

Part 1

Setting the scene

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Excerpt

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CHAPTER 1

Rehabilitation in a historical context

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Those who cannot remember the past are condemned to repeat it.
George Santayana

Introduction

‘Rehabilitation psychiatry’ is a relatively new term. It combines a word that is quite old – rehabilitation (which initially related to restoring one’s title or place in society, and which gained its current meaning only in the early 20th century) – with a word – psychiatry – first coined in the early 19th century (from the Greek ‘healing the mind’). Specific rehabilitation departments were developed in UK mental hospitals only in the 1950s, since when rehabilitation services have flourished, declined and then re-emerged as a core element of mental healthcare, albeit often rebranded under various fashionable rubrics.

This chapter looks at the ‘pre-history’ of psychiatric rehabilitation and its development since the 1950s, when it was first identified as a specialty. The story is inevitably highly selective, given the range of material available. Some important themes, for example the voice of the patient (or service user, or survivor), which was first influential during the 19th century, and the Recovery Movement and its precursors, are discussed in detail elsewhere in this book (see Chapters 6 and 3, respectively). The present chapter draws largely but not exclusively on the evolution of ideas and practice in England: very similar though subtly different stories could be told for France, Germany and the USA (Stone, 1998).

The difficulties of any historical analysis of psychiatry were well described by Berrios & Freeman (1991) in their introduction to *150 Years of British Psychiatry*. One problem is ‘presentism’ – seeing the past from a perspective that takes no account of the intellectual, social and cultural context of the times. A further potential pitfall is developing a story of uninterrupted progress (in historical jargon, the Whiggish interpretation of history¹): in reality, progress in what we would now call psychiatric

1. Whigs were a political faction opposed to Tories in the English Parliament from the 1680s: they became the Liberal Party and the Tories became the Conservative Party. Whigs were identified as believing in progress, Tories as believing in the status quo.

rehabilitation has ebbed and flowed. Another problem with any attempt at understanding the past, not mentioned by Berrios & Freeman, is that historical sources overwhelmingly represent the experiences of a privileged and literate elite.

Understandings of mental disorder

Abnormal mental states and aberrant behaviour are described in some of the earliest written records (Stone, 1998). Historians of psychiatry identify three common ways of understanding mental disorder. The first is a religious perspective, which can be positive, in terms of accessing a higher level of consciousness, or negative, relating to possession by evil spirits. The second is somatic and describes physical causes – though the proposed nature of these causes has varied since the time of Hippocrates (Brown, 1997). The third explanatory framework involves psychological and socio-environmental causation: grief, passion, stress, association of ideas, unconscious mental processes, life events and cognitive distortions.

These alternative ways of understanding have had practical effects. A belief in somatic causation suggests the use of physical treatments, which in the past have included dieting, purging and bloodletting. The psychological approach suggests that understanding the causes of the person's problems and attention to the person's social environment should lead to resolution of the problem. Religious understandings have led to both acceptance and inclusion and very marked exclusion from society.

Ancient ideas on madness and its treatment

There are numerous descriptions of abnormal mental states in the Old Testament. Saul, the first King of Israel, is generally accepted as suffering from an affective disorder, with episodes of depression and possibly mania (Stein, 2011). His affliction is described in religious terms: 'The spirit of the Lord had forsaken Saul, and at times an evil spirit from the Lord would seize him suddenly' (1 Samuel 16: 14). Treatment, however, was psychological: 'And whenever a spirit from God came upon Saul, David would take his harp and play on it, so that Saul found relief: he recovered and the evil spirit left him alone' (1 Samuel 16: 23).

A number of familiar mental disorders are described in the writings ascribed to Hippocrates (c.450–370 BCE): mania, paranoia, hysteria and melancholia. The Hippocratic corpus provides a physical account of mental states: 'from the brain, and from the brain only, arise our pleasures, joys ... as well as our sorrows, pain, grief and tears. It is the same organ that makes us mad or delirious, inspires us with dread and fear, brings sleeplessness ... and aimless anxiety' (quoted in Stone, 1998: p. 10). Disease in general was attributed to an imbalance of humours or elements, which are variously described. Mania was thought to be caused by an accumulation of yellow

bile heating and drying the brain, while melancholia was thought to be caused by an accumulation of black bile.

