‘With care in the community, everything goes’: coproducing oral histories to re-examine the provision of care in mental hospitals

by Verusca Calabria

Abstract: This article draws on oral histories coproduced with former patients of two state mental hospitals in Nottinghamshire, collected thirty years after their closure. The oral histories reveal the mental hospitals to be more welcoming and relaxing environments compared to the current system of acute inpatient services, which is oriented towards crisis management. Former patients found accessing meaningful occupation as well as the ability to move within internal and external institutional spaces to be central to recovery. They expressed a sense of loss of inpatient therapeutic environments when undergoing crisis following deinstitutionalisation and the advent of community care. The findings have important implications for the historiography of psychiatry and bear on current mental health policy.

Keywords: mental health; institutional care; deinstitutionalisation; community care; participatory action research

The central motif in published stories about institutional life mainly centres on punishment and resistance. More positive narratives about care in psychiatric institutions have not usually been told in published accounts, largely due to the vilification of institutional care[1] and the fact that they do not easily fit with government policies on deinstitutionalisation.[2] The sparse published and unpublished oral histories of life in mental hospitals in the UK in the second half of the twentieth century reveal often contradictory meanings of institutional care. Mental hospitals could operate as ‘total institutions’[3] as well as permeable environments in which the social and spatial conditions could be much richer than reported in the anti-institutional literature of the time. Points not usually highlighted about psychiatric institutions are their role as places of safety and sanctuary, of residents liking life in hospital, and their regrets about its demise.[4] Sociological and geographical studies, and community-led projects based on the testimonies of patients and staff, offer conflicting representations of care provided therein. In some hospitals improvements to care practices were slow and uneven, failing to produce adequate care and within which patients were at risk of abuse.[5] In contrast, research based on residents’ narratives has evidenced how mental hospitals could also be remembered as refuges and places of belonging. For instance, Diana Gittins collected sixty oral histories of former residents and staff at Severalls Hospital over eighty-four years of the hospital’s existence. The hospital was widely portrayed as a place of belonging for many, where a sense of community and kinship operated among patients and staff and where patients formed strong bonds with other patients.[6] Similarly, Parr, Philo and Burns reconstructed the meanings attached to Craig Dunain Hospital, Scotland, primarily through

interviews with ex-patients and some staff shortly after the hospital closed in 2000.[7] The narratives reveal a much more complex picture of institutional life holding both positive and negative connotations. Although ex-patients and staff recalled instances of neglect and poor treatment, significantly, the narratives evidenced the hospital as a therapeutic landscape. Ex-patients recounted that the extensive grounds were utilised by staff to generate caring practices, such as providing privacy for patients going through crisis, reported to be lacking in the newly built acute settings that replaced the old hospital. The proximity and exposure to Craig Dunain Hospital encouraged patients to value the hospital environment, based on how useful internal and external spaces could be in aiding recovery. These spaces, including the spacious grounds, contributed to a perception of a place of recovery and retreat.

This article draws on oral histories which I collaboratively produced with former patients of the now-closed large state mental hospitals in Nottinghamshire as part of my doctoral studies.[8] The term patients has been used throughout this article in order to take into account the dominance of the medical model in mental health care at the time when participants were receiving care in the psychiatric hospitals.[9] The research combined participatory action research (PAR) with oral history to examine the impact of the transition from state mental hospitals to the community care model. The oral histories of ex-patients challenged the hitherto prevailing narrative of psychiatric care in institutions in the latter part of the twentieth century as solely dominated by discipline and punishment, by revealing important social and spatial aspects of inpatient care that were helpful for patient recovery, such as the relationships fostered therein.[10] This article aims to highlight aspects of meaningful care that emerged from the oral histories of former patients, perceived to be lost in the current system, following the introduction of acute inpatient units on the site of district general hospitals as a result of deinstitutionalisation and the subsequent advent of community care in the 1990s.[11] The co-produced oral histories provide novel insights into valuable aspects of institutional care that bear on current policy.

