5.1.2. The service delivery context

- the location of contemporary social work within historical, comparative and global persp including European and international contexts
- the complex relationships between public, social and political philosophies, polici priorities and the organisation and practice of social work, including the cor nature of these.

5.1.3. Values and ethics

- the nature, historical evolution and application of social work values.

(QAA, 2008)

Key themes in this chapter

- The pre-history of psychiatry
- The beginnings of institutional mental health care
- The madhouse system
- The rise and fall of the asylum
- The establishment of mental hospitals
- The development of social work practice with the mentally distressed
- The transition toward community mental health care.

INTRODUCTION

It is impossible to fully understand the contemporary context of professional practice with the mentally distressed without reference to the origins of the mental health system. With this in mind this chapter aims to trace the historical foundations of service provision, including: the pre-history of psychiatry; the beginnings of state intervention; the madhouse system; the rise and fall of the asylum; the establishment of mental hospitals; the development of social work involvement; and the transition towards community care practice.

From the outset it is important that we acknowledge the plethora of varying and conflicting histories of psychiatry and its development. According to Newnes:

> the way we tell the histories of psychiatric events, practices and ideas changes over time. The comforting accounts of scientific and medical progress, told predominantly by members of the mental health professions themselves, have gradually been replaced by more searching accounts from historians and sociologists. (1999: 20)

Moreover, Porter comments that 'the history of madness is the history of power' (1987a: 39). From early days society has had to draw a balance between care and control for the mentally distressed. Social work is situated between these opposites. As Horner argues 'social work is situated between the powers of statutory intervention and enforcement, and the historic struggles of an oppressed group' (2003: 59).

THE PRE-HISTORY OF PSYCHIATRY

In medieval England there was no systematic approach to the management of the insane. This is perhaps unsurprising given that at this time 'there was no clear definition of what mental disorder was and certainly no recognition of the mentally ill or handicapped as a category requiring a distinct form of treatment' (Jones, 1972: 3).

Case example

Dr William Perfect, who ran a small rest home in Kent, recalled being summoned in 1776 by the parish officers of Friendsbury to see 'a maniacal man they had confined in their workhouse ... He was secured to the floor by means of a staple and an iron ring, which was fastened to a pair of fetters about his legs, and he was handcuffed. Through the bars of his windows continual visitors were pointing at, ridiculing and irritating the patient, who was thus made a spectacle of public sport'.

(taken from Shorter, 1997: 3)

Elizabethan explanations for lunacy were often contradictory – either situated in religious or supernatural beliefs (possession by the devil or divine retribution) or the idea that 'body humours' were imbalanced. It was believed that four basic qualities, namely coldness, dryness, hotness and wetness (represented by the spleen, blood, choler and phlegm) needed to be in balance; imbalance meant disease (Skultans, 1979). The resultant 'treatments' such as blood letting, purges and ceremonies reflect this. Clerics, astrologers, village wizards, folk magicians, and cunning men and women were as likely as surgeons and apothecaries to be summoned to combat the malignity of mental disorder (Scull, 1993).

Many sufferers were left to their own devices. Scull notes 'the beggar wandering from place to place, community to community in search of alms' (1979: 18). Those who presented as too violent or unmanageable for the community were contained in local gaols. Scull further comments that 'efforts were made to keep lunatics, along with the incurably ill, the blind, and the crippled in the community, if necessary by providing their relatives or others who were prepared to care for them with permanent pensions for their support' (1979: 22). Bartlett and Wright point out that the opening paragraph to Scull's *Museums of Madness* demonstrates the 'stark juxtaposition between this open and tolerant care of the insane in pre-industrial communities with that of the restrictive incarceration of the Victorian period' (1999: 1).

Group reflection exercise

Discuss possible reasons why early communities believed that mental illness originated from the devil.

THE BEGINNINGS OF INSTITUTIONAL CARE

There is a general consensus amongst historians of psychiatry that during the firs half of the eighteenth century the majority of the insane were to be found in th community as there was as yet no formal segregation of the mad in England. Th minority who were confined were either confined under the Poor Laws, vagranc laws, criminal law, in private madhouses, in Bethlem Hospital (in use since 1377 fo those with acute mental disorder financed by public subscription and legacies) o confined alone at their own home. This last category (single lunatics):

> can be divided into three main classes – patients of some social standing who remained in their own home and received medical attention, patients who were 'put away' by their families … and the family scandal allowed to die down; and those in poorer families who were simply tied or chained in a corner of the house to prevent them becoming a nuisance to other people. The whole object of such confinement was secrecy. (Jones, 1955: 10–11)

Bethlem Royal Hospital (later corrupted to Bedlam) is widely acknowledged to b the first dedicated institution to care for the insane from London and its surroundin areas. From its monastic origins, and being one of the oldest psychiatric hospitals i Europe, it survives today over 750 years later in the form of the Maudsley Hospita which was granted NHS status in 1994. Early images of patients confined in a zoo like situation, where the London populace visited for entertainment, are forever stuc in the British psyche (Russell, 1997). This reflected another aspect of understandin mental distress in the eighteenth and early nineteenth centuries, which was to compar the mad to animals – violent, insensitive to heat and cold, and lacking in reason.

