Context: The history of Health Care

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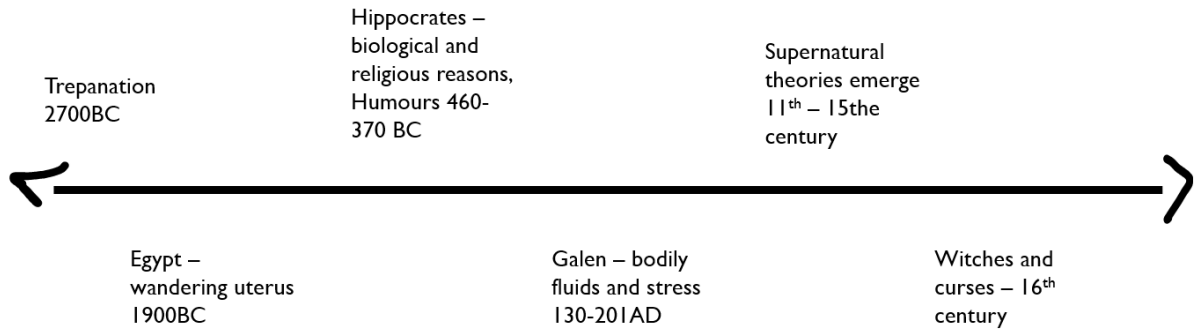
This is the work of Charlotte Carver and for the benefit of the marker David Bowen's work is in red.

Early Mental Health Illnesses and Theories

Context: The history of healthcare in Cardiff and Glamorgan

Understanding the historical context of Whitchurch asylum is an important step in the process of identifying the building's significance. This essay will show the history of mental health through the ages starting from pre-history right through to community care at present. The aim is to give the background to the world Whitchurch Asylum was brought into. We have set out the essay in chronological order, as best as possible; however, there are certain overlaps in certain areas. Firstly, we will be looking at the early history of mental illness from pre-history through to the Greek philosophies and witchcraft in the middle ages. Next are the sections on legislation with the confinement laws and the introduction of nationwide asylums with the County Asylums Act. This sets up to the humanitarian approach popularised in Europe. Following this is the poor laws and scientific approach before looking at example hospitals in Glamorgan. This leads to the 20th century and the impact of the world wars on mental health treatment and the asylums and the introduction of the National Health Service. Finally, the reasons for closures will be investigated in the closing decades of the 20th century and beyond. [DB]

Early Mental Health Illnesses and Theories



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Supernatural explanation

The supernatural explanation is arguably the oldest explanation for the symptoms of mental illness. This can be seen with evidence in skulls found, dating back millennia, with holes drilled into them by the practice of trephination used to release evil spirits (Farreras, 2019). In certain areas of the world we see varying theories relating to mental illness. In China, the idea of imbalance of mental and physical health was seen as undesirable though could be corrected through the balance of yin and yang (Tseng, 1973). The Egyptians had the theory of the wandering uterus whereby a woman with mental illness would be affected by their uterus becoming dislodged and moving to different organs within their body causing different symptoms (Farreras, 2019). They would attempt to cure this by introducing smells to guide the uterus back to the correct place. [DB]

Greek/physical explanation

Hippocrates in 4th-5th century BC theorised the idea of an imbalance of bodily fluids these being blood, yellow bile, black bile and phlegm. Hippocrates was a pioneer for recognising not only the mental illness' of epilepsy, mania, melancholia and brain fever but for characterising mental illness as something that a sufferer should not be shamed or punished for (Viney and Zorich, 1982). 500 years after Hippocrates death, Galen continued to use the theory of the four humours in his work. Galen began the conversation of psychogenic theories only to be rejected for centuries to come whilst practicing physicians continued to pursue the physical causes of mental health. [DB]

The physical explanation to mental health remained widespread into the middle ages with new treatments used to balance the humors. Leech treatment became very common to help balance the blood; too much of which would be the cause of a temperamental person and with discoveries into the new world, the introduction of tobacco was used to cause vomiting in mental health sufferers (Foerschner, 2010). [DB]

