PSYCHIATRIC HOSPITALS IN THE UK IN THE 1960s

Witness Seminar
11 October 2019

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Abbreviations

BMJ	*British Medical Journal*
BJPsych	*British Journal of Psychiatry*
CV	*Curriculum vitae*
DGH	District general hospital
DHSS	Department of Health and Social Security
DPM	Diploma in Psychiatric Medicine
ECT	Electroconvulsive therapy
GMC	General Medical Council
GP	General practitioner
GPI	General paralysis of the insane
IQ	Intelligence quotient
IT	Industrial therapy
LSD	Lysergic acid diethylamide
MHA 1959	Mental Health Act 1959
MHA 1983	Mental Health Act 1983
MRC	Medical Research Council
MRCP	Member of the Royal College of Physicians
MMU	Manchester Metropolitan University
MP	Member of Parliament
MSc	Master of Science
NHS	National Health Service
OT	Occupational therapy / therapist
q.	Year qualified in medicine
RAMC	Royal Army Medical Corps
RCPsych	Royal College of Psychiatrists
RHB	Regional Hospital Board
RMN	Registered Mental Nurse
RMPA	Royal Medico-Psychological Association
RSM	Royal Society of Medicine
SHMO	Senior hospital medical officer
SHO	Senior house officer
SR	Senior registrar
UCL	University College London
WHO	World Health Organisation
WRVS	Women's Royal Voluntary Service

Speakers' initials used in discussion (pages 56-62)

DB	Dora Black
BB	Bill Boyd
JB	John Bradley
TB	Tom Burns
MC	Malcolm Campbell
PC	Peter Campbell
SC	Suzanne Curran
DG	Sir David Goldberg
JG	Jean Gaffin
JJ	John Jenkins
DJ	David Jolley
JL	Jennifer Lowe
PN	Peter Nolan
GP	Geraldine Pratten
AR	Angela Rouncefield
IS	Ian Stout
PT	Peter Tyrer
HZ	Harry Zeitlin

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Introduction

This document is the annotated transcript of a "witness seminar" which addressed the theme of psychiatric hospitals in the UK in the 1960s. The seminar was organised by the Royal College of Psychiatrists' archivist and the College's History of Psychiatry Special Interest Group (HoPSIG). It took place on 11 October 2019.

What is a witness seminar?

A witness seminar is a special tool in the historian's toolkit. It was developed by the Institute of Contemporary British History in the 1980s. It is described as

> a particularly specialized form of oral history...where several people associated with a particular set of circumstances or events are invited to meet together to discuss, debate, and even disagree about their reminiscences.[1]

The witness seminar structure allows designated witnesses to give a brief presentation to an audience comprising more witnesses, historians and others with an interest in the subject. The audience participates by asking questions and contributing from their own experience and knowledge. Seminars are recorded, transcribed and made available to be used as primary historical sources.

Witness seminars provide an opportunity to capture aspects of the lived experience of a situation to create a rich and detailed collage. The content of a witness seminar, as shown in this transcript, is inevitably subjective and selective, including revealing contributors' prejudices and personal agendas. These tend to be less evident in written archives, particularly in those from official or professional sources. Nevertheless, written sources are also susceptible to subjective and personal influences: journalists give different slants to the same events shortly after they take place; letters and e-mails are written with the needs of author and recipient in mind; and memoirs written years after events may be modified by contemplation before putting pen to paper. All sources—oral, visual and written—need to be considered critically. Unlike one-to-one oral history interviews, a witness seminar is open to immediate discussion, clarification and peer review. Witness seminar narratives may therefore provide perspectives with their content at least partly validated, albeit that any one person has limited time to make their contribution.

The rationale for this seminar

In the approach to the 50th anniversary of the foundation of the College (1971), it seemed pertinent to examine the period leading up to that event. The rationale for choosing this theme was also a practical one: the dates were about as far back as we could go, given the age of our potential witnesses.

The 1960s, or as interpreted for the purpose of this seminar, the "long-1960s" (the decade plus the lead-up and follow-up on either side, since innovation and change does not fit into neat ten year time slots), was a time of great change in psychiatric practice but with services still largely psychiatric hospital based. Ideology shifted concerning individuality, personal autonomy and human rights, and the paternalistic approach of "doctor-knows-best" was altering in the face of a more educated, less class-deferent society. The government stated its intentions to close the psychiatric hospitals, the Mental Health Act 1959 came into force in 1960 and the Suicide Act 1961 decriminalised suicide and suicide attempts. Education and training for front line heath service staff became more structured, and the multi-disciplinary team took root.

What we did

We selected a preliminary set of themes for the seminar including: acute wards, long-stay wards, clinical leadership, the Ministry of Health, and the experiences of women doctors and of black and minority ethnic (BAME) staff. We also aimed to find male and female witnesses who were involved with the psychiatric hospitals across the UK. We used the themes and geography help us identify potential witnesses who had lived experience of psychiatric hospitals in the 1960s. We used the HoPSIG newsletter, word of mouth, and our personal knowledge about our senior colleagues, to find suitable witnesses. It was an iterative process: if we could not identify a witness who could shed light on a particular issue (for example, a BAME mental health professional), then the preliminary themes were necessarily revised. Themes were agreed in discussion with the witnesses, and revised according to how each thought they could best contribute to the seminar from their personal experience. Two of our speakers dropped out due to health problems, one a doctor, the other a patient. Two former civil

servants were unable to attend as they had commitments abroad.

Inevitably, most of our witnesses were relatively junior in the hospital hierarchies during the 1960s which may have coloured their interpretations. Unavoidably, the content of the witness seminar reflected the choice and availability of speakers and the time available, on a single day, to host the meeting. Witnesses and other participants travelled from across the UK—from Cornwall to Edinburgh—and from abroad, to attend.

The structure of the seminar

Designated witnesses were asked to speak to the audience for about five minutes, to introduce their allocated topic, based on their own personal experience and their memories of what happened, including whatever detail seemed relevant, such as their emotional responses to the events as they occurred. Speakers were advised to avoid re-interpreting or re-evaluating the events they depicted through a retrospective contemporary lens, but to "time travel" back to what it was like to be there.

The seminar was chaired by the College's historian in residence Claire Hilton. It was conducted under the Chatham House Rule, dictating that the identity and the affiliation of the speaker must not be revealed outside the room until the transcript was checked and finalised. This was intended to allow witnesses to speak freely about difficult and possibly controversial topics, or as one participant commented outside the seminar, that "part of the charm of witness seminars [was] that one got politically incorrect and time-dependent observations."

In keeping with the spirit of the event, there were disagreements between witnesses. Themes emerged which sparked lively debate, such as variations in practice in different regions of the UK. Some evidence posed challenging questions, particularly disclosures about what was perceived as unethical, insensitive or unprofessional behaviour by those witnessing, and responding to it, at the time.

The seminar was audio-recorded, and the transcript created from that recording. All the speakers, the witnesses and those who spoke from the audience, were given the opportunity to check the text of their contributions for any inaccuracies or to make clarifications. Some speakers removed statements which might have identified patients they treated in the 1960s. Because of the need to make changes, the recording is not available online.

A witness seminar is a resource rather than a definitive work on a subject, but it can provide unique insights into events and people in recent history. We hope that this transcript, discussion and accompanying notes will be a springboard for further interest and research into the psychiatric hospitals of the 1960s, and we urge you to read it alongside other, social, political, economic and medical history sources.

Transcript

Claire Hilton: Good morning everybody, and welcome to the Royal College of Psychiatrists' Witness Seminar about psychiatric hospitals in the 1960s. I'm Claire Hilton and I'm chairing the meeting today. You are all here to create a very important resource for researchers, to help them discover what it was really like in the psychiatric hospitals of the 1960s. But before we get going on the formal part of the meeting, I'd like to ask Professor Wendy Burn, President of the College, to say a few words.

Wendy Burn: Thank you, Claire. Thank you for asking me to speak. What an amazing room. I said lots of friends but actually it's kind of lots of heroes and heroines of mine here today, so thank you all for coming and for sharing your knowledge. And thanks to Claire for arranging this and for all the other work that she's doing to preserve our history.

I've been in psychiatry for 36 years but even in that time things have really changed. When I started the asylums were almost empty. You will all remember the programmes to empty the asylums of their last patients and their closing down. And I worked with the elderly and I met many elderly patients who had been in hospital all their adult lives, often come in, had an illness, got better, but stayed there and were quite happy to stay there and it was difficult to discharge them. Some of them didn't want to go out into the world, but we managed, and they did. I'd only been doing psychiatry a few months and came across the notes of one gentleman who had a diagnosis of schizophrenia and he'd spent nearly a year in a catatonic stupor, and then when chlorpromazine became available in the 1950s, he was given some and within days he'd woken up and recovered. It was really interesting reading the notes, and it was clearly a miracle to the people who had treated him. He was still in hospital years later, despite having got better, and we did eventually manage to persuade him to leave.

And now we've got neuroscience. Some of you will know that I'm interested in neuroscience, which is really moving on fast, and it won't be long until we have more answers about the physical basis for some of the illnesses we treat. For example, you can now take skin cells from a patient with schizophrenia, convert them to stem cells, and then into neurons, and if you put them into the right environment, they will form little organoids, little mini brains something the size of a pea, which look exactly like a brain. So, you can imagine that that is going to lead to some changes and new ways of investigating what causes mental illness. As we move into our future, which is going to be exciting, it's important that we remember and that we stay connected to our past.

I've got some other things I need to do today but I'll be in and out. I'm really looking forward to the bits that I can hear, and once again, thank you very much for coming and for sharing your knowledge with us. Thank you.

Claire Hilton: Thank you Wendy. All of you have a programme but I'd just like to remind you of the format. Our speakers were there, in the hospitals, in various capacities, in the 1960s. They introduce a topic, and then each topic is open to the floor for discussion. I feel a little like Nicholas Parsons might do before recording *Just a Minute* for Radio 4, but you'll be pleased to know, we've given each speaker five minutes to speak, not one. We permit hesitations, would rather not have too much repetition, but ask you all, please, not to deviate outside the 1960s, unless you're going backwards into the 1950s, but not into the 1970s. Each of you has a picture card in the programme to remind you to think '60s. There's a moon landing picture up there on the wall to make you think '60s and some archives and books displayed from the time (Fig 1). Like *Just a Minute*, we must keep to time. We do not have any whistles or buzzers, but I will raise a red card if anybody is really talking over. Please also speak slowly and clearly for the audio recording, just as you'd expect on Radio 4.

Some other requests: in 2003, a witness seminar on psychiatry in the UK was recorded but never published. Apparently, the participants were too argumentative about our shared history. In my view, having seen the transcript,[2] I think it was more that the organisers did not understand the nature of psychiatry and the diversity of perspectives and practices. I am happy with lack of consensus but heated discussions about historical psychiatric practice, verging on unpleasantness have occasionally happened, even in the College's History of Psychiatry Special Interest Group. I do not want *that* to happen today. We may get onto some controversial practices of the past. If we do, and I

hope we do, we all need to be respectfully polite, and value diverse memories and experiences. We all have a lot to learn from today's event.

And as I have used the word diverse, before anyone challenges me about the social and professional mix of the speakers, we tried very hard to entice in speakers who were hospital managers, more patients, ethnic-minority staff, and civil servants, but without success.

We have taken advice about tweeting and have decided that it is not appropriate for this meeting. Basically, we want people to feel comfortable to be honest and open in the group. For that reason too, we would appreciate your cooperation with following the Chatham House Rule: "The identity and the affiliation of the speaker must not be revealed outside the room", until the transcript is checked and finalised, and then, when the final transcript appears on the College website—which will probably several months down the line—we will be asking you to tweet and publicise it as much as you can.

Historians are nosey. Psychiatrists are nosey. But when you get them all together in a room…well, I'll leave it to your imagination. But I'm just curious, who was *there* in the psychiatric hospitals in any capacity? Can you put up your hands so we have an idea? About half. Who here are professional historians? Just a couple. Oh, three. Who is a psychiatrist but was not there in the 1960s? About 20. And who is everybody else? Journalists, psychologists, academics? A few. Okay, we've got a good selection.

After that, all I want to say is that I want today to be informative, constructive, historically valuable and, equally, if not more important, fun. So, over to our speakers and to you, our participating audience, to create this important record.

Brief biographies of the speakers are in your programme, so I'm not going to introduce them at length.

Atmosphere and first impressions: Geraldine Pratten and David Jolley

This is Geraldine Pratten whose family lived in a psychiatric hospital house when she was a child and her talk focusses on atmosphere and impressions from that upbringing.

Geraldine Pratten: My father, Sam Robinson,[3] took up a post as a house physician at the Crichton Royal Hospital in 1951 and shortly afterwards he married my mother, Freda.

Initially, they lived in Crichton Hall and I'm presuming I must have been conceived in a mental hospital. I was born in 1952 and spent my first six years in a hospital property, Ladyfield Cottage, on the periphery of the grounds. When I was six, we moved to another hospital property, Hannahfield Cottage, just outside the main gates. I lived there until I was 11 when we moved to our own house on the other side of Dumfries, by which time I had a brother and sister. I continued to visit the Crichton grounds until the late '60s, even though I'd moved away, because my best friend lived in the grounds. I can't say exactly what age I was when I was allowed to roam the grounds without parental supervision: possibly eight? I wasn't aware of my parents being concerned about this.

Compared with a drab, post-war Dumfries with limited facilities, the Crichton was a wonderful playground and we had many facilities at our disposal although I was unaware of what a privilege this was at the time. I learned to play tennis against the tennis wall at the rear of the curling rink—a game I still love and play regularly. I recall that staff and families were allowed to use the swimming pool for an hour on certain evenings. I learned to swim there before any of my classmates from town, who had to wait until the mid-60s before a pool was built in Dumfries.

One of my happiest memories of living at the Crichton was of the long, hard winter of 1962-63 (Figs 2 and 3). The snow seemed to last for weeks and weeks. My father made a toboggan run on the nine-hole golf course and over the weeks it became a real "Cresta Run". It was a sad day when the snow began to thaw and the toboggan run disappeared.

I remember an older male patient who I regarded as a friend. He was quite open about being a patient, though I'm not sure what his problem might have been. I think he was referred to as "the Major" and he wore a long great-coat. I first met him at the bus stop where I was waiting to return to school after lunch—it was commonplace to return home for lunch in those days and it was also normal to see patients making their way to the town and back during the

Week ending 18th May 1968

	1	2/3	4	5	6	6a	7	8	8a	9	10	11	12	Rec.	Inf.	Total
	WARDS															
Attending Religious Services:—																
Church of England	5	4	6	2	10	10	8	7	—	1	—	3	3	4	—	62
Roman Catholic	4	12	4	3	9	4	7	5	5	1	—	6	4	·		64
Free Church						3										3
HAIRDRESSER						1										1
O.T.S **Employment**					1											1
In Wards	41	36	25	14	22	18	24	16	16	18	4	11	10	14	3	272
Sewing Rooms	3		4	2		2										11
Sewing in Wards	4	10	3		3	4	3		4			1		2		34
Laundry	2		5	5	5	10				1		1	1			30
Kitchen and Bread Room/WARD	2	/10	1	1	12	2	1			2		2		3	2	28/10
Carrying Meals	2	1	2	2	5	2		2	2		1	1	2	3	2	27
Nurses' Home / LIBRARY						/1										/1
Mess Rooms / STORES	3					/1										3/1
Officers' Quarters / CAFE	1/1			2						1						4/1
Occupational Therapy (Wards	6	36	4		6	6	3	6	2	2		2	2	6		81
" " (Centre)	10	12	8	4	19	10	8	23	14	10		5	10	8		141
O/T Infirmary / Working in other Wards	1				2		1		1				1			1 / 5
Industrial Therapy			5	10	20	10		1								46
" **Exercise** " (ward)			8			10										18
Open Wards	41			43	49	46	49	42	48	25	30	40	21	40	49	517
Closed "		49	39													88
Village	7			3	9	16	7	3	1							46
Employment beyond Estate						1	2									3
Recreation																
Nos. attending Cinema Night	-	14	-	9	17	16	2	-	-	-	-		6			64
" " " Afternoon																
Literary Evening																
P. T. Instruction		30	10		26			16					8			90
Netball or Rounders																
Gardening												1				1
Country Dancing	·	·	2	2	2	·	5	7	·	3	·	·	9	14	·	46
Beetle Drive																
~~Whist~~ BINGO	7	3	2	11	14	12	10	9	6	4	·	3	·	8	·	92
T. V. Night	14	16	16	30	40	42	20	41	40	25	-	40	16	36	4	400
Community Singing	·	·	2	9	11	9	9	8	5	-	-	-	7	7	-	67
Reading, Writing	10	15	4		18	24	10	20	10	10		11	8	7		147
Indoor games	4	8	4		16	12	12	12				4	8	4		84
Trip		14														
Assoc Entert.		34			15	10	10									69
Outdoor games					16											16

Fig 1: Ward activities book, Prestwich Hospital, 1960s. Credit: RCPsych.

Fig 2: The winter of 1962-63: Crichton Church, in the hospital grounds.
Credit: Archive of the late Dr Sam Robinson.

Fig 3: The winter of 1962-63: Geraldine’s mother
Freda on the “Cresta Run” at Crichton Royal Hospital.
Credit: Archive of the late Dr Sam Robinson

day. We began sitting together on the bus journey into Dumfries. He didn't upset me in any way. I can't remember what we spoke about, but he seemed happy to have company. One day he failed to appear, which did upset me and although I asked my father about his whereabouts, I don't know what became of him.

I have some recollection of visiting one of my father's day-wards. It seemed to be full of seated old ladies and when I entered every head turned in my direction in unison. A vision of this reflex action has remained with me to this day.

There were downsides. I was not the only Crichton child at my primary school in Dumfries. I remember feeling uneasiness amongst my classmates at my having a father who worked at the Crichton. I recall there being a feeling amongst the townsfolk that anyone associated with mental illness must be similarly afflicted. Perhaps we were a bit weird!

I recall vividly one nasty experience with a patient when I was nine or ten. Well, his first words were that he wasn't a patient and, as he was smartly dressed in a suit, this is perhaps why I believed him. Many of the male patients who worked outdoors wore navy overalls. After this I was wary of anyone who said, "I'm not a patient". I always assumed that he was a private patient but there is a possibility that he may have been a member of staff.

Another friend had met him the previous day at the cricket pitch and he'd asked her to get some other children involved in his "quiz". I thought it was odd when he insisted that he take each of us individually into the toilets at the rear of the club house to ask us questions. When it was my turn, he exposed himself to me. He didn't touch me, but I recall being terrified and running out and taking my younger brother and his friend home. I didn't tell my parents as I was ashamed of having gone into the toilets with him, but I avoided the cricket pitch thereafter and forbade my brother from going there despite the fact that he loved rolling down the adjacent bankings. Perhaps this is why I have always loathed cricket! I did discuss the incident with my best friend who thought she had also been exposed to by the same man in the rock gardens, but she reported it to her mother.

Ladyfield House was a residential home for children and part of the department of child psychiatry and behind our house. I remember feeling very uneasy when my father taught me to ride my bike—I was probably about seven—on the driveway outside the home, as lots of little faces stared out of the window. I also recall playing at the back of our house and one of the nurses calling to me to return to the home —she had mistaken me for a resident. I was terrified and stayed indoors for some time after.

As a teenager I recall being left in my father's car at the back of Crichton Hall (Fig 4) whilst he "popped in" to do something on the ward, which was always a lengthy procedure. Whilst waiting I noticed a man ranting and raving and speaking some form of gobbledygook. I wasn't frightened by this but when I asked my father on his return what might have been the problem, he responded: "Last stage of syphilis." I wasn't sure if he was serious or not, as he was a bit of a joker.

I have very few memories of attending hospital events—possibly one Matron's party? I was very shy then and could well have refused to attend or else have blotted these out! I also recall a fete where I won a small paddling pool in the raffle with my lucky number—15—but that's all I recall.[4]

Claire Hilton: Thank you, thank you very much. Before questions, let's move on to Dave Jolley. Dave spent time as a medical student at Severalls Hospital in 1967 with Russell Barton[5] and others. So he is going to say something about first impressions, from a medical student perspective.

David Jolley: Well, before that, when I was at school, my gran got "took away" and spent her last years at St. George's Hospital, Stafford. So, Sunday afternoon was a bit of a practice in the car for me, a large black Austin Twelve and we would drive there. Of course, the mental hospital was just opposite the jail in that part of town. Dad and I would be ticked in on a long list and we would go along the corridors. We didn't have a key, so we had to ring the bell and we would be allowed in to sit with gran (Fig 5). And you could see in the back there were cells, as I thought they were, for the most disturbed people. Otherwise everybody sort of milled around and we sat around at a table and Gran talked about times that I didn't know about and Dad couldn't be quite sure he knew about. It was a friendly sort of place, but it was a bit frightening, I suppose. Quite different from the rest of the world. And as I say, in that part of town where people are put away either in jail or in the mental hospital.

So, then I was very fortunate, from Wolverhampton Grammar School, to obtain a place at Mr Guy's

Medical School in London. In those days you applied to, I think it was 13 medical schools, and you got all their things and applied to as many as you liked. Fortunately, I got in at the first one. Ha-ha! So that was marvellous. And at Mr Guy's Hospital, well, we learned lots of things. I met Jonathan Dare, who became a psychiatrist, and John Cutting, who became a psychiatrist. We used to talk about psychiatric things because we were interested in them as we went back and forth across London Bridge at lunch time. We knew we were going to be psychiatrists. I'd seen David Stafford-Clark[6] on the telly. Did you see him? It was before Anthony Clare was heard of. David Stafford-Clark was there in the flesh at Guy's Hospital.

The new Mental Health Act 1959 had come in and these were exciting times. I met Stafford-Clark and Gerard Vaughan who was a child psychiatrist at Guy's and he became a Minister of State in the Department of Health and Social Security in 1979. And this is Mr Guy's Hospital, the York Clinic, so they taught us a bit. So, they used to have a talk, invited fabulous people to talk to us. The first was Dr Sargant[7] from the opposition, from St Thomas', which is now part of the same medical school, which is bizarre, isn't it? What a strange world. He was inspiring. But the person who really turned me on was Russell Barton. Russell Barton came from the backwoods and he talked about caring for people. He'd been involved in the Belsen situation[8] and he knew about the large mental hospitals, and I thought: "This is someone who gets down to grips with the reality, the real spectrum of mental illness, severe mental illness, amongst the population." And he allowed me to go and spend time with him. It's been with me forever. It was so fascinating.

I went with Russell on out-patient visits around. I went with him to staff meetings where he was trying to encourage staff to be more positive and proud of themselves. There were a lot of doctors and others from other countries, particularly Czechoslovakia. There were people working—the nurses were often from Hong Kong and Mauritius.

They had only recently taken down the bars that separated the male side from the female side. And Severalls, as you will know, was one of the three hospitals in the three-hospital study: it was the bad one.[9] Russell took himself there in essence to make a difference, and he made a huge difference. He and Richard Fox fell out dramatically.[10] They were often on television, and people took an interest. It was marvellous for me to get taken to schools and colleges where Russell would be preaching the gospel and encouraging people not to be frightened of this place on the edge of the town, on the edge of Colchester. And so, I saw the beginnings of community psychiatry based in the mental hospital.

There was a particular emphasis on older people.[11] Tony Whitehead[12] had worked there until a few months before I got there, and I met him and remained friends with him for much of my life. They were taking good practice into the community from the mental hospital.

In the mental hospital they were trying to transform barns into homes. You will remember, they put together strange contraptions that were wardrobes that divided the place up into room shapes or room sized places alongside beds and so on. And people were involved with activities. There was a wonderful, progressive education in work where the most damaged people would do literally turning, turning cement, and that's what they did. And others would get what they produced and make slabs and they would sell the slabs in the town. And he and others demonstrated to people the therapeutic potency of work. And what a tragedy at the moment, if you ask what people are doing, there's no work for people with severe chronic mental illness. People who have been in and out of mental hospitals at the moment are not having that experience. How can we have lost that? The other thing that was going on was bringing the genders together for civilised activities. And how are we now in a situation where we seem to be reversing that because men are just beasts and can't be coached into a better way of living? So, there we were. This was Severalls on the edge of Colchester, a mixture of staff who had different experiences in the past, one or two charismatic figures showing what can be done with dedication and compassion and that was what was happening in those days.

George Ikkos: Was it really that good, Professor Jolley? Did you not notice any things that worried you in Colchester?

David Jolley: Was it all that good and were there things that worried me? You know, I thought it was just wonderful actually. The colleagues were so generous to me. It was marvellous to hear about life in the mental hospitals. One of the things that I learnt about was smoked salmon, because there

was a doctors' house. We had lunch there every day and one day we had smoked salmon. I didn't know what it was at all! And it was in the summer so every day you had the opportunity to play croquet and I'd never played croquet before. There was a lot of civilisation and a lot of involving people and treating everyone with value and respect.

Interestingly, when I talked to one group of older long-stay ladies, they said what they missed was special events. In the new regime people were much more equal in doing things in a civilised way compared with the fairly recent past where people were locked away and so on. But they said: "We miss the spectacular Christmases." It was almost as if the contrast between a dour year and one or two days of celebration, with turkey and presents from doctors and nurses was something wonderful. They remembered that celebration. But actually, they were given so much more by the new regime. People from the town were coming in to support people with knitting activities. Simple things but bringing people together to do things that they never did before. Yes, I think it was good.

John Bradley: I just want to know, how well organised was your IT department? When I say IT of course I don't mean information technology, but the industrial therapy….

David Jolley: Yes, yes. I mean that was a big part, that was a big part of what Russell was doing and achieving. It was a comprehensive vision that he had. So, there was the work, and that same work of course at the Cheadle Royal Industries since, and in Bristol with Donal Early. These are guys, great guys, because they take people's whole lives and help them become people again and give them confidence. And the other thing Russell and people were doing was halfway houses, places in the grounds, people in places in the town, people further afield. But people weren't just put there and left, they were engaged in activities either within the hospital or elsewhere. So, it was a much bigger vision. It wasn't "What are the tablets, doctor?" you know, that sort of thing.

Louise Hide: Geraldine, I had a slightly similar experience to you and was wondering how that experience of growing up as a child in that kind of environment, how you have lived with it since then—and how it has affected your life and the way that you think about mental health treatment—the lasting impression on you?

Geraldine Pratten: That's a good question. I think it's actually made me a lot more tolerant and understanding when I come across people who I think might be, might have mental issues. I think I am far more tolerant than my friends who didn't have that experience. It was normal for me and I'd support what David said about the industrialisation in the hospital because I was aware of all the patients really having jobs and in fact, my father very naughtily got them to build his first Mirror Dinghy in the industrial therapy department! (Fig 6). They did have, you know, proper jobs. I don't know about the women so much. I do know more about the men because I'd see them out and about working on the farm and, you know, doing jobs. So, the women, there's a sort of doubt to me. But I do think I did, I think I benefitted from having that upbringing, yeah.

