580.

periodisation, more usually explored in the context of political or cultural history, has been widely applied to the practice of psychiatry.[3] Professional communication through the medium of international journals, the transmission of professional attitudes via an educational and training system controlled entirely by psychiatrists themselves, and the powers of patronage involved in appointments to Consultant posts, all combined to reinforce shared attitudes which were broadly consistent across national boundaries and which were relatively resistant to change.

The literature review has also highlighted the importance of the roles undertaken by non-medical staff in the day-to-day operation of the hospital. Nurses, clinical psychologists, and social workers, all played a major part in the development and operation of the hospital, yet their experiences tend to be treated in most hospital histories as peripheral to a main narrative centred on the directions laid down by psychiatrists. Patients throughout the period covered by this study would have had far more contact with such professionals, than with medical staff. This marginalisation is still more marked in the case of patients and service-users themselves. It was therefore important to seek evidence from former patients in order to paint a fuller picture of the life of the institution and its therapeutic modalities.

The Characteristics of Qualitative Research

When seeking to answer research questions, the researcher has first to select an appropriate research paradigm. In the field of healthcare, the positivist paradigm, with

[3] L. Jordanova, *History in Practice* (London, 2000), pp.114-140; E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997).

its assumption that key elements of reality are quantifiable, continues to occupy the dominant position, in terms of both prestige and resourcing.[4]

Research questions focusing on the discourses used by practitioners in the past, however, require by their very nature the employment of research techniques which fall within the naturalistic paradigm, explored via qualitative research methods.[5] This paradigm is also referred to as 'interpretivism' by some authors.[6] Within the research literature, there are different positions on the extent to which qualitative researchers bring their own preconceptions to their studies. Creswell, for example, has argued that, qualitative research, 'begins with assumptions, a worldview'.[7] By contrast, Denzin and Lincoln maintain that prior assumptions should be consciously put aside, and in their place, the researcher's understanding of social situations is progressively facilitated by research practices, 'that make the world visible'.[8] While no researcher can be said to be entirely lacking in preconceived ideas about a research topic, an attempt was made in this study to minimise the influence of prior knowledge, so that the oral history interviews made Fulbourn's 'world visible', in the manner that Denzin and Lincoln describe. In the social sciences, and to some degree within the field of nursing studies, much attention has been paid to the theoretical underpinnings of qualitative research activity, with continuing debates between advocates of idealist and realist ontologies.[9] While a realist ontology holds that social phenomena have a continuing existence that is

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[4] N. Burns & S.K. Grove, *The Practice of Nursing Research: Appraisals, Synthesis and Generation of Evidence*, 6th edn (St Louis, 2009).
[5] G. LoBiondo-Wood & J. Haber, *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice* (St Louis, 2006), pp.131-175; J. Mason, *Qualitative Researching* 2nd edn (London, 2002), pp.2-3.
[6] P. Corbetta, *Social Research: Theory and Methodological Techniques* (London, 2003), p.27.
[7] J.W. Creswell, *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (Thousand Oaks, 2007), p.37.
[8] N.K. Denzin & Y.S. Lincoln, 'The Discipline and Practice of Qualitative Research', in N.K. Denzin & Y.S. Lincoln,(eds.), *The Sage Handbook of Qualitative Research*, 3rd edn (Thousand Oaks, 2005), p.3.
[9] N. Blaikie, *Approaches to Social Enquiry*, 2nd edn (Cambridge, 2007), p.13.

external to the individual human mind, an idealist ontology takes an existentialist position in arguing that there are no continuing realities except the thoughts of individual people. An attempt to address the historical research questions concerning discourses about mental health posed for this study therefore requires the adoption of an realist ontology.

Epistemology is concerned with establishing a theory of knowledge, and this study employs as its epistemology, 'social constructionism'. Crotty distinguishes between 'social constructionism', which he regards as the identification of shared cultures which shape the way in which individuals view the world, and 'social constructivism', which emphasises the unique experience of each person.[10] Blaikie shares Crotty's view of 'social constructionism', seeing it as the way in which groups 'socially construct their reality', as they 'conceptualize and interpret their own actions and experiences'.[11] Creswell, however, regards the term 'social constructivism' as synonymous with 'social constructionism', and he emphasises the way in which cultural meanings are negotiated both 'socially and historically'.[12] This study therefore seeks to explore the ways in which historical understandings of mental health problems and their treatment were socially constructed at Fulbourn.

[10] M. Crotty, *The Foundations of Social Research: Meanings and Perspectives in the Research Process* (London, 1998), p.58.
[11] N. Blaikie, *Approaches to Social Enquiry*, 2nd edn (Cambridge, 2007), pp.22-23.
[12]; J.W. Creswell, *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (Thousand Oaks, 2007), p.20-21.

Historical Research: A Literature Review

The debates about the nature of scholarship in history are still heavily influenced by two books published in the 1960s.[13] The first of these was E.H. Carr's *What is History?*.[14] Carr emphasised that while history should be rooted in facts derived from sound evidence, historians had always disagreed about the interpretation that should be placed upon those facts. So he regarded history as, 'a continuous process of interaction between the historian and his facts', and therefore, 'an unending dialogue between the present and the past'.[15]

Carr's stress on the fluid nature of historical interpretation drew a lofty riposte from Geoffrey Elton, who went on to become the Regius Professor of Modern History in the University of Cambridge.[16] Elton claimed that Carr's distinction between 'facts of the past', all the events which have occurred at some time in the past, and the much more limited 'facts of history', only those facts known to historians, opened the way to an extreme relativism. This meant that either all interpretations of the past were equally valid, or that history was essentially unknowable, 'being merely what happens to be said by a given historian at a given moment'.[17] The polarised positions adopted by Carr and Elton encouraged later historians to take up opposing sides of the argument. John Tosh characterised Carr's book as, 'probably the finest reflection by a historian on the nature of his subject in our time'.[18] From the other side of the debate, Arthur Marwick, with his characteristic forthrightness, dismissed Carr's thesis as 'complete rubbish', while

[13] A. Marwick, *The Nature of History*, 3rd edn (Basingstoke, 1989), pp.193-198, 298-299; R.J. Evans, *In Defence of History* (London, 1997), pp.1-3; K. Jenkins & A. Munslow (eds.), *The Nature of History Reader* (London, 2004).
[14] E.H. Carr, *What is History?* (Harmondsworth, 1964).
[15] Ibid, p.30.
[16] G.R. Elton, *The Practice of History* (London, 1967).
[17] Ibid, p.76; G.R. Elton. 'Return to Essentials', in K. Jenkins & A. Munslow (eds.), *The Nature of History Reader* (London, 2004), pp.21-24.
[18] J. Tosh, *The Pursuit of History: Aims, Methods and New Directions in the Study of Modern History*, 2nd edn (Harlow, 1991), p.29.

applauding Elton's position as representing 'the views of most working professional historians today'.[19]

As well as following debates from within the profession, historians have always been influenced by ideas drawn from other fields such as anthropology, sociology and philosophy. The writings of Michel Foucault, such as *Madness and Civilization: A History of Insanity in the Age of Reason*, and *Discipline and Punish: The Birth of the Prison*, were particularly influential during the 1980s.[20] However, Ludmilla Jordanova has argued that while some of his concepts such as 'ideology' and 'discourse' have proved fertile sources of inspiration for historians, his former influence was related to the particular political situation in the 1980s.[21]

In the 1990s, the debates on the nature of historical writing revolved around views supporting or opposing post-modernism, with its rejection of the possibility of objective knowledge, and hence its perceived threat to historical objectivity. Keith Jenkins, a leading British advocate of the post-modern position in historiography, has written approvingly of Carr as the original architect of this view.[22] Critics of the study and teaching of history in British universities still complain that most members of the historical profession continue to dismiss postmodernism as meaningless 'jargon'.[23] While the title of his book reflected a desire to defend his discipline from the extremes of relativism, Richard Evans' *In Defence of History* in fact steered a middle course in

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[19] A. Marwick, *The Nature of History*, 3rd edn (Basingstoke, 1989), pp.195, 299.
[20] M. Foucault, *Discipline and Punish: The Birth of the Prison* (Harmondsworth, 1991).
[21] L. Jordanova, *History in Practice* (London, 2000), pp.79-83.
[22] R.J. Evans, *In Defence of History* (London, 1997), p.8; K. Jenkins, *Refiguring History: New Thoughts on an Old Discipline* (London, 2003), p.16.
[23] S. Gunn & S. Rawnsley, 'Practising Reflexivity: The Place of Theory in University History', *Rethinking History* 10 (2006), pp.369-390.

the argument.[24] He accepted that historical documents are open to a range of interpretations, but at the same time asserted that good historians have always been alert to their nuances. Evans' most telling argument has a striking contemporary relevance, derived from his own field of twentieth century German history, and that was that an extreme relativism can open the way to Holocaust denial.[25]

As well as avoiding the pitfall of post-modernist inspired relativism, the student of history should also consider the need to avoid falling into the trap of writing a 'Whig interpretation' of the past.[26] Herbert Butterfield's attack on the tendency of nineteenth century historians to regard the British constitution as the inevitable triumph of the propaganda promoted by an eighteenth century aristocratic political party, the Whigs, has come to exemplify common short-comings in some teleological historical narratives.[27] These include a tendency to see the past through the lens of the present, and to exclude those, like the eighteenth century Tories, who are held to have 'lost' a particular struggle.[28] So in approaching the task of writing a history of Fulbourn Hospital, it was important to reconstruct debates about the causation and treatment of mental illness and distress as they appeared to participants at the time, rather than imposing a contemporary perspective on the past. Jordanova has argued for the importance of micro-history, sometimes also known as case study history, which focuses in detail on one location and over a limited time period, in order to shed light on broader historical trends in Britain and abroad.[29] This study therefore aims to contribute

[24] R.J. Evans, *In Defence of History* (London, 1997).
[25] Ibid, p.238.
[26] H. Butterfield, *The Whig Interpretation of History* (1951).
[27] A. Marwick, *The Nature of History*, 3rd edn (Basingstoke, 1989), p.334.
[28] L. Jordanova, *History in Practice* (London, 2000), p.124.
[29] Ibid, pp.137-139.

to wider clinical and historical debates on the development of mental health care in the second half of the twentieth century, by the detailed scrutiny of Fulbourn Hospital.

Fulbourn Hospital as a Site for Research

Two years after watching the BBC television documentary, *Unlocking the Asylum*, which celebrated the work of David Clark at Fulbourn, I was appointed as a lecturer in adult nursing by Homerton College, Cambridge's School of Health Studies, which used Fulbourn Hospital as one of its placement areas for student nurses. Several of my new colleagues had worked with Dr Clark and his successors at Fulbourn, so staffroom conversations often turned to the recent history of the hospital. It was only after I had made the original decision to study the history of Fulbourn Hospital, based on these fortuitous influences, that I began to appreciate its importance in the history of institutional psychiatry in Britain. I was also unaware, until beginning the research process, of the rich legacy of contemporary publications that had characterised Clark's stewardship.

Data Collection

This study is based on three historical sources:

(a) Transcripts from 27 oral history interviews and oral history material derived from the transcript of a television programme.

(b) Contemporary printed material

(c) Archival material

(a) Oral History

While there was very limited manuscript and documentary material for the post-1950 period of the hospital's history in the two local archives, many of the key protagonists were still alive and hence potential subjects for a study using oral history. It therefore soon became clear that while some printed and manuscript documentary material was available, the voices of those involved in these conflicts over both theory and practice in mental health care were likely to form a vital source of evidence in addressing the three research questions of this study.

The Historiography of Oral History

The use of oral testimony to understand events in the recent past seems to be as old as humanity itself, and many writings from the Classical era of ancient Greece and Rome have an original basis rooted in oral traditions.[30] In Anglo-Saxon England, the Venerable Bede, its pioneering historian, drew on a range of sources, including both documents and oral sources.[31] Yet by the time of the late eighteenth century 'Enlightenment', scholars began to regard documentary evidence as providing the only sure basis for the writing of history. The most influential figures in the establishment of the modern discipline of history were German scholars of the early nineteenth century, such as Barthold Georg Niebuhr (1776-1831), and they were committed to the belief that written texts should be the sole resource for the historian.[32] Until the middle of the twentieth century, political and diplomatic history dominated the agenda pursued by professional historians, and written records such as State Papers, Hansard, and the Blue

[30] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p. 31.
[31] J. Campbell, ed. *The Anglo-Saxons* (London, 1991), p. 53; P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p. 31.
[32] A. Marwick, *The Nature of History*, 3rd edn (Basingstoke, 1989), p. 39.

Books of diplomatic documents, were their favoured sources.[33] It was not until the years after the Second World War that new interests in social history, labour history, and community history led to a more positive revaluation of oral history. The first organisation to promote its collection and use, the Oral History Association, was founded in 1948, by historians working at Columbia University, New York.[34] Its British counterpart, the Oral History Society, did not come into existence until 1973.[35] Its founder was the historian Paul Thompson, and its home remains the Department of Sociology at the University of Essex. Since this time, oral history has developed into a broad movement with several overlapping strands, encompassing reminiscence work with older people, community history, gender-based studies, family history, medical history, and many others.[36] In a recent review, Joanna Bornat and Hanna Diamond explored how these strands have interacted with each other over the three decades that oral history has been used in Britain.[37]

As scholarly interest in oral history has developed over this period, increasingly nuanced understandings of its potential value have evolved. In an influential study, Cathy Courtney and Paul Thompson argued that while memory for names, dates and other 'concrete facts' may be fallible, '[memory] has proved relatively trustworthy on everyday patterns of working practices and relationships in earlier life'.[38] Therefore oral history may be considered an appropriate vehicle for reconstructing such practices and relationships in Fulbourn Hospital. Al Thomson, in his study of the Anzac legend and

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[33] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), pp. 55-60.
[34] Ibid, p.65.
[35] The journal *Oral History* first appeared in 1969.
[36] R. Perks & A. Thomson (eds.) *The Oral History Reader*, 2nd edn (London, 2006).
[37] J. Bornat & H. Diamond, 'Women's History and Oral History: Developments and Debates', *Women's History Review* 16 (2007), pp.19-39.
[38] C. Courtney & P. Thompson, *City Lives: The Changing Voices of British Finance* (London, 1996), p. xiii.

‘digger’ memories in Australia, was one of the first oral historians to argue that individual memories could be shaped by public discourses.[39] Penny Summerfield, in her reflections on collecting oral history accounts of men’s and women’s service in the Home Guard during the Second World War, makes a similar point.[40] In his account of the extremes of human suffering experienced during Stalin’s Great Terror, Orlando Figes has also recognised that some survivors of the Gulag camps tend to shape their narratives to fit the pattern of published accounts, such as those by Solzhenitsyn and Ginzburg. However, he also argues that the oral history interviewer’s ability to question subjects can test these assumptions in a way that is not possible with other historical sources.[41] Such insights have encouraged more sophisticated readings of the past in the light of the complex strategies that oral historians have to adopt in order to obtain their material, and to incorporate it with other types of historical evidence.

The oral history of a mental hospital involves the recreation of the life of a largely self-contained community, so it is important that lessons are learnt from the broader field of community oral history. Paul Thompson and Brenda Corti have used their experience of a recent community oral history project in Wivenhoe, Essex, to reflect on the ways in which such studies have developed over recent years, from their origins in largely celebratory and nostalgic accounts centred on a dominant class or occupational group. They emphasised the importance of developing a sensitive awareness to previously ignored issues such as social mobility, sexual orientation, and social change, and of

[39] A. Thomson, *Anzac Memories: Living with the Legend* (Melbourne, 1994), pp.7-10.
[40] P. Summerfield, ‘Culture and Composure: Creating Narratives of the Gendered Self in Oral History Interviews’, *Cultural and Social History* 1 (2004), pp.65-93. Green has taken issue with Summerfield’s position and stressed the importance of individual memory: A. Green, ‘Individual Remembering and ‘Collective Memory’: Theoretical Presuppositions and Contemporary Debates’, *Oral History* 32 (2004), pp.35-44.
[41] O. Figes, *The Whisperers Private Life in Stalin’s Russia* (London, 2008), pp.634-640.

what divides people in communities, as well as what unites them.[42] In an oral history study of a Northern Ireland community sharply divided on sectarian lines, Anna Bryson stressed the need for the historian to be aware of the silences in testimony, which may cover areas of continuing sensitivity. She quotes Seamus Heaney's famous line, 'Whatever you say, say nothing', to make the point that subjects are well aware that they will have to continue living in the same community after the oral historian has departed, and so may engage in subtle forms of self-censorship to protect themselves. In the context of a hospital history, the oral history interviewer needs to be aware of the need to offer anonymity to interview subjects.

The development of oral history resources in learning disability has often focused on the former hospitals, settlements, and colonies, as examples of self-contained communities which possess a shared community history.[43] However, it has also sometimes taken a completely different turn, and been associated with advocacy and self-advocacy movements.[44] Helen Graham has reviewed the debates about the relative stress to be placed on 'the individual' and 'society' when developing oral history accounts of learning disability, and concluded that they are not separate but rather are, 'fully mutually producing'.[45] There has also been a lively debate on the issue of who should control the research agenda in the field. The disability activist Simone Aspis has argued that people with learning disabilities should control it.[46] The historian Mark Jackson, however, maintains that if people with learning disabilities 'insist that history

[42] A. Bryson, "Whatever you say, say nothing': Researching Memory and Identity in Mid-Ulster, 1945-1969', *Oral History* 33 (2007), pp.45-56.
[43] D. Atkinson, 'Autobiography and Learning Disability' *Oral History* 26 (1998), pp.73-80.
[44] D. Atkinson, M. Jackson & J. Walmsley, 'Introduction: Methods and Themes', in D. Atkinson, M. Jackson & J. Walmsley, (eds.), *Forgotten Lives: Exploring the History of Learning Disability* (Kidderminster, 1997), pp.1-20.
[45] H. Graham, 'Oral History, 'Learning Disability', and Pedagogies of Self', *Oral History* 37 (2009), pp.85-94.
[46] S. Aspis, 'Researching Our History: Who Is In Charge?', in L. Brigham et al, (eds.), *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster, 2000), pp.1-5.

belongs solely to them, they are closing the door on much knowledge and insight that could help emancipate them from past and present prejudices'.[47]

These patterns of response do not seem to have been duplicated amongst people who have experienced hospitalisation due to mental health problems. Kerry Davies has identified three common narrative frameworks from her own research with former patients of Oxfordshire mental hospitals. These are 'narratives of loss', 'tales of survival and self-discovery', and 'stories of self as patient'.[48] While all these narrative forms produced compelling accounts of personal experience, memories of the hospital as their location remained peripheral to their central subjectivity. Davies speculates that this apparent lack of identification with a particular hospital's story is possibly related to the intensely individualistic rhetoric of 'survivorship' that service-user groups have tended to adopt. In such narratives, the focus remains firmly focussed on the individual life story which rejects any attempt to suggest that it was in any way 'defined' by the experience of having been a hospital patient. Despite this, Davies argues that it does not necessarily mean that such accounts have no value in the writing of hospital histories, but rather that the oral historian must remain alert to the subtle patterns and silences contained within the interview.

Oral History and Professional Elites

Until the second half of the twentieth century, historians focused almost exclusively on the members of elite groups within society, such as aristocrats, cabinet ministers, press

[47] M. Jackson, 'Introduction', in L. Brigham et al, *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster, 2000), pp.xii-xiii.
[48]K. Davies, ''Silent and Censured Travellers?': Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine,* 14 (2001), pp.267-292.

barons, generals, and others wielding enormous power over their fellow citizens.[49] The development of the post-War 'welfare state', and the expansion of university history departments, encouraged a new focus amongst historians upon the marginalised and relatively powerless in society. In a phrase that has become well-known, the Socialist historian Edward Palmer Thompson stated that his history of the English working class, first published in 1963, was intended to,

> rescue the poor stockinger, the Luddite cropper, the 'obsolete' hand-loom weaver, the 'utopian' artisan, and even the deluded follower of Joanna Southcott, from the enormous condescension of posterity.[50]

This new direction in historical studies was fully embraced by the leading British oral historian, Paul Thompson, who called for attention to be paid to, 'the under-classes, the unprivileged, and the defeated'.[51] However, categorizing people in this way can produce its own distortions. Looking back over twenty-five years as an oral historian, Al Thomson has argued that it is necessary to be aware of what divides people, as well as what links their memories together.[52] It also runs the risk of ignoring the outside forces of all kinds which shape people's lives and experiences.

Paul Thompson's own oral history projects have in fact also encompassed the rich and powerful, as in his study of City financiers.[53] So while this thesis was concerned to reveal the impact of particular discourses in mental health on the front-line professionals who had to implement the resultant policies, and on the service-users who underwent the treatment regimes, it was also important to access the memories of the powerful

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[49] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), pp.1-24.
[50] E.P. Thompson, *The Making of the English Working Class* (London, 1991), p.12.
[51] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p. 7.
[52] A. Thomson, 'Oral History and Community History in Britain: Personal and Critical Reflections on Twenty-Five Years of Continuity and Change.', *Oral History* 36 (2008), pp.95-104.
[53] C. Courtney & P. Thompson, *City Lives: The Changing Voices of British Finance* (London, 1996).

individuals who determined those policies.[54] Oral historians have tended to focus their attention on previously neglected groups in society, but this approach is equally applicable to the study of power elites.[55]

The term 'elite' has a range of meanings encompassing status, power and influence.[56] While traditional descriptions of social elites in Britain have tended to emphasise the personal connections between individuals who attended the same public schools or ancient universities, and who therefore could be said to constitute an 'Establishment', Froud and her colleagues argue that in modern capitalist economies, such personal connections are fading. In their place, these authors argue that a distinct social class of individuals has arisen, which shares a position of 'structural equivalence' in terms of its power and control over other people.[57] Some researchers in educational studies and political science, such as Phillips and Puwar, have restricted the use of the term 'elite' to politicians and civil servants making national policy.[58]

However, in nursing studies, Harris and her colleagues have used a broader definition of the term to refer to Directors of Nursing Services working for local NHS Trusts, on the grounds that they are the most senior nursing professionals in their organisations, with

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[54] J.E. Sieber, 'On Studying the Powerful (Or Fearing to Do So): A Vital Role for IRBs', *IRB: Ethics and Human Research* 11 (1989), pp.1-6; J. Froud, M. Savage, G. Tampubolon & K. Williams, *Rethinking Elite Research* (Milton Keynes, 2006).
[55] C. Bull, A. McIntosh & C. Clark, 'Land, Identity, School: Exploring Women's Identity with Land in Scotland through the Experience of Boarding School', *Oral History* 36 (2008), pp.75-88; J. Bornat, L. Henry & P. Raghuram, "Don't Mix Race with the Speciality': Interviewing South Asian Overseas Trained Geriatricians', *Oral History* 37 (2009), pp.62-74.
[56] A.M. Hoffman, 'Who are the Elite, and What is a Non-Elitist?', *The Oral History Review* 4 (1976), pp.1-5; M. Savage & K. Williams, (eds.), *Remembering Elites* (Oxford, 2008).
[57] J. Froud, M. Savage, G. Tampubolon & K. Williams, *Rethinking Elite Research* (Milton Keynes, 2006).
[58] R. Phillips, 'The Politics of History: Some Methodological and Ethical Dilemmas in Elite-Based Research', *British Educational Research Journal* 1 (1998), pp.5-19; N. Puwar, 'Reflections on Interviewing Women MPs', *Sociological Research Online* 2 (1997).

control over large budgets and considerable numbers of subordinate staff.[59] For this study, subjects were drawn from positions of professional prominence at both national and local levels, ranging from senior nurses who were influential in Fulbourn itself, to nationally-prominent individuals who had been connected with the hospital in an earlier period of their careers.[60]

Using Oral History Material from a Television Programme

Oral history as an academic discipline has developed two paradoxical assumptions which have received comparatively little critical scrutiny. The first is that the researcher should conduct all the interviews him- or herself, and the second is that the tapes and transcripts of those subjects who provide the necessary consent should ideally be deposited in an archive to facilitate further use.[61] Indeed, the consent form for this study included the option of agreeing to the deposit of the tape and transcript in an archive and several subjects opted for this outcome. The net effect of such provisions is that many archives have accumulated considerable oral history collections, but anecdotally, archivists report that they receive little subsequent use, one of the few exceptions being that of the museum curator looking for sound sources to illustrate an exhibition.[62] This limited use made of existing oral history material means that there is little guidance for the researcher concerning the issues raised by re-using sources generated in other contexts.

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[59] R. Harris *et al*, 'Accessing Elite Nurses for Research: Reflections on the Theoretical and Practical Issues of Telephone Interviewing', *Journal of Research in Nursing* 13 (2008), pp.236-248.
[60] J. Adams, Conference Paper: 'Reflections on Interviewing with Professional Elites in Psychiatry', Postgraduate Oral History Conference (2007), University of Glasgow.
[61] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000)
[62] S. Davies, 'Falling on Deaf Ears? Oral History and Strategy in Museums', *Oral History* 22 (1994), pp.74-84; A. Day, ''They Listened To My Voice': The Refugee Communities History Project and Belonging: Voices of London's Refugees', *Oral History* 37 (2009), pp.95-106.

One of the few oral historians to employ this approach is Joanna Bornat, who has discussed her re-use, for a study of South Asian-trained geriatricians, of materials originally collected by Margot Jefferys for a more general history of the medical specialism.[63] Bornat accepted that her use of this material to extract incidental remarks solely related to ethnicity and racism might have met with hostility from both the late Professor Jefferys, who could have regarded the new research as unwarranted, and with horror by the interviewees, who could legitimately have complained of being misled as to the purpose of the interviews.[64] Bornat's conclusion was that by agreeing to deposit the interviews in a public archive (in this case, the National Sound Archive), both interviewer and subjects were implicitly renouncing their control over the material.

As television companies have shown an ever greater interest in recording oral history interviews to illustrate documentary programmes, the material that they have generated has become available to the oral historian. However, like all oral history sources, its use requires an awareness of its possible limitations. By its nature, the production of a television documentary is an activity involving several researchers and programme makers rather than a single interviewer. In order to obtain the short sound-bites that they require, television interviewers choose to focus on only 'a small number of themes', which have been identified by researchers in advance.[65] The BBC documentary *Unlocking the Asylum*, presented by Dr David Clark himself, contained short clips of interviews with several of the subjects that I would later interview myself, but it also contained useful material from some who were too infirm to be interviewed, or who had

[63] J. Bornat, 'A Second Take: Revisiting Interviews with a Different Purpose' *Oral History* 31 (2003), pp.47-53.
[64] Ibid, p.51.
[65] L. Rees, 'Talking to History' *History Today* 57 (2007), p.70.

subsequently moved abroad.[66] In re-using that material, issues of consent and confidentiality did not arise as I was merely deploying material already clearly in the public domain, having been broadcast to a television audience of millions. Unlike Bornat, who was using material for a purpose remote from the stated purpose of the original interviews, my aim was similar to that of the programme-makers – to explore the 'Clark era' at Fulbourn. However, it was necessary to bear in mind that the clear purpose of the documentary was to celebrate Clark's achievements at Fulbourn, rather than to provide a nuanced picture of the hospital regime. So the oral historian needs to bring to the use of material contained in television programmes the same critical faculties that should be employed for any other form of evidence.[67]

(b) Contemporary Published Sources

It was fortunate for this study that Dr David Clark published several research papers during his time at the hospital. He also encouraged other members of staff, including both doctors and nurses, to publish their own researches, and also more descriptive pieces about developments at Fulbourn. Through his efforts, funds were obtained to appoint other medical and sociological researchers, and their findings were published in due course. An historian of Fulbourn can therefore access far more contemporary printed primary papers than would normally be found to describe the work of a provincial mental hospital, albeit one on the fringes of a university city. However, these publications require the same degree of critical appraisal as any other source of evidence. They form a valuable source of contemporary information about the functioning of the hospital at key periods in its development, but they also bring with

[66] BBC TV Documentary, *Unlocking the Asylum*, first broadcast in 1996.
[67] R.C. Smith, 'Analytic Strategies for Oral History Interviews', in J.A. Holstein & J.F. Gubrium (eds.) *Inside Interviewing: New Lenses, New Concerns* (Thousand Oaks, 2003), p.348.

them their own agendas. Research funded by outside bodies needs to conform to their priorities in order for the bid to be successful.

Much of the early medical research conformed to the positivist paradigm, and was used to demonstrate that Clark's innovations had brought quantifiable benefits. This generally proved to be unsuccessful, as the statistical tests fell short of the required level of significance, but then subtle changes in social functioning are notoriously difficult to measure. Later qualitative studies capture much of the atmosphere on the wards at that time, but their focus was very selective, and most wards and departments were not studied. One article in the nursing press during this period was by a former patient, and its publication presumably indicates that considerable support was given by staff during the process of its production.[68] Its generally positive tone, while doubtless authentic, cannot therefore be assumed to be more widely representative.

(c) Archives

The source of evidence that the historical profession has traditionally prized above all others is the collection of manuscript materials found in a public archive. If history is seen as largely concerned with the accumulation of accurate 'facts', then contemporary minutes, letters, and administrative orders, seem to provide an unassailable foundation for assembling such narratives. That is certainly the position often taken by authorities on research methods who are not themselves historians. LoBiondo-Wood and Haber felt able to state unequivocally that, 'the historical research method is a systematic approach for understanding the past through the collection, organization and critical appraisal of

[68] H. Crockett, 'Fulbourne [sic] Hospital: a patient's view' *Nursing Times*, 70, 16 (1974) pp.603-604.

facts'.[69] As an archive preserves written material that was created at the same time as the events it describes, it is sometimes felt to be an unimpeachable source of such 'facts', which are free of the 'bias' that is inevitably associated with other sources of evidence.

Historians themselves, however, are now more cautious about such claims, and indeed Jordanova goes so far as to warn against what she calls, 'the cult of the archive'.[70] While acknowledging the importance of archival evidence, she stresses that it is not without its own problems of interpretation, therefore requiring the same skills of critical analysis as all other historical evidence. Booth points out that archives are formed by complex processes which the historian may struggle to reconstruct. Official bodies or private individuals decide what material should be preserved, and what destroyed, and they will have their own reasons for the decisions they make. Therefore sensitive or embarrassing documents, or those felt to give ammunition to critics, may never find their way into archives.[71] Osborne has drawn attention to the need to include the role of the archivists, who collect and maintain the archives, in historiographical accounts, which generally tend to focus entirely on historians.[72] Archives are rarely large enough to accommodate all the archives that they are offered, so archivists choose which sources of evidence should be preserved, and then determine the cataloguing and access arrangements that will be put in place. So even if not explicitly mentioned in their writings, historians need to maintain a critical approach to their archival sources.[73] In

[69] G. LoBiondo-Wood & J. Haber, *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice* (St Louis, 2006), p.163.
[70] L. Jordanova, *History in Practice* (London, 2000), pp.186-189.
[71] D. Booth, 'Sites of Truth or Metaphors of Power? Refiguring the Archive', *Sport in History* 26 (2006), pp.91-109.
[72] T. Osborne, 'The Ordinariness of the Archive', *History of the Human Sciences* 12 (1999), pp.51-64.
[73] M. Johnes, 'Archives, Truths and the Historian at Work: A Reply to Douglas Booth's 'Refiguring the Archive", *Sport in History* 27 (2007), pp.127-135.

the case of Fulbourn Hospital, the most important archival collection is held at the Cambridgeshire County Record Office, in Shire Hall, Cambridge. This collection contains a representative selection of records from the hospital up to the introduction of the National Health Service in 1948, but it has yet to be fully catalogued. There is a complete set of bound volumes of Proceedings of the Visitors running from the opening of the hospital in 1848, to the coming of the NHS one hundred years later. Other sets of volumes include Civil Registers, Medical Registers, and a Register of Diarrhoea and Dysentery. It is probably significant that these are all substantial bound volumes, which would have been better able to stand the vagaries of reorganisation and removal, than loose sets of papers. While there are a few documents from the 1950s, the coverage for later years tails off dramatically, and 1960 seems to be the most recent date represented.

In addition to these records which reached the archive through administrative channels, there is a small collection of documents donated by Dr David Clark himself.[74] The most important of the documents among these are the typescript Annual Reports, from 1949 to 1957, that the Medical Superintendent of the hospital was required to produce. In his memoir, Clark states that while his predecessors regarded these as brief and perfunctory documents, on his appointment in 1953, he took particular trouble to ensure that they were a full record of his stewardship of the hospital.[75] His decision to ensure that they were preserved for posterity in the archive, illustrating the changes that he brought to the hospital in his early years, therefore comes as no surprise.

The second archive relating to the hospital is that held by the local NHS Trust in its Postgraduate Library, which is currently located in a building on the former Ida Darwin

[74] Cambridgeshire Collection R98/9.
[75] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.105.

Hospital site, in Cambridge. It contains much ephemeral material, such as unpublished reminiscences, recruitment brochures, and photograph albums, relating to the hospital from the 1960s onwards, but regrettably, resources do not currently allow for its cataloguing or appropriate storage. Large cardboard boxes filled with haphazard piles of material had to be sifted through, in the hope of finding useful items. Searching was made more difficult by the presence of many shards of glass that had come from smashed photograph frames, and were now mixed up with the archives. Under such conditions, the process of finding material could be little more than serendipitous. In the event, concerns about breach of copyright on the photographs in the archive meant that I was only allowed to copy the photographs from a nurse recruitment brochure from the early 1960s (Appendix 1, photographs 4 – 7).

Ethical Considerations

The most important ethical issues raised by an oral history study are informed consent, and anonymity and confidentiality.[76] Consent can only be considered to be informed if the potential subject is given time to decide whether or not to take part, based upon sufficient information about the purpose and scope of the study. Therefore a copy of the combined Information Sheet and Consent Form was sent to each potential subject when the first contact to request an interview was made. For former service-users, the Information Sheet's references to 'work' and 'job' in the hospital were replaced by suitable phrases relating to the use of its services. Anonymity was offered as an option if subjects did not wish to have their name associated with the transcript. Subjects were also informed that they could anonymise any sensitive information if they so wished, and the offer of a copy of the transcript gave the opportunity for them to review this and

[76] V.R. Yow, *Recording Oral History: A Practical Guide for Social Scientists* (Thousand Oaks, 1994), pp.90-95.

any other aspect of their interview. Similarly, the record of the interview could have been destroyed at that point if they so wished. The Information Sheet also alerted subjects to the possibility that the interviewer could omit material from the transcript in order to protect the confidentiality of third parties. Finally, the Consent Form also committed the researcher to deposit the interview in an archive, if requested. The year 1995 was chosen as the end point of the study in order to distance it from current issues faced by the NHS Trust, in which some subjects were still actively involved.

The project was scrutinised firstly by the Human Participants and Materials Ethical Committee of The Open University. Following modifications to the documentation, approval was granted. As some of the potential subjects were still employed in the NHS, the research governance arrangements of the NHS had to be followed. An approach was therefore made to the Research and Development Department of the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.[77] Once the Trust had given its outline approval to the study, it was necessary to obtain an honorary contract of employment with the Trust. Once this was granted, an outline of the study was sent to the chairman of the NHS Local Research Ethics Committee (LREC) for the Cambridge area for his guidance on the appropriate procedure to be followed. He replied in due course that the study could proceed without a full application being made to the LREC.

The Interview Subjects

In the year 2000, the Homerton School of Health Studies acquired the recently-vacated Victorian central building on the Fulbourn site as its headquarters, and at the suggestion

[77] This Trust is currently known as Cambridgeshire and Peterborough NHS Foundation Trust.

of the mental health lecturers, one of the major classrooms in the building was named the David Clark Room [Appendix 1, Photographs 1, 2 & 3]. At the opening ceremony, my colleague Nick Smithson introduced me to Dr Clark, and he expressed a willingness to take part in an oral history study of the hospital. With Dr Clark as my first interview subject, contacts with other potential subjects were first made on the basis of personal recommendations, an approach described as 'snowball sampling'.[78] This has the advantage of encouraging potentially reluctant subjects to take part, as personal recommendation from a colleague or friend can be helpful in overcoming such barriers.[79] However, after several interviews had been recorded, it became apparent that the snowball sample was largely composed of individuals who were committed to the 'social model' in psychiatry. The fact that snowball sampling only includes individuals who continue to be part of particular social networks is well-attested in the literature, and therefore the researcher needs to actively seek other views in order to minimise bias in the sample.[80]

So I then began to approach former staff members who were believed to be supporters of a more 'biological or medical model'. This strategy produced several positive responses, but also some refusals. In post-interview comments made when the tape-recorder was switched off, broad hints were sometimes dropped that I was assumed to be a committed supporter of the social model, and so individuals who rejected that approach might not wish to be interviewed by me for such a project. It may also be that memories of the BBC television documentary *Unlocking the Asylum*, which some felt to have been too one-sided, reinforced this view. So while I knew that supporters of the

[78] V.R. Yow, *Recording Oral History: A Practical Guide for Social Scientists* (Thousand Oaks, 1994), p. 45.
[79] C. Noy, 'Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research', *International Journal of Social Research Methodology*, 11(2008), pp.327-344.
[80] N. Gilbert, *Researching Social Life*, 3rd edn (London, 2008), p.179.

social model had a continuing network of contacts, maintained, for example, through the arrangement of an annual reunion, the same seemed to be true, to some degree, of their opponents.[81]

The Issue of Bias in Sample Selection in Oral History

For some of the early pioneers of oral history in the UK, interviews were regarded as a direct encounter with the past without the need to reflect on issues such as bias in sample selection or recall. So for example, George Ewart Evans, the historian of working practices on Suffolk farms, believed that the interview transmitted knowledge through a semi-mystical process of 'osmosis', which gave the authentic 'feel of history'.[82] Such a process of direct transmission had no place for a consideration of the individual agendas of informants. Later generations of oral historians took a more detached and reflective stance on sample selection and approaches to interviewing. While recognising that bias is an inevitable accompaniment to any qualitative research, since neither the neutral and value-free interviewer nor the dispassionate interviewee exist, Trevor Lummis was one of many later oral historians to argue that the interactive nature of the interview generally allows the reflective researcher to reveal a great deal about the stances taken by the interview subject, and to evaluate the resulting evidence accordingly.[83] Elizabeth Tonkin has argued in a similar vein that oral history accounts should not be treated as 'thing-like facts', but rather as 'reflective representations of social encounters – often unequal ones – with informants'.[84] For this study of Fulbourn, the aim of the interviews was not to collect detailed factual information about legal and

[81] I made several unsuccessful attempts to gain an invitation to the annual reunion of supporters of the social model. Finally, I was told that it was, 'for family only' – an intriguing use of language.
[82] G.E. Evans, 'Approaches to Interviewing', *Oral History*, 1 (1973), cited in T. Lummis, *Listening to History* (London, 1987).
[83] T. Lummis, *Listening to History* (London, 1987), pp.51-69.
[84] E. Tonkin, *Narrating Our Pasts: The Social Construction of Oral History* (Cambridge, 1992), p.86.

administrative regulations, but rather to explore subjective perceptions of the hospital regime in all its complexity.

Many of the accounts given by oral historians seem to imply that sample selection is entirely under the control of the researcher, with the great majority of those approached readily agreeing to take part.[85] While this may be true for authors with established profiles in the media, junior researchers clearly encounter far more refusals and have to accommodate these gaps in the evidence through the use of other sources, where these exist.[86] It is customary for oral historians to list the interviewees who took part in the study, but little tends to be said about the characteristics they have in common, and how they may differ from those who refused the invitation.[87] Those who agreed to be interviewed for this study of Fulbourn tended to possess certain shared perspectives. Most were relatively senior in their own fields, had served for many years at the hospital, regarded their work as a 'career' rather than as just a 'job', and had strong views about a particular model of mental health. This meant that the testimony of junior staff, who worked in Fulbourn for a short time and who may have had no commitment to specific models of mental health, and who were critical of some of the practices they encountered, were particularly important in seeking to compensate for some of the inherent biases in the sample as a whole.[88]

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[85] A. Seldon & J. Pappworth, *By Word of Mouth: Élite Oral History* (London, 1983), p.64.
[86] N. Puwar, 'Reflections on Interviewing Women MPs', *Sociological Research Online* 2 (1997); R.J. Griffin, 'Concepts of Community in Mental Health, 1935 to 1965: A Modified Grounded Theory Approach used with Oral History and Other Sources' (De Montfort Univ. Ph.D. thesis, 2005).
[87] S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St Andrew's Hospital, 1810-1998* (Woodbridge, 2003).
[88] Neil Chell and MN 01 fell into this category.

Additional Recruitment Strategies

In order to further broaden my contacts, I placed an advertisement on the Web-based message board of the local newspaper, the *Cambridge News*, asking readers to contact me with their memories of Fulbourn. This produced several interesting comments from around the world, and facilitated the interviews with Ken Cross, a former administrator, and Mrs Linda Braden, whose father was the hospital engineer. A similar advertisement circulated among the members of the Social Work History Network produced three responses, two of which resulted in telephone interviews.[89] Finally, I placed an advertisement in the newsletter produced by CAM-MIND, the local voluntary sector organisation supporting mental health service-users in the Cambridge area. Following its appearance, Mrs Judith Binge and Mrs Margaret Waspe agreed to be interviewed.

Table 1 is a chronological list of the oral history material collected for this study.

[89] The Social Work History Network meets regularly at King's College, London, to hear papers delivered by both historians and members of the profession.

Table 1: Chronological list of oral history material[90]

Name	Years at Fulbourn	Transcript number	Occupation
'Unlocking the asylum'	N/A	01	[BBC TV Documentary]
Dr David Clark	1953-1983	02	Psychiatrist
Dr Ross Mitchell	1966-1994	03	Psychiatrist
Rev. Mike Law	1974-1996	04	Chaplain
Male Nurse 01	1970s	05	Nurse
Eric Kaloo	1970s	06	Nurse
Nick Smithson	1975-1978	07	Nurse
John Lambert	1966-1989	08	Nurse
Chas Ramlall	1981-1985	09	Nurse
Dr Jane McKeown	1970-2000	10	Psychiatrist
Dr Graham Petrie	1963-1988	11	Psychiatrist
Dr Oliver Hodgson	1960-1984	12	Psychiatrist
Mrs Pat Lambert	1970-1995	13	Nurse
Neil Chell	1980s	14	Nurse
Dr Duncan Double	1980s	15	Psychiatrist
Professor Geoff Shepherd	1981-1994	16	Clinical psychologist
Jimmy Loh	1971-2008	17	Nurse
Mrs Judith Binge	1970s-1990s	18	Service-user
Mrs Margaret Waspe	1950s-1990s	19	Service-user
Stephen Thornton	1983-1989	20	General manager
Clive Harries	1972-1983	21	Nurse
Dr Alan Broadhurst	1960s	22	Psychiatrist
Mrs Linda Braden*	1960s	23	Engineer's daughter
Ms Barbara Prynn*	1961	24	Social worker
Ken Cross	1937-1977	25	Administrator
Peter Houghton*	1985-1991	26	General manager
Mrs Judith Atkinson*	1967-1968	27	Social worker
Dr Paul Calloway	1985-2005	28	Psychiatrist

[90] * Indicates telephone interview

Data Collection

Issues in Oral History Interviewing

Many authorities on the practice of oral history advocate the thorough absorption of printed sources as a necessary preparation for the interviewer before interviewing commences.[91] Ron Grele is representative of this approach, stating that, 'oral historians are still prone to rush out and ask how it happened without spending the arduous months plowing (sic) through related written materials'.[92] Such preparation has the obvious advantages of reassuring subjects that the interviewer has taken the trouble to understand their field, and providing an agenda for the interview. It suffers from the major disadvantage, however, of potentially confining the interview to well-trodden, pre-determined paths and failing to uncover the unique insights that oral testimony may provide.[93] Southgate has argued that accessing human memories can help to liberate historians from the unquestioned assumptions that they may bring to the study of a particular topic.[94] Open questions, which promote discussion, can allow subjects to convey their own perspective on a topic.[95] There is now a recognised tradition of using relatively unstructured interviews in oral history to explore a single issue on which the subject possesses considerable expertise. This format was established by pioneers such as George Ewart Evans in the 1960s, in his celebrated studies of the skills possessed by Suffolk farm workers in the age of the horse.[96] More recent researchers who have used this approach include Jieyu Liu, in her account of the experiences of Chinese women

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[91] J. Bornat, 'Recording Oral History', in M. Drake & R. Finnegan, *Sources and Methods for Family and Community Historians: A Sourcebook*, 2nd edn (Cambridge, 1997), p.165.
[92] R.J. Grele, 'Movement Without Aim: Methodological and Theoretical Problems in Oral History', in R. Perks & A. Thomson (eds.) *The Oral History Reader* (London, 1998), p.40.
[93] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p.222.
[94] B. Southgate, 'Memories into Something New: Histories for the Future', *Rethinking History* 11 (2007), pp.187-199.
[95] J.D. Aberbach & B.A. Rockman, 'Conducting and Coding Elite Interviews', *PS: Political Science and Politics* 35 (2002), pp.673-676.
[96] G.E. Evans, *The Horse in the Furrow* (London, 1960); G.E. Evans, *The Pattern under the Plough* (London, 1966); P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p.227.

intellectuals, Margaret Black studying clerical workers in the 1950s and 1960s, and Suruchi Thapar-Björkert's paper on interviewing Indian nationalist women.[97] The advantages of using relatively unstructured interviews include an openness to the views and priorities of the subjects, while potential disadvantages include a lack of shared focus which could make the analysis of the transcripts more problematic.[98]

From my previous projects I was aware that, as in all qualitative research, the role of the interviewer in oral history has a major impact upon the nature of the data obtained.[99] Jordanova has warned of the potential danger associated with over-identification with the subjects being interviewed, which may result in, 'an emotional aura that affects the resulting scholarship'.[100] On the other hand, Hamilton has stressed that there must be a certain degree of empathy between interviewer and subject if both parties are to collaborate in the production of an oral history account.[101] Many hospital histories have been compiled by past or present members of staff, and these, quite naturally, tend to stress the positive aspects of the regime. For those institutions, like the former county asylums, which were heavily stigmatised, there is often a tendency to contrast a grim Victorian past with a dynamic and increasingly scientific recent past and present.[102] As a former health care worker myself, it was necessary to maintain constant vigilance in order to preserve an appropriate sense of emotional distance from my topic.

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[97] J. Liu, 'Researching Chinese Women's Lives: 'Insider' Research and Life History Interviewing', *Oral History* 34 (2006), pp.43-52; M. Black, 'Clerical Workers in the 1950s and 1960s: The Use of Oral Evidence', *Oral History* 22 (1994), pp.49-55; S. Thapar-Björkert, 'Nationalist Memories: Interviewing Indian Middle Class Nationalist Women', *Oral History* 27 (1999), pp.35-46.
[98] C.T. Morrissey, 'On Oral History Interviewing', in R. Perks & A. Thomson (eds.) *The Oral History Reader* (London, 1998), pp.107-113.
[99] K. Anderson & D.C. Jack, 'Learning to Listen: Interview Techniques and Analyses', in S.B. Gluck & D. Patai (eds.), *Women's Words: The Feminist Practice of Oral History* (New York, 1991), p.19.
[100] L. Jordanova, *History in Practice* (London, 2000), p.53.
[101] C. Hamilton, 'On Being a 'Good Interviewer': Empathy, Ethics and the Politics of Oral History', *Oral History* 36 (2008), pp.35-43.
[102] One example of this genre is: J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum – St John's* (London, 1990).

So given the polarised nature of the debates surrounding Fulbourn, I felt that it was important to present myself to subjects as an interested but essentially naïve researcher. This has its own advantages, as Michelle Winslow has argued in her account of interviewing Polish migrants while not having any Polish ancestry herself. Being interviewed by an 'outsider' tends to call forth more clarification and background information than would be considered necessary for an 'insider'.[103] Paul Thompson has stressed that, 'there is no point in having any interview at all unless the informant is, in some sense, better informed than oneself'.[104] In Roy Hay's study of Clydeside shipbuilders, a highly technical field of labour of which he had little prior knowledge, this lack could sometimes be turned to his advantage. Hay reported that, 'on many occasions older workers have greeted my naïve questions with amused tolerance and told me, "Naw, naw laddie, it wasn't like that at all" and this would then be followed by a graphic description of the real situation'.[105]

Robert Perks built on an earlier oral history study of the Ukrainian community in West Yorkshire with a visit to their newly-independent homeland in 1991. Of necessity his approach to data collection was that of the naïve interviewer as he had had no personal experience of the country or its culture. On occasion, the exasperation of his subjects at his ignorance was revealed in comments such as, 'You would not ask such a question if you had lived in the Soviet Union. It was because it was. It happened because it

[103] M. Winslow, 'Polish Migration to Britain: War, Exile and Mental Health', *Oral History* 27 (1999), pp.57-64.
[104] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p.222.
[105] Cited in P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p.223.

happened'. He was nevertheless able to collect much illuminating testimony about a society which has been rarely studied by British researchers.[106]

For this study, I restricted my prior exposure to the topic, before conducting the interviews, to the television documentary and memoir produced by Dr Clark.[107] The initial letter or email contact revealed that I am a nursing lecturer, but in so-called adult (previously known as 'general') nursing rather than in mental health nursing. If asked, as I was by some subjects, I further explained that I had experienced student placements in three large mental hospitals (St John's, Stone; Springfield, Tooting; and Friern, north London) before 1981, but that I had had no prior contact with Fulbourn. I hoped that this background information from my biography conveyed the message that while I had some insight into life in the final era of the large mental hospitals, I did not hold preconceived ideas about the nature of mental health problems or their treatment. During interviews, the evident naivety of some of my questions occasionally elicited a mildly exasperated response, but those occasions were more than compensated for when a subject took the trouble to explain issues in depth that had not previously been mentioned.

The Interview Process

The oral history interviews were conducted at a location chosen by the subject. This was usually either their home or office, or a room on one of the sites of the School of Health Studies. Each encounter began with a brief introduction on the purpose of the interview as a contribution to my doctoral research, together with a review of the points covered in the Information Sheet, which had been sent to them in advance. They were then

[106] R. Perks, 'Ukraine's Forbidden History: Memory and Nationalism', *Oral History* 21 (1993), pp.43-53.
[107] BBC TV Documentary, *Unlocking the Asylum*, first broadcast in 1996; D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996).

invited to sign the Consent Form, and indicate which of the options they were selecting by initialling the appropriate box. Four of the interviews were conducted by telephone, because the subjects lived a considerable distance from Cambridge. These subjects had all previously received the Information Sheet and Consent Form by e-mail, and the latter was subsequently returned to me by post. In total, about two thirds of the subjects requested a copy of their transcript, and three subsequently contacted me with corrections in the transcription or typing errors. About a third of the subjects requested that their tape and transcript should be deposited in a public archive. All the interviews were recorded on an analogue battery-operated machine, using either an integral or a lapel microphone. The telephone interviews were recorded via a 'speaker phone' in my office. The relatively unstructured interviews conformed to the category described as 'single issue testimony', in which the focus is placed upon one aspect of past experience.[108] My first question asked about initial impressions of the hospital, and I then encouraged subjects to recall their time there in roughly chronological order.[109] The second part of the interview was concerned with follow-up questions to explore in more detail issues that had been raised. This approach to conducting the relatively unstructured interviews, with its focus on single issue testimony, had the advantage of encouraging subjects to frame their answers in ways which seemed most authentic to them. A potential disadvantage was that some of the material that was collected in this way was not directly relevant to the focus of the study. However, in an institution as complex as a psychiatric hospital, such material could be indirectly useful in illuminating its wider social context in more detail.[110]

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[108] H. Slim, P. Thompson, O. Bennett & N. Cross, 'Ways of Listening', in R. Perks & A. Thomson (eds.) *The Oral History Reader*, 2nd edn (London, 2006), p.146.
[109] A. Portelli, *The Battle of Valle Giulia: Oral History and the Art of Dialogue* (Madison, 1997), pp. 9, 11.
[110] A. Portelli, 'What Makes Oral History Different' in R. Perks & A. Thomson (eds.) *The Oral History Reader*, 2nd edn (London, 2006), pp.32-42.

The two exceptions to this pattern were the interviews with service-users. These were unforgettable personal accounts of a kind which Davies has characterised as, 'stories of loss, tales of survival and self-discovery'.[111] My questions were largely rendered redundant as often painful memories poured out in a connected narrative of their journey through life. While a great deal of this material was not directly related to Fulbourn, it did illuminate very powerfully the context in which the hospital and its services operated.

Issues in Elite Interviews

The interviews for this study included some with individuals who had wielded (and in some cases, still did wield) considerable power and influence within mental health care in the United Kingdom, at local or national levels. They included several nationally-prominent consultant psychiatrists, three NHS Trust board members, and some individuals who were known to be active and influential on the national stage. All these interviews, bar one, were conducted on a face-to-face basis. The exception was a telephone interview, which the subject was able to fit into a gap between meetings, in a way that would probably not have been possible with a conventional interview. This accords with the experience of Harris and her team, who found that their requests for a telephone interview with busy Directors of Nursing achieved a high success rate.[112]

The interviews with elite practitioners followed broadly the pattern described above, but had some shared characteristics of their own. These included the need for preliminary

[111] K. Davies, ''Silent and Censured Travellers'? Patients' Narratives and Patients Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine*, 14, 2, 267-292.
[112] R. Harris *et al*, 'Accessing Elite Nurses for Research: Reflections on the Theoretical and Practical Issues of Telephone Interviewing', *Journal of Research in Nursing* 13 (2008), pp.236-248.

negotiations with the various 'gate-keepers', such as personal assistants and secretaries, who bar access to the subjects.[113] So the interview itself was often the first direct contact I had had with the interviewee. After experiencing a problem, during an early interview, with the built-in microphone on my tape-recorder, when the subject kept turning away from the machine and allowing his voice to fall away into silence, I switched to using a lapel microphone. In subsequent interviews, I was surprised to find that this tiny change had a major impact on elite subjects. It seemed to provoke memories of televised interviews, and hence served to establish my seriousness as a researcher.