Witches and Superstition

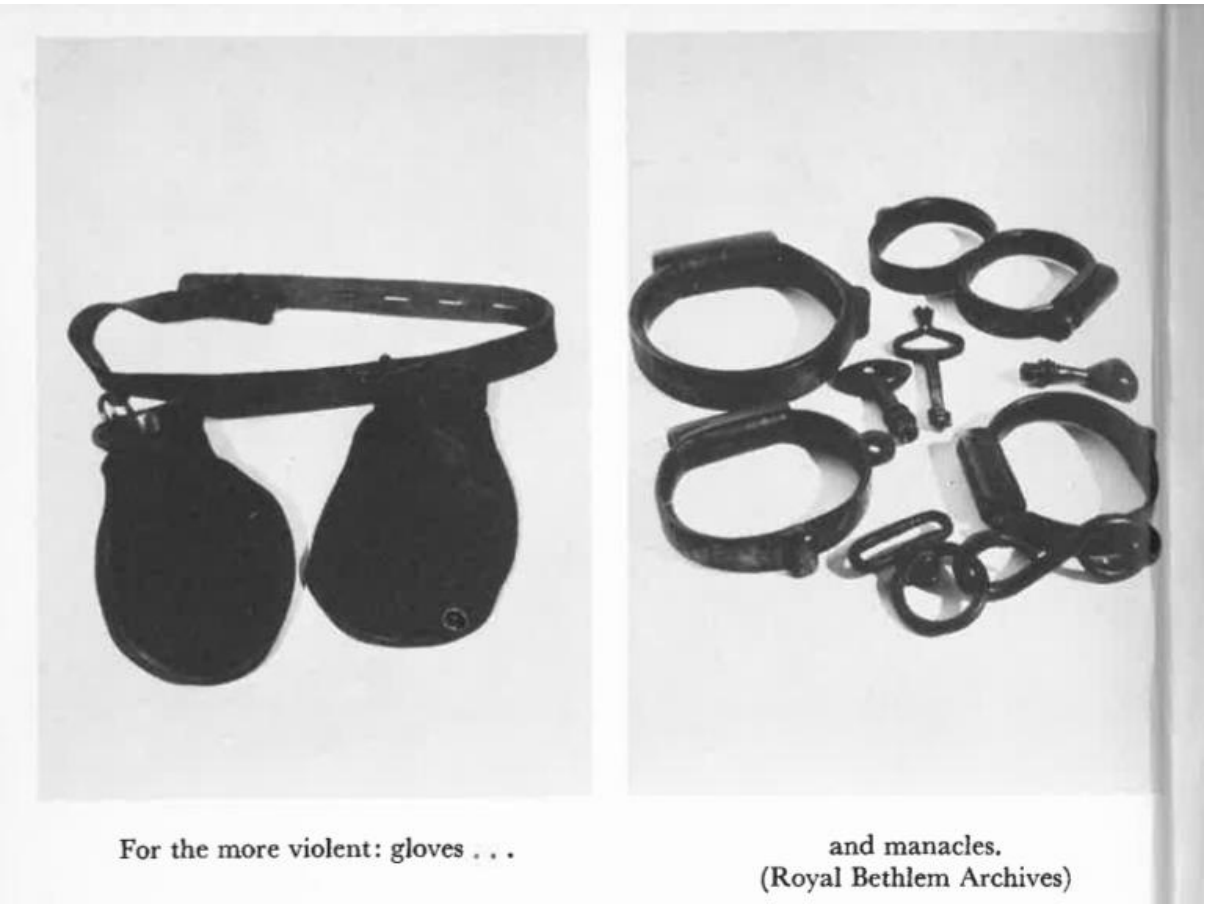
By the end of the Middle Ages, there was a growing belief in the supernatural, as the Roman Catholic Church was beginning to lose power, due to economic and political turmoil which was occurring across Europe (Farreras 2019. 247). Between the eleventh and fifteenth centuries in Northern Europe belief in the supernatural took over as the leading theory about why people became mentally ill and what mental illness was (Farreras 2019. 247). This was a theory based on plague and famine which had been happening across Europe to such a large scale that it was believed that it could not have been the result of natural causes, but that it must have been the work do the devil or satanic like figure (Farreras 2019. 247). At the turn of the thirteenth century, the mentally ill began to be persecuted for being possessed or witches as society understood this to be the cause of the symptoms that mental illness could cause (Farreras 2019. 247). The main group in society who were persecuted were women, as they were seen as the weaker sex so were more likely to be possessed, and individuals who had hysteria and epilepsy (Quintanilla 2010). This is because hysteria and epilepsy are illnesses that can cause symptoms such as convolutions and loss of consciousness, which were believed to be evidence that a person had been possessed or had supernatural powers (Quintanilla 2010). *Malleus Maleficarum* from 1486/87 was written by Kramer and Sprenger, two Dominican monks, and was a guide explaining how to spot and hunt witches which kept its influence for over two centuries (Farreras 2019. 247; Quintanilla 2010). However, this is an overly simplistic view of this period which depicts the public as being less intelligent than they probably were, when in reality it was down to censorship and a lack of available education from outside of the church. This is evident as Johann Weyer and Reginald Scot write a book in the middle-late sixteenth century which aimed to prove that witches were, in fact, women with mental illnesses due to metabolic issues and disease; this book was however banned by the Church's Inquisition and never published (Farreras 2019. 247; Quintanilla 2010). Witch-hunting and prosecution continued into the seventeenth and eighteenth centuries with an estimate 100,000 witches being burnt at the stake (Farreras 2019. 247). Helen Duncan was the last woman to be persecuted under the 1735 Witchcraft Act in 1944 despite the better understanding that the modern world has (Meier 2018). This shows that although to us witchcraft might seem a farfetched idea it was still used as a punishment for women into the twentieth century and so it is unsurprising that it was believed so widely in the Middle Ages when the information available was but a fraction of what is available today. [CC]

The establishment of modern mental health treatments and asylums

Many of the modern techniques for curing and managing mental health issues that we have today in Britain have evolved and been shaped from practices and ideas that were beginning to be established in the sixteenth century (Farreras 2019. 247). These can be seen in the establishment of asylums and hospitals which were designed specifically to deal with particular health issues such as 'lunacy' and 'idiocy' as well as other chronic and contagious diseases (Farreras 2019. 247). These institutions were founded with the aim of detaining and confining those who were deemed as 'undesirables' in society (Farreras 2019. 247). This includes the mentally ill, criminals, the poor, the destitute and the unemployed, as they were the people regarded as the lowest in society, unable to support themselves and the cause of many of the issues society at this time had (Farreras 2019. 247). These members of society deemed as 'undesirables' were arguably a product of a society that had been plagued by war and economic depression, although this is not something that was fully acknowledged in Early-Modern Britain (Farreras 2019. 247). Those who were characterised as an 'undesirable' were consequently sent to these institutions and separated from society (Farreras 2019. 247). This process is what later became known as the policy of confinement (Parry-Jones 1988. 407). [CC]

Confinement policies

In 1601 the first Poor Law Act focused solely on members of society who were destitute and unemployed, without consideration for the 'insane' (Parry-Jones 1988. 407). No provisions were made for members of society who were mentally ill or regarded as 'idiots' or 'lunatics' and they were instead left to live freely under the condition that they were not dangerous or disturbing to society or themselves (Parry-Jones 1988. 407). As a result of this, it is commonly assumed that those who were dealt with by public authorities for lunacy in this period were a problem and caused violence and danger to society and its members (Rushton 1988. 40). McDonald suggests that this resulted in words such as 'mad' and 'lunatic' being used to mean the potential for violence or as actual violence and became close to synonyms (Rushton 1988. 40; MacDonald 1982. 148-173). This identification of the 'insane' as violent continued throughout the seventeenth century, this is demonstrated in the increased use of workhouse-type institutions and the stigma towards those who were mentally ill continued to grow (Parry-Jones 1988. 407). [CC]



For the more violent: gloves . . .

and manacles.
(Royal Bethlem Archives)

Masters A. (1977). *Bedlam.* Michael Joseph LTD.