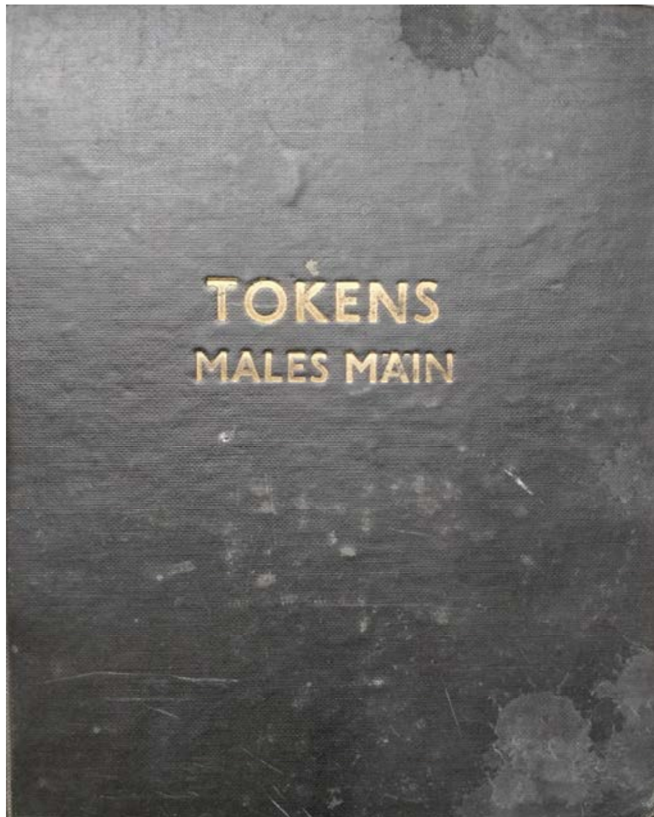
Harry Zeitlin: Very briefly. I went to medical school in 1956 and did my first psychiatric house job in 1962. But the important point is that four of us—we were already consultants around London—were appointed in the '80s (I'm not going to talk about the '80s) to academic posts at UCL and as consultant psychiatrists in Essex, because Essex clinical psychiatry services had deteriorated. The four of us were appointed simply to try to do something about the mess developed over the previous almost 20 years. It is well worthwhile looking at and learning from the '60s.

David Jolley: Well of course Russell took himself off, didn't he? He went away. Charismatic leaders everywhere are important in sustaining the growth, and having a legacy that grows is so important. The fallout between key figures in Essex was such that Russell Barton took himself to America and tried to do similar things there, but I don't think it worked for him rather sadly. But that's right, you can't take it for granted.

Fig 4: Crichton Hall in 1960-61, before they removed the ivy.
Credit: Archive of the late Dr Sam Robinson

Fig 5: David Jolley's "Gran", Emma, as a young woman, with William, and daughters Eadie (right) and Elsie (middle): Gran spent her last years at St. George's Hospital, Stafford (formerly Stafford County Lunatic Asylum).

Fig 6: Building boats in Crichton Royal Industrial Unit in 1969.
Credit: Archive of the late Dr Sam Robinson



TOKENS

Date Received / WARD etc.	7th October 1961 2/-	1/-	6d	3d	Initials	14th October 1961. 2/-	1/-	6d	3d	Initials	21st October 1961 2/-	1/-	6d	3d	Initials
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2/3	115	33	24		[illegible]	115	33.	24		[illegible]	115	33	24		[illegible]
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6A.	65	10	15		[illegible]	65	10	15		[illegible]	65	10	15		[illegible]
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BALANCES

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Fig 7: Token Economy Book, Prestwich Hospital, 1960s. Credit: RCPsych

John Hall: I worked in Whitchurch Hospital in Cardiff in the late 1970s and I got to know there, as a friend, somebody who had been brought up in a hospital house at Whitchurch Hospital. I remember him telling me that he and a group of his friends would play around the hospital chapel at the weekend: there was a crypt underneath the chapel and there was a grill leading to the crypt which they found out how to move. So, here was this friend whose childhood playground was the crypt of the asylum chapel! It is one of those anecdotes which understandably I've never forgotten. The whole question of the lives of children and families at the asylum is I think a subset of this narrative, and there must be some amazing anecdotes sitting around somewhere.

Robert Freudenthal: I'm a higher trainee. I'm just curious, was there, for the patients that were involved in work, an opportunity for them to be paid for the work that they were doing?

David Jolley: Yes, I mean yes is the quick answer, a modest amount, but it was something. Absolutely so. But so much more was the involvement, fellowship, the jokes that would come from work like they do, terrific. But yes, there was, modest reward. But what a fantastic reward if you make the doctor a boat! I mean, that would be great, wouldn't it? I mean…!

Claire Hilton: Don't forget to look at the exhibition of books and archives at lunch time. One of the items is a token economy book (Fig 7), showing one way of rewarding patients at the time.

John Bradley: Just one point about payment. Industrial therapy departments had a manager who would make contracts with outside firms, and that's how they really did get some sort of payment for it. And usually it was spent of course on cigarettes, apart from the free cigarettes which were being given in some of the long-stay wards as part of their sort of general comfort, I'm afraid.

Ally Xiang: I'm a specialty trainee. This is for Geraldine Pratten. I was interested to hear of your early life, but I was also struck by the house, the proximity of your father to his work, and family life, and I wondered if you could say a bit more about the work-life balance. You know, was he on call sort of all the time? And, how much exposure, in terms of his work, did you have?

Geraldine Pratten: Yes. I love a good question. My mother would say he was 24 hours on call. He certainly worked Monday to Friday but on a Saturday morning we regularly went to his office and my mother must have bundled us all into the car and we sat for hours outside what was called Johnstone House in the car while he went in to write up his notes. It seemed like hours. She felt that the work-life balance was bad. That was her impression. I didn't see much of him, to be honest. But he did get three weeks off in the summer, when we all went on holiday together. Is that an answer? I imagine it's probably just as bad now!

Claire Hilton: I think we will have to stop this section here and move onto Peter Campbell. Thank you very much, Geraldine and Dave.

A patient's perspective: Peter Campbell

Peter Campbell: Can everybody hear me okay? Good. I first entered mental health services in October 1967, two days after arriving at Cambridge University for my first term. Initially I was given a diagnosis of acute anxiety neurosis and treated in an annex of Addenbrookes Hospital. My parents came down to take me back to Scotland to be nearer to them. Unfortunately, I had been prescribed barbiturates and I had proved allergic to them with the result that my joints seized up and I could not walk. I was transferred back to Scotland by ambulance and overnight sleeper. I remember lying on a stretcher on Dundee station waiting for the ambulance to take me to hospital. The mental hospital I now entered was Royal Dundee Liff on the outskirts of Dundee.

Gowrie House, the admissions block, was situated in the grounds of the main hospital. For the first few days I was pretty much traumatised by my situation. I was certainly extremely anxious. I believed I'd been taken away to die. I found it very difficult to sleep. I remember lying in bed waiting for the right time to go and ask for chloral hydrate. Too soon, and I would be sent back to try again. Too late, and I would also be refused. And during the day I would wander around the ward. My concentration was extremely poor. I tried to watch the television but could make no sense of it. This distressed me greatly. The ward was segregated. There was a women's ward in the same block. I remember men and women used to come down to mealtimes at slightly different times and sit at different tables. It was a brave person who made up a mixed table. Our ward contained about 20 patients and I was the

youngest by quite a distance. In a way, Royal Dundee Liff was my first taste of adult life. It was a strange environment and I had a lot to learn.

Nothing very dramatic happened on the ward, but the possibility was there, and that gave everything a little edge. People sat and smoked, sometimes they played cards or Scrabble. The nursing staff observed us but did not interact much. In their absence it was up to the patients to support each other. The sense of camaraderie was quite strong. The consultant psychiatrist did a ward round once a week. This was very different from ward rounds today. We stood by our beds with our kit laid out neatly. The consultant and his retinue went from dormitory to dormitory and he interviewed us briefly where we stood and in front of all the other patients. It was nerve wracking, as ward rounds always are, but also lacking any confidentiality. I did not see much of the consultant apart from at ward rounds, but I had meetings with the junior psychiatrist quite frequently. We discussed my childhood, family relationships, school days.

Eventually they reached a judgement that the root of my problems was that I was too close to my mother and too remote from my father. This conclusion may have been correct, but it did not seem particularly helpful. We all muddled along pretty much as before. After about two months I was discharged. Looking back in the following weeks I became aware of just how different the experience had been from anything else I had previously encountered, good or bad. I did not talk about my experiences for many years, not until I became involved in the survivor movement. It was only then that I really removed the stain that stood there from my stay at Royal Dundee Liff Hospital. Thank you.

Claire Hilton: Wow, that was amazing. I know Jean Gaffin wants to say something, is that right?

Jean Gaffin: Yes. My involvement in the mental health services began when I got married in 1958 because my mother-in-law was one of five sisters and my late husband was the only one in the family who drove. And so, when Aunty Sarah went to a very large mental hospital in Surrey, Alec, my husband, drove and I had nothing else to do but to go with. My memories are '59-'60 and I can't tell you the hospital because everybody I could ask is dead. One of the big Surrey ones. And it was just horrendous. It was just a very, very big, huge room with mad people walking about. I knew nothing about mental health, I was just looking at all these mad ladies wandering around and I remember once one peed in a bucket or wastepaper basket and I was quite shocked that nobody took any notice. And that was my abiding memory. I don't know what Aunty Sarah was in for, she was in and out a lot. But I do know that whenever we visited there was no interaction with any member of staff. The nurses got together and chatted, and the visitors sat with the patients, and it was all rather horrendous.

And another anecdote, if I can have a second one, which is about my brother-in-law, who was a paranoid schizophrenic, and he was seen as an out-patient at Guy's a lot. People were very kind and understanding and didn't want to take him in until he met Dr Sargant. And Dr Sargant said, "Maurice, you're mad. You're coming into Horton." He went into Horton Hospital and then my sister divorced him. But he remained well and working and had other successful relationships because they stopped pussyfooting around and they told him he was mad and he went into hospital and he started on medication that he took for the rest of his life. And that of course is a terribly retrogressive thing to say nowadays but in the early '60s it was a great relief.

And just one more thing about his stay in Horton. He often left hospital and went home at 4 or 5 o'clock in the morning. He would bang on the window. My sister had two small children, she was in despair. And I remember ringing up the psychiatrist at Horton saying: "This is just so bad for the children and my sister is really getting very unwell." And he said, "Please don't worry about your sister. As soon as she has a breakdown, we'll take her in."[13]

Angela Rouncefield: Peter, could you tell us, did anything good happen?

Peter Campbell: Yes, I mean I went in and I came out! In some ways, what more could you ask? I mean, I've had something like two dozen admissions in fifty years and at least I keep coming out. But a lot of good things don't happen. I'm not sure that a lot of bad things happen but a lot of good things don't happen. I think I'd say that. In Royal Dundee Liff, it was okay as a hospital, and I got a lot of support from the other patients. I remember when I was recovering, going down to the centre of Dundee and having a meal in a restaurant in the centre of Dundee and then coming back on the bus

in time for roll call, and that was good. I think there's always something good about the fact that when you start recovering, hospital is not such a bad place to be. It's when you're in crisis I think that the hospital is not such a good place. But once you get through the crisis, and you start recovering, then it's not such a bad place...

John Bradley: I'd like to pick up the point you made about Dr Sargant. It was Dr William Sargant, you were saying? I was chief assistant at St Thomas' for five years of my life and it was a mixed experience, I can tell you. Because his direct approach was to say: "You're ill" and "Who has been treating you?" And the patient would say, "Dr Bradley, Dr Boyd" or something. And Dr Sargant would say: "Well, there you are!" That was him. He was so obsessed with physical treatments, actually, and the like. I tell you, when you were his assistant, one had to pick up the pieces because his psychotherapy was all based on Pavlov and it never got much more subtle than that. But certainly this direct approach, it did work, particularly where people do respond to medication.

Maria Turri: I'm a psychiatrist. I wanted to ask Peter about his first in-patient stay about whether his mother or someone else in his family was involved in any way, whether the psychiatrist would talk to the family, and whether they would visit?

Peter Campbell: My family were a little involved. They certainly went and spoke to the consultant; they had a meeting with the consultant psychiatrist. I wouldn't say that they were that much involved. I think my father, who was in the Royal Army Medical Corps in the war, he really didn't get it. I think he found it very difficult to cope with the fact that I was in a psychiatric hospital and what a psychiatric hospital was all about. But to answer your question: yes, my parents were involved but not as much as they were in subsequent years.

Adrian James: Hello Peter. I'm Adrian James, I'm a psychiatrist from the south west of England and I'm Registrar of the Royal College. Thank you for your generosity in sharing your experience. I'm sorry to hear how negative you felt it was. I just wanted to ask you how it really felt to you in the environment that you were in. Did you feel this is a group of people, patients and staff, who are really up against it, poorly resourced and…? Or did you have a sense of feeling that there was a badness about what was happening? I'm struck that, you know if you go into an emergency department, as I have, sometimes you can have a bad experience but actually you look at what's happening and you think: "Well look, they're all up against it, they're just doing their best." But sometimes you can have an experience where you feel: "You know what? There's some badness in the system. I just wondered how it actually felt for you.

Peter Campbell: Looking at Royal Dundee Liff, I don't know it was such a bad place, and I think my experience was okayish, certainly, compared to things that happened subsequently in the '70s and the '80s when I was being given ECT against my will, when I was on a section.[14] I mean, in Royal Dundee Liff, I was a voluntary patient, and that makes quite a difference, I think. The way you feel about the experience of being in hospital is influenced by whether you are free to leave or you are not.

Deepa Parry-Gupta: I'm a specialty registrar. What I'd like to ask you, Peter, and actually everybody, is how do we distil the good and the bad, and make sure that the good keeps happening again and the bad doesn't? Because I've been around long enough to see old, bad stuff be recycled as clever, new ideas.

Peter Campbell: That's a huge question! And I don't know that I'm in the best position to answer that really, but one thing, and I'm talking mainly about the acute ward (what was happening on the back-wards was something different and I think we'll hear about that later on in the day). But the acute ward, what struck me was that nothing much was really happening. People were sitting around in the day room doing nothing. The nursing staff were mostly in the office or watching patients, but not really interacting with patients. So, I think one of the things is that you need to use the resources you've got and to use those resources better. And I think that the nursing staff are key to me in this whole thing. Because, the doctors you hardly ever see, psychiatrists you very rarely see, although it may not seem like that to you! But the people who are actually living, day to day, with the patients are the nursing staff. I think that the nursing staff were not as good as they could be and that applies nowadays too.

Harry Zeitlin: Again, I'll be very brief. These fluctuations with regard to the asylums, I agree with what you're saying, they weren't as bad as they were made out until they started to try to close them

without any real replacement. We can learn from them. I don't know if people remember Wilfred Warren,[15] who used to give a talk *Can we tell the future from the past?* And maybe we ought to look at it.

George Ikkos: Do you remember your first conversation with a psychiatrist at Cambridge and was that a person you thought at the time you'd want to talk with again or not?

Peter Campbell: There was a good psychiatrist where I was in Cambridge. I was in an annex called Douglas House. I don't know if it's still there. And there was a good psychiatrist. I won't name her, but I thought she was sympathetic, and she was quite useful to me, I think, at the time although I was so anxious it was difficult for anybody to get through to me. Then the problem with the barbiturates, that was unfortunate, because that just made me feel terrible and luckily barbiturates are not on the menu anymore. But yes, when I went to Royal Dundee Liff, I didn't find the consultant particularly useful and I didn't see him very much, as I said, and only in this rather artificial environment of the ward round. The junior psychiatrist was very much a junior psychiatrist. And one thing they did was they gave me intelligence tests, I don't know why they thought I needed intelligence tests, but I think they were trying to find some way to persuade me not to go back to Cambridge, which I eventually did. But trying to persuade me that I wasn't intelligent enough to go back to Cambridge was a no-no because I knew whatever other problems I had I was certainly intelligent enough to go back to Cambridge.

Richard White: Do you feel that any of the treatments that you had helped? You had, I think, other medications and you had ECT. Did they, or any intervention, help you particularly?

Peter Campbell: I mean this is going into the '70s now because Royal Dundee Liff was the only hospital, I was in in the actual '60s, the next one was in 1970. But ECT, well I had, I think 18 ECTs over a period and whether they worked or not I'm not sure. I mean there again, I had ECTs, I got better. So therefore, maybe the ECTs helped, but I was also on Largactil, I was on antidepressants at the same time so it could be anything. Medication, well my view on medication, for what it's worth, is that in a crisis situation medication is useful. People taking medications every day, whether they are in hospital or in the community, I don't think is such a good idea and I'm not sure any medication I've been on in the community has actually prevented me from having a crisis. If I have a crisis then the medication I'm given helps me through that crisis probably in two or three weeks and then I can start my recovery and go back to the community. So nowadays I go into hospital for about a month maximum. Back in the '70s I was going into hospital for a year. So things have changed.

Anon: Thank goodness.

Claire Hilton: Can I just say something? Out of sequence for the seminar, but I'm very happy we've got Richard White, who asked the last question, with us. He has come from Australia. So welcome, Richard. One last question?

Mohamed Ibrahim: Just a little curious to how did you find the ECT in particular? How was it back then?

Claire Hilton: I'm allowing this through on the understanding, to the best of my knowledge, that ECT in the late 1960s wasn't practiced any differently from the early 1970s, otherwise we're…

Peter Campbell: Yeah, I mean you get a headache! That's one thing. When you come around, you're a bit disorientated and you get a headache. The thing I remember from the early '70s was the way ECT was administered. I remember being in a Nightingale ward and being lined up on a bed and the ECT machine worked its way down to you. There was nothing like ECT suites or recovery rooms or anything. You were just in the ward and the ECT machine came down to you and you could hear it getting nearer and nearer to you. So, I think ECT, which I'm opposed to, I think ECT is given now in a more humane way than it used to be.

John Bradley: One point about that. I'm sure everybody here has heard of a gentleman called Mr Bolam? Perhaps they haven't. But *Bolam vs Friern Hospital*[16] was a legal case in the bad old days in the 1950s. Then, ECT was given without muscle relaxant, and sometimes without an anaesthetic. Mr Campbell, did you have an anaesthetic when you had ECT, when the ECT was brought around? Just a yes or no. Did you have an anaesthetic?

Peter Campbell: I had an anaesthetic. ECT is a kind of *bête noire*. I remember, in Royal Dundee Liff, another patient saying to me, "Oh, you need ECT. You'll be given ECT. They'll do this and that

to you in ECT." And because ECT sounds awful, you start worrying about being given ECT. And I mean, there's no doubt that ECT is not used as much as it used to be, which I think is a good thing!

Claire Hilton: I think we should draw this session to an end but thank you so much Peter!

Admission and discharge:

Suzanne Curran, a psychiatric social work perspective, and

Professor Sir David Goldberg, the Mental Health Act 1959 (and other matters)

We have two speakers in this session and then after that it's lunchtime. I'd like to ask Suzanne Curran to speak on the psychiatric social work perspective on admission and discharge. And after Suzanne, we've got Professor Sir David Goldberg, who is going to say a few words about the 1959 Mental Health Act.

Suzanne Curran: I started work at the age of twenty in a district of Lancashire as a welfare assistant in a mental health department. Later I went on a social work course and qualified in 1966. As a mental welfare officer, I covered the area from Prestwich, which is just outside Manchester, to the Rossendale Valley, Rawtenstall, around there. The two main hospitals that I'm going to talk about are Prestwich and Rossendale.

Prestwich was a large hospital, long and short stay patients, with an infirmary and a secure unit at Strangeways Prison. Prestwich had its own farm and various activities, workshops and units in which patients worked. At this hospital, patients needing admission, voluntary or compulsory, were mainly referred to us by GPs and the consultants. People who had already had an in-patient stay there sometimes were referred to us by their relatives, but this was infrequent.

The welfare officer visited the client and the family, and for admission, took the patient to hospital in an ambulance if they were being sectioned and in their own car if they weren't. This could be our first and only contact with the patient. Relatives could come with on an admission if they wanted to. But most families, when they got there, they had so little time with the patient that they didn't want to go with. And they were never shown through to the ward where the patient would be. But also, they had a very fearful impression of the place even though they'd had the hospital near them for a long time. We found that a lot of relatives in the end never could be persuaded to visit their family member.

On admission the patient was taken to what we called a receiving unit, and if they were sectioned, the papers were checked and acknowledged, and the mental welfare officer was discharged. We sometimes did ask: "Well, we'd like to go with this particular patient, we think they'd settle better if we came with them," and that was solely up to the nursing staff on duty at that time. We would then accompany the relatives home, and explain what the procedure was, what would happen next, assuring them that we would be available for contact because, as I say, some of them didn't really go near the hospital after that. So we were that contact line.

The other hospital unit, at Rossendale General, was very different, with what I consider to be a more forward-thinking psychiatrist. He would receive a referral and frequently make a home visit with a mental welfare officer present. In the Rossendale area we found the referrals were coming to the mental welfare officers from a larger group: from the psychiatrist, GPs, relatives, and neighbours that knew them well and knew that the illness needed some form of treatment. But also, this community accepted us as welfare officers. In fact, we were known as "The Welfare". Somebody would shout, "The Welfare's here! You know it's for you!"

Where a home visit was not made and it wasn't an emergency, the patient and close family would be invited to the out-patient department at the Rossendale unit. Here, whilst the psychiatrist saw the patient, the welfare officer would interview the family and take a social history in an agreed framework. After this, the welfare officer and psychiatrist would discuss the social history before he saw the family and patient together. To me this seemed a far more controlled and patient-friendly approach. The consultant would hold fortnightly meetings to discuss progress and the future of the patients. In the meantime, he encouraged relatives to keep in touch with the welfare officer and the ward staff. We were encouraged to visit and work closely with the ward staff in planning any discharge.

ECT was frequently used at this time and this consultant insisted that I witness the procedure before forming an opinion or discussing it with

patients. I would say, that I introduced myself to the patient and got his agreement to be present. In that case, it was more kindly done.[17] It was done in a side room. The patient was taken into a separate room and ECT was administered.

Discharge from Rossendale Hospital was more or less planned from the day you went in and everything was prepared and ready. Discharge from the larger, specialist hospital at Prestwich was not planned as thoroughly and sometimes we weren't even told that a patient was being discharged. We relied on relatives to tell us. Even if we kept in touch nobody would actively say, "The patient is going home" on whatever date. Where a patient lived alone, we stood a better chance of being involved because they needed us to set up support services. Any other information would be sent to the GP who may, or may not, have shared it.

Relationships with GPs varied. Some were very interested in mental health, others I'm afraid had a rather old fashioned, uneducated view. During the late '60s Prestwich Hospital did start to review patients, the long-stay ones, with a view to them going out into the community. And this, in the community, started to break down barriers. But in the '60s I don't think barriers between the social work side and GPs ever really got broken down. Certainly, in the Rossendale Valley, one or two would, because they saw the psychiatrist in the community and started to realise the importance of the after care.

And to close, I just wanted to say: there was another service we found very useful at admission and discharge and that was the ambulance service. Ambulance men volunteered when it came to a section, to take the patient to hospital, and as such it was quite a group of ambulance men who became exceptionally good at talking with patients. They developed wonderful communication with patients, and admissions were so much easier and calmer. They made a tremendous difference. The first experience I had of a section, I went with a qualified psychiatric social worker and the ambulance men were taking the patient to the ambulance and the social worker got in her car and I suddenly realised I'd been left on the pavement holding a bird cage! The ambulance men and the patient went off to the ambulance and as they got in, they persuaded the patient to join in with them in singing "My old man said, 'Foller the van'", but in my case, I can tell you it was a budgie, not a cock linnet.[18]

Claire Hilton: Thank you. Professor Goldberg, if you would like to say your bit now and we'll have questions after that?

Professor Sir David Goldberg: I'm feeling a little bit deprived by Claire because she seems to want me to just talk about the Mental Health Act, nothing else, keeping quiet almost. I don't want to do that! And I feel very envious of the rest of you who are free to say what you like. I'm going to do what I can to help her with the Mental Health Act, but it isn't the most interesting thing in the world.

When I was a medical student, the Board of Control[19] ran mental health services in England and Wales and they made a lousy job of it and everybody realised that. At the end of the Second World War, the plan was to set it up properly and to abolish the Board of Control.

As a young doctor, I was interested in the epidemiology of mental disorder and I wrote to Eliot Slater,[20] who was *the* man who knew most about genetics. You won't believe this, but Eliot thought there was a gene for schizophrenia and a gene for manic depressive illness. Not quite right that, but it was interesting. But I said to him, "Tell me about the Board of Control." And he said: "The Board of Control produces data which fall just short of being completely useless."

I was glad that, when I qualified, which was in 1959, we had this brand-new Mental Health Act which was going to do so much for us. The first thing it did was to abolish the Board of Control, which was good. It aimed to provide informal treatment for the majority of people suffering from mental disorders, while providing a legal framework so that, if necessary, people could be detained in hospital against their will. Aiming for informal admissions has always been part of my own philosophy of mental disorder. The "Duly Authorised Officer"[21] now had to be consulted if admissions were to be made under Sections 136[22], 29[23] and 25[24], the sections that you are all familiar with in the Mental Health Act 1983.[25] The local councils were made responsible for people who were thought not to need admission, and that's fine of course, but like any politician's solution to a problem, they don't actually fund them to do that. It was just understood that they would find the money from somewhere

and would look after people who were not thought to need admission.

What was good, was the sort of general setting up of things, even though the detail was not there. There were some drawbacks, which I've been told I have to mention. There was the problem about what was the legal basis for somebody who doesn't want to have psychiatric drugs but you think they should have them, or doesn't want to have ECT but you think they should have it, and doesn't want psychosurgery but dammit you think they should have it. Like its predecessors,[26] the 1959 Act did not provide clarity as to whether, on a legal order to detain a mentally disordered patient, you could impose treatment against that patients wishes. Clarification was necessary to balance the rights of detained patients with the rights of society as a whole. If you wanted to know what the legal framework was for giving somebody treatment against their will, you had to wait for the 1983 Act before that started being made clear.

There was a hierarchy of nearest relatives[27] which had never been defined in the earlier Acts, because if you have to contact people, does someone's husband or wife have precedence over their mother or their father? It was all laid down. It may have been wrong, but they did it. There was at least some advice given.

The 1983 Mental Health Act set up Mental Health Tribunals, which did not even exist in my earlier years as a psychiatrist. They consisted of a psychiatrist, a lawyer and a lady with a big hat. My children tell me that I mustn't say these things, as they show how ante-diluvian I am, but for some reason they always wore big hats, even though this was not stipulated in the 1983 Act itself. Section 12 approved doctors came in with the '83 Act. That was a great idea really, that a doctor who was beginning to get information about mental disorder should have that recognised and be a special doctor who would be asked to do things that ordinary doctors made a mess of. The 1983 Act had Assessment Orders and Treatment Orders, while there were also Magistrates Orders and Police Officer Orders, and Section 37 dealt with people convicted of a crime.

I came from a teaching hospital, St Thomas', which has been referred to by people more of my generation who are sitting over there, and I'm afraid that all these young people won't know what we're talking about. As the only metaphorical equivalent at the moment is Brexit, let me tell you that Dr Sargant was Nigel Farage! You can question me afterwards. I shan't change my opinion. His was a really terrible model for mental disorder. While I was in training at the Maudsley, there were nine people there who had come from St Thomas'. That's more than from all the other London teaching hospitals rolled into a ball. Why were we there? We wanted to get away from Sargant! And from the hands of some other people.

At the Maudsley, I looked about me and I thought, "Is this the model I want to use?" It isn't, of course, because if you were seriously mentally ill and you relapsed, we sent you off to a mental hospital. That's what the Maudsley did. I thought, "This is crazy, this is not what a mental health service should be like."

When the time came for me to move on from the Maudsley, I went to the only place that was worth going to, which was Manchester.

Anon: Hurray!