Background

The impetus to close mental institutions in the UK from the middle of the twentieth century onwards was fuelled by growing concerns about the poor environmental and social conditions of patients, highlighted by hospital inquiries.[12] In the 1960s the anti-psychiatry movement influenced their closure in the western world by articulating strong critiques of mental hospitals. A series of hospital scandals exposed the abuse of elderly patients in some long-stay institutions, which directly arose from their highly controlling environments.[13] In addition, the economic costs of running large-scale institutions and changing attitudes towards institutionalisation in the late part of the twentieth century were key factors in their demise. These political, economic and ideological strands eventually led to deinstitutionalisation, when mental health care shifted from being based in residential institutions to becoming primarily an outpatient service during the latter part of the twentieth century.[14] The over-emphasis on the totalising features of psychiatric hospital environments had the effect of overlooking the support structures within the internal and external spaces therein for vulnerable individuals in need of care. It has meant that the therapeutic value of mental hospitals has not been the focus of research. The recent shift of priority within the survivor movement[15] and its allies towards a defence of both mental health services and disability benefits in the age of austerity suggests the importance of having access to a place of safety and respite when caring for oneself is not an option.[16]

Despite the introduction of community care, forty per cent of the NHS budget is spent on inpatient services as hospitalisation for acute episodes is still an indispensable part of mental health care.[17] In the last thirty years there has been a constant discourse of improving inpatient mental health care. However, it is not clear if there have been any improvements since the inception of community care. Care provided in inpatient settings has been under continued criticism for its perceived lack of quality, which has been reported as being anti-therapeutic.[18] Patients and staff in inpatient wards have consistently reported the lack of therapeutic activities and meaningful interaction due to staff shortages and too many demands placed on staff, such as dealing with crisis situations. The wards have been reported by patients and staff alike to resemble prison-like environments not conducive to recovery due to the ongoing shortage of beds and the concentration of people who are most unwell.[19] The unattainability of therapeutic practice in acute inpatient settings since the 1990s has been further compounded as a result of rising demand for beds, coupled with the steady reduction of available beds.[20] More than half of NHS hospital beds have been cut in the last thirty years.[21]

The study

The oral histories discussed in this article were collected as part of a study located within the defined geographical area of Nottinghamshire, where there has been a long-established tradition of innovation in mental health services, such as the introduction of extra-mural services, therapeutic community principles and an open-door policy from the 1940s onwards.[22] Patients who received care and the staff who gave it at Mapperley and Saxondale hospitals between 1948 and 1994 were invited to take part.[23] Twenty people (six former patients and fourteen retired medical and non-medical staff) with first-hand experience were interviewed multiple times.[24] The former patients who participated received care in the mental hospital for a maximum of six months at a time. The memories of their time there were filtered in light of the shortcomings of care in the community they experienced or witnessed. Their testimonies were coloured by the structural inequalities they share in common, namely

chronic unemployment, abject isolation, and internalised and social stigma.

The study employed PAR as the overall framework, and oral history as the data collection strategy, which are both interpretative and grounded mainly in the lived experiences of individuals. PAR is a collaborative model of research in communities that emphasises participation and action. It aims to improve practices and situations research participants find themselves in by searching for practical outcomes to bring about positive change.[25] It differs from other approaches to health and social care research as it seeks the active involvement of stakeholders in all phases of the research process with the aim of improving care and reducing inequalities.[26] Oral history as a data collection strategy was employed to uncover how former patients, whose historical experiences remain widely marginalised,[27] experienced the closure of the mental hospitals, and to shed light on the complex meanings of care practices therein. The decision to combine oral history with PAR from the outset was driven by the desire to help identify the needs and the problems that are significant to the groups being researched. The project aimed to not only gather collective insights about historical inpatient care practices but also to identify situated knowledge to improve current inpatient mental health provision. This required moving beyond the concept of sharing authority in oral history.[28] Shared authority has been largely understood as a vehicle for combining research with advocacy by going beyond the interview encounter as a platform for movement building through divulging skills and knowledge to the disenfranchised in order to create more representative histories, from below.[29] This PAR-led oral history study made it possible to examine the relationship between personal and collective experiences of living and working in the Nottinghamshire mental hospitals while harnessing stakeholders' knowledge and experience of the current system.