Once the interview began, it was clear that elite subjects felt able to control many of its aspects. The first of these was the control of time, and this resulted in a range of responses. At one end of the spectrum, a senior psychiatrist with a thriving private practice summoned me to fill a twenty-minute consultation when a patient cancelled at short notice, so the interview had to be conducted with constant regard to the clock. Another interview subject kept an electronic device in view throughout the interview, so as to monitor in-coming emails and end the interview if more important matters demanded attention. At the other end of the spectrum, an NHS Trust board member postponed later appointments to spend more time on the interview than had been previously allotted, and several subjects seemed happy to linger over a cup of coffee while they expanded on their answers.

However, the core issue of control was how much elite subjects would be prepared to reveal about what were often personally and organisationally sensitive matters. My

[113] K. Goldstein, 'Getting in the Door: Sampling and Completing Elite Interviews', *PS: Political Science and Politics* 35 (2002), pp.669-672.

original assumption, based on the sparse literature on conducting elite interviews, was that I would encounter guarded replies which provided no potential hostages to fortune.[114] It was of course likely that several subjects would have had experience of hostile interviews with the media concerning alleged scandals in the mental health field, and they may have had specialist training on how to handle them. Far from being guarded and defensive, however, all the interviews were characterised by a willingness to speak about any issues that I raised. Indeed, several of them shared a rather startling willingness to criticise named colleagues in the most trenchant terms.[115] This raised issues in the use to be made of their transcripts, as the act of reproducing defamatory statements can expose the researcher to the risk of being sued for libel.[116] In this context, it was fortunate that at the insistence of an ethics committee, a clause had been inserted in the consent form warning that the researcher reserved the right to omit potentially sensitive material. This had been intended to cover breaches of confidentiality regarding patients. In the event, no such breaches occurred, but the clause proved useful in ensuring that the elite transcripts complied with the law of libel.

Data Analysis

Once an interview was recorded, it was transcribed as a Microsoft Word document by the researcher. The process of turning oral accounts into the written word raises a range of problems, as a decision has to be taken on the balance to be struck between completeness and readability. Therefore transcription can be considered to be part of the data analysis process. Some oral historians have argued a case for including all the

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[114] J.M. Berry, 'Validity and Reliability Issues in Elite Interviewing', *PS: Political Science and Politics* 35 (2002), pp.679-682.
[115] J. Adams, Conference paper 'Reflections on Oral History Interviews with Professional Elites in Mental Health Care', International Nursing Research Conference (2009), Royal College of Surgeons in Ireland, Dublin.
[116] P. Thompson, *The Voice of the Past: Oral History*, 3rd edn (Oxford, 2000), p.253.

‘crutch’ words (such as ‘you know’, really, and ‘actually’) and misstatements, together with representations of filler sounds (such as ‘er’ and ‘um’) and pauses, in the transcript.[117] At the opposite end of the spectrum, others have prioritized the requirements of the user of oral history, by omitting all those kind of elements and correcting apparent mistakes.[118] It was interesting to note that one subject returned the transcript with all the ‘crutch’ words deleted, and the request that that ‘corrected’ version should be used in the thesis. Alessandro Portelli has side-stepped this polarised debate by suggesting that the search for an all-purpose transcript is doomed to failure, and therefore it is more appropriate to consider a range of transcripts serving different purposes, all to be created from the same tape.[119] For this study, an attempt was made to achieve readability, while retaining as many features of the original as possible. Most ‘crutch’ words were retained in the transcript, unless they were particularly repetitious. Strongly emphasised words were represented by underlining, and editorial corrections of obvious misstatements, and additions to improve readability, were indicated by square brackets. The software package NVivo 7 was used to facilitate the location of key words and phrases in the transcripts.

Once the process of transcribing had been completed, the evidence from the interviews could be placed alongside documentary sources in order to highlight material relevant to the research questions for this study.[120] The process therefore followed the conventions of the problem-orientated method of historical research, which seeks to produce a narrative based upon an analytical approach to source material, which has been read in

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[117] E.M. McMahan, *Elite Oral History Discourse: A Study of Cooperation and Coherence* (Tuscaloosa, 1989), pp.xxi-xxii.
[118] F. Good, ‘Voice, Ear and Text: Words, Meaning and Transcription’, in R. Perks & A. Thomson (eds.) *The Oral History Reader*, 2nd edn (London, 2006), pp.362-373.
[119] A. Portelli, *The Battle of Valle Giulia: Oral History and the Art of Dialogue* (Madison, 1997), p.15.
[120] Ibid, p.269.

the knowledge of the wider historical context.[121] The thematic reconstruction of the historical material, from archival, published, and oral sources, was guided by the requirement to answer the research questions posed in Chapter 1, and it will be presented in a broadly chronological sequence.

Conclusion

Drawing on the work of Evans, Thompson, Thomson and Figes discussed above, historical approaches were used to explore the three aspects of the development of Fulbourn Hospital which form the research questions for this study. These are the competing discourses found in mental health care during the period under review, the relationship between developments at Fulbourn and those elsewhere, and finally, the impact that these competing discourses had on nursing practice in the hospital.

This study therefore accords with Jordanova's description of micro-history or case study research, in seeking to illuminate major international trends through the detailed examination of the local and the time-bound.[122]

In the following chapters, I set out the findings of the research.

[121] J. Tosh, *The Pursuit of History: Aims, Methods and New Directions in the Study of Modern History*, 2nd edn (Harlow, 1991), pp.54-71: V.R. Yow, *Recording Oral History* 2nd edn (Walnut Creek, 2005), p.284.

[122] L. Jordanova, *History in Practice* (London, 2000), p.124.

Chapter 4: The New Superintendent

Introduction

The findings of the study in this and succeeding chapters have been analysed in a broadly chronological sequence, with a focus on key themes where appropriate. This chapter explores the early career factors which influenced the decision of Dr David Clark to apply for, and subsequently accept, the position of Medical Superintendent of Fulbourn Hospital in 1953. At first sight, this did not seem to be a promising career move for an ambitious young psychiatrist who had trained in an elite London institution.

The hospital had been opened as the Cambridgeshire and Isle of Ely Pauper Lunatic Asylum in 1858, and the site was still dominated by its massive Victorian buildings (Appendix 1, Photographs 2 and 3).[1] The nineteenth century had been characterised by a belief that the orderly surroundings of an imposing asylum provided the best opportunity to study and treat mental illness.[2] This clinical optimism, which its early medical superintendents brought to Fulbourn, was soon extinguished by the reality of trying to contain a growing patient population in an overcrowded and under-staffed institution. Containment rather than therapy became its essential purpose, and so Clark's decision to work there baffled many of his contemporaries.[3] This chapter locates the impetus for Clark's decision in his war-time experiences, and in the opportunity it gave for a young doctor to put his ideas into practice on a large scale. This chapter also sets

[1] *Proceedings of the Visitors of Cambridgeshire, Isle of Ely and Borough of Cambridge Pauper Lunatic Asylum (1848-58)*. Call mark R63/9. Cambridgeshire Archives . Photographs 2 and 3 in Appendix 1, could be said to represent the 'acceptable public face' of the institution, representing its attractive grounds and its architecturally impressive entrance.
[2] R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London, 1997), pp.501-502.
[3] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), Ch. 2.

Clark's agenda of change for the hospital in the wider context of national discourses on the progressive 'open door' regime of the 1950s.

Fulbourn Hospital Emerges from Wartime

During the first half of the twentieth century, there was little to distinguish Fulbourn Hospital from other county mental hospitals up and down the country Each successive medical superintendent ruled supreme over a few over-worked doctors and a large number of attendants. The patients were confined in stark institutional surroundings and controlled by an oppressive and unchanging regime.[4] In 1926, Dr H. Travers Jones was appointed as Medical Superintendent and he turned his institutional management role into that of a country gentlemen. He reared pheasants and partridges in the fields surrounding the hospital, and held regular shooting parties, reckoned to be the best in the region, for his invited guests.[5] Ken Cross, who was appointed as a junior administrator at the hospital in 1937, remembered this grand style of life:

> *On the site – big house, lived on his own. He had a lady who lived in the staff cottages, who was the wife of Bill Turner, a Charge Nurse – she was his housekeeper. She used to come and cook for him. He used to have shoots, with a lot of the patients on the shooting – what do they call it?*
>
> Oh, beater?
>
> *Yes, beaters.*[6]

[4] J. Adams, Conference paper: 'Voices from the Past: Oral History and the History of Nursing' International Nursing Research Conference (2006), Royal College of Surgeons in Ireland, Dublin.
[5] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.26.
[6] Transcript 25, Ken Cross.

The partridges were fed by Jones' personal servant, 'John', whose other duties included going from his ward each morning to wake the Superintendent with a cup of tea, laying out his clothes, and cutting his hair once a week.[7]

In 1945, Dr Travers Jones was succeeded as Medical Superintendent by his long-serving deputy, Dr J.G.T. Thomas. He was 'a genial giant, [who] knew all his patients by name'.[8] His particular sporting interest was cricket, and he captained the hospital team for thirty years. The cricket pitch had been ploughed up for food production in 1941, but it was reinstated in 1947, when competitive matches recommenced.[9] Both staff and patients took an interest in the matches Dr Thomas organised. As Ken Cross recalled:

> *I don't know if I dare put this in my tape! He was a keen cricketer! He used to have the county police up for the day – and they had a match between the staff and the police. Bob Raines [a hospital administrator] and his brother [a charge nurse] were all in the team. But I think one night, Dr Thomas had an accident in his car – I think he had a bit of a problem with the police. And thereafter, the police were never invited back!*[10]

The hospital was also not isolated from the contemporary forces of change, and it gradually adopted many of the new dimensions of psychiatric practice which were current in the post-War years. Dr Thomas began to establish outpatient clinics in the

[7] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.54.
[8] D.H. Clark, *A Brief History of Fulbourn Hospital* [Typescript] (Fulbourn, 1962), p.47.
[9] Ibid, p.55.
[10] Transcript 25, Ken Cross.

hospital's wide catchment area, with a first opened in March in 1946, followed by others in Huntingdon, Saffron Walden and Wisbech.[11]

Dr Dewi Jones, an Assistant Medical Officer, introduced a range of physical treatments. Insulin coma therapy, for the treatment of schizophrenia, was first used in 1948, and a dedicated unit was established in the male admissions villa in 1950. Electro-convulsive therapy (ECT) was also widely used after 1950. For the treatment of 'general paralysis of the insane' (G.P.I), a condition found in tertiary syphilis, malaria therapy was introduced.[12] The organisational change which had the most impact upon the practice of psychiatry in Cambridge was the decision taken in 1948, the year of the founding of the National Health Service, that all medical appointments should be held jointly between Addenbrooke's, the distinguished teaching hospital, and Fulbourn. At the same time, Dr Derek Russell Davis, the Reader in Psychopathology in the University of Cambridge, was given honorary appointments at both hospitals.[13] The first of the joint appointments as a consultant psychiatrist between the two hospitals was that of Dr Edward Beresford Davies in 1949. 'Beresford', as he was universally known, was also the first psychiatrist in Cambridge to adopt the 'eclectic' approach to treatment, which was to establish an important place in the subsequent development of Fulbourn.[14] His Cambridge MD thesis reported his research into the effects of electro-convulsive therapy and he was an enthusiastic advocate of neuroleptic drugs for the treatment of schizophrenia, but he was also a skilled psychotherapist.[15]

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[11] D.H. Clark, *A Brief History of Fulbourn Hospital* [Typescript] (Fulbourn, 1962), p.55.
[12] Ibid..
[13] D.H. Clark, *A Brief History of Fulbourn Hospital* [Typescript] (Fulbourn, 1962), p 58. This linkage of the three main institutions concerned with psychiatry in Cambridge – Fulbourn, Addenbrooke's, and the University – laid the groundwork for collaboration, but it would be another thirty years before a fuller integration occurred.
[14] The 'eclectic model' of psychiatry combined equal enthusiasm for biological, psychodynamic and social approaches to treatment.
[15] A. Broadhurst, 'Obituary: Edward Beresford Davies', *British Medical Journal*, 324 (2002), p. 549.

The New Broom

The appointment of Dr David Clark, a 32-year old Senior Registrar at the Maudsley Hospital, to the post of Medical Superintendent at Fulbourn in 1953, was an unusual one (Appendix 1, Photograph 1).[16] His relative youth and lack of experience in the management of mental hospitals indicated a courageous choice on the part of the appointment committee, and from his own point of view, a move from the distinguished environs of the Maudsley to an obscure provincial hospital could be seen as perverse. Indeed, his contemporaries at the Maudsley were astonished that he had made this transition 'at one bound'.[17] However, there were several factors which encouraged Clark to apply for the post. Firstly, there was the impact that his wartime service had had on him. As a medical officer in the Parachute Regiment, in the thick of the action, he had not expected to survive the war, but survive it he did, and the experience of liberating the survivors of death camps made a lasting impact on his thinking.[18]

> *During the War I had to deal with concentration camps, extermination camps, internment camps, I had come to have a horror both of people being locked up, but also what being gaolers did to the people who did it, and in mental hospitals, including at the Royal Edinburgh, I had been involved in episodes where I realised that unacceptable brutality was being used, and I found both the degradation and the oppression, but also the brutality of the worst of the back wards deeply disturbing.*[19]

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[16] David Clark, trained in medicine at King's College, Cambridge and Edinburgh University. Qualified in 1943 and served for three years as a Medical Officer with the Parachute Regiment. He trained in psychiatry in Edinburgh and at the Maudsley Hospital, under Sir Aubrey Lewis. This photograph was taken to mark his retirement in 1983.
[17] M. Carstairs, 'Introduction', in D.H. Clark, *Social Therapy in Psychiatry* (Harmondsworth, 1974), p. 7.
[18] D.H. Clark, *Descent into Conflict, 1945: A Doctor's War* (Lewes, 1995).
[19] Transcript 02, Dr David Clark.

During his time at Fulbourn, all staff were aware that Clark would deal with episodes of staff brutality towards patients with the utmost severity.[20]

The Maudsley may have been a stimulating place to work, surrounded by the leading researchers in psychiatry and with the prospect of private practice, but it was also apparent that a permanent position there would be difficult to obtain.

> *Now the chance of being offered a permanent job in the Maudsley itself was very small – it was only the most favoured who got that. There was a possibility of academic psychiatry, but I mean people said it was going to open, but it had barely opened at that stage, and so it was either taking a clinical psychiatrist's job in the NHS, or - a lot of people, of course, were training as psychoanalysts, preparing to set up as therapists.*[21]

The prospect of gaining a senior appointment in the newly-established NHS was also not without its advantages for a young doctor who was married.

> *The medical culture I grew up in, that of my father's colleagues and so on, was that you were a medical student, you qualified. Now you could go straight into general practice and could put your plate up right away. If you wanted to get married, you had to. If you wanted to become a specialist, you had to hang around, for 10 or 15 years, getting paid nothing, and doing scut work for the surgeons, running to and fro, and then if you made it, you might emerge...Now the asylum*

[20] Professor Geoff Shepherd was one of several interviewees who emphasised this point.
[21] Transcript 02, Dr David Clark.

service – an assistant medical officer in an asylum got a house, plenty of servants, and a reasonable salary.[22]

There was also, to some extent, the feeling that being in overall charge of a mental hospital could give considerable scope for innovation to an ambitious young doctor.

But some of the best people in psychiatry at that time were people who had gone to an asylum – for example, Duncan Macmillan of Mapperley told me he intended to be a surgeon, but he needed to work for his final Fellowship. So he took an asylum job to finance it, and then he suddenly found that what he was doing was far more interesting than surgery![23]

This was the reverse of the situation in the USA, where ambitious psychiatrists sought posts in small private hospitals, or set up office-based practices.

These positive factors had to be set against the lack of a significant pay differential between the medical superintendent and the other doctors on the hospital staff. As Clark recalled:

When the NHS came, all the senior asylum doctors became consultants and there was little money for being a superintendent, so nobody wanted a superintendent's job. That's why younger doctors like myself got them in the mid-fifties.[24]

While running his own hospital near Cambridge was an attractive prospect, he had little realistic prospect of landing the job due to his relative lack of experience.

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[22] Transcript 02, Dr David Clark.
[23] Ibid.
[24] B. Barraclough, 'David Clark' [Oral history interview], in G. Wilkinson (ed.), *Talking About Psychiatry* (London, 1993), p.81.

> *Because I'd had a couple of years here at Cambridge, the idea of going back to Cambridge seemed very attractive, but basically I simply took it for a trial run, because you see a lot of my friends who were also senior to me at the Maudsley, had been up for 4, 5, 6 appointments committees, and it was quite clear that you had – it was a lottery, and you had to be prepared to have a certain number of defeats, and I was quite astonished when …[laughs].*[25]

To Clark's great surprise, it soon became apparent that he would actually land the post at Fulbourn.

> *And I remember suddenly realising halfway through the process that there was danger that they might offer me the job. And I thought, 'My God!', because I had seen the hospital – it was appalling! Well, not appalling, but - a seedy, shabby, demoralised, run-down place, and I thought, 'Do I want to commit myself to that?'*[26]

Despite this initial shock, Clark does not seem to have hesitated in accepting an appointment that would give him ample opportunities to put into practice what he had learnt in Edinburgh and London. He had broken free from the tutelage of his seniors and was now the master of his own destiny.

Psychiatry after the Second World War

Clark's arrival came to be seen within a few years as a watershed in the story of the hospital, and the beginning of a new era.[27] It will be argued in this chapter that this spirit of change owed a great deal to his personal vision and drive, but it also originated

[25] Transcript 02, Dr David Clark.
[26] Ibid.
[27] My interviewees were unanimous in that view.

in a context in which a new generation of psychiatrists achieved positions of authority in psychiatric hospitals and set out to effect major changes in institutional regimes.

The emotional stimulus for these changes came from experiences gained in wartime, as in Clark's case with the first-hand knowledge of the degradation and brutality of concentration camps, and the beneficial impact that some of the concepts later formulated as social psychiatry could have.[28] The intellectual stimulus came from a variety of sources. The first of these was the influence of his Edinburgh teacher, Sir David Henderson.

> *The Royal Edinburgh Hospital had a very high reputation, and Sir David was a great teacher, so an obvious place to start…*
> *I went to Sir David, and said, 'Can I come and work for you?'*
> *I spent three years at Craig House, Royal Edinburgh Hospital, which was my basic training in psychiatry.*[29]

Henderson combined a primary focus on psycho-biology, with an interest in the social aspects of mental illness.[30]

However, Clark clearly felt that the former dominated the clinical practice in Edinburgh, and that new developments in social psychiatry were passing him by.

> *I got on fine there, but then what? If I'd stayed with Sir David, he would have got me a job as a deputy medical superintendent somewhere, and I'd have been a medical superintendent in due*

[28] D.W. Clark, *Descent into Conflict, 1945: A Doctor's War* (Lewes, 1945), p.123.
[29] Transcript 02, Dr David Clark.
[30] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman and G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.582.

course. But there was an awful lot more going on in psychiatry, and we weren't getting it at Edinburgh.[31]

As Clark recalled:

The Maudsley, for 10 years after the War, was the one really first-class postgraduate psychiatric place. And anybody who was anybody, it wasn't only anybody with ambition, although that was true, but it was anybody who wanted to explore the subject further went to the Maudsley.[32]

The dominant figure at the Maudsley in the pre- and post-War period was Sir Aubrey Lewis, who held the chair of psychiatry in London University.

His interest in the social context in which psychiatry was practised did not imply a rejection of biological explanations for disease.[33] In an important paper, he argued that:

> Health is a single concept: it is not possible to set up essentially different criteria for physical and mental health.

And that:

> It is misconceived to equate ill-health with social deviation or maladjustment.[34]

While the Maudsley attracted the ablest junior doctors in the field of psychiatry with its reputation for excellence, Lewis' teaching methods were far from ideal:

I learned from DK [David K. Henderson] how to help people grow, and from Aubrey Lewis, how <u>not</u> to help people to grow. Aubrey was a

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[31] Transcript 02, Dr David Clark.
[32] Ibid.
[33] A. Lewis, 'Health as a Social Concept', *British Journal of Sociology*, 4 (1953), pp.109-124.
[34] Ibid, p.124.

man of brilliance, of immense erudition, but the effect that he had on junior doctors was malignant. He terrified them. The only thing that many of them learned at the Maudsley was to avoid being cut to pieces.[35]

However, Clark, the battle-hardened former Parachute Regiment officer, was well able to stand his ground. He found Lewis to be:

Charming, courteous, kind, and witty, once he had come to the conclusion that you were all right.[36]

Under Lewis' direction, the Maudsley provided an eclectic approach to psychiatry in which the biological model of mental illness predominated, but which still found space for other philosophies.

One aspect of the move to London that had attracted Clark was the opportunity to begin a process of psychoanalysis:

I mean, I knew by that stage that I wanted to have a personal analysis, that I couldn't get in Edinburgh, but also I wanted to have some time and the chance really to try and understand psychiatry, and I got it.[37]

Psychoanalysis remained outside the main focus of activity at the Maudsley, but it

[35] B. Barraclough, 'David Clark' [Oral history interview], in G. Wilkinson (ed.), *Talking About Psychiatry* (London, 1993), p.89.
[36] Ibid, p. 90. Lewis provided a positive reference for Clark's application for the Fulbourn post, believing that he 'wasn't Maudsley material'.
[37] Transcript 02, Dr David Clark.

was taken up by some of the younger staff.[38] Indeed, Lewis' attitude can be gauged from his comment regarding the Austrian émigré psychiatrist, Professor Erwin Stengel, when he remarked that, 'Stengel has only been singed' by psychoanalysis.[39]

Clark underwent a personal analysis, and also trained in individual and group psychotherapy with the founder of group analytic psychotherapy, Dr Siegmund Heinz Fuchs (known after his arrival in Britain as S.H. Foulkes).[40] Foulkes was at this time teaching at the Maudsley, but he had developed his ideas on group psychotherapy in Birmingham from 1942 onwards, at the wartime Northfield Military Hospital.[41] This was a unit run by the Army Psychiatric Services for soldiers suffering from neuroses, and it was commanded by Dr J.R. Rees, who had been the pre-War Director of the Tavistock Clinic. Rees naturally brought to the hospital the philosophy of the Tavistock, which was neither committed to mainstream psychiatry nor wholly wedded to psychoanalysis.[42] This permissive atmosphere enabled experiments in small and large group psychotherapy to be undertaken, and it led one of Foulkes' colleagues, Dr. T.F. Main, to coin the term 'therapeutic community' for the approach used there.[43]

Another element of the training in psychiatry available for the junior doctors at the Maudsley was the possibility of developing an interest in 'social psychiatry'. One of the

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[38] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.590.
[39] U.H. Peters, 'The Emigration of German Psychiatrists to Britain', in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.569.
[40] Ibid, p.576; D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.39. Foulkes arrived in Britain in 1933, having trained in psychoanalysis in Vienna and Berlin.
[41] J. Andrews, 'R.D. Laing in Scotland: Facts and Fictions of the 'Rumpus Room' and Interpersonal Psychiatry', in M. Gijswijt-Hofstra & R. Porter (eds.) *Cultures of Psychiatry* (Amsterdam, 1998), p. 132.
[42] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.587.
[43] Ibid, p.588. The dominant influence of Tavistock psychiatrists on the direction of Army psychiatry led to Rees and Main being described as 'the Tavi brigadiers': E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p.235.

first to use the phrase in Britain was Edward Glover, a psychoanalytically-orientated psychiatrist, who in a paper published in 1940, argued for the 'birth of social psychiatry' in order to cope with the psychological problems that medicine would be sure to encounter in wartime conditions.[44] Lewis himself founded the Unit for Research in Occupational Adaptation at the Maudsley, which subsequently became the Medical Research Council's Social Psychiatry Unit.[45]

In making the move from Edinburgh to the Maudsley Hospital in London, Clark was following in the footsteps of the British pioneer of therapeutic communities, Dr Maxwell Jones.[46] Jones and Clark established a lifelong friendship, and Jones' work had a major impact upon Clark's reforms at Fulbourn.[47] Jones' early interest in applying scientifically rigorous animal experimentation to the study of psychiatry had led Aubrey Lewis to recruit him to the Maudsley, and Lewis' powerful support continued to be important as Jones' later career moved in other directions.[48] These new directions included an interest in psychoanalysis, and he underwent analysis by Melanie Klein.[49]

At the outbreak of the Second World War, the patients and staff of the Maudsley were evacuated from inner-city south London and divided between two sites on the fringes of the capital: Mill Hill School in Middlesex and the Belmont Hospital in Surrey. Jones became a member of Lewis' team at Mill Hill, and he was given charge of a unit for service personnel.[50] The unit admitted patients with a range of conditions such as

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[44] E. Glover, 'The Birth of Social Psychiatry', *Lancet*, 236 (1940), p.239.
[45] D. Bennett, 'Work and Occupation for the Mentally Ill', in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.197.
[46] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), pp.582-3.
[47] Ibid, p.600.
[48] Ibid, p.582.
[49] Ibid, p.592.
[50] Ibid, p.583.

depression and anxiety states, but it focused on the treatment of Effort Syndrome, also known as Soldier's Heart or Da Costa's Syndrome, a cardiac condition with symptoms of left-sided chest pain, breathlessness and giddiness, associated with stressful situations.[51] At Mill Hill, Jones worked with the leading cardiologist, Dr Paul Wood, in attempting to find biochemical indicators for the condition.[52] Jones' treatment regime was strongly influenced by psychotherapeutic ideas, and it was his first experiment with regular group meetings.

A key feature of the unit at Mill Hill was that the nurses were educated mature women from professional backgrounds who undertook the role as a contribution to the war effort. So they were not content merely to act as custodians, they were keen to take an active part in the therapeutic regime.[53] This happy accident was to lay the foundation of the important role for the nurse in the therapeutic community movement, and hence to have a major impact on the development of greatly expanded roles for nurses at Fulbourn.

At the end of the War, Jones moved to take charge of the Southern General Hospital in Dartford, a 300-bed military hospital for the most severely disabled amongst returning prisoners of war. This unit built on Jones' Mill Hill experience in that there were daily community meetings, and sympathetic local employers were persuaded to provide part-time work for the men.[54] In 1947, Jones moved to the Belmont Hospital, to direct its

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[51] O. Paul, 'Da Costa's Syndrome or Neurocirculatory Asthenia', *British Heart Journal*, 58 (1987), pp. 306-315.
[52] By the end of his career in the 1960s, Wood had come to abandon the concept of Effort Syndromes and regarded these cardiac symptoms as indicative of anxiety disorder. S. Wessely, 'Neurasthenia and Fatigue Syndromes: Clinical Section', in G. Berrios & R. Porter (eds.) *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995), p.518.
[53] M. Jones, *Social Psychiatry: A Study of Therapeutic Communities* (London, 1952), p.2.
[54] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.586.

Industrial Neurosis Unit.[55] This was supported by the Ministries of Health, Labour, and Pensions, for the purpose of studying 'the problem of the chronic unemployed neurotic'.[56] Apart from a small number of trained nurses, most of the nursing on the unit was provided by young women, many from abroad, with degrees in one of the social sciences who were interested in gaining some short-term experience prior to entering social work. As the philosophy of the therapeutic community maintained that the whole of a patient's time in hospital should be regarded as treatment, their input was vital to the life of the unit as well as to the daily round of specifically therapeutic activities such as group discussions and psychodrama. The Disablement Resettlement Officer was also an important member of the team, given its focus on placing patients in work. Patients stayed in the hospital for a maximum of six months, and on discharge were placed in a job in the community. A follow-up study of the adjustment scores of 104 patients discharged from the unit indicated that 44% were assessed as 'satisfactory', 22% 'fair', and 34% 'poor'.[57] However, it proved impossible to identify a control group of neurotic patients who had not been treated in a therapeutic community with whom these outcomes could be compared.[58]

Apart from the direct impact of his training at the Maudsley Hospital, the other consistent intellectual influence on Clark was the development of research in social psychiatry in the United States of America, from the 1940s and 1950s onwards. The term 'social psychiatry' itself had originated in the United States, to describe the agenda

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[55] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p. 591. M. Jones, *Social Psychiatry: A Study of Therapeutic Communities* (London, 1952), p. 25.
[56] Ibid, p.25.
[57] M. Jones, *Social Psychiatry: A Study of Therapeutic Communities* (London, 1952), p.119.
[58] An American reviewer stated that a final assessment of the unit's effectiveness would have to await such a comparison: H.W. Dunham, 'Reviewed works', *American Sociological Review*, 19 (1954), pp. 359-360.

of joint meetings of the American Psychiatric Society and the American Sociological Society, which had begun in 1927.[59] These meetings were concerned with the possible contribution that sociological research might make to an understanding of psychiatry, rather than to defining a particular philosophy or model of psychiatric practice.[60] One direction eventually taken by this collaboration was the investigation of rates of mental illness in particular populations. This was an early example of an ecological study, a method of evaluation which became an established tool of the public health physician.[61]

Another direction for research was taken by the partnership of Alfred H. Stanton, a psychiatrist with an interest in sociology, and Morris S. Schwartz, a sociological researcher, in studying a particular hospital.[62] The site of their influential study was a for-profit hospital, the Chestnut Lodge Sanitarium (sic), where Stanton worked as a psychiatrist. This hospital provided psychoanalytic therapy for prosperous, upper-class patients from Washington DC.[63] Stanton took the role of a participant-observer, while Schwartz was a non-participant observer who was occasionally inadvertently drawn into participation. Their study focused on the social context of the treatment of mental illness, and presented a generally positive view of what they saw in the wards selected for study. It is likely that Erving Goffman had this book in mind with his comment that:

> The reports that have been published seem to have come from small private hospitals or single wards and seem to add up to the reassuring notion that things would be all right if only the members of the staff

[59] H.W. Dunham, 'Social Psychiatry', *American Sociological Review*, 13 (1948), pp.183-197.
[60] Clark was enthusiastic about the contribution that sociological researchers, such as David Towell, could make to the study of the Fulbourn regime.
[61] J.A. Clausen, M.E. Kohn, & H.W. Dunham, 'The Ecological Approach in Social Psychiatry', *American Journal of Sociology*, 60 (1954), pp.140-151.
[62] A.H. Stanton & M.S. Schwartz, *The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment* (New York, 1954).
[63] G. Blok, ' "Messiah of the Schizophrenics": Jan Foudraine and Anti-Psychiatry in Holland', in M. Gijswijt-Hofstra & R. Porter (eds.) *Cultures of Psychiatry* (Amsterdam, 1998), p.155.

> could get together in democratic communication and feel free to be the nice people they really are.[64]

This caustic aside came in a review of a study of a State mental hospital published by another member of the 'social psychiatry' group, Ivan Belknap. Goffman evidently approved of this study, commenting that, 'with Belknap's work, we finally get down to business.'[65]

The picture that Belknap painted was of hospital attendants working in a grim environment and faced with impossible demands from their superiors. Their response was to create the impression of orderly therapeutic activity while in fact exercising rigid control over uncooperative patients through the use of 'trustees': senior patients allowed to operate a reward and punishment system controlling their fellow-patients.[66]

Clark recalled the impact that some of the earlier works of the 'social psychiatry' group had had on his thinking as a junior doctor, and the subsequent publication of major research works which served to confirm his view of America as a constant source of inspiration in the struggle to reform psychiatry.

> *I read the works of people like Stanton, Schwartz, Warren Dunham, Belknap and others when I was at the Maudsley, I realised that there was a different way of looking at the institution, and so that wasn't at*

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[64] E. Goffman, [Untitled Review], *Administrative Science Quarterly*, 2 (1957), pp.120-121.
[65] Ibid, p.120. Goffman's own study, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York, 1961), explored similar territory. Its re-issue as a Pelican paperback in 1968 made it a hugely influential text in the UK.
[66] I. Belknap, *Human Problems of a State Mental Hospital* (New York, 1956).

> *the top of my list, but it was very definitely in me, a feeling 'it doesn't have to be like this'; it could be better.*[67]

One aspect of American social psychiatry which was to have a major influence on Clark's stewardship of Fulbourn was the willingness to use research, and in particular sociological research, as a means of gauging the effects of reforms and also of promoting those reforms to the widest possible audience. The many publications which emerged from Fulbourn during the Clark years form an invaluable record of its otherwise transient activity.

Working with the Management Structure

While it is tempting to focus entirely upon David Clark's role as the Medical Superintendent at Fulbourn in describing developments at the hospital, it needs to be remembered that he had constantly to gain the agreement of more powerful figures if changes were to be made. Clark may have controlled the day-to-day operation of the hospital, but overall control was vested in the Hospital Management Committee.

> *In those days, the management committees were very important, and all the really successful superintendents handled their management committees well….T. P. Rees …the superintendent of [Warlingham Park] – he was a flamboyant Welshman, and he ran the hospital with flamboyance, and everybody told great stories about him, but he had the committee eating out of his hand.*[68]

When Clark first arrived at Fulbourn, the relationship between the dynamic, young medical superintendent, who was determined to make dramatic changes in the

[67] Transcript 02, Dr David Clark. Another influential study of public provision was: H.W. Dunham & S.K. Weinberg, *The Culture of the State Mental Hospital* (Detroit, 1960).
[68] Transcript 02, Dr David Clark.

institutional regime, and the councillors he was answerable to for his management of the hospital, was a fraught one:

> *You see, the Asylum Committee was a sub-committee of the County Council … and people only went onto it if they wanted to…So they were all people who were to a certain extent compassionate, who wanted to see things better, but some of them found a very brash young man very tiresome. I mean I didn't see it at the time. I saw them as bigoted old fools, but now that I'm a bigoted old fool myself, I can see that their reaction, though wrong, was understandable. It was only five years since they had been a Visitors' Committee, and the Visitors' Committee was very different because it was their job to see that the asylum didn't waste money.*[69]

Even though the National Health Service had been in existence for five years when Clark was appointed, the culture of cheese-paring that local councillors had learned to adopt through representing an agricultural county in the Depression of the 1930s, was still much in evidence, as Clark recalled:

> *One of the great cries was, 'Every £600 is a penny on the rates, doctor' . We had a treasurer who was always saying, 'Well, my duty is to protect the interests of the ratepayer'…They hadn't got accustomed to the idea that as part of the National Health Service, their job was to spend money rather than to save it!*[70]

Help was at hand, however, following the appointment of the wife of the Master of Trinity College as Chairman of the Management Committee:

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[69] Transcript 02, Dr David Clark.
[70] Ibid.

> *Towards the end, of course, I [like Rees] had my committee eating out of my hand, but in my early years I was very fortunate because Lady Adrian had only just been put in charge of the Fulbourn committee, and she was determined to raise the standard of psychiatry in Cambridge, and she backed me a hundred per cent.*[71]

There was an established Cambridge tradition of charitable work in the city by senior members of the University and their wives. Indeed, one of my interviewees joked that in Cambridge, lay involvement meant the participation of a Darwin, or a Keynes.

The other potential check on Clark's activities was provided by the supervision of the medical officer of the Regional Hospital Board, Dr James Ewen:[72]

> *When he went round and looked at them, he found he'd got four awful 'bins', and Fulbourn in some ways was the worst, because it was more over-crowded than any of the others, and he backed me a lot, too. I put my foot in it again and again, but he'd sort of forgive me, dust me off, and set me at it again.*[73]

With this powerful support and encouragement, Clark was able to begin changing policies at Fulbourn in order to bring them into line with the best contemporary practice.

Clark's Early Reforms.

'The Open Door'

One of the most powerful symbols of the fear engendered by mental distress, which the psychiatric hospitals of the 1950s inherited from their Poor Law and Municipal era

[71] Transcript 02, Dr David Clark.
[72] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.31.
[73] Transcript 02, Dr David Clark.

predecessors, was the locked ward.[74] In 1954, four of the five male wards at Fulbourn were locked.[75] This prevented patients who were detained from leaving the hospital, but the staff also recognised that they served to increase tension within the institution. Miss Brock, the Matron, could empathise with their feelings:

> *I can understand the building up of the tensions, because it would happen to anybody – to be locked in a ward and couldn't get out.*[76]

Maurice Fenn, a male nurse, believed that:

> *Broken windows were often an indicator of levels of tension in the wards.*[77]

As Miss Brock recalled:

> *On one particular ward, where the patients were perhaps rather disturbed, we would perhaps have a window broken nearly every day.*[78]

In the early 1950s, the question of whether a psychiatric hospital should retain locked doors was the topical issue in psychiatry. The *Lancet* devoted a first leading article, entitled 'The Unlocked Door', to this debate in November 1954, without coming to any definite conclusion.[79] An article in the same issue of the journal outlined the different stances taken by the advocates of the 'open door'.[80] Dr T.P. Rees, the physician-superintendent at Warlingham Park in Surrey, retained only two locked wards in the

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[74] Before 1947, all the wards in Fulbourn were locked. Clark's predecessor, Dr Davies, began a tentative process of 'unlocking' wards. By 1949, one male and two female wards were opened. Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1957.
[75] E.G. Oram & D.H. Clark, 'Working for the Hospital', *British Journal of Psychiatry*, 112 (1966), pp. 997-1005.
[76] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.
[77] Ibid.
[78] Ibid.
[79] Anon, 'The Unlocked Door', *Lancet*, 264 (1954), pp.953-4.
[80] Anon, 'Freedom in Mental Hospitals: the End and the Means', *Lancet*, 264 (1954), pp.964-6.

hospital, for patients who persistently absconded. Dr Duncan Macmillan, at Mapperley Hospital near Nottingham, opened all the ward doors in both the day and the night, following a period of consultation with his charge nurses. However, some locked side rooms were retained for patients having 'a serious emotional crisis'.[81]

The pioneer in the total abolition of all locked doors was Dr G.M. Bell of Dingleton Hospital, Melrose. He was also unusual in deliberately choosing not to discuss this change with the nursing staff in advance, on the grounds that they would have refused to put it into action. The journalist from the *Lancet* was assured (presumably by Dr Bell), that the nurses had subsequently confirmed that his hunch was correct, but that now, the nurses were pleased with the new approach and believed that, 'it is easier to work than the 'locked door' plan'.[82] The only reference to the impact that recent developments in physical therapies had had on the need for locked doors came in the account of Crichton Royal Hospital, Dumfries. In that hospital, locked garden gates to some of the pavilions were retained. Having reviewed practice in four leading centres, the article concluded that the relatively small size of Dingleton Hospital may have made a complete opening of the hospital easier to achieve.[83]

Although opinions might differ on the best way to proceed, there was a realisation that services for those with a mental health problems had been greatly neglected for many years. Clark realised that the coming of the National Health Service in 1948 had provided a new opportunity:

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[81] Anon, 'Freedom in Mental Hospitals: the End and the Means', *Lancet*, 264 (1954), p.965.
[82] Ibid, pp.964-6.
[83] In his account of Fulbourn Hospital, Clark acknowledges the impact that this *Lancet* article made on him, although he incorrectly dates it to 1953. D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.89.

> *[It] was a wonderful and revolutionary time. They'd realised how appallingly impoverished asylums were and they were pouring money into them, but not only that, there was backing for people who were prepared to make experiments.*[84]

Encouragement to move in this direction also came from a powerful source:

> *The Commissioner of the Board of Control wrote me five names on the back of an envelope, and he said, 'I think you'll find it useful to go and look at those hospitals' and I did. In each of them I saw brilliant things being done, for instance two of them, Warlingham and Mapperley, were 'open door' hospitals, and if they can do it, why can't we? So making Fulbourn an 'open door' hospital – it wasn't just the open doors, it was making the life of the patients worthwhile, challenging, free, and so on.*[85]

The pressure for change in mental hospitals in this period was therefore not just the initiative of individual medical superintendents, but also represented behind-the-scenes impetus from senior administrators.

Three years after having been appointed Medical Superintendent, Clark's agenda for change was ready to be made public.[86] His first paper originated as an address given at the Annual General Meeting of the Cambridgeshire Mental Welfare Association in October 1955. Clark argued that in the last generation, psychiatry had become a respectable medical speciality, and psychoanalysis had increased knowledge while physical treatments had generated therapeutic enthusiasm. While acknowledging that mental hospitals must provide treatment for all those with severe mental illness within

[84] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.89.
[85] Transcript 02, Dr David Clark.
[86] D.H. Clark, 'Functions of the Mental hospital', *Lancet*, 268, (1956), pp.1005-1009.

their catchment area, he also highlighted four special functions of the hospital: the observation ward, the geriatric hospital, the hospital for 'psychopaths', and the neurosis centre. He listed four different ideals of what a mental hospital should be: the general hospital with modifications, the open-door hospital, the active-therapy hospital, and the therapeutic community. Regarding the second of these, he wrote:

> The open door is a great ideal and it is certainly possible in any mental hospital to have all but two or three wards open. But hospitals which are near large towns and receive disturbed urban patients cannot, I think, go further than this, and there is a certain danger that too much emphasis on open doors may lead to patients being too heavily sedated , subjected to too much physical treatment, or kept too long in bed.[87]

Clark made it clear that his favoured model was the therapeutic community, as developed by T.P. Rees in Warlingham Park, although he emphasised that patients might need a period of rest from the social pressures that had contributed to their breakdown before they were ready to take part in such a community.

Two years later, in a letter written from California, he explicitly renounced, on the basis of a new paper on 'open door' policies at Dingleton Hospital, his earlier view that Fulbourn could not be a fully 'open door' hospital.

> Events proved me wrong. In February 1958, we gave up our last locked door and all wards since then have been run on the open-door principle.[88]

[87] D.H. Clark, 'Functions of the Mental Hospital', *Lancet*, 268, (1956),. p.1008.
[88] D.H. Clark, 'Letter: The Open Door', *Lancet*, 280, (1962), p.881.

Even though the doors were unlocked, there remained many patients who were held under the terms of mental health legislation, and who were not free to leave the hospital, as Judith Atkinson, a social worker, recalled:

> *The downside, I suppose, of unlocking the wards was that people who were not supposed to leave the hospital were not allowed their clothes. …So they had to be in dressing gown and pyjamas. And I think that made some people very annoyed. I can remember a person shouting and shouting, 'Clothes or discharge! I want to get out of here – whatever!'* [89]

This recollection underlines the value of personal testimony, as the custom of enforcing the wearing of night clothes during the day, as a means of restraint, does not feature in printed sources.

So while the unlocking of the doors of a hospital undoubtedly had a major impact on the day-to-day lives of many individuals, it did not mean that all patients were free to come and go as they pleased, as its advocates tended to imply. In fact it took on a symbolic significance which went far beyond the issue of locks and keys. To be the medical superintendent of an 'open door hospital' was to be aligned with the most progressive forces in psychiatry and to be committed to a wide range of other reforms to traditional hospital regimes. It was a conscious attack on all the de-humanising aspects of institutional life. Clark himself recalled that there were numerous issues which needed to be resolved before patients could be said to experience a humane caring environment:

[89] Transcript 27, Judith Atkinson.

> *They wore hospital clothing which was taken off them at night, they were not allowed to have any money, or really personal possessions either.*[90]

All of these issues would be tackled in the 'open door hospital'.

'Work for All'

A key aspect of the agenda for 'open door' hospitals was the need to provide training in the life skills needed to sustain patients in the workplace, as it was recognised that work had two functions in such a hospital. It had a therapeutic benefit in providing structure and purpose for the patient's day, but it also provided the springboard for discharge from hospital. Soon after he arrived at Fulbourn, Clark developed a statement of the philosophy that underpinned the first of these aims:

> As many patients are to be occupied as possible; jobs will be selected to suit the patient and aid his recovery; where possible, they will have a bearing on the life of the hospital; wards will be opened where possible; habit training groups will be organized among the incontinent and demented; a graduated system of payment and reward will be arranged; there will be every effort to make patients aware of the hospital and to encourage them to arrange and organize their own activities.[91]

As work soon came to be seen as the mechanism for facilitating successful discharge from hospital, this statement is notable for its modest aspirations firmly rooted within the hospital itself.

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[90] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.
[91] E.G. Oram, & D.H. Clark, 'Working for the Hospital', *British Journal of Psychiatry*, 112 (1966), p. 998.

However, regarding work as a therapeutic activity did represent an advance on the customary asylum view of work as a means of saving expense for the rate-payers by providing free labour for domestic tasks, building maintenance, or the hospital laundry. In the 1950s, some of the traditional forms of work in an asylum, such as gardening, were still undertaken, but generally at an increasingly reduced level of activity. There was still an 'Engineer's Gang' and a 'Farm Gang'.[92] Linda Allison remembered, through the eyes of a child, the last days of the hospital farm when she arrived to live in a hospital house in 1958:

> *I can remember the farm with rabbits – a great big haystack. There was always a big haystack that we used to climb to the top of. Sort of lie in the hay there, and again – quite dangerous! …*
>
> Yes. Were there bigger animals – I mean, pigs and sheep …?
>
> *There were. I can remember pigs and I can remember the sort of a block, which was a bit like a stable block. And there were pigs there, and I can remember rabbits, but I can't really remember any other livestock, but I don't think it was long since there had been. I think probably I'd just missed that.*[93]

The hospital farm loomed large in many of the interviews for this study, as it seemed to represent more clearly than anything else a bygone era in mental health care.

The network of contacts made during his training at the Maudsley continued to be an important influence after Clark's appointment as Medical Superintendent at Fulbourn. Aubrey Lewis had taken an interest in finding work for people with mental health problems, and had been instrumental in founding the Medical Research Council Unit for

[92] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.49.
[93] Transcript 23, Linda Braden née Allison.

Research in Occupational Adaptation at the Maudsley.[94] In 1955, Clark was accompanied by two former colleagues who worked in that Unit, Morris Carstairs a psychiatrist, and Neil O'Connor a psychologist, on a tour of psychiatric centres in Holland, Belgium and France.[95] The purpose of this study visit was to examine current practice in the rehabilitation of chronic psychotic patients, with a particular focus on 'work-therapy'.

They concluded that, rather to their disappointment, psychiatric rehabilitation was not more advanced in the countries they visited than it was at home. However, they believed that clinicians in all four countries were on the brink of new era:

> The new aim is to make the hospital a school for social learning where the psychotic, discarded by society as a whole, may gradually re-acquire social skills and techniques sufficient to allow him to emerge again or to live at as high a level as possible within the therapeutic community. Here it is still possible for the British mental health service to lead the way.[96]

One aspect of the tour that did impress Clark was the quality of the work undertaken in some units in Holland. The sight of patients working to market standards in assembling pens, army equipment, and wireless sets encouraged him to aim for the same kind of commercial work in Cambridge, in place of the conventional activities to service the hospital itself.[97] He brought back some samples of the work undertaken by the Dutch

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[94] D. Bennett, 'Work and Occupation for the Mentally Ill' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.197.
[95] G.M. Carstairs, D.H. Clark & N. O'Connor, 'Occupational Treatment of Chronic Psychotics: Observations in Holland, Belgium and France', *The Lancet*, 266, (1955), pp.1025-30.
[96] Ibid, p.1029.
[97] Clark had also seen a similar industrial unit at Banstead Hospital, Surrey. Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1956.

patients, and Dr Fred Houston, a junior doctor, took them around factories in Cambridge. After about thirty rejections, the manager of a local electronics factory agreed to pay for some small scale assembly work to be undertaken in the hospital. This small beginning was the foundation of industrial work for patients at Fulbourn.[98]

In a paper published in the *British Journal of Psychiatry* in 1966, Clark and E.G. (Eddie) Oram, a Research Fellow supported by a grant from the Nuffield Provincial Hospitals Trust, reviewed the development of the programme encouraging work for male patients in the hospital during the period 1954 to 1961.[99] They divided the work into five categories:

Group A – those working outside the hospital, those employed in the Industrial Unit, and those doing the equivalent of a paid worker's job in the hospital.

Group B – those working in moderately skilled jobs in the hospital for which maximum incentive money (10/- per week) was paid.

Group C – those doing unskilled work under close supervision, for which 5/- per week was paid.

Group D – unemployed.

Group E – ward workers.

[98] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.101.
[99] E.G. Oram, & D.H.Clark, 'Working for the Hospital', *British Journal of Psychiatry,* 112, (1966), pp. 997-1005.

Table 2.

Work groups of patients 1954 and 1961

Group	**1954**		**1961**	
A	5	1.5%	42	14.6%
B	50	14.8%	63	22.0%
C	96	28.6%	65	22.6%
D	132	39.3%	66	23.0%
E	53	15.6%	51	17.8%
Total	336	100%	287	100%

Table 3.[100]

Percentage of Work Groups Discharged

(Rating at time of leaving hospital or at 1961 census)

Group	**Patients at risk of discharge** (sic)	**Patients discharged**	**% Discharged**
A	38	21	55.3
B	48	7	14.6
C	64	26	40.6
D	55	14	25.5
E	42	7	16.7

As Table 2 indicates, Clark's drive to increase the number of patients undertaking useful work demonstrated positive results for three groups, particularly those in Group A holding down a waged job or its equivalent. However, Table 3 shows that a smaller number were discharged from Group B, those undertaking moderately skilled jobs within the hospital for 'pocket money'. This issue provided the focus for discussion in Oram and Clark's paper. They claimed that Group B patients often performed jobs that were essential to the running of the hospital, and that plans for their discharge were frequently frustrated by collusion between the patients and staff members.

The authors supported their argument with several case studies, such as that of G.H.:

> A married land worker, born 1911, [who] was admitted in 1953 suffering from an anxiety state with depression. He worked well on the farm and gardens [Group B jobs] and in the Carpentry Unit when this was formed [also Group B] to provide a service for the hospital. In his spare time he undertook gardening projects at the homes of staff

[100] Tables 1 and 2 are from: E.G. Oram & D.H.Clark, 'Working for the Hospital', *British Journal of Psychiatry*, 112, (1966), pp. 997-1005.

> members, being especially effective at the spring digging or the autumn clearing. He was the object of much staff zeal, and from time to time attempts were made to find him employment out of the hospital [Group A]. This produced anxiety symptoms which so upset him and those around him that plans were always dropped. He remained scowling but content, a good worker in the small select carpentry group.

To the argument that scenarios such as the one quoted above showed that patients should not be employed in hospitals, Oram and Clark replied that the therapeutic benefits derived from work made such a ban untenable. Using the language of psychotherapy, they argued that there was a group of patients with 'permanent, severe ego damage' who could work in a hospital environment but who could not cope with the difficulties of life outside. While accepting the reality of this situation, they advocated 'a number of vigorous trials' of discharge arrangements in the hope that they might eventually succeed.[101]

Miss Queenie Brock, the Matron, was an enthusiastic supporter of the new work regime:

> *The patients worked and they had their money paid out to them every week, and they could spend it in Cherry Hinton or at the hospital shop. If there was anything wrong, I put it right.*[102]

Linda Allison remembered her mother working with the patients to help them to develop work skills:

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[101] : E.G. Oram & D.H.Clark, 'Working for the Hospital', *British Journal of Psychiatry*, 112, (1966), pp. 997-1005..

[102] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.

She worked as an auxiliary nurse – and she worked on the Occupational Therapy Unit for some time, as well, I remember, when that was first set up. And they used to make things like – the little plugs in the ends of aerials. So it was actually a job of sorts. [103]

By the end of the 1960s, work for patients had become an established part of the world of Fulbourn, as Eric Kaloo remembered:

My first experience at Fulbourn Hospital as a student, it was in the days when patients lived there. They were going to work in the morning – some of them worked in the laundry, some worked in the field, some worked on the farm, and the hospital had their own animals. And some of the patients would look after the vegetable areas – the whole of the produce was used in the kitchen to feed the patients. And the patients used to get pay, I can't remember off-hand, something like two pounds a week, apart from being fed, pocket money for their cigarettes and their social activities.[104]

Several interviewees remarked on the tensions involved when patients were receiving only pocket money for working in ways that equated to the hours and tasks completed by waged staff. There was a fine line to be drawn between therapy and exploitation, although these practices were so deeply ingrained in the culture of mental hospitals that there was little serious resistance to them.

Winston House: First Step Towards Care in the Community

In a paper on national policy towards the treatment of mental illness, Busfield

[103] Transcript 23, Linda Braden née Allison.
[104] Transcript 06, Eric Kaloo.

has identified 1954 as the beginning of the era of community care.[105] She described three factors which facilitated this change in policy direction. Firstly, the in-patient population of mental hospitals reached its peak and showed consistent falls in subsequent years. Secondly, 1954 saw the establishment of a Royal Commission on the Law relating to Mental Illness and Mental Deficiency. Finally, chlorpromazine had become widely used in clinical practice for the treatment of psychotic conditions. Busfield went on to make the point that community care for people with a mental illness is a fluid concept which changes over time, but that its dominant focus in the 1950s was the 'after care' of patients discharged from hospital. While the focus of those psychiatrists developing 'open door' hospitals tended to remain fixed on developing services within the hospital, the initiative in providing after care remained with local authorities and charities.

It is significant that the original proposal for a halfway hostel in Cambridge came from Cambridgeshire Mental Welfare Association in 1956, but Clark, with his characteristic energy and enthusiasm, immediately joined the project. Funding from a national charity, the S.O.S. Society,[106] and contributions from the Association and Cambridgeshire County Council, enabled Winston House to be opened in a residential road in Cambridge, two miles from Fulbourn Hospital, in October 1958. L.W. Cooper was the warden, there were three other staff members, and the hostel had places for twelve men and eleven women. As it was based in a large Victorian house, the accommodation was not ideal. All residents slept in dormitories, so sleep disturbance was inevitable and attempts to create a homely atmosphere were hampered by the lack of privacy.

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[105] J. Busfield, 'Restructuring Mental Health Services in Twentieth Century Britain', in M. Gijswijt-Hofstra & R. Porter (eds.) *Cultures of Psychiatry* (Amsterdam, 1998), pp. 9-28.
[106] I have been unable to discover any further details of this charity.

The fact that the patients had close connections with Fulbourn Hospital meant that they tended to treat Winston House as an extension of the hospital rather than as a new beginning in the community, despite the best efforts of the staff to avoid creating an institutional atmosphere. Clark ran a weekly evening clinic, largely to review medication, but noted that no formal psychotherapy had been carried out as the residents were disinclined to form groups or even to relate to each other.

During the first year of operation, there were forty-one admissions and twenty-two discharges, but this impressive-sounding summary tends to obscure the real challenges that the staff faced. Recruitment of suitable residents proved to be problematic, many of those selected had an apathetic attitude to community life, and mental health problems tended to recur. As the authors concluded:

> The patient who gains most seems to be the schizophrenic between 30 and 45 whose illness has passed the acute stage, who has lived for a number of years in a mental hospital, and who is capable of regular work in the community but not able to achieve an independent social life, either because he lacks interested relatives or initiative.[107]

The number of patients who met these criteria was surprisingly small. The authors estimated that a mental hospital serving a population of 360,000 would only have 16 patients at any one time who would be suitable for transfer to a halfway house. So while Winston House represented an important milestone in service development, it did not represent a change which would have a major impact on patient numbers in Fulbourn Hospital.

