

National policy and local contexts: insights from the post-war history of mental health services in Manchester and Salford

Val Harrington

Personal Social Services Research Unit, Dover St. Building, University of Manchester, Oxford Road, Manchester M13 9PL, UK¹

Introduction

History can help us make sense of a complicated world... [it] can present us with alternatives, help us form the questions we need to ask of the present... [But] history does not produce definitive answers for all time. It is a process... there are no clear blueprints to be discovered in history that can help shape the future as we wish²

The aim of this paper is to bring an explicitly historical perspective to the theme of innovation and change within mental health services – a perspective which, in current policy making, is either conspicuous by its absence or, if included, tends to equate the past with failure. For example, *Modernising Mental Health Services*, the 1998 document outlining New Labour's early mental health strategy, contains a chapter entitled 'The failures of the past',³ while the only reference to history in the subsequent 2001 Department of Health publication *The Journey to Recovery* is a page devoted to 'A century of slow progress'.⁴ Within such a framework history is regarded as at worst irrelevant, and at best a counterpoint to the present, something that needs to be broken away from.

The alternative notion of 'learning from history' can be equally problematic, however. The common adage that we should learn from our mistakes – or, more rarely, our successes – implies a straightforward relationship between past and present, in which the conditions of the past are re-created in current contexts. As Macmillan points out, however, 'each historical event is a unique congeries of factors, people or chronology'.⁵ Careful historical analysis can trace how such congeries have helped to shape and structure our current values, beliefs and institutions. At the same time, it serves to underline firstly the huge level of complexity involved, and secondly the highly contingent – and thus un-replicable – nature of any given context. The idea that 'the lessons of history' can provide ready-made solutions to current problems and dilemmas is thus grossly oversimplistic.

Does history therefore have a role in helping to shape mental health policy? I would argue that it does – not by providing a blueprint for the future but more subtly, through its capacity to deepen our understanding of the complexities and challenges of current service provision. Awareness of the historical context of an organisation may, for example, shed light on its current character and difficulties. For example,

¹ Email address for correspondence: valerie.harrington-2@manchester.ac.uk

² Macmillan (2009), 168, 154, 167, 153

³ Department of Health (1998), 24-31

⁴ Department of Health (2001), 4

⁵ Macmillan (2009), 153

Manchester's Mental Health and Social Care Trust, an amalgamation of staff and services from three separate health districts, has a reputation for conflict and division. This becomes much more understandable in the light of the legacies it inherited: the particular – and very, very different – trajectories, politics and cultures of the three main mental health institutions; the relationships they had built up over time, both with each other and with the communities they served; and their highly idiosyncratic patterns of service development and innovation.

One of the aims of my recent research into the post-war history of mental health services in Manchester and Salford was to articulate, explore and make sense of some of these differences. The research also highlighted a number of common themes: themes which, although played out very differently in different contexts, transcended both time and place. This paper will focus on three in particular: the fundamental tensions and contradictions inherent in mental health care; the shifting dynamics of innovation and change, stability and stagnation; and the complex interplay between national policy and local context. All three serve to problematise mental health service provision rather than provide answers. Nevertheless, I shall argue, such historical insights are both valuable and useful – and, if heeded, have a crucial role to play in informing, extending, challenging and even reframing policy debates.

The first part of the paper provides an overview of my research and a brief description of the three case studies around which it is built. Drawing on examples from, and connections between, the case studies I then move on to explore the three themes outlined above, ending with a number of questions which I hope will stimulate discussion during the conference session.

Voices beyond the asylum: a post-war history of mental health services in Manchester and Salford

The aim of my research was to create a local history of post-war mental health services beyond the asylum. The study spanned a fifty year period, from the inauguration of the NHS in July 1948 through to its fiftieth anniversary in 1998, and the particular setting was Manchester and Salford, two adjacent but culturally and historically distinct cities in the north west of England. Through the lens of their mental health services, the project explored how national policies and developments were interpreted and translated on the ground.⁶

The shifting boundaries of mental health care during the post-war period

In broad terms, the post-war period was dominated by the shift from asylum to community care. Contrary to popular representations, however, the story is not of a simple linear move from hospital to community. It is instead a story of increasing complexity and, indeed, fragmentation; of shifts in balance between a range of hospital and community settings and different forms and models of care; and of the shifting boundaries of three distinct but interconnected dimensions of mental health care.

⁶ The project was funded by a Wellcome Trust PhD studentship award. A copy of the final thesis (Harrington (2008)) which, in addition to the three case studies, includes a general overview of mental health services in the area, can be downloaded from <http://www.zizek.demon.co.uk/Val/PhD.html> .