Humoralism was the dominant explanatory framework for disease in Graeco-Roman times and remained so well into the early modern period (Brown, 1997). A range of treatments were advocated by the humoralists, aimed at restoring the balance of the humours. These included bloodletting, enemas, induced vomiting and starvation. Plato, in *The Republic*, advocated that people whose psychological constitution is ‘warped’ (understood here to mean people who are chronically mentally ill) be put to death (Book III 410) – anticipating eugenic policies by more than 2000 years.

Another tradition is linked to the philosopher Epicurus (341–270 BCE), who taught that the right philosophy, which is based on scientific knowledge, cures the anxieties of the soul in the same way that the right medicine cures the pains of the body. The philosopher and physician Asclepiades (c. 24–40 BCE), a follower of Epicurus, rejected humoralism and was sceptical about harsh physical treatments. He recommended instead mild therapeutic methods, such as healthy diet, exposure to light, massage, physical exercise, the use of medicinal herbs and, in some cases, wine. Asclepiades described delusions and hallucinations and ‘was a pioneer of the humane treatment of mental disorders ... free[ing] insane persons from confinement in the dark and treat[ing] them using labor and music therapy, in addition to healthy diet and massages’ (Yapjakis, 2009).

Epicureans believed in a psychological approach to the treatment of mental disorder and also identified psychological causes. Soranus of Ephesus (1st–2nd century CE) in *On Acute and Chronic Diseases* described the symptoms of mania and melancholia and described a range of causes for mania, which included ‘continual sleeplessness, excesses of venery, anger, grief, anxiety, or superstitious fear, a shock or blow, intense straining of the senses and the mind in study, business or other pursuits’ (quoted in Brown, 1997: p. 440)

The Roman encyclopaedist Celsus (c. 25 BCE to c. 50 CE) was a humoralist and as such favoured the use of physical treatments, to the extent that: ‘If it is the mind that deceives the madman, he is best treated by torture, fetters or flogging’. However, he also advocated relieving melancholy with soft music and described the intriguing case history of a wealthy man who lived in fear of starvation. ‘His attendants announced pretended legacies to him, to relieve his anxieties, until he recovered his reason’ (quoted in Stone, 1998: p. 13).

Early nosologies

During the time of the Roman Empire, a distinction was drawn between illnesses that came on in adult life (e.g. mania, melancholia and paranoia), lack of normal mental functioning from birth (amentia) and loss of mental functioning (dementia). Recovery from some disorders was seen as possible, whereas recovery from amentia and dementia was not.

Similar ideas appear in a very early statute in English law, *De Praerogativa Regis*, which dates from the reign of Edward II (1307–27). It relates to the management of the property of people who, in modern terminology, lack capacity to manage their wealth. The statute makes a clear distinction between ‘natural fools’, who have no prospect of recovery, and ‘lunatics’, who may well recover. The ‘lunatic’, in the words of the Blackstone’s 18th-century *Commentaries* (book 1, chapter 8, XVI), ‘has had understanding, but by disease, grief, or other accident has lost the use of his reason’. On recovery, property would return to the control of the former ‘lunatic’.

Enlightenment and later ideas about mental illness

Ideas about mental illness were refined during the Enlightenment, a period of intellectual development that saw the elaboration of the scientific method and a secular as opposed to a religious approach to mental disorder. Prominent during this period were the ideas of the English philosopher John Locke, who developed an ‘associationistic’ psychology, which suggested that people with a mental illness draw reasonable conclusions from false premises (a view echoed by contemporary cognitive psychology). The alternative view, that psychological diseases are diseases of the brain, became the dominant paradigm during the latter part of the 19th century (Brown, 1997). This evolved into an understanding of mental disorder as an expression of hereditary degeneracy (or in the case of general paralysis of the insane, an infective process).

These competing views of mental disorder have been greatly refined over the past 100 years. The early 20th century was dominated by ‘dynamic psychiatry’, under the influence of Freud and his followers (Ellenberger, 1970), although Freud’s ideas had little initial impact on the care of people with severe mental illness, which remained largely institutional. The biological approach was supported by the development of effective treatments for the symptoms of mental illness during the 1950s – which saw the introduction of antipsychotic, antidepressant and anxiolytic medications. Systematic investigation of the person’s social context has been added to the investigation of the causes of mental disorder (Morgan *et al*, 2008). We now know that environmental, psychological and social factors can have an effect on the expression of genes. As a result, the current dominant way of understanding the problems and needs of people with a mental illness is a biopsychosocial model, which seeks to take into account factors working at all these levels.