[107] D.H. Clark& L.W. Cooper, 'Psychiatric Halfway Hostel: A Cambridge Experiment', *Lancet* 275, (1960), pp. 588-590.

Conclusion

Upon his arrival at Fulbourn in 1953, David Clark became the Medical Superintendent of what was regarded as one of the worst mental hospitals in the East Anglian Region of the NHS. He was determined to bring it into line with the most progressive practices in Britain and the United States of America, and rapidly set about implementing 'open door' and 'work for all' policies. These were never regarded by Clark as ends in themselves, as his long-term vision for the hospital was drawn from the social model in psychiatry and focused upon turning as many of the wards as possible into 'therapeutic communities'. While some of the subjects interviewed for this study regarded the discourses which Clark drew upon as having their sole origins in his own personality and priorities, this chapter has shown that while these personal factors were important, he was also influenced by national and international developments in the field of mental health.

In Chapter 5, the place of physical therapies in the Fulbourn regime will be analysed in the context of contemporary and subsequent understandings of what their use implied about the practice of psychiatry in the second half of the twentieth century.

Chapter 5: Winds of Change

Introduction

This chapter begins by examining the apparently paradoxical position of physical therapies in a hospital that became known for its commitment to social therapy. It is argued that it is necessary to see them in terms of the wider intellectual currents in psychiatry during the period 1930 to 1970. Evidence from oral history interviews outlined in Chapter 4 has confirmed that a professional discourse which combined physical, psychodynamic, and social approaches to mental health issues was referred to by its adherents as the 'eclectic model' of psychiatry. Seen from this standpoint, physical treatments were not an aberration, but simply the use of one of the available resources in the psychiatrist's armoury. These changes in therapeutic regimes at Fulbourn also had major implications for the work of nurses in the hospital. The Medical Superintendent had ultimate responsibility for nursing organisation and staffing, and Clark's early years were dominated by the struggle to recruit, in sufficient numbers, nurses of the required calibre. The hospital at this time was still a self-contained community, as many staff continued to live in accommodation in the grounds. A full range of social activities marked the 'hospital year', and these were often shared by patients and staff. This sense of a vibrant community life was a central feature of the institutional experience of both groups in the period.

The Historiographic Background

In identifying a period from the First World War to the 1950s, which he called 'Alternatives', the historian Edward Shorter has drawn attention to the sheer range of

therapies that were used by psychiatrists in that period.[1] These ranged from malarial therapy for general paralysis of the insane (G.P.I.) in tertiary syphilis, to social therapy in art groups for all patients regardless of diagnosis.[2] Shorter regarded this bewildering range of treatments as evidence of therapeutic desperation on the part of psychiatrists, and this desperation to 'do something' overwhelmed any concerns they might have had about the rationale underlying these treatments.[3]

As physical methods of treatment in psychiatry have attracted so much opprobrium in more recent years, it is important to emphasise that they were regarded in a positive light as indicators of progress in this period.[4] They were actively promoted by some of the leading psychiatrists of the period before and after the Second World War, such as Dr William Sargant and Dr Eliot Slater, both of whom were associated with the circle of Sir Aubrey Lewis at the Maudsley Hospital.[5] Indeed, Sargant and Slater's textbook on physical therapies went through three editions between 1944 and 1954.[6]

While in his many writings and interviews David Clark chose to highlight the influence of social psychiatry and therapeutic communities on the reforms he introduced at Fulbourn, these were underpinned by the consistent use of a range of physical treatments. During the

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[1] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997).
[2] Clark's predecessor, Dr J.G.T. Thomas, was remembered as having experimented with malarial therapy: Fulbourn Archives, J. Wheatley, 'Some Reminiscences and Memories in the Evolution of Fulbourn Hospital, 1927-1964'.
[3], E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 238.
[4] One influential novel, first published in 1962 (and subsequently made into a powerful film starring Jack Nicholson), which painted a negative picture of physical therapies was K. Kesey, *One Flew Over the Cuckoo's Nest* (London, 2005).
[5] J. Crammer, 'Training and Education in British Psychiatry 1770 – 1970', in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.240.
[6] W. Sargant & E. Slater, *An Introduction to Physical Methods of Treatment in Psychiatry,* 3rd edn. (Edinburgh, 1954).

1950s, and in fact throughout Clark's career at Fulbourn, most patients in the hospital received some form of physical therapy.[7] This study does not claim to have revealed a deliberately concealed use of physical and pharmacological treatments.[8] In fact, the index of Clark's book on Fulbourn contains ten references to physical therapies, and seven to drug treatments.[9] What this study does highlight, however, is the continuing role for physical therapies. They were not used merely in a temporary transition phase in the achievement of lasting change, but rather as the constant accompaniment to Clark's experiments with the use of social therapy and the establishment of therapeutic communities throughout his career in the hospital.

Physical Treatments at Fulbourn

Electroconvulsive Therapy (ECT)

The treatment of depression has always been one of the major challenges in mental health. Before antidepressant drugs became available, the prognosis was poor. As Dr Alan Broadhurst recalled:

> *In this day and age, we hardly remember that depressive illness was a very serious illness indeed, and many people with it who didn't make a spontaneous recovery, just had depressive illness on a chronic, permanent basis.*[10]

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[7] D.H Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 32.
[8] J. Adams, Conference paper: 'The Elephant in the Room: Physical and Pharmacological Therapies at Fulbourn Psychiatric Hospital, 1950 – 1970', Annual Conference of the Oral History Society (2008) University of Birmingham.
[9] D.H Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 32.
[10] Transcript 22, Dr Alan Broadhurst.

ECT had had its origins in the belief, based on both epidemiological and neuropathological studies carried out in the 1920s, that patients with epilepsy were unlikely to develop schizophrenia. In the 1930s, seizures were artificially induced in patients through the use of the drug cardiazol.[11] Two Italian psychiatrists, Cerletti and Bini, in 1938, were the first to apply electric shocks to the head of a psychiatric patient in order to induce convulsions.[12]

ECT was introduced to Britain by the German émigré psychiatrist Lothar Kalinowsky, who had studied it in Italy under the direction of Cerletti and Bini, in 1939.[13] Clark recalled first coming across ECT when serving with the British army at a temporary psychiatric treatment camp in Palestine in 1946.[14] Beresford Davies gained his MD degree from Cambridge University in 1949 with a thesis reporting his research on the technique. ECT rapidly became established at Fulbourn as a treatment for a range of conditions including schizophrenia and depression. [15] Its high profile in the hospital is indicated by the use in a nurse recruitment brochure produced in around 1960, of a photograph of ECT being administered (Appendix 1, Photograph 4).

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[11] G.E. Berrios, 'Early Electroconvulsive Therapy in Britain, France and Germany: a Conceptual History', in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), pp. 3-15. N. McCrae, ''A Violent Thunderstorm': Cardiazol Treatment in British Mental Hospitals', *History of Psychiatry*, 17 (2006), 67-90.
[12] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 220-221.
[13] U.H. Peters, 'The Emigration of German Psychiatrists to Britain', in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p. 567.
[14] D.H. Clark, *Descent into Conflict, 1945: A Doctor's War* (Lewes, 1995), p. 123.
[15] D.H Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 32. In the year 1956-57, 565 episodes of ECT were given: Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1957.

One patient who experienced depression from the 1950s onwards was Margaret Waspe. She recalled receiving ECT without an anaesthetic, in one of the outpatient clinics of Fulbourn:

> *Yes – at Lensfield Road, on this little bench. With Dr Fogarty walking in with these very elderly-looking earphones, and a little wooden box. And they'd put me on the couch, and I'd have somebody lean across me here [indicates chest] and somebody else here [indicates thighs], and then somebody else across my legs. They all had to get into position – and they'd say, 'No – a little bit further down, nurse.' Or whatever it was. And I'd say, 'Well – I think you usually come about here.' And then zing – off I went.*
>
> No anaesthetic or anything?
>
> *Not at first – no. This would be '59.*[16]

A new procedure, called 'modified ECT', using a muscle relaxant, succinylcholine, and a short-acting anaesthetic, methyohexital sodium ('Brevital'), had been developed in Sweden in 1952, but it took several years for it to be adopted in Cambridge.[17] Clark stated that by 1954, 'the majority of the treatments are modified with a relaxant', but the oral evidence indicates that it took much longer for some of his colleagues, such as Dr Fogarty, to implement these changes.[18]

> *But I hadn't had many, and then I was asked if I minded being put to sleep – because they thought it was better. So ever after, I was in fact put*

[16] Transcript 19, Mrs Margaret Waspe.
[17] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 223.
[18] Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1954.

> *to sleep. But I don't know whether I had six or ten in the first course. I was in a terrible mess – dreadful – I couldn't eat, I virtually became almost like one would say – 'Gosh, she looks anorexic' – I'm not saying I was, but I went to under six stone.*[19]

Margaret Waspe's positive memories of receiving ECT can be contrasted with those of another Fulbourn patient of that time, Doreen Bacon:

> They evidently thought I needed a boost, so set about giving me ECT. This affected me so badly that I didn't recognise my visitors at all, and wondered why no-one had come to see me.[20]

While contemporary research showed that ECT had the potential to save lives, it was not without its own dangers.[21]

Deep Insulin Coma Therapy

Another widely used physical therapy at this time was the artificial induction of an insulin coma (often referred to in the literature as 'deep insulin coma therapy' (DICT)), which was believed to be beneficial in the treatment of schizophrenia. It had been developed in the early 1930s by the Austrian psychiatrist Manfred Saykel.[22] The acceptance of this therapy by psychiatrists worldwide was very rapid, and by 1936, the Board of Control for England and Wales, the official inspectorate for mental hospitals, was actively promoting its

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[19] Transcript 19, Mrs Margaret Waspe.
[20] Fulbourn Archives: D. Bacon, *To Bedlam and Back, 1954-1972* (c.1985), p.3.
[21] A. Kukopulos, D. Reginaldi, L. Tondo, A. Bernabei & B. Caliari, 'Spontaneous Length of Depression and Response to ECT.' *Psychological Medicine*. 7 (1977), pp.625-629; A. Stoudemire, C.D. Hill, R. Morris & S.T. Dalton, 'Improvement in Depression-Related Cognitive Dysfunction Following ECT', *Journal of Neuropsychiatry & Clinical Neurosciences*. 7 (1995), pp.31-34.
[22] K. Jones, 'Insulin Coma Therapy in Schizophrenia', *Journal of the Royal Society of Medicine*, 93 (2000), pp. 147-149.

introduction. Wartime conditions, however, led to a dramatic reduction in its use due to shortages of sugar to reverse the coma, and the lack of staff to provide the required care. By the late 1940s, conditions in the mental hospitals began to improve and it was widely adopted again. The administration of DICT made major demands on a hospital.[23] It required a separate unit with high levels of medical and nursing staff.

In Fulbourn, it was prescribed for most male schizophrenics and it was carried out in the male Admission Villa.[24] Treatment was administered with increasing amounts of insulin until a deep hypoglycaemic coma was established. As this state developed, patients became very restless and severe convulsions were common. The comatose state with absent pupillary reflexes was allowed to continue for up to fifteen minutes, before being ended by the administration of sugar by either nasogastric tube or glucose solution by intravenous injection. Patients' individual reactions to the therapy could vary from day to day, and sudden drops in blood sugar in the hours after the coma had been reversed were common, so constant medical supervision and nursing care were required.

Far from being resented by the Fulbourn staff who were required to work in these challenging environments, the DICT unit engendered great enthusiasm. In place of dull routines in spartan surroundings which seemed to have little or no therapeutic impact,

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[23] In the year 1953-54, 41 patients received a course of DICT. Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1954.

[24] D.H Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 32. Fulbourn Archives, J. Wheatley, 'Some Reminiscences and Memories in the Evolution of Fulbourn Hospital, 1927-1964'.

DICT offered the prospect of active therapy which appeared to have a directly beneficial impact on patients. As Dr Oliver Hodgson, who joined the staff of Fulbourn in 1960, noted:

> *We had an active unit for insulin therapy. The nurses were very keen to get on to that. They felt that they were really doing something.*[25]

Even in the early 1960s, the DICT unit was regarded as one of the 'sights' of Fulbourn, which visiting professionals needed to see.[26] As a social work student, Barbara Prynn was required to sit at the bedside and observe DICT being given in 1961:

> *It was kind of bizarre to be asked to sit in and watch this. Particularly as – clearly, when these people were put to sleep, as it were, they didn't know there was going to be somebody sitting there watching them wake up.*
>
> Yes. And what happened during the waking up process?
>
> *Well, all I remember is that one young man sort of sat up and looked at me and said, 'Who are you?' Which is perfectly reasonable. I think they just sort of woke up and got up, and walked away. I don't know whether anything further happened.*[27]

Treatment continued on a daily basis until the schizophrenia was held to have been improved, with the upper limit of treatments being about 60. Treatments were usually administered in the morning, with afternoons given over to recreation under the intensive

[25] Transcript 12, Dr Oliver Hodgson.
[26] Appendix 1, photograph 5, was taken for a nurse recruitment brochure c1960, so it is significant that it shows a nurse taking a prominent role in administering the glucose solution.
[27] Transcript 24, Barbara Prynn.

supervision of the nurses in the unit. Despite this intensive care, the treatment remained a high risk one, as Hodgson recalled:

> *It was a very dangerous procedure, and I remember one man who nearly died, and having a frightful morning trying to reverse his coma.*[28]

It was estimated that almost one in a hundred patients did indeed die while undergoing DICT.[29] Nevertheless, DICT continued to enjoy the support of many of the most influential psychiatrists of the period. Dr Rudolph Freudenberg, who was later to become a leading advocate of social psychiatry, published a study in 1947 showing positive results.[30] Dr William Sargant and Dr Eliot Slater, from the Maudsley Hospital, were both enthusiastic supporters of DICT.[31]

One of the few hostile voices was that of a young doctor, Harold Bourne, who was working at the Fountain Hospital in south London. In a long letter to the *Lancet*, published in 1953, he argued that the weakness of the evidence in support of DICT for the treatment of early schizophrenia did not justify its use. In its place, he argued for the use of ECT. This vigorous attack on one of the mainstays of psychiatric treatment at the time drew predictably defensive responses from the leading figures in British psychiatry, including Sargant, but its conclusion proved to be a far-sighted summary of the motivation behind the profession's enthusiasm for the procedure:

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[28] Transcript 12, Dr Oliver Hodgson.
[29] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 212.
[30] K. Jones, 'Insulin coma Therapy in Schizophrenia', *Journal of the Royal Society of Medicine* 93 (2000), p. 148.
[31] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 213;

> Can anyone who is not possessed by furor therapeutica, as Freud called it, and not hypnotised by palaver, syringes, coma, and the terror of therapeutic impotence, really believe that the risk and great expenditure are worth it?[32]

The fundamental weakness of Bourne's position, however, was that the scanty research evidence available at that time did not allow any firm conclusions to be drawn and he was therefore forced to add dimensions of high risk and prohibitive cost in order to bolster his case. Yet both of these could have been acceptable if dramatic benefits could have been conclusively demonstrated. So, predictably, his criticisms were drowned out as the profession of psychiatry closed ranks in support of a treatment which seemed to promise so much.

Definitive evidence finally arrived in 1957, in a randomised controlled trial which indicated that insulin did not have a therapeutic effect.[33] Despite this apparently fatal blow to its credibility, DICT was still advocated in the 1960 edition of the leading textbook for junior doctors, *Clinical Psychiatry* by Mayer-Gross, Roth and Slater.[34] When asked to look back and consider if he could remember any occasion on which DICT in Fulbourn seemed to work, Hodgson said:

> *Well, I think that the vast amount of attention that these patients got, the fact that they were singled out for treatment, meant that you thought they were going to get better. But ……I don't think there was any evidence*

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[32] H. Bourne, 'The Insulin Myth', *Lancet*, 265 (1953), p. 1259.
[33] B. Ackner, A. Harris & A.J. Oldham, 'Insulin Treatment of Schizophrenia: a Controlled Study', *Lancet,* 272 (1957), pp. 607-611.
[34] , K. Jones, 'Insulin Coma Therapy in Schizophrenia', *Journal of the Royal Society of Medicine* 93 (2000), p. 148.

that it was more than the placebo effect if you got better. But if you'd have done a blind trial, I'm sure now we would discover it was merely a placebo effect.[35]

Something of the attraction that DICT held for psychiatrists is conveyed by Clark's positive comment recorded in his Annual Report for 1957, the year of the first conclusive evidence that it was ineffective. He wrote that, 'Despite the controversy, we feel that the Insulin Unit continues to be the best way of giving intensive physical and social therapy to early schizophrenic patients'.[36] As Shorter noted, psychiatrists were reluctant to abandon any of their expanding armoury of 'alternatives'.[37]

Leucotomy

In the early 1930s, the Portuguese neurologist Egas Moniz theorised that much mental illness was caused by damaged connections between the frontal lobes and the rest of the brain.[38] He tested this theory in 1935 by injecting alcohol into these areas of the brain of a psychiatric patient and thus performed the first frontal lobotomy. While there was some medical opposition to this procedure at first, it soon became established and this process was aided by the award to Moniz of the Nobel Prize for physiology and medicine in 1949. The operation was taken up enthusiastically in the USA, and by 1951, an estimated 18,000 patients had received it.[39] While in the USA the procedure was referred to as 'lobotomy',

[35] Transcript 12, Dr Oliver Hodgson.
[36] Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1957.
[37] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 238.
[38] J. Braslow, 'Therapeutic Effectiveness and Social Context: the Case of Lobotomy in a California State Hospital, 1947-1954', *Western Journal of Medicine* 170 (1999), pp.293-296.
[39] Ibid, p.293.

in the UK Moniz's original term, 'leucotomy' was preferred.[40] There can be little doubt that one of the factors promoting the adoption of leucotomy in the UK was psychiatrists' long-standing enthusiasm for operative procedures. Involvement in these kinds of procedures, and also with post-mortem examinations, helped to promote a sense of shared identity with other, more prestigious, branches of medicine. Psychiatrists' professional peers were unlikely to have been impressed if their role had been limited to that of mere custodians of the incurable mentally ill.

Soon after David Clark was appointed, he found himself required to undertake a post-mortem examination on a patient who had died in the hospital, because it was assumed to be part of his role as Medical Superintendent. However, while he complied on that occasion, he reflected that he did not share his predecessor's enthusiasm for the knife, and he also felt that his own lack of pathological expertise would not enable him to achieve another of Dr Thomas' aims, that of checking up on the clinical skills of his junior doctors.[41] So although the arrival of the Clark era saw an end to general surgery conducted by psychiatrists at Fulbourn, it did not negate the fact that the hospital already possessed a fully-equipped operating theatre, lying unused, in which leucotomies could be carried out. As two doctors appointed in 1960 recalled:

> *It was under the main front door to the hospital, down there.*[42]

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[40] E.D. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 226.
[41] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 61.
[42] Transcript 12, Dr Oliver Hodgson.

> *The central building there – you go in and on the left hand side are steps leading down, and that went down into the basement where there was an operating theatre.*[43]

Appendix 1, Photograph 6, shows the theatre being prepared, in a publicity photograph taken for a nurse recruitment brochure.[44] Leucotomy operations were carried out at Fulbourn on Saturdays, by a neurosurgeon, Mr Wylie McKissick, from Oxford, who brought his Theatre Sister with him.[45] An anaesthetist, presumably from the nearby Addenbrooke's Hospital in Cambridge, was also required. The final requirement was for a doctor to assist the surgeon, and that task inevitably fell to one of the junior psychiatrists at Fulbourn.

Doreen Bacon, who had been admitted with a diagnosis of 'manic-depressive psychosis' remembered the terror which it inspired:

> Then I noticed the women who disappeared sometimes came back with shaven heads, all bandaged up. 'Please God', I prayed, 'Don't let my husband sign for me to have a leucotomy!' The brain operation makes no difference, any more than the drugs or electric shocks, and the fear was preventing me from eating or sleeping.[46]

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[43] Transcript 22, Dr Alan Broadhurst.
[44] I was told by two former Fulbourn staff members, during informal talk about the progress of my thesis, that this photograph was posed purely for publicity purposes, and did not represent an actual operation.
[45] Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1957.
[46] Fulbourn Archives: Bacon, D., *To Bedlam and Back, 1954-1972* [Duplicated typescript] (c.1985).

Leucotomy began a steep decline in use on both sides of the Atlantic by the early 1950s, but its use lingered on for a few selected patients until the late 1960s, as Oliver Hodgson recalled:

> *And leucotomies were done. … what was the last time I did a leucotomy on somebody? It was certainly after Kent House opened* [i.e. 1964], *and it was a woman with a very severe obsessional state. And was scratching herself so much that she was destroying the skin and that. And we did a leucotomy on her, and the husband came to me and he – sometime afterwards – and she wasn't scratching anymore, and he said, 'Thank you for doing that operation – I wish somebody had done it a long time ago. My life has been an utter misery and now it's tolerable.' People who often go on about leucotomies, but I often think, 'Well, that was the last, and I recommend it!' About 1968, that sort of time.* [47]

Hodgson's final comment shows that he was well aware of the criticism that the operation has attracted on ethical grounds since this period.

Broadhurst too was forced to defend it against the criticisms of the current generation of trainee psychiatrists:

> *And you would be – well, you wouldn't be surprised because I'm sure you've heard this before, but it is the case that even now, people are horrified. We were talking about it in my teaching group last week, and I was asked about it and I said, you know, 'It was a very common treatment' and young doctors were saying, 'It sounds terrible, barbaric'.*

[47] Transcript 12, Dr Oliver Hodgson.

I said, 'No, it wasn't barbaric, but it just wasn't satisfactory, it wasn't successful in the vast majority of patients – except in the obsessional compulsives, in whom it did work reasonably well.'[48]

He would point out to his trainees that he did not observe personally at Fulbourn the devastating side-effects of the operation that critics highlighted:

I didn't see anybody who became, as is most commonly said to be the case, a vegetable. But a lot of people it just didn't work for and they were no better and no worse afterwards, but the small group of obsessional compulsives did do well. One still doesn't know exactly what one was cutting, to make them well, you just sort of knew it was somewhere 'down there', you know – somewhere in the frontal lobe.[49]

Broadhurst's comments could be seen as typifying the pragmatic approach of those psychiatrists who adhered to the 'eclectic model' of treatment.

Both Broadhurst and Hodgson argued that the fundamental problem with leucotomy was not the operation itself, but its inappropriate use on patients that psychiatrists despaired of ever treating.

I think it got a bad press because it was used so widely. Doctors in despair treating patients who wouldn't get better whatever they did, and you mustn't forget that, in schizophrenia and in depressive illness, a lot of patients don't get better, whatever you do. And people in despair after they've seen their patients in hospital for a couple of years – nothing else

[48] Transcript 22, Dr Alan Broadhurst.
[49] Ibid.

> *left, we'll try leucotomy. And of course I should have said that, I mean, ECT was a very important type of treatment, and having failed ECT and all the kinds of medication we had, patients were sent for leucotomy simply as an expression of despair on the part of the doctor. And then it got a bad press, because some of those people were really worse off afterwards.*[50]

Hodgson, however, recognised that a procedure as crude as leucotomy could not have a future in psychiatry:

> *But there's no doubt it was done wholesale, stupidly for the wrong reasons. I don't think, even though it was successful in some people, it was anything more than a blind alley, and that there should be other ways than cutting vigorously into people's brains, without any real idea of what you were doing.*[51]

This statement provides further evidence of what Bourne (referring to DICT) called, 'the terror of therapeutic impotence' as a factor in determining therapeutic procedures.[52] The chronic and intractable nature of many mental health problems put continuing pressure on psychiatrists to turn to any intervention which seemed to offer the possibility of improvement.

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[50] Transcript 22, Dr Alan Broadhurst.
[51] Transcript 12, Dr Oliver Hodgson.
[52] H. Bourne, 'The Insulin Myth', *Lancet*, 265 (1953), p. 1259.

The Impact of Psychopharmacology

David Clark recalled that there was little interest in drug treatments on the part of keen young psychiatrists in the early 1950s, because physical therapies such as DICT and ECT seemed to be so promising. Rather than focusing on the work going on in pharmaceutical laboratories, the emphasis of that time was on ever more complex patterns for administering physical therapies.[53] Soon after he took up his post at Fulbourn, however, Clark had made the fortuitous appointment of Dr Fred Houston to the staff. Houston was an energetic figure who was keen to support all the innovations that Clark was bringing to Fulbourn, and he was also responsible for the first published drug trial carried out at the hospital. This involved the use of the new drug Meratran (α-(2-piperidyl) benzhydrol hydrochloride).[54] Meratran had been developed in the USA as an antidepressant, and a controlled trial had claimed that a group of people suffering from chronic schizophrenia had shown greater cooperativeness and ward adjustment, but these results were not analysed statistically. Houston's paper, by means of a randomised controlled trial, showed that Meratran produced no statistically significant improvement over the placebo. The involvement of the nurses in carrying out the assessments of the patients, and the consistent interest and input by Houston, did however increase nursing enthusiasm in this chronic ward, and social scores for all patients showed an improvement. These would all be factors that would feed into later developments in social therapy at Fulbourn.

In the early 1950s, French researchers working for the Rhône-Poulenc company noticed that a new compound called 'chlorpromazine', which was intended to enhance the effects

[53] D.H Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 33.
[54] F. Houston, 'Group Behaviour in Chronic Schizophrenics Treated with 'Meratran', *British Medical Journal*, 1 (1956), pp.949-952.

of anaesthetics in cardiac surgery, had the effect of calming, or 'tranquillising', patients awaiting their surgery. Trials then showed that it was also effective in tranquilising the agitation and aggression of patients with schizophrenia, and it was claimed that by May 1953, the atmosphere in wards for disturbed patients in Parisian hospitals had been transformed and that physical restraints were no-longer needed. Reports published in French of these dramatic results reached a bilingual psychiatrist in Montreal, who alerted his monoglot English-speaking colleagues to the news.[55] By 1954, the American pharmaceutical company Smith, Kline & French began marketing it for use in psychiatry under the brand name of 'Thorazine', while in Europe it was known as 'Largactil', a name probably intended to convey a sense of 'large action'.[56] It was marketed in Britain by May & Baker, which had strong links with Rhône-Poulenc.

The introduction of chlorpromazine into clinical practice revolutionised the treatment of schizophrenia and hence played a major role in facilitating the kind of changes that Clark was introducing at Fulbourn. As Clark wrote in his Annual Report for 1955: 'It has a remarkable tranquillising effect on the disturbed wards as a whole, lessening the tension, decreasing the violent incidents, and making the patient accessible for occupational and social therapy'.[57] Dr Ross Mitchell recalled that:

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[55] E.M. Tansey, ''They Used to Call it Psychiatry': Aspects of the development and Impact of Psychopharmacology', in M. Gijswijt-Hofstra & R. Porter (eds.) *Cultures of Psychiatry* (Amsterdam, 1998), pp. 82-83.
[56] S. Gelman, *Medicating Schizophrenia: A History* (New Brunswick, 1999), p. 24.
[57] Cambridgeshire Archives, R98/9 (Fulbourn Mental Hospital Annual Reports), Medical Superintendent's Annual Report for the Year Ending 31 March 1955.

> *David's whole idea was – get rid of that, unlock the doors. He was able to do that, I think, largely as many others discovered, because Largactil/chlorpromazine had just come on the scene.*[58]

Spurred on by the obvious commercial opportunities which could be gained from a more effective treatment for 'major mental illnesses', international pharmaceutical companies turned their attention to investigating promising compounds.

One such pharmaceutical researcher was Dr Alan Broadhurst, who was working for the Geigy company in Switzerland and in the UK. Geigy scientists began re-investigating compounds they had previously developed in the hope that one of them might prove to be a more effective competitor for Largactil.

> *And following up the great discovery of chlorpromazine in the treatment of schizophrenia, we were looking at that – but at the same time, believing that chlorpromazine had many other actions too, including its use in cardiac surgery, we were looking for something else that would do something similar but without the side-effects. And in fact, as you may*

[58] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.

have discovered, my little group of three – we discovered imipramine.[59]

Which was the first anti-depressant drug.[60]

As this account indicates, the antidepressant effects of imipramine were discovered largely by accident. Geigy were investigating compounds which could be used in the treatment of schizophrenia, but which would lack the serious side-effects associated with chlorpromazine.[61]

One of these, designated G 22355, was trialled at a Swiss psychiatric hospital on patients suffering from schizophrenia. This drug trial was a disaster.

> *Several previously quiet patients began to deteriorate with increasing agitation. Some developed hypomanic behaviour. One gentleman, in such a state, managed to get hold of a bicycle and rode, in his nightshirt, to a nearby village, singing lustily, much to the alarm of the local inhabitants. This was not really a very good PR exercise for the hospital, and I can't say it endeared the hospital to Geigy either.*[62]

In the face of this apparent set-back, the research team held onto the idea that if G 22355 lifted the flat mood of patients with schizophrenia, perhaps it would also have a similar

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[59] The issue of who 'discovered' something as complex as a new drug is often a tangled affair. In the case of imipramine, the psychiatrist trialling G 22355 (imipramine) was Roland Kuhn and he is often credited as the discoverer. But accounts differ as to whether he requested the drug from Geigy, or whether the company asked him to use it. In either case, without the Geigy scientists there would have been nothing to trial, and without a clinical trial its properties would have remained unknown. E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997), p. 259, and Note 72, p. 399. Tansey acknowledges the complexity of this issue by referring to Kuhn as 'the name most frequently associated with the discovery of imipramine': see, E.M. Tansey, ''They Used to Call it Psychiatry': Aspects of the development and Impact of Psychopharmacology', in M. Gijswijt-Hofstra, R. Porter (eds.) *Cultures of Psychiatry* (Amsterdam, 1998), Note 30, p. 98.

[60] Transcript 22, Dr Alan Broadhurst.

[61] *Wellcome Witness Seminar: Drugs in Psychiatric Practice*, ed E.M. Tansey and D.A. Christie, (London, 1998), vol. 2, pp. 134-205.

[62] Ibid, p. 141.

effect in depression. Trials in Switzerland were successful, so it was clear that an important new drug had been produced.

Beresford Davies achieved a notable coup in persuading the young Alan Broadhurst, to join the hospital staff as a junior doctor.

> *And of course I came just at the moment that we had finished our research with imipramine – that was the initial research and led to its introduction into normal clinical use. And I went to work with Beresford and with David Clark – I mean, they were my two main bosses, at that time. I was in a very junior capacity, having been a very senior research scientist – I became a Senior House Officer [laughter] You have to go through the ranks, you see. But rapidly I became a Registrar. And it was very interesting, really, for me – to go to Fulbourn.*[63]

Fulbourn was one of the first locations in the UK at which imipramine was used in routine clinical practice.

> *It was not part of a clinical trial. We had already conducted clinical trials in Switzerland. Well, in fact I'd started some clinical trials in Britain as well. Martin Roth… had started doing some work for me in Newcastle, where he was working then. And so it was – a lot of double-blind studies had been carried out. 1963 – the Medical Research Council set up their own study to look at the relative merits of placebo versus phenelzine, which is a monoamine-oxidase inhibitor, and imipramine. And found that there was a very distinct improvement in patients, particularly those on*

[63] Transcript 22, Dr Alan Broadhurst.

imipramine. Certainly compared with placebo, and probably compared with phenelzine as well. But I was not doing a clinical trial…. So I was simply treating patients with it, and obviously observing them very closely and looking at results.[64]

So an effective treatment for some forms of depression was now available in clinical practice.

Although it was generally agreed that developments in psychopharmacology had made a dramatic difference to the effectiveness of psychiatric treatment, patient compliance remained a major issue. An early study by Dr Ross Mitchell suggested that only around 50% of the day hospital patients in their sample followed the instructions regarding their medication faithfully.[65] This was an issue that would come to the fore in later years, when the philosophy of the 'therapeutic community' encouraged patients to reveal their own, and others', non-compliance.

Staffing the Changing Hospital

Nursing posts in mental hospitals had many unattractive aspects. In the 1950s, violence from disturbed and psychotic patients was a routine feature of the nurse's working life. Maurice Fenn remembered one particularly frightening episode:

One of them got out of bed - I walked towards [a male patient] a couple of steps, and he hit me full on the chin. Had I known what I know now, I would have left him there, but as it was, I walked over to him, leaned over

[64] Transcript 22, Dr Alan Broadhurst.
[65] R.E. Hemphill, A.R.K. Mitchell & D.F. Dunne, 'Unreliability of Psychiatric Patients in Following Prescribing Instructions', *Journal of the College of General Practitioners,* 1 (1966), pp.65-67.

him and said, 'What did you do that for?' and he jumped up, got hold of my tie – the short bit - and pulled it, and it cut my air off. By sheer fluke a member of staff happened to come in, and he got this person's fingers off my tie. And I think he saved my life.[66]

The nursing staff faced a dilemma in dealing with violent episodes on these wards. They had to be contained, for the safety of both patients and staff, and yet the hospital authorities refused to develop protocols for dealing with violent incidents.

This consistent refusal to face up to the real managerial needs of nursing staff led to a culture of secret violence and subsequent denials. Clark only found out about the techniques they were using once they were no-longer employed:

In later years, as I got to know nurses better, they told me stories of how they'd …hmm … 'had to teach patients who was boss'. Being taken into the lavatory and given a beating is one example. This was regarded as one of the things you had to do, because it was your job [as a nurse] to see that things didn't get out of hand.[67]

A further institutional response to this constant threat of violence was to use some of the patients for security duties, as Clark discovered:

On the 'Male Disturbed Ward' at Fulbourn, there was a group of 'epileptics', who were highly privileged patients, and one of their main

[66] Transcript , BBC TV documentary, 'Unlocking the Asylum', 1996.
[67] Personal collection: N. Smithson, Transcript, 'Oral Interview with Dr David Clark', 1993.

jobs was to protect the staff from the other patients. This was so on the men's and the women's side.[68]

Clothing was sometimes adapted to counter the threat of violence. Clark recalled that:

Some of the women had to wear what were called 'locked boots', which were boots that were locked by the staff, so they couldn't take them off and throw them at people.[69]

The nursing staff developed a routine method of dealing with violent outbursts which became so embedded in the nursing culture that Nick Smithson observed its use in the 1970s:

If there were major disturbance or violence from a known patient who had a history of that particular kind of repertoire of behaviours, I think occasionally they felt they wanted to deal with it the way they always dealt with it – effectively through the combination of quick medicine injection and taking the patient off to a side ward, rather than trying to talk the person down to being calm.[70]

The issue of violence, and how to respond to it, was to be a continuing matter of concern for the nursing staff.

From the beginning of his tenure at Fulbourn Hospital, Clark realised that the number of nursing staff employed, and more importantly their quality, would be central to the success of his plans for the hospital. So he consistently took great pains to publicise the changes taking place in the hospital to a national nursing audience. In 1958, Clark published a short

[68] Personal collection: N. Smithson, Transcript, 'Oral Interview with Dr David Clark', 1993.
[69] Transcript, BBC TV Documentary, 'Unlocking the Asylum', 1996.
[70] Transcript 07, Nick Smithson.

article in the *Nursing Times*, illustrated with several photographs of the hospital and the school of nursing.[71] It was characterised by a cautious tone:

> We have today active treatment units and high hopes: money is again being made available for the treatment of the mentally ill. But centenary reflections are sobering when they make us realize that a century ago, in the same building, similar high hopes were expressed and were later forgotten.[72]

The tone of uncertainty which pervades this article is in complete contrast to the rest of Clark's writings, which are resolutely optimistic about the present and particularly the prospects for the future of the hospital, so it is likely that it reflects a transitory financial crisis.

While some of the nursing staff were aware of developments elsewhere in the country, and were determined to change aspects of the Fulbourn regime, the majority remained wedded to traditional asylum values. Clark summarised their approach as:

> *To keep things good, tidy, and orderly. And keep the door knobs polished and count the cutlery and not to lose any knives, and keep out of the way of the Superintendent.*[73]

The latter requirement was achieved at Fulbourn, as in other psychiatric hospitals, by the nurses signalling from ward to ward by tapping on the water pipes with their keys. Clark discovered that the code at Fulbourn was:

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[71] D.H. Clark, 'Fulbourn Hospital, near Cambridge: Centenary Reflections by the Medical Superintendent', *Nursing Times,* (Nov. 14, 1958), pp. 1341-4.
[72] Ibid, p.1344.
[73] Personal collection: N. Smithson, Transcript, 'Oral Interview with Dr David Clark', 1993.

One tap for the doctor, two for the chief male nurse, three for the medical superintendent.[74]

This signalling system came to symbolise, for several interviewees, the old culture of the asylum attendants which was finally ended by Clark's appointment.

The Hospital Community in the 1950s

Like most psychiatric hospitals of the time, Fulbourn was home to many members of staff, including Dr Clark its Medical Superintendent, and so an active community life developed amongst the resident staff.[75] Linda Allison was the daughter of the hospital engineer. The children of the resident doctors provided other playmates for her:

And there were various doctors that were deputies, or something, that lived there. And they had children. And Dr Buttle as well – who lived somewhere facing the sports ground. I remember him and his children there.[76]

With all these social connections between individuals and families, the boundaries between work and leisure were inevitably blurred. The social life of the hospital, for both patients and staff, followed a regular routine:

And there was also a weekly cinema, which again, I'm sure was just for the patients. But somehow or other, I got to see all the James Bond films – that I shouldn't have seen! [laughter] In those days, we used to sit at the back and watch, while the patients would all be sitting in seats in

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[74] Personal collection: N. Smithson, Transcript, 'Oral Interview with Dr David Clark', 1993.
[75] Griffin's PhD thesis has examined the various meanings of 'community' in St Crispin Hospital, Northampton: R.J. Griffin, 'Concepts of Community in Mental Health, 1935 to 1965: A Modified Grounded Theory Approach used with Oral History and Other Sources' (De Montfort Univ. Ph.D. thesis, 2005).
[76] Transcript 23, Linda Braden née Allison.

front of us. And again, we weren't fazed by the fact that we were in a room full of patients. And that was lovely. I think that Jennie Glen, from the Gatehouse, and I used to go to that, on a regular slot.[77]

This evidence of staff and patients mingling for social events in the hospital is supported by Linda Allison's memories of the dances in this period:

I can remember learning things like the 'Gay Gordons' – so I must have had the strangest background, when I was a child. I can remember learning all those things like the waltzes and those sorts of things. And I did actually dance with the patients – because there wasn't really anybody else to dance with…. And again, my Mum and Dad weren't at all worried about it. I can't remember them being there with me. I'm sure they knew where I was, but I can't remember them being there at all.[78]

This quotation conveys a sense of the security felt by parents to be present in the hospital community at this time.

Changing Social Attitudes to the Mental Hospitals

Legislation continued to play an important role in forming and reinforcing public attitudes to mental health problems and their treatment. When David Clark arrived at Fulbourn, the main piece of legislation governing the operation of the hospital was the Lunacy Act of 1890.[79]

For a person to be certified, two doctors had to give certificates, and then a Justice had to see the person to commit them. You know, some of our

[77] Transcript 23, Linda Braden née Allison.
[78] Ibid.
[79] K. Jones, *A History of the Mental Health Services* (London, 1972), pp.176-181.

Management Committee used to do this. I can remember someone said, 'Oh I hated it, doctor, I really don't like [it]', and others would say, 'Yes, I've been doing this for ten years, I've got a pretty good nose for one that ought to come to you, doctor – I pick 'em carefully! Sometimes I'd say, 'No, no, can't send that one!'.[80]

Minor modifications to the 1890 Act had been put in place by the Mental Treatment Act of 1930. As well as abolishing official references to 'pauper lunatics', this Act made provision for voluntary treatment and so began the slow process of social change that lessened to some extent the stigma associated with mental treatment. [81]

Clark was well aware of the impact that this had had on hospital populations:

But of course, the development of voluntary patient status, informal admissions, that was already beginning to change it, because they were coming to be the majority of the people coming in……'[82]

In 1959, a new Mental Health Act made compulsory detention a medical decision, rather than one for local magistrates. It also abolished the distinction between general and mental hospitals, and sought to encourage community care.[83] Social workers were also affected by the 1959 Act, as Barbara Prynn recalled:

And one of the other things – I mean, this was not very long after the introduction of the 1959 Mental Health Act – so there was a lot of

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[80] Transcript 2, Dr David Clark.
[81] K. Jones, *A History of the Mental Health Services* (London, 1972), pp.249-252; C. Webster, *The Health Services Since the War: Volume 1: Problems of Health Care: The National Health Service Before 1957* (London, 1988), p.9.
[82] Transcript 2, Dr David Clark.
[83] Mental Health Act, 1959 7 & 8 Elizabeth II c.72.

> *discussion in the Social Work department and also with the medical staff, about the implications of that and so on. So I learnt those kinds of things.*[84]

This comment emphasises the fact that while mental health legislation sets broad principles for its implementation, its detailed implementation was left to the professionals concerned.

The national forum for the discussion of issues affecting the psychiatric hospitals was the Annual Conference of the National Association for Mental Health. The Minister of Health of the day customarily gave an anodyne address at the Conference, providing news of new policy developments. In 1961, this convention was shattered by the speech given by Enoch Powell, which has come to be regarded as one of the key turning points in the history of mental health policy in England.[85] Instead of congratulating delegates on their implementation of the 1959 Mental Health Act, the Minister stunned them by stating that only half the existing hospital beds would be required by 1976, a reduction of some 75,000 places. The implications of this policy change were spelt out in stark terms:

> [This policy implies] nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand today. This is a colossal undertaking, not so much in the physical provision which it involves as in the sheer inertia of mind and matter which it requires to be overcome.[86]

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[84] Transcript 24, Barbara Prynn.
[85] K. Jones, *A History of the Mental Health Services* (London, 1972), pp. 321-4. K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), pp. 159-164.
[86] K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), p.160.

The politician who could never resist the use of highly coloured language, (his 'rivers of blood' speech on immigration would become notorious in later years)[87], then delivered what has come to be regarded as the poetic obituary of these doomed institutions in terms reminiscent of medieval siege warfare:

> There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside – the asylums which our forefathers built with such immense solidity. Do not for a moment underestimate their power of resistance to our assault. Let me describe some of the defences which we have to storm.[88]

Reaction to this speech, from the assembled senior psychiatrists, administrators and academics, was mixed. Some psychiatrists believed that the advent of 'the pharmaceutical age' meant that hospital closures were now inevitable.[89]

By contrast, Dr Clark, who was in the audience at the Conference, was reported as urging caution:

> That the mental hospitals were finished and had nothing further to contribute had been said before over the last twenty years. He would like to remind everyone of the revolution which had taken place in British psychiatry during the past decade which had originated in the mental

[87] Powell actually said: 'As I look ahead, I am filled with foreboding; like the Roman, I seem to see "the River Tiber foaming with much blood."' E. Powell, 'Rivers of Blood Speech', *Daily Telegraph* 6 November 2007.
[88] K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), p.160.
[89] Ibid, p.162.

> hospitals, and that it was the hospitals which had led the world by their work in getting patients back into the community. He was particularly worried about two implications arising from the speech: did it mean that there was to be no further upgrading in mental hospitals? Was a running down process intended? That must not happen. Squalid conditions still endured in many mental hospitals.[90]

A subsequent visit to Fulbourn provided a surprise for Enoch Powell. Dr Hodgson recalled taking the Minister around the hospital on a tour:

> *The then Minister of Health, Enoch Powell, came on a visit, and I took him round and I explained that we had managed just to open the 'disturbed ward'. And one of the nurses was standing in front of a side room, and I think he thought we were just pulling wool over his eyes, and he said, 'What is behind that door?' – I think expecting to find some raging lunatic. Well, all he found was a nice little bedroom where one of the patients had managed to get himself so that he could have a bit of privacy. And there was a nicely-made bed and magazines, books, and that. So poor Enoch Powell began to realise how much could be done about emptying hospitals!*[91]

This was a fortuitous reminder for the Minister of Clark's view that mental hospitals could provide a supportive environment for patients who were awaiting the development of community-based resources.

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[90] K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), p.160.
[91] Transcript 12, Dr Oliver Hodgson.

While accepting that patient numbers were falling, Hodgson believed that the Ministry of Health carried the process of extrapolating the trend into the future too far:

> *There was a steady decline in the number of patients on long-term care, and [it] gradually came down. Unfortunately, civil servants at the Ministry got the idea that as the number was dropping, at some finite point in the fairly near future it would come to nothing, and therefore they could empty the hospitals and sell them off, etc.. But with the knowledge that we had then, and I think have now, still, it's not quite possible to empty hospitals. There are some people who become chronic, and need chronic care, need long-term care because of their chronicity, and need some protection from the world.*[92]

One interviewee highlighted for me the irony inherent in this situation. Many patients had been compelled to enter mental hospitals against their wishes, and then with the precipitate implementation of this policy, many who did not wish to leave were compulsorily discharged.

While Clark's first decade as Medical Superintendent of Fulbourn had seen a major change of direction for the hospital, old routines reinforced by the architecture of the hospital, proved resistant to reform. The final door may have been unlocked in 1958, but the layout of the hospital had the effect of reminding staff of the traditional regime for several years to come.

[92] Transcript 12, Dr Oliver Hodgson.

Big airing courts, I remember them outside. The metal railings and the male patients on one side of the hospital, and female patients on the other, and out in the airing yards walking round and round in circles. Yes, that was mid-sixties.[93]

As Ross Mitchell's comment indicates, changes to many outward aspects of the hospital regime were still not visible when he took up his Consultant post at Fulbourn in 1966.

Conclusion

Physical treatments such as DICT and leucotomy are sometimes regarded today as little better than barbarous assaults on patients, while ECT and pharmacological therapies continue in use, but remain controversial.[94] Rather than being aberrations to be discarded once therapeutic communities were established, however, they were in reality continuing features of Clark's regime at Fulbourn. This evidence from Fulbourn provides considerable support for Shorter's identification of the period before the 1970s as encompassing 'alternatives'.[95] Psychiatrists who were desperate to improve outcomes for their patients took up with enthusiasm each new physical mode of treatment that became available, without much apparent concern for the potential conflicts between paradigms that the use of, say, psychotherapy and leucotomy, implied. While in his many writings and interviews David Clark chose to highlight the influence of social psychiatry and therapeutic

[93] Transcript 03, Dr Ross Mitchell.
[94] D. Tantam, 'The Anti-Psychiatry Movement', in G.E. Berrios & H. Freeman, (eds.) , *150 Years of British Psychiatry, 1841-1991* (London, 1991), p.341; A. Scull, *The Insanity of Place/The Place of Insanity: Essays on the History of Psychiatry* (Abingdon, 2006), p.135.
[95] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997).

communities on the reforms he introduced at Fulbourn, these were in fact underpinned by the consistent use of a range of physical treatments and medication.

During the 1950s, and in fact throughout the following decades, most patients in Fulbourn received some form of physical and/or pharmacological therapy.[96] What the oral evidence does do, however, is to move physical therapies and medication from a peripheral and diminishing role in the hospital regime, to a much more central and on-going one. Physical therapies were not the precursor to social therapy: they consistently underpinned its practice.

While Shorter referred to this willingness to embrace a wide range of therapeutic interventions as 'alternatives', the term which emerged from several interviews for this study was 'eclectic'. Dr Alan Broadhurst was one of those who emphasised the importance of that term:

> *I can't remember that [David Clark] ever referred anybody for leucotomy, but he was very eclectic. And I want to make that point clearly. Again, probably it was because of his influence that I became eclectic – and wanted to borrow the best of all treatments, regardless of what they were. And David was much the same.*[97]

This 'eclectic approach' to psychiatry characterised the Fulbourn regime from the 1950s to the 1980s. While colleagues like Broadhurst might have characterised Clark as sharing their eclectic approach to treatment, Clark regarded himself as supporting a social model which

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[96] D.H Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 32.
[97] Transcript 22, Dr Alan Broadhurst.

saw the therapeutic community as its ultimate expression. The process by which he came to establish therapeutic communities at Fulbourn will be analysed in Chapter 6.

Chapter 6: Hereward House and Westerlands: The Creation of a 'Therapeutic Community Proper'

Introduction

This chapter aims to explore David Clark's reform of the wards for 'disturbed' patients at Fulbourn, based on the oral testimony of the staff who worked on them.

It will analyse the ways in which the discourses concerning 'social therapy' in psychiatry shaped practice in one clinical setting. While Clark was influenced by other psychiatrists of the period, the unique features of the regime at Fulbourn will be highlighted. Ward regimes are largely intangible, but oral history can play a crucial role in collecting the subjective opinions of those who experienced them. The consistency of those opinions, and of the language used to frame them, can provide the evidence to recreate what would otherwise be lost to the historian.

Origins of the Therapeutic Community Concept

In 1953 - 54, his first year at Fulbourn, David Clark was very conscious of the need for fundamental change in the hospital, but was uncertain of the form that a new regime should take. Inspiration came in the form of a World Health Organisation report on *The Community Mental Hospital.*[1] This document had been produced by a working party of specialists from around the world, including the French psychiatrist Dr P Sivadon, and Dr T P Rees from Warlingham Park Hospital in Surrey. The particular phrase which caught Clark's attention referred to the role of the hospital as being that of 'a therapeutic

[1] World Health Organisation, *The Community Mental Hospital: Third Report of the Expert Committee on Mental Health* (Geneva, 1953).

community'.[2] Subsequent developments in the creation of therapeutic communities at Fulbourn can therefore be seen, not just as the result of one doctor's personal mission to improve mental health care, but in the far broader context of the international agenda in psychiatry at the time.[3]

As early as 1955, in an address to the annual general meeting of the Cambridgeshire Mental Welfare Association, Clark had made it clear that he regarded the 'open door' hospital as no more than a preliminary stage in the progress towards the establishment of therapeutic communities within mental hospitals. Surprisingly, the *Lancet* article published in 1956, which gave wider currency to his views, cited the work of Sivadon and Rees, rather than that of Maxwell Jones, who was generally regarded as the leading pioneer in the therapeutic community movement and with whom Clark was on friendly terms.[4] Clark summarised the role of the therapeutic community as:

> The reform of desocialisation and the reform of interpersonal relations. This means that great stress is laid on what the patient does and what is done to him.[5]

Its aim would be to train patients to return to the community outside the hospital, and that was to be achieved by fostering individuality, and restoring trust through access to the things usually restricted by mental hospitals, such as knives and mail. Patients would be given responsibility for running ward committees and organising self-government, and would be expected to take part in work-related activities. Finally, interpersonal emotional interactions would be fostered. Such a programme would place

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[2] World Health Organisation, *The Community Mental Hospital: Third Report of the Expert Committee on Mental Health* (Geneva, 1953), p. 18. D.H. Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), pp.88-89.
[3] D.F. Hooper, 'Changing the Milieu in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.111-122.
[4] D.H. Clark, 'Functions of the Mental Hospital', *Lancet*, 268 (1956), pp.1005-1009.
[5] Ibid, p.1008.

great stress upon the role of the psychiatric nurse as 'the specialist in interpersonal relations'. Those nurses who were SRNs would be required to resist their 'natural tendency' to force the patient into a state of 'infantile dependence' upon them, and in a comment which demonstrates Clark's unique vision of the breadth of the therapeutic team, administrative and works staff would be required to 'abandon patronising attitudes to the patients' and become part of the therapy team.[6]

First Steps: 1950s

Once Clark had mapped out the direction in which he wanted to take the hospital, it was time to make the first changes. In 1956, a substantial upgrading of many of the wards took place, and Clark seized the opportunity to focus on the changes taking place in the women's refractory ward.[7] This had been a locked ward containing about 50 patients, which was segregated from the rest of the hospital, and its only furnishings were long tables and hard benches. Most patients remained unoccupied throughout the day, the staff operated a rigid hierarchy (consisting of staff, 'good' patients, and 'bad' patients) and had little interaction with the patients, and visitors were not allowed onto the ward. Any meetings between patients and visitors took place in a controlled environment elsewhere.

As part of the reorganisation of the hospital, it was renamed 'the women's disturbed ward' (or more officially, Ward F5) and moved into the central hospital building. The new accommodation was re-decorated and furnished with curtains, rugs on the floor, and comfortable chairs. Staff from outside the ward, such as occupational therapists, began to encourage the patients to take part in activities, and eventually the doors were

[6] D.H. Clark, 'Functions of the Mental Hospital', *Lancet*, 268 (1956, p.1009.
[7] D.F. Hooper, 'Changing the Milieu in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.111-122.

unlocked, seclusion was used less often, and visitors were allowed on the ward. These developments provided Clark with an opportunity to bring in a researcher to conduct a study of the effect of these changes on the ward population. In planning such a study, Clark was following a tradition established in the 1930s by American psychiatrists who supported the 'social psychiatry' movement, and which had been brought to the UK by Clark's friend, Maxwell Jones.[8] The idea that any such changes should be subject to rigorous evaluation by a researcher with a background in one of the social sciences had therefore become an accepted part of establishing a therapeutic community, and it set a pattern that Clark was to repeat throughout his time at Fulbourn. For this initial study at Fulbourn, Clark obtained a grant from the Mental Health Research Fund and was able to employ Douglas Hooper, a psychology graduate from Reading University, to complete a PhD and publish papers from this study.[9]

For his study of the women's disturbed ward, Hooper was largely restricted to using 'before' and 'after' measurements, taken in 1957 and 1959, in an attempt to quantify the effects of the changes that had occurred.[10] The total number of patients on the ward, and their diagnoses, remained stable over the period of study [Table 4].

[8] R.N. Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community* (London, 1960).
[9] D.F. Hooper, 'Change in a Mental Hospital: A Social Psychological Study' (Cambridge Univ. Ph.D. thesis, 1960-1961). D.F. Hooper, 'Changing the Milieu in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.111-122. D.H. Clark, D.F. Hooper, E.G. Oram, 'Creating a Therapeutic Community in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.123-147.
[10] D.F. Hooper, 'Changing the Milieu in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.111-122.