The study relied on a mix of one-to-one and group encounters to build a shared understanding of how the research would take place, what kind of data would be collected and how meanings would be derived from the data and used to generate findings, including a shared plan for dissemination. Through several iterative phases of PAR, participants took ownership of the research by steering the agenda to include topics that were relevant to them.[30] In doing so, they challenged the dominant overall perception of mental hospitals as undesirable and outmoded institutions. They provided alternative interpretations of aspects of institutional care they found meaningful for their recovery, perceived to be lost in the current system, while also criticising some aspects of care as unhelpful and depersonalising in the old system. PAR therefore provided the opportunity to extend the notion of shared authority[31] to impact policy. The research went beyond the past not only to reflect and record participants' lived experiences of care practices through time but also to re-evaluate these experiences in the psychiatric institutions in the context of modern-day mental health services.

Loss of access to adequate rehabilitation

Former patients expressed a sense of loss of a place of safety when undergoing a mental health crisis since the closure of state mental hospitals. Their sense of loss was contextualised in their accounts of perceived neglect since the advent of community care. Social rehabilitation at Nottingham mental hospitals through the provision of regular structured activities was unanimously perceived to be a key factor during their convalescence. Despite some experiences of the hospital environment as depersonalising, former patients valued having access to purposeful and meaningful occupation which provided structure to their lives during a time of convalescence, as well as access to designated spaces where patients could spend their leisure time.

James was born in Nottingham in 1955 and recalled having a happy childhood. He developed a passion for cricket from an early age and was invited to join his school's cricket team. However, he did not socialise much as he was severely bullied at school. He wanted to take A levels and had ambitions to attend university, however his family were against it as the expectation was to get a job after leaving school and follow in his father's footsteps as a mechanic. The pressure from his family not to pursue an education and being bullied at school contributed to his mental health distress, leading to a breakdown when he was fifteen years old. He was first hospitalised at Saxondale Hospital in 1970 following a psychotic episode and in 1980 during a relapse. Despite experiencing some bullying by a nurse, he found attending occupational therapy (OT) beneficial, describing the atmosphere there as relaxing:

> I quite liked OT, it was quite a creative place, a nice little old building in the hospital grounds, that was the place that I wanted to be. The occupational therapists were creative people but also quite caring, I felt comfortable in that environment, we did more artistic things there.[32]

James found the structured routines during his hospitalisations were helpful during crisis, a service no longer available in the new system of inpatient care:

> It was very habitual, always dinner at half seven, always breakfast in the morning, all sat down on the long room, a veranda, quite nice really, looking down to the grounds, and we were served breakfast by the nurses on a hot trolley and I quite looked forward to it really, I quite enjoyed that and there seemed to be ample food […] when I've been in a more modern hospital at the QMC[33] many years later, no question of being served and usually the way I was feeling it helped me being served because it was a little bit more like the sanctuary aspect of it. You were looked after at Saxondale in the 1970s, you knew what was happening, it was a structured day, and I think that helped, it was much more dismissive at the QMC.[34]

The verandas at the former Saxondale hospital, which was converted into luxury apartments. Photo courtesy of Verusca Calabria.

James relies on mental health services to manage his mental health condition. He reflected on the loss of the hospital in terms of the absence of a place of respite during crisis in the current system:

> That's a big loss to me, in terms of a place for recovering from illness, it was all just money and business and one fell swoop and they call it care in the community. You could admit yourself into a hospital then, the option is no longer there. I feel threatened because it is only people who are more or less sectionable who go in there now, you can't even go in voluntarily.[35]

Despite being told by a psychiatrist that he would never be able to hold down a job or have a family due to his mental illness, James got married and has three children. However, he struggled to find long-term employment and was never able to pursue his dream of attending university due to the severity of his mental illness, as well as the social stigma attached to his condition.