The first of these dimensions relates to the changing conceptions and definitions of mental disorder. In a trend which can be traced back to the inter-war period, definitions and boundaries of mental illness widened to encompass an ever increasing number of people, conditions and areas of human experience.⁷ Secondly, the closure of the large mental hospitals meant that this process was accompanied by a remapping of institutional boundaries.⁸ Not only did the geography change, as sites became smaller, more localised and more widely distributed across the public, private and voluntary sectors, but there was a re-structuring of relationships. As service users negotiated their way through an ever-increasing range of specialist facilities, institutional relationships became more fluid, both within and between individual agencies, and with the wider community. These shifting conceptual and institutional boundaries in turn impacted on the third dimension, professional roles and relationships. Established practitioners took on new functions and responsibilities, while whole new professional groups emerged onto the scene. This entailed a re-negotiation of professional roles and territory: negotiations which were complicated, firstly by historical inequalities in status and power; and secondly by the changing contexts within which they were operating – both on the macro level as the organisational map was constantly redrawn, and on the micro level, within the new and variously configured multidisciplinary teams.

It is this complex and fluid picture which forms the general landscape, both of my research and of existing histories of deinstitutionalisation. These tend to fall into two camps: either broad based accounts, which do much to enhance our understanding of the national processes and factors underpinning recent developments in mental health care, but which offer at best only brief glimpses of the ways in which new policies played out within particular service settings;⁹ or local histories of single institutions, often rich in detail about the everyday life and experiences of both providers and recipients of care, but with an inevitable focus on the internal workings of the institution rather than its relationships with the services outside.¹⁰ My research aimed

⁷ The immediate post-war period, for example, saw a huge increase in the number of people receiving psychiatric care: admission rates rose from 45 per 100,000 population at the end of the war to nearly 300 by the late 1950s, while between 1949 and 1955, the number of new out-patients rose by 30% to 122,300. (Raftery (1996), 21-22; Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957), 319). Over the next forty years, the number of recognised psychiatric conditions almost trebled: the most recent version of the DSM (DSM IV, published in 1994) listing 297 disorders, compared with 106 cited in the original (1952) version. Reported prevalence rates rose correspondingly: by 1992, it was estimated that around 300 people per thousand would experience mental health problems in any year, a third of whom would go on to be diagnosed and treated (Goldberg & Huxley (1992)).

⁸ The run-down of the large mental hospitals began in the early 1960s, initiated by Enoch Powell's famous water-tower speech in which he spoke of the 'elimination of by far the greater part of the country's mental hospitals' which stood 'isolated, majestic, imperious, brooded over by the gigantic water-tower' (Jones, 1993, p,160). By the early 1980s bed numbers had fallen by almost a half, but it was not until the late 1980s that the closure programme began in earnest. Between 1985 and March 1993, 31 institutions shut down, with plans firmly in place to close the rest before the end of the century. (Davidge et al (1993)).

⁹ See, for example, Jones (1993); Busfield ((1986); Payne (1999), Bell & Lindley (2005); Freeman (2005); Welshman (1999) and Rogers & Pilgrim (2001).

¹⁰ These vary in genre: some, like Gittins' evocative history of Severalls Hospital in Colchester, are academic texts (Gittins (1998)); others, such as Goddard's oral history of Littlemore in Oxfordshire, are written for a local, lay audience (Goddard (1996)); while David Clark, former Medical Superintendent of Fulbourn Hospital in Cambridge, describes his book as 'as much autobiography as narrative history' (Clark (1996), xi)

to redress these imbalances: built around three case studies – each representing a site of innovation from a different time period, geographical district and service setting – it was designed to complement the broader histories by focussing on how, at ground level, particular services responded to the changing political, social and professional context of mental health. At the same time, it aimed to provide a sense of connectedness which single institutional histories cannot offer: firstly by looking at how the services in question fitted into the wider configuration of mental health provision, both locally and nationally; and secondly, by exploring the connections between them – and thereby highlighting important continuities and discontinuities across time and space.

Methodology

Oral history is a history built around people. It thrusts life into history itself and it widens its scope. It allows heroes not just from leaders, but from the unknown majority of the people.¹¹

Each case study drew on a sizeable collection of documentary evidence, in the form of official minutes and reports, informal communications and memoranda, and post-graduate dissertations and academic papers. It was the personal testimony, however, which brought the case studies to life – and which, as Thompson discusses in his overview of the history and scope of oral history, illuminated areas only hinted at in the written sources.¹² My aim was to talk both to key figures in the services and to frontline workers; to the drivers of innovation and to those who were required to adapt to and implement the changes within their day-to-day practice. I was interested in whether the reports and papers – written with a particular audience in mind and often strongly upbeat in tone – accurately reflected the experiences of those actually working in the services; in the precise mechanisms through which new ideas and policies were able to take root; in the sources and forms of dissent and the ways in which conflicts were resolved; and in how the impetus was sustained – and eventually dissipated – over time. While the total set of 65 informants thus included consultants, professors, senior managers and health authority members, equally important were the voices of those on the ground – nurses, social workers and other mental health professionals, a support worker and a receptionist/administrator – whose stories and insights, both individually and as a group, helped to capture and recreate that ‘original multiplicity of standpoints’¹³ which the historian is seeking.¹⁴

Clearly there are also limitations to the method, most notably around issues of the unreliability of memory, ‘distorted by physical deterioration and nostalgia in old age, by the personal bias of both interviewer and interviewee, and by the influences of collective and retrospective versions of the past’.¹⁵ In response, theorists have shown how, when acknowledged and addressed appropriately, this subjectivity can become both a powerful tool and a rich object of inquiry for the oral historian.¹⁶ Nevertheless, where possible, I was careful to verify specific details with either other interviewees

¹¹ Thompson (2000), 23.