David Goldberg: In Manchester the district general hospital was where the action was and if you wanted to have a mental health unit you had it in the local general hospital. And I thought, "That sounds sensible" only to discover, to my horror, after I'd been there for a little while, that if you were really mentally ill, they thought of sending you to Prestwich, which you, Suzanne, mentioned. And that is hopeless. That's not how it can be done. It is true, though, that Prestwich, over the years, had been putting people into hospital and leaving them there and that's not a very interesting thing to do in running a mental health service. But even the DGH[28] units around me in Manchester had this tendency to find somewhere to slip people who were chronically mentally ill.

Claire Hilton: I think we need to draw it to a close…

David Goldberg: I'm going to draw it to a close. Stop interrupting!

Claire Hilton: It's just like case conferences at Manchester when I was a junior doctor and Professor Goldberg was chairing!

David Goldberg: That's not so bad! Let me just say, of course she wants me to shut up, that I think that's all I want to say about that. I would love to tell you why I never wanted to work in a mental hospital.

I think that's much more interesting in a witness seminar.

Claire Hilton: Okay, please do.

David Goldberg: I visited various mental hospitals. The only one I admired was Netherne, just south of London, which had eleven levels of IT, and I thought, "This is marvellous but it's ridiculous"—the idea that you can set up those—it was not a feasible way of doing things. Most of the mental hospitals that I went to see, I thought they were horrible. If I was mentally ill myself, the last thing I'd want to be was in one of them. I wanted to be part of a service that helped people and didn't keep them in hospital for a day longer than they needed to be there, and that seemed to be quite important. The average duration of stay was 21 days in our units in Manchester, whereas when I got back to London of course all my London colleagues were prepared to tolerate much longer admissions. After Mr Osborne's cuts, of course, mean duration of admissions in London have necessarily got much shorter.[29]

And it's been a huge change and I'll shut up now, but I do think that we have moved closer to a service which is orientated to sick people and we do train people to talk to them, and all this stuff about "we never saw a psychiatrist", how the hell did anything good happen to you if somebody hadn't been trained in how to talk to people who are mentally distressed? This has been the focus of my life and I'm very happy to have had an opportunity to tell you that before you all go and have lunch.

Claire Hilton: One minute! We've got ten minutes for questions. Can we let Ian Stout speak first as he hasn't said anything yet—and he's from Manchester.

Ian Stout: I have to say, Claire, this morning has turned into quite a surreal experience. I remember in 1975 applying to join the psychiatric rotation at Withington, and the people who interviewed me were Sir David and David Jolley, then a senior registrar. They were my interview committee. So, you know things come round. And I also was very much at the receiving end of Professor Goldberg's fearsome interrogation! You learned not to open mouth before engaging brain. But the question is to our social work colleague: I undertook a very large survey of all the people remaining in the large mental hospitals in the North West. What was very striking was the tale I was told was that when one was looking for a mental hospital bed in Lancashire, the mental welfare officer rang round to see who had a bed. And even though you lived in Salford you could well end up in the Whittingham Hospital, Preston, which was the situation I found when I went around reviewing all those over 65 in the residual population in the large hospitals.

Suzanne Curran: No, I can say I was never involved in finding the bed. It was usually the GP, they did that. Of course, a lot were referred to us by GPs, and by psychiatrists themselves, but I can honestly say, no, I never had to find a bed for anyone.

David Goldberg: When I got back to London in 1993 the people who were looking for a hospital bed sometimes found one in Holland, and these appalling reductions in service during my professional life have been the most distressing things that I've witnessed.

Anon: Yeah.

Harry Zeitlin: This is also for Suzanne. I trained in the Maudsley in the '60s with people like Michael Rutter, Lionel Hersov and Wilfred Warren, and when I left there I had to go and set up services and went back to my trainers to ask them about the best way to do it.

One thing which I wonder if people would like to talk about is, right at the start of a new referral, the move to have a system which could draw skills from different professionals, not referring back and forth like a yoyo, but getting all of these skills together at the start, a team approach. My understanding is that that was initiated during the '60s and was a very, very important move. I'd love to hear comments.

Suzanne Curran: I think that's what started in Rossendale, because, as I said, the ward staff there appeared to get involved. And I think, from a patient's point of view, when they know you are talking to the ward staff, and you are actually talking about them, about when they go home, it's another incentive to feel more secure in being there. Communication and the team approach is good, but the communication at Prestwich Hospital—it just wasn't. I would have to say that the number of times that I saw a consultant psychiatrist there was very few. I could probably count it on one hand.

Anon. Really?

Suzanne Curran: Yes, because we weren't free to just go in and out. There was a view of Prestwich which made people in the area really worried about it, and often the first call from a relative would be: "Well, I want to go and see them but I'm not going unless you go as well." And I had to take them on the visit and stay with them and be with them. So that was a sort of put off really. There must have been other social workers somewhere in the hospital, but I only ever met one, who never left the hospital. She just worked in it.

But the big divide was also in the GPs. Some GPs, well I'll be frank with you, had the old view, "Oh, he needs to pull himself together," "I don't know what you're doing," "He should never have come out." Other GPs were really, really interested. When you worked with them, even when you went into Prestwich, it was better, because they had a direct line to the consultant, which we didn't have.

David Goldberg: I quite agree that the team approach has been the only one that has impressed me over the years. And I remember when I'd go, first as a medical student, to the Warneford in Oxford, it was the team approach. When I got to the Maudsley, it was the team approach. Before I got to the Maudsley I was at St Thomas': it wasn't really a team approach because there were such concentrated, overvalued ideas that were being exchanged between the so-called experts. But also, at the end of my time at Manchester, as the team got smaller and smaller because there weren't enough people around—it's appalling—you can't produce the same service if there aren't different people there discussing what can be done to help someone. So I think it's an important question.

Angela Rouncefield: I'm delighted to see Sir David here, so glad you're still not shutting up. The College and really every trainee still have you to thank. And what many people in this room won't know, is that when the College was being formed, we had a huge battle and the battle was between the junior doctors and the then consultants, who I regret to tell you were led by no less than Will Sargant at the time. And what was it over? You'll all be amazed to know. The seniors in the RMPA[30] just wanted there to be an exam to become a member of the Royal College of Psychiatrists. And led by Sir David, was a group of young doctors who said, "This will not do. There has to be a proper training scheme set up that has to be complied with and this will raise the standard of psychiatry throughout the whole country. And only when you've completed the training, can you do the exam."

And we really have Sir David Goldberg to thank for this. He was quite magnificent at the meetings, speaking even though every time a meeting was held about it, it was moved further and further from London. And the final meeting, I have to tell you, was held in Plymouth. The night before we all met in a crummy bed-and-breakfast when our seniors were at a very posh hotel, and I don't know, Sir David, if you remember but we sent them a telegram. And the telegram read: "Battle lines have been drawn. See you tomorrow." And when we arrived at the Guildhall where the meeting was being held, it was surrounded by police. I don't know what happened to Sir David! Two of my supervisors, one was Professor Linford Rees and one was Professor Ken Rawnsley, came up to me and said: "Angela, please don't do this, you'll never, ever be a consultant." But I said—I was very hot-headed—"Stuff you, I'm going in!" And thank goodness we did because people like Sir David won the day for us and we really have you to thank. I'm so glad you haven't shut up!

Claire Hilton: On that note, firstly thank you so much for speaking. And now it is lunch time. We have 50 minutes for lunch, and I look forward to seeing you all back here afterwards.

Claire Hilton: Welcome back! If anybody finds a phone in a blue case, a lost phone ... someone's found it! Also, George Ikkos is desperate say something.

George Ikkos: So, first of all, please congratulate Claire. She has done tremendous work to prepare for today. So, on behalf of the RCPsych, thank you very much. And it is brilliant to see you all here. I just was desperate to say that on 14th January at the Royal Society of Medicine, the History of Psychiatry Special Interest Group will be holding a joint meeting with the RSM Psychiatry Section on the social history of psychiatry 1960-2010. Louise Hide will be one of our speakers—delighted to see you here. Many other eminent people, Joanna Bourke will be there. Peter Tyrer will be speaking and Diana Rose. So please consider coming to join us there. You can book through the RSM website.

Claire Hilton: And one more thing, now George has introduced himself. A few people have said they'd like to make a contribution towards the food. If anybody wants to, George will collect any money but I'm afraid it will be cash only.

Yannick—our sound technician—are we ready to start? Good.

Acute Psychiatric Wards: Malcolm Campbell and Peter Nolan

Claire Hilton: I'd like to introduce our two speakers on the acute psychiatric wards. We've got Malcolm Campbell who is a doctor, and Peter Nolan, who is a nurse by background. Malcolm, would you like to go first?

Malcolm Campbell: Well, thank you for inviting me. I graduated in medicine in 1960 and had always aspired to a be a neurologist, but I had to do general medical training first. In 1964 I was a SHO[31] in the Whittington Hospital, North London, but I busied myself by attending a visiting neurologist doing consults, and also with a visiting psychiatrist, Dr Richard Hunter, who had a discussion with me about my future training.

I said: "Well, I'm starting training at Queen Square in four-months time."

He said: "What are you going to do in the meantime?"

I said: "I'll do the odd locum, you know, support the family."

He said: "Why don't you come and work for me as a medical officer up at Friern, Friern Hospital? You will see a lot of chronic neurology up there and a lot of other interesting cases. I really want you to come along, see the patients and sort out those who have got organic disease…"

So, there I was. My only direct experience of psychiatry at that stage was a day visit to Shenley Hospital as a medical student.

So, a trip along to Friern and I enter the ward block. I must say I was taken aback. It was a very foreboding experience of a very long, dimly lit corridor about a quarter of a mile long with about thirty or forty wards, Nightingale wards, laterally off the corridor, each of them stuffed with beds very close together, with very little other furniture indeed. And certainly, I don't remember any curtains around the beds at all. There were mobile screens. The overall pervading experience was in fact the smell. The smell was a mixture of incontinence and disinfectant. It was pretty overpowering, so much so that when I went home at night the first thing I would do was have a shower and change. There were one or two rooms off the main ward where bedridden patients or severely disturbed patients could stay and there were certainly two rooms I remember very well off the main corridor, where all the walls and the floor were padded and the mattresses were lying on the ground for safety purposes. I might add it was jolly cold and there seemed to be very little heating in the wards that I remember, so much so that during a cold spell at the end of January '65 the urine in one of the bed pans in this quiet room froze, it was so cold in the room.

The hospital really was very understaffed. Understaffed with nurses. They probably had only two nurses on these long wards. And it was understaffed with medical staff as well, who were mostly from central Europe, as I remember. And not particularly well trained that I could gather. In addition to this main ward block there were two separate villas outside: one was the medical superintendent's house, which also contained the medical mess and rooms for the on-call doctors. And the other was for patients' use; it was a day room when open and they could get light refreshments, I think. That was where visitors came and saw them, mostly at weekends. There were very few visitors on the wards themselves at that time.

I would say that Friern appeared to be a very chronic hospital in terms of decanting many, many patients from central London, particularly from the National Hospital[32] in Queen Square, which is why there were so many neurological patients there, mainly with dementia, Parkinson's disease, Huntington's disease and also, which was of particular interest to me at the time, many with neurosyphilis or GPI.[33] There were a total of 32 patients with neurosyphilis in the hospitals with all the various manifestations of that disease, and which I was interested to see.

My role was mainly that of medical care, medical care of the patients, particularly of epilepsy—more of that in a moment. There were very few acute psychiatric admissions to my knowledge at that time; it was mostly a chronic hospital and people were there and could expect to remain there for the rest of their lives; there was very little movement.

The whole air was that of inertia. There certainly seemed to be no evidence of rehabilitation or rehabilitative measures that I was aware of at the time. And I certainly didn't see a social worker whilst I was there, or at least I can't recall one. I do remember one acute admission, an acute transfer from Queen Square, and oddly, or not so oddly, a woman in her late 50s with multiple sclerosis who had an acute psychotic illness. We had to put her into a quiet room. She was a lady from Golders Green, from quite an upper middle-class family, and the family were absolutely horrified, totally horrified, at the conditions at Friern at the time and created a big fuss to all and sundry. And I have to say that we and other medical staff were feeding them ideas as to who they might complain to so that we could try and get things changed. It wasn't very successful as in effect, she was transferred out of the hospital somewhere else. I never knew where. But it is almost as if the leadership were sweeping things under the carpet, getting away from the problem.

I might add, that my consultant, Dr Hunter, was rather an atypical character. He was anti aggressive therapy. He talked pretty angrily about William Sargant and his ideas, needless to say. It was an interesting ward round on a weekly basis. He would come round with his mother, Dr Ida Macalpine, an historian. She was a psychotherapist, I was told. I'm not sure whether she was ever employed by the hospital or just voluntary. So, it was usually just the four of us going round: Dr Hunter, Dr Macalpine, myself and a nurse from the ward. It was mainly a question of discussing the diagnosis with the patient and what might happen to them. Dr Hunter was very organically orientated and wanted to know about which part of the brain might be damaged. He wasn't interested in psychoanalysis or the speaking therapies and was pretty scathing about Anna Freud and her group up in Hampstead. I didn't know at the time that he was so occupied with the organic nature of illness that he and his mother were in fact interested in writing the seminal book on the madness of King George III, which he attributed to porphyria, which came out a few years later.[34]

I'm not going to talk about the drugs used, of which there were hardly any at all. We certainly didn't do ECT on our patients. Perhaps this will come up later, in terms of drugs and other treatments.

It was an interesting experience that I kept to myself. It wasn't something I added to my CV, I might add, as a neurologist. Thank you.

Peter Nolan: Good afternoon to you. Tooting Bec Common looked as it did most mornings at 6:45am on Friday, 22nd November 1963. I was on my way to work on a 26 bedded admission ward at Tooting Bec Hospital. I'd been in England less than two months and I was still adjusting, seeking to understand what the job entailed and the purposes of a psychiatric hospital. In my student group there were four West Indians, four Irish, four Indian nuns, three Spaniards, one Argentinian, an ex-priest from Lancashire and Liz Carlson, the only Londoner, who eight years later was stabbed to death on one of the female wards.

As the ward door was unlocked, I entered briskly to prevent a possible key snatch or an escape attempt. The necessary rituals of saying good morning to the charge nurse and donning a white coat completed, the day started. Events of the night were relayed to the charge nurse. Getting the patients up, dressed and washed before breakfast were priorities. Only having three wash basins and three toilets[35] often delayed this process and frequently led to annoyances and confrontations.

The fragile, disabled and poorly coordinated patients often asked for help with shaving, doing up buttons, tying shoelaces. Others requested razors, clean clothes, toothpaste and toothbrushes. Assisting with these tasks, patients would sometimes confide to nurses such things as, "It's my birthday today" or "Today is the tenth anniversary of my leaving the army." I often found myself captivated by observing the good-natured gentleness with which able bodied patients helped those less able. After breakfast came the drug round, bed-making and the preparation for ECT. It took two nurses to give out the medication; one to give the drugs and the other to make sure that they were taken. The day room always seemed crowded with constant movement. Although there were few comfortable places to sit, it was where patients smoked, had their meals, met visitors, listened to the radio, watched television, had cups of tea, sat alone or chatted in groups. No matter how often the ashtrays were emptied they were always full. Patients in dressing-gowns were new admissions, or awaiting ECT, or were regarded as suicide risks or were potential absconders. Nurses prepared the

patients for ECT, set up the trays and trolleys, administered the pre-meds and reassured those patients who were anxious or apprehensive. Having assisted with the giving of the muscle relaxant and the anaesthetic, nurses assisted during the convulsion stage of the procedure in order to prevent injuries. Afterwards they remained with the patients until they were fully conscious.

The ward doctor arrived at around 10.00 am. Test results were scrutinised, which included blood counts, the Wasserman test[36] (which was considered important), IQ tests and personality tests. Referrals were made to OT,[37] medicines reviewed, and further tests requested. Patients did get upset when their discharge date was deferred or their requests for ground or weekend leave were not granted. I saw what I considered some insensitive dealings with patients and I did witness aggressive outbursts from staff and patients, memories that haunt me to this day.

I spent many hours with patients listening to their stories, hearing their disappointments, their mistakes and their joys. I was told that talking with patients was an important part of my job. I once asked a patient how he was to which he replied: "I'm all over the place. My suitcase is at Guildford station, my overcoat is in a Rowton House[38] somewhere, my medicines and money are in my pyjama pockets which are somewhere else, and I lost a new pair of shoes." While some had families and jobs to go to, many were on their own. Hearing about rejection, discrimination and being ignored did cause me distress. But despite their adversities, most patients were courteous, grateful and optimistic.

My student group, who were mostly immigrants, had similar experiences with the patients they cared for. Psychiatric hospitals were, I concluded, places where desperate people relied on the care of strangers. That evening after my run on Tooting Bec Common I heard that President Kennedy had been shot. Later that evening I heard on the news that CS Lewis and Aldous Huxley had died. These were people who during my schooling I had read about. In different ways each of them had influenced me.

The following morning at work I was told that John Twomey, an Irish patient who had been discharged some days before, had been found dead on the Common. The only words I ever heard him say were, "I am now too old to get a job on the buildings, I'm finished". Later that day I was asked to take his case-notes to the medical records office to be filed away. His death profoundly affected me. There was no funeral, but I grieved for him.

Claire Hilton: Thank you both for those very moving and powerful descriptions and experiences. There are already…Tony Isaacs and John Bradley want to speak. If you could manage to get as near as possible to the microphone…

John Bradley: Perhaps my voice will travel.

Claire Hilton: I think your voice might!

John Bradley: Let's try that. I just hope that Malcolm Campbell is going to remain for the grand finale when Dr Boyd and I are performing because it's the sequel of Friern Hospital. Because you will then learn that in 1966, the year after you left, I had gone there from the United States and a year later became the medical director—after the superintendent had resigned.

Malcolm Campbell: I've read!

John Bradley: You have read? Okay!

Malcolm Campbell: With some trepidation, I thought I'd give my presentation…

John Bradley: The smell, the smell, is something that young people here won't know what it is. But paraldehyde, you see—here we are, we're birds of a feather—paraldehyde pervaded the corridors.

Malcolm Campbell: I'd forgotten about that, yes. I used it a lot. I used it a lot for acute seizures. It was a standard treatment for status epilepticus.

John Bradley: Yes, a standard treatment for status epilepticus. Apart from Richard Hunter, who of course was a neurologist manqué essentially, and in fact was rather difficult to have as one of three consultant colleagues….

Malcolm Campbell: I can believe that too.

John Bradley: Anyway, we'll say more about that later.

Tony Isaacs: Just a brief anecdote about Richard Hunter. I was very interested to hear you refer to him a little while ago. He illustrates the sort of fanaticism amongst some psychiatrists in those days. He had a very valuable library and I needed to look at a book that he had and arranged to go to his flat to do that. He wasn't yet home, but his mother was there, Ida Macalpine. She showed me the book. I had to wash my hands, then put on a

pair of gloves, and then touch the book. It was dirty, so I was glad I had the gloves on anyway. Eventually he came home. And I thought it was rather charming: he had a little box, nicely wrapped up, which to me looked like a box of chocolates, perhaps for his mother. I thought, “How quaint.” And she unwrapped it with interest. To my amazement, it didn’t contain chocolates or anything like that. It was a pile of gallstones, which had been removed from someone’s gall bladder. I thought how bizarre. It then transpired that the patient had had extensive psychiatric treatment, mainly psychotherapy for her hysterical abdominal pain. She eventually had to go to a surgeon to have her gall bladder removed and these were the gall stones that resulted from that operation. He brought them home as a present for his mother. He claimed that it illustrated the interesting point of what absolute nonsense psychotherapy was and everything that went with it. So, having heard his name, I’m afraid I couldn’t resist being reminded of that unforgettable moment.

John Bradley: He had an appointment at Queen Square, I might say, as psychotherapist. That was the actual appointment, yes.

Tony Isaacs: Exactly the opposite of what he…

John Bradley: Exactly.

Claire Hilton: Any more questions?

Robert Freudenthal: My question is whether or what sort of support was available from the staff on the acute wards after a death of that type or a suicide, or was there any staff support available?

Malcolm Campbell: The simple answer from my experience and memory is nil. I don’t know of any services.

Peter Nolan: From my point of view—I did become emotional about the death of Twomey and in presenting it to you it evoked strong emotions in me after all these years. Thinking about it today I found myself back on that ward again. There was no emotional support, the term was never mentioned. And I think the way it was coped with was merely to ignore it. And of course, his suicide took place on the Common where I had been running and I may have run past where he died. I didn’t like the way that patients who died and who were well known to staff and patients were rarely referred to, there was no mention of them, no funeral. And as I came from an Irish background where funerals were important rituals of saying “goodbye”, it was the least people deserved. Coming into the world and leaving it, birth and death, were important rituals for me. I didn’t like the way I had to take the case notes down to the records office and hand them over to a filing clerk. That was the end of John Twomey. It hit me very strongly. It was insensitive. I think that the nurses had grown indifferent to loss and death, a theme that emerged from the presentations this morning.

And there was a lot of institutionalised indifference, the way patients would be suffering and yet staff would walk past them in order to open a cupboard, take something out and put it back in again. For some staff, being busy was preferable to being engaged. It makes us sound cold, but that was my experience at the time. But equally there were very compassionate nurses such as the person who was stabbed to death, Liz Carlson. She was one of the most beautiful, compassionate nurses I’ve ever met. And on Sundays she would take the Catholics to Mass, the Protestants to their service, and sometimes there was a Jewish service in the afternoon, and it was touching the way she knew who each person was. She would say, “They are believers. That is part of who they are. This is part of their treatment.” And I said to her on one occasion, “Liz, are you a believer?” “Oh no,” she said, “I’m not. It’s not about me, it’s about them.”

Claire Hilton: Time for one more question. John…

John Hall: I’m going to be speaking later but this comment relates to my first wife when we were both working in Norwich in 1969. My wife was also a clinical psychologist, working at Hellesdon Hospital, and I remember that a patient she was seeing had taken her own life. This was the first time it had ever happened to my wife, and one of the consultants there was really good in giving her support. It’s one of those things that stands out in your mind, when it happens to somebody close to you. She was actually very well supported, and that was an act of real compassion and concern by a very experienced psychiatrist to a very young and green clinical psychologist. It’s one of those events I’ll never forget.

Claire Hilton: I think we should move on to our next speakers. Let’s thank these speakers.

The Maudsley and its relationship with other psychiatric hospitals: Tony Isaacs and Peter Tyrer

Claire Hilton: Next, we're diverting a little, because some people have got time constraints today. We are diverting to the Maudsley Hospital, which only had acute psychiatric wards, and after Tony Isaacs and Peter Tyrer have spoken, we will then move on to discuss the "chronic" or long-stay wards. So, Tony and Peter…

Tony Isaacs: I started as a junior doctor at the Maudsley in 1958. This was just prior to the introduction of the 1959 Mental Health Act, which replaced the previous lunacy law and which encouraged community care as an alternative to that provided by the large psychiatric hospitals. It also allowed for patients to be admitted on a voluntary basis, a status pioneered by Henry Maudsley.[39] Within the hospital one was conscious of two competing policies. One stressed the importance of maintaining the teaching and research for which the hospital was originally founded. The other favoured the development of community care, by the hospital assuming responsibility for patients from the former London Borough of Camberwell. It was during the 1960s that these competing policies gradually became integrated.

My consultant appointment started with sessions at Cane Hill Hospital which was the original catchment area hospital for Camberwell. This was linked with out-patient clinics at the Maudsley and the hospitals of the King's College Hospital Group. Assuming responsibility for several hundred patients at Cane Hill was something of a culture shock compared with the Maudsley where responsibility for perhaps 20 patients was considered rather demanding. It became clear that some of the long-stay patients at Cane Hill were there inappropriately. For example, one middle age female patient spent every weekend at home and seemed perfectly normal. When asked why she felt she should remain in hospital she simply said she was waiting to be discharged—and that duly happened. A former headwaiter of a West End hotel provided marvellous service as the headwaiter of the doctors' dining room which perhaps accounted for the apparent reluctance to discharge him.

Gradually the back-up facilities at Cane Hill ran down as the Maudsley built up its local community service. I was part of a team there with some very well-known colleagues such as Dr Jim Birley, a former president of this College, as well as Dr Douglas Bennett, a pioneer of industrial therapy originally from Netherne Hospital. Dr Joseph Connolly, together with myself, completed the team of consultants. Our work was monitored by the MRC[40] Social Psychiatry Unit headed by Professor John Wing. In those days it was difficult to read anything in the psychiatry journals that didn't have the names of Wing and Birley because they were evaluating and monitoring the community care that we provided. We developed a purpose-built district community services centre which provided day care and occupational therapy for Camberwell. A house on the Maudsley site became an in-patient unit for long-stay patients.

A fully integrated local psychiatric service took some 10 years to complete like a jigsaw puzzle which slowly came together. It was quite a revolution for the hospital which had traditionally, because of Henry Maudsley's principles, focussed on early treatment of voluntary patients, especially those of particular interest for research and teaching. This traditional role, however, also continued, strengthened by the close association between the hospital and the Institute of Psychiatry, which has now become the Institute of Psychiatry, Psychology and Neuroscience.

So, in a nutshell that's the late 1950s and early 1960s and I think it covers the period which is the focus of the present seminar.

Claire Hilton: Super. Thank you, Tony. Peter…

Peter Tyrer: Thank you. I had rather different experiences in the 1960s because I came to the Maudsley slightly late, because I had applied, and I was turned down. And so, I decided that the only way to do well was to get an MRCP.[41] I got the MRCP and applied again, and got in, but I'm sure the MRCP had nothing to do with it, because what I've got to describe has nothing to do with anything concerned with genuine psychiatry. I could never forget the Maudsley because even if I never worked there, I could never have forgotten the interview that I had with Gerald Russell[42] in April 1969, which is etched deeply into my brain.

In advance of this I was very nervous because I had worked for Dr William Sargant who has been mentioned already, and I realised that Dr William Sargant was rather like Marmite and some people

thought he was great and some people thought he was the most terrible psychiatrist on the planet. I had worked for him as a house physician, the only house physician in Psychological Medicine I think in the country, where I had only one-half day off a week and one weekend off in two. But that wasn't all that difficult to embrace because in the Royal Waterloo Hospital, which is at the end of Waterloo Bridge and is now I think a university, they didn't have an awful lot of time for the psychiatrists to see the patients because most of the time they were in continuous narcosis. Twenty hours out of 24 they were under narcosis with a mixture of anti-psychotics and sedatives, and when they got up briefly, they were given ECT and sent back to bed again. So there wasn't much time for any form of psychotherapy or assessment. I remember the longest time for assessment I had was when seeing the son of a Viscountess, who was a very exact historian (it was her profession).

I was very nervous about this interview with Gerald Russell, and, when I went into the interview, I was trying to rehearse what I could say about William Sargant which would not cause upset. And when I went in, there was this austere and distinguished man with his odd Belgian accent, Gerald Russell, "Would you like to tell us please something about your most interesting experience in psychiatry?" And I felt, "Oh, I've got a way out of this" because just before I went to the Maudsley I'd led an expedition to Central Africa to collect remedies, herbal remedies, from witch doctors, or ngangas, as they were called (Fig 8). And the whole of the interview, and that's literally the whole of the interview, was entirely based on my experiences of being with ngangas and working out what they did. I was sure others would be quite interested, because we sent all these remedies back and the senior pharmacologist came back to us from Cambridge University and said: "Whatever happens, don't let these people give these substances without denaturing them first—they're all incredibly toxic!"