Table 4: Diagnoses of patients[11]

Diagnosis	**1957**	**1959**
Mental defective and psychosis	11	11
Epileptic and psychosis	3	3
Manic/Depressive	7	6
Schizophrenic	23	26
Senile dementia	6	1
Psychopathic	0	2
Total:	50	49

The mean length of patients' stay in the hospital also did not change significantly (14.7 years in 1957; 14.1 years in 1959). One aspect of the ward that did change significantly over the course of the study ($p < 0.01$) was the treatment regime. This was the period when the newer tranquillizers, such as chlorpromazine, came into use at Fulbourn, initially to supplement older drugs such as sodium amytal and paraldehyde. Electro-convulsive therapy (ECT) also played an increasing role in treatment [Table 5].

Table 5: Individual treatments for 'disturbed ward' patients[12]

Treatment	**1957**	**1959**
Tranquillizers and/or ECT	10	20
As above, plus sodium amytal or paraldehyde	14	18
Sodium amytal or paraldehyde alone	14	2
No treatment	12	9
Total:	50	49

While the observational aspect of the study showed some improvement in levels of behaviour and an increase in interactions, these were modest. The clear distinction

[11] D.F. Hooper, 'Changing the Milieu in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.111-122.
[12] Ibid, p.114.

between so-called ‘good’ and ‘bad’ patients continued to be seen, with the former deriving most observable benefit from the changes.

While the study on F5 Ward was still underway, Dr Eddie Oram, an experienced registrar, took over medical responsibility for a women’s convalescent ward (Adrian ward). He immediately asked Dr Clark if he could turn the ward into a therapeutic community.[13] Clark recalled that he was rather nervous about letting a junior doctor take such a radical step, but the support of the Matron, Miss Brock, and the opportunity to appoint a new Ward Sister, Kay Kinnear, gave him the reassurance he needed. In order to prepare him for his new role, Dr Oram was sent to the therapeutic community at Belmont Hospital, to observe the work of its pioneer Maxwell Jones at first hand.

Defining the Therapeutic Community

Unlike the many physical treatments of the period, such as insulin coma therapy and leucotomy, which were clearly defined and potentially measurable, the therapeutic community remained difficult to define and largely resistant to attempts at measurement. In their concern to promote this form of treatment to their peers, psychiatrists who were convinced of its merits fell back on largely anecdotal accounts of community life.[14] Social networks therefore became important in acting as routes for the transmission of concepts and practical experience, and these flourished from the first experiments during the Second World War. Maxwell Jones himself set up his first therapeutic community at Mill Hill in 1939 [as described in Chapter 4]. Another war-time experiment occurred in 1943 at the Northfield Military Hospital in Birmingham, as

[13] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), pp.165-168.
[14] Clark himself wrote that they ranged from the ‘sober descriptive to enthusiastic journalism’. K. Myers & D.H. Clark, ‘Results in a Therapeutic Community’, *British Journal of Psychiatry*, 120 (1972), p.55.

developed by the psychoanalyst Dr Wilfred R. Bion.[15] Faced with poor morale and slovenly conduct in a rehabilitation ward for military personnel, Bion instituted a daily 'parade', at which the patients were encouraged to begin to take responsibility for the running of the ward. Bion depicted the problems of the ward in psychoanalytical terms as a neurosis affecting the whole unit.[16] So just as in individual psychotherapy, where the therapist took an unobtrusive role so as not to inhibit the client, Bion refused to reduce anxiety within the group by taking on the role of decision-maker. Under this regime, the standards visible on the unit improved markedly, but after only six weeks, Bion was posted elsewhere and the 'first Northfield experiment' came to a premature end. This set-back did not, however, spell the end for the philosophy at Northfield. For a period of eighteen months, Dr S.H. Foulkes and Dr Tom Main re-established a 'second' therapeutic community, but they had learnt from Bion's experience that great attention needed to be paid to explaining these novel developments in psychiatric practice to staff in the rest of the hospital.[17] This would be a lesson that Oram and Clark were later to apply in the context of the regime changes at Fulbourn.

After the War, Maxwell Jones set up another therapeutic community at Belmont Hospital in Surrey, focusing on returning individuals with a poor employment record to work. Each weekday at Belmont, patients followed a deliberately structured pattern: [18]

(1) Breakfast completed by 08:00.

(2) 08:00 – 09:00: tidying the ward.

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[15] M.F. Ettin, B.D. Cohen & J.W. Fidler, 'Group-as-a-whole Theory Viewed in its 20th century Context', *Group Dynamics: Theory, Research and Practice*, 1 (1997), pp.329-340.
[16] D.W. Millard, 'Maxwell Jones and the Therapeutic Community' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), pp. 581-604.
[17] Ibid, p. 588.
[18] M. Jones, *Social Psychiatry: A Study of Therapeutic Communities* (London, 1952), p. 29.

(3) 09:00 – 10:00: Monday: Unit conference where patients can air their grievances and make constructive suggestions; Tuesday: Films dealing with job training and rehabilitation; Wednesday and Thursday: Discussion group led by a member of the Unit staff; Fridays: Psychodrama.

(4) 10:00 – 12:00 and 14:00 – 16:00: Work in the hospital or outside.

(5) 16:00 – 19:00: Those patients considered well enough were given a pass to leave the hospital grounds.

(6) 19:00 – 21:00: Social programme organised by a committee elected by the patients.

(7) 21:00: Bed time.

The daily programme for patients was one of the few tangible elements of the therapeutic community at Belmont, but of course it can give little information about the actual quantity and quality of the interactions that patients experienced. Despite Jones' claims to have developed a conceptual model for his therapeutic community, later critics have considered it to be inadequately conceptualised and shaped by social forces rather than by scientific imperatives.[19] Central to the success of Belmont was Jones' own charismatic personality, and this could also be deployed to great effect outside its gates. As David Clark recalled, 'After a visit from Max, a hospital would be reverberating for weeks with new ideas and challenges'.[20] On his return from observing Maxwell Jones' work at Belmont Hospital, Oram drafted eight aims for the new therapeutic community and his own role within it:[21]

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[19] N. Manning, *The Therapeutic Community Movement: Charisma and Routinization* (London, 1989), p.198.
[20] D.H. Clark, 'Therapeutic Community Memories: Maxwell Jones', *PETT Archive and Study Centre Publications*, 2, 2 (2005), p.5.
[21] D.H. Clark, D.F. Hooper & E.G. Oram, 'Creating a Therapeutic Community in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.123-147. In this paper, the location is thinly disguised as 'Darien ward'.

(1) To clarify the ward's aims and methods.

(2) To provide a framework in which these aims could be accomplished, which would survive staff changes, rapid patient turnover, and variable time from the medical officer.

(3) To use the nurses' personalities and psychiatric training, making the ward sister the pivot of the scheme, since her relationship with the ward, in time, was most constant.

(4) To encourage nurse/patient interaction and self-government by patients.

(5) To reduce formality.

(6) To analyse ward happenings to provide insights for staff and patients.

(7) To improve relations with the admission ward and the hospital as a whole.

(8) To give support and theoretical instruction to the staff when requested by them, but not direct instruction as to how they were to manage any particular situation.

Aims four, five and six represented core principles for establishing a therapeutic community. The seventh one reflected a particularly important aim for Adrian Ward. Even though it was located in one of the newest villas on the Fulbourn site, other staff in the hospital remained suspicious and hostile towards it, and so patients were often reluctant to be transferred there. To counteract this problem, Clark had asked Douglas Hooper to study the ward's statistics and interview staff throughout the hospital. This demonstrated that the hostility felt by many staff members at Fulbourn was based upon mistaken assumptions about the ward, so a determined public relations campaign was

undertaken, but with limited success. Once Oram began to make changes on Adrian Ward, he asked Hooper to meetings as an observer, so that the ward could benefit from his disinterested research expertise. Following further discussions, Oram and Kay Kinnear, the ward sister, agreed on a programme for the ward:[22]

(1) General ward meeting once weekly for patients and interested staff.

(2) General staff meeting once weekly.

(3) Division of patients into three alphabetical groups with one weekly discussion period for each group. The groups were composed in this random fashion because they were not to be psychotherapeutic in the ordinary sense of the word.

(4) Ward staff (including doctor) meeting twice weekly for discussion of ward events and individual cases. The ward to continue to accept all those patients transferred and to work with the staff it was given.

This programme of activity for the ward was markedly less intensive than the one that Oram had observed at Belmont Hospital. Maxwell Jones' regime was founded upon a programme that filled each weekday. Despite this more limited beginning, the initial period in which the concept of the therapeutic community was put into practical operation proved to be an anxious time for both patients and nursing staff. The replacement of the rigid traditional philosophy of following medical instructions by seemingly formless and inconclusive meetings proved to be deeply unsettling for all concerned. Matters came to a head with the discovery of a fire early one morning in the patients' lounge. It was believed that it had been started deliberately, although the culprit could not be identified with certainty. While the excitement engendered by the

[22] D.H. Clark, D.F. Hooper & E.G. Oram, 'Creating a Therapeutic Community in a Psychiatric Ward', *Human Relations*, 15 (1962), pp.128-129.

fire temporarily increased a sense of communal feeling on the ward, it also served to confirm the negative views of other hospital staff about the decline of standards.

Ward meetings soon returned to their former pattern of an hour's gloomy silence, but Dr Oram persevered. His next initiative focused on the need to reduce formality. At one ward meeting, to the consternation of those present, he referred to the Sister as 'Kay'. This deeply symbolic action provoked a strong reaction from the ward staff, and a deputation subsequently came to him to protest at such undignified conduct in front of patients. However, despite these concerns, the ward staff started to use first names in front of patients, but Oram noticed that his was not used. As time went by and further experience was accumulated, Oram came to realise that he had made a serious mistake in not establishing individual activity plans for each patient. The message that the dismantling of the authority structure had given to the patients was that nothing was being put in its place, so participation in therapeutic activity of all kinds dwindled markedly.

Another problem that the new regime posed was that of keeping the ward acceptably clean and tidy. Housekeeping activities had now become the responsibility of the patients, but an inspection visit by the Matron prior to an Open Day caused a crisis of confidence when Adrian Ward was deemed unacceptable for public display. As a result, Sister took back responsibility for domestic tasks and a staff rota was re-established. The issue of non-compliance with domestic tasks was to prove an enduring problem as the therapeutic community philosophy was adopted more widely at Fulbourn. Despite these and other setbacks, and frequent changes of personnel, the ward continued to be run in a broadly permissive style. However, these factors probably had an impact on the

effectiveness of the new regime, and while a trend towards shorter lengths of stay was apparent in the wake of the changes in the ward, other measures were inconclusive.[23]

Oram himself drew four lessons from the experience:[24]

(1) Staff and patients regarded events on the ward as moral issues rather than as psychiatric ones. So concepts of reward and punishment remained important.

(2) Changing surroundings, such as selecting a previously unused venue for ward meetings, helped to change attitudes and interpersonal relations.

(3) Individual psychotherapy proved to have a disruptive impact on the ward, as it tended to reinforce the view that some patients were favoured over others.

(4) Change initiated by a junior doctor provoked irritation from both senior and junior colleagues at the 'inconvenience' caused.

Californian Interlude

While stimulating innovations like the 'open door' policy, the promotion of work for patients, and Oram's attempt to turn a traditional ward into a therapeutic community, seemed to Clark to represent a coherent policy of advance for the hospital, they clearly lacked an overarching label to link them together. There was also a need to re-claim a central role for senior psychiatrists in a hospital environment that increasingly rejected traditional roles and lines of authority.

[23] D.H. Clark, D.F. Hooper & E.G. Oram, 'Creating a Therapeutic Community in a Psychiatric Ward', *Human Relations*, 15 (1962), pp. 128-129.
[24] Ibid, p. 141.

In casting about for such a label, Clark had settled on the term 'administrative therapy', which he adopted from a book of that title published by W. Bryan in 1937. Clark then used the phrase in the title of a talk given to the psychiatry section of the Royal Medico-Psychological Association [the forerunner of the Royal College of Psychiatrists] in 1957, which was published in the *Lancet* in 1958.[25] Clark, no doubt influenced by his training under the pioneer of group therapy, S.H. Foulkes, argued that the next stage in the progression from individual psychotherapy to group therapy should be therapy for the hospital as a whole. Therefore he regarded administrative therapy as treatment for an entire institution, and he went on to identify its four main facets:[26]

(1) Organisation of the patient's life

(2) Staff organisation

(3) Medical organisation

(4) Community leadership

The *Lancet* paper was re-published in revised form in the *American Journal of Psychiatry* in 1960, and this brought Clark's work at Fulbourn to the attention of an American audience and he was invited to undertake a six-week lecture tour, from New York to California, in October 1961.[27] The warm reception that he received in the USA motivated him to apply for a year's sabbatical stay at the Center for Advanced Study in Behavior Sciences at Stanford University near San Francisco, and as his application was successful, he and his family spent August 1962 – August 1963 on the other side of the Atlantic.

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[25] D.H. Clark, 'Administrative Therapy: Its Clinical Importance in the Mental Hospital', *Lancet*, 271 (1958), pp. 805-808

[26] Ibid, p. 807.

[27] D.H. Clark, 'Principles of Administrative Therapy', *American Journal of Psychiatry*, 117 (1960), pp. 508-510. D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 181.

This period of study, with its generous financial support, enabled him to meet many of the leading American figures in the fields of humanistic psychology, sociology and social psychiatry, such as Erving Goffman, Ken Kesey (author of *One Flew Over the Cuckoo's Nest*) and to restore his contact with Maxwell Jones.[28] Jones had pioneered social therapy through the creation of a 'therapeutic community' at Belmont Hospital, Sutton, Surrey, but by this time he was working at the State Hospital in Salem, Oregon. Erik Erikson and Carl Rogers were both Fellows during Clark's stay in Stamford, and he got to know each of them. In later years, Clark recalled that Erikson 'used to reminisce about summer holidays with the Freud family. He would bubble off in all directions about anything and anybody'.[29] The aspect of Rogers' personality that struck Clark most forcibly was his refusal to write book reviews on the grounds that it would require him to be negative and critical. Rogers believed very strongly that his role should be a positive one in helping people discover their potentialities rather than highlighting their weaknesses and failures.[30]

The major product of Clark's year at Stanford was his book *Administrative Therapy*, published in 1964.[31] This work appeared as the ninth in the series *Mind & Medicine Monographs*, edited by Dr Michael Balint, the pioneer in the application of techniques drawn from psychotherapy to the patient consultation, particularly in general practice. The theme of the series was stated to be, 'the physiological and the human and emotional problems that arise in the course of work with ordinary patients'. The larger format of a book enabled him to develop at greater length issues outlined in his earlier

[28] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.183.
[29] B. Barraclough, 'David Clark' in G. Wilkinson (ed.), *Talking About Psychiatry* (London, 1993), p. 94. The interview was conducted in 1985.
[30] B. Barraclough, 'David Clark' in G. Wilkinson (ed.), *Talking About Psychiatry* (London, 1993), p. 94.
[31] D.H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community* (London, 1964).

papers. Clark was clearly aware of the apparent conflict between the two terms in the book's title, and sought to justify their linkage:

> I have called it 'Administrative Therapy' because it combines two activities often seen as antagonistic, namely psychotherapy – the positive treatment of patients by psychological means – and administration – the daily business of planning, conferring, sitting on committees, and dealing with regulations and paperwork. I define administrative therapy as the art of treating patients in a psychiatric institution by administrative means or as the art of fulfilling the true doctor's role in a therapeutic community.[32]

The term therefore reflects Clark's position as the Medical Superintendent of Fulbourn, creating the conditions under which psychotherapy can take place, rather than necessarily providing the therapeutic input himself.[33] Indeed, the final section of the book confronts a major issue for psychiatrists in a self-governing community whose members provide the therapy through their meetings: what role is there for the doctor? Clark's answer was to state that the medical role is that of the facilitator.

The opening chapters of the book outlined some of the key developments in recent psychiatric hospital practice, culminating in the four 'milieu therapies': work therapy, open doors, therapeutic communities and social psychiatry. The next three chapters concerned the role of the doctor in administrative therapy. Clark accepted that role change was challenging, but argued that it was essential:

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[32] D.H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community* (London, 1964), pp. ix-x.

[33] The phrase 'administrative therapy' has a long history in psychiatry. Kathleen Jones has recorded its use in 1861. K. Jones, *A History of the Mental Health Services* (London, 1972), p.155.

> As a doctor becomes an administrative therapist his own self-image will change: he will learn to see himself not as the omnipotent medical expert (an image fostered by the general teaching hospitals, in surgical firms and other situations) but as a member of a team, a member with high skills, but nevertheless just a member. He will learn to think in terms of 'we' not 'I' and learn a certain amount of humility. This sounds reasonable, but is in fact difficult for most doctors.[34]

Clark went on to argue that while the doctor needs to be able to undertake any of the leadership tasks in a therapeutic community – group conductor, group interpreter, goal-setting, slogan choosing, and spokesman – others may in fact take some or all of them at any given time.

Detailed guidance was then provided to the three medical grades of ward doctor, consultant psychiatrist and medical superintendent, concerning their respective functions in facilitating administrative therapy. After coverage of the selection and training of administrative therapists, Clark considered the relationship between administrative therapy, with its concern for the institution as a whole, and psychodynamic theory, with its focus on the therapist's relationship with an individual patient. While accepting that the needs of the individual and of the group sometimes conflict, he argued that these conflicts are not fundamental, and he went on to stress the debt that administrative therapy owed to group analytic psychotherapy. The book concluded with a chapter bewailing the lack of 'theory' underpinning such developments in psychiatry and pointing out how difficult it is to measure the effects of the kind of changes that he was advocating.

[34] D.H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community* (London, 1964)., p. 61.

Clark's Ideology of the Therapeutic Community

The essentially intangible nature of many of the developments which went into the creation of a therapeutic community presented difficulties of definition from the beginning. How could a genuinely therapeutic community be differentiated from a psychiatric ward which simply appropriated the fashionable term without changing its fundamentally traditional practices? Building on the writings of Dr Tom Main, who pioneered a therapeutic community approach at the war-time Northfield Hospital in Birmingham, Clark in a paper published in 1965, distinguished two categories of therapeutic communities.[35] The first was the 'general therapeutic community approach', which addressed issues involving the restructuring of patients' lives within any psychiatric institution. Clark stated that this approach was particularly associated with the reforms introduced by Dr. T.P. Rees at Warlingham. The second was the 'therapeutic community proper', a small dedicated unit employing intensive therapeutic strategies. Maxwell Jones was credited with pioneering this approach. This binary classification of therapeutic communities has proved to be influential in later studies of the field.[36] Oram had pioneered the application of Jones' ideas at Fulbourn, but by 1963, Clark was determined to develop a unit meeting the criteria for a 'therapeutic community proper' under his own leadership.

The Second Phase: Hereward House

As soon as he returned from his study visit to California in 1963, Clark set about reorganising the wards at Fulbourn, and re-assigning consultant responsibilities, so that he could put his new plans for creating a therapeutic community into action. These

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[35] D.H. Clark, 'The Therapeutic Community – Concept, Practice and Future', *British Journal of Psychiatry*, 111 (1965), pp.947-954.

[36] J.K.W. Morrice, 'Basic Concepts: A Critical Review', in R.D. Hinshelwood, &N. Manning (eds.) *Therapeutic Communities: Reflections and Progress* (London, 1979), p.50; N. Manning, *The Therapeutic Community Movement: Charisma and Routinization* (London, 1989), pp.30-32.

alterations were the first stage in a continuing process of changing ward organisation, the names by which wards were known, and sometimes their physical location, which characterised the next four years. Central to this plan was the creation of an 'intensive nursing unit', combining five wards, with Clark himself as the consultant in charge. Two of these wards were the former 'disturbed' wards for men and women (wards Male 5 and Female 5 – now renamed James Ward and Hillview Ward respectively).[37] The composition of the intensive nursing unit therefore highlighted from the beginning a key aspect of Clark's approach to the use of therapeutic community techniques. This was his belief, not shared by other pioneers, that patients with the most severe mental and behavioural difficulties would derive benefit from living in such an environment.

The new sister of F5, the reorganised women's disturbed ward, who had been appointed to manage its transition to a therapeutic community, had been Kay Kinnear. She took up her post in 1960, after having demonstrated her commitment to the new direction of therapy at Fulbourn while working with Dr Eddie Oram on Adrian Ward.[38] Changes in the ward regime to make it less authoritarian were made slowly and cautiously, but even so, violence from some of the patients, directed at both staff members and fellow patients, became a major issue. One patient in particular, referred to as 'Mary', frequently attempted to strangle other people, and on one occasion, Sister Kinnear's ankle was broken in the subsequent mêlée. Clark responded by giving Mary regular ECT, increasing sedation for other patients presenting with challenging behaviour, and allocating extra nurses to the ward. He was unhappy at this move in a controlling, authoritarian direction, but nevertheless recognised that more democratic approaches, such as ward meetings, required a certain degree of order before they could be

[37] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.185.
[38] Ibid, pp.166-168.

implemented.[39] Clark himself realised that he had to give more of his attention to the ward, and he began to chair a regular Wednesday morning meeting for all patients and staff on the ward, followed by a meeting for staff alone. In its early days, the former would often be interrupted, or even terminated, by violence, but gradually patients became more able to express their opinions to the meeting in more constructive ways.[40]

In 1964, Ruby Mungovan was appointed as the ward sister of Hillview, as F5 had become. This was an inspired choice as she was to become a leading advocate amongst the nursing staff for the philosophy of the therapeutic community, both within Fulbourn and to the wider world.[41] Her appointment was followed soon afterwards by a major ward re-organisation. The opening of the new building for admissions, Kent House, released the former admissions villas for other uses. So Clark decided to make a dramatic statement about his commitment to therapeutic community techniques for some of the most disturbed patients in the hospital by moving the former James and Hillview wards from their relatively hidden position in the vast Victorian asylum building and relocating them in the two former admission villas – Sunnydale (for men) and Westerlands (for women). Their new prominence was a dramatic expression of Clark's total belief in the philosophy of the therapeutic community.[42]

The charge nurse of Sunnydale was Norman Harwin, and although he had been running ward meetings for some time, they had a traditional and formal atmosphere, with a chairman, a rule book and a formal debating style. It took consistent pressure from

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[39] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), pp.175-176.
[40] Ibid, p.177.
[41] R. Mungovan, 'Evolution of a Therapeutic Community', *Nursing Times*, March 15 (1968), pp. 365-366.
[42] Ibid.

Clark for them to become less structured and more informal.[43] On Westerlands, Ruby Mungovan had shown herself to be more in tune with Clark's informal approach from the beginning. Changes in the management of the hospital then began to have an impact on the wards. In 1965, Miss Brock retired as Matron, and Clark was able to persuade the Hospital Management Committee to advertise the position as that of Chief Nursing Officer, to be in charge of both male and female nurses. The successful applicant for this new combined post was the former Chief Male Nurse at Fulbourn, Jack Long.[44] This development provided a powerful impetus for the unification of the formerly separate male and female 'sides' of the hospital, and in 1967, Sunnylands and Westerlands were combined into one unit, re-named Hereward House, with Ruby Mungovan in overall charge. She later recalled that there was a degree of resistance to her appointment on the part of some of the senior male nursing staff, who felt that it was inappropriate that a woman should be in charge of such a challenging unit, but that these concerns were, in true therapeutic community fashion, resolved at a series of meetings.[45]

Analysing the Therapeutic Community

In 1954, Maxwell Jones had recruited an American anthropologist, Richard Rapoport, to study his therapeutic community unit at the Belmont Hospital. Through his observations of activity on the unit, and in interviews with the staff, Rapoport identified four themes which characterised the unit's ideology.[46] These were:

- democratisation,
- permissiveness,

[43] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.199.
[44] Ibid, p. 189.
[45] R. Mungovan, 'Evolution of a Therapeutic Community', *Nursing Times*, March 15 (1968), p.366.
[46] R.N. Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community* (London, 1960), p.54.

- communalism,
- reality confrontation

These four major themes were further refined by the addition of seven more specific themes, or 'practices', identified by Morrice in a review of Rapoport's work, published in 1979.[47]

- Freeing of communications
- Flattening of the authority pyramid
- Sharing of responsibility
- Decision-making by consensus
- Analysis of events
- Provision of living-learning opportunities
- Examination of roles and role-relationships

Given the major influence that Jones' pioneering concepts and practices had upon Clark's developing plans for his hospital, these themes provide an appropriate frame of reference to apply to the developing therapeutic community philosophy at Fulbourn. So in the account that follows, Rapoport's four 'themes' have been combined with Morrice's seven 'practices' in the manner set out in Table 6 (below):

[47] J.K.W. Morrice, 'Basic Concepts: A Critical Review', in R.D. Hinshelwood & N. Manning (eds.), *Therapeutic Communities: Reflections and Progress* (London, 1979), pp.49-58.

Table 6: Themes and practices in the therapeutic community wards

Themes	Practices
1. Democratisation	• (a) Flattening of the authority pyramid • (b) Examination of roles and relationships • (c) Sharing responsibility • (d) Decision-making by consensus
2. Permissiveness	• (e) Provision of living-learning opportunities
3. Communalism	• (f) Freeing of communication
4. Reality confrontation	• (g) Analysis of events

1) Democratisation

(a) Flattening of the authority pyramid

The characteristic of a therapeutic community that was most striking to many who had lived or worked in a traditional asylum environment was the flattening of the conventional hierarchy of status and authority. One reason for this principle was the belief, influenced by psychoanalytic theory, that patients tended to transfer negative feelings towards authority figures from their earlier relationships on to hospital staff. When Neil Chell moved to Fulbourn as a staff nurse from a more traditionally-run psychiatric hospital in Staffordshire, he was immediately struck by the fact that:

> *The relationship between the doctors, the nurses, the psychologists was much, much more informal – the hierarchies seemed much more flattened.*[48]

Dr Ross Mitchell, a newly-appointed Consultant, was aware of the potential tension inherent in Clark's contrasting roles – guiding a more democratic therapeutic community while at the same time retaining his role as the doctor responsible for all that happened within the hospital:

[48] Transcript 14, Neil Chell.

And then, I remember - David was the medical superintendent, very much in charge. So there was a paradox. Here he was trying to flatten the authority pyramid - but you've met him – he is a very authoritarian person. Very nice, but still very definite, very clear, he knows what he wants and he usually gets what he wants. So he was a paradox. Here was a man running a flattened authority pyramid, who himself could be quite authoritarian.[49]

Even though the authority pyramid may have been flattened, the ultimate source of authority was never in doubt. Ruby Mungovan argued that this sense of support had a positive therapeutic impact:

It gave them confidence, it gave them the ability to make yet another stride. And of course there was Dr Clark – powerful, strong, supportive. But never saying, 'This is the way you do it' – everybody had their own contribution to make. You know, it was very exciting.[50]

This view of Clark as a powerful supporter of the implementation of the philosophy of the therapeutic community was widely shared by staff at this time, and it gave them confidence to take the risks that were inherent in that approach.

(b) Examination of roles and relationships

The philosophy of the therapeutic community soon started to be applied outside the purely clinical arena. One example was its extension to staff meetings. Several of those who participated in them testified to the importance that the Friday morning doctors' meeting held for them. It was originally started as a traditional management forum for

[49] Transcript 03, Dr Ross Mitchell.
[50] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.

Dr Clark, as Medical Superintendent, to receive reports and to issue instructions. When Dr Ross Mitchell was first appointed to his consultant post at the hospital in 1966:

> *It was very much a business, medical officer's, medical superintendent's business.*[51]

Such meetings were routine in mental hospitals of the period, as orders and reports needed to be conveyed along the chain of command.

However, Clark's commitment to the principles of the therapeutic community was all-embracing, and soon extended to this most traditional of staff forums.

> *But I think gradually he realised he wanted to bring the therapeutic community into that, and we very much wanted it as well.*
> *So it stopped being a business meeting, being very much an exploratory meeting – a supportive meeting, where we'd talk very much about what it meant to be a psychiatrist in the sixties and seventies – there were a lot of developments going on.*[52]

A conscious attempt was made to emphasise the shared experience of both senior and junior psychiatrists:

> *And particularly for the junior doctors to learn, you know, the seniors didn't have the answers to everything, and that we were all learning together. Very much allowing the junior doctors to be able to show their fears and their anxieties, because the seniors were doing exactly the same. And then that meeting really carried on through the years, and when you ever meet other people who have been to Fulbourn as a*

[51] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.
[52] Transcript 03, Dr Ross Mitchell.

> *junior, the thing they always say they remember, and the thing that shaped their careers, was the Friday morning meeting.*[53]

So the Friday morning meeting came to fulfil an important role in providing 'healing for the healers'.

The idea that the therapists needed support and therapy themselves was promoted within the sphere of individual psychotherapy practice, but Clark was a pioneer in extending the concept to the entire medical staff of a hospital. It proved to be particularly helpful in providing support in circumstances of loss:

> *We went through a number of divorces, we went through in fact a death. A consultant psychotherapist in fact died of liver cancer, sadly – Malcolm Heron – and he was dying but he came to the meeting. And we went through our grief work with him before he died, and that was itself quite an experience to do that, so that was very important.*[54]

Amongst my interview subjects who attended the meeting at this time, all of them reported being deeply affected by this experience.

(c) Sharing of responsibility

A more radical element of democratisation, as practised by Maxwell Jones, was the belief that patients should have a say in deciding treatment regimes for their fellow patients. This aspect of therapeutic community practice tended to outrage more traditional staff as it seemed to undercut one of the most basic tenets of the therapy process. Maurice Fenn, a nurse who was later to have a distinguished career at Fulbourn, remembered what was said outside Hereward House:

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[53] Transcript 03, Dr Ross Mitchell.
[54] Ibid.

Well, some of the older members of staff used to say, 'I don't know what this place is coming to – patients are telling people what to do!'[55]

However, there was a substantial difference between patients 'having a say' about other patients' treatments, and actually determining that treatment. This distinction was not always recognised by critics of Hereward House within Fulbourn:

One of the myths, for example, would be that patients would prescribe treatment for one another.[56]

The therapeutic communities at Fulbourn operated against a perpetual background of grumbles of this kind from other parts of the hospital.

In fact, feedback to prescribing doctors about what was actually happening to the medication that they prescribed could be very useful, as David Clark explained:

Quite a lot of people handed over to me a tin full of Largactil tablets, they'd been saving up for months. Other people told of regularly putting their medication down the lavatory, and I thought it was much better to bring this out into the open, and I can remember times when people said to me, 'You're giving John too much Largactil: if you try giving him half that amount and he'll do much better', and we did.[57]

While this kind of feedback could prove to be very helpful, it was not accepted unquestioningly by the doctors:

[55] Transcript 03, Dr Ross Mitchell.
[56] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996. Dr Ross Mitchell.
[57] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996. Dr David Clark.

> *Sometimes they were wrong, sometimes they were right. But people leaving Hereward House had a much better idea of what they were taking and why, and what would happen if they stopped it.*[58]

Such an approach would be regarded as unexceptional in today's NHS, but at that time was seen as revolutionary.

'Constructive' patients were encouraged to act as surrogates for staff, in presenting rehabilitative strategies in a more acceptable form. This use of the talents of the 'constructive' patient could also be rehabilitative – so the benefits were mutual. As Judith Atkinson, a social worker for Hereward House, recalled:

> *The culture developed in which patients could begin to feel that they had some responsibility, and some capacity themselves, for not just working on their own needs but helping other people – mostly challenging other people. Being quite disruptive on occasions, but later on, coming to make some very positive comments about how other people might be helped to live their lives without illness.*[59]

Despite the limited input to the decision-making process that patients were allowed, critics both inside and outside the hospital readily latched on to this aspect of the regime as self-evident folly.

(d) Decision-making by consensus

To Dr Ross Mitchell, a newly-appointed Consultant Psychiatrist from a conventional professional background, the ubiquitous groups seemed very strange at first:

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[58] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996. Dr David Clark.
[59] Transcript 27, Judith Atkinson.

> *And [I] discovered they did all kinds of strange things – they spent a lot of time sitting round in a circle, talking! And I couldn't understand what all this was about, and then gradually I began to learn it was the way David was running the therapeutic community.*[60]

However, Mitchell recalled that Clark practised the philosophy he expounded, and agreement was usually possible:

> *And everything happened in Fulbourn provided David approved! If David didn't approve, well there was a time when it had to be discussed and then eventually some compromise would be arrived at.*[61]

As the philosophy of the therapeutic community began to be taken up in many places in Europe and the United States, some new staff members, such as Judith Atkinson, brought previous experience with them.

> *I'd had a little bit of experience of the therapeutic community idea when I was in America, because that was the model on which they were hoping to develop the adolescent group, that I worked in.*[62]

Atkinson was able to share her American experience with staff attempting to implement the approach in Fulbourn.

Sister Ruby Mungovan described the central role that ward meetings played in the communal life of Hereward House:

> *We had meetings every day, that's what you do when you're in a therapeutic community – you have face-to-face confrontation, you*

[60] Transcript 03, Dr Ross Mitchell.
[61] Ibid.
[62] Transcript 27, Judith Atkinson.

discuss all the things that need discussing, you find a solution if it is possible, and help people through the meetings.[63]

Ward meetings were intended to promote discussion and interaction, but on some occasions nothing would be said. To a junior social worker like Barbara Prynn, the whole experience made little sense at the time.

I remember there were silences – I certainly don't remember, I had no idea what people talked about, if people talked about anything at all. And I don't remember any strong emotion of any sort being expressed. I mean it was all pretty much – I mean I was very young and it was a sort of mystifying experience, as far as I was concerned.[64]

This memory indicates the difficulty of making generalisations about ward regimes. Had Prynn visited the ward on other occasions, or been on placement for longer, she might well have remembered voluble outbursts and emotional confrontations

2) Permissiveness

Behaviour that fell outside social norms was tolerated for the opportunity it gave for others to comment upon it and hence aid the process of therapy. The therapeutic community shared with psychoanalysis a belief that encouragement to 'act out' previously hidden aspects of the self could provide both direct catharsis and an opportunity for the original sources of the behaviour to be discussed with the patient.

Ruby Mungovan described the challenging atmosphere that characterised many ward meetings in Hereward House:

[63] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.
[64] Transcript 24, Barbara Prynn.

> *It wasn't all, you know, intelligent – talk, talk, talk, stuff. Sometimes it was shouting, sometimes it was swearing, and sometimes it was fighting, even.*[65]

As many patients could be disruptive, much anxiety was generated, but this was regarded as a positive influence on encouraging engagement with the treatment process. However, anxiety was also generated outside Hereward House. As David Burnet, a Charge Nurse, noted:

> *People in other areas were watching carefully to see if it would work.*[66]

(e) Provision of living-learning opportunities

The provision of work for as many of the patients at Hereward House as possible was seen as vitally important to the process of restoring and retaining skills of daily living. Even though the patients in the unit were some of the most disturbed in the hospital, most of them were engaged in a paid occupation of some kind. In their paper analysing the functioning of the unit, Clark and Myers summarised patient occupations on a sample day in 1969 [Table 7]:

[65] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.
[66] Ibid.

Table 7: Occupation of patients in Hereward House on 2 February 1969[67]

In Hereward House all day: not working	6
In Hereward House all day: working on ward	7
Paid employment elsewhere in hospital	23
Fully employed outside hospital	8
Full-time student (attending college classes)	1
On leave at home	11
TOTAL	56

Although only 9 patients were listed as either in education or employment outside the hospital on that day, it constituted a considerable achievement given that such patients would previously have been confined on a locked ward.

3) Communalism

(f) Freeing of communication

Central to the philosophy of the therapeutic community was the idea that all resources should be shared. In theory at least, there should have been no areas of the unit that were restricted to use by members of staff, and meetings should have been open to all. The actual practice in Hereward House seems to have taken some time to move in that direction. When Hereward House was first set up, the daily communal meeting was followed by one for staff alone. In response to what Mungovan called 'staff irritations', a 'staff book' was also maintained to foster communication between the staff on the early and late shifts.[68] By 1969, two elected patients were attending the daily staff

[67] D.H.Clark & K. Myers, 'Themes in a Therapeutic Community', *British Journal of Psychiatry*, 117 (1970), pp. 389-395.
[68] R. Mungovan, 'Evolution of a Therapeutic Community', *Nursing Times*, March 15 (1968), p. 366.

meeting.[69] According to the philosophy of the therapeutic community, responsibility for the mundane issues arising from communal living should also have been shared, but in practice, the nurses often felt compelled to maintain a basic standard of tidiness. Sister Mungovan did her bit to keep squalor at bay:

> *I made beds, picked up cigarette ends, you know, you name it, it was all over the place, wasn't it?*[70]

This was also an issue mentioned by other nurses in my sample.

Another aspect of the regime designed to break down barriers was the removal of traditional aspects of the formality which were felt to create barriers between patients and staff. At Fulbourn, one of the aspects of informality which caused the most controversy was the question of whether nurses should wear uniform. On arrival at Fulbourn, Staff Nurse Neil Chell was immediately struck by the fact that:

> *Nobody wore a uniform, as far as I could see. I don't know whether they were issued, but no-one wore them anyway.*[71]

Judith Atkinson was the unit social worker for Hereward House from 1967-68.

> *People [were] quite troubled by certain aspects of it, and I think there were some troubling aspects. It wasn't clear – since nurses were now out of uniform and everybody was known by their first name – it wasn't clear always what the roles and responsibilities were. I mean, it was quite clear there was a doctor, there was a social worker, there*

[69] D.H.Clark & K. Myers, 'Themes in a Therapeutic Community', *British Journal of Psychiatry*, 117 (1970), p. 390.
[70] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996.
[71] Transcript 14, Neil Chell.

was a ward sister, there were nurses, but I think a lot of people were quite confused about who was taking responsibility.[72]

In the light of this observation, it is interesting to note that the photograph illustrating Ruby Mungovan's article describing the work of Hereward House, published in the *Nursing Times* in 1968, shows both Mungovan and a staff nurse wearing traditional nursing uniforms.[73] It is therefore likely that this was an editorial requirement imposed by the journal, and did not reflect normal practice at that time in Hereward House.

As many patients were believed to lack experience of intensive communal relationships – for example in the family home – the unit aimed to provide this missing experience. The social work team also made intensive efforts to explore the family background of patients

And also – I was quite proud of it – I ran a parents' group, or a family group, for three of the youngest patients on Hereward House. Because there was so much feeling that they weren't getting enough support. And, I suppose, half a dozen times, I met with these three families and a couple of nurses, and on one occasion the doctor, and we just talked about what it was like for them, having a family member in hospital.[74]

The fact that patients were meant to participate fully in the running of the unit also had the effect of showing them the consequences of their negative behaviours if the unit malfunctioned.

[72] Transcript 27, Judith Atkinson.
[73] R. Mungovan, 'Evolution of a Therapeutic Community', *Nursing Times*, March 15 (1968), p. 366.
[74] Transcript 27, Judith Atkinson.

There was a dramatic use of this technique by the team on Westerlands. In February 1964, patients responded to the loosening of the authoritarian ward regime by smashing numerous windows in the sleeping areas. The normal hospital procedure would have been for the glass to be replaced immediately by staff from the hospital Works Department, but on that occasion a decision was taken to use therapeutic community techniques. The glass was not replaced for some time, so patients were forced to spend several nights in a cold and uncomfortable environment.[75] Ruby Mungovan, the Ward Sister, recalled that:

> *Windows were going at a rate of panes a day, and then the meeting decided that the people should be punished. I remember there was some at ten shillings, that was what had to be paid . Relatives weren't allowed to pay. Then we had a graph showing how they came down from something like a hundred panes a week to three or four.*[76]

While fining patients for breaking windows had a generally positive impact in curbing that kind of behaviour, it also generated an unintended side-effect.

A former patient on the unit recalled that the expense associated with breaking a window could increase the significance, and hence the cathartic effect, of the gesture:

> *'You could have a good ten shillings worth, sometimes!'*[77]

One aspect of this policy unremarked upon at the time was its indication of the powerlessness of patients in a mental hospital. If general hospital patients had been exposed to the elements in this way, the complaints might well have reached Parliament.

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[75] R. Mungovan, ,'Evolution of a Therapeutic Community', *Nursing Times*, March 15 (1968), p. 366.
[76] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996, Ruby Mungovan.
[77] Ibid. Margaret Hind.

4) Reality Confrontation

Patients were to be continuously given feedback on their behaviours as interpreted by others. In practice, the frequent ward meetings provided the forum for such feedback.

(g) Analysis of events

The term 'analysis' itself reveals the pervasive if rather superficial influence of psychotherapy on the philosophy of the therapeutic community. Both staff and other patients were encouraged to act like a Freudian analyst in seeking hidden meanings which were believed to lie behind socially unacceptable behaviours of all kinds.

Clark's and Myers' Themes from Hereward House

It is perhaps a reflection of the largely intangible nature of the regime in a therapeutic community setting that there are different views as to the themes which should be discernable within one. Clark and Myers, in their study of Hereward House, identified a further six rather more pragmatic themes which they felt had characterised the regime created there.[78] These were:

- rejection,
- violence,
- sexuality,
- staff divisions,
- dependence-independence, and
- relations with outside bodies.

These will now be dealt with in turn:

[78] DH Clark & K Myers, 'Themes in a Therapeutic Community', *British Journal of Psychiatry*, 117 (1970), pp. 389-395.

Rejection

Clark emphasised the shared experiences of rejection suffered by both patients and staff in Hereward House. While patients often experienced rejection by family and friends, and the stigma of being a in a mental hospital, staff experienced rejection by their colleagues in the hospital who viewed them as complicit in allowing standards to decline to an unacceptable level.

Violence

Violence, in the form of self-harm or attacks on others, was a frequent occurrence in Hereward House. In the almost five years covered by Clark and Myers' paper, there were seven suicides. Four patients died from overdoses of tablets, one woman set fire to herself, another absconded and died of exposure, and one man died under a train on the railway line that runs beside the hospital. 'Wrist slashings were too numerous to count'.[79] In 1968, there was a murder in Hereward House, as Judith Atkinson recalled:

> *A very disturbed young woman obviously developed some kind of fantasy and obsession with a much older, vulnerable woman patient. And said, 'I'm going to kill her! I'm really going to kill her!' And one day she did – she drowned her in the bath.*[80]

Not surprisingly, this shocking event proved to be very traumatic for the whole community:

> *It was obviously a huge shock. Somehow they dealt with it, but everybody was saying, 'She told us, she told us she was going to do this, and we didn't really protect [her]'*[81]

[79] D.H. Clark, K. Myers, 'Themes in a Therapeutic Community', *British Journal of Psychiatry* , 117 (1970), p. 393.
[80] Transcript 27, Judith Atkinson.

True to the philosophy of the therapeutic community, the feelings triggered by the murder were analysed in exhaustive detail:

> *It was talked [about] – not just in meetings – people were talking about it all the time. And people were blaming themselves and each other, in the meeting.*[82]

Without skilled handling, such potentially destructive emotions risked causing permanent damage to the cohesiveness of the ward team.

Sexuality

David Clark cited Margaret Hind as an example of a patient who had benefited from the integration of the male and female wards.

> *Margaret was the sort of person who would have received the worst of the old system. She had no possibility of rehabilitation, of normal social life, and certainly would never have met any male patient, and one can only be glad that there are no longer hundreds of people doomed to be - sentenced to decades of life in hospital.*[83]

A stable relationship enabled her to gradually develop the skills to cope with life outside the hospital

> *I met John in hospital, and we were married in 1973, and I still had to go back occasionally, like when Sarah was born, and then I never went back again, never.*[84]

In this case, marriage itself took on therapeutic properties.

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[81] Transcript 27, Judith Atkinson.
[82] Ibid.
[83] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996. Dr David Clark.
[84] Transcript, BBC TV documentary, 'Unlocking the Asylum', 1996. Margaret Hind.

The breaking down of the old barriers also meant that patients were no-longer being nursed exclusively by nurses of the same sex, so problematic relationships developed from time to time, and this had a negative impact on the therapeutic environment, as Judith Atkinson remembered:

> *And there were occasions on which friendships or – yes, friendships – between staff and patients, which were highly inappropriate, could develop. And I think patients were sometimes very confused – even more, families were very confused.*[85]

The attitude that the hospital authorities should take to consensual sexual relationships between patients and nurses in therapeutic community environments continued to generate controversy for many years to come.[86]

Staff Divisions

As well as the expected divisions between doctors and nurses, and trained and untrained staff, the fact that the therapeutic community in Hereward House began to attract graduates who were considering a career in some form of social service led to further divisions, as David Clark recalled:

> *Well of course there were tensions. There was one stage when the staff group at Hereward House was completely split between 'them as went to college', and 'them as didn't'. And I and the doctors were seen as being on the same side as these nursing assistants, whereas the trained nurses felt they were being put down with long words.*[87]

The hospital's location in a university city, which also hosted an arts and technology college, made it relatively easy to attract graduates to a variety of roles.

[85] Transcript 27, Judith Atkinson.
[86] Transcript 05, MN01.
[87] Transcript 02, Dr David Clark.

Dependence-Interdependence

While Hereward House was intended to foster independence, and ultimately discharge from the hospital, some patients continued to demand direction and the security of a stable role as a hospital patient. Clark tended to blame nurses for fostering a nurturing climate on the ward.[88] Some nurses, on the other hand, felt that they detected a reluctance to discharge patients on the part of David Clark, as John Lambert argued:

> *He was a great one for talking about, you know, care in the community, but really he liked to have his beds! [laughs]*[89]

Clark's view reflects the traditional value-system of all hospitals at that time, both general and psychiatric, in regarding the possession of a certain allocation of beds as a key status indicator.

Relations with Outside Bodies

Ever since the 'first Northfield Hospital experiment', the importance of a therapeutic community maintaining open channels of communication with other parts of the hospital, and with the wider social care network, was realised. Dr Oram had made this a key aspect of his innovations on Adrian Ward, and Clark saw to it that it was continued in Hereward House. One channel for this communication was provided by Ken Cross, a hospital administrator:

> *Now, with these areas, each area had a weekly meeting in one of the wards. And I, as the link administrator for the social therapy area, would be invited to go to that meeting. Dr Clark was very much involved with the social therapy area. All the nurses there – even the student nurses who could be spared from the wards, the occupational*

[88] D.H. Clark & K. Myers, 'Themes in a Therapeutic Community', *British Journal of Psychiatry* , 117 (1970), pp. 393 – 394.
[89] Transcript 08, John Lambert.

therapists – we all used to go down to this weekly meeting. And I would bring information from the Ministry directives – feed them into the meeting. They would feed, perhaps, problems back to the administrators. It worked wonderfully.[90]

Over time, the suspicion surrounding Hereward House began to dissipate, as its philosophy began to percolate to the rest of the hospital.

Westerlands

By 1970, the concept of the therapeutic community had been adopted by three further wards at Fulbourn, all of which were admission units, so the numbers of patients being transferred to Hereward House began to decline as they could receive the equivalent therapy on their initial wards. So in 1971, Hereward House was divided into two wards. Sunnydale, intended for 'less disturbed' patients, maintained its viability for three years before it was closed. The second ward was Westerlands, catering for the more disturbed patients. It had as its charge nurse John Wise, who had been Ruby Mungovan's deputy in Hereward House. John Lambert was appointed as one of Wise's deputies:

It was very interesting work, and I mean we had very, very difficult people – ex-Broadmoor patients – in an 'open' ward! [laughs][91]

Lambert was particularly attracted by the large scope for using initiative that Clark allowed his nursing staff:

Dr Clark was the consultant for that, and he was pretty good to work for. He gave us more or less a free reign.[92]

Clark evidently recognised Lambert's particular talent, attested to by several interviewees, for working with such challenging individuals.

[90] Transcript 25, Ken Cross.
[91] Transcript 08, John Lambert.
[92] Ibid.

Student nurses had to have an early placement on Westerlands, but they were relieved that the reality was nothing like the fearsome reputation it generated amongst other hospital staff:

> *You started off in low-key mental health, if you like, and from there I went to Westerlands, which they called the extremely aggressive ward, in those days. So most patients there were supposed to be violent, but in all honesty, I never saw anything.*[93]

In place of the predicted violence, student nurses were struck by the nature of the therapeutic community regime, and the contrast with other more traditional areas of the hospital:

> *The psychiatrist, David Clark, was a very progressive psychiatrist – didn't believe very much in medication. Believed much more in the nurses and the doctors having time with the patients, talking with the patients. In fact he didn't like the word even, 'patients': he would regard them as 'clients'. There were lots of meetings, he said, 'Every morning there would be a meeting.'. And in the meeting, the patients were allowed to talk about their problems, or whatever issue comes up at them. We would only use medication as a very last resort, and we would use seclusion also as an extremely last resort – in those days. A lot of the nurses, I would find, were very much in that mode of thinking, as well, which in many ways helped the patients.*[94]

While this nurse was impressed by the low levels of medication, and the infrequent use of seclusion, supporters of the therapeutic community model in

[93] Transcript 04, MN01.
[94] Ibid.

other hospitals continued to look askance at Fulbourn for using these methods at all.[95]

Burnet House

In 1979, Westerlands was closed for a year for upgrading and re-decoration and it then re-opened as Burnet House. It continued to provide an open-door therapeutic community for highly disturbed men and women, in accordance with Clark's philosophy. In 1982, it was the setting chosen for a BBC TV documentary, *The Way Back*.[96] Reactions to this programme seem to have reflected prior opinions on Clark's approach. Supporters felt that it showed a humane therapeutic setting as it really was, while opponents were appalled by the disorder and violent outbursts.[97]

Professor Geoff Shepherd, who was appointed as head of the clinical psychology services at Fulbourn in 1981, took a particular interest in the unit, which was a key part of what Clark had called 'the Cambridge Psychiatric Rehabilitation Service' or CPRS:

> *I was always interested in the process by which patients became long-stay patients, and that process in CPRS in those days was very much focused around Burnet House. But Burnet House was the place where patients were admitted if they became sufficiently ill in the community and most of them would go out again, but some of them would stay.*[98]

[95] L. Clarke, *The Time of the Therapeutic Communities: People, Places and Events* (London, 2004).
[96] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 201.
[97] Some of this footage was used in the later documentary: BBC TV documentary, 'Unlocking the Asylum', 1996.
[98] Transcript 16, Professor Geoff Shepherd.

Shepherd was aware that despite the best efforts of the ward team to return all the patients who were admitted to Burnet House to the community, an increasing number resisted this development:

> *The ones who stayed were the ones who were called – by John Wing, a little bit later – the so-called 'new long-stay'. And they were a particular group of people, younger people, nearly all with schizophrenia … they were people with really bad schizophrenia. Very treatment-resistant and lots of other difficulties – mainly aggression, violence, socially inappropriate behaviour and so on. Which meant they were difficult to look after outside the hospital, which is why they stayed in Burnet House.*[99]

Shepherd had been inspired to tackle the care needs of this challenging group by his time spent working with the influential psychiatrist Dr Douglas Bennett at the Maudsley Hospital:

> *Douglas was… part of that great… generation of English post-War social psychiatrists – of which David Clark was also one. He knew David Clark well. And Douglas had had a background working in a big institution called Netherne, down in Surrey, with a German psychiatrist called Rudolf Freudenberg…. I would just sit almost at [Bennett's] feet… for case conference after case conference, week after week, month after month, year after year, trying to understand how Douglas thought about patients, because he seemed to have a unique, original way of thinking about people and about*

[99] Transcript 16, Professor Geoff Shepherd.

rehabilitation, and I'd try to learn that. And when I left the Maudsley, came to Cambridge, and was seeing patients on my own…I still would think, 'Well, what would Douglas have done with this chap? How would Douglas think about it?'[100]

This excerpt underlines the influence exerted by charismatic individuals on psychiatric practice.

Shepherd went on to establish a national reputation for his work in developing small community units for these service-users:[101]

We set up the first specialist, new, long-stay [house]. First in Cambridge Road… then after that there was Number One, The Drive, and then after that there was Cobwebs. And that all – people would dispute this – it sounds a terrible, arrogant thing to say, but I think it came because of my previous involvement with Douglas and having seen him set things like that up.[102]

The organisational background to this process of moving patients out of the old Fulbourn site is outlined in more detail in Chapter 10.

[100] Transcript 16, Professor Geoff Shepherd. Dr Freudenberg was mentioned in Chapter 5 as an advocate of DICT: he was later a leading social psychiatrist.
[101] P. Barham, *Closing the Asylum: The Mental Patient in Modern Society* 2nd edn. (London, 1997), p.106.
[102] Transcript 16, Professor Geoff Shepherd.

Conclusion

The decision to turn the unit caring for some of the ‘most disturbed’ patients in the hospital into a therapeutic community represented a radical departure from contemporary norms on the part of David Clark. The pioneers of the therapeutic community movement, such as Maxwell Jones, had always carefully selected patients experiencing neurotic problems for their units. Such patients were required to have high levels of competence in communication and social interaction, so that they could contribute fully to the frequent meetings and discussion groups. Similarly, the levels of drug treatment were very low, and physical therapies such as ECT were not used. As consent and cooperation were regarded as essential elements of the philosophy of the therapeutic community, all patients had agreed to transfer to the unit and to take a full part in its activities. The use of compulsion under the terms of the Mental Health Act 1959 was unknown.

Hereward House, and later Westerlands and Burnet House, under Clark turned all these principles on their head. Such was the strength of Clark’s belief in the efficacy of the therapeutic community philosophy that he was convinced it would hold benefits for patients who met none of the traditional criteria. This placed Fulbourn outside the mainstream of the movement, and marked out Clark as a radical reformer. Evidence for the effectiveness of particular therapeutic regimes was hard to gather, but Clark remained convinced that the principles of the therapeutic community held benefits for

all the hospital's patients. Its later implementation on Street Ward, discussed in Chapter 7, indicates that Clark remained committed to this idiosyncratic approach.

Chapter 7: 'Social Therapy' in Practice

Introduction

While David Clark was building up Hereward House, and later Westerlands, into what he categorised as a 'therapeutic community proper', he was keen that as many of the new practices as possible, such as a flattening of the authority pyramid, frequent ward meetings, and encouraging an atmosphere of informality, should be used in all the other wards of the hospital. Clark labelled this philosophy, 'the general therapeutic community approach'.[1] This chapter examines the way in which this approach was implemented in practice, with a focus on the implications for the nursing staff. While nurses could see many positive features in this philosophy of care, such as the development of reciprocal relationships between patients, and the opportunities for greater involvement with families, they were concerned at the greater degree of risk that was implied in the new approach.