At the start of the eighteenth century in 1714, an Act was passed which made it legal to restrain lunatics who were considered crazy or unsafe (Parry-Jones 1988. 407). In most cases, this led to the confinement of these individuals who were placed into the care of 'madhouses', which would later be referred to as private-asylums (Parry-Jones 1988. 407). The confinement of the 'mad' and 'insane' in the seventeenth century, in the eyes of many historians, is something depicted as a morally questionable way of protecting society and social order, as more humane treatments of these individuals did not exist until the eighteenth century (Parry-Jones 1988. 408). When reading the words of these historians it is important to remember that they have an understanding of mental health that was not available in the sixteenth and seventeenth centuries, consequently, it is likely that the actions and policies of this period will be viewed as inhumane even if they were not by contemporaries (Farreras 2019. 248). Although this is clear, it is not possible to look back on actions and policies of the past with total objectivity and with a subject such as mental illness and its treatments opinions are not only varying for modern-day writers but also among writers and medical professionals of this period. However, that at this time the treatment of mental illness was somatogenic and patients were treated using some of the same techniques that physical ailments were treated with, such as bleeding and purges of the body (Farreras 2019. 248). The physical confinement and restraint of patients suffering from mental health issues began to lessen in the eighteenth and nineteenth centuries in Britain as policies in private-asylums moved away from shackles and chains and towards patients to be treated with dignity (Farreras 2019. 248). William Tuke started this movement in Britain in 1796 with the established the Yorkshire retreat, although he was not the first as these techniques had started in France and Italy in the 1780s (Farreras 2019. 248). This movement towards using fewer restraints does not signal the end of confinement,

however, as individuals exhibiting behaviour associated with mental illness were still segregated from society in 'madhouses', private-asylums and retreats. Moreover, it must be considered that these asylums only catered for those who were seriously ill and very little is known about individuals who were high-functioning and that were not placed into the care of asylums as they were seen as manageable and able to live at home with their families, despite having mental illnesses. [CC]

Bethlem hospital

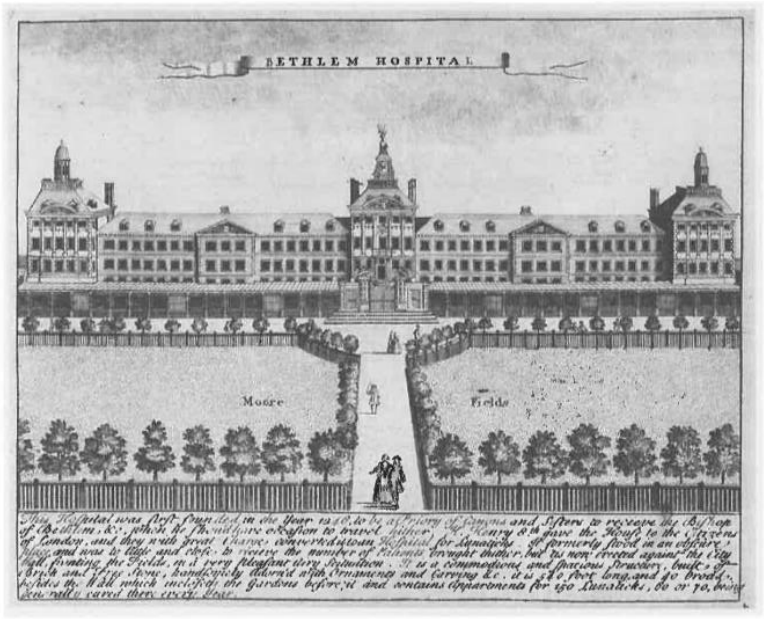


Plate 15.1 'Bethlem Hospital', from *British Views* (*c.* 1723), inexpensive popular prints published by John Bowles which appeared with 'Particular accounts'; this one gives an overall length of 540 feet for Bethlem, after the 1720 Stow edition. Reproduced by kind permission of the Wellcome Institute Library, London.

Andrews J, Briggs A, Roy Porter, Tucker P and Waddington K. (1997). *The History of Bethlem.* Routledge p. 231

When looking at the origins of asylums and the history of mental health in the UK nearly every historian references Bethlem Hospital to some degree. This is because it is the first documented example of psychiatric services existing in Modern Britain (Killapsy 2006. 246). The hospital originated from a monastic priory in 1247, at a site in the city of London, situated where Liverpool Street Station now resides (Killaspy 2006. 246). It was only from 1330 that this priory was referred to as Bethlem hospital and became infamous for dealing with the sick and infirm of London (Killapsy 2006. 246). 'Bethlem' and 'bedlam' soon became words which were tantamount to chaos and disarray which is an indication of how these sites in this period were perceived (Scull 1993. 51). It is in 1403, when an investigation into the hospital, under King Henry IV and the royal commission, finds evidence and documents that six men are being treated at this site for insanity not just physical illnesses and injuries (Killapsy 2006. 246; Shorter 1997. 4). The hospital continued to care for individuals with insanity and mental illnesses and over the next century became entirely dedicated to the care of the insane and would persist as the main city-run asylum until 1948 (Shorter 1997. 5). The work that was being done at Bethlem hospital was seen as valuable and unique and as a result, it was granted a new building in Moorefield which was bigger and better equipped in 1676 (Killaspy 2006. 247). As a result, although there may have been a great deal of stigma surrounding mental

health in this period, it shows that it was not an issue in society which could be pushed to one side. This stigma was however ever-present in this period and although Bethlem hospital was one of the