Rodney was born in 1953 in Papua New Guinea where his British parents had moved to work as Roman Catholic missionaries. At the age of nine he was sent back to England to attend school while his parents remained abroad. Rodney did well at school and secured a place at university in Northern Ireland. He experienced a psychotic episode in his last year at university. He returned home to Nottingham where he was hospitalised at Saxondale Hospital in 1975, and was subsequently rehospitalised in 1986 after a relapse. The neglect he experienced as a young child and the experiences of feeling marginalised as an English student at an Irish university in the early 1970s contributed to his breakdown. During his first hospitalisation, he had a difficult relationship with a psychiatrist who dismissed Rodney's own views on his illness when making decisions about his treatment plan, a common feature in the literature on psychiatric institutions.[36] Despite some depersonalising experiences, he was keen to stress the helpful aspects of care he received when compared to his experiences of inpatient care in the new system. He recounted how access to OT during his hospitalisation was of paramount importance during his convalescence:

> It was part of our treatment to go to every day, it was absolutely key in terms of raising people back to their aspirations, in terms of therapeutic activity, and restoring people to their place as citizens in the community, what we get now is nothing, at Saxondale we were encouraged to do the creative things because that's where our strengths lay.[37]

Rodney expressed a strong feeling of loss of structured rehabilitation with the hospital's closure:

> Saxondale Hospital was taken away from us and nothing put in its place […] a lot of the modern facilities haven't carried these meaningful activities, without this many fall back into vegetation, and actually not being motivated anymore to make progress in their hopes to be restored to community.[38]

In the 1980s the industrial therapy unit at Mapperley Hospital was renamed the Skills and Practical Activity Network (SPAN) and moved to modern buildings in the city centre to provide reskilling for long-term service users.[39] Due to funding cuts, the service was closed in the late 1990s. Rodney attended SPAN from 1986 onwards and the day service meant a great deal to him:

> While SPAN lasted, it retained the best qualities of in-house therapeutic activity, it was extremely well geared to what people actually needed to go back into the community […] there was a computer workshop and that was giving people the opportunity to develop skills of a technical nature but also to develop office skills, it was wonderful […] but I'm afraid there were people within the system that were more interested in cutting services.

Rodney felt that the consequences of closing the large mental hospitals were for people with long-term needs like himself to remain 'untreated, neglected and completely forgotten'. He referred to the closure of the mental hospitals as 'mass land-grab' by the state and as having an 'earth-shattering effect' for mental health service users in need of a place of safety and sanctuary. He compared deinstitutionalisation to a form of 'daylight robbery as the resources [that] were all there and made available to patients are gone'. He gave a damning critique of community care policies: 'there's just a skeleton of mental health left in services and I'm afraid people are left to their own devices'. He thought that short-term interventions available in the current system are inadequate to support people with long-term mental health needs. Rodney viewed the need for longer-term rehabilitation, namely adequate support between the hospital and returning to the community provided at the mental hospitals, as essential to personal recovery:

> What you swept away by closing the old mental hospitals was what was needed, the services that were for people in continuing care restored people to the right stepping stones between hospital and illness and a place back into society, those stepping stones have been callously kicked away.[40]

Rodney felt that staff in the current system are not easy to relate to as 'they don't have enough time to get to know you and support creative activities', reflecting findings from the literature that suggest nurses in the current system do not have time to interact meaningfully with service users and struggle to offer therapeutic activities on the ward.[41] Such comments effectively signal the loss of professional, specialised interpersonal knowledge in the old system. Rodney has struggled to find work, which he puts down to not being awarded a degree as he did not sit his final exam. Moreover, he faced stigma when revealing his mental health diagnosis to potential employers to justify gaps in employment. In the last thirty years he has relied on the social activities run at a local day centre as his main source of social support.

Kay's father was an English army officer who was posted to Germany, where she was born in 1957. The family came back to live in England when Kay was five years old. She developed depression and anxiety during her early teenage years. She was the first in her family to attend university in 1975, however, she left university after the first year due to severe depression. She set up her own successful business in the 1980s after a time of relatively good health. In the early 1990s she developed severe depression and hallucinations. Following an attempted suicide, she was hospitalised at Mapperley Hospital for six months. During her hospitalisation, she learnt to make art as a coping strategy:

> They had an excellent OT, I started doing pottery and I loved it. It stimulated my interest in getting into art and after that I found that whenever I became very depressed and couldn't work, I'd resort to artwork again, so it was good, I remember the woman at OT was just lovely.[42]