Developing the Rest of the Hospital

Reinvigorated by his sabbatical in California, and boosted by the injection of considerable funds for new buildings, Clark set about re-organising many areas of the hospital. He was aided in this endeavour by the opening of a new admission building in 1964. As Dr Ross Mitchell recalled:

> *When I arrived I found they had a large admission unit, quite a modern building, called Kent House because it had been opened by Marina, Duchess of Kent, and that was where everyone was admitted,*

[1] D.H. Clark, 'The Therapeutic Community – Concept, Practice and Future', *British Journal of Psychiatry*, 111 (1965), pp. 947-954.

and then the rest of the hospital was either the long-stay or the rehabilitation service, and this building.[2]

While Clark maintained his primary focus on the work of the 'intensive nursing unit', in 1964 Dr Leslie Buttle was given charge of the geriatric unit while Dr Oliver Hodgson ran a newly-linked group of wards designated as a rehabilitation unit. All these consultants, plus three others, also admitted patients into Kent House.

It did not take long for the drawbacks in this complex system to become apparent. As a newly-appointed consultant, Dr Ross Mitchell was immediately aware of the difficulties it posed:

Here were six consultants, and they would all arrive at different times, sometimes together, [sometimes] separated - males on one side, females on the other, and it seemed to me to be a bit chaotic.[3]

But despite his recent arrival, he was gratified to be consulted about the ways in which Kent House should be reorganised in order to improve the efficiency of its medical organisation and the milieu experienced by the patients:

What ideas did I have? It was a good thing, whenever a new consultant came round, well what new ideas could the new consultant bring? Which was great! Whereas in other places, the new boy had better keep quiet, learn his place.[4]

Despite his rather autocratic personality, David Clark was always genuinely concerned to hear the views of his colleagues.

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[2] Transcript 03, Dr Ross Mitchell. The patients called Kent House, 'Butlin's holiday camp', Fulbourn Archives: D. Bacon, *To Bedlam and Back, 1954-1972* (c.1985), p.2.
[3] Transcript 03, Dr Ross Mitchell.
[4] Ibid.

At this time also, a bungalow unit in the hospital grounds became available for admissions. So newly-renamed as Adrian Ward, it joined the existing Street and Friends Wards in Kent House as the third element in the admissions unit.

> *And so we decided what we would do is divide [the admissions unit] into three consultant teams – two consultants working together.*[5]

While maintaining his input to Friends Ward, Clark was content that the other two admission wards teams should develop his therapeutic community principles in ways that seemed best for them. As Mitchell summarised the position:

> *It allowed each team to begin to develop a particular character of its own, although the therapeutic community was a sort of underlying philosophy, each of the teams interpreted that and did it as they wanted.*[6]

Mitchell's comment highlights once again the difficulty faced by the historian in attempting to marry the discourses used about mental health in Fulbourn with the clinical practices that flowed from them. While phrases like 'social model', 'social therapy', and 'therapeutic community' held a core of shared meaning, individual clinicians felt free to interpret them in their own way.

These changes in medical organisation provided the opportunity for modifications in nursing management introduced following the publication of the Salmon Report on senior nursing staff structures.[7] The former job titles, such as 'Matron', 'Assistant Matron', and 'Chief Male Nurse', were replaced with military-sounding grades such as 'Nursing Officer', 'Senior Nursing Officer', and 'Principal Nursing Officer'. At

[5] Transcript 03, Dr Ross Mitchell.
[6] Ibid.
[7] Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure* (The Salmon Report) HMSO (London, 1966).

Fulbourn, six Unit Nursing Officer posts, each covering a functional division of the hospital, were created, and they reported to a Senior Nursing Officer (Clive Harries) and to Maurice Fenn, the Principal Nursing Officer.[8]

'Administrative Therapy' Replaced by 'Social Therapy'

During his sabbatical year in California, Clark's varied agenda for Fulbourn, composed as it was of elements drawn from psychoanalysis, humanistic psychology, and the therapeutic community movement, was further developed under the umbrella term of 'administrative therapy', which he had first adopted in 1957 [see Chapter 6]. It was significant that the sub-title of the book he published on his return in 1964 should have focused on the role of the doctor.[9] Six years later, in 1970, Clark was commissioned by Penguin Books to write a book on his innovations at Fulbourn for a general readership. This happy accident of timing coincided with a subtle yet discernable change of emphasis in Clark's thinking, symbolised by the adoption of the term 'social therapy'. He was ruefully aware that the concepts underlying 'administrative therapy', as well as the term itself, had failed to make a significant impact on doctors working in psychiatry. It is possible that the sphere of the administrator seemed too far removed from the clinical encounter to merit its link with therapy. Presumably also, changes to customary practice, such as the flattening of the authority pyramid, an increased role for patients in the choice of treatments, and a general move in the direction of informality, were inherently unappealing to those psychiatrists content with the status quo.

[8] M.F. Fenn, R. Mungovan & D. Towell, 'Developing the Role of the Unit Nursing Officer', *Nursing Times* 13 February (1975), pp.262-264.
[9] D.H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community* (London, 1964).

This change was justified in the memoir he published almost a quarter of a century later on the grounds that his 'ideas had moved on', but the fact remains that 'administrative therapy' never caught on in the psychiatric circles it was intended to influence.[10] So the commission from Penguin provided Clark with the opportunity to promote his ideas to a wider audience and under the new banner of 'social therapy'. As he explained in the new book:

> I tried some years ago to convey this to some of my professional brethren, the doctors, in a book called *Administrative Therapy*. Now I am trying to set the matter out more generally for all those involved in the process and also for any others who might be interested.[11]

So while psychiatrists inevitably maintained a crucial role in the adoption of Clark's 'general therapeutic community approach' by the admission, rehabilitation and geriatric wards at Fulbourn, they were no-longer regarded by him as the sole agents of change. Other staff groups, and in particular nurses, were now to be actively recruited to the cause of promoting 'social therapy'.

However, even though social therapy was clearly a more attractive term, it was not without its own difficulties. In his introduction to the book, Clark's old Maudsley colleague Dr Morris Carstairs, was at pains to clarify the terminology. He emphasised that Clark's theme was not 'Social Psychiatry, but the more precise area which he designates 'social therapy'' and defined as, 'the use of social and organizational means to produce desired changes in people'.[12] Other members of staff at Fulbourn, however, did not follow this fine terminological distinction. For example, David Towell, a

[10] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p.193.
[11] D.H. Clark, *Social Therapy in Psychiatry* (Harmondsworth, 1974), p.13.
[12] Ibid, p.8.

sociological researcher who studied developments at Fulbourn, referred in print to 'a social psychiatric approach to treatment' in the hospital at this time.[13]

Like many pioneers, Clark himself claimed that social therapy was not an innovation at all, but the continuation of a tradition 'about two centuries old'.[14] The names of Tuke, Pinel, and Conolly were invoked and 'moral management' was seen as the ancestor of the contemporary therapeutic community. Clark regarded the Victorian and later asylum, in the hundred years before 1950, as interrupting this progression but ultimately providing an environment for positive developments. A chapter examining 'the theory of social therapy' displayed only meagre results, as Clark concluded that 'there is no coherent, succinct body of theory lying behind social therapy, though it has been practised, wittingly and unwittingly, for centuries'.[15] The formulation which Clark used to fill this vacuum was 'the sociological model of illness', although the only names cited in support of this perspective were those of Erving Goffman and R.D. Laing. The chapter on hospital settings for social therapy was formulated around the three words – activity, freedom, and responsibility. This was followed by one on other settings for social therapy, which suggested schools, religious communities, and penal institutions could make use of its insights. The section on roles in social therapy contained the expected ones, such as doctor, nurse and patient, but also included were others who rarely appeared in psychiatric texts but who were such a feature of the Fulbourn approach – the voluntary worker, the lay administrator, the maintenance staff, and the research social scientist.[16]

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[13] D. Towell, J. Burgess, L. Bhim, & C. Harries, 'Creating Environments for Social Therapy' in D. Towell & C. Harries, (eds)., *Innovation in Patient Care* (London, 1979), p. 41.
[14] D.H. Clark, *Social Therapy in Psychiatry* (Harmondsworth, 1974), p. 14.
[15] Ibid, p. 54.
[16] The success of this book is indicated by the second edition published by another firm: D.H. Clark, *Social Therapy in Psychiatry*, 2nd edn. (Edinburgh, 1981).

Nursing on the Admission Wards

As noted above, one of the challenges facing clinicians in the 1970s, and later historians of their work, was that the actual practices of each 'therapeutic community' ward were very variable and largely intangible. It was therefore difficult to distinguish with certainty between a ward which was a 'therapeutic community proper', one which applied the principles in a more general way, and a ward which was only paying lip-service to the principles while continuing to apply a more 'medical' model. Clark's own account reflects this difficulty. In his memoir published in 1996, he stated in one place that:

> 'therapeutic community practice' was developed on Friends Ward in 1971 and Street ward in 1978.[17]

However a few pages later, a much larger claim was made:

> In the early 1970s we at Fulbourn were able to say that out of the twenty-three wards at Fulbourn hospital, four – Friends, Street, Westerlands and Mitchell – were functioning fully as therapeutic communities proper and that several others were functioning as modified therapeutic communities.[18]

A rather different interpretation of the state of the wards at Fulbourn in the 1970s was given by Dr Geoffrey Pullen. Pullen came to the hospital in 1975 as a senior registrar, and subsequently went on to a consultant post in Oxford, where he became a leading advocate for the therapeutic community movement. Looking back at his period of professional development in psychiatry, he was in no doubt about the uniqueness of the therapeutic regime on his own training ward at Fulbourn:

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[17] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p.190.
[18] Ibid, p. 205.

> Street Ward (1975-1979) is probably still the most sustained and intensive British attempt that has been made to run an orthodox acute admission ward as a therapeutic community.[19]

Ward life on Street during this period revolved around the morning's 'community meeting', which was held daily, from 09:30 to 10:15.[20] Attendance was expected on the part of all those who were on the ward at the time. Unlike the daily meetings on some other wards, there was no chairperson or agenda and the content could be wide-ranging. The main focus for the often turbulent discussions were the happenings on the ward since the previous day's meeting. After the open meeting, the staff then withdrew for their own private meeting which lasted for around half an hour. In addition to the daily community meeting, all patients also attended small group meetings twice a week, and were encouraged to join in the weekly sociodrama and art therapy sessions.

In his account of Street, Pullen stresses how unusual it was in the 1970s for a ward claiming to be a therapeutic community to be continuing to treat its patients with both drugs and electroconvulsive therapy (ECT). Some of these patients, indeed, were treated against their will under a Section of the Mental Health Act 1959, and a later critic has maintained that such coercion on Street ward 'fatally contaminates the essence of what communities have traditionally represented.'[21] Pullen himself seems to have set modest aims for the ward:

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[19] G. Pullen, 'Schizophrenia: Hospital Communities for the Severely Disabled', in P. Campling & R. Haigh (eds.), *Therapeutic Communities: Past, Present and Future* (London, 1999), p.142.
[20] Ibid.
[21] L. Clarke, *The Time of the Therapeutic Communities: People, Places and Events* (London, 2004), p. 155.

> A minimum desirable outcome, therefore, was to create a group living experience on Street that was not anti-therapeutic and did not interfere with other treatments.[22]

Street was also unusual in this period for its commitment to obtaining data on its outcomes, but this was fully in accord with David Clark's focus on collecting research findings to demonstrate the effectiveness of his philosophy of treatment. In 1982, Pullen published the following table of results [Table 8], showing that the ward compared favourably with others in the hospital and that a shorter average length of stay was not associated with an increase in re-admissions.

Table 8: Admissions, re-admissions and patient numbers for Street and other acute wards.[23]

	Street	**Ward A**	**Ward B**
Number of admissions 1.7.78-30.9.78	77	73	65
Number of patients	69	63	58
Number of patients re-admitted during following 12 months	16	15	22
Number of admissions 1.10.78-30.9.79	300	277	232
Average length of stay 1.10.78-30.9.79	16.8	34.9	38.1

Another element of Clark's philosophy that was fully shared by Pullen was the conviction that the pressures they faced meant that staff needed therapeutic support too. Indeed, he went so far as to assert that, 'Street could be seen as two parallel and interrelating therapeutic communities: the short-stay patient community and the longer-

[22] G. Pullen, 'Schizophrenia: Hospital Communities for the Severely Disabled', in P. Campling, & R. Haigh (eds.), *Therapeutic Communities: Past, Present and Future* (London, 1999), p.142.
[23] S. Davies, 'Survival and Growth in the Marketplace: Does Every District Need a TC?', in P. Campling & R. Haigh (eds.), *Therapeutic Communities: Past, Present and Future* (London, 1999), p. 226.

stay staff community.'[24] While Clark concentrated on the needs of doctors throughout the hospital in his 'Friday meetings', Pullen focused on those of nurses at ward level. He subsequently claimed that this supportive atmosphere resulted in Street experiencing nurse sickness rates that were only three-quarters of those in the other two admission wards.[25]

In the light of these conflicting claims about the implementation of concepts drawn from the therapeutic community movement, the reality seems to be summed up most accurately in Ross Mitchell's comment which was quoted above:

> *Although the therapeutic community was a sort of underlying philosophy, each of the teams interpreted that and did it as they wanted.*[26]

Whatever the precise nature of the developments carried out under the banner of creating a 'therapeutic community', nurses were well aware of the changes being implemented in the three admission wards. As Jimmy Loh recalled his student nurse placement:

> *For Street Ward, it [was] getting more therapeutic community minded. There were a lot more groups going on, and at that time we had an Art Department, we had a Psychology Department, an OT Department. And 'family work' was beginning to be important, and psychotherapy's important, group work's important, and all that.*[27]

The new stress on family work was to become one of the key features of the new ward regime.

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[24] G. Pullen, 'Schizophrenia: Hospital Communities for the Severely Disabled', in P. Campling, & R. Haigh (eds.), *Therapeutic Communities: Past, Present and Future* (London, 1999), p.143.
[25] Ibid.
[26] Transcript 03, Dr Ross Mitchell.
[27] Transcript 17, Jimmy Loh.

Kent House was a two-storey building, so both Street and Friends Wards had accommodation upstairs that was used for patients who were felt to be showing signs of improvement. So being transferred 'upstairs' held a positive symbolic meaning for both patients and staff, as Loh testified:

> *The downstairs level, right, are people who are either newly-arrived or more ill. If you were better – you go upstairs. So you can see the patient's view – there's improvement, 'that means I'm improving! I'm going upstairs!'*[28]

Student nurses of this period were well-aware of what constituted the key elements of the 'therapeutic community approach':

> *At that time it was the 'in thing', people were very therapeutic community-minded, and there was a lot of – you know, community meeting every morning – and then …giving patients responsibilities, like looking after the stores, doing the ordering, and looking after each other – you know, especially when we had very depressed old ladies coming in, who won't eat.*[29]

As student nurses formed a major part of the nursing workforce, their commitment to the innovations was vital.

In a rare departure from normal practice, a woman who had been a patient in Fulbourn's admission unit wrote in a nursing journal about her experience there.[30] It was very unusual for any patient to contribute to the *Nursing Times*, let alone one from a

[28] Transcript 17, Jimmy Loh.
[29] Ibid.
[30] H. Crockett, 'Fulbourne [sic] Hospital: a patient's view' *Nursing Times*, 70, 16 (1974) pp.603-604.

stigmatising area such as mental health, so this article by a patient who spent two weeks in the admissions unit, Kent House, was probably unique in the history of the hospital. Presumably its publication was facilitated by the nursing staff, but there is no indication of this in the article. It presented a positive view of the helpful contribution that other patients made to this woman's recovery from a mental breakdown that she attributed to the stress of arriving back from South Africa with her husband and two young children. The nurses also received positive comments, but the interaction with other patients, and in particular the sharing of burdens via the ward meeting, formed the article's focus.

Jimmy Loh also stressed the perceived benefits of encouraging patients to take responsibility for their fellows:

> *Some people actually feel obligated to say, 'Look, instead of sitting around doing nothing, myself, I'll look after somebody, and take them out and go out to shops, and whatever.' And they did all sorts of things – they would do it for you, they would do it for fellow-patients, and so it was very much a community. And you could rely on each other.*[31]

The development of reciprocal relationships between patients was one of the positive features of such a ward, and it was noted by several nurses who were interviewed for this study.

Occasionally, patients made such a contribution to the smooth running of the ward, and became so settled in the hospital, that they joined the hospital staff. Such a development was regarded with equanimity by Loh

[31]Transcript 17, Jimmy Loh.

> *And I was very fortunate later on when I was in-charge of Friends Ward that actually I had a cleaner who was obsessionally clean, and he also used to be a patient.*[32]

While the employment of a conscientious member of staff who would be likely to make a long-term commitment to the job was a pragmatic solution which gave immediate benefit to the ward, it also raised fundamental questions about the purpose of the therapeutic community approach used on the admission wards. The process of turning the abler patients into staff members was a common feature of the old-style asylums for people with mental health problems or learning disabilities.

However, in the context of the implementation of the therapeutic community philosophy as practised on the admission wards, it did raise questions about its effectiveness. Did the community prepare patients for life outside the hospital, or was it a comfortable retreat from the outside world that encouraged dependence rather than independence? As described in Chapter 5, the hospital continued to provide a continuing round of social activities throughout the year, so there was little impetus to break away to a life in the often unwelcoming society outside its grounds. This issue will be explored in more detail in the next chapter.

Three major themes affecting nurses working in the admission wards can be identified in the research undertaken in Fulbourn at the time, and in the oral history interviews conducted for this study. These were, the issues for nurses implied by the 'medical servicing' model of care; conflict over uniforms; and attitudes to risk. These issues will now be explored in turn.

[32] Transcript 17, Jimmy Loh.

Nurses and 'Medical Servicing'

David Towell, a postgraduate sociology student, first approached David Clark in 1967 with the proposal that he should base his PhD thesis on a study of the impact on nurses of the changes being adopted in Fulbourn. Clark enthusiastically supported this plan and Towell completed his doctoral thesis in 1973.[33] A modified version of this thesis, with an introduction by Clark, was subsequently published in 1975 by the Royal College of Nursing in their series of research monographs.[34] These monographs, funded jointly by the RCN and the Department of Health and Social Security, collected together some of the most important nursing studies of the period and their semi-official status ensured that they were to become available in every nursing library in the country. At a time when the evidence base for nursing practice was still barely developed, studies chosen for publication in this way achieved a prominence which would not be replicated. Through this fortuitous circumstance, Towell's study of nursing in the pseudonymous 'Eastville' hospital became a milestone in the development of research in mental health nursing, although only a minority of those who used it in their studies would have known that the hospital was in fact Fulbourn.

One of the three clinical areas that Towell chose to focus on was 'Swift ward', one of the two admission wards in what was described as 'the new, purpose-built accommodation', which was clearly Kent House.[35] To provide a contextual basis for his study, Towell outlined the characteristics of the patients admitted to the ward during a two month period. There were a total of 52 admissions, with approximately twice as

[33] D. Towell, 'Understanding Psychiatric Nursing' (Cambridge Univ. Ph.D. thesis, 1973).
[34] D. Towell, *Understanding Psychiatric Nursing: A Sociological Analysis of Modern Psychiatric Nursing Practice* (London, 1975).
[35] Ibid, p.45.

many women as men admitted. Over forty per cent were re-admissions. Most of the patients were ‘informal’, but about ten per cent were held on a Section of the 1959 Mental Health Act. Those most commonly used were Section 25, Section 26 and Section 29. Table 9 outlines the characteristics of these powers.

Table 9: Mental Health Act 1959

Section	Powers
25	Admission for observation of a patient who: (a) 'is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital under observation (with or without other medical treatment) for at least a limited period; and (b) that he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.' Period of observation not to exceed 28 days.
26	Admission for treatment of (a) a patient 'suffering from a mental disorder, being – (i) in the case of a patient of any age, mental illness or severe subnormality; (ii) in the case of a patient under twenty-one years, psychopathic disorder or subnormality; and that the said disorder is of a nature or degree which warrants the detention of the patient in a hospital for medical treatment under this section; and (b) that it is necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should be so detained'. Two doctors were required to sign the prescribed form. Initial period was 12 months.
29	Admission for observation in case of emergency. 'An emergency application may be made either by a mental welfare officer or by any relative of the patient.' One medical recommendation required: period of detention not to exceed 72 hours.

The diagnostic labels applied to the patients admitted to 'Swift Ward' are given in Table 10:

Table 10: Diagnoses of patients admitted to 'Swift Ward'[36]

Diagnosis	**Number admitted**
Depression (including endogenous, reactive, and agitated)	20
Depression with hysterical features	3
Anxiety depression with a hypochondriacal history	1
Hypochondriac	1
Schizophrenia (including paranoid)	6
Full details not given by Towell (includes personality disorder, hypomanic, presenile dementia, alcoholic)	8
Not diagnosed on admission	13

Towell's main method of data collection for this element of his study was close observation of the activities and interactions of a student nurse assigned to the ward. A total of 300 such episodes were recorded over a period of two shifts.[37]

This focus on student nurses emphasises their importance in delivering nursing care on the wards of Fulbourn. Jimmy Loh recalled the staffing level for a 29-bed admission ward, where students often outnumbered trained nurses:[38]

> *We had a Charge Nurse, working eight to five, we had two deputy Charge Nurses … and two Staff Nurses, and then you had a Nursing*

[36] D. Towell, *Understanding Psychiatric Nursing: A sociological analysis of modern psychiatric nursing practice* (London, 1975), p. 46.
[37] Ibid.
[38] Maurice Fenn, the Principal Nursing Officer, had done considerable work on nurse staffing levels at Fulbourn: M.F. Fenn, 'Change in a Psychiatric Hospital after 100 Years of Traditional Management', *Nursing Times* 24 May (1968), pp.716-717.

Assistant, right? That's nursing … one OT. Then you had Social Workers coming in and out. Then you had Psychologists who helped to run groups – who spent some of the time there, but were also doing Outpatients and all that… And then you had about five to seven students, of first-year, second-year, third-year.[39]

Towell's concern with the role of the student nurse led him to question the appropriateness of the focus on psychiatric diagnoses, both on the ward and in nurse education. He was not the first researcher to demonstrate that such labels could be seemingly imprecise. One example he cites concerns the patient referred to as 'Dora'. Within a short space of time she was diagnosed as having schizophrenia, then as being a psychopath, and finally as having a hysterical reaction.[40] Towell demonstrated that the nurses' attitudes to the patients, and hence the amount of attention and interaction they received, were determined by the diagnostic labels that became attached to them. These attitudes were based upon shared assumptions about which patients were 'really' ill, and hence could not be held to be responsible for uncooperative or challenging behaviour. So at one end of a spectrum, patients diagnosed as suffering from schizophrenia were regarded as genuinely sick, and so their often difficult behaviour was accepted. At the other end of the spectrum, patients with diagnostic labels such as 'inadequate', 'psychopath', or 'hysterical personality', received a much more negative response from the nurses.[41]

This 'medical model', based upon nurses' understandings of diagnoses, obviously ran counter to the stated philosophy of a therapeutic community, in which intense

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[39] Transcript 17, Jimmy Loh.
[40] D. Towell, *Understanding Psychiatric Nursing: A sociological analysis of modern psychiatric nursing practice* (London, 1975), pp. 76-77.
[41] Ibid, p. 57.

communication within a non-judgemental frame of reference was held to be vital. For those student nurses who were more in tune with the philosophy of the therapeutic community, Towell identified the potential problem of intense relationships developing with individual patients. These gave rise to accusations of favouritism and attracted sanctions from the trained nurses. In the absence of significant teaching input from the ward doctors, or clear guidance from the School of Nursing, it was probably unsurprising that student nurses seemed unsure of their role in the therapeutic community and so tended to fall back on the more 'traditional' approach that they saw their seniors espousing.

The Issue of Nurses' Uniforms[42]

Major conflicts of principle sometimes come to be encapsulated by apparently minor symbolic gestures, and for nurses at Fulbourn, the issue of whether nurses should wear uniform or 'mufti' while on the ward came to assume major proportions.[43] In the context of mental health nursing, uniforms conveyed a range of messages. For female nurses, uniforms proclaimed the wearer's position within the nursing tradition of Florence Nightingale and the general hospitals. With Addenbrooke's, a prestigious teaching hospital, only a few miles away, this identification was felt to be particularly important. Until the 1980s, the uniform consisted of a blue dress fastened with a belt bearing an impressive silver buckle. A white card or lace cap was balanced precariously above hair swept up to clear the collar. A staff nurse or ward sister wearing such a uniform therefore proclaimed both her status as a 'real' nurse in the Nightingale

[42] Material from this section and subsequent ones has been accepted for publication: J. Adams (In Press), 'Nursing in a Therapeutic Community: The Fulbourn Experience, 1955-1985' *Journal of Clinical Nursing.*
[43] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p. 205.

tradition, and via the gradations of uniform styles, her place within the Fulbourn nursing hierarchy.[44]

For male nurses, uniform carried much more ambivalent messages. The suit and the white coat could lead to a male nurse being mistaken for a doctor, so the epaulettes on the white coat formed an important distinguishing mark, as well as establishing his place in the nursing hierarchy. Neil Chell recalled the practice at his training hospital, St Edward's, Cheddleton, near Stoke-on-Trent:

> *We had a suit – a hospital suit – I think it was every year or eighteen months – where the hospital tailor would actually measure you up and it's the only time, before or since, that I've actually been measured up for a suit. And you would have a black – dark grey/black – suit which you had to wear on duty, with a shirt, white shirt, a tie, and a white coat – a doctor's-type coat with epaulettes, depending on, again, similar colour-scheme to the female nurses.*[45]

For those men with a background of service in the armed forces, wearing a uniform could seem a reassuring feature of a job in the public service. Quasi-military attitudes to uniforms for male nurses were common in psychiatric hospitals across the country. Chell underlined the importance accorded to badges at Cheddleton:

> *And I remember that the badges – you had to wear them in a certain order – so, I think it was, your State Registered badge had to be on the top, your hospital badge had to be second, and your trades union badge was third. And you were reported to the Nursing Office if your*

[44] It is significant that a publicity photograph for a nurse recruitment brochure taken circa 1960 shows three out of the five female nurses in uniform (Appendix 1, Photograph 7). While purporting to show nurses relaxing off duty, it is more likely that nurses who were on duty were asked to fill out the scene.
[45] Transcript 14, Neil Chell.

badges were in the wrong order or one was missing. So it was almost sort of very military in its regime.[46]

However for those nurses with an awareness of the history of asylums, male staff uniforms symbolised the harsh institutional regime that they were striving to reform.

There was also a generational issue. The younger men who had not experienced wartime military life or National Service were inevitably influenced by the 'pop culture' of the 1960s, with its stress on the expression of individuality through hair and clothing. Chell was immediately struck by the contrast between some of the Fulbourn nurses and those he worked with in his previous post, and he recalled:

Going onto an elderly ward and some of the staff there were in jeans, t-shirts, and long hair – which I would have loved to have done at St Edward's, but I would have been shot at dawn![47]

While Chell was excited by the prospect of wearing fashionable clothes to work, other junior staff in the hospital at the time were concerned that 'unprofessional' clothing implied sub-standard nursing care.

But the rejection of nursing uniforms carried an importance far beyond the dictates of fashion. When John Lambert was asked by the Senior Nursing Officer to move from Westerlands to Adrian House, uniform issues were part of the agenda:

One of the admission wards was in a pickle, there was constant warfare between the nurses and one of the consultants. And there were splits within the nurses as well – half of them wearing uniform,

[46] Transcript 14, Neil Chell.
[47] Ibid.

half of them without, the sickness rate was very high, and Maurice Fenn asked me to go and sort it out.[48]

Upon being appointed to the Charge Nurse post, Lambert wasted no time in clarifying his future relationship with the consultant psychiatrist:

He grabbed my arm as I walked across the grass, down towards Kent House, and he said, 'Now, I shall tell you how I want my new charge nurse to behave.'

And I said, 'Well, let's get one thing straight, I am not your charge nurse, I have a profession in my own right – whether you want to see it like that or not, and I will run the ward! If you want to run the ward – you go and do three years of nurse training!'

[He replied] 'Oh – I'm going to have problems with you, then.'

I said, 'Well, I hope you don't see it like that, but yeah – if that's going to be your attitude. You don't run me.... I run the ward and I'll make it possible for you to treat your patients on it.'[49]

Lambert's second move was to emphasise the professional boundary between nurses and social workers on the ward, even though it was hardly in the inclusive spirit of therapeutic community practice in the admission unit:

So then I tried to give the nurses back their sense of identity by – I had a special meeting, just for nurses only, and one of the social workers was very upset that I didn't invite her in. I said, 'I'm sorry – this is for nurses only.' And she could see that I was going to take her authority

[48] Transcript 08, John Lambert.
[49] Ibid.

away, and – don't get me wrong, she was a brilliant social worker, and we became very good friends! [laughs][50]

Lambert's third element in his strategy to improve nursing morale was to enforce a common policy on the wearing of 'mufti':

We didn't wear uniforms – we didn't wear name badges.[51]

This change expressed in symbolic form the ward's commitment to the philosophy of the therapeutic community.

This change had the desired effect, but it was not without its own problems, as he subsequently acknowledged:

People, very often, if they are feeling unsure of themselves, won't come up and interact with somebody – they'll sit tight and they'll merge into the background. So it did take some – quite a lot of work with the nurses and the students – students in particular. If you see somebody come into the ward, who looks a bit lost – go and talk to them, and introduce yourself.[52]

A friend visiting his ward to see a patient brought the problem caused by the 'mufti' policy, and the need for leadership on the issue, forcefully home to him:

Shortly after I took over, he said, 'It's very difficult trying to find out who the staff is, and who aren't.'

So I said to him, 'Anybody come up to you and introduce themselves?'

He said, 'No, they didn't.' [53]

[50] Transcript 08, John Lambert.
[51] Ibid.
[52] Ibid.
[53] Ibid.

Visitors were not the only ones who were confused, and nurses themselves were sometimes unclear about the ward hierarchy.

> *In those days we didn't have any uniform, there is no badge, you couldn't really tell whether you were a first-year student, or a third-year student, or anything like that, or post-registration student.*[54]

One of the intended effects of this policy, which seems to have been generally successful, was that it would make student nurses more likely to contribute their opinions in ward meetings.

While this clearly achieved the aim of the promoters of the therapeutic community philosophy in flattening the authority pyramid, it could have a serious impact on ward management and ultimately on patient safety. Policies concerning matters such as the checking and administering of medication required that only nurses with appropriate experience should carry them out, so any confusion about stages of training was potentially dangerous. Judith Atkinson voiced similar reservations from her perspective as a junior social worker:

> *It wasn't clear – since nurses were now out of uniform and everybody was known by their first name – it wasn't clear always what the roles and responsibilities were. I mean, it was quite clear there was a doctor, there was a social worker, there was a ward sister, there were nurses, but I think a lot of people were quite confused about who was taking responsibility.*[55]

[54] Transcript 05, MN01.
[55] Transcript 27, Judith Atkinson.

Atkinson has here highlighted a key issue in the therapeutic community: if hierarchy was lessened, who is responsible for what the community decides? This question is linked to the issue of risk, which is discussed in the following section.

Four years after completing his study of the admission ward discussed in the preceding section, David Towell was invited back to it.[56] He immediately noticed a change in the atmosphere of the ward, with a much greater commitment to social therapy. The previous senior registrar had been replaced by one who had a strong commitment to the concept of the therapeutic community, and in place of the long-serving ward sister there was a new and much younger successor. The invitation to Towell was extended in the hope that he could act as a facilitator to help the nursing staff resolve their differences on the issue of giving up nursing uniforms. On interviewing individual members of staff, Towell found that some objected to the cost of providing their own clothes for work, while others felt that a uniform gave them confidence in the clinical area. Both sides of the argument referred to the situation in general hospitals. Supporters of uniforms felt that uniforms in general hospitals gave patients confidence in the wearers, and that the same would be true in Fulbourn. Opponents argued that mufti conveyed the message that unlike in general hospitals, nurses at Fulbourn were not there 'to do things' for patients.

Listening to such comments, Towell came to the conclusion that the issue of whether nurses should wear uniform or mufti served to mask a deeper disagreement (he used the psychoanalytic term 'displacement') about the philosophy of the therapeutic community, which underpinned nursing on the ward. In response, he set up a regular

[56] D. Towell, J. Burgess, L. Bhim & C. Harries, 'Creating Environments for Social Therapy', in D. Towell & C. Harries, (eds.), *Innovation in Patient Care* (London, 1979), pp. 39-60.

series of meetings to increase staff understanding of the philosophy of social therapy and to more closely define the contributions that they could make. It was hoped that this would decrease reliance on physical methods of treatment. There was also a new focus on liaison with agencies outside the hospital so as to improve understanding of the patient's psycho-social background.[57] As a result of this initiative, outreach from the ward became an accepted part of the nurse's role, as Jimmy Loh recalled:

> *We were learning from each other and then we were doing actually 'family work' – while we were on the wards.*[58]

Nine months after Towell had been called in to help the ward staff, the transition to mufti was made with general agreement.[59] He remained, however, more concerned to ensure that the underlying issues concerning lack of communication should continue to be addressed through constant attention to mechanisms such as staff meetings.

The Concept of 'Risk'

In his book *Social Therapy*, Clark had identified 'freedom' as one of the key characteristics of the hospital regime that he was attempting to create. By doing so, he was consciously extending a concept that had first been formulated at Fulbourn and other 'progressive' hospitals as the 'open door' policy. Freedom was of course the antithesis of the philosophy on which Fulbourn, like other nineteenth century asylums for pauper lunatics, had been founded. Containment and regimentation were built into the very structure of its buildings and airing courts, but they were also central to the expectations that the wider society had of the mental health system.

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[57] D. Towell, J. Burgess, L. Bhim & C. Harries, 'Creating Environments for Social Therapy', in D. Towell, & C. Harries, (eds)., *Innovation in Patient Care* (London, 1979), p. 48.
[58] Transcript 17, Jimmy Loh.
[59] D. Towell, J. Burgess, L. Bhim & C. Harries, 'Creating Environments for Social Therapy', in D. Towell, & C. Harries, (eds)., *Innovation in Patient Care* (London, 1979) , p. 45.

Society required that some patients should be detained under a provision of the Mental Health Act. If a death by accident or suicide occurred, the full weight of the coroner system would be brought to bear, while a murder would inevitably involve a criminal prosecution. The regimentation of personal care meant that activities like dressing and feeding could be carried out in a predictable manner. The relatives of patients generally prized high standards of personal cleansing and dressing, so evidence of slovenly appearance often generated criticism of the ward regime. A failure to meet societal expectations in any of these areas could easily result in hostile coverage in local newspapers, with damage inflicted upon the reputations of individual clinicians and the hospital as a whole. So an inevitable concomitant of a policy designed to move the hospital regime in the direction of greater freedom for patients was a willingness on the part of the hospital management and influential sections of society outside the hospital, to accept risks of all kinds.

Considering the fundamental importance of 'risk' in the practice of social therapy, it received surprisingly little coverage in printed sources on Fulbourn. However, risk proved to be a consistent theme in some of the oral history interviews with nurses. The only doctor in the interview sample to mention it was Duncan Double, who agreed that the ability to accept risk was an essential accompaniment to David Clark's philosophy:

> *It's not so long ago that the asylum doors were opened and David Clark was so important. These days, they're so worried about risk and risk assessment. You know, if you read his books – all the sort of risks he had to take – opening doors and people saying he couldn't do it.*

> *People can be so defensive these days. And a lot of good came from it.*[60]

A similar contrast between attitudes in the 1970s and those of today was expressed by the Rev. Mike Law, who was the chaplain at Fulbourn:

> *We've gone right to the other extreme now, people now can't be creative, people won't take risks. They're frightened – it's the blame culture. Fulbourn is rather like a microcosm of what was happening globally, really, you know, the blame culture, people are very careful now – they won't take risks whereas at one time they would take them.*[61]

Several former and current Fulbourn nurses used the phrase 'blame culture' in informal conversations about the present state of the hospital.

The issue of risk loomed large for nurses, presumably because they felt themselves more exposed to punitive sanctions if things went wrong. Jimmy Loh mentioned risk in the context of his time as the charge nurse of Friends Ward:

> *Once a week I would go out with another member from my team and we would go out and we'd do family work. So if you've only got very scarce resources, if people are committed and creative enough, you can do it. But it does mean taking a lot of risks. We were prepared to do that.*[62]

Eric Kaloo, another Fulbourn nurse, mentioned the issue of risk in connection with taking patients on holiday.

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[60] Transcript 15, Dr Duncan Double.
[61] Transcript 04, Rev. Mike Law.
[62] Transcript 17, Jimmy Loh.

That was a trip [to Rhyl] I used to take them – people weren't very keen to take patients out because they feel, apart from hard work, it was quite risky for some of the patients.[63]

Chas Ramlall moved from a nursing post in Manchester to one at Fulbourn, and immediately became aware of the change in attitudes:

And I think that was a little to do with the culture, because on the one hand we had a philosophy of – if you want to work with people, it's OK to take a risk, and working with them, and discussing what should be done, and who should do what, these were community meetings.[64]

But in retrospect, John Lambert was concerned about the possible negative repercussions that some of the risks he took when caring for patients could have had for himself and for others:

I go hot and cold sometimes when I think of the risks we took![65]

Fortunately, none of these episodes ended badly.

Jimmy Loh associated a risk-averse philosophy with adherence to a more medically-dominated approach to psychiatry, during his time in Adrian House:

And at that time [the therapeutic community] principle still applied, even though one of the Consultants was more 'medical-minded' than the others – a bit more anxious. I think that's because […] they're not sure whether they could take that risk. But if you run a therapeutic community, you have to take risks. There's no two ways about that![66]

[63] Transcript 06, Eric Kaloo.
[64] Transcript 09, Chas Ramlall.
[65] Transcript 08, John Lambert.
[66] Transcript 17, Jimmy Loh.

He was also clear that planning, teamwork and support from colleagues were effective ways to minimise the fallout if things should go wrong:

> *And as long as it's a calculated risk, as long as you build in safeguards, so that people can come back to you. You know the person well enough to know you can take that risk, and you have to be prepared to drop things and go out to help sort things out. So, it worked well, to my mind. In fact, that set my sort of culture in psychiatry, my own preferences.*[67]

A perennial dilemma for the nursing staff was how to maintain satisfactory levels of observation on the ward while ensuring the fullest possible attendance at the frequent ward meetings. This was a particularly acute issue as the patients choosing not to attend the meetings were likely to be either the most restless and disturbed, or the most depressed and withdrawn. As patients in both these groups were likely to be at considerable risk of self-harm, constant observation was essential.

Jimmy Loh recalled the nursing response which developed to minimise these risks:

> *We devised a system called, 'the duty doc'. It could be a student, it could be one of the trained staff – if you are doing it that day or that week, right?, you don't go into groups. So then that enables the others to be in the group. Because most patients went into groups, that means you only have a few people to look after outside, right? It's safer.*[68]

This simple arrangement came to be widely adopted throughout the hospital.

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[67] Transcript 17, Jimmy Loh.
[68] Ibid.

Unlike many other wards and units claiming to implement the philosophy of the therapeutic community, Fulbourn never abandoned the resort to forcible sedation followed by seclusion if it was felt to be necessary. If a situation developed in which patients were felt to be a danger to themselves or to others, ward nurses would attempt to inject the patient with a powerful sedative, such as chlorpromazine or haloperidol. Nurses could not do that on their own initiative as medical sanction was always required. In the early 1970s, paraldehyde was still being used on occasion, and Jimmy Loh retained negative memories of it:

> *That is very awful stuff because it's one that you have to use glass syringe – otherwise it melts. And if you think of it, it's pretty potent. Yes, you feel it – the patient feels the pain – the patients would know that's been done! Awful stuff! But we didn't use that much, but I have known it to be used quite a few times, when I was doing my training.*[69]

Paraldehyde also had a strong and characteristic smell, which was widely remembered as the distinctive feature of many unreformed mental hospital hospitals.[70]

Maintaining control of the ward always remained the fundamental concern for nursing staff, and if his ward staff could not achieve it unaided, Loh used to call upon outside help:

> *Now you ring whoever is the Nursing Officer on duty, right, you say, 'I need the heavy gang'. And what he does is ring up all the male staff on all the other wards [laughs] and says, 'they need you!'. And you'd*

[69] Transcript 17, Jimmy Loh.
[70] W.L. Jones, *Ministering to Minds Diseased: A History of Psychiatric Treatment* (London, 1983), pp.42-43; H. Freeman, 'Alex Baker' [Oral history interview], in G. Wilkinson (ed.), *Talking About Psychiatry* (London, 1993), p.197.

> *find that half-a-dozen staff would come along, and then you'd inject the first patient.*[71]

Once the disruptive patient had been successfully injected with sedating medication, Loh would help them into a side room:

> *But at that time we did have what we called a blue room – the seclusion room. It used to be what they called the padded cell – they took away the padded bit, took away the straight-jacket – that's what David Clark did… Somebody would have to go in and take their BP and pulse and all those, in order to make sure that they are OK.*

While Clark's determination to extend the philosophy of the therapeutic community to even those wards caring for the most disturbed patients probably made the retention of such sanctions inevitable, it did mean that Fulbourn continued to stand outside the main tradition, with its emphasis on selecting, on the basis of informed consent, co-operative participants who were receiving few if any physical treatments.

Conclusion

While David Clark originally set out to convince his fellow psychiatrists working in large county mental hospitals that 'administrative therapy' represented the appropriate philosophy for them to adopt, by the end of the 1970s he had to recognise that it had made little impact. Instead, he shifted his focus to other members of the hospital team, and in particular to the nursing staff. Rebranded as 'social therapy', Clark's ideas were to prove highly influential in developing the nursing culture within Fulbourn and

[71] Transcript 17, Jimmy Loh.

beyond [see the following chapters]. However, Clark did not require his medical colleagues to replicate his methods of ward management exactly, so each ward tended to implement the philosophy of the therapeutic community approach in its own way. Clark's focus upon research and publishing ensured that books and articles about developments in Fulbourn reached a wide audience, and reinforced the personal contacts established through study days, conferences, and personal contacts.

Major changes to ward regimes naturally have a major impact upon the nursing staff who work there, so their role was crucial. There was general agreement that the new philosophy encouraged patients to take a more active role in their own and others' treatments, and also encouraged new initiatives in family work. Many of the nurses at Fulbourn felt empowered to take up Clark's new approaches to nursing care by the perception that he would support them if things went wrong. The concept of 'risk' and its management continued to loom large in mental health nursing.

While Clark's initial attention focused on the admission wards, he soon moved to introduce similar changes to the so-called 'back wards' of the hospital, which housed patients requiring long-term rehabilitation or continuing care. This aspects of his reforms is explored in the next chapter.

Chapter 8: Nursing Reforms at Fulbourn

Introduction

The previous two chapters have analysed some of the implications for nurses of the introduction of 'therapeutic communities' as part of David Clark's commitment to the 'social model' in psychiatry. While Clark was introducing his 'therapeutic community' principles to the admission and acute wards in Fulbourn, he was also fully aware of the need to develop nursing in the hospital as a whole. So the same approach was also employed on the rehabilitation wards, and the wards caring for older people. He focussed upon the issues of nurse recruitment and education, as he realised that staff shortages and inappropriate skill-mix risked undermining his reforms. In addition, he fostered a culture of research and publishing by nurses at the hospital. So this chapter will review changes to the wider hospital, largely from the perspective of the nursing staff.

The 'Back Wards'

County mental hospitals throughout the country were effectively divided in two. The division was between the admission and acute wards, and the so-called 'back wards', housing the long-stay and older patients.[1] The former largely monopolised the input of consultant psychiatrists and had better ratios of nursing staff and better physical surroundings and amenities. The latter were often associated with infrequent medical rounds, low ratios of nursing staff, and lack of further career opportunities for all who worked in them. The working conditions demoralised nurses, and the unchanging drudgery of care delivered in such poor physical surroundings tended to lead to patients

[1] R. Hunter & I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum, Friern Hospital 1973: A Medical and Social History* (London, 1974), p.164.

being regarded as ‘objects’ of labour, rather than as ‘people’. David Clark remembered the situation that he found:

> *Certainly on the ‘back wards’, one’s feeling was that the women staff were harried, grey-haired, middle-aged women, who attempted to cope with an impossible situation. So yes, I mean I saw the issue, it was quite clear to me that if we were to improve things, we had got to get other, new, different, better people into the place.*[2]

It was unsurprising that when a wave of patient abuse scandals arose in mental hospitals in the 1960s, ‘back wards’ featured prominently in the complaints.[3] It is therefore important to stress that Fulbourn, under Clark’s stewardship, did not attract such negative attention.

However, patients at Fulbourn could not be shielded from the reality that transfer from the acute wards meant that their stay in the hospital was likely to be a long one, as Doreen Bacon recalled:

> Then came the bombshell. I was to be sent to the dreaded long stay wards in the main building. My tears fell night and day for 48 hours. Here I was – 40, with no home, family, money, and few possessions left. No hope of a future either. One could not sink any lower in life, I reasoned.[4]

These comments serve to focus attention upon the human dimension of becoming consigned to the ‘back wards’ of a mental hospital.

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[2] Transcript 02, Dr David Clark.
[3] P. Nolan, *A History of Mental Health Nursing* (London, 1993), pp.134-136: J.L.T. Birley, *Psychiatric Scandals: Past, Present and Future* (London, 1994).
[4] Fulbourn Archives: D. Bacon, *To Bedlam and Back, 1954-1972* (c.1985), p.4.

Nursing on the Rehabilitation Wards

One of the common strategies used by managers to encourage change in a service is to use a new name as an instrument to promote movement in the desired direction. On his return from California in 1963, Clark had announced the creation of a new 'rehabilitation unit' under the leadership of Oliver Hodgson. While this new name may have given the impression of a planned programme leading to early discharge, the reality was that most of the patients in the rehabilitation unit had been there for periods of many years. When Dr Ross Mitchell was appointed as a Consultant Psychiatrist at Fulbourn in 1966, it gave Clark the opportunity to re-organise again. Mitchell was given the rehabilitation unit while Hodgson moved to the geriatric unit. Part of Clark's plan was that each of the three admission wards would be linked to a specific rehabilitation ward for those patients who could not be discharged [Table 11].

Table 11: Ward Links, From 1966

Admission ward	Rehabilitation ward
Friends	Mitchell
Adrian	Ferndale
Street	Fenmere
	[Not allocated: Southview, Hillview, Elm]

Despite the label 'rehabilitation', Ross Mitchell was under no illusion about the reality that lay behind it:

> *We had the medium long-stay patients, who were recruited from the acute admission service.*[5]

[5] Transcript 03, Dr Ross Mitchell.

The usual practice was to transfer patients from admission to rehabilitation wards if they still needed hospital treatment after three months, but there was no set period for the subsequent stay on the rehabilitation ward. So many patients stayed for several years.[6]

In 1969, Mitchell was assigned to other duties and another ward re-organisation ensued. Jimmy Loh arrived at the hospital as a student nurse in 1971 when this new arrangement was already established, and hospital gossip attributed this change to previous medical neglect

> *Now at that same time, Dr Clark had already set in motion – that instead of all these … wards, as back-up wards for admission wards, he agreed with his Consultant colleagues that he would take them on as one service, right, and try and do something about that. Because what happened was that most of these – except for Mitchell – most of the other wards, the Consultant only goes there once a year! [laughter]*[7]

Clark took the opportunity to re-name the 'rehabilitation unit' as 'the social therapy area' to reflect his recent adoption of the term to designate the changes to ward regimes that he was intending to foster at Fulbourn.[8]

While all six wards may have been grouped together under this designation, they actually served patients with widely differing needs. At one end of this spectrum was Mitchell ward, which was designated as a 'hostel' ward because the patients were felt to

[6] D. Towell, *Understanding Psychiatric Nursing: A Sociological Study of Modern Psychiatric Nursing Practice* (London, 1975), p. 33.
[7] Transcript 17, Jimmy Loh.
[8] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p. 220.

be largely self-caring, and so there were no night nurses allocated to work on it. Jimmy Loh described its informal approach, which was fully in tune with Clark's philosophy:

> *We were all called by our first name, and patients had got leave – some of them were actually working outside. Then they also come back and we have evening meetings … they decide the care plan, you know, look at what they wanted to do, then move on. It was very much on the principle of a therapeutic community.*[9]

Nick Smithson reflected on the democratic approach adopted on Mitchell ward, but he was also aware that there were critics of this approach in other parts of the hospital:

> *It was again the idea of trying to involve patients in the decision-making process on the ward. It might have been chaotic and at times cumbersome, but it felt both a humane and a practical and sensible thing to try to get the whole group of people to do. So in one sense, the patients were almost construed as part of a team, rather than just subjects or objects, the recipients of 'expert' care.*[10]

The patients on Mitchell ward were able to make contributions to the process of therapeutic decision-making that went far beyond the merely tokenistic and which could make a real difference to care:

> *On occasions they would contribute to trying to change… a particular other patient's treatment, be it the treatment medicine – as it occasionally was – or some form of occupational therapy, or visits out of the ward. Sometimes it did involve patients who were being more*

[9] Transcript 17, Jimmy Loh.
[10] Transcript 07, Nick Smithson.

disturbed than others – how best to work with them, or live with them, or to deal with them if difficulties persist.[11]

Smithson's account testifies once more to the success of the therapeutic community in fostering reciprocal care amongst the patients.

At the opposite end of the spectrum from Mitchell ward was Fenmere, which had a largely static population of ex-servicemen who were still trying to cope with the psychological scars inflicted by their war-time experiences. When Jimmy Loh joined the hospital in 1971, Fenmere was a by-word for traditional nursing practices. As was the case for all hospital wards, the tone was set by the nurse in charge, who combined a regimented ward regime with enthusiastic support for Clark's philosophy of 'work for all':

> *He used to work part of his time in the mortuary – chopping up livers and brains and, you know, parts of organs! … So some of them were very traditional – so they had [a] 'men Thursday bath/women Wednesday bath, and a change of clothes' [mentality].*
>
> So I guess they wouldn't be having groups for the patients, or anything like that?
>
> *No, no, they sent them all to work in the garden, in the workshop, in that sort of thing. At that time we had some workshops we called 'the industries'.*[12]

Eric Kaloo took over as the Charge Nurse of the ward later in the decade, and he decided that the focus of the ward should be on therapy for what would later be called 'post-traumatic stress disorder':

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[11] Transcript 07, Nick Smithson.
[12] Transcript 17, Jimmy Loh.

> *I was working with patients who had been there for a number of years – something like twenty or thirty years, some of them… Obviously the War had caused a lot of harm to them, mentally, so they were able to feel very comfortable, having a home and having people to look after them.*[13]

The final phrase, 'having people to look after them', encapsulates a ward philosophy that was far removed from that of the therapeutic community. By 1983, Fenmere was known as a 'hospital-hostel', with a focus on preparing patients who had spent many years in the hospital for transfer to group homes in the community.[14]

Between these two poles could be placed Ferndale, a 29-bed long-stay ward for men and women. In 1975, the average length of stay was twelve years, ranging from two to thirty-seven years. A desire to change the nature of the ward regime led the charge nurse to approach Clive Harries, a senior nurse who was then working in the hospital as a social research advisor, for help to make improvements.[15] The ward had already embraced many of Clark's reforms, as it was run on 'open door' lines and the nurses did not wear uniforms. However, the staff felt that they had tried to go further and implement the full philosophy of the therapeutic community, but that the patients had been unresponsive and so the attempt had come to nothing. In addition, nursing morale was low as the staff felt forgotten and ignored by the rest of the hospital: partly because of their failure to implement the therapeutic community model of care, and partly due to the physical location of the ward at the back of the hospital site. So this was another example to support Pullen's argument, discussed in chapter 7, that changes to the

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[13] Transcript 06, Eric Kaloo.
[14] M. Frois, B. Kole, H. Jack & C. Harries, 'A 'Hospital-Hostel'', *Nursing Times* 14 September (1983), pp.46-48.
[15] D. Towell, J. Burgess, L. Bhim & C. Harries, 'Creating Environments for Social Therapy', in D. Towell & C. Harries, (eds.), *Innovation in Patient Care* (London, 1979), pp.50-60.

regimes of Fulbourn wards needed to give equal attention to the psychological needs of the staff. This is not to argue that patients' needs were forgotten, but that high standards of nursing care were more likely to be delivered to patients by nurses who were personally committed to a consistent model of care and who felt valued by the hospital as a whole.

The tool chosen by Harries to explore the regime on Ferndale was the individual interview. Nurses were encouraged to interview individual patients about their lives in general but also about their perceptions of life on the ward. The results were then fed back to the patients for further comment or for correction, and were then discussed by the nurses and ward medical staff. The themes that emerged from these interviews were dominated by the patients' sense of powerlessness to make changes in their lives. There was passive acceptance of the ward regime and a lack of feeling for other patients, with the exception of those who caused annoyance by their angry outbursts or their disruption to the ward routine. As a result of this exercise, it was decided to abandon the twice-weekly community meetings, as patients were showing decreasing levels of commitment to them. In their place, smaller groups of nurses and patients were formed. Harries described these groups as creating a 'counselling approach to care'.[16] In place of the psychodynamic philosophy that was supposed to underpin the therapeutic community meetings, the Ferndale model focused explicitly on practical issues of concern. Even this more modest approach to nurse-patient interaction almost foundered when senior staff were away and the ward had to rely on student nurses to maintain its functioning. Therefore Harries introduced ward orientation procedures for new intakes of student nurses so that they could be briefed on their role on the ward. This issue

[16] D. Towell, J. Burgess, L. Bhim & C. Harries, 'Creating Environments for Social Therapy', in D. Towell & C. Harries, (eds.), *Innovation in Patient Care* (London, 1979), p. 54.

serves to underline the important role that students played in the life of Fulbourn and the widely perceived need to ensure that the system of nurse education kept in step with clinical initiatives on the wards.