Scull A. (1993). *The Most Solitary of Afflictions – Madness and Society in Britain, 1700-1900.* Yale University Press p.52

Fig. 3 An Engraving of Bedlam by William Hogarth, 1735, retouched 1736, from the final episode of *The Rake's Progress* (1735), with madness represented as the wages of sin.

smallest and least affluent hospitals in London at this time it gained popularity and notoriety within contemporary journalism, literature and art, becoming a source of entertainment and intrigue for the British public (Scull 1993. 51). This can most famously be seen in William Hogarth's *The Rake's Progress* which depicts Rake restrained half-naked on the floor being inspected by a medical professional in Bethlem Hospital in 1733 (Shorter 1997. 5). It is believed that until 1770 that the doors to Bethlem hospital were open to nearly anyone and the general public could walk through the hospital galleries and view the patients being treated there (Scull 1993. 51-52). Although the number of tourists who visited the site for entertainment can only be estimated it is expected that large groups of people would travel to see this spectacle of London (Scull 1993. 52). The reason that this hospital becomes so prominent and crucial to the study of the history of asylums and mental health is that it is able to give an indication of public perception and the stigma which existed in this period and without it a lot of the information we have would be lost. This is not just because of how it is fundamentally the first hospital for the insane in Britain but also because any other institutions

which cared for the insane for this period were private and part of the fee was to fulfil the desire families and individuals had for confidentiality so as a result not as much is known of these institutes (Parry-Joness 1988. 408). Consequently, Bethlem Hospital becomes key in understanding mental health treatment in this period however it does result in a history which is predominantly London focused and further and more in-depth research is still required on other areas of Britain. [CC]

County Asylums Act 1808

In 1807 a select committee was created to inquire on the condition of the lunatic asylums of England and Wales and the laws that affect them. It was found that the 1744 Vagrancy Act was the law that had greatest influence over the asylums. Asylums of the time were found to have inhumane conditions which correlates with the attitude shown towards people with mental illness' at the time(Jones, 1993). Following on from their investigation, it was suggested by the committee that an asylum should be constructed in every county and was to be run by governors appointed by local justices and thus the County Asylum Act of 1808 was passed. [DB]

The County Asylum Act 1808 also known as 'Mr Wynn's Act', so named due to the member of parliament who promoted the act – Charles Watkin Williams-Wynn. Charles Williams-Wynn was a leading figure in the select committee of 1807. The 1808 Act incorporated the 1744 legislation whereby houses of correction were built to house 'unruly poor' and vagrants (Bartlett, 1999). This act introduced the notion of building an asylum in every county to house the mentally ill. However, '…it will be seen that this legislation was not compulsory, and therefore utterly failed in attaining the object of its promoters. It only authorised magistrate to act' (Tuke, 1882). In the fifteen years following the act in 1808 only 9 county asylums were created out of the 52 counties of England and Wales. [DB]

The lunacy legislation of 1845 made it compulsory for counties to construct asylums and a Lunacy Commission was created to publish annual reports on the newly founded asylums. This was seen as a step forward in human rights as there was a central authority insuring the maintenance of standards and the punishing of neglect nationwide (Jones, 1993). [DB]

Despite striding in the right direction, the 1808 County Asylum Act could not completely secure the standards of care for the patients of asylums as the legislation was not written for this purpose. The Act's purpose was to begin the process of having centralised control over the nations mentally ill population by guaranteeing them a facility away from the workhouses. This crucial step did begin at an important time in the history of care for the mentally ill with a number of the first asylums to be opened, following the act, adopting the humanitarian approach to care which will be discussed in greater detail below (Jones, 1993). [DB]

Moral Ideas – Humanitarian

From the 16th century, asylums were few and far between. These facilities were constructed to house the mentally ill who were seen as undesirables. The status of undesirability meant that these people were locked away against their will so that they could not mix with other members of society. Inmates at the asylums were treated very much like animals – chained up and brought out for public amusement which would bring in money to support the running of such institutions (Butcher, 2015). [DB]

The late 18th century into the early 19th century, protests rose over the conditions that asylum patients lived in. French physician, Philippe Pinel and former patient, Jean-Baptiste Pussin, created moral treatment at la Bicetre and the Salpetriere in 1793 and 1795 respectively. The philosophy of moral treatment included the unshackling of patients and allowing them freedom to roam around

the grounds. Although these policies allowed for a better quality of life for the patients at the asylum, they were still forced to remain in the facility by law (Micale, 1985). [DB]

William Tuke was one of the first in the UK to adopt the method of moral treatment at the York Retreat in 1796 where patients were more like guests than prisoners (Farreras, 2019). However, it is important to note that these patients were not allowed to leave the premises but were free to move around the asylum. William Tuke pursued this method due to his religious beliefs as a Quaker. Many of the patients at the Retreat were themselves Quakers and from relatively well of families who were able to pay as the institution was not owned by the county but by a committee of like-minded businessmen. Regardless of who was responsible for running the Retreat and or the restrictions put on the admission of patients, the care and treatment given to patients was to a high standard and met the needs of the patients at that time. [DB]