¹² Thompson (2000), 25-117.

¹³ Thompson (2000), 6.

¹⁴ What is clearly missing is the voice of service users. This is due to the constraints of both time and space and reflects how, with a primary focus on service dynamics and organisational issues, staff rather than patients were the natural target group.

¹⁵ Perks and Thomson (2006), 3.

¹⁶ Perks and Thomson (2006), 3-4; Thompson (2000), 156-172; Portelli (2006); Yow (2206).

or with written sources and to highlight and explore where apparent contradictions occurred, or where the ‘rosy-glow’ effect may be operating. Given that innovation was one of the key features of the case studies, this ‘rosy-glow’ effect was perhaps particularly pronounced: as I shall discuss later, one of the key features of successful innovation is the degree of personal involvement and emotional commitment generated among the participants, and many of my informants reflected on how their involvement with the service in question represented a ‘golden age’ within their career. Clearly, in such cases there is a risk that the accounts will exaggerate the positives and glide over problems and conflicts. At the same time, however, this sense of excitement and commitment, particularly when replicated across a number of interviews is, in itself, central to our understanding of the dynamics of the services. Another factor which may have contributed to a nostalgic bias is the way in which, in contrast to actors in many other branches of science and medicine, so few of my informants regarded their history as one of progress. Again, although at one level this may have resulted in distortions of memory as interviewees wistfully looked back to earlier periods, at another it served to emphasise the ongoing and inherently problematic nature of the mental health services – a key theme in this paper.

Recruitment was largely through the ‘snowballing’ technique.¹⁷ Initially I cast my net widely to get a sense of the overall landscape. Within a fairly short period of time, however – and largely as a result of certain key interviews – I decided on the three case studies and from that point onwards concentrated on creating three ‘data sets’ of informants, who between them spanned both the relevant time period and as broad a range as possible of professional and ideological perspectives. The method proved highly effective and I was both grateful to, and touched by, the interest and generosity of the people I approached. In all only two people declined to be interviewed and it was pressure of time rather than lack of potential informants that forced me to limit the number of interviews I conducted.

Consent was obtained, copyright and use of interview material negotiated and data stored according to NHS and Oral History Society guidelines.¹⁸ In most cases just one interview was carried out, usually in the informant’s own home or place of work and usually lasting between one and two hours. With one exception, all interviews were recorded. Most were transcribed by a professional transcriber and participants were asked whether they wished to see the transcript. The interviews themselves were semi-structured, intended to be purposeful but not dictatorial. I prepared by identifying the themes and details I hoped to address (such as team relationships, professional identity and loyalties, and more concrete matters such as dates, personnel and service structures) but the actual interview very much followed the career history of the informant, and the issues which they brought up. At the same time, the aim was to maintain a balance between the individual and the service they had worked in – and, ultimately, to create a dialogue between interviewer and interviewee, in which we re-constructed the life narrative of the institution.¹⁹ As a set, the 65 interviews provide a fascinating and invaluable record of mental health service development in the post-war period. And, although, unlike recent oral histories of learning disability,

¹⁷ Crossley (2006), 6.

¹⁸ Oral History Society (2003). NB The project had NHS ethics committee approval.

¹⁹ NB Thompson states very firmly that ‘the interview is *not* a dialogue or conversation’ (Thompson (2000), 238 and I very much agree with this. I am using the term dialogue more broadly, to capture the sense of a shared encounter.

my subjects took no part in the writing-up process, the structure and focus of the research was very much shaped by their interviews.²⁰

From community to hospital and back: an outline of the case studies

As highlighted above, the three case studies represent sites of innovation from different time periods, geographical districts and service settings. They are written from a developmental perspective, with the aim of creating a ‘life history’ of each service, from birth through maturity to death – with a sense, almost, of them having a life-force or momentum of their own. Within this framework I explore how the actors both shaped and responded to local and national service structures and policies, focussing particularly on two sets of dynamics: inter-professional and team relationships; and the processes of innovation and change.

