Mental Health Service reform post-World War Two

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Mental Health Reform

During World War Two, government-sponsored research identified in two population groups at risk of adverse mental health. First, civilians who had experienced intense or repeated air raids were shown to suffer from severe traumatic illnesses. Secondly, it was recognised that veterans who been held in prisoner-of-war camps or served for extended periods overseas might need specialist care to re-integrate them into civilian society and employment. A survey of out-patient and community psychiatric services conducted in 1943 suggested that there was insufficient capacity for the post-war period.

E. Jones (2021), COVID-19 and The Blitz compared: UK mental health outcomes. *Lancet Psychiatry* 8(8):708-716; E. Jones and S. Wessely (2010), Prisoners-of-War: from resilience to psychological vulnerability, reality or perception, *Twentieth Century British History* 21: 163-83.

The Blitz

In the UK, 146,777 civilians were killed or seriously injured during World War Two as a result of air-raids, of whom 80,397 (54.8%) were in London. However, between March and November 1941, 1,104 inhabitants of Hull (0.4% of its pre-war population) were killed by a series of heavy raids, which destroyed almost half of the port's housing stock. A 10-month, follow-up study of civilians treated for psychological trauma conducted by Russell Fraser found that 31.8% continued to suffer from a range of distressing symptoms. He concluded that a "severe personal bombing experience", rather than pre-existing mental illness or vulnerability, was the primary cause of their ill-health.

T. H. O'Brien (1955), *Civil Defence*, London: HMSO, 1955, p. 677; Fraser R, Leslie IM, Phelps D. (1942), Psychiatric effects of severe personal experiences during bombing. *Proc R Soc Med* 36: 119-23.

The Blitz

In 1943, a government study of four historic cities hit in the “Baedeker raids” (Norwich, Exeter, York and Canterbury) and three industrial centres (Bootle, Clydebank and Greenock) showed that the intensity of attacks together with the destruction of housing and loss of jobs determined the level of psychological casualties. Traumatic illness experienced in heavily bombed areas was often severe and individuals were unlikely to recover without professional help.

C.W.E. Emmens, Assessment of air-raid morale from local press, Home Intelligence, social survey and damage reports in Britain, June 19, 1943 (The National Archives, HO199/456).

With reliable data about the causes of civilian psychiatric casualties and evidence from World War One about the enduring effects of shell shock for ex-servicemen, the government recognised that post-war recovery was at risk. In 1943 to assess the demand for mental health services after the conflict, the Ministry of Health commissioned C.P. Blacker, an infantry veteran and a Maudsley-trained psychiatrist, to conduct a survey psychiatric out-patient clinics in England and Wales.

C.P. Blacker (1946), *Neurosis and the Mental Health Services*. London: Oxford University Press.

Carlos Blacker found that 58% of the 159 directors of psychiatric clinics in England and Wales believed that a "latent neurosis" existed in the civilian population likely to emerge in the post-war period. Clinical directors based in large towns (68%) were more likely to support the prediction than those in small towns (53%), though only 44% of those in London took this view. Psychiatrists in the capital may have been influenced by a sustained campaign of film and posters to establish London as a symbol of resilience. In the expectation of an increased demand for treatment, Blacker urged investment to address severe shortages of staff, replace nineteenth-century buildings and develop community services.

Blacker, *Neurosis and the Mental Health Services*, 175-76; Edgar Jones (2021), COVID-19 and The Blitz compared: UK mental health outcomes. *Lancet Psychiatry* 8(8): 708-716.

The National Health Service and psychiatry

The government's White Paper on the creation of the National Health Service, published in March 1944, emphasised the importance of integrating hospital and specialist services on a national scale to improve standards of care. The plan "to bring physical and mental health closer together in a single service," met concerted opposition from the Board of Control. Set up in 1913 from the Commissioners in Lunacy, it regulated the national asylum system. Under the proposals its powers were to be transferred to the Minister of Health. The Board objected, arguing that no transfer could take place without major changes to the 1913 Mental Deficiency Act, which would require a Royal Commission.