So the whole of this interview with Gerald Russell was carried out about my experiences as an honorary member of the Central African Witch Doctor Association (an honour given to us for our research efforts). I concluded that, after I had been accepted on the basis obviously of my great experience, that the Maudsley must be keen on lateral thinking. And so when I arrived for my first post, which was at the Bethlem in Witley House, which I was absolutely amazed to find, as people will know, is in the middle of the country, miles away from anywhere, with marvellous vegetation around, I thought this was the right environment to start looking for herbal remedies.

And my second patient was the schizophrenic nephew of a very well-known person. He was very interested about my witchdoctor experience. In fact, he felt he'd been bewitched and wanted me to help him with various forms of treatment to deal with his witchdoctor problems. So, I guessed, it's obvious Gerald Russell knows all about this, so he's given me this ward with patients who are interested in witchdoctors. He must be a clairvoyant as well as a great psychiatrist. So that was my very odd early experience and after that I came under the influence of Anthony Clare[43] and realised what psychiatry was all about. Thank you.

Claire Hilton: I think that's a very good point to lead into the subject of the Maudsley's interactions with psychiatry elsewhere, and that's really what we want to do, how the Maudsley related outside the institution rather than within.

Harry Zeitlin: Anthony Clare I knew well. I could give you lots of stories, but I won't. I'm afraid there's one name I left out, but it's not to do with any interaction outside. On my first day at the Maudsley I went to the Institute, to the café, and I sat down with a group of people and we were chatting. I had got on reasonably well in general medicine and I was spouting about all that I knew, and we came to the end of our meal and the grey-haired gentleman opposite me said, "That's what I like to hear, back to first principles." Then he got up and walked out and the other people said, "Now you've met Aubrey Lewis."[44] And I think he's a name that we should not leave out.

Claire Hilton: Any other…?

John Bradley: Just one point. I'll shout. Robert Graves[45] actually helped write William Sargant's book *The Battle for the Mind.*[46]

Peter Tyrer: I know he did! I know he did! William couldn't put two words together coherently. He was completely hopeless!

John Bradley: Don't get me on William Sargant! As you know I spent five years trying—

Peter Tyrer: I know you did! I know you did. I met you.

John Bradley: You met me there?

Peter Tyrer: Yes. And you met David Owen[47] as well.

John Bradley: David Owen, at that time, was working as a registrar shared between neurology and psychiatry.

Louise Hide: I was hoping that you could explain the kind of ethical processes that you went through, if any, in terms of the different types of treatment and what kind of ethical requirements there were at that particular period?

Peter Tyrer: Well, of course you have immediately picked up something there. There were absolutely none and it was quite amazing. I remember the first patient I ever saw, my very first patient I was asked to put under insulin coma therapy. Now insulin coma had already been shown to be ineffective in two trials,[48] but Sargant was still practising it.

I said: "Look, has he got clinical consent for this? Is this something that's been fully appreciated?"

Sargant replied "Oh no, go ahead! All these pen pushers at the Department of Health, ignore them, go straight ahead. I'll take all responsibility."

And that's really how the whole arrangement at the Royal Waterloo Hospital worked, and it wasn't just Sargant involved. John Pollitt,[49] who was really quite a careful and cautious psychiatrist, was taken in by this enthusiasm for physical treatments. No one said anything about ethics. I first got my interest in randomised controlled trials by working for William Sargant and I've always said that actually I learnt more from him by what he did to excess than from others who taught me more correctly. But you're absolutely right about your concern, and I know that people like Celia Imrie[50] have written about how terribly lax decisions were made then. As I say, he was like Marmite, but every so often he hit the target. He didn't give up with patients, admittedly, sometimes wrongly. One of the patients I saw for over 30 years afterwards (she has appeared in the *British Journal of Psychiatry*) had four leucotomies and she worshipped him, insisting that "The final one did it. The final one did it!" But occasionally he did hit the jackpot, insisting to others, "Well why didn't you continue with this, if you thought it was going to work?"

But of course, you're absolutely right, it really concerned me. I've just been reading various criticisms about Sargant and I have wondered, was I complicit in this in my very first psychiatric post after just completing my first two house-jobs? I kept on asking questions throughout my time there. The patient that got the insulin coma did get remarkably better (in the short term at least) and his parents were so pleased they gave a cheque to William Sargant, who gave it to me and said: "Go and buy a couple of books". The first one I bought was *Principles of Medical Statistics* by Austin Bradford Hill.[51] The post made me realise that doing things without any proper evidence was shocking. And the other thing to emphasise was that the reason why people did relatively well in these narcosis wards in the Royal Waterloo Hospital was that they were looked after by true Nightingales, as they were called. These were Nightingales from St Thomas' Hospital, incredibly well-trained nurses who kept people alive. When other psychiatrists tried similar narcosis treatments, they had many deaths from paralytic ileus[52] and things like that. You can't keep people asleep for twenty hours out of twenty-four and expect them to remain healthy. But because Sargant had these marvellous nurses, they all survived.

Louise Hide: So, what I was asking was, were there any institutional guidelines?

Peter Tyrer: No, there was no institute, never mind a guideline. There was no institute. It was a completely isolated unit on its own and it operated under its own rules, and you couldn't challenge them. It was a unit run by someone like Donald Trump, you know. Any time you challenged William Sargant you got shouted down, not quite so abusively as Donald Trump, but not far off.

Tony Isaacs: But just on the point of ethical controls, there was an ethics committee[53] and research projects had to be submitted and heavily scrutinised, to try to make sure that the risks were minimal.[54] But despite that, it wasn't always possible to predict what might happen, with the best will in the world. And I can think of two cases, situations, which illustrate that. One was in the early stage of lysergic acid, LSD, treatment, an hallucinogenic drug. It was thought to have potential therapeutic properties. But unfortunately, there were occasions where the patient received it, having given consent, informed consent, and did

not recover, and it became uncertain whether the patient really was suffering from a psychotic illness or was it, you know, a prolonged side effect of that particular medication.

But another slightly more, I won't say amusing, but unusual example is in some research concerning hypnosis. Actually, I volunteered as a subject as well thinking it was absolute nonsense, that someone was going to hypnotise me. Well, I was in a deep trance in about three seconds. It was quite amazing going under it successfully. But, one of the patients in the actual project was hypnotised and it was suggested that she was deaf, and given that suggestion under hypnosis, it actually happened, the patient became deaf. But they hadn't formed some way of waking her up. So, they then tried to wake her up, but she was deaf, and again it was a much more prolonged change which hadn't been anticipated. Those are just two examples. But there was an attempt to ensure that, before any sort of a research project with any potential risk, it was carefully spelt out to the patient and the appropriate forms were signed and informed consent obtained. So, on the whole I think it was under fairly strict control, if that's what you had in mind?

Harry Zeitlin: I'd like to make a little disagreement: there was a battle going on in the '60s. I used to listen every week to Heinz Wolff[55] and Hans Eysenck arguing as to which form of therapy was appropriate: psychoanalytic or behavioural therapy. And that was going on week after week after week.

Dora Black: I was at the Maudsley and Bethlem Royal from '57 to '60. And when I was at the Bethlem Royal, at the adolescent unit under Wilfred Warren, a group of us were asked to take LSD as an experiment. I just wondered if either of you knew anything about that?

Claire Hilton: What was it like?

Dora Black: I didn't do it! I was much too frightened to do it but there was quite a group of us; they were all registrars who took it, and there were some interesting experiences, I think.

Peter Tyrer: This was not unusual at the time.[56] I used to work with Ronald Sandison[57] in Southampton, where I was a senior lecturer after leaving the Maudsley. Ronnie was a psychotherapist there. He had run a unit at Powick Hospital[58] (Fig 9) in Worcestershire (which was rather like the old Friern Hospital) and he offered all of them LSD. And he still maintained, even to his dying day—he came from Shetland so was a bit outside the normal things, old Ronnie was—he still maintained that this was a highly valuable treatment. And my current colleague, David Nutt, at Imperial College is doing exactly the same things now with magic mushrooms that Ronnie was doing way back in the 1950s, except with a good dollop of science thrown in.[59]

Peter Campbell: I'm interested to hear a lot of mention about William Sargant. And of course, by the '70s, William Sargant was a *bête noire* to a lot of service user activists. I wonder what your feeling would be about the importance or otherwise of William Sargant in the '60s?

Peter Tyrer: Well, I think he was an interesting figure because he was influential.[60] When I was a medical student at Cambridge, my mother, who was a psychologist, said, "You've got to go to St Thomas' Hospital for your training because they've got this great psychiatrist there who is taking people out of the snake pits[61] and showing that now we've got treatments for them." And I think that was his positive role, but he was not a particularly nice person in the flesh. He attracted attention but also sought it unmercifully, rather like Donald Trump, and so much of what he did was self-promotion. At his 80th birthday David Goldberg made a speech in which he mentioned a puzzled Aubrey Lewis asking, "How does he do it? How does he get all these medical students to go into psychiatry?" William had charisma. Aubrey had none; he invoked respectful terror.

William also would not have survived long in the #MeToo movement of today. He had more than wandering hands. There was a famous photograph circulating, taken at a Christmas party at St Thomas', when someone had put a mirror in the middle of the group photo. So when you actually saw the photograph all were smiling at the camera but in the middle you just saw Sargant completely

Fig 8: Peter Tyrer returning to base with witchdoctor remedies (in briefcase) in preparation for interview at the Maudsley. Credit: Peter Tyrer

Fig 9: Powick Hospital: former medical superintendent’s house, and the central administrative block from the footpath (2019). Credit: Claire Hilton

enveloping a young Nightingale nurse at the back of the room. He doubtless would have called it "locker room talk" but it was much more than that.

Peter Tyrer: Well, he always used to say, "You won't find the answers to psychiatric problems in an MRC statistician's office, you're going to find it at the bedside." And I said to several of my patients who had been through this, "Yes, he certainly found it at your bedside!"

Harry Zeitlin: I think we're bypassing what was happening therapeutically. Malcolm Sargent, who I remember well—No, William Sargant (I like music)[62]—Yes, William Sargant was there, he was a rigid figure, and he represented a much more static form (of management and treatment). What was coming in was the idea of behavioural therapies, of more dynamic behavioural therapies, and in the combination of how you use different techniques. That was really developing during the '60s and that's why I quoted Eysenck because he had a huge, I don't know what other people feel, but Eysenck had a huge influence.[63]

Peter Tyrer: But Eysenck never treated a patient. Let's remember that.

Harry Zeitlin: But he treated us. I listened to him lecturing every week, all the time. But this argument was developing, and the ideas were developing and moving away from the image that Sargant gave of "that's what you do, that's how you do it and that's that." And I do think it would be a pity to miss out this very important development of much more dynamic therapies, much more focused therapies. But if I'm wrong, please do say.

Deepa Parry-Gupta: I'm probably slightly breaking the rules but I'm thinking about the fact that a lot of things that happened in the '60s and '70s have shadows, positive and negative, that affect us today. My dad trained in child psychology in the '70s, early '70s, and in a very behavioural time and he taught me that depression didn't exist and family therapy was a load of rubbish, and it's only been fairly recently in my training that I've accepted that family therapy has been astonishingly valuable. But that's a sort of heritage from probably the late '60s and early '70s. So those things do still affect us.

Peter Tyrer: I think you're right. And one of the things which of course—and it stills applies to some extent to psychoanalysis, is that in the '60s when someone very important made a statement or made an observation about a clinical problem, that was evidence. That was regarded as evidence. And that was the thing that has obviously changed out of all proportion now. I suppose it was the only evidence we had to go on. So, when people like Sargant and Eysenck and everybody else made these statements, and here I would say Eysenck was going on better evidence, they were our figures of authority and we agreed with their judgments. And when you were saying about the pros of all these other therapies at the time we were talking about, I think that was, that was independent of Sargant. It made Sargant more aggressively pro-physical treatments—he even converted our child psychiatrists to primary drug treatment strategies—because he was so forceful. But I always found this rather bizarre because of course the person he always promoted was Ivan Pavlov, a behaviourist. Allegedly, I'm sure this was apocryphal and may have been a Trumpian lie, but he maintained he was called out to someone who was about to commit suicide from St Thomas' Hospital by jumping from a high building, and he shouted at them, "Jump!" because he thought this practical illustration of paradoxical inhibition would prevent him from doing so. Of course, he didn't jump. A good story, but one I find hard to believe.

Claire Hilton: On that note, I think we'd better draw this session to a close and move onto our third session before tea. But first to thank Peter and Tony.

<u>The "Back" wards: Jennifer Lowe and John Jenkins</u>

Claire Hilton: Jennifer Lowe was an occupational therapist … late 1950s…?

Jennifer Lowe: I left school in July 1957 and started my training at Dorset House School of Occupational Therapy in Oxford the September following. My first impressions, as a student, of a mental hospital were during the very beginning of my training when we were shown the OT departments in both physical illness and mental hospitals. We visited Littlemore Hospital. I was horrified: locked doors, very disturbed patients and padded cells and patients who seemed totally unresponsive to anything.

During the three years of my training, psychiatric treatment changed a lot and by the time I got my job at Littlemore, the introduction of new drugs had

changed the face of psychiatric wards completely. No more locked doors, padded cells were made into private rooms. The main drug was called a "miracle drug", "Largactil".

I really wanted to work with the younger short-term patients where I felt that I could have been of more use in rehabilitation. However, I was given a position, along with a colleague, with the female long-term patients.

I found it hard to feel that there was any good that I could do when I started on that ward, so I read all the patients case notes to find out a little bit more about how I could be of use. In so many ways it was a very sad place to work. Some of the patients had been in hospital from teenage years and they were now middle aged. One poor lady who had been so violent she had been locked in a cell most of her time had not been able to be allowed to wear a bra and had very heavy breasts. They ended up hanging down to her knees and she had to have them amputated. Two of the patients had Down's syndrome and had been put in homes as small girls. When too old they were transferred to Littlemore. Their families didn't want anything to do with them; out of sight, out of mind. Nobody ever visited any of these patients. The two Down's syndrome women had never been taught anything, not even how to hold a pencil or what it was for. Their OT was to give them coloured pencils and paper and show them what they could do with them. They were very excited by this and spent hours together scribbling away. They even began to learn their colours. How much could they have learnt if they had been given a chance as little girls? They were so affectionate and sweet and always wanted to do things to help.

There were one or two other patients who stood out: one little old lady called Lizzie had her own unique occupation. She was dressed in the morning by the nurses and the moment they had done, she started to take everything off again. This was repeated all day; either one of the nurses or one of us would put all the clothes on again. It would be fully clothed to birthday suit and back all day long. Dear little Lizzie. Another was Margie, who loved knitting. She only knew plain knit stitch but would knit reams and reams of what she called scarves. When they got to about six-foot-long, we would suggest that she would start a new one and say that we would give the finished one to the farm workers. In fact, we unravelled them, wound them into new balls and she never ran out of wool. She felt she was being very useful. The other patients were given craft work and simple embroidery and weaving table mats. They were mainly so heavily sedated that we had to do most of it for them whilst trying to get them to do a little for themselves. Some of them couldn't do anything.

These were our morning activities. The afternoons were devoted to bingo. This, as an activity for heavily sedated patients, was very badly decided upon. For us to have to organise such an activity had certainly not been thought out. Patients sat around tables with their bingo cards in front of them and one of us shouted out the numbers. We would then run around the tables moving the numbers for them and when a card was full, we would pick up a hand and shout, "Come on Jan! Come on Alice!" or whoever it was, "Shout Bingo! You've won!" It was impossible and exhausting. The two Down's syndrome girls loved it and would keep shouting, "Bingo! Bingo!" and having to be told, "Not yet dear." But we always gave them a prize at the end. However, the worst was Friday afternoon, when we were joined by the male long-term patients for a tea dance. This was most definitely not for Lizzie. Can you imagine? The one urge Largactil did not suppress or inhibit in the men was their sexual one. Even the ladies who were not capable of anything were groped and as far as the nurses and OTs were concerned, we were fair game. Thank goodness for the male nurses. I don't know what we would have done without them.

Finally, I'd been married for just over a year and I discovered I was pregnant. Oh dear. I was advised by friends not to say anything until it became obvious. When I was found out, the powers-that-be said that it was not their policy to employ pregnant women, so pretty bluntly they gave me the sack.

I thought about the whole situation of OTs employed at Littlemore Hospital after I'd left and came to the conclusion that we were just a cosmetic addition, but that was 1962.

John Jenkins: Good afternoon. I started as a nurse in 1964, having left the Midland Bank, which I detested, and then walked into another career, though at the beginning I didn't enjoy it.

Anyway, I had an interview which consisted of some general questions, but the more intense questions were about my sporting activity and my musical prowess, which was nil. But I used to play rugby for

Bridgend Athletic and Cricket and so I got the job, and that was it; didn't ask anything else about my ambition or about my inclination to help the people at all. It was just about sport and musical things.

So, this was the Parc Gwyllt Hospital in Bridgend, that's the Welsh, and in English it means Wild Park, and it couldn't have been any more apt when I started there in 1964. The Parc Hospital was opened in 1886 and closed in 1996, and then it became a prison. Not much had changed, from my memory of the Parc Hospital as a prison.

I entered the hospital at 6:45 in the morning and reported to the Chief Male Nurse's office, which was at the beginning of a very dark, long corridor. Many nurses were signing in to work and allocated to various wards and duties. I was last. And after some interrogation by a senior male nurse I was given a very large key and taken by this nurse to ward eight. He only spoke a few words, but I remember, I will never forget, that he said, "The key is the most important thing here and what it represents is your power over the lunatics." His very words. He told me to use the key to open the ward and I fumbled with it nervously and the heavy door opened. He pointed to the charge nurse office and left. I saw the charge nurse eating his breakfast and smoking a pipe. He seemed like a king with all the other nurses surrounding him.

Some staff cooked their breakfasts and they had it before the patients. He told me to go to the dining room and wait. I had no idea what to expect and then, with six other members of staff, they opened the dormitory door and 120 naked patients ran out. Some fumbled and some fell over. They came staggering out to search for their clothes, which were on dining tables in piles, in bundles with their names on wooden spatulas. Some were missing, so there were fights to struggle to get dressed. There were side rooms where the so-called "dangerous patients" were still naked and locked. They never came out day or night. We were sent to the kitchen to peel the boiled eggs; I can remember the smell of that. The breakfast was on a food trolley where the patients filed in order and of course it wasn't in a very orderly fashion because some of them wanted food more than others and there were fights that broke out. After breakfast the patients either sat down or wandered aimlessly around. Some patients were loyal workers and began cleaning duties, including large floor buffers that polished the wooden floors; very heavy, and sometimes these were thrown at objects and people.

I was put under the supervision of a staff nurse on shaving duty. This was difficult as the blade became blunt after ten patients, and only then it was changed. Nothing happened in terms of activities and therapies, just watching the patients aimlessly wandering around. The charge nurse routine, I remember this quite vividly, his highlight was at about 10:30 each morning, going to the toilet with his pipe and newspaper and staying there for about an hour. And this routine continued every day, at the same time. He didn't do much else. We needed permission to go ourselves to the toilet. And the only medication that was given, and we've heard this before, was paraldehyde orally or by injection. It was a terrible drug. The patients always wanted more. They were addicted. The smell was terrible and I can remember that when some people had it by injection, how it burnt the tissue and it was so painful and people were screaming.

Sometimes some trusted patients were taken out into the airing court. This was the only time that most of them went out of the ward. Lunch routine was similar to breakfast. The afternoon was similar, with nothing much happening. When a patient became agitated or shouted or hit someone, they were always beaten, sedated, and put in a side room for several days. Some patients had visitors, albeit very few. They waited in the hospital theatre and their relative was called for under escort. The charge nurse went to the charge nurse store and took out a brand-new suit or sports jacket and trousers and new shirt, and they were dressed into this for their visitor. When they returned to the ward they changed back into their dirty and ill-fitting clothes.

Once a week the patients were bathed. This was particularly degrading as they queued naked for their turn. The water was only changed after eight patients use. I complained about the beatings and the situation and was told that this control—we had to control them—and for them to learn the lessons. I stuck this for several weeks and then I asked for a transfer. Fortunately, my father was the hospital secretary of the general hospital, so this was made easier, so I was transferred to Glanrhyd Hospital where the situation was better. And some of the things we've heard about in terms of the therapy

activities that went on in the '60s happened in Glanrhyd but never happened in the Parc Hospital. Glanrhyd was the first mental hospital built in Glamorgan,[64] followed by the Parc, and it was built for what were called the "incurable patients". And that was true because they never left there. And at its peak there were one thousand five hundred patients there.

Two years later, in the same month after starting at the Parc, there was the Aberfan disaster,[65] and the hospital authorities asked for young and able men to volunteer to go there to help. When I got there the help was all to do with moving the coal from the school. And actually, there was no chance to help anybody to recover. Some people did survive but very few. That memory is probably fixed more in my mind than the memory of working in the psychiatric hospitals.

I vowed to change institutions ever since and when I've been given the opportunity in my career, several times in the UK and other countries, I have closed institutions and developed community mental health services, and that memory is the one that spurred me on, as well as learning from inspirational people and we've heard about some of them today. And most of them have been psychiatrists in my career: Douglas Bennett, Maudsley Hospital, London; Len Stein, Madison, USA; Paul Polak, Colorado, USA; Alan Rosen, Australia; and so forth. And that gave me the inspiration to change mental health services and it's been my career ever since.

Ian Stout: As a consultant at Prestwich Hospital,[66] I was immediately given five hundred long stay beds largely because the general psychiatrists never went near the patients. I had a wonderful Scottish colleague, Dr Morag Mckay, who ran our rehab, so she took the other five hundred beds. At least we kept the general psychiatrists happy. But it was very interesting hearing about grief and support of staff because at Prestwich we had this amazing Church of England priest, he was the hospital chaplain, a chap called Neil Barnes. And he was really quite an exceptional individual. He provided an enormous amount of support to all staff. Indeed, he established a practice of ensuring that staff, some of whom, especially untrained staff, had cared for a patient for twenty to thirty years, went with the nursing staff to the funerals, always. And Neil arranged for support for the nursing staff who were grieving, and also often arranged to do follow up work in the community e.g. home visits to relatives, or training chaplains of various denominations to carry out grief work with the extended family.

In many ways, he was the moral core of the whole hospital and he was very important to me because, being a fresh young consultant, in 1982, I wanted to change terminal care policy, and he came around with me and we visited every single long stay ward and discussed with the staff how they felt about my proposals for terminal care. I think without his support, and the trust that everybody had in him, it would have been much, much more difficult for me to make any changes.

Claire Hilton: Thank you very much. Peter?

Peter Tyrer: This may have been after your time, Jenny, but did you have any dealings with the Phoenix Ward[67] at Littlemore Hospital that was organised as a therapeutic unit?

Jennifer Lowe: That was after I'd left.

Peter Tyrer: Oh, well this was a rather chaotic place, because it was meant to be a therapeutic community or milieu therapy or something odd like that. But I saw it when I went to have my Oxford training, and I must say that it was complete and utter chaos. No discipline, complete anarchy everywhere, everyone could say what they liked, no formal treatment. It may have been an improvement on what it was like when you were there because what you've told us was terrible, but it certainly wasn't a big improvement.

Jennifer Lowe: It was crazy; rushing around the ward putting numbers on, "Come on, shout bingo!" Who thought up such a stupid occupation for completely drugged to the eyeballs people?

Tom Stephenson: This question is for John. I just wondered to what extent there was a distinct culture in Wales?

John Jenkins: That's a dangerous question! I don't know. That was my reflection. I mean, I worked in psychiatric hospitals in England and there was a difference but of course it was a different period, more in the '70s and '80s. In fact, in Exeter I closed one of the big psychiatric hospitals where there were a lot of good things happening but we believed, and it came about, that most people benefitted more from community mental health care than the hospital although there were some good

things there, which I didn't see in the Parc Hospital at all, nothing good at all.

Tom Burns: Just to quickly pick up on that point you made: one of the things that strikes me listening to these presentations is that we talk about the era as if it was in some way homogenous. Your description, what you saw in Wales, was at the same time that I started psychiatry in Scotland and it hadn't had a locked door for twenty years. It had outreach, it had all sorts of things. We've heard about this enormous variation and I hope it's one of the things that the History of Psychiatry Special Interest Group will be able to look at—how did such incredibly different standards of care coexist in quite a small island without, you know, more sort of, proselytization and shifting? And it is remarkable because what you describe sounds to me like three hundred years ago compared to what I experienced at about the same time. But the reality is that both were going on.

John Jenkins: I think it was a lot to do with vision and leadership.

Tom Burns: Yes, but why did that leadership not spread?

John Jenkins: The same as today. You know, good practice doesn't spread. People are resistant to change.

Claire Hilton: I find John's comments credible. They were very much what Barbara Robb revealed in her work *Sans Everything* and her campaign in the '60s.[68] So, for anybody who is terribly shocked, I think there is plenty of evidence to back it up…. I've spoken enough as chair. Ian had his hand up first.

Ian Stout: It was very good to see my old boss, David Goldberg, here. He used to terrify us…

Claire Hilton: Yes, me too.

Ian Stout: …on a regular, weekly basis. What he didn't say was that the reason the North West developed DGHs before anyone else is because we had a very psychiatry friendly regional medical officer. That's an animal that's now disappeared. The regional medical officer made a big impression on the region and with his support we obtained the funding, in the 1960s,[69] and the necessary revenue to set up the community services supporting the embryo DGHs all around the North West long before everybody else did. I think purchasing was very much on a sort of almost an American state by state basis, the way that all the various states have different laws for apparently the same things. It was very much a picture of purchasing before purchasing became more centralised, not necessarily for the general good. But none the less I think that's what happened.[70]

Claire Hilton: Thank you.

Dora Black: I just thought you might be interested that in 1993, I went on a lecture tour of China and the University of Beijing and the mental hospital associated with it. I walked into it and it took me back to the 1950s at Napsbury. There was no difference. The patients were in pyjamas, they stayed in pyjamas, there was no activity of any kind for them and they were being treated with alternative medicines, which were pretty useless, I think. 1993. China.

John Jenkins: There are worse places in the world today, in India and Africa, and some other, and Eastern European countries as well. Well, actually their conditions are worse than I remember in the '60s, with people chained to beds and chained to objects on the floor. And in one hospital I've been to recently in Nagpur, India, there's no sanitation whatsoever, no sanitation system at all.

Harry Zeitlin: To my understanding, from my own experience, there is a range of reasons why people change or not, but there are two big things: dealing with people who have disordered thinking is frightening. Therefore, what a lot of people did was to say, "This is our regimen, this is the way we do it." I went to Claybury Hospital as a student to have a look in 1957 and there were padded cells and strait jackets.[71] So, one way of thinking was, "We've got to fix it like that, this is what we must do," and it was frightening if you moved outside. The other was, when I went to the Maudsley, in 1967, they were only taking people who had done something else first. There was a deliberate policy of getting people into psychiatry who could think outside the box. So, there were these two really big contrasting pressures, and I think it had a lot to do with the differences all around the country. Change is expensive, and those who had more money could get people in who had had other careers, who would do other things. It was, I think, fairly clearly going on: this huge contrast between these two flows.

Rob Freudenthal: I was just wondering if you could comment or say something about the influence that

RD Laing and the anti-psychiatry movement had in this period on institutional change, if any.

John Jenkins: I know what influence he had on some of the families in America because I knew Lauren Mosher[72] very well, who was a friend of RD Laing. Lauren Mosher recalled the story that once, when RD Laing was staying in his house, he [Mosher] and his wife went on holiday and came back and drove up to the house. There was RD Laing sitting naked on the doorstep, so he drove off, and went around the block a few times, and his wife said, "That's where we live. Why don't we stop and go in?" And RD Laing didn't move when they went up there, and paraded himself naked up and down the street. So that's the effect he had there.