(i) Integration in a divided world: Salford community mental health services, 1948-1974

Salford City Council’s mental health department provides a rare example of the vision of community care contained within the 1959 Mental Health Act. More interesting than the minutiae of service provision – which included very early examples of community-based day centres, hostels and psychiatric social clubs – were the conditions which produced them. The case study explores a variety of factors, from key personalities such as Lance Burn, Salford’s slightly maverick Medical Officer of Health, to the department’s unusual organisational structures. These were transformed by Mervyn Sussler, a South African epidemiologist who, in a unique joint arrangement with Manchester University’s Department of Social and Preventive Medicine, was employed part time within the service from 1957 to 1965. He quickly identified two key problems endemic within local authority mental health services: poor coordination with other agencies and the low status of mental welfare officers. Focussing on the twin themes of integration and professionalisation, and with mental health social workers taking centre stage, the case study traces how, over the subsequent decade, the department not only forged strong links with local hospital and community services, but also evolved into a highly skilled, professional workforce. At the end of the 1960s, however, a combination of financial cuts, changes in local authority personnel and the imminent introduction of the new Social Services Department, resulted in a mass exodus of staff. Although efforts were made to preserve the ethos of the old service within a very different organisational structure, by 1974 the majority of specialist mental health social workers had retreated into new bases within the hospital.

(ii) The golden age of district general psychiatry? Withington Hospital Psychiatric Unit, 1971-1991

It is just such a hospital base which is the setting for the second case study. Known as ‘The Maudsley of the North’, Withington Hospital Psychiatric Unit, which opened in 1971, was attached to a large district general hospital (DGH). It had a dual role: to provide a local service for the people of South Manchester and to provide teaching facilities for doctors, nurses and social workers – including the explicit aim,

²⁰ I am referring here to the work of the Learning Disability Research Group, based at the Open University (Learning Disability Research Group (2008)). For a discussion of how subjects were involved in producing their own ‘end-product’ see Atkinson (1993).

articulated by Neil Kessel, Professor of Psychiatry, of training up a generation of psychiatrists to go out into the north west region and disseminate good practice. As a case study it is therefore doubly fascinating: a window not only onto the workings of a modern, purpose built DGH unit – and the newly emerging concept of district psychiatry – but also onto the education of key mental health professionals and, crucially, the relationship between academia and practice. Of particular significance was the emergence of the concept of the multidisciplinary team. The ways in which these teams functioned, in the context of a consultant-led, strongly medicalised service ethos, is a key focus of the case study. Ironically, within less than twenty years of its highly lauded beginnings, Withington had become the subject of considerable external criticism. The case study explores some of the underlying reasons for its decline, arguing that, although political and financial factors played a significant role, ultimately the problem lay within: in its internal structures and its relationships with the wider community; and, more systemically, in the tensions inherent in the DGH model of psychiatry.

(iii) Radicalism in a backwater: The Harpurhey Resettlement Team, 1982-1998

Regarded as the ‘poor relation’ of the city, North Manchester Health Authority had no teaching hospital and a legacy of several hundred long-stay psychiatric patients, housed in Springfield Hospital, a former workhouse adjacent to the district general hospital. On the face of it, it was thus a surprising site for innovation. In the 1980s, however, in the context of the accelerating programme of mental hospital closure, a radical resettlement project was set up, in which a group of long-stay patients were resettled into ordinary tenancies within a small geographical district. Based on the concept of normalisation, and strongly influenced by radical mental health activism, it challenged traditional conceptions of mental illness and offered new service models in which community development and community/service user involvement were key features.²¹ Set against the Thatcher government’s assault on public services, the case study analyses the fascinating power dynamics which underpinned the developments: the battles between two left-wing public health doctors and a highly marginalised group of psychiatrists; the unpredicted effects of both the 1982 NHS reorganisation and the introduction of hospital general management; the team’s reluctant evolution into a full CMHT; and the increasingly problematic – and ultimately unsustainable – relationship between the developing service and its mainstream ‘masters’.²²

Though clearly very different in terms of context and service dynamics, the three case studies are, as earlier highlighted, connected by a number of recurring themes – themes which, having endured over a significant time period and across a variety of settings, arguably still have relevance for our current policy context. It is to these that we now turn.

Common themes

²¹ Based on labelling/social deviancy theory, the advocates of normalisation argued that the main problem for people with mental health problems was not their condition per se, but their segregation from ordinary life and ordinary roles. This segregation was compounded by the way in which traditional specialist services were located, organised and delivered. In order to combat this, it was argued, the focus of services should be on creating and maintaining ordinary social roles in ordinary social settings. (Wolfensberger (1972); Emerson (1992)).

²² For a more detailed account of the setting up of the team see Harrington (2009)

(i) Tensions and contradictions in mental health care

The first set of tensions both arose from, and contributed to, the shifting boundaries of mental health care discussed in the introductory section. The expanding boundaries of mental illness, for example, produced huge tensions as the system attempted to balance increasing demand with its all too finite resources. This was further complicated by the emergence of two distinct but overlapping populations: the traditional constituency of, in modern parlance, the ‘severe and enduring mentally ill’ and a newer group of people, less severely impaired, but nonetheless experiencing considerable psychological and social distress.