One of the last wards at Fulbourn to experience Clark's philosophy of the therapeutic community was Southview. It was home to 18 men and 7 women who had been in the hospital from between 15 to 30 years. Their living conditions were poor:

> To the casual observer, Southview Ward in … seems like a typical back ward of any traditional mental hospital. Its narrow passage, doubling up as a lounge (to which is annexed a television room, dining room and dormitories), might easily be mistaken for a corridor leading to the main ward. However, this is the main ward.[17]

The catalyst for change was the retirement of the previous ward sister in 1979. The new Charge Nurse, Michael Frois, was keen to give the nursing staff a new role as 'social therapists' rather as institutional care-takers. Change was also envisaged for the patients. The former rule which prohibited smoking anywhere but in the designated area was abolished, and patients were no-longer required to knock before entering the staff office.[18] A determined attempt to break up patient cliques was made by, for example, changing the positions of the chairs in the ward. To these strategies was added a formal programme of social skills training for the eight residents who agreed to take part. Following these initiatives, three patients chose to move out into a cottage in the hospital grounds as a first step towards living in the community. The setting itself took on the characteristic appearance of a therapeutic community in the Clark era, as Frois noted:

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[17] A. Astor & M. Frois, 'A Change for the Better', *Nursing Times* 28 August (1980), pp.1534-1535.
[18] Ibid. Smoking was still banned in the kitchen and dormitories.

> The ward gives the impression of being less neat and tidy, but more boisterous, lively and habitable.[19]

The changes in Southview crystallise the later debate about the hospital regime under Clark. To supporters of the 'social model', some visible disorder was a positive sign of a therapeutic environment. For critics, whose views will be presented in the following chapter, they were an indication of culpable neglect.

Nursing in the Geriatric Wards

The fourth division of the hospital, after the admission, acute and rehabilitation areas, and by general consent the most disadvantaged, was the geriatric unit, consisting in the 1970s of nine wards housing around 300 patients.[20] In this respect, the situation in Fulbourn was the same as that in psychiatric hospitals across the country.[21] The majority of patients had the diagnostic label of 'senile dementia' attached to them, and as that condition was untreatable until finally ended by death, a profound therapeutic pessimism characterised ward regimes. Visits from doctors were notoriously infrequent, nursing staffing levels were invariably inadequate, and a general air of neglect characterised these wards. Throughout the 1960s, there was a rising tide of public concern about the scandalous conditions in the 'back wards' of some hospitals, and this came to a head with the publication of Barbara Robb's book, *Sans Everything* in 1967.[22] Conditions in the geriatric unit at Fulbourn never formed the basis of a national scandal, but by the early 1960s, everyone was aware that conditions left a great deal to be

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[19] A. Astor & M. Frois, 'A Change for the Better', *Nursing Times* 28 August (1980), p.1535.
[20] D. Towell, *Understanding Psychiatric Nursing: A Sociological Study of Modern Psychiatric Nursing Practice* (London, 1975), p. 105.
[21] P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff, 2003), p.193; S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St Andrew's Hospital, 1810-1998* (Woodbridge, 2003), p.286.
[22] B. Robb, *Sans Everything: A Case to Answer* (London, 1967).

desired. Clive Harries was clear where much of the credit for the slow process of improvement in the geriatric ward should be directed:

> *It wasn't points to David Clark, because he didn't deal with the elderly, and it wasn't points to Ross Mitchell either – it was Oliver Hodgson.*[23]

Dr Hodgson's key, but understated, role in supporting Clark's programme of reform was also commented upon by other interviewees.

If Clark did not take a direct role in improving the hospital regime for elderly patients, he can nevertheless be credited with ensuring that the geriatric wards were included in the research projects that were carried out in the 1970s. So one section of David Towell's major study of Fulbourn was devoted to the nursing issues that they faced.[24] Through the use of observational methods, Towell concluded that there were two main themes that characterised the nursing sub-culture on those wards: a task-oriented conception of nursing work, and a lack of interaction with patients. The focus on physical care tasks was to some extent inevitable given the physically demanding nature of the nursing care and the lack of staff, as Jimmy Loh remembered:

> *Because you only had a handful of staff and you've got thirty-odd beds …..*[25]

In these circumstances, the needs of patients required unremitting labour from the nurses. Before he commenced his nurse training, Loh worked as a nursing assistant on Stuart Ward:

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[23] Transcript 21, Clive Harries.
[24] D. Towell, *Understanding Psychiatric Nursing: A Sociological Study of Modern Psychiatric Nursing Practice* (London, 1975), pp. 105-142.
[25] Transcript 17, Jimmy Loh.

Now, work was hard in those days…you needed to get patients up, because bear in mind there were demented patients as well as all the elderly patients, and then you helped them with their feeding, helped them with their medication – you just take it to them. Trained staff dished them out and you – you know. And then you had to change them and put them back. And because we didn't have domestics after five [o'clock], then you had to clean the floor, and buff the floor.[26]

Towell recorded that rather than the diagnostic labels that he had encountered on the admission wards, nurses working in the geriatric unit tended to categorise patients through their physical care needs. So some patients with dementia would be labelled as 'wanderers', while others would be referred to by dehumanising terms such as 'vegetable' or 'dregs'. Nurses were also heard to label those who were incontinent of urine as 'wetters'[27]

Even in such a seemingly unpromising environment, Clark was adamant that the philosophy of the therapeutic community should be applied, despite the complete lack of support from other leading figures in the field. This was fully in accord with his determination to employ these principles in the wards for the most disturbed patients, Hereward House and Westerlands, even though this too seemed to fly in the face of the accepted wisdom of the time. Nurses who worked there, however, certainly claimed to have been aware of the beneficial influence of this approach. Jimmy Loh noticed the effect on staff relations:

We all go by our first name, we tried to flatten the hierarchy as much as possible so that it helps with communications, helps with decision-

[26] Transcript 17, Jimmy Loh.
[27] D. Towell, *Understanding Psychiatric Nursing: A Sociological Study of Modern Psychiatric Nursing Practice* (London, 1975), pp. 126, 128.

making, and it helps with people feeling part of the workforce and part of the whole community.[28]

Staff morale was further maintained by a notably tolerant attitude to horse-play on the ward:

We were under a very nice Sister, called Sister Jacobs, and she was very welcoming. But there was always time to play jokes on each other. We would call our Sister 'Helga' [laughs]. And sometimes, if there was something to celebrate, we would put her in the bath! And she would take it![29]

Arriving at Fulbourn from Liverpool in 1975, Student Nurse Nick Smithson was also struck by the atmosphere on the wards caring for older people:

I kicked off my own training working with the elderly here at Fulbourn on two wards – one of which was long-stay, and one which was an admission unit. And the admission unit was non-uniform, apart from one or two staff who elected to, perhaps because they were involved in more physical care in a particular shift.[30]

Student nurses were not alone in noticing the changes. The level of activity for some elderly people had greatly impressed Clive Harries, who was inspecting the hospital on behalf of the Hospital Advisory Service, before he decided to work there:

Many of the places that I went to, they were sat in chairs with a tray across the front of them, so they couldn't get up and go anywhere. But at Fulbourn there was this terrific [atmosphere] – I don't know, it was

[28] Transcript 17, Jimmy Loh.
[29] Ibid.
[30] Transcript 07, Nick Smithson.

just elderly people going somewhere in the morning, about nine o'clock.[31]

From his range of professional experience in many comparable psychiatric hospitals across the country, Harries was able to link the greater amount of activity amongst elderly patients at Fulbourn with a willingness to accept risk.

By making the patient- experience the central issue, the hospital was prepared to tolerate criticism from those who might be shocked at what could be interpreted as neglectful nursing care:

> *I realised that there was something quite special about it because although an elderly lady might have her knickers dropped around her ankles in the corridor, or somebody might be incontinent, they are often the two reasons why, in other hospitals, an excuse for inactivity was given… the domestics don't like clearing up in the corridor… So what you got is a web of interconnecting excuses why not, which you are supposed to accept – the patients are supposed to suffer.*[32]

While levels of 'activity' for older patients were plainly raised at Fulbourn, there seems to have been little interest in the emerging psychological 'therapies', such as reality orientation, which by the end of the decade were becoming influential in such environments.[33] Instead, considerable effort was invested in improving liaison between nurses in Fulbourn and social workers based in the community. This initiative was led by Bev Savage, the charge nurse of Denbigh Ward, and Anthony Wright, a senior social

[31] Transcript 21, Clive Harries.
[32] Ibid.
[33] One exception was the creation of a Fulbourn rating scale: L. Powell-Proctor, N. Chege & B. Savage, 'Creating and Working with Small Groups in a Psychogeriatric Hospital', *Nursing Times* 23 September (1981), pp.1639-1682.

worker based in Cambridge.[34] It built upon a ward-based initiative to assess the functional abilities of elderly patients using a new scoring system developed in Fulbourn to measure the need for nursing care. This new tool was then used as part of a joint assessment process, involving both nurses and social workers, in the homes of patients who had been referred for possible admission to Fulbourn. Over time, specific beds on Denbigh ward were set aside for patients admitted in this way, and close liaison was maintained between nurses, social workers and families throughout the whole cycle of admission, assessment and planned discharge. This initiative therefore anticipated by at least a decade the kind of close liaison between health and social services that would come to be accepted as the norm.

The Reform of Nurse Education

The recruitment and training of nurses was one of the manifold responsibilities of the medical superintendent of a mental hospital, and David Clark maintained a keen interest in nurse education throughout his career. Nurse recruitment in the early 1950s proved difficult, but help came from an unlikely source, courtesy of an enterprising advertising salesman:

> *We advertised in French women's magazines, and got a flood of eighteen-year-old French girls over. Actually, one or two of them are still – well, they've retired now – but they did stay on into psychiatric nursing, and some even took RMN training. Most of them simply*

[34] B. Savage, 'Rethinking Psychogeriatric Nursing Care', *Nursing Times* 21 February (1974), pp.282-287; B. Savage & A.L. Wright, 'Shared Care of the Elderly', *Nursing Times* 31 March (1977), pp.465-468; B. Savage, T. Widdowson & T. Wright, 'Improving the Care of the Elderly', in D. Towell & C. Harries, eds., *Innovation in Patient Care* (London, 1979), pp. 61-81.

stayed for a year and cleared off. It was just having fresh, lively young women in the place – a breath of fresh air![35]

Several other interviewees also commented on the beneficial effect on staff morale caused by the frequent arrival of workers from France.

During his initial years at Fulbourn, Clark was more concerned to develop the existing unqualified staff in order to meet immediate needs:

There were a number of very good people, doing very good work with the patients, who'd been hired as ward orderlies, as nursing assistants, all sorts of headings they'd been, they'd got no qualifications, and yet their intuitive … There was a lovely little man called Aubrey Gentle, for instance, who was officially a ward orderly, in fact was in charge of the heavy construction gang that worked for the engineer.[36]

So Clark instructed the Nurse Tutor, Mr Tudgay, to concentrate on providing refresher courses for such people. This helped to meet the short-term needs of the hospital, but did not accord with national policy:

I got into a lot of trouble with the ladies from the GNC. They said, 'We are deeply concerned that too much of the tutor's time may be taken up with teaching people who are not student nurses, and would remind you, doctor, that the task of the tutor is to train people for the register.'

I said, 'As far as I'm concerned, our job is to get decent treatment for the patients, and if we've got to get that, we've got to get the people

[35] Transcript 02, Dr David Clark.
[36] Ibid.

who are looking after the patients understanding what they are doing'.[37]

This was to be the first of several clashes that Clark had with the GNC over this issue.

While such staff members provided a short-term answer to the problem of nurse staffing, the recruitment of student nurses studying for the RMN qualification, or for post-registration or specialised qualifications, was the only long-term solution. Students gave considerable clinical commitment during their training, and then were able to take up the senior positions in the hospital once they qualified. However, there was little to attract them to Fulbourn at this stage, as the School of Nursing was located in one of the cellars of the hospital, and the single nurses' accommodation was poor.[38] Some nurses, indeed, still lived on the wards, alongside their patients.

Up until the mid-1950s … they had accommodation on the wards. I'm not sure what percentage of staff that actually was, but my understanding was it was two or three particular staff, and then the remainder would be living nearby.[39]

This arrangement was advantageous for the hospital, as it meant that they could be called upon to help out in a crisis at any hour of the day or night.

The standard of staff accommodation was improved during the late 1950s, and the social life it encouraged soon became an important attraction, as Pat Lambert recalled:

When I came, as a seconded RGN student, it was the most amazing social atmosphere that I've ever experienced in my life! [laughs] It was very friendly, very much – we'd make our own fun, so there's

[37] Transcript 02, Dr David Clark.
[38] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p.160.
[39] Transcript 07, Nick Smithson.

parties, there's this, there's that. And just sitting up and talking – lots of interesting people to meet. A much freer, less restrictive, [atmosphere than at Addenbrooke's nurses' homes].[40]

It was clear from informal conversations with interviewees when the tape-recorder was switched off, that career choices in nursing could often depend on such factors

In 1958, Clark had the good fortune to be able to appoint Reg Salisbury to take charge of nurse training at Fulbourn. Salisbury had a major influence on the hospital, as he fully shared Clark's philosophy, and he is still warmly recalled by his former students:

And at that time there was a really, really progressive tutor, whose name was Reg Salisbury.[41]

Many interviewees testified to his friendly and supportive manner towards them in their student days.

The recruitment process took various forms. John Lambert and Maurice Fenn lived locally and so knew about the hospital, and Pat Lambert had trained at Addenbrooke's Hospital in Cambridge. Nick Smithson and Neil Chell were attracted by the national reputation of Fulbourn. In addition, the NHS ran a series of recruitment drives in overseas countries, such as Malaysia, Mauritius, Singapore, the Caribbean and Hong Kong, in the 1960s and early 1970s, and Fulbourn benefited from these. As Jimmy Loh said:

I was living in Singapore. I applied to do nurse training – it was one of the three hospitals I was accepted. And because I took my GCE 'O'-levels from Cambridge, so that was more reason why I should

[40] Transcript 13, Pat Lambert.
[41] Transcript 05, MN01.

come here and maybe further my education in the meantime. So I arrived, thinking I was most probably the only Chinese student in this hospital – Fulbourn Hospital – and I was pleasantly surprised. There were twenty-four others already there! [laughter] So I was astounded.[42]

Given the ethnic diversity of the nursing workforce, I asked all the nurses if racism or prejudice were ever encountered at Fulbourn. All replied in the negative, and in fact the only instance I was told about involved insensitive comments from a senior nurse visiting Fulbourn from another hospital. John Lambert put this harmonious situation down to the fact that no one group of in-comers predominated:

We had people from all over the world working here, but they didn't dominate. The dominant [group] was Anglo-Saxon, Cambridge people. And also staff who were well-integrated, from ethnic minorities - and a few people from abroad. Quite a lot of northern Europeans, funnily enough, from Scandinavia and Holland.[43]

Nick Smithson had a rather more positive view of the opportunities that diversity provided, remembering nurses from:

Sri Lanka, Malaysia, Hong Kong, occasionally Singapore, and then occasionally other countries… such as the Seychelles and the Philippines. And these ethnic groups – these cultural groups – were represented in the nurses' home, so they had a distinct impact on the sort of gregariousness of [student nurses] – not least of course because of the cuisine! So I think a lot of resident English natives

[42] Transcript 17, Jimmy Loh.
[43] Transcript 08, John Lambert.

were very happy to be sort of magnetised by the aromas and the spices of an otherwise relatively-speaking bland English cuisine![44]

Smithson was one of several Fulbourn nurses who married colleagues from abroad: in his case, a staff nurse from Malaysia.

Reg Salisbury's approach to the interview process introduced the note of informality that characterised his whole philosophy of education:

[Reg Salisbury] interviewed me – it wasn't an interview, just a chat – and it was about twenty minutes. And at the end of the twenty minutes he said to me, 'When would you like to start?' And I told him the truth about my experience at [a previous hospital], and he said, 'Would you like to start tomorrow?'

And I said, 'Yes, please!'

And within about a couple of hours everything was arranged. A room was available for me to move to, and a placement was sorted out.[45]

When Clark and his family moved out of the Superintendent's House in 1959, the School of Nursing was able to take it over as the first suitable accommodation it had ever had.[46] This new start allowed Salisbury to raise the prominence of education in the life of the hospital, and Fulbourn soon became known for its progressive approach. Eric Kaloo, for example, who was adding the RMN qualification to his SRN status, particularly valued the freedom he was given to use his time in the hospital to follow his own interests:

[Reg Salisbury] said to me, 'What do you want to achieve during that short period you will be here?'

[44] Transcript 07, Nick Smithson.
[45] Transcript 05, MN01.
[46] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p.160.

> *In other words, I … designed my own training programme – where I want to be, and when can I take the exam, and I was able to go and see him and he was able to accommodate my needs or wishes.*[47]

The relatively small scale of the student intakes at Fulbourn enabled Salisbury to plan individual programmes with this high degree of flexibility.

As the provision for student nurses at Fulbourn gradually improved, Clark was given an opportunity to influence nursing developments at the national level. In 1965, he was appointed by two Ministry of Health bodies, the Standing Nursing and the Standing Mental Health Advisory Committees, to chair a sub-committee to make recommendations about 'the functions of psychiatric nursing staff' and 'nursing staff patterns'.[48] He was joined on the committee by his old friend, Duncan Macmillan, the Medical Superintendent of Mapperley Hospital. The other members were all nurses, and included Queenie Brock, the Matron of Fulbourn. It was no surprise, therefore, when their report focussed on a Fulbourn agenda, with the developing role of the nurse in a 'social therapy' environment highlighted. Specific mention was made of milieu therapy, group therapy and therapeutic communities.[49] The Committee's recommendations centred on the need for continuing education in the new specialised roles that were emerging for nurses, and they deprecated the custom of regarding the acquisition of a SRN qualification as the sole requirement for promotion in a mental hospital.[50]

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[47] Transcript 06, Eric Kaloo.
[48] Ministry of Health, *Psychiatric Nursing: Today and Tomorrow* (London, 1968)., p.1.
[49] Ibid, pp.48-49.
[50] Ibid, p.50: P. Nolan, *A History of Mental Health Nursing* (London, 1993), p.129.

By the time Nick Smithson started his nurse training in 1975, clear links had been established between what was taught in the School, and actual clinical practice on the wards at Fulbourn:

> *Clark and some of his colleague …in the School of Nursing … had noticed was that there was a distinct gap between what was going on in the School and what was going on out in practice. This group were virtually introducing the 'social model', so they tried to introduce and innovate changes in the School, that would connect … with what was going on in practice.* [51]

One area of the mental health nursing curriculum that continued to cause controversy was the space devoted to content regarded by some as more relevant to 'general' nurses. Smithson was concerned that change in that direction was not happening quickly enough:

> *The 1957 experimental syllabus, was quite innovative. But still quite a bit within that was underpinned by general nurse training – indeed at some stage, 'cause the '57 experimental syllabus didn't come in fully blown, I think, until about '64, and was revised in '74 or '75. But there was, you know, a large influence from the general nursing arena, certainly in terms of anatomy and physiology, and medical approaches to care and treatment and diagnosis.*[52]

The question of what constituted appropriate educational preparation for the changing role of the mental health nurse was to remain controversial throughout this period.[53]

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[51] Transcript 07, Nick Smithson.
[52] Ibid..
[53] P. Nolan, *A History of Mental Health Nursing* (London, 1993).

Changes to the educational philosophy subsequently became firmly entrenched. When Neil Chell started his post-registration course at Fulbourn in 1981, the 'social model' as understood at Fulbourn, still exerted a major influence upon the style of course delivery:

> *You could almost tell the Fulbourn-trained nurses from the nurses that had come from other parts of the country. In my group of six there were – four Fulbourn nurses, myself and a lad from Manchester – and the differences were clear. We had to have sort of group sessions with a facilitator, the six of us, once a week – to discuss emotional things. And I remember being asked if I wanted to share something with the group. And when I said, 'No', because I didn't feel I wanted to, that wasn't the answer that was expected! [laughter]*[54]

As this excerpt indicates, by this time participation in group activities had become the defining characteristic of all aspects of life at Fulbourn.

As confidence in the educational provision at Fulbourn grew, links outside the hospital were increasingly developed. Having at first spurned the offer of placements for her student nurses at Fulbourn, in 1956 the Matron of Addenbrooke's Hospital approached David Clark to request such experience, and he was happy to oblige.[55]

In 1967, the School of Nursing at Fulbourn was given approval by the General Nursing Council to train pupil nurses based at the nearby Ida Darwin Hospital for the Mental Handicap part of the Roll.[56] With the introduction of the new training syllabus for general training in 1969, the two hospitals set up a working party to formulate appropriate learning objectives, so that the Addenbrooke's nurses could derive the maximum benefit from their exposure to a mental health setting. In fact, the

[54] Transcript 14, Neil Chell.
[55] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p.159.
[56] National Archives: Reference DT33/473: GNC Mental Nurses Committee, 12th October 1967.

collaboration between the nursing staff of both hospitals became so close that they published a joint article in the *Nursing Times* to share their experiences more widely.[57] The new-found confidence of the nursing staff at Fulbourn also expressed itself in the form of study days for staff from other hospitals. In 1973, Clive Harries organised a national symposium on the subject of 'disturbed behaviour', which drew participants from London, Liverpool and Wales, and was reported in the *Nursing Times.*[58] In the next year, papers on the developments on Denbigh Ward were presented at the prestigious King's Fund Centre in London.[59]

At the national level, concern was mounting that nurse education had not kept pace with developments in other health-related disciplines. In 1970, Richard Crossman, the Secretary of State for Social Services, asked the Oxford historian Asa Briggs to chair a committee to consider future arrangements.[60] The Briggs Committee reported in 1972 and proposed a common portal of entry to nurse training for all student nurses. After an eighteen month foundation course, students would spend a further eighteen months in studying for one of the branches of the Register, one of which would be for mental nurses.[61] In January 1973, the Briggs Report was discussed by the Fulbourn and Ida Darwin Hospitals Management Committee. The local newspaper reported that, 'the most bitter attack came from Dr David Clark'. He fulminated against the lack of coverage of mental nursing, saying:

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[57] J. Aitken, et al., 'Improving General Nurse Training by Psychiatric Secondment', *Nursing Times* 27 June (1974), pp.29-32.
[58] C.J. Harries, 'Disturbed Behaviour', *Nursing Times* 16 May (1974), pp.748-750.
[59] B. Savage & T. Widdowson, 'Revising the Use of Nursing Resources – 1', *Nursing Times* 5 September (1974), pp.1372-1374; B. Savage & T. Widdowson, 'Revising the Use of Nursing Resources – 2', *Nursing Times* 12 September (1974), pp. 1424-1427.
[60] M. Green, 'Nursing Education – 'Reports are not Self-Executive', in M.E. Baly, *Nursing and Social Change* 3rd edn. (London, 1995), pp.304-307.
[61] Department of Social Services, *Report of the Committee on Nursing (The Briggs Report),* Cmnd. 5115. HMSO (London, 1972).

> ‘Psychiatry is not even in the index of this report. Frankly, I’m appalled … If it is implemented as it stands, it will be bad for all our clients. I hope the Government lets it drop out of sight as it has done with other reports …’[62]

This last comment was an obvious reference to the lack of attention accorded to his own report which had been published just four years earlier.

In fact, similar changes to the ones proposed by Briggs did come, but they occurred over a long timescale. It took a further Report, *Project 2000*, published by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in 1986, to promote the concept of an eighteen month ‘common foundation programme’, followed by a branch programme of the same length.[63] Other recommendations of Project 2000 included the phasing out of so-called second level training (for Enrolled Nurses), supernumerary status for nursing students, and closer links with the higher education sector. In 1989, the School of Nursing in Fulbourn lost its independence and became part of the Cambridgeshire College of Health Studies, which was subsequently affiliated with Hatfield Polytechnic (later becoming the University of Hertfordshire), and the changes envisaged by *Project 2000* were introduced under its auspices.

The Progressive Nursing Culture at Fulbourn

When he was first appointed as the Medical Superintendent of Fulbourn in 1953, David Clark inherited a nursing culture that had changed little since the days of the Victorian attendants in the closed asylum. The limited numbers of trained nurses were required to

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[62] Fulbourn Archives: *Newspaper Cuttings Book*: Cambridge Evening News, 20 January 1973. In fact, the index lists ‘Mental Nurses’: Department of Social Services, *Report of the Committee on Nursing (The Briggs Report)*, Cmnd. 5115. HMSO (London, 1972), p.322.

[63] M. Green, ‘Nursing Education – ‘Reports are not Self-Executive’, in M.E. Baly, *Nursing and Social Change* 3rd edn. (London, 1995), p.307.

direct the activities of the untrained care staff in maintaining unchanging ward routines in the segregated male and female 'sides' of the hospital. The expectations held of them were minimal. They were to maintain control of the ward at all times, without resorting to excessive violence, and to keep the patients safe, fed and clean. Once he had surveyed the management task he faced, Clark was clear that the complex process of improving the delivery of nursing care at Fulbourn needed his unwavering commitment. There were no simple solutions. Nurse recruitment needed constant attention, educational provision had to reflect the changes in therapeutic regimes that he was keen to introduce, and attractive posts had to be created to retain the most talented staff.

While some hospitals concentrated reforms in their admission units, it is to Clark's great credit that he always regarded the improvement of nursing practice in the 'back wards' as an equal priority.[64] When nurses from Fulbourn were seconded to review other hospitals as part of a Hospital Advisory Service panel, they were often shocked by the conditions they encountered. John Lambert remembered one visit to Roundway Hospital in Wiltshire. The psychiatrist chairing the panel said at their final presentation:

> *'We like to point people in the direction – we don't only criticise, we point people in the direction of things we think they ought to see. And at Roundway .....' and everybody [in the audience of Roundway staff] started to preen themselves, 'we have decided to show people how psychiatry was practised fifty years ago!' [laughs]*[65]

Lambert was struck by the stark contrast with the conditions he was used to at Fulbourn:

[64] I noticed the contrast between a modern admission unit and run-down back wards at both St John's Hospital, Stone, and Friern Hospital, London, in 1976 and 1980 respectively.
[65] Transcript 08, John Lambert.

> *I was so thankful I worked in a place like this [i.e. Fulbourn]. I mean, you criticised it, but you go to places like [Roundway] and you think, 'My God, this is dreadful!'*
> *And I'd only ever known this place, I'd never really known anywhere else – so as far as I'm concerned, it was the norm*[66].

Clive Harries reported similar experiences during his time with the Hospital Advisory Service.[67]

A unique feature of Clark's tenure at Fulbourn was his energetic promotion of publications by the nursing staff. His support for research by sociologists such as Douglas Hooper and David Towell had its inspiration in the 'social psychiatry' movement in the USA from the 1940s onwards, and in Britain, Maxwell Jones had employed Robert Rapoport to study his therapeutic community unit at Belmont, Surrey, in 1954.[68] Clark, however, seems to have had no such exemplars in his determination that as many nurses as possible should write about the hospital. This new 'writing culture' saw Maurice Fenn, Ruby Mungovan, and Clive Harries publishing book chapters and articles in journals such as the *Nursing Times*. Even more unusual were the articles published by nurses such as Bev Savage, Tony Widdowson, Tony Wright, and Michael Frois, who worked on what were traditionally regarded as the 'back wards'.

Conclusion

Clark was well aware of the central importance of developing the nursing staff's knowledge, skills, and attitudes, if genuine change was to occur on the 'back wards' of Fulbourn. Nurses formed the professional group who had the most continuous contact

[66] Transcript 08, John Lambert.
[67] Transcript 21, Clive Harries.
[68] A. Life, 'Obituary: Robert Rapoport' *The Independent* 23 November 1996.

with patients, and who therefore determined the nature of the ward culture as it was experienced by the patients. The contribution of researchers such as David Towell and Clive Harries had a beneficial effect in helping to highlight positive changes, and bringing them to the attention of the wider hospital community. This gave a new sense of pride in achievement to staff who had previously been alternately denigrated or forgotten. Writing accounts of change became part of the accepted culture of the hospital, and publications by Fulbourn staff, particularly nurses, reached levels never achieved before or since

While most of the accounts of the changes undertaken by Clark at Fulbourn quoted so far have been broadly positive, the ‘social model’ also attracted much criticism. The views of the critics will be analysed in Chapter 9.

Chapter 9: The Critics of the Fulbourn Regime

Introduction

Critics of the social therapy regime that David Clark created at Fulbourn can be divided into three broad categories. These were, firstly, those who were generally sympathetic to the approach but disagreed with one or more aspects of its implementation. Secondly, those who were committed to a 'biological' model of mental illness and who therefore regarded attention paid to the social aspects of the hospital regime as an unnecessary diversion. Thirdly, there were those who felt that in the later years of Clark's time at the hospital there was a critical loss of impetus which allowed poor standards of care to be condoned under the pretext of social therapy and patient choice. In the following section, oral history evidence will be used to support the contention that some aspects of the 'therapeutic community' approach survived the departure of Clark and the arrival of Roth, but were reformulated as 'nursing work' rather than as 'medical work'. Finally, the reaction of leading figures at Fulbourn to the rise of the 'anti-psychiatry movement' will be evaluated.

Critical Supporters

One of the key characteristics of the culture that Clark was trying to create at Fulbourn was its openness to discussion and debate. So it was not surprising that dissenting voices made themselves heard at an early stage in the process of developing therapeutic communities in the hospital. One of the first critics to make his concerns public was Clark's consultant colleague, the psychotherapist Dr Bernard Zeitlyn. He may have selected the rapier rather than the blunderbuss as his weapon, but Zeitlyn's choice of the *British Journal of Psychiatry* as the platform for a meditation on whether the therapeutic

community was fact or fantasy could only have alerted his professional peers to the lack of unanimity in the Fulbourn medical team.[1] The main thrust of his criticism concerned the way in which psychoanalytical terms were used in what he regarded as a rather loose way by enthusiasts for therapeutic community working. Zeitlyn's criticism was confined to the use of terminology, as he was fully supportive of Clark's ways of working. An obituary produced by his Fulbourn colleagues at the time of his tragic death in a road accident states that, 'his approach was truly eclectic and depended mainly on the patient's need: be it drugs, ECT or a more analytic approach'.[2]

While Dr Ross Mitchell was generally supportive of the underlying philosophy of the therapeutic community, he was not alone in questioning how appropriate it was for patients experiencing psychotic episodes. :

> *David really believed the idea of giving back autonomy to the patients, and making them responsible for what went on, and as it were allowing the patient group to discipline their own members, That seemed to me to be fine, provided the person was sufficiently in touch with reality to be able to sort of test that out, but if you'd got somebody who is quite seriously disturbed with a psychotic disorder, particularly a schizophrenic disorder, then I wasn't quite sure how much somebody who's living in a fantasy world, trying to cope with that and at the same time trying to cope with so much based on reality.*[3]

[1] B.B. Zeitlyn, 'The Therapeutic Community – Fact of Fantasy?', *British Journal of Psychiatry*, 113 (1967), pp.1083-1086.
[2] Fulbourn Archives: Anon, 'Bernard Zeitlyn in Cambridge, 1957-79'.
[3] Transcript 03, Dr Ross Mitchell.

As Clark's determination to apply the philosophy of the therapeutic community to the wards caring for the most disturbed patients in the hospital was arguably his distinctive contribution to the field, it is not surprising that later critics have echoed the points that Mitchell raised.

One example of this tendency was Liam Clarke, who expressed scepticism about some positive comments on the regime practised on Street ward:

> They [ie therapeutic communities] also become an improbable proposition if participants are actively psychotic for long periods. When they are, the psychotic therapeutic community will undergo genuine difficulty in disallowing the (traditional) divisions which determine staff and client relationships.[4]

At a more fundamental level, Mitchell also questioned the extent to which a therapeutic community, with its emphasis on frank and often abrasive communication, was a useful preparation for social interaction in the outside world:

> *I think that was just probably my reservation, at that time. Yeah, the great belief was that if people learned to live within, say the Hereward House therapeutic community, if they were then discharged to the outer [world] – where people don't say all the time what they mean, and behave in a very open and challenging way. If they behave like that outside, of course it wouldn't work – that was the whole question.*[5]

[4] L. Clarke, *The Time of the Therapeutic Communities: People, Places and Events* (London, 2004), p. 155.
[5] Transcript 03, Dr Ross Mitchell.

This point of view anticipated later concerns about the nature of 'the community' that patients were being discharged into under the terms of the policy of 'community care'.

So Mitchell's position was that Clark had pushed the concept to its extreme extent, when restricting its implementation to patients with insight and making the ward climate less pressurised might have produced greater dividends:

> *An intense therapeutic community programme works within the boundaries of that community, but can it be generalised? Whereas if you have a more relaxed therapeutic community, which is using – yes, the general principles of allowing ideas to come from the bottom up, as well as from the top down, and allows dialogue and multiplicity of views, but teaches people that you've got to learn to rub up against people who don't always agree with you, and not fall out over it, then that perhaps is preparing people better.*[6]

However, if a multiplicity of approaches were to be encouraged under the banner of therapeutic community working, as Mitchell advocated, it could be difficult to maintain its distinctive features, as experience of Kent House demonstrated.[7]

Supporters of the 'Biological Model'

In his controversial overview of the field, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, Edward Shorter identified what he claimed were the characteristic phases in the development of the discipline.[8] The 'first biological psychiatry' of the nineteenth and early twentieth centuries involved a focus upon the

[6] Transcript 03, Dr Ross Mitchell.
[7] See Chapter 7.
[8] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997).

study of the anatomy and physiology of the brain in an attempt to classify mental illnesses, study their causation, and develop effective treatments. This period was brought to an end by the rise of psychoanalysis, which Shorter regarded as a hiatus in the process of deepening understanding of such conditions. This phase of dominance in the 1930s and 1940s, particularly in North America, was followed by a period Shorter labelled 'Alternatives', in which psychiatrists were happy to employ an eclectic mix of therapies without apparent regard for any unifying theoretical concepts. Thus the typical British psychiatrist of the 1950s to the 1970s was happy to prescribe insulin coma therapy, ECT, the newly developed drugs for depression and psychosis, as well as to employ psychoanalysis, psychodrama and the therapeutic community meeting.

This is a fair summary of the positions taken by several of the leading psychiatrists at Fulbourn in this period, including Beresford Davies, Oliver Hodgson, and even to some extent, David Clark. It was well-summarised in my interviews by Alan Broadhurst, himself the co-discoverer of the antidepressant imipramine:

> *Again, probably it was because of [David Clark's] influence that I became eclectic – and wanted to borrow the best of all treatments, regardless of what they were. And David was much the same. And although his specialty was group work, social model, he was very prepared to allow his staff – or indeed to undertake physical treatments himself. So he was a very, all-embracing man, who was very happy to work with colleagues who perhaps didn't share his principal interests.*[9]

[9] Transcript 22, Dr Alan Broadhurst.

As noted above, the term used consistently by Fulbourn psychiatrists to describe this approach was 'eclectic'. According to Shorter, this period of eclecticism came to an end when, 'in the 1970s, biological psychiatry came roaring back on stage'.[10]

Although he gained barely a mention in Shorter's account of this period he termed 'the second biological psychiatry', there is no doubt that its leading British figure was Professor Sir Martin Roth.[11] Roth had trained in psychiatry at the Maudsley Hospital under Sir Aubrey Lewis, as had David Clark, but he clashed with Lewis and left to pursue his career elsewhere. In 1950, he took up a research post at Graylingwell Hospital, near Chichester, and then moved to a Chair in psychiatry at Newcastle in 1956. His research focused on the mental health needs of older people and his contributions to knowledge in that field have stood the test of time. One of the major developments made during his time at Newcastle was the establishment of a distinction between reactive and endogenous depression.[12] Another of these centred on the careful study of the range of conditions previously lumped together as 'senility', so as to distinguish depression from the different presentations of dementia. Roth was responsible for re-discovering Alois Alzheimer's description of dementia and linking it with the presence of neuro-fibrillary tangles found at post-mortem. As part of the search for a reliable diagnostic tool, he was a pioneer in the development of questionnaires to measure declining cognitive function in such individuals. Attempts at accurate classification of psychiatric diseases were part of the climate of the times, and Roth was a major contributor to the American Psychiatric Association's Diagnostic and Statistical

[10] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997). p. 239.
[11] Shorter cites Roth's co-authored textbook, *Clinical Psychiatry*. Ibid, p. 415.
[12] D. Healy, 'The History of British Psychopharmacology', in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p.76.

Manual of Mental Disorders (DSM), and the World Health Organisation's International Classification of Diseases (ICD).

His successes in developing the knowledge base in the field of psychogeriatrics served to confirm his fundamental view that progress in psychiatry would come from the scientific study of mental illness, in order to refine diagnosis and treatment. Psychiatry was therefore regarded by him as no different in essence from any other branch of medicine. Like many psychiatrists in the 1960s, Roth was also anxious to see the former asylum doctors' organisation, the Royal-Medico Psychological Association, transformed into an academically ambitious college, to stand alongside the colleges for the more prestigious specialisms such as medicine and surgery. Despite their conflicting views on the practice of psychiatry, Roth and David Clark were able to work together to achieve that aim, and in 1971, the Royal College of Psychiatrists came into being, and Roth was elected as its first president. A knighthood followed in 1972.[13]

When Cambridge University came to elect its first professor of psychiatry in 1976, Roth was widely regarded as the most distinguished figure in British psychiatry, and so was a natural choice to serve as one of the electors. Dr Bernard Zeitlyn from Fulbourn was also an elector, as the representative of the hospital consultants. David Clark applied for the post and the assumption in the hospital and beyond was that he was sure to be elected. His academic background was secure. He was a member of King's College and possessed a Cambridge PhD awarded for his publications in psychiatry, and he had been granted the title of Associate Lecturer of the University through his teaching programme for junior doctors. Fulbourn Hospital under his leadership had achieved an international

[13] Anon, 'Obituary: Professor Sir Martin Roth' *The Times* (24 October, 2006); C.M Wischik, 'Obituary: Professor Sir Martin Roth' *Independent* (19 October, 2006).

reputation for its work in social therapy, which had always been underpinned by research programmes to examine its effectiveness. Despite the confidence of those around him, Clark himself always doubted that he would be elected.[14] However, the long process of selection took an unexpected turn, as Dr Graham Petrie recalled:

> *I don't know what name they had arrived at, but the following morning Martin Roth wasn't there – he was one of the outside assessors – and the Regius [Professor of Physic][15] said, 'Well, gentlemen, you obviously realise that Professor Roth isn't here. This is because he has put himself forward as a candidate!' So he was duly appointed, but without any input from us, because we hadn't known anything about it.*[16]

From the University's perspective, this appointment was clearly a major coup. Its fledgling department had secured the services of the country's foremost psychiatric researcher and the acknowledged leader of the profession. Roth was immediately elected to a Fellowship of Trinity College as a further mark of distinction. From Roth's perspective, however, the decision to accept the post must have represented something of a gamble. On the positive side of the equation, the move to Cambridge enabled him to work with leading researchers, such as the Nobel chemistry laureate Sir Aaron Klug, on the molecular structure of the abnormal proteins in Alzheimer's disease. It also ensured a ready supply of able research students from around the world, such as the Australian, Claude Wischik.[17] However, Roth was leaving an established academic department that he had worked to develop over many years, for one that existed only on

[14] Transcript 02, Dr David Clark.
[15] The Regius Chair of Physic (sic) was established by King Henry VIII in 1540, and is the most senior post in medicine in the University of Cambridge.
[16] Transcript 11, Dr Graham Petrie.
[17] C.M Wischik, 'Obituary: Professor Sir Martin Roth' *Independent* (19 October, 2006).

paper. Its base remained in a Victorian asylum and soon the harsh economic conditions on the late 1970s put paid to many of the planned developments, as David Clark observed:

> *He came down to Cambridge and there wasn't even a place for him to interview patients, there were no rooms, there was no department, and of course that was the time when the money ran out, and nobody had any.*[18]

As the development of the clinical medical school in Cambridge was still in its early stages, there was no other suitable accommodation for him available on other sites in the city.

One of the key roles of the head of an academic department is to establish the direction of travel for the department and to plan the research activities accordingly. In disciplines where there is a widely-shared intellectual consensus, this may be relatively straightforward, but Roth's arrival at Fulbourn represented a seismic shift in direction for the institution. In the television documentary on the hospital, Roth summarised his differences with Clark:

> *Whereas a community was supposed to be engaged in the main tasks of evaluation and treatment. I regard psychiatric examination and treatment as an individual matter, as a task which is undertaken by a professionally trained individual, of course in consultation with others.*[19]

It was therefore perhaps inevitable that personal relations between Clark and Roth would suffer. Dr Petrie was one of many who witnessed this development:

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[18] Transcript 02, Dr David Clark.
[19] BBC TV Documentary, *Unlocking the Asylum*, 1996.

And it has to be said that he and David never got on. His approach was so totally different – he was a straight-down-the-line, British, organic psychiatrist. He had no time at all for David's concept of social psychiatry – the democratic sort of set-up. And so it really caused a lot of friction in many ways.[20]

For the other psychiatrists at Fulbourn, the key event of the week was David Clark's 'Friday morning meeting'. This was the communal expression of the shared philosophy of social therapy, and also a very practical source of support in their professional roles.

Dr Ross Mitchell was one of its leaders:

Martin came once, and said he just wasn't comfortable – he just wasn't used to being questioned by junior staff – it just wasn't how he worked. And he said he wouldn't come any more, and neither would he want his junior doctors to go either. And we thought, 'Oh dear – here we go!'

And in the end we had to abandon the Friday morning meeting because things were becoming too polarised, and David and I said we can't go on like this, we don't want to polarise things like that.[21]

Unfortunately, this hope was not to be fulfilled and the hospital staff soon became aware of the poor personal relationship between the two leading psychiatrists at Fulbourn.

From her perspective as the Ward Sister of Roth's new professorial unit, Pat Lambert was aware that, '*David Clark was glowering over the grass at him!*'[22] In his

[20] Transcript 11, Dr Graham Petrie.
[21] Transcript 03, Dr Ross Mitchell.

biographical account, Clark recalled that while the philosophy of the therapeutic community continued to operate in Street, Friends and Adrian Wards for several more years, 'gradually a sour atmosphere developed among the Cambridge psychiatrists' and it was with some relief that he was able to retire from the hospital in 1983.[23] Fortunately for the hospital, the other psychiatrists generally established good personal relationships with the new professor. For Ross Mitchell, this was based upon an appreciation of the different strengths that each man brought to the hospital:

> *David's ideas arose out of the social and the psychological model, looking at the behaviour of people in groups, whereas Sir Martin's great strength was his incredible encyclopaedic knowledge of medicine, of looking at mental illness in its biological element.*[24]

Oliver Hodgson felt that Roth's election represented another positive step in the development of the hospital, and he welcomed the kudos that he brought to Fulbourn. He was aware that psychiatry was moving in a 'biological' direction and he wanted to keep abreast of the latest developments:

> *So it was an upheaval when he came, but it was foolish to think that – if it wasn't him it was somebody else. And it was something we should all welcome because without it we'd get further and further behind.*[25]

This was a significant observation, as Hodgson had always been Clark's most supportive lieutenant.

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[22] Transcript 13, Pat Lambert.
[23] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 232.
[24] BBC TV Documentary, 'Unlocking the Asylum', 1996.
[25] Transcript 12, Dr Oliver Hodgson.

Dr Jane McKeown was equally enthusiastic about Roth's arrival at the hospital. She had only recently started working at Fulbourn, but she already had doubts about some features of the hospital regime:

> *Well, of course the problems really resulted from David's philosophies about psychiatry. And when I started… in my view, there was a certain amount of anarchy on the acute admission wards. They weren't functioning particularly or safely, in my view, and needed a bit of turning round, really.*[26]

She felt strongly that safety was compromised by the lay-out of some of the wards:

> *The suicidal patients were not monitored enough, in those days, and Kent House where I worked was a very unsuitable building, really, for psychiatry. It had many doors, and it had an upstairs where patients would easily just leave. And that was a great problem – … Fulbourn has a railway line at the back, and a road at the front. So it wasn't a very safe place, really, for patients with those sorts of disorders.*[27]

She also believed that the lack of discipline and control on the wards led to some staff undermining medical orders, which could have had potentially fatal consequences:

> *On some occasions, patients were told by members of the staff – not necessarily the nursing staff – there were social workers and other people there – to eat on the morning that they had electrical treatment. And of course you'll know that is a dangerous thing to do before having a general anaesthetic.*[28]

[26] Transcript 10, Dr Jane McKeown.
[27] Ibid.
[28] Ibid.

At a more fundamental level, McKeown believed that Clark's 'democratic' approach to therapeutic interventions encouraged nurses to trespass on the proper preserve of the psychiatrist:

> *And, as I say, there was a certain amount of anarchy, a certain amount of nurses treating patients in ways they were not qualified to undertake. They really hadn't got the training for group therapy, and that sort of thing. There was a tendency to suggest to patients that they should or should not have treatments that psychiatrists had advocated …*[29]

Whatever the state of personal relationships, nothing could disguise the fact that the hospital was now being led in a completely different direction.

Roth's view of the 'medical model' extended to a strictly hierarchical view of staff working in the mental health setting, and so it was immediately attractive to those psychiatrists who shared his more 'traditional' views. This approach was obviously completely at odds with the democratic style of ward life that had been developed by David Clark. An early example of this clash of philosophies entered hospital folk-lore. This version was recalled by Dr Graham Petrie, but I heard the same anecdote from several other members of staff:

> *[Roth had] just been appointed, he had beds in both our wards, and he wanted a bed at half-past nine at night… And the nurse said to him, 'Who are you?'*
>
> *And he said, 'Professor Sir Martin Roth.'*

[29] Transcript 10, Dr Jane McKeown.

She said, apparently, 'Well, I've never heard of you – I'll make a note of it and ask the team in the morning!' [laughter] Which didn't help![30]

Roth then apparently rang round among his consultant colleagues to complain about the flagrant insubordination this episode revealed. This caused some wry amusement, but none of the dramatic responses that Roth demanded actually took place.

The key feature of the wards that had adopted the therapeutic community model was the constant round of meetings. Roth immediately began to phase them out in his academic unit, despite the resistance of some nurses:

The ward that I found myself working in was still having these regular community meetings each day, and it took some time for us to make an impression on this, to get this slowly deleted.[31]

In their place, Roth and the colleagues like McKeown who shared his philosophy adopted a more formal and hierarchical approach to assessment and planning:

I think we had to put in protocols to make sure people got – their cases were discussed, in detail, consistently, at ward rounds, and discussion with other staff, gaining their views and opinions, before making any judgements. And doing it in a more formal way, formalising and formulating their problems, and organising treatment – making sure that it was carried out correctly.[32]

Once Professor Roth was in post, other academic psychiatrists were appointed to the new department and Friends Ward, previously a show-piece as a therapeutic community, was turned into an environment dominated by the 'biological model', as Dr McKeown recalled:

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[30] Transcript 11, Dr Graham Petrie.
[31] BBC TV Documentary, 'Unlocking the Asylum', 1996.
[32] Transcript 10, Dr Jane McKeown.

> *The time I became a Consultant, other Consultants had joined at the same time…and Jonathan Dowson and German Berrios had also joined – they were all members of the academic department and I worked with them on Friends Ward. So I was the only NHS Consultant, and they were all academics, but obviously we all had very much the same view about what had been going on.*[33]

This closing of ranks around a more biological model of psychiatric practice, coupled with a return to a more hierarchical approach to ward organisation, was a local reflection of national and international trends in psychiatry, which will be explored in more detail in the following chapter.

When Geoff Shepherd was appointed as head of the psychology department of the hospital in 1981, he was immediately aware of Roth's influence on his psychiatrist colleagues:

> *And it's true, you know, that he did establish a very, very straight kind of biomedical model. Absolutely no doubt about it. And some of the people who were young Consultants then, some of whom have now retired, took that on.*[34]

It was unsurprising that those members of the nursing staff who felt a strong personal commitment to Clark's philosophy of social therapy viewed these developments with dismay, as Nick Smithson testified:

> *There was a lot of anxiety, frustrations and disillusionment about the future of Fulbourn and what people had begun to feel it stood for. If I was to sum it up – something along the lines of 'humanity' or*

[33] Transcript 10, Dr Jane McKeown.
[34] Transcript 16, Professor Geoff Shepherd.

> *'humane-ness' of care, regardless of the pros and cons of, or the efficaciousness of a particular approach, or strands of the overall approach or model. But certainly in some quarters among both medical and nursing staff, there was a sort of pessimism about the future.*[35]

Smithson's use of the phrase, 'regardless .. of the efficaciousness of a particular approach' is highly significant in this context. It captures the essence of Clark's philosophy of social therapy which owed more to the eighteenth and nineteenth century traditions of 'moral management' of the mentally ill, than it did to the world of scientific positivism.[36]

The therapeutic community was consistently defended on ethical grounds rather than with reference to its clinical effectiveness. However, it was also apparent that by no means all the staff in Fulbourn shared this enthusiasm for the 'social model', as McKeown observed at the time:

> *Not all members of the nursing staff were in any case advocates of what was happening, and were not very comfortable with it. So… it wasn't all one-way, by any means.*[37]

While older nurses with more 'traditional' attitudes appreciated the return to formality that Roth and his colleagues brought to Fulbourn, those who regarded themselves as 'forward-looking' also found much to admire.

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[35] Transcript 07, Nick Smithson.
[36] 'Social therapy in psychiatry is about two centuries old …'. citing Tuke, Pinel and Conolly. D.H. Clark, *Social Therapy in Psychiatry* (Harmondsworth, 1974), p. 14.
[37] Transcript 10, Dr Jane McKeown.

Pat Lambert, Roth's first ward sister on his newly-created professorial unit, was an active and enthusiastic advocate of the new approach, as became clear when I asked her, 'how did you get on with Professor Roth?':

> *Oh, fantastically! He was inspirational. It was very traditional in the sense of, you know, we wore uniforms and it seemed OK at the time – not sure I would have thought that now, but that's what I thought at the time.*
>
> *Professor Roth was very much the father figure of the unit – it was his baby … very traditional medical style. So we were quite separate, really, and it was important to try not to be seen as elitist – I certainly saw that, but it was a brilliant job and I loved it!* [38]

Almost inevitably, this dramatic change in ward philosophy led to a change in the composition of the nursing staff. Those committed to the 'social model' gradually left to find more congenial settings in which to work, As Jane McKeown noticed:

> *I think obviously people who didn't like it sort of moved on, and people who were more amenable to the new situation moved in – you know, it was very much a gradual process.*[39]

Pat Lambert found it easy to recruit able nursing staff to the ward, aided by the cachet of its professorial status and also by the belief that it represented the future direction that psychiatry was going to take:

> *It was very interesting the sort of staff we got – we really did attract some very interesting staff – perhaps a bit more good on the theory than practice of nursing. But we overcame that.*[40]

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[38] Transcript 13, Pat Lambert.
[39] Transcript 10, Dr Jane McKeown.
[40] Transcript 13, Pat Lambert.

It is also likely that the hospital's location on the outskirts of a famous university city aided this process.

While the total hostility of Clark and Roth to each other's philosophy of psychiatry was apparent to all the staff at Fulbourn, other psychiatrists from both sides of this debate were able to take a less polarised position and see some merit in both stances. Even though McKeown found some elements of the therapeutic community meetings absurd, she also saw the benefit of bringing people together to foster contact:

> *The only problem was, at that time, communication in psycho-therapeutic groups of that time – there tended to be a lot of silence. So everybody might sit in silence for twenty minutes, which I found fairly pointless myself, but this is how it was then. But there were very good things about it, I'm not saying things against it, doing things together ….*[41]

Similarly, she felt that she did derive a certain amount of benefit from attending David Clark's Friday morning meeting for doctors:

> *Well you know there were silly things about it and there were funny things about it, and there were helpful things about it, and there were supportive things about it. It was good for junior doctors to have the opportunity to be in the same room as the consultants for an hour every week. That was good – and feelings could be ventilated.*[42]

But she was also aware that some patients could not face the pressure of submitting their problems to the often abrasive scrutiny of the ubiquitous groups that were such a feature of ward life at Fulbourn:

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[41] Transcript 10, Dr Jane McKeown.
[42] Ibid.

> *Patients who had some sort of pressing wish were able to ventilate – if they were bold enough – [to] maybe thirty people. So it didn't suit, a lot of patients didn't like it and wouldn't come, and this caused difficulties. but it was quite an intimidating situation, a large meeting.* [43]

This was an aspect of the therapeutic community approach which its most enthusiastic supporters tended to overlook. As these wards naturally tended to attract staff who felt comfortable taking part in groups, they found it difficult to acknowledge that this potentially confrontational approach did not suit everyone.

Neil Chell, with his outsider's perspective, was the only other interviewee to mention this area of discomfort (as discussed in Chapter 8).

Oliver Hodgson and his colleagues David Muller and Brian Davey had beds in the other admission ward in Kent House. They remained enthusiastically committed to the philosophy of social therapy, with daily group meetings and close collegial working arrangements, but they also felt the influence of Roth and McKeown in their greater focus on the process diagnosis than had been customary under David Clark, as Hodgson recalled:

> *I used to go every day, went to a group meeting and with their permission, saw their patients in the group setting. I wasn't attempting to alter their therapy, but if there was something interesting came up, I talked to them about it. That was the main difference, I think. Mind*

[43] Transcript 10, Dr Jane McKeown.

you, we all had to try and make accurate diagnoses, because without that psychiatry becomes waffle![44]

To an original supporter of the eclectic model, such as Hodgson, combining the two approaches did not pose difficulties.