National Health Service, The Government's White Paper, March 1, 1944, p. 2. (Warwick University, Modern Records Centre); Ministry of Health, Correspondence from Board of Control, May 4, 1944 (The National Archives of the UK, MH77/25).
https://cdm21047.contentdm.oclc.org/digital/collection/health/id/1127

The National Health Service and psychiatry

Progress towards an integrated NHS stalled and the chief medical officer's report of 1946, which looked forward to the new institution, made no mention of psychiatry. Only when the Ministry of Health backed down and guaranteed the Board of Control's continuing authority over mental hospitals did it abandon its objections to the NHS. The Board continued to hold executive power until it was dissolved by the 1959 Mental Health Act, which was designed to remove the enduring distinction between psychiatric and other hospitals, and to ensure that patients suffering from mental illnesses could benefit from general health and social service facilities.

Ministry of Health, Correspondence from Board of Control, May 4, 1944 (The National Archives of the UK, MH77/25); Mental Health Act, 1959 7 & 8 Eliz 2, Ch 72.

Although the Bill presented to Parliament in May 1946 included the asylums within the proposed National Health Service, the investment and reforms recommended by Blacker were pushed aside. The myth of the Blitz played a key part in the continued marginalisation of psychiatry.

National Health Service Bill, Summary of the Proposed New Service, Cmd 6761. London: His Majesty's Stationery Office, March 1946. (Warwick University, Modern Records Centre).
https://cdm21047.contentdm.oclc.org/digital/collection/health/id/1127

Myth of the Blitz

In 1940, when there were realistic fears that Britain could be defeated, the Ministry of Information had promoted London as a symbol of resilience to stiffen the resolve of the civilian population facing the threat of invasion. Indeed, in autumn 1942, Joseph Goebbels, German Minister of Propaganda, acknowledged the British government's success in lionising stoical determination during the Blitz and making "a legend of London" to counter feelings of despair. However, once the threat of invasion lifted, the value of the narrative eroded, and it deterred those suffering from post-traumatic illnesses from seeking help.

J. Friedrich (2006), *The Fire, The Bombing of Germany 1940-1945*. New York: Columbia University Press, 96, 420; Angus Calder (1991), *The Myth of the Blitz*. London: Jonathan Cape.

In the post-war period, politicians characterized Britain as a new nation forged in war, adaptable, resolute and without the need to develop mental health services. No follow-up studies were conducted of traumatised air-raid casualties, apart from a small study of children treated at Great Ormond Street. Official histories promoted the idea that Britain's mental health had improved during the war, attributed to a common purpose and a sense of shared identity. The myth of the Blitz undermined the claims of psychiatry for improved funding and investment within the new NHS.

David Edgerton (2019), *The Rise and Fall of the British Nation, A Twentieth-century History*, London: Penguin, 26; Carey-Trefzer C. The results of a clinical study of war-damaged children, Great Ormond Street. *J Ment Sci* 1949; 95: 535-59; Richard Titmuss (1950), *Problems of Social Policy*. London: HMSO, 13, 343.

The reality

War pension data testified to impact of the conflict on peoples' mental health. In 1947, 48,000 civilians and emergency responders were receiving pensions for physical and psychological wounds, of which 24,000 remained in payment in 1956. A post-war survey of German civilians found that 91% identified bombing as the most traumatic experience of the war and over a third said it had broken their morale. In addition, 50,000 UK veterans were awarded a pension for a psychological disorder, though little specialist treatment was offered.

Ministry of Pensions. *Twenty-Eighth Annual Report for the Period 1 April 1952 to 31 March 1953*. London: Her Majesty's Stationery Office, 1953; G.S. King (1958), *The Ministry of Pensions and National Insurance*. London: George Allen and Unwin; Richard J. Evans (2008), *The Third Reich at War, How the Nazis led Germany from conquest to disaster*. London: Allen Lane, 462-63; Ministry of Pensions, *Twenty-Eighth Report… for the period to 31 March 1953*, HMSO, London, Appendix 4, 97.