In broad terms, these tensions grew as the century progressed. Thus, while the early Salford mental welfare officers were lauded for their efforts to attract an ever-widening client base (by, for example, setting up one of the earliest GP attachment schemes in the country):

I think, in one sense, during the 60s we were, we saw ourselves as growing and the fact there were more people knocking at our door was seen as a good thing²³

by the mid 1980s, their CPN successors, by this time based out in GP practices, were severely criticised for operating an ‘all-comers welcome’²⁴ approach – in which, it was argued, the needs of people with severe and enduring problems were being neglected.²⁵ Such criticisms were not confined to Salford CPNs. By the early 1990s there were calls from both within and outside the profession for ‘a realignment of CPN service delivery in favour of the interests of severely mentally ill people’²⁶ – a message which resonated with that of Sayce, in her 1991 report on the first generation of community mental health centres and CMHTs.²⁷ And certainly, by the end of the period, access to secondary care was far more regulated and controlled, with an increasing emphasis on service thresholds and eligibility criteria.

The overall picture is, however, far more complicated. For example, despite the relatively unboundaried approach of Salford’s mental welfare officers, there is no evidence that the needs of the severely mentally ill were neglected – to the contrary, a significant proportion of the department’s service development and research activities were directed towards those with chronic schizophrenia and related disorders. And, in the same time period that CPNs in Salford were arguably overextending the boundaries of their service, less than ten miles away, in South Manchester, their counterparts were operating within a much tighter set-up. Under the close supervision of the Withington consultants, the nurses here spent most of their time assessing, monitoring and supervising hospital patients in the home. However, although such a system guaranteed that people with severe and enduring illnesses remained centre stage, it did little to either support GPs in their day to day encounters with mental health issues or to foster communication between primary and secondary services. The boundaries may have been clearer than in Salford, but a significant proportion of the population remained firmly on the outside. Over in North Manchester, a different set of tensions played out. As earlier described, the Harpurhey Resettlement Team was originally set up to support the resettlement of a group of long-stay patients from

²³ Interview 1: Salford Mental Welfare Officer during the 1950s and 1960s

²⁴ Interview 2: Salford CPN from the late 1980s

²⁵ Wooff et al (1988).

²⁶ White (1994), 217

²⁷ Sayce et al (1991)

Springfield Hospital. Over time their remit was broadened and they evolved into a CMHT – albeit reluctantly, due to concerns that their original service users were being sidetracked. They did, however, continue to insist on working only with people with serious, chronic mental health problems. Ironically, this stand led to their eventual demise: resisting the introduction of new, nurse-led home treatment service aligned to primary care, they were summarily disbanded – just at the time when national policies were beginning to refocus on the needs of people with severe and enduring mental illness.

The second dimension – the increasing fluidity of the institutional landscape – created a further set of tensions and contradictions, as the needs and concerns of individual services were set against those of the wider system; and the traditional institutional values of autonomy, identity and loyalty clashed with the more fluid concepts of co-operation, co-ordination and integration. These again played out very differently across the three services. In Salford, for example, service development was driven by what Mervyn Susser referred to as ‘active coordination’.²⁸ Adopting an epidemiological rather than clinical framework, he identified the connections – or, more accurately, disconnections – between the three arms of the tri-partite NHS (hospital, GP and local authority), directing his reforms towards the creation of a single, seamless mental health service. This outward-looking ethos was both complemented and reinforced by measures explicitly designed to professionalise and strengthen the team. A pivotal feature of these was the weekly case discussion, a genuinely open and democratic affair which served as a vehicle not only for education, but also for shared reflection on all aspects of team functioning – particularly its internal and external relations. In contrast, a recurrent criticism of Withington was that it was too inward looking, focussing almost exclusively on the narrow concerns of the hospital and its individual patients, rather than the broader picture. In part this grew out of a commitment to improving standards of clinical practice and in the early years its clear professional structures and strong internal relations undoubtedly contributed to its success in this area. Over time, however, an elitist, non-inclusive ethos developed, with the unit increasingly alienated from outside agencies. As the mental health landscape began to change, and new actors, models and configurations of mental health care emerged, Withington became increasingly isolated, unable to accommodate or adapt to the world outside. For the Harpurhey team, on the other hand, integration with the outside world was not the issue: indeed the whole service ethos was centred around neighbourhood working and the forging of strong relationships with local services and community groups. A consequence of this – and in part a deliberate choice – was their detachment from mainstream mental health services. Away from the centres of power, however, the team was arguably less prepared and equipped to influence, and ultimately stand up to, the forces of change which eventually destroyed them.

These institutional tensions were echoed at the professional level – the third dimension – where the new emphasis on multidisciplinary teamworking raised fundamental issues of professional identity. Should practitioners’ loyalties lie with their primary profession, such as community psychiatric nursing, or with their colleagues in the team? And, more broadly, did they see themselves predominantly as mental health specialists or as part of their generic occupational group, such as social

²⁸ Susser (1962), 76.

