Psychiatry 50 years ago

The 1960s was a period of reform and innovation in the provision of care for people with mental health problems. The most important development was the move away from residential institutions and the development of community services based on district general hospitals.

For psychiatry, the 1960s was a period of optimism and innovation. The Mental Health Act 1959 had given the mentally ill and the mentally handicapped the same legal status and protection as the physically ill. Patients with mental health problems or learning difficulties could now be admitted voluntarily to hospitals of any kind and were no longer automatically subjected to any restriction. Accordingly, the admission and care of mentally disordered patients was now as informal as those of patients with a purely physical illness.

Doctors starting their psychiatric training at the Maudsley Hospital in the mid-1960s would have been immediately struck by the general sense of optimism surrounding their work. This seemed to have several elements:

- The belief that psychiatry was now a medical discipline with a serious scientific basis
- A sense that drugs introduced in the previous decade, notably chlorpromazine and amitriptyline, meant that many patients were for the first time expected to respond to physical treatments
- The fact that new kinds of psychological treatment, including behaviour therapy, were becoming available and were free of the mysteries, unintelligibility and expense of the psychoanalytic procedures which had previously been the only psychotherapies available.

Group approaches and therapeutic community methods, owing much to experiences treating psychiatrically ill service personnel during the Second World War, raised expectations of more successful treatments for some intractable conditions.

Also in the 1960s psychiatrists were becoming increasingly aware of the effects of the social environment on the mental health of the individual. In his Reith lectures in 1962, the psychiatrist and anthropologist, Morris Carstairs referred to the extravagant hopes that had been centred on the drugs developed to relieve agitation and depression. He warned that when these drugs were prescribed:

> **'to relieve emotional stress which is caused by problems of living, they are merely an anodyne, offering no lasting solution. To allay the symptoms while failing to explore, and if possible eradicate, the cause has always been bad medicine' (Carstairs, 1963).**

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Carstairs drew attention to the importance of social and cultural influences in the genesis and maintenance of mental disorders.

The move to care in the community

In 1957 TP Rees gave a presidential address to the Royal Medico-Psychological Association which was published under the title 'Back to Moral Treatment and Community Care' (Rees, 1957). Rees expressed the optimistic view that many if not most mental hospital inmates could be discharged into the community. The critical agent in this process was to be continuity of personal care, ideally by the nurses who had initially met the patient in the hospital and would continue to see this patient after he/she left.

The conjunction of this community care policy with 'moral' treatment referred back to the humane therapeutic practices initiated at the York Retreat in the early 19th century, most particularly in the belief that with sufficient numbers of staff who had the right personal qualities, patients will be expected to recover. That effective care of the severely mentally ill requires sufficient numbers of staff has been recurrently ignored to the present day.

The development of care in the community was one aspect of the radical transformation taking place 50 years ago in the organization and provision of mental health services. Psychiatric innovators such as Rees, public attitudes, and hospital scandals all accelerated the changes. As ever, there was suspicion that government favoured whatever was the cheapest option.

There were emerging views that large mental asylums were harmful. One factor was the recognition of 'institutional neurosis', the term coined by Russell Barton (1959) to describe the deterioration of personality and the loss of

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drive, initiative, self-reliance and motivation resulting from long-term residence in what Goffman (1961) called a 'total institution', where the patients, inmates or prisoners are entirely dependent on managerial arrangements for all aspects of their daily lives, physiological, social and personal. The imperative of economy of scale in the total institution, however benign the intent, tends to lead to a rigid and inflexible routine with uniformity of clothing, diet, accommodation and activities, and the development of secondary handicaps such as apathy and inertia (Brown and Wing, 1957). Nevertheless, arrangements in some large mental hospitals, for example Fulbourn in Cambridge, showed how enlightened management could create a wide variety of potentially helpful environments for patients with the whole range of mental disorders (Clark, 1996).

The programme which emerged during the 1960s was that the large mental illness and mental handicap hospitals should be closed down in due course and that the hospital care of the severely mentally ill should be based in psychiatric units in general hospitals. This would have the advantage of integrating psychiatry within medicine and joining together with what became known as the consultation-liaison psychiatry already in the general hospital. General hospital-based psychiatry was to become increasingly associated with better and varied community services including enhanced mental health expertise within general practices. As so often, fiscal considerations ensured that both general hospital and community services were, from the beginning, less extensive than was necessary. The historian Kathleen Jones (1993) noted in her authoritative work *Asylums and After*:

> **'In the medical enthusiasm for the district general hospital which followed [the 1962 Hospital Plan], arguments that psychiatric patients needed a different kind of architecture and use of space from general hospital patients, because they were ambulant and needed occupational and social activities, were ignored; so was the suggestion that good psychiatric treatment took time and was more than a matter of prescribing tablets.'**

Academic development of psychiatry

One organizational change through the 1960s and into the 1970s was the creation of more units of psychiatry; the aim became to have a professor of psychiatry with supporting staff in every medical school. The purpose was to promote the teaching of psychiatry, to undertake research in the subject, and to develop clinical services. Professors were supposed to be capable of clinical innovation, experience throughout medicine having been that service improvements were usually initiated by individual clinicians. This changed progressively with the introduction of general management from the 1980s, with increasing preoccupation with finances. Nowadays no-one would dream of hiring a professor in order to improve some aspect of the clinical service.