Harry Zeitlin: He drank alcohol, didn't he?

John Jenkins: Yeah, you could say that. You could say that a lot.

John Bradley: One brief anecdote about that: I went to a lecture of RD Laing at the Royal Free and the thing that was noticeable about it was he had a bottle of whisky on the table in front of him and consumed virtually the whole lot during the lecture. I can't remember what the lecture was about.

Tom Burns: His accent was very strong so it could be difficult sometimes to understand what he was saying. So, people would often say, "I went to a lecture by RD Laing" so they could say they went to a lecture by RD Laing, not necessarily because they could follow what he was saying. I think one positive impact was that Laing increased recruitment into psychiatry. In my year at Cambridge all of us read Laing and all of us wanted to be psychiatrists. So even though psychiatrists didn't like him, the rest of us did. And I think he brought lots of people into psychiatry. And when he was sober, and I have heard him sober, he was brilliant, early on. Okay, he went downhill, but he said some very important things we could still pick up today, and he did increase recruitment into psychiatry, not decrease it. He said some pretty good things, and some pretty rubbish things.

Ally Xiang: I was very saddened to hear about Ms Lowe's experience having gotten pregnant and then having lost her job and it made me think … hopefully later on we'll hear about the women doctors' perspective. But I wonder about other women professionals at that time and how it sounds as if compassionate, caring care was, sort of, you know hijacked, or they were sacked as a result of their gender. What was the impact of that on the patients and on the women professionals at the time?

Jennifer Lowe: I think it still happens in various countries. I know that my elder daughter, who lives in Italy, says that it still happens to women in Italy, that they get removed from their occupation for daring to become pregnant.

Claire Hilton: And on that note, we've moved into the present time. Let's stay in the present time and have cake, fruit, coffee and tea, and we'll start again in twenty minutes. Thank you very much.

Claire Hilton: Ladies and gentlemen, we're running a bit late. Can you be seated, please. You'll see from your programme that we built in a little spare time in case we were running late, and my closing remarks will only take about one minute. So just before we go on, if anybody is leaving early, we have loads of fruit and cake left, please take it for your journeys home, or for your tea this evening. Don't leave it all here. There are napkins, you can make doggy bags…..

To move onto our final part of the afternoon, we've got John Hall and Dora Black, who are going to talk on two very different aspects of new roles and treatments within the psychiatric hospitals.

New roles and treatments: Dora Black and John Hall

Dora Black: Well, good afternoon. I think I'm on the only child psychiatrist speaking here today and I'm one of the few women psychiatrists speaking here today.

So, I qualified in Birmingham in 1955 and when Claire asked me to speak about Napsbury in the '60s, I said, "I can't help you." And she said, "Why?" and I said, "Well, I was at Napsbury in the '50s." Nobody else I think was working in a mental hospital in the '50s, or there may be one or two.

In medical school at Birmingham, psychiatry was a sort of parade of "funny patients" that were brought for us to laugh at, I suppose, or to wonder at, you know. So, we saw a schizophrenic with hallucinations and a lobotomized patient. And so, after my house jobs, for various reasons which I won't tell you about, I got a house job, a senior

house officer job, at Napsbury, in, I think it was, 1956-57.

If you remember, or you may not remember, there was a County Asylums Act in 1808, which began to create a ring of mental hospital or asylums all the way around London. There were about fourteen of them, I think, there may have been more. They were asylums. And I think it's important, everybody's been talking about how horrible they were, but they were asylums, they were there to give people asylum. We talk about it a lot nowadays but that's what they were there for. Napsbury opened in 1905 and it was really rather classy. I mean the architecture, there were villas all over this very big estate and the former medical superintendent's house housed the people who were on duty. And we had two servants to look after us and they cooked very nice food for us and there was a croquet lawn and billiards, and you know, we were looked after very well. And I look back on those days and most of them became my friends, most of the SHOs and the registrars that we messed with, and they're all dead, so I'm the sole living survivor of the 1950s Napsbury era. I was GP to five hundred chronic patients. I mean, I'd only done a year's house jobs; I was a complete novice. I'd done no psychiatry in my undergraduate days and yet here I was looking after five hundred chronic patients in I can't remember how many wards.

And I was responsible to the senior registrar who was mainly working on the acute ward, because the acute ward was treating the newly admitted patients and they were doing interesting things like insulin coma therapy; amazing really. I looked insulin coma therapy up in the Gelder book of psychiatry,[73] I think the version I've got is 2009, there's not even a mention of insulin coma therapy, not a mention. You look it up and there's nothing there. We were giving, insulin coma therapy and, of course, ECT. And we were giving it, I think, with an anaesthetic at that time as far as I remember. But none of my patients had ECT because I had chronic patients and they'd been there for years and years and years.

But in 1957, early '57, my senior registrar came round and she put everybody on reserpine, which was being used for the treatment of psychiatric disorders.[74] And before that it was phenobarbitone or something like that. And of course we had our padded cells, and we had straitjackets and I've been through all that with patients, but it was like Oliver Sacks talked about with levodopa;[75] they all, well not all, but many of them, just started walking and talking and being human again after having been doped for twenty years. It was really an amazing experience, especially for a young person who hadn't got any clue about psychiatry. The consultants came around every five years to recertify the patients. I mean, other than that they had absolutely nothing to do with the patients in the chronic wards; I think they were doing things in the acute wards but nothing in the chronic wards.

Well you know insulin coma therapy was introduced in 1927[76] and really, by the '50s, it wasn't any good. There's an interesting description I came across, in *The Bell Jar*, do you remember the novel by Sylvia Plath? She was treated with insulin coma therapy[77] in America in her early days and she said all it did was made her fat, and I suspect that's what happened to most of the patients because they were being given an enormous number of calories to compensate for the insulin.

I want to tell you about just a few patients, if I've got time? The one that perhaps I remember the most, because it's been on my conscience for the whole of my career, was a seventeen-year-old epileptic girl. I don't know why she was in hospital; I think it was mainly her epilepsy as far as I know. And she asked for permission to be allowed to go out into the grounds and she'd been very stable and I didn't see any reason why I shouldn't give her permission and I did. But there was a railway that ran on the north border of Napsbury Hospital. It was a siding that brought goods into Napsbury, you know food and whatever, for the patients. And she was found dead on that railway track. She was seventeen years old. And nobody was sure whether she'd deliberately gone and killed herself or whether she'd had an epileptic fit perhaps when she was near the railway. And it was never really sorted out. I never really knew what happened. And I always wondered if I should have given her permission to go out. And you know I've remembered it for how many years? Seventy years, something like that, sixty years.

But there were some really successful results in the reserpine-neuroleptic revolution and one of them was Dorothea. Dorothea wasn't a patient of mine, she was a patient of another SHO, and he asked me if I would take her on. He knew I was looking for

someone to clean my house. And Dorothea had been on the ward for thirty years and she'd been cleaning the ward for thirty years, but she had been put on reserpine and she'd responded to it. I think she had been diagnosed originally as schizophrenic and she was really very well and would we take her on? And I did. And I just gave her the keys of my house and she went and cleaned my house. And occasionally she would put the chairs around the dining table in the wrong way and then I knew she was relapsing, and she'd be brought back to the ward for a bit and then she would recuperate. And eventually she decided that she was well enough to leave the hospital and she got a job as a housekeeper for a local family who knew she was from Napsbury, so therefore they paid her hardly anything. And then she was successful at that job, so she got a better job and she used to come and visit me and our children, bringing little presents for the children, she became a friend of the family. And all went well, and we used to see her quite regularly. And then she went to Canada to see the only relative she had, her brother who lived in Canada, and I had a phone call from the brother to say, "What am I going to do? Dorothea has gone mad; I don't know what to do!" And she had relapsed while going to Canada. And she had been well for years and years and years. And we brought her back to England and she went back on her medication and as far as I know she was fine until she died. So that was Dorothea.

And I have other patients but I'm not going to tell you anymore because I think that gives you a flavour of the revolution, it was really a revolution, the neuroleptic revolution. Reserpine of course was pretty toxic, and it wasn't used anymore. There was Largactil and there were other things that came and you know the rest. Just to tell you that I realised that I wasn't getting any training at Napsbury and so I went to the Maudsley after a year.

John Hall: Okay! We're getting to the point in the day when there are some recurring themes, and one or two of the points I had prepared have been made already. I'm a clinical psychologist by background, so together with social workers and occupational therapists, with psychiatrist and nurses, this completes the quintet of what were then seen as the core mental health professions.

The first time I worked in a mental hospital was in the summer of 1965, in the long vacation before the last year of my psychology degree in Durham. I worked as a nursing assistant in St Augustine's Hospital, Canterbury, where many of you will remember that, later on, there was a major inquiry.[78] I remember the dormitories, the ranks of bed-locker-bed-locker-bed-locker with no subdivision at all. In the morning one of my jobs was to take a coat hanger with a wooden roller to smooth the bed covers, and to make sure that all the coverlets had hospital corners—that was really very important! I remember polishing the wooden floors with a cloth-covered "bumper" on a long handle, I think it was carpeting around a brick. I remember seeing, though admittedly unused, hydrotherapy baths in a pale green distempered room with wooden covers over the top.

The experience of that summer was foundational in my deciding to become a clinical psychologist, which at that time was really a very new profession. I was accepted on to the Leeds University MSc course, which I started in September 1966. That date is important because in the early '60s a number of new two-year clinical psychology courses were being established. They followed the earlier two philosophically-opposed courses here in London, one at the Tavistock Clinic and the other at the Maudsley, and the third very interesting course at the Crichton Royal, Dumfries, led by John Raven.[79] This was an important period because of the growth of these new training courses. Away from London in this period most psychologists were still being trained essentially as three-year postgraduate apprentices, without any formal qualification. You sat next to Nelly for three years and if Nelly signed you off, you were in!

The Leeds course was established by Ralph McGuire who had previously been at Glasgow. Some of you may remember a paper on electrical aversion therapy by him and a psychiatrist, Maelor Vallance,[80] and as he was keen on aversion therapy, so we were taught how to do it. I'm going to return to the ethics of behaviour therapy later, because that's important. The course was based at the Department of Psychiatry at Leeds University. If David Goldberg was scary, believe me, so was Max Hamilton, the professor of psychiatry there and, of course, developer of the Hamilton Depression Rating Scale.[81]

For the first year of the training course I was based at St James' Hospital Leeds, then a completely

unreconstructed old Poor Law infirmary. For the second year I was placed at High Royds Hospital at Menston (Fig 10), a large late-nineteenth century county asylum. In my second year I also spent some time at Lynfield Mount Hospital in Bradford, which was then a new district general hospital psychiatric unit. Our training was heavily biased towards psychometric assessment, with some very basic behaviour therapy skills, both aversion therapy and systematic desensitization. But in the second year I had some experience in group-work with young psychotic patients, which stood me in good stead later on.

When I qualified in 1968, I took a post at St. Andrew's Hospital in Norwich. I was the first junior trained psychologist they had ever had, and to be honest I am not sure they knew what to do with me! I've given to Claire the advertisement for the job and a letter to me from the head psychologist explaining what the job would involve (Fig 11). It is an interesting document because it sets out what was expected of me. My main function was to be a psychologist for one group of consultants, and in answer to a point that was raised earlier, full psychometric testing was still mandatory for all new in-patients. This involved doing a cognitive test, which was usually the Weschler Adult Intelligence Scale, which took an hour to administer and then an hour to score. And then we were also expected to do some personality tests, one of which was the Eysenck Personality Inventory, and another was called the Cattell Sixteen PF Test Profile. Here I have the analysis sheet of my scores on the 16PF in February 1968—my psychometrically validated personality in 1968 (Fig 12).

Nobody has talked so far about the role of SHMOs, Senior Hospital Medical Officers. When I trained there were many of them working in mental hospitals, and there were two SHMOs at St Andrews. One of them was a Polish doctor, who had been in the Polish armed forces, who had remained in Britain after the war, but he'd not taken the DPM (Diploma in Psychological Medicine). I remember one of my very first referrals from him when I was at St. Andrew's consisted of three words only: "Full psychometrics please." And, of course, I knew what that meant—give him an IQ and personality test. That was a core activity, but quite what use was made of it, to this day I do not know. But that's what we did, that was one of the core tasks.

Apart from that, I did some pretty basic behaviour therapy, mostly out-patients with systematic desensitization, but with one or two aversion therapy cases. There was an important critical review of the effectiveness and ethical acceptability of aversion therapy by Jack Rachman and John Teasdale in 1969 which contributed to the later reduced interest in aversion therapy.[82]

We served most of Norfolk. I never saw any patients away from the main hospital; everything was done in the hospital. And, of course, we relied on secretaries to type up our hand-written notes. I began to do some ward-based work with the longer-stay patients, running a patients' group with one of the younger consultants, which was significant for all the clinical work I've done since. I also did quite a bit of teaching. I taught psychology to student mental health nurses, and to junior doctors studying for the DPM. So there I was, a year out of my MSc, teaching the psychology for the DPM. The general standard of the junior doctors was not very high in rural Norfolk. It was not a good form of training as they had a very limited range of clinical experience and no contact with psychiatric trainees from other mental hospitals.

Research was one of the things which was expected as part of the job so I carried out a couple of research projects. One of them was into the reasons why the RMN student nurses at the hospital were withdrawing from the training course at such a high rate, and that study was published.[83]

So, reflecting on that experience 50 years ago, and trying to do a bit of time travel as Claire has asked us to do, a number of memories stand out. Although on the outskirts of Norwich, a major city and service centre in East Anglia, the hospital was an isolated and self-sufficient community, still with its own farm. I have memories of endless corridors. My work was unpressured, with very little demand on what we had to do. The hospital clearly had difficulties in recruiting good junior doctors, as I've already hinted, and I can only remember one trained occupational therapist and one social worker in the whole hospital. And there was really very little that could have been called multi-disciplinary work.

It's interesting that so many people speaking today have talked about work in or around London. I have never worked in London but I have worked in East

Anglia, Yorkshire, South Wales and Oxfordshire, but that's an interesting issue in itself. Away from London, and away from the regional medical centre at Cambridge, which anyway at that time had no University Department of Psychiatry, many services were static. Attempts at "rehab" were only just beginning, although of course by the late 1960s, David Clark was working away at Fulbourn Hospital.[84] So, underlying again the point which Tom Burns has made about these enormous variations, even within the East Anglian Regional Hospital Board area, which was a very small RHB, people did not communicate these changes to each other.

My psychologist boss was kind and supportive, but there were no opportunities for professional development. I was becoming aware of other developments in behaviour therapy and so in 1970 I moved from Norfolk to a research post which was part of the role-transforming, explosive growth of behaviour therapy. So bye-bye "test-bashing"—that was, in the trade, what we called giving everybody a test.

In the light of the discussion, I want to make one or two points about ethics and behaviour therapy, because I think this is really important. When I went back to Leeds in late 1970 I worked under Max Hamilton, Professor of Psychiatry, and Gwynne Jones, who a number of you will remember when he was at the Maudsley and at St Georges Medical School, before he went to Leeds as Professor of Psychology. I was working on a Medical Research Council funded research study on the effectiveness of token economies, and token economies had quite profound ethical implications, as they carried the potential for patients to be deprived of amenities and rewards. Although we designed the study to avoid this risk, I remember at the time being surprised that there wasn't much ethical scrutiny. As a result of my involvement in that project, again some of you may remember, in the early 1970s there was a Department of Health working party to review ethical guidelines on behaviour modification, chaired by Oliver Zangwill, who was Professor of Psychology at Cambridge. The Royal College was represented on the working party, and I was one of three British Psychological Society representatives.

The working party had in fact arisen out of issues of a rather different nature which arose at Napsbury Hospital under Dr Scott. The Zangwill Report on the ethics of behaviour modification[85] was one of the first to look carefully at some of these ethical implications. I think one of the things we've heard today is about some of the really quite profound ethical implications of some psychiatric innovations and experiments. For better or for worse, you know, without any criticism of anybody here, it has been interesting listening to the stories. We didn't know any better, not least I think because services were so isolated. So that's my experience of the 1960s, one of the new boys of the psychiatric professions. And I have a key to prove it as well (Fig 13).

Claire Hilton: Is that for a ward?

John Hall: Yes it was, it is marked as a master key. I think it was for one of the wards at Wakefield. There we are, and I've heard somebody else, John Jenkins, say his key was bigger! I think there was one firm in the Midlands who made nearly all of them, didn't they?

Claire Hilton: Any questions? George has got one.

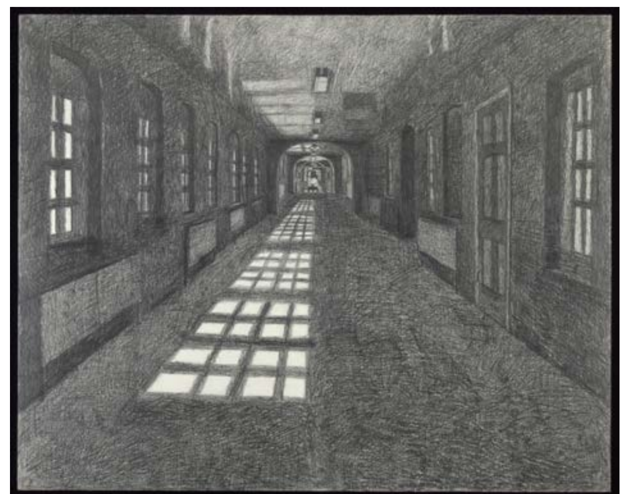

Fig 10: High Royds Hospital, Menston, Ilkley, Yorkshire: a corridor. Pencil drawing by Paul Digby, 2003-2004. Credit: Wellcome Collection. CC BY

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Applications areinvited for the post of BASIC GRADE/PROBATIONER CLINICAL PSYCHOLOGIST in the above dept. There is a Full Time Senior Psychologist in the post, and the dept. provides the Psychologist Services for two Adult Psychiatric Hospitals (1140 and 280 beds) and serves an out-patient population from a large rural and urban area. Opportunities exist for participation in Behavioural Therapy programmes; research is actively encouraged; facilities exist for training, with special reference to the Diploma in Clinical Psychology; there is a good professional library; and a wide range of Clinical problems.

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Dear Mr.Hall,

Thank you very much for your letter. The vacancy here is still open and we are still looking for a suitable candidate. The establishmer here is for two Psychologists One Principal/Senior(me) and one Basic/Prob(vac) St.Andrew's is a general Psychiatric Hospital of 1,140 beds, with another Hospital(St.Nicholas) for male patients(280)beds), in Gt.Yarmouth. The Psychology Dept. is situated in St.Andrew's Hospital, which is on the outskir of the City of Norwich. We serve a cachment area of the whole of Norfolk (except for NOrwich itself and King's Lynn) and most of Nth Suffolk. There is another hospital (Hellesdon) which serves Norwich which has an active Psychology Dept. 2 miles from St.Andrew's is Little Plumstead the area Mental Deficiency Hospital, which also has an active Psychology Dept. The three Depts. hold a Journal Seminar about once every six weeks, so we remain in contact with other psychologists. We have jst started a Branch of the Division of Clinical Psychology which will provide a further professional forum. There is also a Regional Group of Psychologists, a less formal group which holds about 4 meetings a year, and consists of Educational,clinical and other Psychologists, where papers of general interest are presented.

St.Andrew's has a team of 5 Consultants and the Dept.shares its time betwe service and interest in research and developmemt. The atmosphere is encouragi toward research and the Psychologist can function reasonably autonomously. As regards research we have just completed an investigation into the use of Automated Testing devices in conjunction with testing Geriatric Patients and we hope to extend this into a much bigger project. We have a lot of help and contacts with the MRC unit for the Application of Psychology to Medicine in Cambridge .

I have also been working on a tentative classification system, useing personality Variables instead of symptom patterns, applying numerical taxonomy to the data, and we hope to extend this and use it in a piece of epidemiological work.

We have a planned program for further research A) Investigating memory impairments and recovery with uni-lateral ECT,B)Investigating certain parameters of Anxiety - utilising techniques of forearm plethysmography, C)Exploring the uses of Automated Testing devices in a general way, and D)the epidemiological work.

I am particularly interested in Personality and the extension of Behaviour therapy techniques, and there are opportunties for the right candidate to pursue their own research bents. I have only been here since mid'66 and I am still building up and expanding the Dept and its work.

We are close to the Broads here, and only 14 miles from the Sea, and it is a pleasant area to work in, and I think full of interest.

If you are interested in this post, or want further information you might care to apply formally to the Medical Superintendant, and we would fix a time for you to come down and meet us,

With Best Wishes,
Yours Sincerely, David Castell

Fig 11: Advertisement for psychology post at St. Andrews Hospital, and letter from David Castell, senior clinical psychologist, March 1968. The letter laid out what would be expected of the person appointed, and what would be seen as attractive opportunities. Credit: John Hall

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A – XI–10

16 P.F. TEST PROFILE

FACTOR	Standard Score	LOW SCORE DESCRIPTION	STANDARD TEN SCORE (STEN) 1 2 3 4 5 6 7 8 9 10 (→ Average ←: 5, 6)	HIGH SCORE DESCRIPTION
A	7	**RESERVED,** DETACHED, CRITICAL, COOL (Sizothymia)		**OUTGOING,** WARMHEARTED, EASY-GOING, PARTICIPATING (Cyclothymia)
B	10	**LESS INTELLIGENT,** CONCRETE-THINKING (Lower scholastic mental capacity)		**MORE INTELLIGENT,** ABSTRACT-THINKING, BRIGHT (Higher scholastic mental capacity)
C	8	**AFFECTED BY FEELINGS,** EMOTIONALLY LESS STABLE, EASILY UPSET (Lower ego strength)		**EMOTIONALLY STABLE,** FACES REALITY, CALM (Higher ego strength)
E	8	**HUMBLE,** MILD, OBEDIENT, CONFORMING (Submissiveness)		**ASSERTIVE,** INDEPENDENT, AGGRESSIVE, STUBBORN (Dominance)
F	5	**SOBER,** PRUDENT, SERIOUS, TACITURN (Desurgency)		**HAPPY-GO-LUCKY,** HEEDLESS, GAY, ENTHUSIASTIC (Surgency)
G	3	**EXPEDIENT,** A LAW TO HIMSELF, BY-PASSES OBLIGATIONS (Weaker superego strength)		**CONSCIENTIOUS,** PERSEVERING, STAID, RULE-BOUND (Stronger superego strength)
H	7	**SHY,** RESTRAINED, DIFFIDENT, TIMID (Threctia)		**VENTURESOME,** SOCIALLY BOLD, UNINHIBITED, SPONTANEOUS (Parmia)
I	6	**TOUGH-MINDED,** SELF-RELIANT, REALISTIC, NO-NONSENSE (Harria)		**TENDER-MINDED,** DEPENDENT, OVER-PROTECTED, SENSITIVE (Premsia)
L	3	**TRUSTING,** ADAPTABLE, FREE OF JEALOUSY, EASY TO GET ON WITH (Alaxia)		**SUSPICIOUS,** SELF-OPINIONATED, HARD TO FOOL (Protension)
M	8	**PRACTICAL,** CAREFUL, CONVENTIONAL, REGULATED BY EXTERNAL REALITIES, PROPER (Praxernia)		**IMAGINATIVE,** WRAPPED UP IN INNER URGENCIES, CARELESS OF PRACTICAL MATTERS, BOHEMIAN (Autia)
N	6	**FORTHRIGHT,** NATURAL, ARTLESS, SENTIMENTAL (Artlessness)		**SHREWD,** CALCULATING, WORLDLY, PENETRATING (Shrewdness)
O	3	**PLACID,** SELF-ASSURED, CONFIDENT, SERENE (Untroubled adequacy)		**APPREHENSIVE,** WORRYING, DEPRESSIVE, TROUBLED (Guilt proneness)
Q_1	7	**CONSERVATIVE,** RESPECTING ESTABLISHED IDEAS, TOLERANT OF TRADITIONAL DIFFICULTIES (Conservatism)		**EXPERIMENTING,** CRITICAL, LIBERAL, ANALYTICAL, FREE-THINKING (Radicalism)
Q_2	6	**GROUP-DEPENDENT,** A "JOINER" AND SOUND FOLLOWER (Group adherence)		**SELF-SUFFICIENT,** PREFERS OWN DECISIONS, RESOURCEFUL (Self-sufficiency)
Q_3	4	**CASUAL,** CARELESS OF PROTOCOL, UNTIDY, FOLLOWS OWN URGES (Low integration)		**CONTROLLED,** SOCIALLY-PRECISE, SELF-DISCIPLINED, COMPULSIVE (High self-concept control)
Q_4	4	**RELAXED,** TRANQUIL, TORPID, UNFRUSTRATED (Low ergic tension)		**TENSE,** DRIVEN, OVERWROUGHT, FRETFUL (High ergic tension)

A sten of	1	2	3	4	5	6	7	8	9	10	is obtained
by about	2.3%	4.4%	9.2%	15.0%	19.1%	19.1%	15.0%	9.2%	4.4%	2.3%	of adults

© 1963. Institute for Personality and Ability Testing.

Name: John Hall 28.2.68

Psychologist's Comments:

Fig 12: Test Profile for the Cattell Sixteen PF "personality test" questionnaire, with scores, as completed by John Hall, 1968. Credit: John Hall

Fig 13: Hospital master key (8.6cm long) from Stanley Royd Hospital, formerly the West Riding Pauper Lunatic Asylum, Wakefield. Made by Gibbons of Wolverhampton. Credit: John Hall

George Ikkos: Napsbury was mentioned twice. I worked in Napsbury and I got the aftermath, the crisis intervention service that was set up in Napsbury. I don't know, I don't know what the crisis was.

John Hall: A patient died at Napsbury, and at post-mortem there were injuries which nobody knew about. It raised a whole set of questions about what had happened, and the fact that there was this major wide-ranging review was almost incidental to the actual circumstances of the death. The major committee of inquiry focussed on Dr Scott's innovative practices, and whether there had been adequate ethical scrutiny of them.[86]

George Ikkos: Can I ask another question, maybe not just for you two, but more generally about staffing: I'm fascinated by the composition of the nursing staff in mental hospitals, but equally surprised to hear about Eastern European and Czech nurses in hospitals. And I wonder is that Jewish nurses from Nazi Germany, or is it refugees from Communist Europe? Do we have any information?

John Hall: Well, it's interesting, Littlemore has been mentioned several times. I worked for twenty-two years at the Warneford Hospital and also at Littlemore Hospital. If you went through the main gates at Littlemore Hospital there was a zebra crossing immediately opposite, with warning signs written in Spanish. The Spanish student nurses didn't know which way the traffic came, so the sign was making sure they looked the right way when they crossed the road. Dr Felix Letemendia, who was the lead consultant for one half of the hospital, was Spanish, alongside Bertie Mandelbrote, who was far better known for his work in the other half, and he was South African. Many nursing students came from Ireland, and I'm sure that all of us of that generation remember a very high proportion of nursing students who were not British.

Dora Black: Certainly when I was at Napsbury, which was earlier probably than you were there, there weren't foreigners. There were a lot of Irish staff, otherwise they were British. There were very few people who didn't speak English as their first language.

George Ikkos: There were lots of Irish staff when I was at Napsbury, and an IRA cell was found in Napsbury with a lorry parked there with explosives. I had a very obliging Irish CPN working with me in the early '90s, very nice gentleman who did not turn up for work again after this incident.