Critics of Poor Standards of Care

For staff who had previous experience of institutional psychiatry in other hospitals, their first encounter with the democratic culture of Fulbourn, still present in the early 1980s, could be a considerable shock, as Professor Geoff Shepherd, a clinical psychologist, recalled:

> *There were still things going on which were very, very remarkable. I do remember… ringing up the ward and the phone being answered by a patient! And being told that all the staff had gone somewhere, you know! And that kind of thing was, for somebody like me, with the Maudsley training and all the rest of it, that was a rather strange experience.*[45]

Shepherd was certainly not opposed to the 'social model' in its entirety, and he recognised Clark's major contribution in transforming the culture of Fulbourn for the better, but he was aware that by 1981, that influence was waning:

> *I would say it was a bit – the kind of dog days of the changes that David had inspired. And I think – and this often happens – that David, as a sort of clinical leader, the sort of leader he was, one of the*

[44] Transcript 12, Dr Oliver Hodgson.
[45] Transcript 16, Professor Geoff Shepherd.

features that is most vital is that you keep bringing new ideas into the organisation.[46]

So, based on his philosophy of the need for constant change in order to energise an institution, Shepherd was concerned by the complacency which he encountered amongst some staff during his early days at Fulbourn.[47]

One senior nurse who was deputed to show him around the hospital when he first arrived left him in no doubt about his view of the therapeutic regime at the hospital:

I remember being taken round and I was told in no uncertain terms that, 'this was Fulbourn Hospital, it was the leading therapeutic community in the country and we'd been doing it for some years and we were not going to change.' And that's what I was told. And I thought, 'OK, alright, thank you!' [48]

While some supporters of the 'biological model' of psychiatry were totally opposed to the use of the 'social model' at Fulbourn on intellectual grounds, there was sometimes a much sharper edge to their opposition. As Professor Shepherd recalled, some of the psychiatrists who shared this view tended to equate the 'social model' with the wilful neglect of patients:

And some of the people who were young consultants then… and they were a powerful group in the psychiatric establishment here – [felt] that what had gone on under David's direction in the hospital was a scandal. A disgraceful scandal.[49]

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[46] Transcript 16, Professor Geoff Shepherd.
[47] Shepherd summed up his position by saying, *'Without new ideas, things very quickly become rather stuck, rather rigid, and actually rather defensive.'* Ibid.
[48] Transcript 16, Professor Geoff Shepherd.
[49] Ibid.

Other critics felt that whatever the merits of social therapy in improving the quality of life of patients in the 1970s, it had since become a rather empty routine and, even more importantly, an excuse for neglectful care practices.

One male nurse who trained at Fulbourn summed up this position:

> *And I found at times, because the psychiatry seemed to be very much this laissez-faire, airy-fairy kind of thing, at times when patients really needed care, the care wasn't there.*[50]

From the perspective of his background as a general nurse, he felt that one reason for these poor standards of care was a lack of emphasis on the physical needs of patients:

> *I had a mental health patient who had type one diabetes, and none of the psychiatric nurses knew how to give an injection of insulin. When the doctor wrote up ten units of insulin, the charge nurse drew up ten mls. of insulin. And luckily, I was there to say to the charge nurse, 'Actually, ten units is not ten mls.!'.* [51]

Such a comment could be dismissed as representing the prejudice of a general nurse who did not appreciate the special nature of mental health care. However, Neil Chell, who had trained as a mental health nurse in Stoke-on-Trent, expressed similar reservations:

> *So it was unclear boundaries, unclear leadership, unclear expectations. Lots and lots of therapy, but the basics that I'd been brought up to understand were required didn't seem to be there, or if they were, they were hidden.*[52]

Chell was particularly struck by the neglected appearance of some long-stay patients:

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[50] Transcript 05, MN01.
[51] Ibid.
[52] Transcript 14, Neil Chell.

I remember one elderly guy – it was winter and he was out in his pyjamas, and he'd got a beard that was fairly matted – he looked uncared-for over a reasonably long period of time. I remember being quite shocked by that, and… that was where the contrast between looking after someone's physical needs, and trying to look after someone's emotional and spiritual needs – where the two hospitals came from either end of the continuum. If that old man had been in Stoke-on-Trent, the charge nurse would have been in serious trouble the second time – serious trouble. They would probably have been moved. But the emotional or spiritual care – that could have been left for years and nobody would have noticed. Whereas at Fulbourn it seemed to me that it was the exact opposite.[53]

It was clearly difficult to give sufficient priority to physical care needs when the dominant philosophy in the hospital could be interpreted as giving total priority to social needs. There was also an element of self-selection which had developed among the staff. Several interviewees made the point to me, informally and once taping had ended, that some charge nurses were rather unkempt themselves, or behaved in ways that others considered eccentric and 'unprofessional'.

Chell identified the key issue was patient autonomy. To what extent should the staff have intervened if the patient had 'chosen' not to address basic issues of personal cleansing and dressing? He was in no doubt where the line should be drawn:

Somehow the philosophy of autonomy had almost led to a sort of laissez-faire style of nursing, whereas you don't infringe that person's

[53] Transcript 14, Neil Chell.

autonomy by encouraging them to have a bath and get dressed, which I found – perhaps it was because of my own background or upbringing, or early training, I found it very difficult. I wondered why you couldn't do both, really.[54]

Geoff Shepherd, was at pains to emphasise this same point:

There were some good things going on, but also there were some things going on which I found frankly neglectful – justified on the basis of, you know, some nonsense which they still talk about – they are now talking a lot more today, about 'choice' and so on. Where patients were actually neglected under the guise of choice.[55]

However, Shepherd was clear that such occurrences were not the inevitable outcome of David Clark's philosophy , but rather a result of slack standards of supervision at lower managerial levels:

And I think that did happen, and I think it happened in ways that weren't sufficiently severe that they would be brought to David's notice – had they been brought to his notice, he would have done something about it.[56]

It must also be remembered that Clark's increasing international renown meant that he was sometimes away from the hospital for extended periods.

Clark's attitude to the physical abuse of patients, however, was widely known throughout the hospital, and Shepherd felt that it provided a vital safeguard within Fulbourn:

[54] Transcript 14, Neil Chell.
[55] Transcript 16, Professor Geoff Shepherd.
[56] Ibid.

> *David, because of his military background … made it absolutely clear that if anybody was caught beating the patients up, or abusing them in any way, he would be down on them like a ton of bricks. And everybody knew that and that helped… curb what could have been some quite highly unpleasant situations from developing. So, I think there were some checks and balances in place.*[57]

As noted before, Fulbourn was never involved in a patient abuse scandal

The issue of 'choice' in a therapeutic community setting also extended to communal facilities. Working to contribute to the common good was a central tenet of the philosophy. So the entire community, via its regular meetings, was encouraged to take responsibility for cleaning areas such as kitchens. However, it was not clear what should happen if the imperative to maintain the health and safety standards in the ward kitchen clashed with the democratically-expressed will of the ward meeting to ignore it. As a nurse, Chas Ramlall encountered this dilemma on the Drinking Problem Unit, which in 1981 was still being run on therapeutic community lines:

> *Like, if the kitchen was dirty, it's not nurses' duty to sort it – it's for the community to sort it out. That wasn't working. And the kitchen and the dining room were left unattended, and it stank, so dishes not washed, and people eating there, and I felt that that was not right.*[58]

His well-meaning intervention had the effect of rousing hostility in his colleagues, a majority of whom believed that the democratic will of the ward meeting should be regarded as sovereign.

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[57] Transcript 16, Professor Geoff Shepherd.
[58] Transcript 09, Chas Ramlall.

> *So after I took that view … we need to clean it up. The first thing was to clean the kitchen area and the dining area. And there was a feeling that I was trying to be too 'clinical'. So that started a clash of ideology – I was too clinical, and why should I make things happen?*[59]

Over time this ideological conflict intensified and Ramlall felt that he had to leave. In fact, the hospital authorities offered him a new post as the charge nurse of Hinton, a ward for older patients with severe dementia, so this issue did not arise in that kind of environment.

A related issue that critics of 'social therapy' also tended to raise in the oral history interviews was the laxity of some staff conduct. As one male nurse recalled:

> *Many a time I found the nurses themselves, because of this therapeutic community mentality, their own behaviour became slightly – not what I would call normal.*[60]

He recalled one particularly shocking assault involving two members of Fulbourn's nursing staff:

> *A male nurse had an argument with another male nurse, and he just went back to his room and came back about five minutes later, and he took a hammer and just bashed the other guy right in the head. There I was, seeing this other male nurse with an enormous hole in his head, which made me realise that somewhere along the line, there was a need for certain rules and that kind of thing.*[61]

[59] Transcript 09, Chas Ramlall.
[60] Transcript 05, MN01.
[61] Ibid. The Fulbourn authorities apparently took no action against the perpetrator.

A further point he made was that the close family relationships among many of the staff at Fulbourn sometimes seemed to militate against the maintenance of appropriate standards of professional conduct:

> *And so families, on the whole, all worked there. So father would be charge nurse, daughter might be student nurse, uncle might be the senior nurse.*[62]

And he felt that this was definitely a factor impeding the adoption of new approaches to the task of care:

> *And so one of the problems we had of course was because new blood wasn't coming in, you know, there was never the scope for changing things.*[63]

So while the cohesive and stable hospital community explored in Chapter 5 supported an attractive social life, it could lead to an insular outlook which ignored beneficial developments outside.

Was Social Therapy 'Slowly Deleted'?[64]

David Clark has argued since his retirement from Fulbourn that his departure effectively marked the end of psychiatrists' interest in social therapy at the hospital. In the television documentary he made in 1996, he stated that the dominance of psychiatrists wedded to a 'biological model':

> *Very rapidly disrupted the therapeutic atmosphere in the wards, and many of them became sour, squabbling places, and as a result the*

[62] Transcript 05, MN01.
[63] Ibid.
[64] This phrase was used by Professor Roth, in the BBC TV Documentary, 'Unlocking the Asylum', 1996.

> *patients did badly, and then there was trouble, and then there were enquiries – demands for more restrictions, and so on.*[65]

In his biographical account of the hospital, Clark bemoaned the fact that:

> Some of our more exciting experiments have proved transient – the therapeutic communities, the Fulbourn culture of growth, the doctors' sensitivity meetings …[66]

As noted above, Professor Sir Martin Roth confirmed that he had managed to ensure that the community meetings, the hallmark of social therapy, were 'slowly deleted' in the new professorial unit.

Having heard similar comments to the effect that from several other sources, in my interview with Pat Lambert, the first ward sister of the professorial unit, I made the assumption that all the elements of social therapy had indeed been extinguished there. So I was surprised by her comment that:

> *In fact the nurses did everything. So they certainly did do groups, and we did run daily groups, and we did run small groups, and we did do one-to-one counselling, and we ran a therapeutic programme. In perhaps more traditional style than might have been undertaken in the proper therapeutic community models that were going on … Yeah, I think we had pretty open house, as I recall.*[67]

She was also insistent that the impression I had gained from other sources that the medical dominance implied by the biological model resulted in ward rounds being restricted to the transmission of medical orders was wide of the mark:

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[65] BBC TV Documentary, 'Unlocking the Asylum', 1996.
[66] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 233.
[67] Transcript 13, Pat Lambert.

> *No, no, no, we had – well, I suppose we had weekly ward rounds, and just the traditional model that everyone would attend, and as I recall – this is twenty years ago! – as I recall, we would discuss what there was. But no, I don't think it was that prescriptive, actually.*[68]

The impression that much of the culture of 'social therapy' lived on in the work of nurses and therapists was confirmed by the testimony of Mrs Judith Binge, who was a patient on the Professorial Unit for several months in 1981.

> *Friends Ward, at that time, was extremely well-run. And again they had a very varied and full programme and they again were able to actually fulfil this programme. They didn't ever cancel anything – and art was another thing we did a lot of…*[69]

That this was not an isolated view is confirmed by the account of Dr Duncan Double, who had a placement as a medical student on Friends Ward, after Pat Lambert had moved on to another post. I asked him what he thought of Professor Roth's 'biological model' regime, and he replied:

> *Believe it or not, it didn't totally affect the whole ward – despite what you might think. The charge nurse was very broad-minded in his approach.*[70]

So the 'social model' had not been 'deleted' in Roth's unit, it had simply become the province of the nurses rather than of the psychiatrists. This process was probably aided by the fact that Roth only visited the ward to conduct his formal rounds. For the rest of the time, the nurses were largely free to care for his patients according to their own priorities. There were therefore parallels between this process at Fulbourn, and Shorter's

[68] Transcript 13, Pat Lambert.
[69] Transcript 18, Mrs Judith Binge.
[70] Transcript 15, Dr Duncan Double.

description of the fate of psychoanalysis in North America.[71] As American psychiatrists withdrew from the practice of psychoanalysis, and focused instead upon prescribing medication, other non-medical workers moved in to fill the gap left by the medical retreat.

The Challenge of 'Anti-Psychiatry'

Roth's tenure of the Chair of Psychiatry in Cambridge coincided with the high-water-mark of the so-called 'anti-psychiatry' movement. The term itself had been coined in 1967 by the South African psychiatrist David Cooper in his book *Psychiatry and Antipsychiatry*.[72] However, the attack on the medical practices of psychiatry had been inaugurated by Thomas Szasz in 1960. Szasz was an American psychiatrist with a gift for coining memorable phrases, such as the title of his first major article, 'The Myth of Mental Illness', and his subsequent publications 'Involuntary Mental Hospitalization: A Crime Against Humanity' and 'Psychiatric Classification as a Strategy of Personal Constraint'. He claimed to detect in the profession of psychiatry, a 'perspective that diminishes man as a person and oppresses him as a citizen'.[73] In place of what he believed were bogus attempts at classifying psychiatric conditions in terms of diagnoses, along the lines adopted by physicians, Szasz argued for a focus on 'problems in living whether these be biologic, economic, political, or sociopsychological'.[74]

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[71] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997).
[72] S. Snelders, 'LSD and Dualism between Medical and Social Theories of Mental Illness', in M. Gijswijt-Hofstra & R. Porter (eds.), *Cultures of Psychiatry* (Amsterdam, 1998), p. 104. Strictly speaking, this was a revival of the phrase, as Beyer had first coined it in 1912. D. Tantam, 'The Anti-Psychiatry Movement', in G.E. Berrios & H. Freeman, *150 Years of British Psychiatry, 1841-1991* (London, 1991), p.333.
[73] T. Szasz, *Ideology and Insanity* (Harmondsworth, 1974), p.6.
[74] Ibid, p.23.

A second influential figure in the anti-psychiatry movement was the British psychiatrist R.D. (Ronnie) Laing.[75] His career had several parallels with that of David Clark. They both came from Scottish backgrounds, but Laing trained in Glasgow while Clark went to Edinburgh. Both served as psychiatrists in the British Army, and both held positions at prestigious London research institutions. For Clark it was the Maudsley Hospital, while Laing worked at the Tavistock Clinic. Laing famously promoted the view that much supposedly psychotic behaviour could be understood as the outcome of unequal power relationships within the family. Rather than trying to understand these existential issues, Laing accused many psychiatrists of colluding with a repressive State in silencing such people. It is significant that he framed his attack on the practice of psychiatry in terms of the kind of policies that Clark had introduced at Fulbourn:

> In the best places, where straightjackets are abolished, doors are unlocked, leucotomies largely foregone, these can be replaced by more subtle lobotomies and tranquillisers that place the bars of Bedlam and the locked doors *inside* the patient.[76]

The ideas of Szasz and Laing found a ready audience among the 'counter-culture' generation of the 1960s. The combination of apparent evidence of Establishment repression, together with a challenge to received notions of normality, held obvious appeal for those young people in conscious revolt against social conventions and experimenting with mind-altering drugs in order to 'turn on, tune in and drop out'. Despite the lack of evidence to support these arguments, it was certainly true that for the decade after 1965, psychiatry became a fashionable area of concern for young people in

[75] J. Andrews, 'R.D. Laing in Scotland: Facts and Fictions of the 'Rumpus Room' and Interpersonal Psychiatry', in M. Gijswijt-Hofstra & R. Porter (eds.), *Cultures of Psychiatry* (Amsterdam, 1998), pp. 121-150.
[76] R.D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Harmondsworth, 1965), p. 12.

a way that has not happened before or since. The effects of this temporary phenomenon were certainly felt at Fulbourn, as David Clark recalled:

> *In the sixties, we got a lot of students from the Tech and from the University, and a certain number of them, fired by Ronnie Laing's writings, came and actually enrolled first of all as nursing assistants, and then some of them even trained as nurses. Of course they found out it wasn't like Ronnie Laing said it was!*[77]

This dismissal of Laing represents Clark's view from the perspective of retirement, but the writings of Fulbourn psychiatrists published at the time reveal a more ambivalent attitude to Szasz and Laing.

In his book, *Psychological Medicine in Family Practice*, published in 1971, Ross Mitchell stressed the parallels between his concept of the neurotic patient and the model put forward by Szasz.[78] He also expressed support for Szasz's attack on 'body-mind dualism', and described Szasz's approach to hysteria as 'helpful'.[79] Laing's ideas on family conflict also received a favourable comment.[80] When Mitchell came to publish his second book, *Depression*, in 1975, Szasz's *Myth of Mental Illness* was included in the reference list.[81] In the first edition of Clark's *Social Therapy in Psychiatry*, published in 1974, Laing was praised for his 'fruitful' ideas on family therapy.[82] He was invoked as a supporter of the idea that pathology lies not in the individual, but in

[77] Transcript 02, Dr David Clark.
[78] A.R.K. Mitchell, *Psychological Medicine in Family Practice* (London, 1971), p.34.
[79] Ibid, pp.117, 150.
[80] Ibid, p.132.
[81] R. Mitchell, *Depression* (Harmondsworth, 1975), p. 110.
[82] D. H. Clark, *Social Therapy in Psychiatry* (Harmondsworth, 1974), p.63.

the group, even though his later writings were castigated for their 'naïve simplistic conclusions'.[83] Clark concluded that:

> Laing has proposed new models for families; Szasz has questioned the whole basis of psychiatry. These are exciting writings, despite their imperfections and we cannot guess where they will lead us.[84]

By the time the second edition of the book was published, in 1981, Clark took a much more critical line towards both Laing and Szasz.[85] The former was only mentioned once, when previously he was cited five times, while the latter was condemned for denying 'any value or any sincerity to any social therapy'.[86]

While Clark and Mitchell tended to invoke key members of the 'anti-psychiatry' movement rather uncritically, particularly in its early years, Roth was totally hostile to it from the beginning. In a paper published in the *British Journal of Psychiatry* in 1976, he roundly attacked both Szasz's contention that because conditions such as schizophrenia did not manifest altered physiology, they could not be considered as diseases and hence the 'medical model' was inappropriate, and also Szasz's failure to subject his own claims of successful treatment to independent scientific scrutiny.[87] Roth retired in 1985, and was granted the title of emeritus professor, but he continued with his research work and published 150 papers and several books during this period.[88]

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[83] D. H. Clark, *Social Therapy in Psychiatry* (Harmondsworth, 1974), p.53.
[84] Ibid, p.150.
[85] D.H. Clark, *Social Therapy in Psychiatry* (2nd ed., Edinburgh, 1981).
[86] Ibid, p. 33.
[87] M. Roth, 'Schizophrenia and the Theories of Thomas Szasz', *British Journal of Psychiatry*, 129 (1976), pp.317-326.
[88] C. Richmond, 'Obituary: Sir Martin Roth', *British Medical Journal*, 333 (2 Dec 2006), p.1175.

One fruit of this 'retirement' was a further attack on the supporters of 'anti-psychiatry' that he co-authored with the American psychiatrist, Jerome Kroll.[89] This book restated their total rejection of the fundamental tenets of the 'anti-psychiatry' movement, and an assertion of the reality of psychiatric disease and the responsibility laid upon psychiatrists to treat it. The 'critics of psychiatry' were divided, according to Roth and Kroll, into three groups. First, there were those who assert that there are no such things as mental illnesses. Szasz was said to believe that most people presenting with mental illness are merely frauds (the title is a play upon Szasz's book, *The Myth of Mental Illness* , which had been first published in 1961). A second group, which included the sociologist Erving Goffman, 'claimed that persons begin to act as though mentally ill only after and as a result of having been labelled as such by psychiatrists acting as agents of the dominant social order'. [90] A third group, exemplified by R.D. Laing, claimed that mental illnesses are reactions to unbearable stresses, particularly within the family. Several critics of psychiatry (and particularly Szasz) claimed that diseases are only real if physical pathology, as for example in pneumonia, brain tumours and bone fractures, can be demonstrated. Roth and Kroll argued that this was too narrow a definition of disease, and point to examples such as hypertension, diabetes and asthma which are conditions reflecting altered function but which lack simple physical pathology.

Roth did not confine his struggle against the supporters of 'anti-psychiatry' to the literary sphere, and one example became a *cause célèbre* in Cambridge and beyond. In 1979, David Ingleby, a social psychologist in Cambridge University's department of social and political sciences, applied for tenure. As he had produced twenty-five serious

[89] M. Roth & J. Kroll, *The Reality of Mental Illness* (Cambridge, 1986).
[90] Ibid. p.10.

papers and one book in his nine years as an assistant lecturer, it was assumed in the department that his appointment to a permanent post as lecturer was a foregone conclusion. So there was consternation when tenure was refused, and this only increased when it was rumoured that the rejection was due to unfavourable reports from the two referees. Dr Duncan Double was a medical student at Trinity in this period and recalled the reaction in Ingleby's department:

> *But the fact that David [Ingleby] didn't get the tenure actually led to undergraduate protests – all sorts of agitation – and eventually he left to get a chair in the Netherlands.*[91]

One of the referees, Peter Sedgwick, published an article in *New Society* in support of Ingleby and disassociating himself from the committee's decision.[92] The second referee was Sir Martin Roth, and Sedgwick drew attention to the fact that Ingleby's recent book was critical of Roth's approach to psychiatry.[93] Looking back on these events from his current position as a consultant psychiatrist sympathetic to many of the arguments espoused by supporters of 'critical psychiatry', Dr Double felt that the issue had become unnecessarily polarised:

> *And the interesting thing is that if you read David's chapter now, it hasn't got the same sort of excesses you might have expected from a David Cooper, or even an R.D. Laing, or a Thomas Szasz. But Sir Martin didn't appreciate that. He thought there was a conspiracy against psychiatry, so it was his position to preserve orthodoxy.*[94]

Double argued that such clashes are an inevitability, given the nature of psychiatry:

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[91] Transcript 15, Dr Duncan Double.
[92] P. Sedgwick, 'The Grapes of Roth' [Reprinted from *New Society* 30 April 1981] http://www.critpsynet.freeuk.com/Grapes.htm. Accessed 19/06/2006.
[93] D. Ingleby (ed.), *Critical Psychiatry: The Politics of Mental Health* (Harmondsworth, 1981).
[94] Transcript 15, Dr Duncan Double.

There was a lot of conflict – it is something to do with the nature of psychiatrists![95]

In his interview, Double highlighted the disputes between Freud, Adler and Jung as indicative of the creative tensions engendered by the fluid nature of many concepts in psychiatry.

Conclusion

During the years of his retirement, David Clark has tirelessly promoted the view, through lectures, the publication of his memoir, and the presentation of a television documentary, that the arrival of Professor Roth at Fulbourn definitively ended 'social therapy' at Fulbourn. He has painted the picture of a hospital community that was united in its support for his favoured model, and which was devastated when it was superseded by the implementation of a 'biological model'. Clark's case concludes with the assertion that sooner or later, psychiatrists will realise the error of their ways, and the 'social model' will have to be rediscovered. [96]

The oral history evidence collected for this study suggests that this perspective on events requires considerable modification. Far from being united in unquestioning support for Clark's experiments with therapeutic communities, there was in fact considerable disquiet on several grounds. Some of his colleagues thought that his insistence on creating therapeutic environments for highly disturbed patients was

[95] Transcript 15, Dr Duncan Double.

[96] 'Much of what we achieved has been lost and much is being forgotten. It was partly for that reason that I decided to publish this story, to put on record what we achieved', D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996),, p.245; 'We wrote about it, and we tried to describe it, and I believe it will be available there for later generations, when they have to go back to it, because they will have to go back to it, whatever they are doing at the present time.' BBC TV Documentary, *Unlocking the Doors*, 1996.

unworkable. Others were critical of what they regarded as his rather loose use of diagnostic categories, or psychoanalytic principles. In terms of the basic care needs of patients, several staff members have testified at their mounting concern over neglect justified as 'patient choice'.

Professor Martin Roth has promoted a similar view to Clark's, by suggesting that the establishment of a professorial unit at Fulbourn ushered in a new era in psychiatry. He claimed that he did indeed succeed in 'slowly deleting' the key features of Clark's practice, such as patient groups, from the hospital. The evidence presented above indicates that this shared view is too simplistic. Rather than confirming the 'deletion' of social therapy from the wards at Fulbourn, the oral testimony indicates that there was a divergence of view between psychiatrists and mental health nurses and the therapy staff, about the appropriate therapeutic model to use. While the psychiatrists who adhered to the biological model structured their clinical interviews with patients, and their ward rounds, around the process of formal diagnosis and medically-planned treatment, they were apparently unaware, or perhaps were unconcerned, that the rest of the patient's time in the hospital was shaped by social therapy.

In one place in his memoir, Clark indicates that he had some awareness of this division between the views of psychiatrists and mental health nurses:

> On most wards nurses are out of uniform: on many admission wards, ward meetings are still held (though doctors do not attend them) … the spirit of the best of psychiatric nursing still persists despite the disinterest of the doctors, and the conformist pressure of managers.[97]

[97] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 245

This process by which a therapeutic philosophy was discarded by doctors but embraced enthusiastically by less powerful groups of workers has some parallels with Shorter's account of the fate of psychoanalysis in the USA.[98] Shorter chronicled the way in which non-medically trained analysts fought to break the medical monopoly on accreditation. Once that monopoly was broken, psychiatrists began to lose their enthusiasm for psychoanalysis and moved to embrace the fruits of what Shorter has termed 'the second biological psychiatry'. So while at Fulbourn, nurses took over the practice of social therapy from psychiatrists, no inter-professional battles were required. The doctors willingly abandoned it, and lost interest in nursing activities that did not directly affect them. With the increasing acceptance of a shared psychiatric discourse that gave more prominence to biological issues than to social ones (what became known as the 'medical model'), disputes at Fulbourn moved on to organisational issues, and these will be analysed in Chapter 10.

[98] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997).

Chapter 10: Reaching Out from the Institution

Introduction

This chapter traces the way in which competing discourses about the nature of mental health problems and their treatment, which had dominated the life of Fulbourn for thirty years, were superseded by a new orthodoxy centred on adherence to a 'medical model', which focused on biological aspects of psychiatry while not denying a subsidiary role for other approaches. This new discourse did not, however, spell the end of conflict at the hospital, as fresh areas of contention arose, such as the increasing power of general managers, the desirability of moving to the main teaching hospital site, and the way in which the community mental health service should be organised. All these issues were also to have a major impact upon nursing practice. The decision to open a secure unit on the Fulbourn site marked the definitive end of the 'open door' policy, and reflected new public concerns about the threat posed by some people with mental health problems.

A New Consensus

With the retirement of Dr David Clark from his post as a Consultant Psychiatrist in 1983, supporters of a 'social model' of psychiatry within the hospital lost their leading advocate. However, his influence within Fulbourn had been on the wane since the election in 1976 of Sir Martin Roth as Cambridge University's first Professor of Psychiatry. This turning point in the history of the hospital was followed by the appointment of several other consultant psychiatrists who broadly shared Roth's views on the centrality of a 'biological model' of mental illness. Nick Smithson, who joined the hospital as a student nurse in 1975, was aware that the tide of consultant opinion

was turning against the social model that had attracted him to the hospital in the first place:

> *The acute admission wards often had two or three – possibly four … consultant psychiatrists on each. So there were a mixture of regimes, and certainly other consultants had a stronger emphasis on drug and medication practices.*[1]

In 1985, Professor Sir Martin Roth retired from the Cambridge chair in psychiatry, and his successor was Dr Eugene ('Gene') Paykel, who came from a chair at St George's Hospital in London. Dr Paul Calloway, who was appointed to a post as a Consultant Psychiatrist in Fulbourn at this time, shared the new professor's philosophy of mental illness:

> *As it happens, we actually shared the same research interests. His area of research was life events and depression… The notion that mental illnesses were brain-based, had to be treated, but that psychological and social factors were important in aetiology and in treatment.*[2]

So Roth's consistent focus on the biological was superseded by a 'medical model' incorporating some social aspects.

This willingness to accept that mental illnesses had both biological and social dimensions shared some common ground with the 'eclectic model' espoused by an earlier generation of Fulbourn psychiatrists, such as Dr Alan Broadhurst and Dr Oliver Hodgson. However, a key difference lay in their views of the role of the psychiatrist. Supporters of the eclectic model, such as Dr Broadhurst, were willing to take part in

[1] Transcript 07, Nick Smithson.
[2] Transcript 28, Dr Paul Calloway.

group meetings on the wards. Psychiatrists of a later generation, such as Dr Calloway, supported the existence of group meetings on the wards, but did not feel the need to join them. Above all, the emerging consensus in the 1980s had no place for Clark's enthusiasm for the 'therapeutic community'. In fact, supporters of the therapeutic community concept tended to be characterised in highly pejorative terms by psychiatrists who supported the new orthodoxy, as Calloway became aware soon after taking up his post in 1985:

> *Of course, I did find myself in the sort of later stages of this continuing … ideological tussle between what one might call a slightly medical model, and whatever the other model was. Which was, say, social model – or [what] some people would unkindly call a slightly anti-psychiatry model – although that's obviously being unfair.*[3]

Calloway had brought with him from his training at the Royal Free Hospital a thoroughgoing commitment to this 'medical model'.

Professor Geoff Shepherd, who was appointed to Fulbourn in 1981 as head of the clinical psychology service, was also aware of the hostility that was directed at the previous culture of Fulbourn:

> *And it's true, you know, that [Roth] did establish a very, very straight kind of biomedical model. Absolutely no doubt about it. And some of the people who were young consultants then… took that on and there was a feeling in that group – and they were a powerful group in the psychiatric establishment here – that what had gone on under David's direction in the hospital was a scandal. A disgraceful scandal. And,*

[3] Transcript 28, Dr Paul Calloway.

you know, if I was a bit harsh on it, they were wildly kind of inappropriate, really. You know – talk about throwing the baby out with the bath water![4]

Calloway was also aware that the past commitment to the 'social model' at Fulbourn continued to sustain a reputation, in the wider world of British psychiatry, for being outside the mainstream of psychiatric practice:

Some of my colleagues in London had almost slightly warned me off – saying, you know, 'This is a funny place you are going into!'[5]

With a few notable exceptions, the psychiatric profession in the UK generally united behind this version of the 'medical model', with its view that mental illnesses were disorders of the brain, that the main treatment options were drugs or ECT, but that other approaches might have a minor role, which came to dominate Fulbourn. [6]

Dr Ross Mitchell, who retired from Fulbourn in 1994, summed up the new consensus in the following terms:

I don't imagine [Fulbourn is now] different from any other units – hardly different from Peterborough or King's Lynn – but just in its size. The model is the same, like most places; the medical model, yes, but enlightened with psychodynamic and psychosocial concepts.[7]

The pioneering era at Fulbourn had come to an end, and its dominant psychiatric discourse now conformed to the expected pattern as found across the country.

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[4] Transcript 16, Professor Geoff Shepherd.
[5] Transcript 28, Dr Paul Calloway.
[6] This philosophical position could be said to represent a consensus view in late twentieth century European psychiatry: H. Oosterhuis & S. Wolters, 'The Changing Professional Identity of the Dutch Psychiatrist, 1960-1997' in M. Gijswijt-Hofstra & R. Porter (eds.) *Cultures of Psychiatry* (Amsterdam, 1998), pp. 203-220.
[7] Transcript 03, Dr Ross Mitchell.

Those psychiatrists who did not share this new orthodoxy, found it impossible to gain a consultant appointment at Fulbourn, and struggled to obtain NHS posts elsewhere. Dr Duncan Double trained as a psychiatrist at Fulbourn, but he did not hide his scepticism about the 'medical model':

> *I took my Membership exam. Eugene Paykel didn't want me to stay in Cambridge, although I did apply. It was very difficult for me, because I'd got a family. But I got a job in Sheffield with Alec Jenner.*[8]

While these dramatic changes in the ethos of Fulbourn could have major impacts upon individual careers, Ross Mitchell was philosophical about Fulbourn's ability to absorb the revolutionary changes brought first by Clark, then by Roth:

> *It has had to incorporate, on at least two occasions, cultures which really are counter to the main culture – and come to terms with them, and arrive at some sort of compromise, and that has been really very good.*[9]

So for the last ten years of the period covered by this study, the main focus of activity at Fulbourn ceased to be concerned with models of mental health, and conflicts over treatment options, and turned instead to the way in which patient services were organised.

The Origins of Community Mental Health Care in Cambridgeshire

This account of Fulbourn Hospital in the second half of the twentieth century has so far focused on developments on the main hospital site. While that is an accurate reflection

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[8] Transcript 15, Dr Duncan Double. Professor Jenner was an unusual figure in British psychiatry at the time, combining as he did a research interest in psychopharmacology with support for social psychiatry: D. Healy, 'The History of British Psychopharmacology' in H. Freeman & G.E. Berrios (eds.) *150 Years of British Psychiatry: volume II: The Aftermath* (London, 1996), pp. 61-88. Jenner's position was therefore very similar to that espoused by Dr Alan Broadhurst at Fulbourn twenty years earlier.
[9] Transcript 03, Dr Ross Mitchell.

of the dominance that the Fulbourn site exercised over the activities of the psychiatric service within the county of Cambridgeshire in this period, it does not tell the whole story. From very tentative beginnings, the post-Second World War period saw a slow but consistent process of service development away from the Fulbourn site. The first Outpatient Clinic had been opened at County Hall, March, in 1947, when Dr J.G.T. Thomas was Medical Superintendent. Its establishment was followed by that of further clinics at Huntingdon, Saffron Walden, Wisbech, and at Addenbrooke's Hospital in Cambridge.[10] In 1953, the latter was moved from its cramped location on the main hospital site to its own building in Bene't Place, and this provided the space in which to develop both 'physical' treatments, such as electro-convulsive therapy, and 'talking' treatments, such as psychotherapy.

By 1961, when Barbara Prynn was there as part of her social work course, Bene't Place had also become the springboard for a wide range of activities in the community.

> *I was actually placed in 2 Bene't Place in the outpatients… And I also saw people in their own homes – on my own... There was also a kind of club for ex-patients, which happened in Cambridge. And they met and did social things together, like going to the cinema, and so on, and I was kind of attached to that as well.*[11]

At the national level, the process of moving from a service which based most psychiatric care in large Victorian hospitals, towards one which emphasised 'care in the community', proved to be a much slower one than its supporters had hoped. Nevertheless, it was to be the main direction of Government policy from the 1950s

[10] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 38.
[11] Transcript 24, Barbara Prynn.

onwards. The Royal Commission on Mental Illness and Mental Deficiency, 1954-1957, chaired by Lord Percy, met against a backdrop of political concern that these services had suffered neglect despite the establishment of the National Health Service in 1948.[12] It was one of the first government publications to use the phrase 'community care'.[13] The subsequent Mental Health Act 1959, emphasised the need for care outside hospital by making it a requirement for local authorities to provide facilities for 'after-care'.[14]

David Clark, who always tried to position Fulbourn fully abreast of current developments in psychiatry, was an early pioneer of community care, in the form of hostel provision to ease the transition from hospital to home. The original proposal for a halfway hostel came from Cambridgeshire Mental Welfare Association in 1956, but Clark embraced it with his typical enthusiasm (Discussed in more detail in Chapter 4).[15] When Enoch Powell, the Minister of Health, made his celebrated speech in 1961 announcing the policy of closing mental hospitals and reducing the number of psychiatric beds by half, David Clark, who was in the audience, pointed out that existing practice was already moving in that direction. He stated that, 'it was the hospitals which had led the world by their work in getting patients back into the community.'[16] However, it was difficult to deny that developments in that direction remained tentative. So when Dr Ross Mitchell, who was appointed to his post at

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[12] K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), pp. 148-155; R. Porter, 'Two Cheers for Psychiatry: The social history of mental disorder in twentieth century Britain' in H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), p. 401.
[13] J. Boardman, 'New Services for Old: An overview of mental health policy', in A Bell & P Lindley (eds.) *Beyond the Water Towers: The Unfinished Revolution in Mental Health Services 1985-2005.* (London, 2005), p. 28. The concept of community care had been previously included in the Mental Deficiency Act 1913.
[14] Mental Health Act, 1959, 7 & 8 Eliz. 2 Ch. 72, Part II.
[15] D.H. Clark & L.W. Cooper, 'Psychiatric Halfway Hostel: A Cambridge Experiment' *Lancet* 275, 7124 (1960), pp. 588-590.
[16] K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), p. 162.

Fulbourn in 1966, surveyed existing service provision outside the hospital, his dissatisfaction with the very limited outreach facilities mirrored national policy developments:

> *I was still unhappy with the outpatient unit – at Bene't Place, which was part of the Addenbrooke's outreach. But I thought, 'Well… it's about time. We've got a therapeutic community in the hospital, what about a therapeutic community outside?'*[17]

Mitchell's idea was to develop a community team based on the existing 'patches' allocated to each consultant:

> *So my patch was the Fens, which was the north of Ely right up to Peterborough, right up to King's Lynn. So I thought, 'How are we going to organise this? Well, we'll have a team – we'd then got what were then known as the DROs – the Disabled Resettlement Officers – I could bring myself and a junior doctor – the medical element… so we now had what I called the District Psychiatric Team – the DPT.* [18]

This initiative, which developed from the early 1970s onwards, was regarded by Mitchell as being the logical outcome of a commitment to the 'social model' in psychiatry, as his comment above indicates.

Another key factor in the development of this new service in the community was the creation of a role for community psychiatric nurses. This was a national initiative which was transforming the role of an increasing proportion of nurses working in the area of

[17] Transcript 03, Dr Ross Mitchell.
[18] Ibid.

mental health care.[19] While some psychiatrists were resistant to this new development, Mitchell could see the potential for development of this role and he was an enthusiastic supporter:

> *Just about this time, the whole idea of a community psychiatric nurse was beginning to be developed, and they were beginning to look at outreach, going out into the patch – run by the hospital end. But really coming from the hospital and going back to the hospital again, whereas what I wanted was people who would be recruited who would work actually in the community full-time. And we got two or three, four, men and women, appointed in that capacity.*[20]

While much of the official thinking emanating from Whitehall at this time emphasised the potential role of the district general hospital, or the social services department, as the base from which such a team could operate, Mitchell was clear that individual general practices were the ideal location:

> *In the Fens, because of the dispersed nature of the population the GPs were organised into group practices. So it was very easy to link up with a group practice. And myself and the junior doctor – and later the psychologist.*[21]

This radical approach soon won the enthusiastic support of the GPs, as they often felt unprepared to deal with the numerous mental health problems with which they were confronted.

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[19] P. Nolan, *A History of Mental Health Nursing* (London, 1993), p. 137. The Royal College of Psychiatrists remained ambivalent in its attitude towards this new role: see J. Boardman, *Community Psychiatric Nursing: Occasional Paper 40* (London, 1997), pp. 23-25.
[20] Transcript 03, Dr Ross Mitchell.
[21] Ibid.

A further factor in gaining their support was that apart from the provision of a consulting room, the new service did not cost the practice anything. Mitchell also noticed that it soon had an effect on bed occupancy at Fulbourn:

> *My beds were usually half empty, because I wasn't admitting so many people. But if we did admit somebody, we knew that when we discharged them, they were going back into a team – so you got continuity of care. So the length of stay in hospital was less.*[22]

Mitchell's method of working was based on the model developed by Michael Balint, which involved providing clinical supervision for GPs in order to help them to work more effectively with their patients:[23]

> *Balint got the GPs to look at their patients, and to say that the GP was part of the prescription – it was the relationship between the patient and the doctor that was part of the healing process, as well as the medication they were using.*[24]

Once GPs felt more confident about their own role in helping people with mental health problems, Mitchell's team could focus both on more challenging cases, and the provision of support to the GPs.

While Mitchell was pioneering a model of mental health service based in primary care settings, the mental hospital site with its in-patient beds continued to dominate provision, both locally and nationally. Enoch Powell's prophecies of rapid hospital closure proved to be wide of the mark, as the White Paper, *Better Services for the*

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[22] Transcript 03, Dr Ross Mitchell.
[23] M. Balint, *The Doctor, His Patient and the Illness* (London, 1964); R. Mitchell, *Psychological Medicine in Family Practice* (London, 1971); A.R.K. Mitchell, 'Psychiatrists in Primary Health Care Settings', *British Journal of Psychiatry*, 147 (1985), pp.371-379.
[24] Transcript 03, Dr Ross Mitchell.

Mentally Ill, published in 1975, was forced to concede.[25] However, Government policy continued the emphasis on community care and highlighted a need to establish acute psychiatric services on District General Hospital sites.[26] This was to become a major theme in the later history of mental health services in Cambridge.

The Advent of General Management

Health service reorganisation from the 1970s onwards had the effect of ending the isolation of Fulbourn and of tying the hospital ever more firmly into the wider management structures of the NHS. Until 1974, Fulbourn had been run by a Hospital Management Committee consisting of local politicians and leading figures from the University of Cambridge, such as Lady Hester Adrian, wife of the Master of Trinity College, and Sir Henry Willinck, Master of Magdalene College.[27] Subsequent management changes tended to cast this period in a golden light for those psychiatrists who resented the growing influence of health service managers and the perceived diminution of their own power within the mental health service. However, there was never a 'golden age' of untrammelled power and influence exercised by psychiatrists, free of all 'lay' constraints on their actions. Medical Superintendents like David Clark were subject to the constant scrutiny of their Hospital Management Committee.[28] Furthermore, its meetings were reported at length in the local press, and so outside scrutiny of all policy decisions concerning the hospital was a constant reality.[29]

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[25] Department of Health & Social Security, *Better Services for the Mentally Ill* (London, 1975).
[26] K Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), pp. 190-193. L. Warner, 'Acute Care in Crisis', in A. Bell & P. Lindley (eds.) *Beyond the Water Towers: The Unfinished Revolution in Mental Health Services 1985-2005*. (London, 2005), p. 39.
[27] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), pp. 38, 186.
[28] Ibid.
[29] Ibid. p. 73.

Medical Superintendents also had to work in concert with the Hospital Secretary and the administrators in his department. In some hospitals this may have produced tensions, but the Fulbourn administrators were enthusiastic supporters of the 'social therapy model' that Clark had introduced on the wards, as Ken Cross testified:

> *We all used to go down to this weekly meeting. And I would bring information from the Ministry directives – feed them into the meeting. They would feed, perhaps, problems back to the administrators. It worked wonderfully. And when there was a problem – it wasn't very often – they would ring the link administrator.*[30]

In 1971, the role of Medical Superintendent was abolished throughout the NHS, and Clark became simply one of the Consultant Psychiatrists in the hospital. However, his role as *primus inter pares* was recognised by his election by his peers as the first Chairman of the newly-created 'Division of Psychiatry'.[31]

Further change followed the publication of the White Paper, *Management Arrangements for the Reorganised National Health Service* in 1972, which proposed the replacement of hospital management committees by district management teams.[32] This change was put into effect in 1974, and Fulbourn came under the strategic management control of the Cambridge Area Health Authority. Operational management was delivered through a link with the nearby Ida Darwin Hospital, which cared for people with a severe learning disability, by the Fulbourn and Ida Darwin Hospital Management Committee.

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[30] Transcript 25, Ken Cross.
[31] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 226. Clark held this position until 1975.
[32] Department of Health & Social Security, *Management Arrangements for the Reorganised National Health Service* (Chairman: Sir Philip Rogers) HMSO (London, 1972).

The guiding management philosophy throughout the NHS during this period was 'consensus management', based upon decisions being taken at every level by teams made up of doctors, nurses and administrators.[33] This philosophy was fully in accord with Clark's consensus-based approach to hospital management from the level of the individual ward upwards, so it is not surprising that Ken Cross recalled harmonious working relationships:

> *I must say at this stage that Fulbourn was a very, very happy place to work with. Contributed to by the liaison with the local trade union secretaries – we knew each other by first names. Any hint of any problem, they'd come and talk to us.*[34]

With the arrival of a Conservative government from 1979 onwards, Secretaries of State, and Mrs Thatcher herself, expressed increasing frustration with consensus management on the grounds that it was unwieldy, it was too ready to accede to union demands, and did not hold one person accountable for the performance of individual units of management. The Nodder Report on the management of psychiatric hospitals, published in 1980, had broadly supported consensus management, but had recommended that a more structured approach, through the establishment of 'unit management teams', would improve their effectiveness.[35] It also advocated an enhanced role for the administrator in co-ordinating developments. Fulbourn was one of the small number of hospitals which put management arrangements in place as recommended by Nodder. Stephen Thornton, a product of the NHS Management Training Scheme for high-flying graduates, was appointed to the new post:

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[33] R. Levitt, A. Wall & J. Appleby, *The Reorganized National Health Service*. 6th edn. (Cheltenham, 1999), p. 17.
[34] Transcript 25, Ken Cross.
[35] Department of Health & Social Security, *Organisational and Management Problems of Mental Illness Hospitals (Nodder Report)*. HMSO (London, 1980). R. Levitt, A. Wall & J. Appleby, *The Reorganized National Health Service*. 6th edn. (Cheltenham, 1999), p. 138.

> *In 1983, there was one of these periodic NHS management upheavals, where – from memory – they created what was called 'units of management', and they needed people to run them – 'Unit Administrators', they were called. …And I applied to Fulbourn – well, in fact it was the Mental Health Services Unit, as it was then called. And in a sense it was my first senior job, really.*[36]

Dr Graham Petrie was a member of the interview panel, so there was a medical perspective as part of the appointment process.

Thornton had first been attracted to working in the mental health area of the NHS by an earlier placement at the vast Prestwich Hospital, in Manchester. Even as a junior administrator, it gave him more scope to improve conditions for patients than his colleagues found in general hospitals:

> *I had a free hand because these places were unmanaged, really. They were 'administered', but nobody was actually getting a grip and doing anything about, in my view, the plight of the patients. And so it seemed like a fantastic opportunity.*[37]

Thornton was in no doubt about what his role was to be under the new management arrangements at Fulbourn:

> *[Nodder] was a really early precursor to [the Griffiths Report], and it laid out what was called 'the co-ordinating role of the administrator'. So it was an acknowledgement that the administrator was kind of a 'first among equals' – of his peers, her peers, around the table. Rather*

[36] Transcript 20, Stephen Thornton.
[37] Ibid.

than this assumption that we would all reach a consensus decision – somehow, magically, kind of thing. So, if you can see, that was right at the beginning of managerialism in health care in this country. Coming bump up against the David Clark philosophy, right?[38]

On arriving at Fulbourn to take up his new post, Thornton experienced contrasting reactions to the state of the hospital as he found it:

I thought it was a filthy mess, I thought it was disgusting. And then I was told – that was the community, really. And I say this with mixed emotions, because it genuinely was disgusting. And on the other hand it also had a kind of spirit about the place that I've never seen in any other psychiatric hospital I've been in – and I've been in lots, trained in one and visited many and so on. It did have a kind of warmth about it and some of the most damaged individuals I've ever come across seemed to – if I use the word 'thrive', that's always an exaggeration because in a sense these people because of their condition never thrive, that's part of the horrors of what they are suffering. But to the best of their abilities, within the confines of their condition, they did seem to thrive, really.[39]

Fulbourn was therefore one of the first hospitals in the country to experience the clash between the philosophy of consensus management, and the new 'managerialism'.

One of the committees through which consensus management operated at Fulbourn consisted of representatives of the Cambridge Psychiatric Rehabilitation Service

[38] Transcript 20, Stephen Thornton.
[39] Ibid.

(CPRS) Parliament, such as the catering manager and the hospital pharmacist.[40] Jimmy Loh, who was a nursing representative, recalled its organisation:

> *10:30 [in the morning], you'd go to the boardroom, then [Clark] would chair it, Geoff [Shepherd] would come in as well. And then we'd debate policies, we'd debate what needs doing, what's a problem, issues. People learn from it. It's all minuted and sent out – and patients actually got to see those minutes.*[41]

Stephen Thornton recalled his reaction on first being told of this committee's existence:

> *I was told by my secretary – and I'll never forget this – she said, 'Stephen, on Wednesday you're appearing before the Fulbourn Representatives Committee.'*
>
> *I said, 'Excuse me – what do you mean I'm appearing before – who are, what is – this thing?'*
>
> *… And then she told me about the CPRS Parliament and my mind just blew, really. I thought – 'Who's in charge around here?'.*[42]

After what he described as some 'sticky' initial meetings, Thornton came to appreciate the scope which this committee gave him to influence developments at Fulbourn.

> *At the end of the day, when the psychiatrists got difficult, it gave me a degree of legitimacy to actually try and push through some change. So I think that was one aspect of the old way that we did manage to pull into the new world, really, quite effectively.*[43]

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[40] 'Parliaments' had been introduced by David Clark as a feature of his 'social therapy' model. D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 221.
[41] Transcript 17, Jimmy Loh.
[42] Transcript 20, Stephen Thornton.
[43] Ibid.

This comment reflects the intensely 'political' character that this struggle between psychiatrists and general managers at Fulbourn took on.

In 1983, Norman Fowler, the Secretary of State, asked Roy Griffiths, then the managing director of the Sainsbury supermarket chain, to report to him on improving management in the NHS.[44] Griffiths reported that the efficiency of the NHS would be improved if consensus management was replaced by making one individual at each level personally accountable for all the management decisions taken at that level.[45] This recommendation was accepted by the new Secretary of State, Kenneth Clarke, in the following year, and 'general management' replaced 'consensus management' throughout the NHS.[46] Some of the new cadre of general managers were senior figures drawn from industry or the armed services, and this provoked much hostile comment from NHS staff, but in fact the great majority were drawn from the ranks of existing NHS administrators.[47] Fulbourn was in advance of this national trend as Stephen Thornton, a career NHS administrator, was already in the kind of post envisaged by this latest reform.

The advent of general management provoked predictably hostile responses from those psychiatrists, like Dr Graham Petrie, the Chairman of the Division of Psychiatry during this period, who were comfortable with their role in consensus management:

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[44] C. Ham, *Health Policy in Britain: The Politics and Organisation of the National Health Service.* 5th edn. (Basingstoke, 2004), pp. 32-33.
[45] Department of Health & Social Security, *The NHS Management Inquiry (The Griffiths Report)* HMSO (London, 1983).
[46] Department of Health & Social Security, *Health Services Management: Implementation of the NHS Management Inquiry.* Circular HC(84)13 (London, 1984).
[47] C. Ham, *Health Policy in Britain: The Politics and Organisation of the National Health Service.* 5th edn. (Basingstoke, 2004), p. 33.

During this time there had been an over-taking by managers, which I found pretty sickening, actually. I mean – it was awful.[48]

In their oral history interviews for this study, both parties to this power struggle between psychiatrists and managers portrayed themselves as acting in the interests of the patients of Fulbourn. Dr Petrie recalled one sharp exchange with a senior manager about the poor state of the wards in the hospital:

I said, …'Let's make sure that we won't, in a couple of years, have nice, warm, air-conditioned offices with low ceilings for your people, and my people in these awful places.'

[The manager said] 'Oh, no – that won't happen, that won't happen.'

Well, of course, it did. And that was very sickening, that sort of thing.[49]

The use of the phrases 'your people' for managers, and 'my people' for patients, served to underline this message.

Stephen Thornton also focused upon improving the condition of the hospital buildings, in order to improve the living conditions of the patients.

Frankly, to do something about what I thought was the pretty parlous state of the physical surroundings. I mean, the acute psychiatric wards down in that new block [Kent House] – was awful. The thing that comes to mind the most is the awful louvered windows. They broke, and … it could be bloody bleak in Fulbourn in the winter, it was cold in there, and that was really, really grim.[50]

[48] Transcript 11, Dr Graham Petrie.
[49] Ibid.
[50] Transcript 20, Stephen Thornton.

It was significant that it took a relative newcomer to the hospital to focus on an issue that long-serving staff had ceased to notice.

Dr Petrie disliked the new management arrangements so much that when, in 1988, an attractive opportunity in the private sector presented itself, he resigned from the NHS.

> *But the management – it was just too much. I think it's probably my fault too – if you've been a GP for ten years, which I was, you're an independent chap and you don't like being told what to do! [laughs] So perhaps it was my fault! But anyway, that's how it worked out, and that's why I left.*[51]

While some of the consultant psychiatrists were very hostile to the increased influence exercised by managers, Fulbourn's senior clinical psychologist Professor Geoff Shepherd, maintained that this was an over-reaction on their part:

> *A lot of the stuff around general management is the reaction from some of my erstwhile medical colleagues about the loss of power of doctors. Because there was always a Hospital Secretary – you know, even in David's day. You know, there was the Medical Superintendent, the Head Nurse and the Secretary. And what we're talking about is the Secretary – and that Secretary person having a lot more explicit power than they had in David's day.*[52]

So rather than focusing on the new breed of general manager, Shepherd argued that the main challenge to traditional notions of medical professionalism lay in the lack of trust exhibited by the central NHS bureaucracy in the delivery of mental health services:

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[51] Transcript 11, Dr Graham Petrie.
[52] Transcript 16, Professor Geoff Shepherd.

> *To me the most pernicious part of what has happened with the growth of 'general management' and 'managerialism' is this notion that the way that services must be regulated is through external inspection. And the way to improve services is through external inspection. Now, there is absolutely no evidence to support that proposition. And in fact the evidence that there is suggests that the greater the weight of external inspection, the more it will crush any attempt, internally, to improve services.*[53]

It is probable that the current regime of outside inspection, which has intensified after 1997, has coloured this speaker's view of the situation in the 1980s, because the senior staff of Fulbourn had generally been enthusiastic supporters of the inspections carried out by the Hospital Advisory Service (as discussed in Chapter 8).

A Presence on the Addenbrooke's Site

As well as sharing a common philosophy on the nature of mental illness, Professor Paykel and Dr Calloway were also both focused on the ambition to develop psychiatric services on the nearby teaching hospital site.

> *We both aspired to having more of a presence on the Addenbrooke's site. Sir Martin Roth had developed his professorial unit on the Fulbourn site. I think he'd tried to put it on the Addenbrooke's site. And Gene was quite – a very astute operator, and he was able to work*

[53] Transcript 16, Professor Geoff Shepherd.

closely with management – who had their own set of aspirations at this time.[54]

While Paykel and his academic colleagues focused on the improved research opportunities that such a move might bring, Calloway was motivated by a desire to reduce the stigmatisation experienced by patients, and the prospect of better resourcing for the service. Rather than harbouring resentment at the rise to prominence of the powerful cadre of general managers, such as Stephen Thornton, the politically astute new professor's approach was to engineer a trade-off between the ambitions of the two parties:

Gene Paykel – his approach was to say, 'Look, management want us to do these things', which was sectorisation, which was to try and get consultants into patches, responsible for their patches, basically a way of making sure that patients were seen quickly, closer liaison with the GPs. And he sort of played that off against getting what he and some of us wanted – [a presence at Addenbrooke's]

Calloway's account emphasises once again the 'political' manoeuvring that characterised the struggle between psychiatrists and managers.

