Care and confinement: A reflective overview of mental health service development in Lancaster and the UK

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Abstract
This article examines the development of mental services in the UK, with a particular focus on Lancaster. The changing treatment of and perspectives on mental health and their relationship to changes in society, wider medicine, and the legal system are reflected on; as are the reasons for the institutional models that occurred in previous centuries.

Keywords
mental health; Lancaster; psychiatry; asylum; reflection

Introduction
Health services are undergoing a major transition. The NHS is facing significant financial pressure and The Health and Social Care Act (Department of Health, 2012) is driving a reorganisation of services. In Lancaster, the city is venue to a historic county asylum, and in 2009 the local mental health trust announced that the acute adult inpatient service would move to a community setting. It is therefore opportune to examine, compare, and reflect on previous development of mental health policy, delivery, national trends, and the impact of broader social change.

Before the asylum era
Care of those with mental illness was predominantly laissez faire prior to the 18th century. Modern psychiatry was non-existent and formal organisation of mental health services had not been considered. Writing on madness had survived from Ancient Greece and in 1621 Robert Burton wrote An Anatomy of Melancholy; one of the first modern textbooks on the subject. However, the aetiological basis of madness remained both divine in origin and focused on the ‘four humours’ (Porter, 2002). Porter identifies that the majority of inpatient care was provided in small-scale private madhouses, often managed by a solitary medical attendant. A notable exception is Bethlam hospital in London (originally opened in 1247 and the etymological origin of ‘bedlam’).

Changing minds – the case of James Hadfield
The crescendo of the Enlightenment encouraged a re-evaluation of madness. The archetype of this ‘age of reason’ was the Quaker-run York Retreat (established in 1772), which promoted a humane and moral treatment of mental illness (Digby, 1985).

Public perception of madness was also affected after James Hadfield attempted to assassinate the reigning monarch, King George III. It was possible to ‘plead insanity’ but this demanded that the defendant was “lost to all sense … incapable of forming a judgement upon the consequences of the act which he is about to do” (Moriarty, 2001). In this case, Hadfield had planned his actions, meaning that he was considered legally sane. However, it was clear that he was suffering from delusions, and Thomas Erskine (the defending barrister) challenged the law, arguing that as Hadfield did not fully appreciate his actions, he did not commit treason. The Judge, Lord Kenyon, also described the verdict as “clearly an acquittal” but “the prisoner, for his own sake, and for the sake of society at large, must not be discharged” (Moriarty, 2001). An Act of Parliament was necessary to change the law, and now a ‘not guilty’ verdict was possible on the grounds of (latterly known as) ‘diminished responsibility’. This was a dramatic and sympathetic change of legal and public perception of mental illness. The high profile of the case confirmed that it was rapidly becoming an important medical, social, and legal issue.

Lancaster County Asylum (1816–1840)
The 1808 County Asylums Act enabled local magistrates to commission rate-supported asylums and 1816 marked the opening of the County Lunatic Asylum for the County Palatine for Lancaster. This was the fourth asylum in the country built after the Act and, by 1836, patient capacity had increased to 406 (Williamson, 2002).
When the asylum was first opened the profile of patients also differed significantly from the profile that would be found today. For example, mothers of illegitimate children, vagrants, and other marginalised members of society were frequent attendees at the asylum. This demonstrates the dearth of alternative social support and reflects wider religious and moral values of the time. Mental illness associated with older age was less prevalent, as the percentage of people over 65 in 1881 Lancaster was 4%, compared to 17.8% in 2001 (University of Portsmouth, 2014). Additionally, tertiary syphilis accounted for approximately 20% of psychiatric admissions prior to the advent of penicillin (Friedrich & Geusau, 2009). Hypoxic brain injuries from complicated, prolonged labour were also more prevalent. This vividly illustrates the impact that antibiotics and obstetric techniques have played in transforming the nature of psychiatric morbidity.

Conditions and treatments (1841–1857)
In 1841, a local physician and surgeon, Dr Edward de Vitre and Dr Samuel Gaskell, co-authored a report of the Lancaster County Asylum (Williamson, 2002) describing the conditions and treatments they encountered. The asylum now housed over 530 patients and it appears that gastro-enteric infections were prevalent "of which many of the patients died within a few weeks". They also described an "extensive use of mechanical restraint". This was partially consequential of overcrowding and restraints used on "idiotic and violent patients, and those of filthy habits" included handcuffs, leg locks, and straight waistcoats.