work or medicine? Certainly, Withington's psychiatric social workers identified far more strongly with the hospital-based clinical team than with their social work colleagues out in the field – and were thus horrified when, under a reorganisation of social services in 1988, they were moved out of their hospital bases. Similarly, the nursing staff often felt more supported and understood by the consultants in the psychiatric unit than by their senior nurse managers, whose background was in general nursing. Interestingly, however, the primary allegiance of those I have interviewed were to their ward-based nursing colleagues rather than the multi-disciplinary clinical team. In Harpurhey, a very different set of professional tensions emerged. In line with its radical origins, the team had been founded on egalitarian principles: nurses and social services support workers were paid on similar scales and had almost identical job descriptions. Inter-disciplinary differences were therefore initially played down, with some members adopting an explicitly anti-professional stance. In the late 1980s, however, a national re-grading exercise meant that the nurses were awarded a massive pay rise, with an associated shift towards taking on more clinical roles and responsibilities. Although the team survived this upheaval and, by all accounts, relationships remained strong and cohesive, it undoubtedly led to tensions – and, for one member, 'the end of a dream'²⁹ in which professional interests undermined the project's radical agenda.

A further fundamental and recurring tension – inextricably linked to these shifting boundaries of mental health care, and captured in the over-simplistic notion of 'care versus cure' – was the tension between a treatment oriented service model and the need to provide longer-term, supportive care. This was most acutely felt at Withington which, while championing the new DGH vision of acute, episodic care, soon found both its beds and day hospital filling up with patients with long-term needs. Interestingly, however, even here – the most medical of all the settings – the oft-quoted polarity between social and medical models of mental disorder was distinctly blurred, with the social dimensions of mental illness playing a crucial role in the whole process of diagnosis and treatment. Similarly, even within the more socially oriented contexts of Salford and North Manchester, the language of treatment and illness was still common.

Part of Withington's solution to its growing chronic population was to create a 'ward in the community': a Victorian house, about half a mile from the hospital, which was converted into accommodation for 20 long-stay patients needing 24 hour care. Registered as hospital patients and supervised by a team of nurses, the residents were expected to shop, cook and do their own laundry, in addition to taking part in a programme of domestic and therapeutic activities designed to prepare them for life in the outside world. While undoubtedly both imaginative and successful, it could not, however, resolve one of the fundamental contradictions faced by what, in the late 1960s, Apte termed 'transitional institutions' or 'halfway houses'.³⁰ To be effective, support involves the establishment of meaningful interpersonal relationships and networks; but the implied permanency of such relationships clashes with the transitory nature of the rehabilitation process. This tension was particularly evident within the fascinating history of Kersal House, Salford's rehabilitation hostel which opened in 1961. A series of unsuitable wardens in the early years meant that it quickly

²⁹ Interview 3. Nurse on the Harpurhey Resettlement Team.

³⁰ Apte (1967 & 1968)

developed into ‘almost a replica of the worst aspects of old Institution life’³¹ and it was not until the appointment of Tom McAlpine, a highly charismatic and unconventional character, that the atmosphere became much more open, permissive – and genuinely ‘homely’. As his assistant warden reflected, however:

There was this basic tension all the time about people have got to move on versus, you know, the informality. And that was one of the clashes that I became more and more aware of, I think probably after I left the place. But you know, if you’ve got a kind of, what seems to be a very friendly informal home, where people live and are comfortable and it’s a nice environment, which it was, at the same time you’re chivvying them and saying, ‘Well, come on, you’ve gotta get out of this.’ There’s a contradiction there, which is a huge contradiction ... and the two things, it was bound to happen because there was this policy of making it pleasant so that it was non-institutional, at the same time that means that it’s somewhere you want to stay.³²

The aims of rehabilitation are intimately bound up with notions of social integration and inclusion and it is these that give rise to the final set of tensions and contradictions. The post-war period was characterised by the move away from segregated settings and the case studies highlight the variety of forms this could take: from Salford’s psychiatric social club and day centres; to the purpose-built district general unit of Withington; to the back streets of North Manchester. Each represented a different approach to the age old problems of stigma and isolation: Salford, by offering its clients a protective and sympathetic ‘society to fit into’;³³ Withington by locating services alongside their physical counterparts; and North Manchester by treating social integration as an organising principle rather than a goal of treatment. Each approach raised new problems, however. Salford’s specialist facilities, for example, helped foster social skills and self confidence but the sheltered nature of the environment arguably failed to prepare its members for the realities of ordinary social life; integration with the rest of Withington may have created less stigmatising services, but the very particular needs of psychiatric patients did not fit readily into the highly regulated, sick-role oriented culture of the general hospital; while, in the opinion of Nahima Mayouche, a Belgian mental health worker invited to evaluate the Harpurhey service, the reluctance to provide specialist group activities and drop-in facilities resulted in high levels of isolation and loneliness, thus perpetuating the cycle of stigmatisation that the principles of ordinary living were designed to break.³⁴

The shift from asylum to community care thus brought with it a whole new set of problems and tensions – and indeed, at one level the post-war history of mental health services can be characterised as a series of attempts to resolve these.³⁵ What the history so potently demonstrates, however, is that these attempts were firstly neither uniform nor linear in character; and secondly, were ultimately unsustainable. Thus, although it is possible to discern some broad chronological trends – for example, the

³¹ Mountney (1964), 24

³² Interview 4 . Assistant warden at Kersal House in the late 1960s

³³ City of Salford (1951), 90 .