Case example

Dr William Black (1811) described some of the Bedlam patients as 'ravenous and insatiable as wolves' or 'drenched by compulsion as horses', and the Incurables 'kept as wild beasts, constantly in fetters'. The Parliamentary Commissioners (1815) commented on a room in Bethlem that was like a dog kennel. *The Quarterly Review* (1857) referred to Bethlem patients being enclosed with iron bars, like 'the fiercer carnivore at the Zoological Gardens'.

(taken from Russell, 1997: 5)

Notwithstanding occasional hints of scandal, Bethlem had been a favouri London charity. While there were a few patients from wealthy backgrounds, mo

were paupers (Scull, 1993). Despite the early scenes of patients suffering brutality, with the regime focusing on control rather than care, pioneering changes were made over the centuries that followed. Yet for all the 'improvements' Russell argues that 'many of the old problems were constantly being recycled – how to manage violence, expressions of sexuality, gender issues, struggles for power between staff and staff, staff and patients, the use of medication, and relationships between the institution and the community' (1997: 213).

THE MADHOUSE SYSTEM

Madhouses were run privately and run for profit, often owned and managed by lay rather than medical proprietors, with a resultant 'trade in lunacy' occurring (Parry-Jones, 1972). They catered for a predominately middle- and upper-class clientele and are known to have existed before the eighteenth century (MacKenzie, 1992). They varied in size from those taking two or three patients to those which accommodated three or four hundred, with the quality of provision ranging from dire to innovative (Jones, 1955). Residents consisted not only of the mad, but also those wrongfully held at the behest of their relatives, as, for example, in the case of women who bore illegitimate children or those who were deemed to be socially embarrassing. As Bartlett and Wright explain, the 'working class and their wealthy counterparts were anxious to conceal the shame of insanity, lest the entire household be stigmatized as insane' (1999: 172). For some the inability to afford madhouse fees and the anxiety about their insane relative becoming public knowledge often resulted in the barbaric containment of the insane in attics and outhouses.

Rogers and Pilgrim note that 'there were sixteen metropolitan licensed houses in 1774 rising rapidly after 1780 but by 1819 there were just forty' (1996: 41). The Metropolitan Commissioners Report of 1844 recorded 37 licensed madhouses in the metropolitan area and on their tour of inspection their chief impression was not one of widespread cruelty and neglect, but of a common evasion of the law. The law relating to the registration of certified persons was often bypassed by proprietors declaring that the patient was merely suffering from 'nerves' (Jones, 1955). Doctors keeping madhouses gained increasing power in managing the insane, with Porter arguing that 'mad doctors all over Europe started to believe that they held madness in their power ... as it was amongst the more curable maladies' (1987a: 41). Commanding, even manhandling, the mad often formed part of the treatment. By 1845 the medical profession had secured powerful support for the proposition that insanity was a disease, and thus was naturally something which doctors alone were qualified to treat (Scull, 1979, 1981).

Despite the conclusions of the 1844 Commissioners Report, some cruelty did exist (Scull, 1996). It was following the suspicious death of a patient called Hannah Mills at the York Asylum in 1791 that the Quaker William Tuke, a wealthy tea and coffee merchant, established a quite different but still privately funded, not for profit, establishment for the care of the mentally ill in 1792. Named neither a hospital nor an asylum, the York Retreat was to be a home where the patient was to be

known and treated as an individual and where his/her mind was to be constantl stimulated and encouraged to return to its natural state. Here even the rage of mad ness could be reigned in without whips, chains, or corporal punishment amidst th comforts of domesticity (Scull, 1996).

Meanwhile in France, Philippe Pinel (considered the founder of modern psychiatry was also removing chains from patients. Though he had never heard of Tuke, Pine had also come to the similar conclusion that the key to using the asylum therapeuti cally lay in 'moral therapy'. Both were instrumental in pioneering more humane way of treating the mad, supported by the notion that proper care of lunatics was akin to good child care (Porter, 1987a).