The Poor Law Amendment Act and reforms

The enactment of the Poor Law Amendment Act in 1834, also known as the New Poor Law, was passed with the aim of cutting the amount of government expenditure that was spent on individuals living in poverty and those lowest in society (Rutherford 2003. 101). The law was fundamentally constructed around the idea that those lowest in society could be divided into the 'deserving' poor and the 'undeserving' poor to try and diminish the number of people eligible for government help (Crowther 2016. 1-4). Those who were deemed as able to work had all government financial aid taken away from them and those who were still seen as vulnerable enough, or as 'deserving', which included the infirm, elderly and juvenile, would receive support from the government in the form of admission to workhouses where they were expected to work for their keep (Griffiths 1998. 12; Rutherford 2003. 101). As part of the Act, it was stated that those with mental illnesses who were considered dangerous were not to be kept in workhouses for longer than a fortnight before they must be relocated to purpose-built asylums or facilities (Smith 1999. 115). This was a clause in the Act which left a lot of room for interpretation, as it never defined what 'dangerous' behaviour was and it caused variations across Britain in care as a result (Smith 1999. 115). Moreover, it was used by parishes to keep mentally ill individuals in workhouses rather than transferring them to asylums or private licensed establishments which might have been more expensive (Smith 1999. 115). Consequently, the Poor law Amendment Act of 1834 had a lasting effect on admissions to asylums and mental hospitals despite not directly defining admission criteria for them (Smith 1999. 115). [CC]

It is evident that although the Poor Law Amendment Act caused suffering for those lowest in society it was successful in cutting government expenditure on the poor relief (Griffiths 1998. 12). In 1831 poor relief cost the British Government seven million pounds which by 1851 had decreased to five million pounds (Griffiths 1998. 12). Although it is easy for modern-day historians to look back at the reforms that were enacted in 1834 as inhumane, it is clear that they fulfilled the aim of the government in this period whilst creating spaces where the lowest in society could receive at least some refuge. [CC]

Workhouses

Workhouse and prisons were another type of social control which developed parallel to asylums with workhouse arguably being the best comparative to asylums (Rutherford 2003. 14). The two main differences between asylums and workhouses are the location of them and the people who were meant to occupy them, despite providing for the same social class (Rutherford 2003. 14). However, the demand for spaces in workhouses was higher than asylums and as a result it is estimated that 500 more workhouses were built after 1834 (Rutherford 2003. 15). Workhouses were institutes established to house individuals who were able-bodied but were unable to provide or support themselves (Rutherford 2003. 101). They were not necessarily, however, built with the aim of improving the lives of the poor but with the aim of reducing the cost that the poor burdened the government with (Griffiths 1998. 12). Furthermore, they were used to promote the ideal that hard work done by working men was the way to avoid hardship and that nothing was free in such an industrial period (Griffiths 1998. 12). This is evident as those who occupied workhouse were expected to work for their food and shelter while experiencing conditions lower than the lowest in the working class (Griffiths 1998. 12). Workhouses were run by paid professionals, referred to as Masters or Matrons, Clerks and Medical Officers, who were hired by members on the Board of Guardians for the workhouse (Griffiths 1998. 12). [CC]

Before 1834, in Wales, there were few workhouse spaces for members in society who required the support of the government for shelter and food (Evans and Jones 2014. 110). In 1776 there were only nineteen workhouses across the entirety of Wales, with only Cardiff and Swansea workhouses having a capacity of over 100 people (Evans and Jones 2014. 110). This is in comparison to 1800 workhouses that were located across England in this period (Evans and Jones 2014. 110). Previous academics have reasoned that Wales had very few workhouses due to an unwillingness to fund workhouses and asylums for the lower classes (Evans and Jones 2014. 111). However, more recent historians have looked at the economic evidence around this and concluded that this is unlikely the case as North and South Wales had the highest level of spending compared to property value and in the period 1827-1840 (Evans and Jones 2014. 110). After 1834 the animus towards workhouse in Wales did not decline and it was written in *The Time* that the reasons workhouse and the New Poor Law was not being welcomed in Wales was because it took the responsibility off of individuals to care for people they knew (Evans and Jones 2014. 113). For this reason, much of the research and writing that has been done by historians focuses on England rather than Wales. This makes it crucial when looking at the work of historians not to make generalisations about Wales from research done on the UK or Britain as they are likely to be skewed towards England. [CC]

Asylums

Although arguably the first asylum in the UK was centred in the city of London this is not a characteristic which continued for the rest of the asylums later built across Britain. The majority of asylums were built on the periphery of large cities in rural settings (Killaspy 2007. 247). It is believed that most asylums were purpose-built as a specific environment was required for them to be able to fulfil their principal function of helping individuals who were mentally ill (Rutherford 2003. 5-14). A large proportion of the asylums that we have knowledge of in Britain were built to be self-contained and self-efficient; most asylums had their own water tanks, farms, laundry facilities and in some cases factories (Killaspy 2007. 247). In 1806 the *A Treatise on Insanity* by Pinel was published in English and advocated for treatments which included laborious activities with variety as a treatment for the mentally ill in asylums (Rutherford 2003. 66). This indicates that asylums were not designed with farms and factories as a way of being self-efficient but that these different parts of the asylum also served therapeutic functions. [CC]

Rutherford (2003. 10-15) argues that a big proportion of the asylums in Britain were built based on country homes and estates but with altered functions as they needed to be able to have higher capacities and fulfil medical requirements. However, this is an oversimplified view and romanticise the purpose of asylums, forgetting that they also worked as tools of separation of the mentally ill and society. Smith (2007. 43), in comparison, suggested that the biggest influence of asylum design was confinement and that patients were admitted for their own and the general public's safety. As a result, he argues that there was a key acknowledgement of containment and security in the architecture of these buildings and that features of prison design were influential on the development of public asylum sites (Smith 2007. 43). These two arguments are indicative of the two different bodies of thought that surround mental health architecture of this period. However, they are views that are predominantly one-sided, and it is more likely that asylums were built with both of these elements become factors in their design, this is evident in the work of Scull. Scull takes a more physical approach when looking at the architecture of asylums before taking into consideration how purpose might affect it. He concludes that asylums are made of three basic types (Scull 2005. 26). The first type he characterised as 'irregular' as they were "hodge-podge" in style made up of multiple buildings with no unity (Scull 2005. 26). The second he characterised as being asylums which were originally buildings used for other purposes which had been converted (Scull 2005. 26). The third type of asylum that Smith describes is a purpose-built asylum that was usually symmetrical with corridors characterising the building layout (Scull 2005. 26). These corridors resulted in asylums sometimes being likened to 'rabbit warrens' (Scull 2005. 26). [CC]