However, the first Superintendent and resident surgeon, Paul Slade Knight, demonstrates a degree of compassion by demanding "good, moral and religious characters" as staff (Williamson, 2002). Whilst it is unwise to categorically deny that incidences of abuse occurred, the evidence in Lancaster is antithetical to the cruel asylum superintendent caricature. It is also unsurprising that Victorian asylums were custodial in nature. With no effective drug therapies available for the treatment of psychotic symptoms or effective sedation, confinement was often a practical compromise. Nevertheless, the tenure of Dr de Vitre (of which De Vitre House in Lancaster is eponymous), coincided with the abolition of mechanical restraint at the asylum, as an atmosphere of persuasion over coercion appears to have been adopted. Patients were increasingly free to move around the asylum, the gardens were landscaped and occupational therapy was introduced. Visitors included Charles Dickens and, in 1846, commissioners reported patients to be "clean, tranquil and in a contented state with few exceptions" noting the development of a therapeutic community (Williamson, 2002).

Continued expansion and change (1858–1916)
During this period, the state became increasingly interested in social control and welfare. The metropolitan police force was established in 1828 and, in 1870, the Elementary Education Act introduced the beginning of universal education. The public health reforms of Edwin Chadwick had been progressing since the 1840s and the 1834 Poor Law meant that many previously reliant on community support now migrated into the workhouses. Reflecting this, the 1881 census reveals that 99 resided in Lancaster’s Union workhouse and by 1883, the asylum (now with an annex extension) had 825 beds (Higginbotham, 2011). The Royal Albert Hospital opened for the care of children with intellectual disabilities in 1870 and was later opened to adults in 1913.

The 1890 Lunacy Act recognised that those "of unsound mind" were to receive inpatient care. Now administered by Lancashire Asylums board, Lancaster witnessed a further expansion in patient numbers (Roberts, 2005). The reasons for this mass confinement are complex and multifactorial. Pertinently, the industrial revolution catalysed unprecedented urbanisation in Lancashire. Arguably, this massive societal change was accompanied by increased vulnerability, recognition, and decreasing tolerance of mental illness. Whilst inpatient care was necessary (asylum is Greek for ‘refuge’) the removal of patients from society fostered stigma of the ‘unknown’, institutionalisation, and deskilled long-stay patients. The place of refuge often became a place of lifelong confinement.

In 1916 the "Ladies’ and Gentlemen’s villas" (eventually Ridge Lea Hospital and Campbell House) were constructed and, in 1929, the asylum was renamed the Lancashire County Mental Hospital. Williamson (2002) cites the motivation for the villa as due to the families of wealthier patients objecting to the class diversity present at the asylum. This provides an interesting commentary of how openly class divided British society was a century ago.
Lancaster Moor Hospital, the National Health Service and beyond (1948–)
In 2000, Lancaster Moor Hospital closed for the last time, following a sequence of events over half a century. The NHS was founded in 1948 and was an antecedent to the Mental Health Act in 1959 (Parliament, 2007). Patients were now entitled to attend hospital voluntarily, rather than being committed for a prolonged time. ‘The Moor’ was converted into a ‘comprehensive hospital’ with the addition of elective surgery and physiotherapy. Yet whilst the hospital’s population peaked over 3000 in 1940 (Williamson, 2002) the age of the Victorian asylum was already over.

The psychopharmacological revolution of the mid-20th century had meant that active treatment was quickly replacing long-term confinement. The Griffiths Report (1988) recommended flexible care packages and more patients were now receiving community care. By 1999, all but 22 of Britain’s 130 asylums had closed. Edward Shorter (1998) recognised that asylums had been chronically underfunded over this time of unprecedented demand, leading to a decline in quality. This pressure was compounded by the antipsychiatry movement, who challenged conventional wisdom surrounding long-term confinement (Paulson, 2012). Whilst closures ensured that patients no longer orbited the asylum and provided patients with independence, adequate support did not consistently follow.

Conclusions
The history of Lancaster’s mental health services, in context of wider development, is extremely relevant. It describes the evolution of British psychiatry and also broader societal changes. Mass confinement coincided with urbanisation, state intervention, mass movement of people, and the scientific enlightenment. Medical advances created an optimism for cure, if not always care, and whilst mechanical restraint must not be excused, it does, however, reflect the compromise involved with underfunded services and, more positively, how medication has subsequently transformed management.

Despite the spectre of mass confinement, it is important to ensure that hospitals remain available for the very ill. In context of bed reductions, it is vital to reiterate that all areas of medicine are migrating to the community, as demand shifts towards chronic conditions such as diabetes, cancer, and dementia. This is likely to continue as GPs receive further commissioning responsibilities. The history of mental health must be retained, as not only does it contextualise present services and attitudes, but also advises on how to approach future challenges.

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References