Decriminalisation of suicide

A momentous change in this period was the decriminalisation of suicide in 1961. Previously, attempted suicide had been punished as a crime in England and Wales. A Ministry of Health circular published in 1961 recommended that attempted suicide should be treated as a medical and social problem and that all cases of attempted suicide brought to a hospital should be assessed by a psychiatrist. The social and psychological concomitants of attempted suicide were studied authoritatively by Stengel (1964) and Kessel (1965a,b); at the time barbiturate hypnotics were the commonest drugs taken in overdose, and the motivation of many who survived self poisoning was shown to be complex and ambivalent. A little later it was shown that as many as half the attenders at a hospital accident and emergency department (not only but including self-poisoners) had significant psychiatric and/or social problems (a phenomenon that remains the case and is still ignored today) (Stengel, 1969).

As suicide was medicalized in a humane and positive way in the early 1960s so was the understanding of the impact of bereavement. Murray Parkes' pioneering work demonstrated the causative link between bereavement and significant medical and psychological morbidity and led to the development of invaluable counselling services (Parkes, 1964).

Subspecialization

The 1960s also saw the development of subspecialties within psychiatry, notably old age, child and forensic psychiatry. Interested individuals and groups explored ways in which the methods of the developing scientific psychiatry could be applied to a range of behavioural, medical and socioculturally induced problems, including eating disorders, alcohol and drug misuse, and uncontrollable gambling. Housing, employment, and group social and artistic activities began to assume a vital role in rehabilitation programmes. As the 1960s progressed, for the first time sexual problems began to be amendable to treatment, following the publications of Masters and Johnson (1966). The availability of such treatment was and has always been to this day patchy.

In this period liaison-consultation psychiatry evolved out of the recognition that in every physical disease specialty there are patterns of symptoms which cannot be entirely explained by the organic disease itself. In 1961 Denis Hill established a model liaison service at the Middlesex Hospital in which psychiatrists using a biopsychosocial approach were attached to individual medical units in order to investigate and treat patients with 'functional' disorders which until then had usually been dismissed as 'supratentorial', ' hysterical' or 'neurotic' (Hill, 1969).

Improvements in psychiatry since the 1960s

In the authors' view one of the most marked improvements between the 1960s and today is the care of the demented elderly and in the understanding of the cerebral diseases

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from which they suffer. When the authors were training there was little interest in this topic and they remember being taught that most people die within 2 years of a dementia diagnosis, while large numbers of patients with dementia lived out their days in dementia wards in mental hospitals. A second great and shamefully long overdue change over the past 50 years has been the move towards the integration of people with intellectual disability into mainstream community life. Finally, at long last, the need for locally available psychiatric mother and baby units on a national scale has been recognized.

The current situation

As retired practitioners the authors are spectators of the current psychiatric scene, which they inevitably compare with what they knew when training more that half a century ago and subsequently. The authors have concerns about what they see now: the abandonment in many places of the principle of continuity of care, difficulty in providing long-term or indefinitely long care for people with chronic problems, fewer staff than are actually needed in many places, usually for reasons of economy, and insufficient acute bed numbers, so that the illest patients cannot stay long enough in hospital and may indeed be sent to hospitals many miles away from their homes.

On the other hand, the authors applaud efforts to improve community-based services, with recognition that a wide range of such services is needed, efficiently integrated with social care provision. It should be possible to ensure that modern technology can be applied in many ways, many now unimaginable, to the benefit of individuals with mental health difficulties (Craig et al, 2015). **BJHM**

Professor JP ('Jim') Watson died on 3 August 2016. This article is dedicated to his memory as an inspiring teacher, colleague and friend.

Conflict of interest: none.

KEY POINTS

- Changes in social attitudes which started half a century ago have reduced the stigmatisation and exclusion of people with intellectual disabilities and mental health problems.
- Suicide was decriminalised in the 1960s and the morbidity and increased mortality associated with bereavement were recognized.
- Social psychiatry, with its recognition of the pathogenic effects of unemployment, poor housing, isolation and discrimination, became established in this period.
- Using the biopsychosocial model, psychiatrists began to contribute significantly to the care of patients in general hospitals and in primary care.

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