Peter Nolan: That's very interesting. Just in response to staffing: you may remember in Birmingham there was a consultant psychiatrist who was found to be an IRA sympathiser and who gave refuge to terrorists on the run in the 1960s and 1970s. During the 1950s and 1960, all the Irish papers carried adverts for physios, doctors, pharmacists, nurses, and trainees of all descriptions in England. That's how I came to be here because after I left a monastery, I was desperate for work, and having replied to an advert I received an invitation to train as a nurse without an interview. On arriving I was welcomed. So there was assertive advertising in newspapers in various countries to recruit staff. What I found when I arrived at Tooting Bec, was that my colleagues came from many countries. I think the vast majority came to learn English and once they had become proficient in the language they moved to other work. Few of the student nurses remained in the service. In Birmingham, Dora, you probably remember Tom Lambo, a Nigerian psychiatrist,[87] who arranged for Nigerian nurses to train in Birmingham with the aim of returning on completion.

Dora Black: It was probably after my time. I qualified in '55 in Birmingham.

Peter Nolan: It was after your time, yes it was. And he brought Nigerian nurses over to train to go back to Nigeria to set up something similar to the Birmingham services. It didn't work culturally. The nurses couldn't make sense of what they were taught, the business of cultural differences was overlooked. And going back to the question of Jewishness, the first professor of psychiatric nursing in the UK was an Austrian Jewess, Annie Altschul,[88] a delightful lady who did an enormous amount for raising the standing and status and professionalisation of nurses.

Claire Hilton: I'd like to thank John and Dora and I think we should then move on.

Perspective of a woman doctor in the psychiatric hospital: Angela Rouncefield

Claire Hilton: Angela's going to talk about the perspective of a woman doctor in the mental hospitals of the 1960s, I think…

Angela Rouncefield: That's right. Just a tiny little bit before then. I come from a non-medical background, from a working-class area in South East London, which just tells you my sort of social status and how I started life.

I lied about my age when I was 14 and said that I was 16 and started life as what you would now call a health care assistant, initially in London where I was very happy, and then at St Mary's Portsmouth where I cried every day on a *Sans Everything* ward.[89] So that's a just a little bit about me.

My first job though, as a trainee psychiatrist, was as a senior house officer in 1963. At that time the University of Liverpool had a small psychiatric unit in a district general hospital consisting of three wards, which then was quite an unusual arrangement, large mental hospitals being the norm. I started a two-year rotation with two other SHOs but immediately found myself marginalized as my previous jobs, whilst being on Merseyside, were not with eminent consultants. The other two trainees, one of whom was female and the other male, had worked for very eminent consultants.

The male senior registrar, who in those days was in charge of organizing trainees, felt it perfectly in order to tell me that the other two trainees were clearly more prestigious than I was and I would be placed with a SHMO who was a notch down from a consultant. This placement proved to be excellent for me as the doctor concerned was caring, compassionate and knowledgeable and was very happy to spend time teaching me and giving me opportunities. There were very strict male and female divisions between the patients and the nursing staff, so initially I was in an all-female environment: female patients, female nurses. The senior nurses had little time for trainees and, I noticed, formed around the male consultants. Within three months the other two trainees had departed, one (the male) completely disenchanted and the female very sadly had a breakdown.

For the next three months I was therefore the only trainee. I was duly advised that instead of being on duty one night in three, and one in three weekends, I would now be on duty every weekend and three nights a week. At this point, I decided that I would just have to take charge of the situation and made it very clear that, whilst I would do anything of an emergency nature during the night, being up for five nights a week would completely destroy me and therefore any admissions during the night, I would allocate to the consultants for them to decide who clerks the patients in detail. This gave me excellent managerial experience and I have to admit that, at the time, I felt very powerful. Being on duty so much gave me massive experience and also opened the door to a wonderful opportunity to be involved in research. Liverpool University was involved in a research project with New York University and this required urine samples to be collected from psychiatric admissions who had not had any medication. There was also a protocol to fill out relating to symptomatology. At the end of the research project nobody throughout the region had collected more samples of urine than me. Why? No one else was on the front line as often as I was.[90]

During this intensive period, the senior registrar, who had been so disparaging towards me, completely changed his attitude and we remained firm friends until very sadly he died twenty years ago. Trainees were allowed to attend the university department of psychiatry on two afternoons a week to attend lectures leading to what was then known as the Diploma in Psychological Medicine, which was considered to be the postgraduate qualification opening the door to consultancy. Trainees from the region all attended and there was only one other female. One of the lecturers was quite inspirational and I learned from him that he'd instituted a very innovative unit for maladjusted young adults at the large mental hospital in North Wales. Having visited this special unit in North Wales, I immediately instigated a mini therapeutic community within the psychiatric unit in Liverpool. No one attempted to stop me.

In summary, my experience at that time was that it was all male-dominated and I felt I was constantly having to prove myself. There were practical difficulties, no ladies' [toilets] in the male units: a male nurse would stand outside the gents while I went in. However, the first senior psychiatrist I worked with was amazingly supportive and enhanced my confidence daily, and the inspirational lecturer opened the door to the world of psychotherapy and working with young people.

After two years I was successful in gaining my Diploma at my first attempt and in my mind I thought I would just be working for another year, now as a registrar, before I could apply to be a senior registrar. I felt I was well placed to be a senior registrar, after all I'd had massive experience, had my Diploma and had started a mini therapeutic community, and was very firmly entrenched in a big research project at the university.

I did not get the post. I was visited that evening when I was on duty by my then-boss, male, and the professor of psychiatry, to inform me that they'd decided to appoint one of the male applicants because he had three children. I hit the roof at the time with both of them as it had not passed through their minds that I too was married and that if anybody needed a consolation prize, it was me because so far I'd not had any children, and while they did not know, I had in fact lost my first baby. The inspirational lecturer who had been so kind to me at the university contacted me to find out whether I'd secured the senior registrar post. When I told him I hadn't he said, "Come over and see us at North Wales Hospital," which I did. They offered me a research post, a post to work in the psychotherapy unit for maladjusted young adults, what would now be called a low secure unit for violent males. I gave my resignation the following day. My then-boss counselled me that I was acting impulsively and advised me, "You will never, ever be a senior registrar if you take this post as a lowly clinical assistant."

I decided however that I was not going to stay in Liverpool just repeating the same experiences and that it would be much better to get new experiences and skills. I duly left a month later. It was while I was at the North Wales Hospital that the research work for New York University and Liverpool University came to an end, and the professor from New York University came over to Liverpool. I'd not been invited to any of the meetings in relation to this but he insisted on contacting me, as, although I didn't know until he told me, I'd collected more specimens than any other doctor throughout the whole of the research project, both in the USA and here. I duly went to Liverpool and met him and, to my surprise, he asked me if I'd like to apply for a job at New York University saying I could go there for a week to see what it was like before making a decision. So that very intense period, when initially I felt I was being abused i.e. on duty every other night and every weekend, actually opened a door for me. It was only for family reasons that, even though I went out to New York and saw the job and knew I'd love it, I decided not to go.

My time at the North Wales Hospital was most enjoyable and I learnt new skills, being involved in another research project following up two hundred chronic patients, who had been discharged over a two-year period, to determine the factors that had led to a successful discharge. I also had a wonderful training in psychotherapy and working with young people. I now had no fear of working with acutely psychotic male patients. Within two years I was appointed the first female consultant to the North Wales Hospital, and I enjoyed going to visit my old boss, advising him: "You were absolutely correct: I've never been a SR[91] and I never will be. You need to congratulate me on becoming a consultant." He was extremely gracious and said how pleased he was. So overall, yes it was male dominated, there were misogynists, but there were also some lovely senior people, enough of them to nurture me and enable me to grow. Thank you.

Claire Hilton: I think there must be quite a lot of women in this room who can empathise with at least some of that. Any quick questions before we move onto our final sessions?

Harry Zeitlin: For quite a long-time I was regional tutor including in this region, and most of my colleagues were reluctant to appoint young ladies because young ladies have children. We decided on a plan and that was that I would see young ladies first and say, "Do you have a plan if you decide to have a family?" not, "Are you going to have children?", or what that plan was, but do you have a plan? As a result, I had the choice of the brightest young ladies. At one point, nine of our eleven posts were filled with young ladies. I can give you their names; they are all over as senior consultants now. But they could go to the appointment interviews and say, "I have a plan. Don't worry about that, I have a plan." Do you want to guess what happened?

Angela Rouncefield: They were appointed?

Harry Zeitlin: I got reported to Equal Opportunities.

Angela Rouncefield: Really?

Harry Zeitlin: But we had the best young women. Most became senior consultants…

Angela Rouncefield: Well, I was asked that question at my interview. When I applied to be a consultant, I didn't think for one moment I would be appointed, partly because of the number of years I'd been qualified, and I applied so I could have the experience of making an application and going to the interview and seeing what it was like. And when they asked me, you know, what are you going to do if you have a family? I said, "Well, I've always been very well organized and I will continue to be so."

Harry Zeitlin: It's a similar thing except that they would go with a plan and that would rule out any challenge about it.

Maria Turri: I'm becoming very interested now in the last couple of panels to know a little bit more about the social background of doctors and perhaps also nurses that went into mental health care in the '60s, whether there were patterns and whether being from a disadvantaged social background meant that you were more likely to choose a profession like psychiatry, rather than other medical or surgical specialties?

Angela Rouncefield: I chose this profession and, I'll be as brief as I can: my father died when I was eleven, the letter offering him a bed under the NHS came the week after he died, and I was so angry that I decided I would be a doctor. I didn't come from that background at all, socially or academically. So that's how I decided to be a doctor. Then, when I became a doctor I thought that I'd be a surgeon but in fact it was during that period that I lost my first baby and I started to have nightmares that I'd cut a ureter and I thought, "This would never work with a family." And I was working on a breast unit at the time and the women there, until I went there, were not counselled before, during or after. I became very interested in counselling them before, during and after surgery, that sort of thing, and I thought: "I can't do surgery, it's never going to combine with the family. I'm very good at this counselling, I'll be a psychiatrist." So that's how it happened.

Dora Black: When I applied for medical school, I had to apply to twenty-two. In 1947, the government asked all medical schools to take both sexes. Up until then, the medical schools in London were only taking men and the Royal Free was only taking women. The Royal Free then immediately took 50% men, so we actually lost places in London because the male medical schools took only a sprinkling of women. I had an interview at St Mary's, with the Dean, and it was really a very good interview I thought. We were getting along like a house on fire. And then he said, "Your father is a doctor, isn't he?" Well, my father wasn't a doctor. He was a businessman. I was the first person in the family to go to medical school, in fact to go to college. I said, "No." He said, "My dear girl," he said, getting up, "And you expect to get into medical school? Good day."

Angela Rouncefield: Absolutely. I had a very similar interview at Bart's. I went in and they said to me,

"Is anybody in the family a doctor?"

"No."

"Anybody been to university?"

"No."

Looked at my address and said, "This is a working-class address."

"Yes."

And then they said to me, "Do you know how many lecturers we've got in the medical school?" I said, "Oh yes, I've looked it all up exactly," which I had.

And they said, "Alright, correct. How many of them do you think are married?" I said, "75%." "Correct."

"How many of them have got children?" "50%"

"Correct."

"How many of them have got daughters?"

"25%"

"How many of them are 18 and applying here?"

I said so many, and they said,

"Well, there we are madam, good afternoon."

Claire Hilton: Well if that was Bart's when you applied, they didn't ask me any of those questions when I applied. So, they'd learnt by 1977. I think we should move onto the last session, or as John says, a grand finale! Thank you, Angela.

Leadership and change: John Bradley and Bill Boyd

John Bradley: Now, do keep yourselves refreshed, I'm not going to go on too much. Look, now, Claire here is a great expert on Barbara Robb, who really did a wonderful job in the mid-60s with her book *Sans Everything*, pointing out the horrors of mental hospitals.[92] We've heard so much about horrors of these hospitals this morning and this afternoon that I won't go on about them. I was thrust into the

physician superintendent role at Friern Hospital, Colney Hatch Lunatic Asylum to you—which had been founded in 1851, opened by no less than the Prince consort on the day of the Great Exhibition—and so I went there and he, the physician superintendent, decided to resign after a few months and then I was asked to take on the job as medical director and chairman even though I had never worked in a mental hospital before.

I'd only been there a short time when it looked as though the GMC[93] was going to get me because a patient told a nurse, she said, "Dr Bradley, the new doctor, he comes and has sex with me every other night." Now, this was a very intelligent nurse because she said to this patient (she didn't really think that I was really quite such a Don Juan, even though of course I was only 35 at the time) and she said, "Well, what happens on the intervening nights?" And the patient said, "I reserve those for the Duke of Edinburgh." So that let me off the hook.

Anyway, now my psychiatric training. As I said, I'd not worked in a mental hospital, but it started in the Royal Air Force, which is where I learnt all about deep insulin therapy, believe it or not. That was 1954. And I learnt a lot about it and one thing I did learn about it is that it kills people sometimes too. And that was a horrifying experience.

But anyway, on return to civilian life I went to a psychoendocrine research unit in a small selective psychiatric hospital near Epsom called St Ebba's. I was in this research unit run by a Czech, I think, a man called Professor Max Reiss.[94] Now, Professor Reiss was very middle European, and I hope you'll forgive me if I give you a sample of how he spoke, because he was interested in the physical immaturity of both males and females and how far this made them vulnerable to developing mental illness. And if you could hasten their maturity by giving them chorionic gonadotrophin or something like that, then that would make them less liable to become mentally ill. I remember one day we were having a sort of ward round with us all in white coats, they brought in this lady he was seeing, and Professor Reiss says, "Will you pull down your knickers for me?" And she said, "No, this is terrible." And he wanted to reassure her, he was actually a very kindly man, but he wasn't very good at sensing patient's needs. And he said, "I only want to look at your pubic hair." Now there is an example of gross insensitivity, but one comes across it throughout one's professional career, how insensitive doctors, even psychiatrists, can be.

I then went to two teaching hospitals. Part of it was to spend five years at St Thomas' under the great or not so great William Sargant. I won't dilate any more about that because other people have said what a pain he was in many ways. So then I went off to the United States, where I was offered a post as an associate director of a small general hospital psychiatric unit but under the overall direction of Professor Nathan Klein, who was the man who introduced the antidepressants.[95] So it was quite interesting being there but after two years I decided that I didn't like American medicine very much, largely because I was really wedded to an NHS philosophy. And so I came back here, I applied for this job at Friern Hospital plus the Whittington Hospital, the Royal Northern Hospital, and the City of London Maternity Hospital. When I got to Friern, I found that I was responsible, as so many people have said, for five hundred of two thousand beds. There were four consultants and as I said, the physician superintendent decided to resign. Another one—we've heard about some of his problems—was Richard Hunter, author of *George III and the Mad Business*, who was really a neurologist manqué. And there I was as the boss.

I used to walk along those mile-long corridors,[96] feeling acutely anxious, (you know, you might go and have a look at it; it's a very, very posh housing estate now. I took Richard White [my previous registrar] there once). And I used to have panic attacks. I didn't trust any psychiatrists enough so I couldn't go and get any treatment, apart from the one I used to look at in the mirror, so I sweated it out. So that was quite something.

There were two redeeming features, and this is where leadership came in, because I wasn't really competent to give much leadership, but I had two supporters. One was the local MP and she used to ride up and see me and once every six months we would have lunch together. She'd come in a rather clapped out old Ford Anglia, I remember. But she was rather an elegant woman, and very bright, intelligent and energetic, and she would listen to me. Now, I didn't really see eye to eye with her politically all the time but she was very useful because she pushed all these things, as I said, we need more staff, we need more facilities, we need this, that and the other thing, and she got onto the

Regional Board, onto the Department of Health and so on. So this MP, who alas is no longer with us, her name was Margaret Thatcher, you may have heard of her! And she knew something about leadership, anyway, and its problems.

Now, the next one who was of help to me was another fairly dynamic woman. I don't know whether anyone's ever met her. Any Royal Free people here? Yes. Did you ever know the Dean? Frances Gardner. Now, she was a chain-smoking, cardiologist who drove a Rolls Royce. She was also married to a rather successful surgeon, I think, as well. But she was determined to get some really good psychiatric teaching at the Free. And there wasn't much going on there at that time; that was obviously before your time or after your time, Dora? When did you go to the Royal Free?

Dora Black: 1984

John Bradley: Oh, I see, no. When I said Royal Free I meant undergraduate teaching. Oh, God, no, quite different, that was when Gerald Russell came in on it.

Frances Gardner and I, we got together and she offered me an honorary senior lectureship and she managed to persuade Gerald Russell who at the time was Dean at the Maudsley that he would come and take the chair and we set up a professorial unit with two consultant senior lecturers at Friern. And that made all the difference. Because we had this, the regional health authority was very happy to establish more consultant posts, junior posts, training posts. People wanted to come because they wanted to go on the training programme with a professorial unit. It really paved the way for an establishment of consultants and juniors, and of course we really got going on the rehabilitation side of it. An industrial therapy manager. A volunteer organiser, I don't know whether other hospitals had that, but volunteer organisers were very helpful in getting people from the local community in to do things. And we had quite a lot of help from the WRVS, the Women's Royal Voluntary Service, and all that sort of thing.

That was a good start. And then of course we decided to start a community nursing service of our own, just informal, sending nurses out to see patients who had been discharged. This of course blossomed into a full community nursing service, and we established much more liaison with the local social services.

What's that? Telling me to stop? I'm going to, right now. Just a hint. Anyway, last sentence, I went in '76 to start a new job setting up a new general hospital unit at Highgate.

Claire Hilton: You missed out one very important bit, that you managed to go from four to twenty-three consultants!

John Bradley: Oh yes! She's reading over my shoulder!

Claire Hilton: He sent me a copy!

John Bradley: From four to twenty-three consultants. Now that deserves a round of applause. Then after that I went on my way, a further leadership challenge in setting up the district general hospital unit. Thank you, Claire.

Claire Hilton: Thank you, John.

John Bradley: Now Bill, very different, much more refined.

Bill Boyd: This is a very gentle account of life in the Scottish countryside. I should start by saying that Claire invited me to give a personal perspective, to time travel backward, to recall my thoughts at that time and the memories. She went on to say five minutes, six hundred words, so I'm almost finished already before I start; and after fifty years it's quite difficult, is it not, to remember the exact details. Fortunately, I don't know anyone else who was around the hospital at which I worked, at Herdmanflat, to the east of Edinburgh (Fig 14). I don't think any of them are still around, so I can say anything I like, and no one will contradict me.

Herdmanflat Hospital was one of several county asylums built in the 1860s or so.[97] It had 235 beds. It was supervised by a local general practitioner. The matron was the boss of the hospital, she ran it, and the GP looked after it. And later on, there was an SHMO, and a consultant came down from another hospital thirty miles away once a week, I think it was, to keep an eye on things. So it was fairly conservative, shall I say, in its psychiatric service. I was appointed there in '64 as consultant psychiatrist and then very shortly afterward, the group medical superintendent, who was an ex-RAMC colonel decided that he would give up psychiatry, so I became physician superintendent and was there for the next four years. I did get an extra financial inducement too, which was very useful for somebody with small children, so there we were.

The hospital was in Haddington, a small county town, twenty miles away from Edinburgh. It was ripe for development in so many ways and apart from a few diehards, the nursing staff were just waiting to be brought into the modern world. Now, I was very fortunate in that I knew quite a lot about Dingleton Hospital. I'd known about it for many years, and I'd known about Dr George Bell who had started an open doors policy years before. And now there was another well-known psychiatrist, Maxwell Jones,[98] developing the idea of a therapeutic community. So I got to know him even better after I'd taken this job, and he would come up to Herdmanflat and he'd talk to the nurses, and we'd send nurses down to Dingleton Hospital to see his special therapeutic community approach, which was interesting and very valuable to me at that time.

I was asked about management. Well, because the psychiatric hospital was part of a group with three general hospitals, I think the management people were so occupied with acute surgery, and so on, that they more or less left me to my own devices. And I was able to, well, do the things I wanted to do. But perhaps the most important thing while I was there was that we opened a brand-new admission unit, lovely, modern, wood and glass and so on and so on. And I had to decide what we would use it for. We used it as a new admission unit and one of the things I remember is going up to Edinburgh to choose the furniture for my office. Looking back, I don't think that would be in a job plan these days, but at the time it was perfectly acceptable. So I went. And I also decided to have some paintings around the walls. And the other thing I did was help to arrange the seating in the new sitting area and we got lovely comfortable chairs with coffee tables so that the patients could sit in nice little groups. Of course, when I came in the day after it was in action, the patients were all sitting around the wall. They all got their backs to the wall and I said, "What's happening?" And the nurses said, "Well, that's what the patients wanted to do" so we just had to go along with it.

I was kept pretty busy with routine clinical work in the hospital and outside with three out-patient clinics in neighbouring towns and I went to one of them each week, I think it was. And this dealt very nicely with the sort of person who hadn't really got used to modern psychiatry and who still looked at Herdmanflat as the asylum and were not really prepared to go there for interviews and treatment at all. And the treatment, we've been hearing all about different treatment…we had certainly passed the days of insulin coma; we had done that in the '50s I suppose. We did do ECT under anaesthetic. The only slightly worrying thing was we gave the anaesthetic ourselves, but there were always two of us present. Looking back now it seems surprising, but others have probably experienced exactly the same. And just to continue, still within my five minutes, I hope, we did lots of exciting things that I remember. I had a colleague up in the north of Scotland running a hospital much the same as my own, so we did an exchange of patients. Got a bus and sent 30 in one direction and 30 in the other direction. I don't know what they thought about it, but we called it a holiday for them, and I think it was, it was something different, which I think was good.

We created a recreational therapist post, which of course allowed us to have holidays and dances and all these things, which were not available before. We even had the centenary ball because we'd been open for one hundred years, which was a great success—brought in all the local people. Which reminds me that the other thing we did, I did, part of the development, was making much more, having much more contact with the local GPs, who up to then they'd been a bit distant from the hospital. The local clergy were all very excited, they were all anxious to know about psychiatry, and we had sessions where they discussed lots of things that I didn't know about and sometimes about psychiatry. But it brought us together, so it was quite a therapeutic thing. And then one Sunday I had a telephone call from the Duchess of Hamilton. It does not trump Mrs Thatcher, but you know someone…

John Bradley: I accused him of name dropping earlier!

Bill Boyd: And she was wanting to start a psychiatric day unit in an ancient city town house which she was renovating, and so she wanted me to provide patients. I don't think we ever did it, but it was an interesting contact with other people in the county. And the Round Table, the young version of Rotary, I got involved with them quite a lot and they became very interested in the hospital, ran events, and visited the hospital and so on.

So these are my memories, very simple events, simple improvements, and oh yes, we changed the

wards from being numbered. We gave them all names, local landmarks, that seemed to make it a little more informal. We insisted that night nurses wore rubber heeled shoes. I think that was a great development, and pretty important too. The next thing that comes into my mind was we did have blocked beds, blocked beds which to this day as far as I know are a huge problem for psychiatric units and very difficult to cope with.

As far as the clinical work, I've said this already, the clinical work it was pretty straightforward, and coming from Edinburgh where I'd had to spend hours discussing with Frank Fish[99] Schneider's First Rank Symptoms and so on, it was really a joy not to have to talk much about these things and to just get on with treating patients. And that's what I enjoyed doing. And I am perhaps having false memories that it's all rose coloured spectacles but it was a pretty good experience for me.

Claire Hilton: We've got just about ten minutes for any questions. Or is everybody too exhausted? Any questions? George.

George Ikkos: A couple of questions, about Hunter. In 1985 I applied for a senior registrar post but the successful candidate was Dr Rogers, who had looked at Hunter's patients. Hunter didn't believe in mental illness so he had not given anyone neuroleptics in the '60s and '70s. So, Dr Rogers went to study movement disorders in neuroleptic naïve mentally ill patients.[100] Naturally he then published a very good book, a very interesting book, *Motor Disorder in Psychiatry: Towards a neurological approach*.[101] Question: Hunter has written a history of Friern Barnet[102] which I think is less well known than his other books. I thought it was very good, and I wonder what your opinion is.

John Bradley: Very good, yes. And of course, he and his mother did a history of psychiatry as well.[103] But no, I mean they were very good, but he had a bee in his bonnet about everything being neurologically…looking for some kind of…Yes!…Dr Stephanie Felsenberg, a senior hospital medical officer who was a refugee from Vienna, used to say, "He's always looking for the *morbus Hunter*." You know, he wanted to make a kind of eponymous syndrome.

Harry Zeitlin: I'll be very brief. We have clearly got some very bright young people here and I am delighted about that, but we've also spoken a lot about the aversion that is being created to coming into this profession and about the numbers leaving to work abroad. Is there anything we can learn from what we've discussed this afternoon that can be done to attract good quality, young doctors into this field because I fear those sitting behind me may be the last of the best coming in. But what can we do? I know many who have left the country, about half my best trainees have gone. Any suggestions for what we can do to continue to attract these young people, to keep them here and to attract more?

John Bradley: I knew you were going to answer that one.

Bill Boyd: Surely there's a great possibility for people to go into psychiatry and to lead really, to start out new ideas, to change the way things are arranged, the chronic conservative attitude which we've heard about today, which is still there. I would have thought it's quite an exciting specialty.

John Bradley: I've done quite a lot of postgraduate teaching in my time, until fairly recently. I'm sure you have. People show an awful lot of interest. I mean things are changing all the time, it isn't static.

Tom Burns: A less philosophical point. My experience working in Scotland just after the '60s was all the nurses were home grown; there weren't many foreign nurses. It's very different from what we've heard about from London and down here. And, they were spectacularly good. And I wonder if that is a cultural difference between the two countries? Or was I just lucky, do you think?

Bill Boyd: I'm not sure that I can answer the question now because in those days, in the '60s, they were local people. They were all local people, with their families, living in the town and they had strong a personal interest in the set up at Herdmanflat.

Tom Burns: But we've heard that they weren't in the '60s in the south of England.

Bill Boyd: I spent more years in the Royal Edinburgh Hospital, but it was still local people.

John Bradley: But in London they were mainly Irish, I think.

Peter Nolan: When the York Retreat was opened at the end of the 18th century, the issue of attendant nurses was important. For William Tuke, the founder of the Retreat, recruiting local people to look after local people was what he believed. Not only that, it was a community of believers. It was where Quakers looked after Quakers. And that,

according to the Tukes, was terribly important. And that contrasts with the picture that I have been presenting to you, where people from many parts of the world were employed to care for local people. And it was a conflict that I probably didn't see at the time but which I've thought about subsequently. It is one that has not been resolved and remains so today. And people are still being recruited from overseas to work in culturally sensitive areas of care. So, the recruitment and retention of nurses remains as problematic as it has always been.

John Bradley: The point is that the clientele in London, in any rate, they are multi-ethnic, you know. And I mean, I remember a patient vividly. I was doing a sort of teaching round and this patient came in in a white robe, she was of Caribbean origin you see. Then she looked at the wall and pointed at me and said, "Mene, mene tekel upharsin". Well, of course, you all understand, yes? Who understands that?

Michael Hilton: It's Daniel Chapter 5, the writing on the wall.

John Bradley: It's Daniel, of course, the writing on the wall. You have been weighed in the balance and found wanting. That's what she was trying to tell me. I'm sure she was right.

Deepa Parry-Gupta: This is just an answer, my response to the question about getting medical students interested. I think we need to plan their placements more carefully. We get told when medical students are going to come. We've got a chronic shortage of consultants who don't have the time mostly and it gets left to us. If we're interested, we make the most of the day for them. If not, we just sort of dump them on the team. And I think we need to be looking at not just trying to recruit psychiatrists, making it an exciting day, but also aiming at the people who definitely don't want to do psychiatry, get them to think about it, as a future orthopod perhaps, why they need to be here today. What are you going to get out of it? What are you going to take into your future career from today? So, make psychiatry not a little nucleus that doesn't count anywhere else, but something that has importance for everybody.