Wars

The two World Wars offered up similar challenges with reference to the worsening of conditions and the restriction on resources. However, particularly in the inter-war period and the second world war, we see an improvement in legislation and policy through a series of reports and investigations. [DB]

World War 1

At the outset of the first world war, there were over 140, 000 patients in asylums across England and Wales. The asylums were staffed by both male and female nurses with each sex exclusively caring for patients of the same sex. Initially, it was thought that the outbreak of the war would bring about an increase in patient numbers and would put a strain on the asylums, this was not to be the case (Devine and Wright, 2014). The strain came about when male nurses took the call to arms for king and country with female nurses moving onto better paid work. Combined with conscription in January 1916 42% of asylum staff had been enlisted to the war effort with lower qualified and minimally experienced staff were brought in as replacements (Jones, 1993). [DB]

In early 1915, 9 asylums were emptied of patients who were transferred into the remaining 88 institutions under the instruction of the War Office. 15000 beds were made available immediately at the most modern and well-equipped asylums; eventually, 31000 beds were made available by the end of the war (Crammer, 1992). The displaced patients were distributed to the remaining asylums putting a strain on the receiving asylum's, already stretched, resources. [DB]

With the disruption to asylums during the war, we see a rise in patient deaths. The biggest cause of death was Tuberculosis which spread quickly throughout the overcrowded hospitals. With malnutrition being a leading factor in the contraction of the disease, Crammer points out that the shortage of food at that time as being the main cause of the uptake as seen in table 1 where the

difference in caloric intake between members of staff and patients at the Buckinghamshire Asylum is shocking (Crammer, 1992). These figures were taken based on food allocated to the asylum by the Board of Control and does not account for the food grown on the farm at the asylum. With the inclusion of the death toll figures of influenza, the death rate peaked at just over 20% before dropping back to the pre-war levels of 10-11% by the end of 1920 (Crammer, 1992). [DB]

The board of control carried out a report on the War's impact on mental health lead by Sir Marriot Cooke and Dr Bond. This report found that 38,440 soldiers were suffering from psychoneurosis with much of these wounded soldiers being transferred from the general health wards to the asylum wards already in place. Further bed provisions were required to accommodate the growing number of cases including at the Welsh Metropolitan War Hospital in Cardiff whereby a further 600 bed spaces were created (BMJ, 1920). [DB]

There was much distaste on the use of "pauper lunatic asylums" as the media and the public felt it disrespectful to put the wounded heroes of the war into such places (BMJ, 1920). However, with the service provided by the highly skilled medical staff at the asylum facilities, by the end of the first world war many of the attitudes towards asylums changed for the positive (Crammer, 1992). [DB]

WEEKLY FOOD ALLOWANCE FOR MEN, 1916

	Patients		Staff		1918 ration
	oz.	calories	oz.	calories	oz.
Bread[a]	48	3360	112	7840	84 then 98
Flour	12	1200	24	2400	
Meat	27	2332	112	9632	16+16 fish
Bacon	5	700	24	3340	7
Cheese[b]	1	120	16	1920	
Suet	2	524	6	1572	
Butter	3½	790	8	1808	3½
Sugar	3½	390	16	1776	5½
Vegetables	48[c]	1640	not stated		80 (as potatoes)
Total calories per week		11056		30288	
Daily intake		1580		4327	

	oz patients	oz. staff
[a]Bread up to 1891	106	140
after 1891	64	140
late 1916	39	56
1917	84	84

Table 1 (Crammer, 1992)

Inter-War years

Between the Wars we see a great deal of movement in terms of metal health treatment and philosophy. In 1919, The Ministry of Health was formed to take over from the Home Office with regards to the powers given to them by the Mental Deficiency Act of 1913. The Mental Deficiency Act gave the Ministry of Health the power to hold inquiries and in 1922 this was carried out by Dr Montague Lomax. [DB]

Dr Lomax reported on Prestwich hospital and the poor conditions found there. His report outlined abuses and neglect on an extreme scale that would have been commonplace in the past. Unqualified nurses were incapable of providing the sufficient levels of care and the patients were victims of their neglect (Lomax, 1922). To validate these claims a committee was organised lead by Sir Cyril Cobb. [DB]

The Cobb Committee were unable to confirm the claims made by Dr Lomax. It was found that Dr Lomax was based at Prestwich Hospital during the was when resources were stretched, and conditions were known to be worse. The investigation brought into question Dr Lomax's competency in investigating the matter as he was 'temporary medical officer' (Harding, 1990). It should be noted however that Harding was also able to see that Dr Lomax was a conscientious doctor with the right intentions with the patient's quality of life being priority (Jones, 1993). [DB]

Dr Lomax requested a Royal Commission in 1924 and the Macmillan Commission was formed in the same year. The Commissions purpose was to investigate the legislation and administration of people suffering from mental disorders. Arguably, the major thing that the commission established was the reinstatement of the principles made by the Board of Control in 1918 as below (1927):

1. The interaction of mental and physical illness – Both aspects of health were to be treated hand in hand with each other.
2. Terminology – General health terminology was adopted such as hospital, nurse and patient.
3. Voluntary Treatment -This ensured the proper treatment of patients.
4. Class Distinction – The distinction between private and pauper patients should be removed.
5. After-care – Help with the transition from full-time care back into society.