THE RISE AND FALL OF THE ASYLUMS

Private, profit-based provision for the mad continued until the coming of the asylums and only waned when licences were restricted from 1890. In the early part of the nineteenth century reformers such as Lord Shaftesbury, the Tukes, evangelists and philanthropists called for new approaches to the treatment of the insane and fixed on publicly financed asylums, with vigorous inspection by outsiders, as the way for ward. The reformers achieved their objectives, but not without 'three decades of Parliamentary manoeuvring, a mass of periodicals and reviews extolling the merits of their proposed solution' (Brown, 1985: 31).

The passing of the County Asylums Act in 1808 enabled public asylums to be financed and built at the discretion of local magistrates. The number of such institu tions expanded greatly when the 1845 Lunacy Act made the provision of public asy lums compulsory. Asylums soon achieved gigantic proportions, some with facades tha stretched for nearly a third of a mile containing wards and passages of more than six miles (Brown, 1985). It was official policy to site asylums in the countryside or in 'retiring' places near towns where land was more readily available, cheaper, and allowed for extensive grounds with plenty of fresh air (Donnelly, 1983). Porter main tains that, 'by the beginning of Victoria's reign psychiatric doctors were even represent ing the asylum as, potentially at least, more rational, harmonious, and civilized than society itself' (1987a: 156).

By 1890 there were 66 county and borough asylums in England and Wales, each with an average of 802 inmates. In total there were 86,067 officially certified cases of insanity, more than four times as many as 45 years earlier. By 1930 there were nearly 120,000 patients in public asylums and by 1954 there were over 148,000 (Gibbons 1988). Scull argues, 'the relationship between the construction of asylums and the increase in insanity again suggests that on the whole it was the existence and expan sion of the asylum system which created the increased demand for its own services' (1979: 245). Similarly, Porter comments, 'no sooner were asylums built than they were filled to overflowing' (1987a: 20). Torrey (2003) describes this steady increase in the numbers of people identified with a mental illness as 'the invisible plague'.

Each asylum was under the direction of a medical superintendent answerable only to the visiting committee and the Lunacy Commission. Doctors were the officers and nurs

attendants were under the control of a matron; a command structure that would last until the 1959 Mental Health Act. While the external architecture of each asylum was often grandiose complete with its own church or chapel, the internal structures were indicative of the then current theory of mental illness (Jones, 1972). The architecture, with its elaborate therapeutic, sanitary and panoptic rationalities was based upon nineteenth-century science as pioneered by William Stark and Andrew Duncan, with Jeremy Bentham and his Panoptican as its patron saint (Porter, 1987a). Donnelly explains:

> the exercise of 'the power of mind over mind' which moral treatment represented to the lunacy reformers depended equally upon the skills of architects; it was their task to prepare the physical spaces of confinement, where in turn physicians could create the proper therapeutic environment' (1983: 48).

Long corridors, large square wards and stout lockable doors made for easy surveillance. Safe seclusion rooms (padded cells) existed and straightjackets were used for the restraint of the most uncontrollable individuals before sedative drugs came to dominate (Scull, 1993). Patients worked on the farms and gardens, in the laundries and sewing rooms; but their work was organized for the maintenance of the institution rather than for their own benefit. They moved from place to place in groups and they were counted in and counted out by nurses who often could not remember names or faces.

Case example

Life ... was governed by a rigid regime of sleep, work, eat. Whitewashed walls; plain brick, stone or wooden floors; deal benches and tables; and two WCs for thirty or forty patients provided a fairly cheerless though roomy environment. Windows were generally barred and many wards were locked, although the better asylums gave considerable internal freedom to the inmates.

(taken from Murphy, 1991: 38).

Out of sight and out of mind, such large numbers were incarcerated in this way in England and across Europe that Foucault describes this as 'the great confinement'. Madness was thus 'left' at the asylum with 'confinement seen as its natural abode' (1967: 36).

Initial enlightened ideas and the promise of cures turned sour. Shorter argues that 'the rise of the asylums is the story of good intentions gone bad' (1997: 33). By the start of the First World War asylums had become vast warehouses for the chronically insane and demented. Controversy exists about the reasons for this failure, with some arguing that the sheer weight of numbers was the problem, caused by two components – a genuine increase in psychiatric illness, and a 'redistribution effect' where individuals were shifted from the family and the workhouse to the asylum (Bynum et al., 1985; Shorter, 1997). Others argue that the increase was due to capitalist society avenging itself on the patients for their unwillingness to work. Society's growing intolerance of deviance thus led to greater confinement of intolerable individuals (Szasz, 1961).