Claire Hilton: I was wondering if Tom Stephenson was waving at me to tell me I've got to stop, but no, he's got a question.

Tom Stephenson: I'm just interested in the wider context in the '60s discussing kind of leadership and change. I wondered, what did people think, non-medical people, outside of the mental health system, when you said you worked as a psychiatrist? How were you regarded?

Bill Boyd: I think they didn't say anything to me, people kept saying to my wife, "What's it like being married to a psychiatrist?" That was always being said. It became a little joke. I can't remember the answer she gave.

John Bradley: I have no recollection of not being accepted socially. People, I mean, you know, would say, "Oh, I don't want you analysing me!" That kind of joke. But I suppose you get that now, don't you?

Claire Hilton: Yes, some things don't change.

John Bradley: They don't, no.

Bill Boyd: Just one thing, I didn't start with the beginning of my life. I was born in the grounds of a mental hospital, my father being a physician superintendent of a very large hospital, and so I've sort of grown up accustomed to being a psychiatrist, attached to psychiatry through all my years. And I do remember the wards of the Stratheden Hospital. I wanted to speak about the '30s, didn't I? I said I'd like to speak about the '30s and she wouldn't let me.

Claire Hilton: Well, perhaps someone here today would like to go to Edinburgh to interview you?

John Bradley: You see, Bill and I have got something in common: we're the same, more or less, the same age you see. So, we're, you know you get something consistent here.

Bill Boyd: Just maturity.

John Bradley: On that note.

Claire Hilton: Right, very great maturity, and I'm very grateful to you. We're going to stop, and I've just got a few small things apart from thank you to both of you. And just to have another Bible quote, I'm going to say, as in the words of Job (32:7): "Age should speak; advanced years should teach wisdom." Well, all the speakers today have certainly shared their wisdom with us, and really, we are very grateful to all of you for joining in this. I've certainly learnt a lot and I hope everybody has, as well as making new friends and enjoying the experience.

There is a feedback form. We only have two questions on it and if you could fill it in, leave it at the back or at the front, I'll go around and collect them up afterwards. Our next step will be to get the audio recording to the transcriber, let all the speakers check their contribution, and then to

annotate and illustrate the text before we get it online. And then we would appreciate you publicising it in journals, social media and so on. So, you'll be hearing more from us in due course. Right now, thank yous.

I'd like to say thank you to the Royal College of Psychiatrists for funding this event and the amazing people who have made it possible. All the speakers, volunteers, audience, college staff from archives, library, estates, admin, catering and media teams. Thank you, Yannick, with the technology! Yannick, that's for you. And somebody who we haven't heard much about, Louise Hide. Louise has been wonderful. She volunteered, if for any reason I couldn't manage to do today, she would take the chair. That's for you, Louise.

Louise Hide: The best thing was that it never had to happen!

Claire Hilton: And thirdly I've got a little present for my partner in crime in organising all this, Tom Stephenson, a little present for you. All the coordinating of the audience, and he's advised me when I've got stuck, and he's got me thinking in the right lines when I've been thinking along some dead-end line. So, everybody else as well, thank you so much for coming. And I hope you all have safe journeys back home and please help yourselves to the cake and fruit and take it with you.

Fig 14: Herdmanflat Hospital c.1985.

Credit: Lothian Health Services Archive, Edinburgh University Library, image (P/PL47/B/E/001)

Discussion

Many witness seminar transcripts, such as in the *Wellcome Witnesses* series, conclude at the end of the transcript, adding little or no comment.[104] However, in view of some contentious issues which arose during our witness seminar, we thought that some discussion was necessary. Many of the topics mentioned in this discussion, and other aspects of the seminar, would be worthy of further analysis, framed in the context of social, human rights, equality, political, economic and health care agendas of the 1960s. This discussion is necessarily short, a starting point rather than an endpoint. We encourage you to read the transcript, and this discussion, alongside other primary and secondary historical sources about the period.

Variable standards

In contrast to the overwhelmingly disparaging historiographies about psychiatric hospital care in the 1960s,[105] the witnesses in this seminar indicated that clinical practices and standards were far from uniform across the UK. TB asked how

> such incredibly different standards of care coexist in quite a small island without…more…proselytization and shifting?

SC mentioned local variation, between Prestwich Hospital and the psychiatric unit in the DGH at Rossendale 15 miles away. In her experience, communication and team working, attitudes of the public to the psychiatric service and of the service towards the patients, were more constructive in the DGH. Even more startling variation was indicated in the descriptions of Herdmanflat Hospital in Scotland compared to some psychiatric hospitals south of the border. Variable standards within individual hospitals were also reported during the 1960s and early 1970s. For example, a committee of inquiry into practices at Whittingham Hospital, Preston, found a "hospital of wide contrasts", with grave concerns about some wards but not about others.[106]

Various factors may have contributed to different institutional standards and cultures.[107] For example, psychiatric hospitals in Scotland functioned under different mental health legislation and with a system of governance separate from that for England and Wales.[108] BB also mentioned that local people staffed Herdmanflat and the Royal Edinburgh Hospital. This may have facilitated stronger links between hospital and community, and better communication and understanding between patients and staff, compared to hospitals with many staff from abroad who had to work in a different culture, and sometimes also a different language.

John Wing and George Brown's seminal "three hospitals" study (1960-68) also revealed variable standards. They compared Mapperley, Netherne and Severalls, three large psychiatric hospitals.[109] Mapperley and Netherne had high standards. Earlier, those two hospitals had forward-thinking leaders, Duncan Macmillan at Mapperley and Rudolph Freudenberg at Netherne, who were innovative and encouraged liberal therapeutic practices.[110] Wing and Brown described low standards at Severalls at the beginning of their study. However, Russell Barton, about whom DJ spoke, was appointed physician superintendent there in 1960, and over the next 10 years, transformed Severalls into a model therapeutic institution. The three hospitals study highlighted the importance of idealistic leadership. This concurs with JJ's view that vision and leadership were key to improving standards, helping to deal with the tendency for staff to be resistant to change as they feel comfortable with established practices which they regard as safe and appropriate (HZ).

Other contemporaneous reports, such as in *Sans Everything: A case to answer*[111] and the inquiry into Ely Hospital, Cardiff, exposed inadequate and sometimes abusive care on some wards similar to that which our witnesses experienced. The Ely Inquiry did not attribute poor standards to inherent malice, rather to defective leadership in an inward-looking institution.[112] In contrast, BB described the outward-looking approach at Herdmanflat Hospital. This included: making links with other hospitals; providing training for nurses (the lack of which was also criticised at Ely[113]) and for local clergy; and involving the local community in the hospital's centenary celebrations. Similarly, Russell Barton made links beyond his hospital walls, as did JB at Friern.

Other factors in the 1960s had the potential to affect standards of care. These included government plans to close the psychiatric hospitals,[114] which discouraged interest in them and expenditure on them. In addition, between 1960 and 1969, there was no official system of external regulation and governance to monitor standards of psychiatric hospitals in England and Wales. The MHA 1959

had abolished the Board of Control which had this role, and there was no replacement inspection authority until the DHSS established the Hospital Advisory Service in 1969.[115]

On the wards

Several speakers (DJ, JG, JJ, PN, MC) focussed on their initial impressions of what they saw and experienced in the hospitals. Those who sensed that something was amiss may have lacked the confidence, courage or know-how, to break with established etiquette of deference to seniors. Junior staff may also have feared that, if they criticised seniors who would normally provide a reference for their next job, their response would have negative consequences for their future career. Also, the NHS had no structured complaints procedure until 1966 when the Ministry of Health published brief guidance.[116] This, however, hardly shifted the defensive attitudes of NHS authorities which continued to dismiss complaints and complainants.

Inadequate facilities at Friern Hospital (MC), and ward conflicts which included physical violence perpetrated by staff and patients (PN) created a disturbing picture of ward life. NHS authorities usually denied that staff could be perpetrators of violence and did little to investigate or prevent it, only publishing its first specific guidance on managing violent behaviour in 1976.[117]

JJ recalled his instructions from the chief male nurse that: “The key is the most important thing…it represents…your power over the lunatics”. This conveyed two main messages. The pejorative and outdated word “lunatics” suggested that the speaker, a senior member of staff and therefore with potential to influence attitudes and practices, held stereotypically demeaning and old-fashioned attitudes about patients. The term “power over” suggested a coercive culture. The combination was unlikely to promote respect towards patients. PC also recalled lack of respect for patients in his description of the consultant’s ward rounds, with discussion between patient and consultant standing at end of the bed, on an open ward. This style of ward round was unacceptable at the same time in more progressive institutions, such as at Crichton Royal in Scotland.[118]

Work, activities and reward

The subject of patients working within the hospitals was another contentious issue, concerning whether work was therapeutic for the patient or was mainly in the interests of the hospital economy and how it was rewarded. A work routine has long been regarded as a “normal” adult activity, intrinsically beneficial to self-esteem and well-being, through involvement, fellowship and creativity. Throughout the 20th century (and before), mental health services advocated for people with mental disorders to have as near normal a life as possible, and a work routine was part of that.

“Industrial therapy” (IT) was conceptualised in the mid-1960s as being when

> patients are employed in factory-type work under medical and nursing supervision which aims at their rehabilitation and/or resettlement, the nature of the work being related to the needs of the individual patient, giving him both psychological and economic satisfaction.[119]

JB explained that patients were paid for their work through external business contracts set up by the IT manager. Occupational therapy (OT) at the same time focussed more on long-stay patients.

GP’s anecdote about her father’s boat being built by patients at Crichton Royal, raised questions about how the project fitted into the IT concept. One participant commented after the seminar: “It jarred a bit for me, it seemed to be genuinely a therapeutic activity without ill-will, but it was also perilously close to looking like exploitation.” Employment of patients in psychiatric hospitals, and other issues raised in the course of the seminar, are ripe for further historical investigation.

Psychiatric hospitals used different systems to reward patients who worked, whether in IT or in other jobs around the hospital. These included: cash; “token economy”; and rewards in kind, the last of which the Board of Control in 1959 considered “out of keeping with modern views”.[120] A token economy was underpinned by established psychological principles, but whether it achieved its goals is less clear.[121] Overcrowded wards and a dearth of lockers for personal possessions meant that cash and other belongings were at risk of theft, a problem which could deter the hospitals from providing cash or token rewards.[122] The system in the 1960s had deficiencies, but community care in 2020 is also far from ideal with regard to employment for patients; it is salutary, as DJ mentioned, that today many people with severe enduring mental disorders under community care are unemployed. A recent report (2013) found UK

employment rates of around 8% for people with schizophrenia, and stated that many more could work and wanted to do so.[123]

Charismatic leaders in biological psychiatry, anti-psychiatry and social psychiatry

William Sargant (1907-88), a long-time advocate of biological approaches to treatment, was one of several charismatic figures recalled by witnesses. Encouraged by like-minded colleagues from the Maudsley Hospital, Sargant prescribed physical treatments before and during the Second World War,[124] and, with his colleague Eliot Slater, published *Physical Methods of Treatment in Psychiatry* in 1944, based on their "direct clinical study on a fair scale".[125] Witnesses at the seminar who had encountered Sargant in person criticised his clinical methods and his approach to patients and colleagues. An audience participant (JG) commented that he helped her relative recover, but some former patients, outside the seminar, have stated that his treatment scarred them for life.[126] Seminar participants compared Sargant to Donald Trump, including for his manner of shouting down anyone who challenged him, "not quite so abusively as Donald Trump, but not far off" (PT). Sargant: "attracted attention but also sought it unmercifully, rather like Donald Trump" (PT).[127] DG made other comparisons: "As the only metaphorical equivalent at the moment is Brexit, let me tell you that Dr Sargant was Nigel Farage!" These comparisons suggest that Sargant had some problematic personality traits, such as reluctance to listen, negotiate or shift on clinical matters. PT worried that, as a junior doctor, he was complicit in Sargant's unconventional treatments by failing to challenge him, even though challenge was unlikely to succeed.

Seminar participants queried whether Sargant practiced beyond the bounds of medical and research ethics. This is complex as his practice needs to be considered in the context of several factors including the MHA, the perceived benefits and risks of the treatments, and expected standards of research. Under the MHA 1959, a patient detained for treatment "must submit to treatment for his mental disorder, whether or not he agrees".[128] This placed the recipient in a potentially unfavourable position for receiving idiosyncratic treatments, even if they were considered "evidence based" by the standards of the time.

Regarding the risks and benefits of the treatments which Sargant prescribed, in the context of available alternatives, is another subject for further historical analysis. However, to touch on just one treatment, prolonged sleep or "narcotherapy", it is worth considering the views of John Marshall, a neurologist, in his book on the ethics of medical practice (1960):

> Reducing a patient to a somnolent or even stuporous condition by drugs is usually referred to as narcotherapy. This may be done solely to give the patient rest and freedom from anxiety, being used in this way for patients with acute anxiety and panic attacks. It was especially valuable for men with battle-exhaustion, as a few days of continuous sleep with the horrors of battle shut out of their consciousness was frequently a very effective way of restoring them to health.

Marshall regarded narcotherapy as an acceptable and established procedure, not an experimental one. His concern about its ethics lay, not in the physical risks or outcome of treatment, but on what the patient might say during an induced sleep.[129]

Concerning research, the *Nuremberg Code* (1947)[130] was the first "modern" internationally recognised, medical research code of practice, but it was hardly implemented. It included the need to obtain the subject's consent, but it did not cover the interface between research and accepted but unconventional clinical interventions, as relevant to Sargant's practice. The World Medical Association *Declaration of Helsinki* in 1964[131] attempted to address this:

> In the treatment of the sick person, the doctor must be free to use a new therapeutic measure, if in his judgment it offers hope of saving life, re-establishing health, or alleviating suffering. If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation….
>
> The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

The 1964 *Declaration* was an important step but proposed neither a mandatory framework of research ethics nor mandatory consent from the

patient. It mentioned neither research ethics committees, nor the case of psychiatric treatment associated with legal detention. Ethics committees appeared in the second *Declaration of Helsinki* in 1975, alongside advice that research proposals should be submitted to a "specially appointed independent committee for consideration, comment and guidance."[132] Sargant had retired from his NHS work by then.[133]

Some institutions had research ethics committees before 1975, such as the Bethlem and Maudsley Hospital.[134] Its authority did not extend to the Royal Waterloo where Sargant worked, which was part of St Thomas's Hospital. St Thomas' had a Research Advisory Committee for which minutes exist from 1957 to 1964. However, the minutes do not mention ethics, or an ethics committee, or reveal any concern about risk or harm to patients, even when discussing Sargant's work. Its main objective appeared to be to ensure that research was feasible so would produce results commensurate with funding.[135]

The MRC published five pages about "responsibility in investigations on human subjects"[136] in 1964. Maurice Pappworth's whistleblowing report on research ethics, "Human guinea pigs: a warning",[137] probably stimulated its creation. The MRC recommended the need for research to be "planned and supervised by a group of investigators and never by an individual alone"[138] but stated the

> impossibility of formulating any detailed code of rules which will ensure…irreproachability of practice which alone will suffice where investigations on human beings are concerned.[139]

Pappworth's subsequent book, *Human Guinea Pigs*, in 1967,[140] led to more discussion including a *Lancet* editorial "When is consent?" It explained that Pappworth

> illustrates all too clearly that consent has been secured for investigations or experiments for which it should never have even been asked—if, he would add, it ever was.[141]

Sargant's unfaltering adherence to all things physical, to the near exclusion of psycho-social treatments, was unusual but not unique.[142] His analysis of the effect of his treatments in the *British Journal of Psychiatry* in 1972 received no criticism in the journal's correspondence columns in the months after publication.[143] The overall impression from the literature is that Sargant was on the fringes of acceptable practice, but not beyond them. In the 1960s context, it would be hard to assert that he practiced outside the existing murky ethical framework.

Witness seminar participants mentioned Sargant over 30 times, three times as often as the next most frequently referenced figure, RD Laing (1927-89), a psychiatrist, born, bred and educated in Glasgow who worked for much of his career in London. In contrast to Sargant's biological methods, Laing was an exponent of anti-psychiatry ideology which refuted the possibility of biological causes or treatments of mental illness. Undoubtedly controversial, he also constructively highlighted the plight of mentally ill people at a time when they were frequently ignored and when many were detained in inadequate facilities.

Sargant and Laing were radical, charismatic and visionary personalities, diametrically opposed in methods of clinical practice. They held rigidly to their own theories and both caused harm to some patients by encouraging idiosyncratic treatments. They also provoked debate, opposition and support. Professor Alwyn Lishman (b.1931) spoke in 1991 about the co-emergence of anti-psychiatry and biological psychiatry, and public concern about psychiatric practice:

> Every action has an equal and opposite action. …As psychiatry got more power in the sense of drugs and ECT, it was natural that there should be a lot of people around who would say that power was being misused. Power was being misused now and again. Patients were put in chemical straitjackets now and again. Some people were given too many ECTs. It was right in the event that there should have been somebody saying this. Of course, they overstated it. There is always a fanatic, saying all ECT should be banned, all drugs. People with placards outside the hospital, booing…
>
> Ultimately it was a healthy thing, not an unhealthy thing. At the worst of it, it was terribly unhealthy. I had parents coming to me asking if I could take their child out of a different hospital where a fanatical doctor was refusing to give any medication and they could not bear to see their child suffering any longer. Those doctors got more sense in the end. I think everyone is more chary of ECT and drugs now…

> Critical feeling outside plays an absolutely essential role. The absence of critical feeling outside allowed the persecution of political dissidents by the labelling of them as mentally ill in Russia.…One has to realise that a levelling effect of society is worth its weight in gold and must always continue.[144]

Russell Barton was another charismatic leader, mentioned by DJ. Barton was vociferous about providing humane and dignified care for mentally ill people in NHS psychiatric hospitals, but in the 1960s, his dynamic person-centred rehabilitative approach was of an order of radicalness almost as great as Sargant's biological methods and Laing's anti-psychiatry. A Ministry of Health civil servant in 1965 described Barton as the Chief Medical Officer's "tiger".[145] Barton's colleague, Henry Rollin, characterised him as a

> maverick…who thrived on controversy…could exhibit a variety of courage neighbouring on foolhardiness: he insisted on speaking his mind when others would have found it politic to keep their own counsel.[146]

After many conflicts with the RHB and with some of his colleagues at Severalls, Barton left in 1970. He had introduced many improvements, but after his departure, good practices waned, and Severalls "reverted to a situation of poor leadership."[147]

As with Sargant and Laing, Barton's charismatic and radical approach generated support and opposition. All three stood on the fringes of conventional psychiatry. Their dogmatism and styles of communication seemed to be as contentious as their clinical methods. Their personality traits may have been strengths in some situations, but also risked being detrimental to patients and to their own relationships with colleagues, the very people they wanted to influence. Their personalities and determination to spread the gospel of their own ideologies troubled many of their colleagues, although others, such as Anthony Clare and Allan Beveridge, valued their intellectual arguments as contributing to developing more person-centred practice overall.[148] It is noteworthy that books about psychiatry by Sargant, Laing and Barton written half a century ago are now published as e-books.

Other psychiatrists in the 1960s, such as Duncan Macmillan (Nottingham) and Professor Sir Martin Roth (Newcastle-upon-Tyne), were as influential as Sargant, Laing and Barton in shaping UK psychiatry but were not mentioned in the seminar. Macmillan was a pioneering psychiatric hospital physician superintendent. Roth was known for his ground-breaking research; his leadership, including as first president of the Royal College of Psychiatrists; and his *magnum opus*, *Clinical Psychiatry*, written collaboratively with other leading psychiatrists Willi Mayer-Gross and Elliot Slater.[149] Omitting Macmillan, Roth and others, led some participants to comment afterwards that the *discussion* was London-centric, despite the witnesses speaking about their experiences in many parts of the UK. This may have been partly because many of the witnesses, and their contemporaries participating from the audience, had undertaken at least part of their professional training in London in the 1960s. Their memories of people who directly influenced them point to the importance of role models in career progression. A further witness seminar may be relevant, on their scientific and clinical contributions and those of many other leaders.

Strong emotions

The seminar captured personal experiences and opinions, facts and emotions.[150] As far as we can identify, any factual errors outside the purely personal, were corrected in the editorial process before finalising the text. Emotions may have been associated with over- or under-stating good and bad aspects of the past, a recognised pitfall of oral history.

For many of the witnesses, memories of their experiences and the emotions associated with them had remained vivid life-long, with the potential to influence their own lives, the care of their patients, and the careers of those whom they taught and supervised and worked with more broadly. For DB, the death of a young woman patient in the late 1950s, possibly by suicide, had "been on my conscience for the whole of my career." It is important for today's clinical students and junior staff to learn from this the profound and prolonged impact which a single patient tragedy can make.

Many reminiscences triggered emotional reflections during and after the seminar, in addition to those about controversial psychiatrists, consent to treatment and research practices. Particularly disturbing to many seminar participants were the descriptions of clinical practices which infringed upon human dignity. Such practices were

commonplace in health care more broadly.[151] Nursing and medical textbooks included remarkably little guidance about protecting patients' dignity, apart from reminders to avoid "unnecessary exposure",[152] an instruction which could be interpreted loosely.

In the 1960s concerns about undignified practice were attracting public attention. The Patients Association, founded in 1963, aimed to improve patients' experience of health care, promote high standards of clinical practice, and shape health policy.[153] In 1964, Gerda Cohen's "Penguin" book, *What's Wrong with Hospitals?* gave many descriptions of insensitive treatment. Concerning health care for physical illness, she characterised the patients' experience of admission to hospital as being "like a chipped flowerpot in for repair".[154] She also described an ante-natal clinic without a changing room where the "nurse broadly commanded, 'Knickers off girls!' before they went upstairs for examination, stowing their lingerie into handbags".[155] This is not far removed from JB's account of Max Reiss requesting to see a patient's pubic hair.

Other strong emotions persisting from the distant past concerned the relationship between junior and senior hospital staff. For some (e.g. MC, IS, PT) being in awe of, or fearing, certain senior colleagues has never left them. MC mentioned his trepidation of speaking at the seminar about his experiences as a junior doctor at Friern Hospital while in the presence of JB, a consultant there at the time and subsequently medical director. PT mentioned that Aubrey Lewis "invoked respectful terror" and IS commented about Sir David's "fearsome interrogation".

Several speakers indicated their uneasiness when reflecting that their seniors were negative role models or undertook practices which they considered inappropriate. Although they did not express their concern to seniors at the time, those experiences inspired several witnesses in their subsequent careers to focus on bettering the lives of patients, through clinical work, as a patient "survivor", and through research and teaching. The overall impression was that those who witnessed good practice wished to emulate it, and those who witnessed bad, sought to change it. These effects lasted long into the lives of the next generation.

The seminar left participants emotionally moved. Correspondence afterwards included shock and distress caused by some of the revelations made by witnesses. For many of us, descriptions conjured up frightful images: the ECT machine being moved along a row of patients lying in their beds and gradually getting closer (PC); SC's descriptions of relatives of patients too frightened to visit them in Prestwich Hospital; the hospital lives of the patients in JL's occupational therapy group; PN's sadness at the death of John Twoomy and the way the hospital authorities dealt with it. There were also positive memories; gratitude for support received from senior colleagues (JH); the sense of personal achievement in countering misogyny and stereotypical assumptions towards women doctors (AR, DB); praise for ambulance personnel (SC); the excitement of creating new services which improved care and treatment (AR, DG); and the delight at seeing people recover when taking new medications (DB).

Feedback after the seminar included criticism that the discussion resembled an "old boys' rugby club reunion", or too much of the "great man, kings and battles" approach. Part of that rested on the gender imbalance of the witnesses and their contemporaries in the audience. It may also have been due to witnesses doing as they were asked—time travelling back in their thoughts—into the gendered and hierarchical world of health care of the 1960s. Doctors, mainly male, were at the top of the pyramid. Psychiatric nurses, usually subservient to doctors, were divided roughly half and half, men and women, to serve the usually gender-segregated psychiatric hospital wards. Other professions such as occupational therapists and social workers were largely female, and low in the hierarchy, as JL and SC indicated in their accounts of being peripheral to the main hospital. Recent experience of creating this transcript and sitting on committees with some of the now senior doctors, has revealed them as more egalitarian than might be imagined from the transcript, while still displaying a sense of humour in times of difficulty (and while completing this report during the Covid-19 pandemic).

During the seminar there was laughter as we responded to witnesses' frank anecdotes about locked wards, maverick colleagues and other matters. There were also stunned silences, and

participants designated some accounts as "harrowing". One witness described the seminar as an "interesting and somewhat moving experience returning to the world that I had left nearly 30 years ago", and another reflected with his eye to the future:

> We must never go backwards but there is a danger of this! We must find leaders and innovators like we have done in the past. That is why young psychiatrists and other professionals are so important.

To understand the rationale behind that statement, requires the young professionals to have some understanding of the past. This seminar, we hope, will be a step towards achieving that.

The contributors: affiliations and biographical details

The witnesses

Dora Black

1955	q. Birmingham
1956–57	SHO, Napsbury Mental Hospital
1966–2015	Gt Ormond St (honorary consultant) and Royal Free hospitals, and elsewhere
1993	Founded first national children's psychiatric trauma clinic at the Royal Free
1995	UNICEF adviser, former Yugoslavia
1998	Advisor to Home Office on Prison Mother and Baby Units

Vice-chairman Cruse and founding co-editor *Bereavement Care*

Assistant then associate editor, *British Journal of Psychiatry*

Lectured worldwide

Publications include: Jean Harris-Hendriks, Dora Black, Tony Kaplan, *When Father Kills Mother: Guiding children through trauma and grief* (2nd edition) (London: Routledge, 2000)

Married. Three children. Enjoys family life, especially her only grandchild (b. 1997), friends, theatre, opera, concerts, exhibitions, reading and travelling.

Bill Boyd

q. Edinburgh, 1954.

After house jobs, 2 years National Service including general medical duties in Japan, Korea and Hong Kong and psychiatry at the British Military Hospital, Singapore. Then returned to Edinburgh.

Consultant psychiatrist and physician superintendent, Herdmanflat Hospital 1963-68, then consultant in general psychiatry and honorary senior lecturer at Edinburgh University. Later worked in old age psychiatry. Finally, full-time vice-chairman, Mental Welfare Commission (Scotland).

Involved with the RMPA and RCPsych, including as chairman of the Scottish Division and Treasurer of the College. Directed the confidential inquiry set up by the RCPsych into homicides and suicides by mentally ill people. Other activities: Age Concern Scotland; Music in Hospitals.