The care of people with mental illness

Throughout history, the primary responsibility for caring for people who were behaving abnormally has been within the family or the very local

REHABILITATION IN A HISTORICAL CONTEXT

community. People of means might have access (for good or ill) to medical treatment and be looked after by attendants. Where families or local communities were unable to provide support, some care was provided haphazardly by religious institutions.

The first hospitals to be recorded as treating people with mental illness were in the major cities of the Islamic world, including Cairo, Baghdad, Basra and Aleppo (Youssef & Yousef, 1996). Similar institutions sprang up in major European cities during the Middle Ages (Bynum, 1983). In London, the Priory of St Mary of Bethlem was founded in 1247 as a focus for the collection of alms. It gradually evolved during the 1400s into a specialist institution for the confinement of the ‘insane’ – remaining the only one in England for over 200 years (Donnelly, 1983).

Boarding out of people with a mental illness either locally or with landlords who took residents in (for a fee) was a common practice. It was particularly associated with the small town of Geel in Belgium. Geel, site of the shrine to St Dymphna, patron saint of people who are mentally ill, attracted visitors from across Europe. (St Dymphna is said to have been killed in Geel in the 7th century by her mentally ill father, a petty Irish king.)

The Church authorities encouraged local people to offer foster care.

In England there has been a system of relief for the poor and vulnerable since Tudor times. The Elizabethan Poor Law created a system that was administered by Parishes funded by the rates, a local property tax. Those who were too ill or old to work received payment and food (‘outdoor relief’); in some places elderly people could reside in alms houses (‘indoor relief’). Access to relief was dependent on showing a connection to the parish. Vagrants and beggars were strongly disapproved of and could be sent to a ‘house of correction’. People with a mental illness might end up in a house of correction or a local gaol.

The 18th century saw the development of workhouses (the residents of which were expected to contribute by productive work). These became catch-all institutions for poor and vulnerable people. They were the central provider of support after the introduction of the New Poor Law in 1832, which drastically restricted outdoor relief. There was a parallel development of specialist institutions for people with a mental illness during the 18th century and early 19th century (Donnelly, 1983). Hospitals and asylums were opened in provincial cities as charitable foundations, along with a large number of for-profit ‘madhouses’. Both would take in ‘pauper lunatics’ (paid for through local rates) or people of means.

Conditions in 18th-century madhouses and hospitals such as the Bethlem could be very degrading: a visit to view the lunatics at the Bethlem was seen as an enjoyable day out. However, we know that people who were sent to madhouses got better. A notable example is the poet William Cowper, who suffered from a severe recurrent affective psychosis. Cowper spent a period in ‘Dr Cotton’s Home for Madmen at St Albans’. While at Dr Cotton’s Home Cowper was for a period bound to his bed to prevent

him from killing himself. He went on to spend a productive life, living with an Evangelical Christian family, despite subsequent relapses that were managed, not without difficulty, at home (Cecil, 1933).

The magistrates visiting Ticehurst House (a purpose-built asylum catering for a wealthy clientele) noted that ‘all [residents] expressed themselves well satisfied with the arrangements made for their comfort and convenience’ (Scull, 1982). In 1799 the Bethlem admitted 201 patients and reported having ‘cured and discharged’ 179 patients and buried 20. Of the 243 residents on 31 December 1799, 130 were described as ‘under cure’ and 113 as ‘incurable’ (House of Commons, 1815: p. 388).

Moral treatment

Towards the end of the 18th century there was a movement to reform practices in asylums, exemplified by the actions of Philippe Pinel, physician successively to two large hospitals in post-revolutionary Paris, the Bicêtre and the Salpêtrière.² Pinel is remembered for removing the chains of inmates at the Salpêtrière and introducing a more humane approach to the treatment of the insane (*traitement moral*); in fact, similar initiatives had been taken previously, notably by Chiarugi in Florence, Daquin in Chambery and Pinel’s colleague Pussin at the Bicêtre (Stone, 1998: ch. 5).