³⁴ Mayouche (1990), 1.

³⁵ NB See Busfield (2000) for an analysis of two other important sets of tensions, which, she argues were central to the twentieth century history of mental illness: custody/control versus care/cure; and body versus mind. I have chosen not to address them here, since they surfaced only rarely within the case studies.

general widening of service boundaries during the first part of the period, followed, towards the end of the century, by much tighter regulation – the overall picture, even within such a relatively small geographical area, is one of huge diversity and fluidity. This fluidity, I would argue, is in part both a product and a reflection of the enduring tensions underpinning the whole system: tensions which, because they are unresolvable, create a system which is fundamentally unstable. The best that can be hoped for is that some sort of balance can be reached. But, as I now go on to suggest, the complexity of the system, and the multitude of forces acting on a particular service at a particular point in time, means that this balance will always be precarious.

(ii) Innovation and change, stability and stagnation: dynamic equilibrium in post-war mental health services

It was this sense of fluidity, movement and precariousness which led me to develop the notion of dynamic equilibrium. This is offered neither as a fully developed conceptual model, nor as a blueprint for change. Rather, it is a heuristic: an analytical tool which helped me to both capture and make sense of a field which, in the early stages of my research, proved almost impossible to pin down. Within the case studies it serves two main functions. Firstly, it is a device for exploring the shifting dynamics of service development: how, over time, services simultaneously sought to hold the fundamental tensions and contradictions described above; to absorb and contain the pressures from both inside and out; and to create a balance between stability and structure on the one hand, and the need to remain responsive to new ideas and demands on the other – a state which could not be maintained indefinitely, resulting in dissolution and reconfiguration. Secondly, I use it to highlight some of the myriad of factors which impinged on the services and, in particular, the ways in which national and local forces interacted.

1. Innovation and change: national policies and local contexts

For example, the publication of the Percy Report in 1957, followed by the 1959 Mental Health Act, was instrumental in shaping and supporting Mervyn Susser's programme of service reform.³⁶ As the very different situation in neighbouring Manchester demonstrated, however, what was achieved in Salford was as much a reflection of the ethos of Salford's public health department, and of the vision and energy of Lance Burn, its Medical Officer of Health, as of the national policy context. Similarly, Withington Psychiatric Unit was a product of the 1960s policy of replacing large mental hospitals with small, locally based units – a plan which fitted well with the much broader NHS agenda of structuring hospital services around the new concept of the district general hospital.³⁷ Its pristine new buildings, extensive facilities and distinctive style of operation, however, owed much, firstly to the backing of the Manchester Regional Hospital Board which, having pioneered the development of small psychiatric units in Lancashire during the 1950s, was particularly sympathetic to the notion of DGH psychiatry;³⁸ and secondly to senior figures in the University of Manchester's Department of Psychiatry, who were adamant that academic psychiatry should be developed in tandem with service delivery. By the 1980s, as the drive to close the large mental hospitals gathered pace, the focus had moved away from the hospital to community-based services. It was this policy context – which not only gave official endorsement to the principles of

³⁶ Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957).

³⁷ Ministry of Health (1962)

³⁸ Pickstone (1992).

resettlement and community care but, more crucially, provided additional funding – which paved the way for the emergence of the Harpurhey Resettlement Team. Its particular trajectory and form, however, represented a unique convergence of local factors and forces: a marginalised and weak institution, which had been criticised nationally for its poor conditions; a newly formed district health authority, espousing a much more socially oriented agenda than its teaching-hospital dominated counterparts in Central and South Manchester; a charismatic and radical young public health doctor, willing to take on the psychiatric fraternity; a critical mass of staff who she succeeded in enthusing with her ideas; and, the crucial support of a new general manager who had the power and authority to drive through the changes within the hospital.

The above examples, although superficial and incomplete, serve to underline just how complex the processes of innovation and change are: the often fortuitous convergence of local initiatives and national policies, and of key actors brought together within a very particular social, economic and political climate. They also hint at the intense activity and energy involved – something which transfused many of my interviews, helping to both re-capture and communicate some of the feelings that were around at the time. Another significant feature of these interviews, and one which I shall briefly return to, is the sense that the actors were genuine participants in the change process: that, rather than being imposed from without, it had its own internal energy and momentum – an energy which reinforced and strengthened both the individual's sense of commitment and the internal dynamics of the team.