However, the consultant psychiatrists at Fulbourn were not united in this prioritisation of a strengthened presence on the Addenbrooke's site

And again there was a rift in the consultant body about who wanted to be on the Addenbrooke's site…It was a time when I would say the medical and the nursing establishments were really quite split.[55]

[54] Transcript 28, Dr Paul Calloway.
[55] Ibid.

Stephen Thornton, from the other side of the negotiating table, was also very much aware that there was little agreement amongst the psychiatrists:

> *[The academic psychiatrists] were utterly obsessed with getting their unit on the 'general' hospital site – everybody was moving up to the 'new site' [of Addenbrooke's], as it was then called. And they were single-mindedly focused on that… The Division of Psychiatry was as it was described – it was a division! [laughs] You know, there were always more voices than there were psychiatrists – it was a nightmare, absolute nightmare, to try and get any decision out of the medical body.*[56]

Ultimately, Professor Paykel's negotiating tactics prevailed, and some token wards were sustained on the Addenbrooke's site for a short period:

> *Initially, we got the Academic Unit on the Addenbrooke's site – Paykel's and the R4 Unit – and eventually we did get a couple of wards on the site as well. Although of course, since then [laughs] it has all swung back and it's closed!*[57]

At the time of writing (2009), the Addenbrooke's site is about to undergo a major expansion, so it remains to be seen if the Academic Unit of Psychiatry will move back there into purpose-built accommodation.

As well as the debate about psychiatric wards on the Addenbrooke's site, there was also a wider debate about whether Fulbourn should be linked for management purposes to Addenbrooke's. In 1985, that link was finally made. Participants in this process have different recollections about how well Fulbourn did out of this new arrangement.

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[56] Transcript 20, Stephen Thornton.
[57] Transcript 28, Dr Paul Calloway.

Stephen Thornton, who became the general manager of the new Priority Services Unit felt that:

> *We were always on the back foot – we were always the last. Because then we were re-organised – and we became, ironically, the Priority Services Unit! [laughs] I don't know – 'priority' didn't seem to mean much in financial terms, but it was everything except Addenbrooke's – so it was Fulbourn, Ida Darwin, it was the community health services, it was … the geriatric hospital at Brookfield, it was Ely.*[58]

Calloway, in contrast, felt that the actual experience of a managerial link with Addenbrooke's vindicated his position in advocating closer ties with the nearby teaching hospital:

> *Ironically, we found that when we were with Addenbrooke's, we had no cuts in our resources, they actually looked after psychiatry very well. At a time when other units were facing cuts. I mean, partly because we played the 'little us' bit – you know, we are a small part of this huge [organisation] and 'you wouldn't want to attack these services'.*[59]

The NHS and Community Care Act 1990 paved the way for units of management within the NHS to become 'Trusts', with at least the prospect of more independence from central direction. Again, opinions in Fulbourn were divided, as Calloway recalled:

[58] Transcript 20, Stephen Thornton.
[59] Transcript 28, Dr Paul Calloway.

> *And then of course it was the era of the Trusts – and there was another great debate about whether we should be an independent, separate Mental Health Trust.*[60]

In the event, the former Priority Services Unit became the Lifespan NHS Trust, so community services, those for older people, and for those with a 'mental illness' or learning disability, were managed together, and the link with Addenbrooke's was broken.[61]

Sectorisation and the Increasing Influence of the GP

In the period between its opening in 1858, and the middle of the 1980s, Fulbourn, like similar county asylums, could be said to have stood in splendid isolation from other health and welfare services.[62] Even during his years of dynamic reform, David Clark had been largely concerned with what went on in the wards of the hospital and there was little interest in how Fulbourn related to the wider NHS outside its grounds. However, the last decades of the twentieth century saw an increasing focus on how the NHS functioned as a 'system' or 'service' rather than as a collection of 'stand alone' units. As a manager, Stephen Thornton felt that the new dominance exerted by academic psychiatrists at Fulbourn was impeding an appropriate reaction to this change:

> *[The academics] seemed to me to have negligible interest in 'the service'. They may have had some interest in individual patients, but absolutely no interest in the service. And that was profoundly depressing, really. Because the only people who did were kind of out of the 'old guard', as it were. So the 'old way' was coming to an end*

[60] Transcript 28, Dr Paul Calloway.
[61] Pat Lambert became Director of Nursing for the Lifespan NHS Trust.
[62] J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum – St John's* (London, 1990), p.161; S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St Andrew's Hospital, 1810-1998* (Woodbridge, 2003), p.277.

> *and there was no clinical leadership taking on 'the new way'. So there was a huge, huge clinical vacuum.*[63]

It was evident that the demands of teaching and research left little space for a broad view of the service needs of the county of Cambridgeshire.

At the heart of the wider NHS service was the general practitioner (GP), who assessed the patient's need for specialist psychiatric services, and who would be responsible for coordinating care when the patient was discharged. Dr Ross Mitchell had ploughed a lone furrow in pioneering psychiatric services in group general practices, but the routine requirement to provide efficient admission and discharge services for GP referrals did not receive a high priority. However, this is not to say that the general psychiatrists at Fulbourn had light caseloads. Dr Paul Calloway, who was appointed in 1985, recalled that:

> *We were partially sectorised – out of Cambridge, we were sectorised, not in Cambridge. I had a big chunk of the Fens, Newmarket, Ely, and also a non-sectorised part of Cambridge. So it was a very busy general psychiatry job … I mean, compared to today's catchment areas, I think I had a catchment area of over 100,000, whereas now the typical one is about 25 – 30,000.*[64]

As a relatively new arrival, Calloway was well placed to reflect on the weaknesses he observed in the operation of psychiatric services.

Myths associated with the 'therapeutic community' phase of Fulbourn's past continued to have currency even after David Clark's retirement:

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[63] Transcript 20, Stephen Thornton.
[64] Transcript 28, Dr Paul Calloway.

> *It did become apparent to me quite early on, that a lot of the GPs were not happy with psychiatry… They said [that] they couldn't get patients into hospital, they couldn't get patients seen. Patients were discharged in a kind of random fashion…There used to be rumours around… that patients' councils would vote on whether patients were discharged or not! [laughs] I don't know if that was a malicious rumour – but certainly when I came, there was a bit of an ethos of the therapeutic communities lingering on.*[65]

As noted above, the quid pro quo for management support to open some wards on the Addenbrooke's site, was an agreement to base consultants' working patterns on the principle of implementing complete sectorisation across the county.

Sectorisation, based on the establishment of psychiatric teams taking responsibility for all the mental health services within a small geographical catchment area, had spread rapidly across Europe in the 1980s. The planning for the full sectorisation of Cambridgeshire began in 1987, shortly after the arrival of Professor Gene Paykel.[66] A study published in 1993 reported that 81% of the District Health Authorities in England and Wales that responded to the questionnaire had sectorised their mental health services.[67] The main advantage of sectorisation was held to be the opportunity for GPs to build close working relationships with the psychiatrist responsible for their sector. In some districts, sectorisation also proved the impetus to base psychiatric services within community units situated in each sector, but in Cambridgeshire, in-patient services remained on the Fulbourn site. Once the link with Addenbrooke's was made, as

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[65] Transcript 28, Dr Paul Calloway.
[66] Fulbourn Archives: Anon, 'Acute Psychiatry Sub-Group Mental Health JDT: Report of Working Party on Sectorisation'.
[67] S. Johnson & G. Thornicroft, 'The Sectorisation of Psychiatric Services in England and Wales' *Social Psychiatry and Psychiatric Epidemiology*, 28, pp. 45-47.

Calloway recalled, its senior general manager, John Ashbourne, began to cast a critical eye over the organisation of psychiatric services:

> *Ashbourne brought these sort of management methods to Addenbrooke's. And one of his approaches was to take quite comprehensive surveys of GP attitudes. And they rated all the different services – you know, it was 'naming and shaming' really. And the first one they did, when we were starting out on this enterprise, psychiatry came right at the bottom. There was the least satisfaction – they were very unhappy with the services across the board, really. You know, all the things you can think of – getting patients in, treatment, and all the rest of it.*[68]

Once the new service arrangements had had time to establish themselves for three years, Ashbourne repeated the GP survey exercise. Calloway was gratified to note the difference that had been recorded:

> *We had gone right up the scale. So certainly I think what we did in terms of sectorisation, going out into the community a bit more, improving the duty rotas as well – the duty rota system didn't work very well – led to more GP satisfaction.*[69]

Such quality improvement initiatives were to become more widespread as the 1990s progressed.

Calloway's views were not, however, universally shared amongst the consultant psychiatrists at Fulbourn. Dr Jane McKeown felt that the lack of choice in referral that sectorisation brought with it had damaged relationships with GPs:

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[68] Transcript 28, Dr Paul Calloway.
[69] Ibid..

> *They did not like, for example, the 'sectorisation' that came into play when Professor Paykel arrived. Because previously they had been able to choose their Consultant Psychiatrists, and GPs always have a feeling that they can sort of match patients and consultants successfully, you see! And probably, they can, because they've known these people, their families, often for years and years and years …the fact is, they were pushed into a situation of having no choice – it was me, or whoever it was going to be, and that was resented.*[70]

She was also concerned that the skills of community psychiatric nurses were not being used appropriately in the new system:

> *The CPNs were placed in primary care, that happened initially. But what happened then, of course, was that GPs just used them for anything…I suppose they got swamped with … minor psychological, psychiatric problems. And that was completely unsatisfactory because their role was to help the seriously mentally ill – that was their perceived role. Then they were moved back into the hospital teams, which for some of them resented greatly. And so did the GPs – losing <u>their</u> CPNs*

The issue which McKeown highlighted here became a focus of national concern during the early 1990s. Leading voices in mental health nursing began to make the same point, and CPN services were gradually refocused on the needs of people with serious and enduring mental health problems.[71]

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[70] Transcript 10, Dr Jane McKeown.
[71] B. Wadeson, 'Psychiatric Nursing: We Don't Do Mad People Now', *Nursing Standard*, 6 (6 May 1992), p.56.

Moving Out into the Community

Moving the centre of gravity of mental health care in Cambridgeshire from a largely hospital-focused service to an outward-looking one, grounded in the community, was a long and arduous process which required sustained involvement from many individuals and organisations.

While David Clark had taken an initial step towards community care through founding Winston House, his main interest remained centred on Fulbourn hospital itself, as John Lambert, a former charge nurse, observed:

> *[Clark] was a great one for talking about, you know, care in the community, but really he liked to have his beds! [laughs] And he liked to have his beds in the hospital.*[72]

Another nurse, Jimmy Loh, on the other hand, remembered the Cambridge Psychiatric Rehabilitation Service (CPRS), under Clark's leadership, as laying the foundations for future care in the community:

> *[Clark] could see potential in giving people more aspirations, or moving out – 'we are creating our own lives'. As a result, then, in fact we discharged quite a lot of people and closed wards. So this thing about, you know, 'care in the community', closing wards…It's nothing new. I mean we've done it before, and we've done it quite successfully.*[73]

Certainly, the 1970s saw the first experiments in establishing 'group homes' for Fulbourn patients who were assessed as being suitable for life outside the confines of a ward.

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[72] Transcript 08, John Lambert.
[73] Transcript 17, Jimmy Loh.

Jimmy Loh was one of the nurses who was actively involved in this process, which began with the resettlement of people who had been displaced after the Second World War:

> *There was one Polish group home – a Polish charity…bought a house just off Cherry Hinton Road, in which we put some Polish [men]. At that time we didn't realise that there was a difference between Polish and Ukraines. Later on there was a lot of trouble with that because we mixed them – and in fact they were trying to kill each other, really! Anyway, we got that and we got altogether fourteen group homes. And we had one community nurse – to be the social worker! [laughs] Still, it was so young. That's always been Fulbourn's way of doing it – we were ahead of time!*[74]

Accommodation on the Fulbourn site was utilised in order to provide a graduated process of acclimatising patients to the demands of independent living, as Loh recalled:

> *And people were prepared – like for eighteen months, you are going to try-out as a group. It works and you are out. If patients struck up relationships, right, then we put them into what we used to call Cedars – one of the staff accommodation upstairs and patient accommodation downstairs. There were double beds there and they can try it out. Share, live together, you know, and if they like it they can move out.*[75]

Loh was also at pains to stress that Clark's philosophy of the 'therapeutic community' also underpinned key aspects of the move back to independent living:

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[74] Transcript 17, Jimmy Loh.
[75] Ibid.

> *It was very liberal-minded, in that sense. I mean, you wouldn't think a hospital would condone that – two people sleeping together, you know – making a life for themselves …That's how the attitude changed by having a therapeutic community – people's attitudes – staff and patients.*[76]

It was apparent to nurses like Loh that the new policy direction was not receiving adequate financial support:

> *We weren't putting resources into the community – that was a problem. And there came a crisis in 1981. One of the group homes – City Road – the kitchen ceiling fell down, which had the bathroom on top, and the bathroom ceiling fell down – all at the same time! And a resident died, so there was a crisis. She died because she had pneumonia – not because of any neglect. With so many things happening, they decided that they needed to reorganise the community care bit – even though we had no money.*[77]

As a response to this crisis, Jimmy Loh was asked to move from his ward-based role to one more specifically focused on supporting former Fulbourn patients in the community.

Although he made light of it in his interview, Loh evidently had to work very hard in order to get the new arrangements off the ground:

[76] Transcript 17, Jimmy Loh.
[77] Ibid.

> *It was a seven-day service. We were taking people home, we were seeing people at home at weekends…And we were doing shopping, painting people's houses, digging their gardens…*[78]

The initial concept was that all aspects of the group homes, including maintenance and finance, should be supported by NHS staff, as if they were outlying wards of Fulbourn. Loh was well-placed to see the impracticality of that arrangement:

> *We found …that doesn't work. Because the hospital [was] managing these group homes – we got into a lot of financial problems, because we are not housing providers. So we were … propping up all these homes. …So we were visiting Oxford and all the other [schemes], and we decided we needed to do something about that. So Granta [Housing Association] came in and as a result Granta took over management, and we paid them a certain amount of money and that helped them employ staff and manage it.*[79]

The Granta Housing Association became one of Fulbourn's main partners, as it moved accommodation into the community.

While Loh worked in the community as part of Fulbourn's outreach services, and remained an NHS employee, other nurses made more radical changes in their working arrangements. In 1979 Ruby Mungovan, who had been one of David Clark's leading supporters in developing the nursing role in the therapeutic community wards, left Fulbourn to become a social worker with the City Team of the Social Services

[78] Transcript 17, Jimmy Loh.
[79] Ibid.

Department. In that role, she became the key worker for three houses for discharged patients that the Cambridge Mental Welfare Association had established in the city.[80] Other nurses were less enthusiastic about changing their working arrangements, as Peter Houghton, who was appointed as Deputy Unit Manager at Fulbourn in 1985, recalled:

> *I do remember some of the staff who were employed by us and working in [community houses], did resent having to be either re-deployed or offered the opportunity of working with Granta [Housing Association] – a negative step by them. So the pull of the old institution in terms of, you know, being employed by it, and being a part of it and part of professional networks was very, very strong. And that was one of the things we had to deal with as we developed more community services.*[81]

These major organisational changes, with more specialised roles for NHS staff, laid the foundations for the process of resettling patients with more severe problems.

Much of the work was led by Professor Geoff Shepherd, a clinical psychologist, who had been greatly influenced by his previous experience of working with the psychiatrist Dr Douglas Bennett.

> *Douglas made a huge contribution to community psychiatric services in this country through work that he did when he was at the Maudsley and also prior to that at Netherne. And so I arrived with an interest… I think I learnt from him about trying to understand services as 'systems' and – looking at housing, looking at work and employment,*

[80] J. Woodcock., *CAM-Mind: The First 75 Years of Voluntary Endeavour: Part II.*
[81] Transcript 26, Peter Houghton.

looking at acute wards, looking at community teams and trying to understand how the 'system' worked.[82]

Bennett had a special interest in the community-based rehabilitation of those patients with schizophrenia who exhibited particularly challenging behaviours, and Shepherd made this group his focus also:

[They were] very treatment-resistant and [had] lots of other difficulties – mainly aggression, violence, socially inappropriate behaviour and so on. Which meant they were difficult to look after outside the hospital, which is why they stayed in Burnet House [in Fulbourn]…We set up the first specialist, new, long-stay house. First … in Cambridge Road, then after that there was Number One, The Drive, and then after that there was Cobwebs.[83]

Names like 'Cobwebs' for such community houses were to become a feature of the move to community care in both mental health and learning disability areas.

Shepherd was able to exploit the social security arrangements in place at that time in order to develop community housing projects through collaborative working with local non-profit organisations:

At that time the way that benefits were organised – it became possible in the early '80s to set up a lot of community houses… people could be discharged with dowries that would pay for community housing. I did a lot of work with Granta… particularly through a chap called Ivan Molineux. And Ivan was the lead development person for Granta Housing, and we did a lot of work setting up the housing people went

[82] Transcript 16, Professor Geoff Shepherd.
[83] Ibid.

to, and then a lot of staff training – trying to help staff, from our end and from his end, deal with people.[84]

It had become clear that an effective transition between Fulbourn and the community was unlikely to be accomplished without considerable investment in retraining the front-line staff.

Community psychiatric nurses had a major role to play in supporting service-users outside the hospital.[85] However, this new role also presented major challenges, as Dr Jane McKeown explained:

> *It wasn't exactly easy for nurses to move out into the community. Although they theoretically wanted to do so, because it gave them more freedom, and enabled them to have higher pay and status, nurses who had been based in the hospital always had the support – immediate support – of the nursing team. When they became Community Psychiatric Nurses, they were much more isolated, and that was quite stressful.*[86]

While some of the more committed nurses were keen to move into new roles as soon as possible, Peter Houghton recalled that:

> *[This] presented its own set of problems, because it meant that – the quality of the staff who were left behind, on average, reduced. And I do remember, you know, some resentment as well – that a lot of*

[84] Transcript 16, Professor Geoff Shepherd.
[85] P. Nolan, 'Mental Health Nursing in Great Britain', H. Freeman & G.E. Berrios (eds.), *150 Years of British Psychiatry: Volume II: The Aftermath* (London, 1996), pp.186-190.
[86] Transcript 10, Dr Jane McKeown.

people had moved out into the community and that people felt left behind.[87]

Nevertheless, the reality was that the remaining in-patient services on the Fulbourn site required nursing staff throughout the period up to 1995.

The George Mackenzie Unit and Changing Attitudes to Mental Health Care

At the outset of this research project, I assumed that the over-arching theme in the oral history interviews covering the 1990s would be hospital closure, or at least, closure of the imposing Victorian hospital buildings on the Fulbourn site. That this did not prove to be the case was partly due to the fact that Kent House, and some of the outlying villas, continued in use, so Fulbourn still remained an essential component of the mental health services in Cambridgeshire. The eventual closure of most of the wards that had been moved to Addenbrooke's also reinforced this sense of continuity on the Fulbourn site.

The move towards establishing secure accommodation at Fulbourn marked the final end of the post-Second World War era inaugurated by David Clark, in the memory of some long-serving psychiatrists. The background to this issue was that the East Anglian region did not have any secure psychiatric accommodation for patients who required that type of care. After much discussion from the late 1970s onwards, it was decided to site a maximum secure unit, known as the Norvic Centre, in Norwich. That left open the question of where the required medium secure unit should be built, and attention focused on Fulbourn. Ross Mitchell recalled the hostile reaction to this proposal, which seemed to challenge the traditional ethos of Fulbourn:

[87] Transcript 26, Peter Houghton.

And we said, 'Here, hold on a minute! You want to have a lock-up in a hospital which has open doors? We are running on a therapeutic community basis – your whole philosophy, if you are going to be maximum security is restraining people's liberty, and keeping a watch on them, and you have already classified them as dangerous, or whatever, according to their mental disorder, and that's why you want a maximum secure unit.[88]

Feelings ran high over this issue, as it was felt to represent a fundamental negation of the 'social therapy' philosophy which Fulbourn had embraced.[89] Mitchell recalled that:

We argued backwards and forwards, and we threatened to resign over it. But in the end, we had to give in…so we had an intermediate secure unit.[90]

As could be expected, psychiatrists who were not committed to the 'social model' of psychiatry did not share this hostility. Dr Paul Calloway, as Clinical Director of the hospital at this time, worked hard to ensure that the new building, named the George Mackenzie Unit, was built at Fulbourn:

I was wholly in favour of it, because what was happening before that – it's not that we were locking up patients who were otherwise on open wards – patients were sent off to prison, you know, where they weren't treated very well. Or off to the Regional Secure Unit in Norwich – where for some patients, it wasn't necessary at all. And… it meant that patients could be kept locally – they didn't have the

[88] Transcript 03, Dr Ross Mitchell.
[89] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p. 243.
[90] Transcript 03, Dr Ross Mitchell.

spectacle of police coming onto the ward to drag off psychotic patients.[91]

The decision to build a new regional medium secure unit, with its high barbed wire fence, on the Fulbourn site, seemed to some of the former members of staff to symbolise the definitive abandonment of the 'open door' ethos.

The new secure unit represented the increasing focus on controlling potentially violent individuals who might pose a threat to public safety. Its Medical Director, Dr Neil Hunt, said in the television documentary:

> *It is a locked ward, and we opened in January [1995]. It's for severely ill patients. They may be hearing voices, they may be having very strange ideas about themselves and other people. I think doctors and nurses are very aware of the perception from the public that more and more violence is being committed by mentally ill patients.*[92]

The financial arrangements that underpinned the unit reflected the dictates of the complex organisational climate in which the Lifespan NHS Trust was required to operate, and they placed a premium on admitting patients from outside its boundaries

> *When that was first opened, we had this sort of 'internal market' business, so we had what were called ECRs – extra-contractual referrals – and again, [the Trust Chief Executive] Marian Earle's deft financial practice meant that we were able to fund a better unit than we might have expected by banking on these ECRs coming.*[93]

[91] Transcript 28, Dr Paul Calloway.
[92] BBC TV Documentary, 'Unlocking the Asylum', 1996.
[93] Transcript 28, Dr Paul Calloway.

By the time of his retirement, Ross Mitchell had become reconciled to the presence of the medium secure unit:[94]

> *We grew to learn to work with it. OK, it was different, the staff worked differently, and we just had to come to terms with that, which over time we did, and things weren't nearly as bad as we anticipated.*[95]

In part, this mellowing of attitudes reflected an increasing realisation by psychiatrists that the nature of their role was changing, as a result of hardening public attitudes to people with serious mental health problems. Calloway characterised this as:

> *A reflection of changing expectation of psychiatric services – the whole move towards – it's hard to say this without sounding judgemental – I don't mean being over-cautious, but I suppose a more defensive practice.*[96]

This represented a sea-change in public attitudes from the permissive ethos which characterised the 1960s.

Local psychiatrists therefore came to see the unit as a useful resource in containing patients who would have disrupted the regime on their own Fulbourn wards, and as a result their referrals increased, as Calloway went on to note:

> *People were obviously always concerned about dangerousness, but it became more of a preoccupation, after a number of high-profile incidents – I mean, across the country. So that increasingly, year by year, really, George Mackenzie [Unit] started to take more a*

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[94] Although the regimes are apparently unchanged, at the time of writing (Nov. 2008), the Norvic Clinic in Norwich is now described as 'medium secure' and George Mackenzie House as 'low secure'. E.E.S.C.G., 'George Mackenzie House: Unit Information' (N.D.).
[95] Transcript 03, Dr Ross Mitchell.
[96] Transcript 28, Dr Paul Calloway.

proportion of local patients rather than people from the region – or indeed, around the country.[97]

As he prepared to leave the hospital in 1994, Ross Mitchell was able to reflect on the ways in which the changing characteristics of the patients who were admitted to Fulbourn had forced a change in the regime of care:

> *You've got these very disturbed people, because all the easy psychiatry is …dealt with in private practice … and the ones that [were] admitted to the hospital were the more disturbed ones. And now it's the people who have got these multiple pathologies – alcoholism, drug addiction, compounded with personality disorders – the most difficult people to treat: chronic, resistant schizophrenic disorders, bi-polar disorders and so on. So it's getting them into hospital, treating them as vigorously and effectively as you can, get 'em out, so that you've got room to bring the next lot in. It's that constant working at high pitch.*[98]

Mitchell was articulating here the view that the nature of the problems experienced by those using mental health services had changed radically in the last twenty years, and so the services provided for them needed to reflect that salient fact.

[97] Transcript 28, Dr Paul Calloway.
[98] Transcript 03, Dr Ross Mitchell.

Conclusion

Rather than simply reflecting a clash of personalities between Clark and Roth, the conflicts at Fulbourn were the symptom of a fundamental shift in the consensus within British psychiatry as a whole. The profession adopted a ‘medical model’, which while it paid lip service to the social and psychodynamic dimensions in the treatment of mental illness, in fact focused the role of the psychiatrist upon the issues of diagnosis and psychopharmacology. The other components of the role were increasingly abandoned to other staff, such as clinical psychologists and nurses. With an increasingly shared vision of the role of the psychiatrist, attention turned to the organisation of services in the community. Fulbourn, unlike many similar county mental hospitals, was never scheduled for complete closure, so the psychiatrists were required to service the hospital site while developing new services outside. While they had a major impact on issues like sectorisation, it is difficult to escape the conclusion that the leading role in some aspects of mental health care was being taken by other professionals. Increasingly, the new breed of general managers came to dominate organisational decision-making, and clinical psychologists filled the gaps left when psychiatrists withdrew from their previous role in service development.

These changes occurred against a back-drop of rising public concern about the dangers posed by the tiny minority of people with mental health problems which led them to be violent. When such crises occurred, blame was heaped upon the psychiatrists held to be responsible. In such an atmosphere, it was hardly surprising that defensive and self-

protective attitudes came to dominate mental health practice.[99] Newspaper portrayals of care in the community throughout the 1990s added to this air of crisis by routinely concluding that it had 'failed', and demanding a return to locked wards.[100] The opening of the George Mackenzie Unit in 1995 came to symbolise the changed atmosphere for many of those who worked at Fulbourn.

[99] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), pp.242-243; M.Law, *On The Edge: The Life and Work of a Mental Hospital Chaplain* [Duplicated typescript] (Ely, 2003), pp.22-23; J. Busfield, 'Restructuring the Mental Health Services in Twentieth Century Britain', in M. Gijswijt-Hofstra & R. Porter (eds.) *Cultures of Psychiatry* (Amsterdam, 1998), pp.9-28.
[100] Professor Geoff Shepherd told me of his consternation at being asked by his teenage daughter in the mid-1990s: 'Dad – weren't you part of the failed policy of care in the community?'

The findings from this study are summarised in the following Conclusion.

Chapter 11: Conclusion

This thesis has examined key themes in the historical development of Fulbourn Hospital, Cambridgeshire, for the period 1953 to 1995, through the medium of three sources: the oral testimony of witnesses with direct experience of hospital life, archival sources, and research studies published in this period. It sets the thematic analysis within the context of a broadly chronological frame of reference. Its three research questions, as set out in the Introduction, were:

(1) What were the competing discourses in British mental health care in the second half of the twentieth century?

(2) What light can the study of one English hospital shed upon the history of institutional mental health care?

(3) How did the competing medical discourses impact upon nursing practice?

The Competing Discourses in British Mental Health Care

This study has shown that the identification of discrete 'models' related to particular discourses that were used in the mental health field is an inexact process. Ward regimes are essentially intangible, patients come and go, and so do the junior doctors and the nurses, who are the staff spending the most time in a particular ward. Similarly, the emphasis that psychiatrists may place upon the different aspects of their practice is an individual matter, and may also vary over time. With these caveats borne in mind, it is nevertheless clear from the oral evidence that the interviewees were able to identify the models that they used, and those that were used by others, on a sufficiently consistent basis to make their retention meaningful.

Particular attention has been paid to the career of Dr David Clark because of the international reputation that he established for the hospital in the area of social therapy. The appointment of Professor Sir Martin Roth led to a new prominence for the hospital, this time in the biological study of 'mental illness'. However, it is argued that there were many more elements to the recent history of Fulbourn than the straightforward clash between two psychiatrists that Clark has consistently portrayed. The hospital needs to be set in the wider context of national and international developments in the field of mental health, and in particular of the seismic shifts which occurred in successive cohorts of psychiatrists' concepts of mental illness. In fact the evidence from Fulbourn indicates that in the period covered by this study, its psychiatrists adopted four models for the treatment of mental illness: the eclectic model, the social model, the biological model, and the medical model.

The Eclectic Model

This model did not concern itself with the causation of mental symptoms, but was based upon the pragmatic adoption of any therapy which appeared to show therapeutic promise. Psychiatrists who adopted it were equally happy to prescribe physical therapies, such as DICT and leucotomy, or to lead group discussions in the ward, or to practice individual psychotherapy. They did not regard adherence to a particular paradigm as an important issue, relying as they did largely on judgements based on their own clinical experience. This model has its origins in the 1930s, with the development of physical treatments and the increasing popularity of psychoanalytical methods. The failure of post-mortem pathological studies to shed light on important conditions, such as schizophrenia and the dementias, served to discredit biological approaches to mental illness until the 1970s, so professional attention moved from trying to understand

causation, to experimenting with the wide range of promising treatments that were appearing. Fulbourn psychiatrists who favoured an eclectic model of treatment included Dr Beresford Davies, Dr Oliver Hodgson, and Dr Alan Broadhurst. The inclusion of the latter in this category demonstrates that a commitment to research in psychopharmacology did not necessarily preclude a willingness to take part in ward meetings, and to apply psychoanalytical insights to treatment.

The Social Model

The main difference between the social and the eclectic models was one of emphasis. While the Fulbourn advocates of the social model were equally enthusiastic in their use of physical and pharmacological treatments, their focus remained on encouraging patients to function more effectively in the wider society outside the hospital. So they emphasised the need to develop strategies that would help patients to improve their communication and social coping skills. The origins of this approach lay in the Army psychiatry practised during the Second World War, and it is no coincidence that its two main supporters at Fulbourn, Dr David Clark and Dr Ross Mitchell, had both served in the armed forces. Further encouragement was provided by developments in humanistic psychology in the USA in the 1960s. Their ideal vehicle for effecting changes in the patients' repertoires of coping strategies was the ward run on therapeutic community lines, with its informal atmosphere, flattened hierarchy, and frequent meetings for democratic decision-making. While other hospitals were highly selective in the patients that they admitted to their therapeutic communities, Fulbourn, under Clark, was unique in attempting to apply these principles to all its patients. This meant that physical and drug treatments were commonly used, and that some patients were confined to a therapeutic community under the terms of mental health legislation. Mitchell, on the

other hand, took the view that patients needed to possess a certain level of insight and social skill in order for them to benefit from the experience of the therapeutic community. Both Clark and Mitchell emphasised the important role that other professionals, particularly nurses, played in the therapeutic community, and both were very supportive of their research and publishing activities.

The Biological Model

Professor Sir Martin Roth's clinical practice exemplified a version of psychiatry which was centred upon the study of biological aspects of mental illness. It was based upon the premise that the diseases recognised in psychiatry were similar in principle to those recognised in other branches of medicine. Mental illnesses were regarded as discrete disorders which were primarily caused by still-to-be-discovered pathological processes located in the brain.[1] The researcher had a vital role in developing the knowledge-base that underpinned this process by conducting epidemiological studies indicating the incidence and prevalence of these disease entities. The task of the psychiatrist, as conceived by Roth, was to analyse the patient's signs and symptoms appropriately so as to arrive at an accurate diagnosis. Once that was achieved, the correct pharmacological treatment could be prescribed by the psychiatrist and administered by the nursing staff. Roth's clinical practice was underpinned by a prodigious output of research papers. He made major contributions to the understanding of Alzheimer's disease, but other conditions, such as anorexia, did not yield such productive findings. Roth appeared to have little interest in the activities of other professionals working in the field of mental health, their role being confined to following the instructions of the psychiatrist.

[1] This view is still strongly supported by academic psychiatrists in Cambridge. Dr Sabine Bahn states that, 'Severe mental illness is like other illnesses only it affects the brain. We have been very much based in the psychoanalytical era – that has to change'. M. Garner, 'Mind Games', *CAM* 57 (2009), p. 31

The Medical Model

By the 1980s, British psychiatry had reached a new consensus on the nature of mental illness and its treatment, which some at least of its proponents termed the 'medical model'. Dr Paul Calloway was an important figure who used this approach during his time at Fulbourn. It owed most to the biological model, in focusing on the accurate diagnosis and treatment of mental illnesses located primarily in altered brain physiology, and its two preferred modes of treatment were ECT and psychopharmacology. Its practitioners tended to regard all the characteristic aspects of the previous generation of social model psychiatrists as an unfortunate aberration that was best forgotten. However, it differed from the biological model in according some status to psychological therapies and psychoanalytic techniques in the office-based consultation between psychiatrist and patient. It also differed from the eclectic model in that while psychiatrists still supported the wide range of group activities continuing on the wards, they no-longer felt that it was an appropriate use of their time to take part in them.

Fulbourn's Place in the History of Institutional Mental Health Care

This thesis provides an opportunity to assess the extent to which Edward Shorter's outline of the development of psychiatry in North America in the twentieth century is applicable to the UK. It can be concluded that while there are some differences, the broad outline does provide a helpful schematic representation of developments. Although the wholesale commitment to psychoanalysis that Shorter describes as being characteristic of psychiatry in the USA for much of the twentieth century was not as prominent in the UK, it nevertheless remained a consistent undercurrent. However,

Shorter's characterisation of the period he calls 'alternatives' is an accurate summary of what Fulbourn psychiatrists of the 1950s and 1960s described as their 'eclectic' model. The appointment of Sir Martin Roth to the Cambridge Chair in Psychiatry, and his subsequent research career there, could also be taken as applying to the period that Shorter terms 'the second biological psychiatry'. Finally, Shorter describes North American psychiatrists retreating into an office-bound practice centred upon drug prescribing and leaving psychoanalysis to non-medical staff. A similar process happened at Fulbourn, with psychiatrists focusing on individual consultations, but with group activities continuing, even on Roth's ward, run solely by nurses. So the evidence from Fulbourn suggests that the 'social model' has not been lost, as Clark feared, but rather it has been taken over by nurses.

Once British psychiatrists in the 1980s had settled upon the 'medical model' as the shared basis for contemporary clinical practice, Clark's 'social model' was cast aside as belonging only in the past. As the later career of Dr Duncan Double illustrated, critical views which would have been unexceptional at Fulbourn in the Clark era, could subsequently lead to professional marginalisation.[2] However, anecdotal evidence also suggests that Clark's ideas may have had more lasting impact upon the clinical practice of Japanese psychiatrists than on those in this country. Clark was a valued advisor to the Health Ministry in Japan, and several Japanese psychiatrists spent study periods at Fulbourn before returning to senior positions in their own country.[3] It will be interesting to see if future histories of Japanese psychiatry acknowledge this influence.

[2] D. Double, *Critical Psychiatry: The Limits of Madness* (London, 2006).
[3] D.H Clark, *The Story of a Hospital: Fulbourn 1858-1983* (London, 1996), p.226.

In the same way, Clark's most lasting influence on the training of professionals was on nurse education rather than that for junior psychiatrists. He may have had frequent conflicts with the General Nursing Council, and he despaired of his report on nurse education ever receiving the official recognition that he craved for it, but nevertheless educational programmes for mental health nurses continue to have many aspects of the 'social model' at their core.[4]

A more definitive account of the possible influence that the policy and practices developed at Fulbourn may have had upon the wider world of mental health law and practice in Britain must await further detailed studies of individual institutions and professional bodies, and the complex relationships between them. In the absence of comparable studies, an account focusing on one hospital should be cautious in making claims about its wider influence,. Fulbourn was evidently exceptional, but it was not unique. To the list of self-consciously 'progressive' psychiatric hospitals of the 1950's to 1970s already mentioned, which included Dingleton, Mapperley and Warlingham, could be added Claybury Hospital in Essex. As at Fulbourn, a Medical Superintendent appointed in the 1950s introduced an 'open door' policy, fostered group activities on the wards, and encouraged the staff to write about their experiences.[5] This study did not discover any links between Fulbourn and Claybury, but it is possible that a detailed history of the latter might shed more light on the issue of connections and influence within psychiatry. In addition to the unexplored links between the minority of hospitals which introduced such reforms, most of the reformers were also linked through their efforts in the wider political sphere to turn their professional association into a Royal College to stand alongside the prestigious bodies which governed other branches of

[4] Ministry of Health, *Psychiatric Nursing: Today and Tomorrow* (London, 1968).
[5] D.V. Martin, *Adventure in Psychiatry: Social Change in a Mental Hospital* (Oxford, 1962); E. Shoenberg, (ed.), *A Hospital Looks At Itself: Essays From Claybury* (Oxford, 1972).

medicine. While Clark's position in the Royal College of Psychiatrists provided a national platform for his views, its control of the training of junior psychiatrists also restricted some of the initiatives which he wanted to introduce at Fulbourn.[6] Again, the wider professional context within which Fulbourn was situated requires further elucidation.

The Impact of Competing Medical Discourses Upon Nursing Practice

While Clark failed in his mission to convince the psychiatric profession at large of the merit of taking up what he first called 'administrative therapy', and then re-named 'social therapy', he was one of the influential figures creating the agenda for much current psychosocial mental health nursing practice in in-patient settings. This is rarely acknowledged in the nursing literature, where the credit tends to be given to pioneering nurses such as Hildegard Peplau and Annie Altschul, or to Dr Tom Main at the Cassel Hospital. Indeed, Barker describes Main as the 'symbolic father figure of psychosocial nursing'.[7] One of the few nursing historians to recognise Clark's influence on mental health nursing was Nolan, who highlighted his role in promoting the role of the nurse in the therapeutic community.[8] Winship et al have also acknowledged Clark's part in that process.[9] That nursing role, shorn of some of its original theoretical aspects, has now become the accepted norm in acute inpatient settings. One current nursing textbook emphasises that team meetings should have the following characteristics:

- 'Open 'whole team' discussion.
- Allowing the team to focus on what it means in human terms to be an inpatient.

[6] D.H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London, 1996), p.210.
[7] P. Barker, *The Philosophy and Practice of Psychiatric Nursing* (Edinburgh, 1999), p.10: original emphasis.
[8] P. Nolan, *A History of Mental Health Nursing* (London, 1993), pp.117-118.
[9] G. Winship, J. Bray, J. Repper & R.D. Hinshelwood, 'Collective Biography and the Legacy of Hildegard Peplau, Annie Altschul & Eileen Skellern: the origins of mental health nursing and its relevance to the current crisis in psychiatry', Internet publication.

- Identifying what people in acute distress need nurses to do.
- Allowing the team to propose the actions that need to be taken to meet the human care needs of the person in acute distress.[10]

These elements fit perfectly with Clark's philosophy as practised in team meetings in Fulbourn from the late 1950s onwards. Nurses have also almost universally continued to value group activities on hospital wards, and despite the rise of the 'medical model', they still form an important aspect of the patient experience in the secure George Mackenzie House on the Fulbourn site.[11] The main difference from the practice in Clark's day is that while nurses, therapists, social workers and clinical psychologists take part in them, psychiatrists now do not. So professional boundaries have shifted, but Clark's philosophy lives on.

The Impact of Clark's Influence On the Direction of Patient Care at Fulbourn

While attempts to measure in a definitive way the impact of any historical therapeutic regime on patient care in a mental health environment are likely to prove fruitless, it is still possible to assemble contemporary evidence of change. During Clark's period in charge of the hospital, Fulbourn went from being considered by senior NHS administrators as one of the worst in the region to a new status as one of the most progressive. Fulbourn members of staff, such as Charge Nurse John Lambert, were sought by the Hospital Advisory Service for their inspection teams so that the lessons learnt in providing humane and therapeutic environments for challenging patients in Hereward House and its successors could be applied nationally. Clive Harries, a highly experienced nurse who had observed mental health hospital practice throughout the

[10] A. Simpson & P. Dodds, 'Acute Inpatient Nursing Care' in P. Barker, (ed.), *Psychiatric and Mental Health Nursing* (London, 2003), p.352. original emphasis.
[11] Personal communication: Paul Baird.

country, decided to work at Fulbourn specifically because of the positive way in which older patients were treated.

Clark's personal influence was crucial to the development of good practice in the hospital, but he was also able to attract able colleagues who extended his philosophy in other directions. Dr Oliver Hodgson greatly improved care on the so-called 'back wards' of Fulbourn, while Dr Ross Mitchell extended the influence of the 'social model' to primary care settings across the county. That influence was extended still further by Clark's policy of encouraging research and publication by psychiatrists, nurses and sociologists. This policy also resulted in a rare publication by a former patient, providing eloquent contemporary testimony to the changes for patients that Clark brought to Fulbourn.[12]

Reflections

It has only been possible to complete this thesis because of the generosity of many former and current members of staff and service-users from the hospital, who were prepared to co-operate with the process of oral history interviewing. My experience in this regard has been completely different from that of Rod Griffin, who attempted to write an oral history of St Crispin Hospital, Northampton, but who found it very difficult to obtain the necessary interviews.[13] I feel that that in itself is a indication of the particular culture of Fulbourn, which placed a high priority on a thoughtful commitment to therapeutic practices, and a high value also on research. This was true of all staff members, whichever model of mental health practice they personally espoused.

[12] H. Crockett, 'Fulbourne [sic] Hospital: A Patient's View' *Nursing Times*, 70, 16 (1974) pp.603-604.
[13] R.J. Griffin, 'Concepts of Community in Mental Health, 1935 to 1965: A Modified Grounded Theory Approach used with Oral History and Other Sources' (De Montfort Univ. Ph.D. thesis, 2005).

While it is always necessary to guard against the temptation to regard a self-selected interview sample as necessarily typical of the hospital staff as a whole, it is nevertheless clear that constant reflection on the nature of mental health problems and their treatment was a common feature of working life there. No doubt there were some for whom a job at Fulbourn was merely a set of tasks to be done in a routine manner, but such individuals did not set the tone of the hospital. Fulbourn was not staffed by people following time-honoured institutional routines until they could draw their early pensions, as so many similar hospitals seem to have been.

Lessons Drawn from the Interview Process

Oral history differs from archival research in that each interview is a live encounter which can never be repeated in exactly the same form. Success or failure in recruiting interview subjects depends as much upon timing and chance as it does on prior planning. My strategy, which involved approaching Dr David Clark first, and then using 'snowball sampling' to interview the other staff he had kept in contact with, was effective in recruiting supporters of the 'social model' who had worked at Fulbourn. I assumed that academic psychiatrists, and in particular supporters of the 'biological model', would then be keen to add their 'side' of the story. As events turned out, this plan greatly underestimated the hostility that was still felt towards Clark even twenty years after his retirement. Hints dropped when the tape-recorder was turned off suggested that the roots of this hostility combined a feeling that the social model had brought Fulbourn into disrepute within the psychiatric profession in Britain, with resentment directed against Clark's later attempts to construct a tendentious historical account of the hospital. Particular ill-feeling was caused by his television documentary, which was felt to have unfairly portrayed his opponents in a negative light. As a result,

an impression was created that I was engaged in a similar exercise as a partisan who was personally committed to defending and promoting the social model, rather than a dispassionate historian. With the benefit of hindsight, I might have been better advised to attempt to interview Clark's opponents first, before prior assumptions about my motivation could be developed and transmitted.

The use of a 'naïve' approach in conducting the oral history interviews proved to be effective in drawing information out of subjects that could have remained unspoken if I had been assumed to possess a detailed prior knowledge of the hospital. One example was the detailed account of the introduction of 'general management' to Fulbourn which revealed a history that predated the publication of the Griffith Report, which introduced those changes across the NHS as a whole. If the interviewee had believed that I had previous knowledge of the subject, it is likely that this element would have been omitted. My focus on 'single issue testimony' provided the overall framework for exploring working life or the patient experience at Fulbourn, while the relatively unstructured form of the interviews allowed subjects to develop their accounts in ways that seemed most relevant to them. As oral history interviews are unique occasions, it is of course not possible to be certain how, if at all, changing these approaches might have affected the data collected. Interviews with a stratified sample, focused on a structured questionnaire, and delivered by an interviewer with extensive prior knowledge, could have resulted in different accounts. However, so could interviews collected by an interviewer from a different ethnic background, gender, age group or professional training.[14] As Alessandro Portelli states, 'Oral sources are not *objective*..... But the inherent nonobjectivity of oral sources lies in specific intrinsic characteristics, the most

[14] M. Barber, 'Hearing Women's Voices: Female Migration to Canada in the Early Twentieth Century', *Oral History* 33 (2005), p.69.

important being that they are *artificial, variable and partial*'.[15] He goes on to argue that this makes oral historians no different from more traditional historians working in archives, as the latter were equally, 'subjectively involved in the history they were writing'.[16] By arguing in this way, Portelli, like most authorities in the field of oral history, aligns himself with the historiographical position established in the 1960s by E.H. Carr.

Conclusion

This thesis represents the first sustained attempt to analyse the therapeutic regimes employed in an English provincial mental hospital in the second half of the twentieth century. Previous studies have tended to present either an all-embracing narrative covering all aspects of hospital life, from ward staffing levels to the management of the hospital farm, or to have focused instead on one discrete aspect of the institution, such as the patient experience, or problems with medical staffing.[17] Fulbourn rates a brief mention in some general histories of mental health care, but solely as an exemplar of a hospital that employed the social model as its therapeutic approach. Such brief accounts cannot do justice to the complexity of the competing discourses that characterised the hospital in this period. David Clark himself has used his retirement to create a picture of Fulbourn centred upon his introduction of the social model, and its neglect once he left

[15] A. Portelli, 'What Makes Oral History Different' in R. Perks & A. Thomson (eds.) *The Oral History Reader*, 2nd edn (London, 2006), p.38.
[16] Ibid, p.41.
[17] For example, R. Hunter & I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum-Friern Hospital 1973: A Medical and Social History* (London, 1974); J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum – St John's* (London, 1990); P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff, 2003); D. Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London, 1998): S. Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum: St Andrew's Hospital, 1810-1998* (Woodbridge, 2003); R.J. Griffin, 'Concepts of Community in Mental Health, 1935 to 1965: A Modified Grounded Theory Approach used with Oral History and Other Sources' (De Montfort Univ. Ph.D. thesis, 2005).

the hospital. He has claimed that even though it is currently neglected, psychiatry will be forced to rediscover it in the future. This thesis shows that Clark's account represents only a partial, uni-dimensional representation of the actual situation.

The wealth of contemporary research and professional publications that illuminate various key aspects of the operation of the hospital is also a legacy of Clark's desire to prove the effectiveness of his model of psychiatry, and to place the findings before the widest possible professional audience. This evidence of a vibrant culture in the second half of the twentieth century helps to balance the existing historiography of such hospitals, which is dominated by accounts of therapeutic inertia, declining standards, and hospital closure.

Future Research

This account of Fulbourn Hospital has tended to emphasise the ways in which it differed from other county mental hospitals, but that may be because the regimes of potentially similar hospitals have yet to be explored in detail. Further research is needed into the discourses and models employed at other 'open door' hospitals of the period, such as Mapperley, Warlingham Park, and Claybury, and the ways in which the discourses employed in them influenced nursing practices. Only then will it be possible to fully situate Fulbourn in the context of late twentieth century 'social therapy'. Similarly, detailed research into the politics of the founding of the Royal College of Psychiatrists, its shaping of the examination syllabus for entry to the profession, and its

on-going control via the system of hospital visitations, is needed to elucidate the ways in which the 'medical model' has come to dominate British psychiatry.[18]

[18] Unfortunately, the recently-published history of the College fails to address any of these issues: T. Bewley, *Madness to Mental Illness: A History of the Royal College of Psychiatrists* (Trowbridge, 2008). See critical review by N. Thalassis, *Social History of Medicine,* 22 (2009), pp.208-209.

APPENDICES

Appendix 1: Illustrations

{Illustrations removed for copyright reasons}

1: Dr David Clark at Fulbourn, on his retirement from the NHS in 1983.

2: Aerial view of Fulbourn Hospital, circa 1953

3: Main entrance to Fulbourn Hospital, circa 1963.

4: Electroconvulsive therapy being administered, circa 1960.

5. The Deep Insulin Coma Therapy Unit, circa 1960.

6: Preparing the Leucotomy Theatre, circa 1960.

7: The sitting room in the Nurses' Home, circa 1960.

Appendix 2

Brief biographies of oral history interviewees

Mrs Judith Atkinson

Social worker. In 1967, appointed as a Social Work Assistant in Dr David Clark's team. Left the next year to undertake a qualifying course in London.

Mrs Judith Binge

Service-user. Has used Fulbourn services as both an in-patient and out-patient over many years. Currently undertaking a new role to provide service-user perspectives in staff training activities.

Mrs Linda Braden

Childhood spent on hospital site. Her father was the Fulbourn Hospital Engineer, and her mother worked as a Nursing Auxiliary on one of the wards. Lived in a hospital house in the grounds.

Dr Alan Broadhurst

Psychiatrist. Original career as a medical scientist: co-discoverer of the anti-depressant, imipramine. Qualified in medicine in Sheffield in 1955 and took posts as a junior doctor at Fulbourn, and at Papworth Hospital.

Dr Paul Calloway

Psychiatrist (retired). Studied medicine at the Royal Free Hospital in London. Appointed as a Consultant at Fulbourn in 1985. Served as chairman of the Division of Psychiatry. Worked closely with Professor Eugene Paykel, the second holder of the Cambridge chair.

Neil Chell

Mental Health Nurse. Trained at St Edward's Hospital, Cheddleton, Staffordshire. Specialised in child and adolescent mental health, and came to Fulbourn to undertake the specialist course in that field. Stayed to work on the Children's Unit.

Dr David Clark

Psychiatrist (retired). Studied medicine in Cambridge and Edinburgh and then served as a Parachute Regiment Medical Officer during the Second World War. Trained in psychiatry at the Maudsley Hospital under Sir Aubrey Lewis. Appointed Medical Superintendent of Fulbourn in 1953.

Ken Cross

Hospital Administrator (retired). Joined the Fulbourn staff straight from school in Cambridge in 1937. After wartime service, he returned work in the general office and retired in 1977.

Dr Duncan Double

Psychiatrist. Medical student and trainee psychiatrist in Cambridge. Appointed as a Consultant Psychiatrist in Sheffield: current post in Norwich.

Clive Harries

Mental Health Nurse (retired). Trained at Nethern Hospital, Surrey, and worked with Dr Douglas Bennett at the Maudsley Hospital. Served on Hospital Advisory Service inspection visits. In 1972, joined Fulbourn staff in a research role. Published edited collection of Fulbourn papers with David Towell, *Innovation in Patient Care* (1979).

Dr Oliver Hodgson

Psychiatrist (retired). Studied medicine at Cambridge and St Bartholomew's Hospital. Trained as a psychiatrist in Birmingham. Appointed as a Consultant Psychiatrist at Fulbourn in 1960.

Peter Houghton

General Manager. Graduated from Oxford University and joined the NHS Graduate Training Scheme. Worked under Stephen Thornton (q.v.) as a general manager for the Fulbourn site, from 1985 to 1991.

John Lambert

Mental Health Nurse (retired). Trained at Fulbourn. Specialised in the care of some of the most challenging patients in therapeutic community environments. Seconded to the Hospital Advisory Service.

Mrs Pat Lambert

Mental Health Nurse (retired). Trained initially in general nursing at Addenbrooke's Hospital, Cambridge. Additional training as a mental health nurse at Fulbourn, where she met and married John Lambert (q.v.).

Rev. Mike Law

Hospital Chaplain (retired). Trained for the ministry at Westcott House, Cambridge. Appointed to Fulbourn and Ida Darwin Hospitals in 1974. Studied at the Institute for Group Analysis, London.

Jimmy Loh

Mental Health Nurse. Recruited to Fulbourn from Singapore. Took a major part in implementing the 'community care' programme in Cambridge.

Eric Kaloo

Mental Health Nurse (retired). Recruited to Fulbourn from Mauritius. Had a particular interest in the care of long-stay patients.

Dr Jane McKeown

Psychiatrist. Trained at Fulbourn from 1970. Appointed as a Consultant and worked alongside Sir Martin Roth in his Professorial Unit. Appeared in BBC TV documentary *Unlocking the Asylum*, expressing sceptical views about some aspects of the 'social model' in psychiatry. Retired from NHS in 2000 and established a private practice.

Dr A.R.K. 'Ross' Mitchell

Psychiatrist (retired). Trained in Edinburgh. Appointed as a Consultant Psychiatrist at Fulbourn in 1966. Noted for his outreach work with general practices in Cambridgeshire.

Male Nurse 01

Mental Health Nurse. A male State Registered Nurse who trained as a Registered Mental Nurse at Fulbourn in the 1970s, and who wished to remain anonymous.

Dr Graham Petrie

Psychiatrist (retired). A Cambridge GP whose interest in the mental health problems of students led him to re-train as a psychiatrist. Worked at Fulbourn from 1963 to 1988, specialising in the treatment of adolescents.

Ms Barbara Prynn

Social Worker. Came to Fulbourn in 1961 on a placement as part of a Diploma in Social Studies course at the University of Hull.

Chas Ramlall

Mental Health Nurse. Originally from Mauritius. Trained as SRN at St Margaret' Hospital, Epping, and as RMN at Severalls Hospital, Colchester. Worked in Manchester before moving to Fulbourn.

Professor Geoff Shepherd

Clinical Psychologist. Trained in Cardiff, and at the Maudsley Hospital with Dr Douglas Bennett. Appointed head of clinical psychology service at Fulbourn in 1981.

Nick Smithson

Mental Health Nurse. Trained at Fulbourn in 1975.

Stephen Thornton

General Manager. Graduated from Manchester University and joined the NHS Graduate Training Scheme. Became Fulbourn's first 'general manager' in 1983.

Mrs Margaret Waspe

Service-user. Has had a life-long battle with depression, and used Fulbourn services since the 1950s.

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