The York Retreat, moral treatment and the Tuke family

In 1791 a Quaker woman from Leeds, Hannah Mills, died some weeks after admission to the York Asylum. Investigations by her co-religionists in York, who had been asked by her family to visit her but who had been refused access, revealed very poor conditions at the Asylum. William Tuke, a tea merchant, subsequently led the foundation by subscription of an alternative asylum, initially only for Quakers. The York Retreat opened in 1796 and still exists. Although always a small institution, its design, principles and working practices, as described by Samuel Tuke, the founder’s grandson, in his book *Description of The Retreat* (Tuke, 1813), were to prove highly influential. *Description of The Retreat* remains a founding text of rehabilitation psychiatry (see Chapter 17, ‘Rehabilitation in hospital settings’).

Samuel Tuke’s book is organised in an exemplary fashion. Two introductory chapters provide a historical context, including the bureaucratic details of obtaining funding for the project. Four years elapsed between the first committee meeting and the opening of The Retreat. The third chapter describes the acquisition of the site and building work. A fourth chapter, using original notebooks Tuke had obtained, describes the approach of the first physician to The Retreat, Thomas Fowler, to medical treatment. Dr Fowler’s approach was cautious and empirical and the conclusion was that

2. After the French Revolution, multifunctional institutions were established that contained many thousands of inmates – including people deemed ‘insane’ – but the Bicêtre (for men) and the Salpêtrière (for women) pre-dated these.

contemporary medical treatment was not effective, other than warm baths for women with melancholia. Tuke advocated attention to the treatment of what we would now term comorbid physical illness. A fifth and substantial chapter describes moral treatment (a term Tuke consciously appropriated from Pinel, although the practices of *The Retreat* evolved independently of Pinel's work). The book ends with a description of cases, some statistical material, a brief discussion of nosology and some comparative material about the ways in which particular asylums were run.

William Tuke and his committee hired a superintendent, George Jepson, and a nurse in charge of the female patients, Katherine Allen, who would have been the people most crucial to the way *The Retreat* worked in practice. Together they elaborated moral treatment, which was based less on theory than on practice (Samuel Tuke frequently refers to Jepson's experiences in his book). The basic tenets of moral treatment were: to strengthen and assist the power of patients to control their disorders; to be clear about the appropriate use of coercion (only when it is 'absolutely necessary'); and to promote 'the general comfort of the insane' (Tuke, 1813: p. 138). *The Retreat* offered a positive environment, where patients were treated with respect and encouraged to be involved in a daily routine of activity and leisure, which was specific to their previous life and interests. Patients were talked to as human beings, 'in a kind, and somewhat low tone of voice', and were encouraged to develop self-restraint. The use of chains and corporal punishment, common in the 18th-century asylum, was forbidden. Tuke discusses the limitations of punitive measures towards disturbed behaviour and value of kindness (he provides a case history). He describes how the superintendent would interact with the patient as a rational person and how the regime could foster self-esteem.

William Tuke, his son Henry and his grandson Samuel all had strong connections with *The Retreat*, but none was medically qualified. Samuel's book evidences a very sophisticated understanding of the care of mental illness. It is much more accessible to contemporary readers than the writings of his son, Daniel Hack Tuke, who was one of the most eminent English psychiatrists of the second half of the 19th century.

The 19th-century asylum

A complex and lightly regulated system of private madhouses and charitable hospitals and lunatic asylums had evolved in England during the 18th century. Well-publicised scandals about conditions in these institutions led to pressure for reform. A series of parliamentary investigations in the first decades of the 19th century resulted in legislation. In 1808, counties were allowed to build asylums, funded by local rates, and finally in 1845 they were required to do so (Donnelly, 1983).

A Select Committee on Madhouses set up in 1815 heard evidence about abuses in asylums, madhouses and workhouses and the harm caused by traditional medical approaches to the treatment of inmates (Scull, 1982).

WOLFSON & HOLLOWAY

The Quaker Edward Wakefield provided particularly striking evidence in the case of James Norris, who was held in chains in solitary confinement at the Bethlem for over a decade. Importantly, the Committee also heard about positive practice – William Tuke gave evidence to the Committee (House of Commons, 1815: pp. 160–163). Members of the Committee had read Samuel Tuke’s account of *The Retreat*.