John Bradley

I retired from my NHS and university appointment after thirty years as a consultant in general adult psychiatry. My current and recent appointments are as follows:

1973–2005	Medical member, Mental Health Review Tribunal
1978–98	Member of Council, Medical Protection Society
1988–96	Chairman, Medical Protection Society
1992–98	Member, Parole Board for England and Wales
1996–	Psychiatric adviser, National Counselling Service for Sick Doctors / BMA Doctor for Doctors Service, Wellbeing Service
1997–2008	Mental Health Act manager, Capio Nightingale Hospital
1999–2015	GMC associate: health examiner for Fitness to Practice, Medical Practitioners Tribunal Service
2000–5	Consultant, Cayman Islands Government on Mental Health Law
2003–8	Chairman, Homicide Inquiries, Essex NHS Strategic Health Authority

Malcolm Campbell

1960	q. London
1960–64	General medical posts from St Mary's Hospital Medical School, London
Jan–Mar 1965	Locum medical officer in psychiatry, Friern Hospital, London
April 1965	Commenced training in neurology, National Hospital, Queen Square, including house officer to neuropsychiatric unit
1967-71	Further training and research in neuromuscular disease, Newcastle-upon-Tyne, then 2 years in Cleveland and San Francisco, USA.
1971-73	Wellcome Senior Research Fellow and honorary lecturer in neurology, Newcastle-upon-Tyne
1973	Appointed consultant neurologist and honorary senior lecturer, Bristol University
2001–17	Retired from NHS, but continued private work as clinical neurologist and medico-legal expert

Peter Campbell

Peter Campbell is a mental health system survivor. Born and raised in the Scottish Highlands, he entered mental health services in 1967 and has been receiving them consistently ever since. He has had more than two dozen admissions, two thirds of which were under sections of the Mental Health Act. He has received a full range of treatments in hospital, including ECT, solitary confinement (seclusion) and medications. Occasionally, he has received psychological support like Cognitive Behavioural Therapy.

From the mid-1980s, he was involved in the new survivor movement. He was a founder member of Survivors' Poetry and of Survivors Speak Out, a national networking group. In 1990, he began working as a freelance trainer with mental health workers. He has contributed numerous chapters on user involvement to textbooks.

Peter has been awarded two honorary doctorates in education, one from Anglia Ruskin University, the other from the Open University. He continues to write poetry and hopes that a second collection will be published soon.

Suzanne Curran

1963	Mental welfare assistant Lancashire Council
1964–66	Certificate of social work course, Manchester Metropolitan University (MMU)
1966–69	Mental welfare officer, Lancashire
1972–73	Following birth of children, worked nights as nursing auxiliary, Prestwich Hospital
1975	Casework consultant, generic team, Trafford Council
1976	Casework consultant, childcare, Trafford
1981	Social worker, Ancoats Hospital
1983	Team leader, generic team, Trafford Social Services
1990	Managed physical disabilities unit during reorganisation
1992	Area resource manager for adult services, including private sector; budgets and implementation of Griffiths Report; postgrad certificate in management studies, MMU
1999	Retired

Professor Sir David Goldberg[156]

1959	q. Oxford University and St Thomas' Hospital, London
1962–69	Trained in psychiatry at the Maudsley Hospital
1972–92	Professor of psychiatry, University of Manchester
1993–99	Professor of psychiatry and director of research and development, Institute of Psychiatry, London
1996	Knighted

Publications include:

David Goldberg, *The Detection of Psychiatric Illness by Questionnaire: A technique for the identification and assessment of non-psychotic psychiatric illness* (Oxford: OUP, 1972).

David Goldberg, Peter Huxley, *Mental Illness in the Community: The pathway to psychiatric care* (London: Tavistock Publications, 1980).

David Goldberg, Peter Huxley, *Common Mental Disorders: A biosocial model* (London: Tavistock/Routledge, 1992).

David Goldberg, Ian Goodyer, *The Origins and Course of Common Mental Disorders* (Hove: Routledge 2005).

Professor John Hall

1966-68	Clinical psychology training, Leeds
1968-70	Clinical psychologist, St. Andrew's Hospital, Norwich
1971-77	MRC research psychologist, Leeds University Department of Psychiatry
1977-80	Principal clinical psychologist, Whitchurch Hospital Cardiff
1980-2002	Head of clinical psychology services for Oxfordshire, based at the Warneford Hospital, Oxford
1988-93	Consultant adviser in clinical psychology Department of Health
2002-10	Professor of mental health, Oxford Brookes University, and research director, Health and Social Care Advisory Service, London

Publications include:

John Hall, David Pilgrim, Graham Turpin, *Clinical Psychology in Britain: Historical Perspectives* (Leicester: British Psychological Society, 2015)

Anthony Isaacs

1954	q. London
1955–57	National Service, RAMC, in Germany
1958	MRCP (later, fellow; and fellow of RCPsych)
1958–63	Registrar and senior registrar, Maudsley and Cane Hill hospitals
1963–90	Consultant, Cane Hill Hospital, Maudsley and King's College Hospital Group
	Sub-dean, Institute of Psychiatry, supervising training programmes for overseas doctors
1990	Retired from NHS and continued in private and medio-legal practice

Publications include:

Anthony Isaacs, Felix Post (eds.) *Studies in Geriatric Psychiatry* (Chichester: John Wiley, 1978).

Julian Leff, Anthony Isaacs, *Psychiatric Examination in Clinical Practice* (Oxford: Blackwell Scientific Publications, 1978).

John Jenkins

John trained in South Wales (1960s-70s) and qualified in mental and general nursing, plus a diploma in health studies and master's in business studies. He also worked at the Cassel Hospital, London, gaining a diploma in psychotherapy. In 1977-89, he had senior NHS management roles in Devon, developing new community mental health services and closing institutions. He was a senior policy adviser in the Department of Health. In 1992, he established and directed the Center for Mental Health Services Development, King's College London, a Department of Health initiative to assist the implementation of mental health policy across England. He was also director of operations and service development at North Birmingham Mental Health Trust which pioneered mental health community functional teams, later implemented throughout England.

He established the International Mental Health Collaborating Network (IMHCN) in 1993 and is currently its chief executive. He advised health ministries and authorities in: Australia, New Zealand, India, Malaysia, Serbia, Romania, France, Italy, Ireland and Argentina and had senior roles with WHO in Kosovo, Albania, Macedonia and Palestine. He provides consultancy and training on the Whole Life, Whole Community, Whole System Approach in the UK and abroad.

David Jolley

From a non-medical family, educated at Wolverhampton Grammar School and Guy's Hospital Medical School, q. 1969. When a medical student, spent a month with Dr Russell Barton and others at Severalls Hospital and saw one of the

earliest psychogeriatric services. After qualification, trained in psychiatry at Manchester, in general hospital units. As a senior registrar, had a special year of training for work with older people, spending time with Tom Arie at Goodmayes, Felix Post at Bethlem, John Brocklehurst in Manchester and visiting other units.

1975-95 First consultant psychiatrist with special responsibility for older people in the North West Region. Provided a service in South Manchester, developed a blueprint for services in the Region, and taught and researched with the University of Manchester.

1995-2003 Consultant psychiatrist, medical director and honorary professor in Wolverhampton, redeveloping the mental health and community services.

2003- Part-time in Wolverhampton, then Tameside and South Manchester again. Also undertook innovative work in primary care at Gnosall and at the Tameside and Glossop hospice.

Jennifer Lowe

Born in a field hospital on the North West Frontier of India and Pakistan when her father was in the Indian army. Lived in the foothills of the Himalayas, where the only transport was horse, donkey and mule. A very sparse education, taught mostly at home. Her ayah and one of her father's subalterns taught her to swim and ride a pony. When the war in Europe ended, she came back to England on a troop ship with her mother and brother. England was very strange. It was called "home", but it didn't seem like it. She was sent to boarding schools and spent holidays with her very Victorian grandparents. She got a place at the Slade School of Art but couldn't go, so she trained at Dorset House School of Occupational Therapy, Oxford, then worked at Littlemore Hospital. Various other jobs later including designing clothes, doing upholstery, running a nursery school, working as a chef, and helping run her husband's building business. Now lives alone and sees her children and 10 grandchildren a lot.

Geraldine Pratten

Geraldine's father was Dr RA (Sam) Robinson, consultant in old age psychiatry at Crichton Royal Hospital, Dumfries then in Edinburgh. He was chairman of the RCPsych Section for the Psychiatry of Old Age, 1978-81.

Born in 1952, Geraldine lived in two hospital houses on the borders of Crichton Royal until she was 11 years old. Educated at Dumfries Academy and the University of Stirling, she obtained a degree in biological sciences, majoring in psychology. She joined Sainsbury's head office as a graduate trainee in 1975, working there for six years, and helped establish a market research department, becoming deputy market research manager. Afterwards, she established herself as a freelance qualitative researcher, with particular expertise in education, finance, health, local government and retail.

Professor Peter Nolan

Peter spent seven years in a monastery in Dublin before training as a general and psychiatric nurse in London in the early 1960s. Following this, he spent three years working as an occupational nurse in the Sahara Desert with Mobil Oil. On returning to the UK, he worked at Broadmoor Special Hospital, subsequently as nursing officer and nurse tutor, before taking up a lecturing post at the University of Birmingham in 1986. In 1998, he was awarded a personal chair in mental health nursing. Throughout his career he has retained an interest in understanding how people with mental health problems make sense of their engagement with mental health professionals and services. Collaborative work with colleagues in the USA, Europe and Australia have focused on different aspects of this experience. He has also explored the ways in which a person's faith, beliefs and religious practices contribute to the maintenance of good mental health. He published widely on the history of mental health nursing, and now, in retirement, continues to teach and write on aspects of mental health care. He believes that the history of mental health care, until relatively recently, has been written from a limited perspective and a much more inclusive narrative is urgently required.

Publications include:

Niall McCrae, Peter Nolan, *The Story of Nursing in British Mental Hospitals: Echoes from the corridors* (London: Routledge, 2016)

Angela Rouncefield

1962 q. Liverpool

After a two-year psychiatry training rotation in Liverpool, Angela obtained the DPM (London) then worked at the North Wales Hospital, Denbigh, in psychiatry and epidemiology. She worked in an innovative in-patient unit for maladjusted young adults, the first female doctor to work in what would now be called a low secure unit for psychotic male patients.

1969-74 Consultant psychiatrist, North Wales

1974-2001 Consultant psychiatrist, Cornwall

2001-11 A variety of other consultant roles in the NHS in Cornwall

Achievements include establishing: a psychogeriatric service with a joint assessment unit with a consultant physician; the first supported domestic house in Cornwall; a day activity and social centre for recovering mentally ill people; a substance misuse rehab unit; the Cornwall Alcohol and Drugs Agency; Macmillan nursing and Cruse bereavement services. She was medical adviser to the Samaritans, and the Restormel Association for Mental Health. She enjoyed teaching trainee psychiatrists, medical students and nurses.

2011- Left the NHS but continues in private practice. She is consultant psychiatrist to the Community of St Antony and St Elias, Devon, https://www.comae.org.uk/about-us/ and clinical lead at Sea Sanctuary https://seasanctuary.org.uk

Professor Peter Tyrer

1965 q. Cambridge

1969 Began training at the Maudsley Hospital

2003-13 Editor, *British Journal of Psychiatry*

Currently, emeritus professor in community psychiatry, Imperial College.

His main interests are in models of delivering community psychiatric services, the classification and management of personality disorders and common mental disorders, particularly anxiety and health anxiety. He also leads on research into the management of patients with intellectual disability and on new psychological treatments for health anxiety. https://www.imperial.ac.uk/people/p.tyrer

Speakers from the audience:

Professor Wendy Burn: Consultant old age psychiatrist and president, RCPsych.

Professor Tom Burns CBE: Professor of social psychiatry, Kellogg College, Oxford University, 2003-14. Currently, honorary professor of psychiatry, University College London.

Robert Freudenthal: Higher trainee, general adult and old age psychiatry, Barnet, Enfield and Haringey Mental Health NHS Trust.

Jean Gaffin OBE: Previously: senior lecturer in social policy, South Bank Polytechnic; chief executive, Arthritis Care and National Hospice Council; chair, Brent Primary Care Trust. Currently: member, Patient and Carer Network, Royal College of Physicians; expert by experience, Care Quality Commission; associate hospital manager (MHA 1983).

Louise Hide: Wellcome Trust research fellow in medical humanities and social sciences, Birkbeck, University of London.

Claire Hilton: Witness seminar chair and co-organiser, and RCPsych historian in residence.

Michael Hilton: Rabbi and mental health campaigner.

Mohamed Ibrahim: Core psychiatry trainee, East London NHS Foundation Trust.

Professor George Ikkos: Consultant liaison psychiatrist and chair of RCPsych History of Psychiatry Special Interest Group.

Adrian James: Consultant forensic psychiatrist and RCPsych registrar and president-elect.

Deepa Parry-Gupta: Specialty registrar in psychiatry, Chester.

Tom Stephenson: Witness seminar co-organiser. Core psychiatry trainee, South London and Maudsley NHS Trust, with research interests in prison health.

Ian Stout: Consultant old age psychiatrist 1982-2009. At appointment, responsible for 20 wards at Prestwich Hospital. Developed one of the most

comprehensive old age psychiatry services in the UK.

Maria Turri: Psychiatrist and lecturer in creative arts and mental health, Centre for Psychiatry, Queen Mary University of London.

Ally Xiang: Specialty trainee in medical psychotherapy and general adult psychiatry, West London.

Richard White: Psychiatry training at Netherne Hospital and Friern Hospital, 1968–69. Main career in liaison psychiatry, Sydney, Australia. Currently undertaking PhD (University of Sydney) on the development of general hospital psychiatry in New South Wales.

Professor Harry Zeitlin: During his first psychiatry job, Harry was dismayed by the non-scientific approach, so he changed to chest medicine. In 1967, he told a senior psychiatrist that his report on a depressed, breathless patient was of no help. When calmer, the senior psychiatrist told Harry that if he could do better, "go and do it".

1973-89 Consultant, Westminster Children's Hospital

1989 Appointed professor, University College Hospital, with the task of improving child and adolescent psychiatry in Essex.

Acknowledgements

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Our witnesses and other speakers are acknowledged above. In addition, members of the audience helped on the day, as "buddies" for witnesses, or with microphones, or with administrative tasks. Others advised at the planning stages, or critiqued the transcript, introduction and discussion prior to publication. Our thanks to them all:

Graham Ash
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Susan Lister
Mohamed Ibrahim
Jane Mounty
Deepa Parry-Gupta
Essie Tough
Maria Turri
Sophia Williams
Verity Williams

Notes

[1] Tilli Tansey, "The History of Modern Biomedicine: What is a witness seminar?" http://www.histmodbiomed.org/article/what-is-a-witness-seminar.html

[2] Mark Jackson, Daphne Christie (organisers), "Beyond the asylum: anti-psychiatry and care in the community" witness seminar, unpublished archive (GC/253/B/4, Wellcome Library).

[3] Anne Gulland, "Ronald Arthur (Sam) Robinson" *BMJ*, 26 July 2014: 28.

[4] The institution, originally called Crichton Institution for Lunatics, opened on 3 June 1839. It had 54 beds for private paying patients and 50 for pauper patients. It gained its royal title in 1840. It began to be referred to as Crichton Royal Hospital around 1945, and in 1948 it became part of the NHS. NHS Dumfries and Galloway sold Crichton Hall in 2019 for £50k to the owners of Fonab Castle Hotel, Pitlochry, who plan to turn it into a five-star hotel. The NHS say that this will save about £800k a year in running costs. Midpark Hospital which opened in 2012 is now NHS Dumfries and Galloway's mental health facility for in-patient care.

[5] Russell Barton, *Institutional Neurosis* (Bristol: John Wright and Sons, 1959); David Jolley, "Remembering Russell Barton" *Psychiatric Bulletin*, 2003: 27, 233-4; Henry Rollin, "Russell William Andrew Charles Barton: formerly physician superintendent, Severalls Hospital, Colchester, Essex, and later, inter alia, director, Rochester Psychiatric Center (USA)" *Psychiatric Bulletin*, 2003: 27, 35.

[6] David Stafford-Clark, *Psychiatry Today* (London: Penguin Books, 1954); James Willis, "David Stafford-Clark, Pioneering psychiatrist who brought compassion to his patients and lucidity to broadcasting" 10 September 1999. https://www.theguardian.com/news/1999/sep/10/guardianobituaries2.

[7] HRR, "William Sargant" *BMJ*, 14 September 1988: 789-90: "the most controversial British psychiatrist of modern times".

[8] Claire Hilton, "Dr Russell Barton, Belsen concentration camp and 1960s psychiatric hospitals in England: the controversy" *Contemporary British History*, 2018: 32, 307-35. Barton was one of 96 volunteer London medical students who went to Belsen just after liberation in 1945 to tend sick and starving survivors.

[9] John Wing, George Brown, *Institutionalisation and Schizophrenia: A comparative study of three mental hospitals 1960-1968* (Cambridge: Cambridge University Press, 1970).

[10] Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London: Routledge, 1998), 85-9.

[11] Anthony Whitehead, *In the Service of Old Age: The welfare of psychogeriatric patients* (Harmondsworth: Penguin Books, 1970).

[12] David Jolley, "John Anthony Whitehead" *Psychiatric Bulletin,* 2003: 27, 478.

[13] Jean Gaffin added that, after the witness seminar, she phoned her sister and told her that she had "praised Dr Sargant and that he was described as the Farage of psychiatry" and her sister replied "No wonder, he was a horrible man" although his approach was good for her husband.

[14] i.e. detained under a "section" of the Mental Health Act.

[15] MR, "Wilfred Warren" *Psychiatric Bulletin,* 1991: 15, 458-9.

[16] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

[17] Compared to description by Peter Campbell.

[18] From *My Old Man* by Fred Leigh and Charles Collins (1919): "I walked behind wiv me old cock linnet". A linnet was a songbird, popular in Victorian homes.

[19] A central government office, 1914-59.

[20] Brian Barraclough, "In conversation with Eliot Slater" *Bulletin RCPsych,* 1981: 5, 158-61.

[21] A mental welfare officer authorised to carry out statutory duties under the MHA 1959. Equivalent to "approved social worker" in terminology of MHA 1983.

[22] Mentally disordered in a public place: for removal to a place of safety, up to 72 hours.

[23] Emergency Order, up to 72 hours, required the signature of only one medical practitioner.

[24] Observation Order, up to 28 days, authorized by two medical practitioners (one being an approved psychiatrist under Section 28).

[25] Under the MHA 1983, Sections 136, 4 and 2.

[26] The MHA 1959 repealed Lunacy and Mental Treatment Acts 1890-1930, and Mental Deficiency Acts 1913-38.

[27] MHA 1959 section 49.

[28] District general hospital.

[29] e.g. Mohsin Khan *et al*. "George Osborne's cuts could create an unsafe NHS" *Guardian*, 27 November 2015.

https://www.theguardian.com/society/2015/nov/27/george-osbornes-cuts-could-create-an-unsafe-nhs

[30] Royal Medico-Psychological Association.

[31] Senior house officer.

[32] National Hospital for Neurology and Neurosurgery.

[33] General paralysis of the insane.

[34] Ida Macalpine, Richard Hunter, *George III and the Mad Business* (London: Allen Lane, Penguin Press, 1969).

[35] Peter Nolan, February 2020:

> The ward had 26 beds and three mornings a week upwards of six additional patients came to have ECT. As it was a locked ward, and because many were on sections, most of the patients tended to sit in the dayroom, but there were insufficient chairs. The only escape was to sit in the toilets smoking or just sleeping which often happened, thus blocking the use of some toilets.
>
> Ward staff preferred all patients to shave in the morning and some patients had to stand outside the washroom waiting for a spare washbasin. Most of the time washing and toileting occurred without problems. But not always.
>
> I recall severe serious incidents that required suturing and x-rays. Distress was also caused to other patients, particularly the vulnerable and quiet ones. Some became very frightened and avoided patients whom they deemed aggressive.

[36] For syphilis.

[37] Occupational Therapy.

[38] Rowton Houses: hostels for destitute or low paid working men, created by philanthropist Lord Rowton. The first opened in London, 1892. http://www.workhouses.org.uk/Rowton/

[39] And others e.g. Lunacy Act Amendment (London) Bill. *Hansard* HC Deb 05 April 1905 Vol 144 C477; "The Medico-Psychological Association of Great Britain and Ireland" *Journal of Mental Science*, 1914: 60, 644-95, 670.

[40] Medical Research Council.

[41] Membership of the Royal College of Physicians.

[42] Geoff Watts, "Gerald Francis Morris Russell" *Lancet*, 3 November 2018: 1620.

[43] Caroline Richmond, "Anthony Clare: Irish psychiatrist successful in raising the profile of his discipline through books, radio and TV" *Guardian*, 31 October 2007.

https://www.theguardian.com/news/2007/oct/31/guardianobituaries.obituaries2

[44] *Professor Sir Aubrey Lewis (1900-1975): A pioneering partnership: Aubrey and Hilda Lewis.* https://kingscollections.org/exhibitions/archives/lewis/

[45] Robert Graves (1895-1985), British poet, historical novelist, critic, and classicist.

[46] William Sargant, *Battle for the Mind: A physiology of conversion and brain-washing* (London: Heinemann, 1957); Robert Graves helped Sargant write *The Unquiet Mind: The autobiography of a physician in psychological medicine* (London: Heinemann, 1967).

[47] Baron Owen, physician and politician, b.1938. Foreign Secretary 1977-79. One of the "Gang of Four" who left the Labour Party to establish the Social Democratic Party (SDP) in 1981.

[48] Brian Ackner, Arthur Harris, A Oldham, "Insulin treatment of schizophrenia; a controlled study" *Lancet*, 23 March 1957: 607-11.

[49] Alan Poole, Howard James, "John Deryk Pollitt" *Psychiatric Bulletin*, 2005: 29, 355-6.

[50] Celia Imrie, *The Happy Hoofer* (London: Hodder and Stoughton, 2011).

[51] Austin Bradford Hill, *Principles of Medical Statistics* (8th edition) (London: The Lancet, 1966)

[52] Obstruction of the intestine due to paralysis of the intestinal muscles.

[53] Bethlem and Maudsley Hospital: General Purposes sub-committee, 6 June and 5 September 1968 (Museum of the Mind Archives). There did not appear to have been an equivalent at St Thomas', of which the Royal Waterloo was part (London Metropolitan Archives).

[54] The Nuremberg Code on medical research ethics (1947) was largely ignored. The Thalidomide scandal and Maurice Pappworth, "Human guinea pigs: a warning" *Twentieth Century*, 1962: 171, 66-75 prompted further consideration of clinical research ethics in the UK.

[55] MP, "Heinz Woolf" *Psychiatric Bulletin*, 1989: 13, 584-5.

[56] Claire Hilton, "Psychiatry past and present: do we need history?" *BJPsych Bulletin*, 2019: 43, 126-30.

[57] Ben Sessa, "Dr Ronald Arthur Sandison" *The Psychiatrist*, 2010: 34, 503.

[58] Formerly, Worcester County Asylum.

[59] JJH Rucker, J Iliff, DJ Nutt, "Psychiatry and the psychedelic drugs: past, present and future" *Neuropharmacology*, 2018: 142, 200-18.

[60] Also see: Vicky Long, "Adventures in psychiatry: narrating and enacting reform in post-war mental healthcare" *Studies in the Literary Imagination*, 2015: 48,1, 109-125.

[61] *The Snake Pit*, 1948, a film about an American mental hospital, starring Olivia de Havilland.

[62] Sir Malcolm Sargent (1895-1967) was an internationally renowned conductor.

[63] Recently, evidence has come to light concerning Eysenck's research ethics, particularly during the 1980s and 1990s: Anthony Pelosi, "Personality and fatal

diseases: revisiting a scientific scandal" *Journal of Health Psychology*, 2019: 24, 421-39.

[64] Since 1996, in Bridgend County Borough.

[65] Welsh Office, *Report of the Tribunal Appointed to Inquire into the Disaster at Aberfan on October 21st 1966.* HL 316, HC 553 (London: HMSO, 1967): colliery tip landslide in 1966 that killed 116 children and 28 adults. The inquiry blamed the Coal Board, the statutory authority that ran the nationalised coal mining industry.

[66] Starting in 1982.

[67] Established by Dr Bertram Mandelbrote. Jonathan Leach, "Madness and chaos in the culture of a therapeutic community" *Therapeutic Communities: International Journal of Therapeutic Communities*, 2019: 40, 16-24; Bertram Mandelbrote, "Factors associated with the rapid conversion of a custodial institution into a therapeutic community" 102-11 in *Psychiatric Hospital Care: A symposium,* ed. Hugh Freeman (London: Balliére, Tindall and Cassell, 1965).

[68] Barbara Robb, *Sans Everything: A case to answer* (London: Nelson, 1967); Claire Hilton, *Improving Psychiatric Care for Older People: Barbara Robb's campaign 1965-1975* (London: Palgrave Macmillan, 2017).

[69] Val Harrington, "Voices beyond the asylum: A post-war history of mental health services in Manchester and Salford" PhD thesis, University of Manchester, 2008. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.495613

[70] Also see David Jolley, "Evaluation of a psychiatric service based in a district general hospital" *International Journal of Mental Health*, 1976: 5, 22-36.

[71] On other wards there was more activity. Denis Martin, *Adventure in Psychiatry* (Oxford: Bruno Cassirer, 1962).

[72] Lauren Mosher (1933-2004), professor of psychiatry. http://www.moshersoteria.com/

[73] Michael Gelder, Nancy Andreasen, Juan Lopez-Ibor, John Geddes, *New Oxford Textbook of Psychiatry* (2nd edition) (Oxford: Oxford Medical Publications, 2009).

[74] Reserpine became available after chlorpromazine (Largactil) but reserpine may have been used before chlorpromazine on the wards where Dr Black worked. Dr Black raised the possibility that chlorpromazine had been used for patients elsewhere in the hospital but had caused side effects, or possibly the consultant had personal preferences about medication. Introducing reserpine at that time may have related to a series of papers in 1956-57 about it. e.g. Lorna Wing, "The use of reserpine in chronic psychotic patients: a controlled trial" *Journal of Mental Science*, 1956: 102, 530-41.

[75] Oliver Sacks, *Awakenings* (Harmondsworth: Pelican Books,1976).

[76] By Manfred Sakel, Vienna.

[77] Sylvia Plath, *The Bell Jar* (London: Faber, 1966) 203:

> The nurse jabbed the needle in, and I winced, savouring the tiny hurt. Three times each day the nurses injected me, and about an hour after each injection they gave me a cup of sugary fruit juice and stood by, watching me drink it.
>
> "Lucky you," Valerie said. "You're on insulin."
>
> "Nothing happens."
>
> "Oh, it will. I've had it. Tell me when you get a reaction."
>
> But I never seemed to get any reaction. I just grew fatter and fatter. Already I filled the new, too-big clothes my mother had bought, and when I peered down at my plump stomach and my broad hips I thought it was a good thing Mrs. Guinea hadn't seen me like this, because I looked just as if I were going to have a baby.

[78] South West Thames Regional Health Authority, "Report of the Committee of Enquiry, St Augustine's Hospital, Chartham, Canterbury" 1976, typescript (RCPsych Archives).

[79] John Carlyle Raven, "Raven's Progressive Matrices and Vocabulary Scales". https://www.jcravenltd.com/dr_raven.htm

[80] R McGuire, M Vallance, "Aversion therapy by electric shock: a simple technique" *BMJ*, 18 January 1964: 151-3.

[81] Brian Barraclough, "In conversation with Max Hamilton" *Psychiatric Bulletin*, 1983: 7, 42-5, 62-6.

[82] S Rachman, J Teasdale, *Aversion Therapy and Behavior Disorders: An analysis* (Florida: University of Miami Press, 1969).

[83] John Hall, WT Andrews, "Apparent homogeneity in characteristics of student nurse groups" *International Journal of Nursing Studies*, 1972: 9, 103-9.

[84] David Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London: Process Press, 1996).

[85] DHSS, *Behaviour Modification: Report of a joint working party to formulate ethical guidelines for the conduct of programmes of behaviour modification in the National Health Service: A consultation document with suggested guidelines* (Chairman: Oliver Zangwill) (London: HMSO, 1980).

[86] DHSS, *Report of the Professional Investigation into Medical and Nursing Practices on Certain Wards at Napsbury Hospital, nr St Albans* (London: HMSO, 1973).

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