Civil Resettlement Units (1945-46)

A study of 1,154 repatriated prisoners-of-war conducted in 1944 found that they exhibited poor health and behavioural disturbances compared with a control group of soldiers. Twenty Civil Resettlement Units were opened in summer 1945 for returning POWs. They offered re-education, training and 'resocialisation' programmes under light military discipline. Input was provided by a Ministry of Labour vocational officer, a civil liaison officer and when needed a psychiatric social worker. Periods of trial employment were organised. Attendance was voluntary for Army personnel, and 53,000 veterans attended the six-week residential courses. Psychiatrists were to have been attached to the units but not appointed due to shortages of trained staff.

A. Curle and E. Trist, 'Transitional communities and social reconnection, part II', *Human Relations*, 1 (1947), 240-88.

Scale of the challenge

The NHS came into being on 5 July 1948. The mental health service was ill-equipped to face the post-war challenges in terms of beds and staff. At the end of the conflict there were 147,000 patients in asylums together with a further 53,000 hospitalised with learning difficulties, and an estimated 47,000 receiving care in the community. Traumatised veterans, emergency responders and civilians added to the demand, whilst some mental hospitals had been diverted to the Emergency Medical Service treat the wounded and injured.

Andrew Land, Rodney Lowe and Noel Whiteside (1992), The Development of the Welfare State 1939-1951. London: HMSO, 1992, 114-15.

Practice in the late 1940s and 1950s

The number of patients in asylum beds fell only marginally from 147,300 in 1950 to 141,000 by 1960, whilst the number of in-patients with learning difficulties rose from 51,300 to 57,200. In 1954, the Percy Commission estimated that 46% of patients in mental hospitals had been resident for more than ten years, and 10% for more than 30 years. However, 40% of new admissions in the 1950s were discharged within three months and 80% within a year. Out-patient attendances rose from 523,000 to 1,265,000 between 1950 and 1960. Staffing was improved. The number of mental health nurses rose by 30% to 25,000, whilst the number of consultant psychiatrists increased by 33% to 679, at a time when the UK population grew by 5.2% to 46.1 million.

John Turner et al. (2015), The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research, *Medical History*, 59(4): 599-624, 605.

Plausibly the expansion of out-patient services and shorter admission times were made possible by therapeutic revolution of the 1950s, enabling mental health services to cope with the increased demand. A range of novel drugs to treat psychosis and mood disorders were approved: chlorpromazine (1952), haloperidol (1958), iproniazid, a monoamine-oxidase inhibitor (1952), imipramine (1958) amitriptyline (1961) and lithium (1949).

Expenditure on the NHS

Forecast to cost £134 million annually, the NHS took a growing share of government spending, rising to £225 million in 1948-49 and £272 million in 1949-50, when it represented 3.75% of GDP. In 1950, alarmed by runaway health expenditure, Clement Attlee, the Labour Prime Minister, set up a Cabinet Committee with himself as chairman to introduce cuts. The 1951 Budget, which introduced charges for teeth and spectacles, divided the Labour Party and led to Aneurin Bevan's resignation from the Cabinet.

Peter Hennessey (2006), *Never Again, Britain 1945-51*, London: Penguin, 416-17.

Expenditure on the NHS

Under a Conservative government, the Treasury insisted on a rigorous spending review at the end of 1952, and by 1953-54 cuts had reduced the overall cost of the NHS to 3.24% of GDP. By comparison, total health expenditure in the UK was 6.9% in 1997 and 10.2% of GDP in 2019. In the post-war period, psychiatry found itself at the tail of the queue for investment as expenditure on physical medicine grew at a much faster rate. Not until New Labour's mental health initiative (1998-2010) did funding rise significantly.

Peter Hennessey (2006), *Having it so Good, Britain in the Fifties*, London: Allen Lane, 220-21; Turner, Mental Health Services, 604.

Conclusion

Although research conducted during World War Two identified the causal variables of post-traumatic illness and laid the foundations for care in the community, the power of the Board of Control and the vast capital investment in the asylum system served as a brake on reform. Despite the creation of the NHS in 1948, significant change to the design and delivery of mental health services was delayed until the 1960s. It was enabled by the passing of the 1959 Mental Health Act, which removed the Board of Control, allowing the Department of Health to develop psychiatric services in district general hospitals and in the community, and embark on the progressive closure of the asylums.