Reformers in England, France and the USA were clear that what was required were purpose-built asylums organised on the therapeutic principles of moral treatment that would lead to cure and discharge. Conditions improved. Non-restraint was introduced into public asylums in England by Robert Gardiner Hill in Norwich and John Conolly at the Hanwell Asylum in Middlesex (which is now St Bernard’s Hospital). Emphasis was put on engaging patients in activity. Success rates for at least some of the new therapeutically oriented asylums were initially high: over 20 years (1833–52) 71% of the patients admitted to the Worcester State Hospital, Massachusetts, who had been ill for less than a year were discharged (Bockhoven, 1954).

There was another element to the reformed asylum – the management of risk. The Criminal Lunatics Act 1800 set out a procedure for the indefinite detention of a person acquitted on the ground of insanity. Initially, such people often ended up in prison, an unsatisfactory situation that suggested the need for special provision. Following a Select Committee report in 1807, negotiation between the Home Department and the governors of the Bethlem hospital resulted in a special wing being built at its new premises (located in what is now the Imperial War Museum). This wing, the State Criminal Lunatic Asylum, opened in 1816. Its direct descendants are the three high secure hospitals in England and the ever-expanding network of forensic mental health services.

The latter half of the 19th century and the first half of the 20th century saw what has been described as the ‘long sleep’ of the mental hospital. Therapeutic optimism evaporated and the proportion of patients identified as curable by asylum superintendents decreased steadily (from a not very impressive 15% in 1844 to a dismal 7.7% in 1870). By 1890, more people each year were dying in the asylums than being discharged cured (Scull, 1982: ch. 6). Throughout the 19th century and in the first part of the 20th, asylums grew in size and new asylums were built, usually on the outskirts of conurbations. To contain costs, these institutions were as self-reliant as possible and depended on the labour of the better-functioning patients. These custodial asylums existed alongside an overwhelmingly organic understanding of mental disorder, which was seen as a degenerative and hereditary condition. However, even during this bleak period there was evidence of interest in supporting people who left the asylum. In 1879 the Reverend Henry Hawkins, chaplain to Colney Hatch Asylum, founded the Mental Aftercare Association (now the charity Together) ‘to facilitate the readmission of the poor friendless female convalescent from Lunatic Asylums into social life’.

Rehabilitation in the 20th century

Organised rehabilitation in the UK has its beginnings in the horrors of the First World War, as attempts were made to help ex-servicemen with disabilities return to employment (Bennett, 1983). In 1919 the Ex-services Mental Welfare Society (now Combat Stress) was formed to assist shell-shocked ex-servicemen. The Society set up a convalescent home in Leatherhead and subsequently a business manufacturing electric blankets. Although this group of people had very different problems to those of patients in asylums, the Society's consultant psychiatrist, Professor Mapother, observed that a similar scheme of sheltered work would be appropriate for 'ordinary psychiatry'. It was only long after the Second World War that work rehabilitation became an integral part of the life of the mental hospital.

Asylums in the early 20th century showed no sign of awakening from their 'long sleep'. The *Journal of Mental Science* (now the *British Journal of Psychiatry*) printed a brief report on 'habit training for mental patients' (McWilliam, 1926). This was an early example of the use of occupational therapy within a mental hospital setting, which dates back to the 1900s at the Henry Phipps Clinic in Baltimore. There is no evidence that McWilliam's report had any effect on practice within the UK asylum system.

Following a Royal Commission on Lunacy and Mental Disorder, there were significant reforms to mental health law: the Mental Treatment Act of 1930 allowed, for the first time, voluntary admission to publicly funded in-patient care in what were now termed 'mental hospitals' and permitted local authorities to develop aftercare services. A study tour of mental hospitals in Holland introduced to British psychiatry the influential ideas of Dr Hermann Simon, director of the asylum in Guttersloh. Simon described 'active therapy' – which meant engaging patients in productive work to prepare them for life outside hospital.³

The Second World War provided a surprising stimulus to psychiatry in Britain. The army, mindful of the experience of the First World War, expected its medical officers to treat psychiatric casualties, most of whom were suffering from neurotic or stress-related conditions. Many got better; those who relapsed were reassigned to other duties or discharged back into civilian life. There were fascinating experiments in working with soldiers with a neurosis at Northfield Hospital in Birmingham and Mill Hill Hospital in London, which went on to inform group analysis and one strand of social psychiatry – the hospital as a therapeutic community (Clark, 1974). In 1944 the Disabled Persons Act set out a programme for the rehabilitation of people with both physical and mental disability. Some army doctors became psychiatrists after demobilisation and brought with

3. Less well known was Simon's espousal of Hitler's racist and eugenic policies, which seems at odds with the humanistic perspective that 'active therapy' implied.