In 1930 the Mental Health Act was introduced whereby much of the principles above were set in law. Funding for the principle of after-care was secured providing the facilities of out-patient clinics. Asylums were to become known as mental hospitals. Voluntary treatment became more widespread whereby patients could apply for treatment. This became more of an issue in terms of treatment as nurses found it difficult to distinguish between mental illness sufferers and those that just wanted somewhere to sleep and some food (Jones, 1993). Much change was to be put on hold at the end of the 1930s due to the outbreak of war in 1939 but the decade leading up to the war had shown a bright future. [DB]

World War 2

The Second World War brought about many of the issues seen in the First World War. Overcrowded and understaffed hospitals created Tuberculosis outbreaks and the forward-thinking principles from the Macmillan commission were all but dismissed. Despite the setbacks of the war, it was the eve of the National Health Service and the potential positive impact that would have on the care of the mentally ill nationwide was just around the corner. [DB]

As the impending war loomed in 1939, the Government were set in preparation of mass hysteria that was predicted to occur at the on-set of war (Jones, 1993). Fortunately, this was not the case and in fact the population as a whole took on a demeanour of defiance against fear and hysteria (Harris, 1992). This did not take away from the worsening conditions in the mental hospitals at that time as men and women were called to support the war effort leading to many nurses and doctors leaving the asylums. The rise of tuberculosis required the isolation of infected patients. First to be moved were the voluntary patients as they were not seen as priority and there was not the space to cope with the high numbers of patients. [DB]

The Beveridge plan was published in 1942 where it laid out the plans for the National Health Service. Questions arose as to whether mental health would be included in such a service or would be left to local authorities. Initially, it was the latter as laid out in the White Paper in 1944 where the Macmillan Commission were quoted in the principles they laid out with emphasis on the interconnected treatment of physical and mental health (Jones,1993). [DB]

World War 2 ended in 1945, and with it, the worsening conditions of the mental hospitals due to a lack of resources from the war effort. Although we saw much of the Macmillan Commission's principles put on hold over this period, the progression towards centralised mental healthcare was

positive. Much of the standards returned to pre-war levels and we begin to see the movement towards nationalisation in 1946 with The National Health Service Act. [DB]

Glamorgan Hospitals

The hospitals below represent a general history of mental healthcare within Glamorgan. Glamorgan County Lunatic Asylum was chosen due to its direct connection with Whitchurch Asylum and its history. Hensol Castle is a local example that goes right up until the times of community care and we can see the change of its uses from that of a home to a mental hospital and finally a commercial property. Below are the brief histories of these hospitals. [DB]

The Glamorgan County Lunatic Asylum

The Glamorgan County Lunatic Asylum opened its doors on the 4th of November 1864 with the ability to accommodate 350 patients. At the start of the hospital's life, the care was directed towards the humanitarian approach lead by Dr David Yellowlees who was the first Medical Superintendent for the County of Glamorgan and who was responsible for the administration of the hospital. 'Dr. Yellowlees was a remarkable man' with the aim "to distract from morbid thoughts by occupation or amusement…to soothe by kindness…and to make their daily life as comfortable, happy and homelike as possible. Harshness, punishment or restraint are absolutely forbidden" (Annear, 1995). In 1865, there were 80 patients at the asylum with facilities that offered the patients comfort and homeliness including horsehair mattresses, books, newspapers and washbasins with tower rails. A farm on the grounds allowed the patients to work on the land generating provisions for the hospital with no restraint. [DB]

Over the ten years since its opening, the patient numbers rose to 274 and up to 492 in 1874. The increase in patient numbers and the movement of staff members to higher paid work put a strain on the remaining staff members. As the numbers grew further, 330 patients became employed at the hospital and by 1978 patient beds were in the corridors as numbers reached 583. Around this time, there was call for another hospital to help deal with the growing numbers peaking at 600 in 1881. In 1887 the call for another hospital was answered with the opening of Parc Gwyllt Hospital. [DB]

Figure : Parc Gwyllt (Source: Coflein, accessed 12-01-2020)

Parc Gwyllt Hospital is the next step in the history of the Glamorgan Asylum. In the closing years of the 19th century, Tuberculosis became a major issue at the hospital and new level of cleanliness were met. Desite the outbreak, the number of patients hit 1783 in 1901 this number was reduced on the opening of the Whitchurch Asylum in 1908. [DB]

In the late 1920s into the early 1930s, Dr Yellowlees encouraged the practice or recreational and occupational treatments including sports, sewing and working the farm. With the long waiting list into the asylum, patients were often prioritised if they had musical talents (Annear, 1995). [DB]

The first outpatient clinics in Bridgend and Pontypridd opened in 1932 and were arguably the beginning of the end of the Glamorgan Mental Hospital as we see the move towards community care schemes. 1988 was the year the hospital closed its doors following a consultation by The Health Authority. [DB]

Hensol Castle

Figure : Hensol Castle (Source: Coflein, accessed 11-01-2020)

Built in the early 18th century, The castle itself was owned by the Jenkins family from its origin in the late 17th century undergoing a remodelling into a more Gothic style building in 1735. (CADW, 1995) In November 1926, the building was sold to Glamorgan County Council for the use as a mental hospital opening in July 1930. [DB]

The hospital was used as a colony for 100 men suffering with mental illness. This number was expanded 5 years later to hold 460 men, women and children. Little is known of the day to day life at Hensol and the standards of care being provided. However in September 1937, during his tour of South-Wales, Sir Kingsley Wood - Minister of Health – 'made a tour of inspection of the institution [after which] he said that it was by means of such visits that he hoped to take back to his work in London fresh ideas which one could never obtain from minutes and records' (The Times, 1937)

The move towards community care saw the numbers of patients dwindling in the latter part of the 20th century. In the 1980s, the ground floor of the building became a wedding venue which continues through to today. [DB]