2. Stability or stagnation, disintegration or reconfiguration?

Within all three case studies, this intense period of change was followed by a 'post-innovation' phase – a time of relative stability, in which the services were closest to the classic definition of dynamic equilibrium: beginning to settle and stabilise after a period of ultimately unsustainable activity, and able to contain and absorb the underlying tensions and forces. Such a balance is difficult to maintain over time, however. In the cases of both Withington and Harpurhey, stability arguably evolved into stagnation. Both services were accused of becoming fossilised: holding too tightly onto their founding principles, of becoming too inward looking and inflexible, unable – or unwilling – to adapt to a changing world. Ironically, therefore, the seeds of destruction lay, in part at least, in the very features which had contributed to their initial success. In contrast, there was little or no sense of stagnation within the Salford service. This may in part be an artefact of the time period: the pace of change in the 1950s and 1960s was slower than in the later decades of the century and for most of the period the team were free of significant external pressures – including financial concerns – giving them the time and space to evolve organically. A detailed study of the department's way of operating, however, suggests a rather different interpretation: that it continued to grow and develop precisely because the team had, from the outset, developed a pattern of working which combined internal reflection with an outward-looking approach; in which attention to its internal processes was balanced by an awareness of its relationships with the wider mental health system; and which enabled the team to keep sight of certain fundamental service principles whilst remaining open and responsive to new ideas. It was in fact this sense of balance which initially led me to articulate and develop the notion of dynamic equilibrium within my work.

Even in Salford, however, the balance could not be maintained indefinitely. The service eventually succumbed to a combination of both internal and external forces, which shifted the whole centre of gravity. In the space of two years it was subject, firstly to threatened budget cuts – the consequence of a swing to the Conservatives in the local elections; secondly, the retirement of its champion Lance Burn and his replacement by ‘the most chair-bound office wallah it has ever been my misfortune to meet’³⁹ ... ‘a bureaucrat down to his socks’;⁴⁰ thirdly, the not unrelated exodus of a number of senior staff; and finally, the 1971 Seebohm reorganisation, in which the local authority’s mental health functions were transferred to the newly established social services department. Each factor was, in itself, potentially destabilising. In combination, the situation proved impossible to contain and, as earlier described, the locus shifted, as specialist social workers retreated into hospital bases and there was a redefinition and reconfiguration of mental health care across the city.

In the context of the individual case studies, the demise of the service quickly turns into a narrative of disintegration and loss. This is, however, only one narrative. An alternative narrative – and one which resonates more closely with my notion of dynamic equilibrium – is the narrative of reinvention and reconfiguration: a narrative in which new centres of gravity appear and disappear in response to the shifting tensions and forces at work; a narrative, ultimately, of both change and continuity within the post-war history of mental health services.

Policy futures – learning from the past?

Echoing the title of the conference, can such a small-scale, local history contribute anything to future policy making? Many historians consider that issues of relevance lie well outside their remit, and although I clearly do not share this view, I still feel ill-equipped to respond to the question in anything other than a superficial manner. Rather than attempting to offer any definitive answers, I shall therefore conclude by offering a few, unworked-through thoughts and comments, which I hope will stimulate some discussion during the conference session.

- At one level, my research has served to muddy rather than clarify the present, adding new levels of complexity to an already bewildering picture. When asked what my conclusions are, my usual response is ‘Its all very complicated!’
- At another level, however, ‘the long view’ has helped me identify certain key themes and patterns – in particular, a number of inherent and enduring tensions which, I would argue, have arisen as a direct consequence of the move from a custodial to a therapeutic model of mental health, and from the segregated site of the asylum to the ill-defined locus of ‘the community’.
- The inherent nature of these tensions means that mental health services are fundamentally unstable and notions of permanence illusory. I would argue that it is more helpful to frame our responses to current problems in ways that acknowledge this, rather than basing them on the fantasy that, if only we keep trying, we will find the solution. To quote Plsek and Greenhalgh, writing about complexity theory:

whereas conventional reductionist scientific thinking assumes that we shall eventually figure it all out and resolve all the unresolved issues,

³⁹ *Personal letter from undisclosed writer to ‘Malcolm’* (1969).

⁴⁰ Interview 1: Salford Mental Welfare Officer during the 1950s and 1960s.

complexity theory is comfortable with and even values such inherent tension between different parts of the system ⁴¹

- A historical analysis of the processes of change raises other important questions about the validity of current approaches. Local studies highlight how national policies, while crucially important in setting the broad agenda of change, are subject to a multitude of factors and forces on the ground – many of which can be neither predicted nor controlled. To echo Plsek and Greenhalgh's earlier comments, rather than seeking uniformity and centralised control, it may benefit us to become more comfortable with, and even begin to value, a certain degree of uncertainty and local diversity.
- Finally, my interviews have underlined how productive – and creative – change can be when people feel, firstly that they are genuine participants in the process; and secondly that they have the space and time to both ponder and reflect. The current obsession with targets and outcomes, policies and structures needs to be balanced, I would suggest, by an approach which explicitly acknowledges and supports the very human processes through which these are mediated.

Acknowledgements

I would like to thank staff and PhD students in the Centre for the History of Science, Technology and Medicine at the University of Manchester for their support throughout the research, particularly Emm Barnes, my supervisor. I especially wish to thank my informants, whose interest, enthusiasm and generosity has not only made this project possible but has brought the whole history to life. I am also grateful to the Wellcome Trust for funding the research.

⁴¹ Plsek and Greenhalgh (2001), 626.

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