WOLFSON & HOLLOWAY

them positive views on the outcome of mental illness (and quite a lot of organisational expertise).

After the war, the mental hospitals continued to accumulate patients; bed numbers reached a maximum in both the UK and the USA in 1954. However, things were changing. In the traditional mental hospital the doors to wards had been locked. Pioneering hospitals began to open these doors (T. P. Rees, medical superintendent of Warlingham Park Hospital, in Surrey, is credited as the pioneer of the 'open door movement'). From 1950, mental hospitals became more open institutions, in the sense that the numbers of both admissions and discharges increased markedly and the average length of stay decreased. This change started just before the introduction of effective pharmacological treatments for mental illness became available, the first being chlorpromazine, which was available from 1954 onwards.

Although there was increasing interest in rehabilitation, the dominant theme of mental hospital care was resettlement (Bennett, 1983). It was already apparent by the late 1950s, however, that, in the absence of adequate community care, there was a price to pay for this, in terms of the burden on families (Mills, 1962). Specific rehabilitation services initially focused on preparing people for work and mental hospitals began to offer 'industrial therapy' (Early, 1960). At one level, industrial therapy was successful (this was an era of full employment), but it became clear that other issues relating to social functioning needed to be addressed. Mental hospitals developed a gradient of increasing social expectations on patients – the ladder model of rehabilitation. The ladder was later extended to a range of supported settings out of hospital (Early, 1973).

That mental hospitals might have a bad effect on their patients had been clear since the 19th century. In 1894 the American neurologist Weir Mitchell exclaimed to the American Medico-Psychological Association, 'upon my word, I think asylum life is deadly to the insane' (quoted in Bennett, 1983). Asylum care became the focus of empirical research in the 1950s. In a seminal study the sociologist Erving Goffman (1961) described the impoverished social world of the 'inmates' of a psychiatric institution. Russell Barton (1966) viewed this effect as an illness in itself – 'institutional neurosis'. Most persuasively, Wing & Brown, in their 'Three Hospitals Study' (1970), investigated the relationship between the way that three hospitals worked and the outcome for patients with schizophrenia. They found that the quality of the social environment was associated with what we now call the negative symptoms of schizophrenia and that as the environment changed, the frequency of negative symptoms changed (in one hospital the social environment improved and negative symptoms decreased; in another it worsened and negative symptoms increased). The most important environmental factor was 'time spent doing nothing'.

The 1962 Hospital Plan envisaged the closure of 13 of the 109 large mental hospitals in England and Wales by 1975, an overall reduction in bed numbers and the opening of acute in-patient units in district general

hospitals. It was not until 1986 that the first large public mental hospital (Banstead Hospital in Surrey) actually closed. Since then, almost all have closed or vastly down-sized. Most of the sites have been redeveloped for housing. The hospital closure programme in England has been the best studied in the world and has provided valuable insights about the process and outcomes of hospital closure and the impact of the social environment on people's social functioning.

The mental hospital closure programme and the TAPS study

In a relatively short period the majority of the large mental hospitals in England and Wales closed. The Team for the Assessment of Psychiatric Services (TAPS) study is the most thorough evaluation of a hospital closure programme and its aftermath that has ever been undertaken. The focus was the closure of Friern Barnet Hospital, which had opened as the second Middlesex County Asylum, or Colney Hatch, in 1851. It became the largest mental hospital in the UK, with, at its peak, some 3000 beds (and reputedly the longest hospital corridor in the world). The North East Thames Regional Health Authority resolved to close Friern and from 1985 funded a research team led by Professor Julian Leff to evaluate the closure process. The hospital closed in 1993. The site was converted to an 'exclusive residential development set within 30 acres of parkland' (according to the website marketing the properties, <http://www.princessparkmanor.net>) and the railings that once served to keep patients in now keep the less desirable elements out.