The End of Asylums

The closure of asylums is arguably the result of no one singular factor but as a result of different intertwining and complex reasons. These reasons include public perception, advanced in medicine, the National Health Service (NHS) and community-based care. [CC]

Public Perceptions of Mental Health Care

After the Second World War attitudes in Britain changed towards some of the medical treatments that were being used before 1945 (Rutherford 2003. 15). There was now a strong aversion to the idea of detaining people for mental illnesses against their will which had been common practice with 125,530 asylum patients still being treated in the 1930s (Rutherford 2003. 15). [CC]

In 1961 this reluctance towards previous mental health treatments and asylums was utilised by the Minister of Health, Enoch Powell (Rutherford 2003. 16). This speech was to be known as the *Water Tower Speech*, in this speech Enoch Powell supported the dissolution of asylums and predicted that over the next 15 years the requirement for beds in mental hospitals would be halved (Rutherford 2003. 16; Killaspy 2006. 249). This was a proposal which advocated the removal of an estimated 75,000 mental health beds and pushed for the creation of specialised wards in general hospitals instead (Rutherford 2003. 16). This speech used the fear that had grown around asylums to demonise them and push forwards plans for closures. An example of these specialised mental health wards being opened can be seen in the form of a new district general hospital unit being opened in 1972 at the University Hospital of Wales (Williams 1974. 140). [CC]

As a result of this speech the 1962 document *A Hospital Plan for England and Wales,* which included an integrated plan considering the entirety of Wales, was drawn up and it wanted to push NHS funding into generalised hospitals and move away from specialised hospitals such as asylums which were to be closed (Killaspy 2006. 249; Griffiths 1998. 51-52). [CC]

After the *Water Tower Speech* by Enoch Powell and the movement to general hospitals and community care stigma surrounding mental health was still negative. In the 1990s fearmongering became an issue surrounding the perception of mental health and pushed for charitable help for the mentally ill out of fear (Killaspy 2006. 250). One of the most famous examples of this is the case of Christopher Clunis, a man suffering from schizophrenia, who lost contact with mental health services and murdered Jonathan Zito in Finsbury Park, London (Killaspy 2006. 250). [CC]

Medical Advances and the NHS

The founding of the NHS in July 1948 was a huge turning point for medical care in Britain as it was the first time that free health care was made available to all who required support (Killaspy 2006. 248-50). The NHS resulted in an upheaval of the administrative structure of hospitals across Britain and as a result there became more unity between England and Wales as the Welsh Hospital Board was dissolved and they were governed under the same organisation (Griffiths 1998. 9). [CC]

With the establishment of the NHS, there was a movement towards more community-based care which aimed to focus on other areas of health services than hospital admission (Killpasy 2006. 249). However, it can be argued that this process was, in fact, started in the 1930s and mental hospitals started to use outpatient care techniques as a result of the 1930 Mental Health Act (Killaspy 2006. 248). This movement towards outpatient care and community care was one of the biggest factors as to why asylums and mental hospitals began to close across Britain. [CC]

Moreover, the development of psychological pharmacology with the advancement of chlorpromazine, haloperidol and imipramine by the early 1960s has been argued to have affected the number of patients admitted to mental hospitals (Turner 2004. 2). Some Historians place this new development of pharmaceutical for mental health as one of the leading factors on patient admissions, however, this is a naïve idea to as there has not been enough research into what extent these drugs have actually made to admission rates (Turner 2004. 2). [CC]

The move away from Asylums

The end of the era for asylums began to set in during the 1970s with the philosophy of normalisation gaining strength. Italy offered Britain the example of what could be if normalization was introduced but should be taken with a grain of salt. Despite, some issues in Italy the move towards mental health service being controlled by Local authorities in the 1980s. [DB]

Normalization

The idea of normalization was developed in Copenhagen in the 1950s whereby human dignity would be given to those that were mentally ill. Normalization began the movement away from central expenditure on mental health resources and the reduction in specialist treatments for many members of the mentally ill community (Emerson, 1992). As Kathleen Jones argues, '…in the 1980s, when it became "normal" for large numbers of people to live in poverty…mentally ill people were often first to lose their jobs, or drift into sub-standard accommodation. The fact that they were not separately designated was hardly a consolation' (Jones, 1993). Normalization is a step in the right direction but not when it comes at the cost of the level of care available to the vulnerable (Szivos, 1992). [DB]

Italian example

In the late 1970s, Italy began to move away from the use of asylums and more towards alternative care options. This meant that current patients were beginning to be discharged after being assessed and no new patients could access the mental hospitals. Initially, everything looked good as the restrictive asylum buildings opened their doors giving the patients the freedom to leave and to be cared for by the community. However, this was not necessarily the case. The more serious patients who required 24-hour care, remained in the hospitals, which, by law should not remain open at all. The funding was not available meaning facilities deteriorated and untrained nurses did what they could day to day (Mangen, 1989). Britain took what they saw in Italy as a positive sign of what could occur with community care and acted upon their ambitions in the coming years (Jones, 1993). [DB]

Power to the local authority

In November 1989, the Department of Health and Social Security released the proposal *Caring for People*. The document begins the movement of mental health away from central government and towards the responsibility of local authorities. Local authority social workers are to assess suffers of mental health issues and determine the best cause of action with residential care being 'the last resort' (Jones, 1993). To support the funding of local authority mental health facilities, the sale of the local asylum was encouraged; However this money does not need to exclusively be spent on such facilities (Uk Parliament Department Of and Uk Parliament Department Of Social, 1989). In 1990 the movement of care to the local authorities was confirmed with The National Health Service and Community Care Act 1990 being introduced – between 1985 and 1992 14 mental health hospitals had been closed (Jones, 1993). [DB]

A combination of factors led to the closure of the mental hospitals in the late 20th century and it is not straight forward to put the blame on just one of them. [DB]

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