TAPS provided data on outcomes for patients discharged from Friern between 1985 and its closure and a cohort of patients discharged from the rather less glamorous neighbouring Claybury Hospital. TAPS also looked at the outcomes of 'difficult to place' patients from the Friern catchment area and outcomes for elderly patients with dementia. TAPS generated a huge amount of data, published in 46 named TAPS papers, a book (Leff, 1997) and a brief overview paper (Leff *et al*, 2000). The headline findings were that patients who were discharged to community settings (mostly offering a high level of support) gained social and domestic skills, experienced enriched social networks and had a much better living environment (Leff & Trieman, 2000). Only 10% of patients were in hospital at 5-year follow-up (Trieman *et al*, 1999). Many of the 'difficult to place' patients moved into newly developed specialist local services (Trieman & Leff, 2002). Challenging behaviours decreased over time and over 5 years 40% of patients moved to less supported settings.

TAPS and other studies tell us a lot about outcomes. Large mental hospitals were closed to the benefit of their residents, although local in-patient mental health services struggled for a time because of pressures following these bed reductions (Leff *et al*, 2000). Less well documented

are the complex ideological underpinnings of the closure movement and the financial arrangements that allowed it to proceed. The earlier writings of Goffman and Barton, which suggested that the problems that long-stay hospital residents presented were largely if not entirely the result of the experience of living in an institution, were influential. Many 're-provision' services were influenced by the principles of 'normalisation'. This is a complex set of ideas first elaborated in the context of learning disability that emphasises both the right of people living with disability to occupy valued social roles and the negative impact of labelling and stigmatisation on people's ability to function (Brown & Smith, 1992).

Rehabilitation and community mental health services

It was not until 1983 that the first substantial textbook on psychiatric rehabilitation was published in the UK (Watts & Bennett, 1983). At that time, rehabilitation practice was largely limited to in-patient units (usually located within a mental hospital and focusing on people who had become long-stay patients) and day-care facilities (day hospitals and day centres). Some rehabilitation went on in hostels and group homes. Occupational therapists, whose focus is on functioning rather than illness, were already integral to mental health teams. Watts & Bennett (1983) included chapters on working with families, the importance of community support and how specific aspects of social functioning might be addressed, such as employment, daily living skills and interpersonal skills. The reality for patients leaving hospital often fell far short of the practices Watts & Bennett promoted and the deficiencies of community care became increasingly apparent (National Schizophrenia Fellowship, 1984).

Inadequacies in community support for people living with mental illness spurred the introduction of the Care Programme Approach (CPA) in 1991 (Department of Health, 1990). CPA, which is essentially a care planning mechanism for in-patient services and community mental health teams, has gone through successive subsequent refinements (Department of Health, 2008). Although the term 'rehabilitation' is not used in the policy documents, CPA is clearly rehabilitative in focus:

Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.... Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews. (Department of Health, 2008: p. 7)

Rehabilitation into the 21st century

The National Service Framework for Mental Health was published in 1999 (Department of Health, 1999). It included a very substantial chapter on services for people with severe mental illness and specifically stated that for people discharged from in-patient care there should be 'a written after-care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis' (Department of Health, 1999: p. 41).

It is something of a historical puzzle that rehabilitation did not appear at all in the subsequent Policy Implementation Guide (Department of Health, 2001) or in the plethora of Department of Health policy documents that followed it. It is likely that policy-makers believed that the hospital closure programme had abolished the need for long-term high-support care. A review of future bed needs in England proposed that all psychiatric rehabilitation in-patient beds should close (Department of Health, 2000), although, in line with a long-term policy focus on issues of risk in mental healthcare, it did propose a massive expansion in intensive care and forensic provision.

The focus of policy in the first decade of the 21st century was on the development of functional community teams providing assertive outreach, crisis and home treatment, and early intervention in psychosis. These teams were often built from the ashes of community rehabilitation teams that had supported patients with complex needs coming out of hospital (Mountain *et al*, 2009).

It has become clear that the deinstitutionalisation promised by the hospital closure programme of the 1980s and 1990s did not in fact abolish institutional care. It was replaced by a 'virtual asylum', a complex and highly fragmented system involving public and private sector hospitals, residential and nursing home care, and various forms of supported housing (Poole *et al*, 2002). This phenomenon of transinstitutionalisation has been observed across Europe (Priebe *et al*, 2005).

Despite the lack of a clear policy lead during the past decades, both in-patient and community rehabilitation services continue to have a vital place in a comprehensive mental health system (Wolfson *et al*, 2009; Joint Commissioning Panel for Mental Health, 2012). This book seeks to put flesh on the bare bones of this statement.

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WOLFSON & HOLLOWAY

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REHABILITATION IN A HISTORICAL CONTEXT

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