Similarly to Rodney, Kay felt the closure of the hospital was misjudged:

> Mentally ill people were being robbed of the facilities that they had, unfortunately we lost the baby with the bathwater with blowing these institutions away. The propaganda that was put around about these buildings was that they were old Victorian institutions, but in actual fact they had moved with the times like any other institutions and they were much more progressive than anybody was prepared to concede.[43]

She explained that the hospital was a safe environment during her mental health crisis and wanted to highlight the lack of support in the current system:

> There was an awful lot that was good and that was necessary. Care in the community often doesn't work because the community is where everything goes wrong. What Mapperley Hospital did for me was relieve the situation that had caused me to have a breakdown. I needed to be taken out of the situation, because I was on this treadmill that was going too fast for me, and I'd have had to stay on it if I hadn't been taken out of circulation for a while […]

Judith Estrop, former nurse, playing cribbage with a patient on a ward at Mapperley hospital, 1973. Courtesy of Judith Estrop.

there are no peer-support workers in the community, you can see that's what good friends should be doing for each other in the community, it's what families should be doing for each other but we have to face the fact that it doesn't happen, so the hospital was helping people with mental health problems out that way.[44]

Since her breakdown in the 1990s Kay has not been able to return to work and she volunteers for local charitable organisations instead.

The introduction of psychotropic drugs from the mid-1950s onwards was heralded as a revolution in psychiatry for enabling clinical improvements, making early discharge possible and permitting the management of many conditions outside the hospital, including the treatment of people with severe mental illness in the community. It gave impetus to the psychosocial model of psychiatry, a more enlightened and humanitarian pattern of care introduced by reformers of the asylum system, including Duncan Macmillan at Mapperley Hospital[45] and David Clark at Fulbourn Hospital.[46] The social turn in psychiatry encouraged reforms to shorten hospitalisations and the development of early community-based care.[47] The introduction of psychotropic drugs to control the worst symptoms also allowed for changes in the role and function of psychiatric nurses towards a more therapeutic nurse-patient relationship to be achieved. These new policies emphasised the changing role of mental health nursing towards the provision of psychotherapeutic approaches to nursing care.[48]

Mapperley and Saxondale hospitals embraced the post-war social turn in psychiatry by introducing the social rehabilitation model with a focus on patient occupational and social functioning after discharge. The introduction of OT in British mental hospitals as a form of inpatient and outpatient care from the 1950s onwards represented the pinnacle of community-oriented psychiatry, and the shift from institutional to extra-mural services in British psychiatry played a major role in patients' psychosocial treatment.[49] These practices were developed to facilitate the rehabilitation of long-stay patients. Occupation was generally perceived as both therapeutically and economically beneficial, albeit highly gendered, reflecting dominant societal values of the time.[50]

Traditional critics of the mental hospitals argue that social rehabilitation did not promote social inclusion or the opportunity for individuals to reclaim a sense of self after being labelled a mental patient. However, Gittins found that the occupational therapy unit opened in 1960 at Severrals made a great difference to patients.[51] Moreover, Wing and Brown, in their social psychiatric study of the relationship between institutionalisation and schizophrenia between 1960 and 1968, concluded that rich social environments where patients had access to occupational and industrial therapies were helpful in improving outcomes and reducing mental disturbance for individuals with long-

Mapperley hospital today, half of which was converted to luxury flats with commanding views over South Nottinghamshire. Courtesy of Verusca Calabria.

term mental health conditions within and outside institutions.[52] Goffman viewed the then newly developed idea of industrial therapy as a form of tyranny, as a means of re-organising the life of 'inmates', in which a system of punishment and reward operated to regulate behaviour.[53] However, the extracts from James, Rodney and Kay's oral histories show the value of structured rehabilitation in the mental hospitals and highlight the lack of rehabilitative services between crisis and recovery in the current system. There was a consensus among former patients that the environment of the mental hospitals provided a welcoming and relaxing atmosphere conducive to recovery, which was perceived as lacking in current inpatient settings. Crucially, former patients felt they have lost the choice to access a place of safety under the current crisis in the provision of mental health inpatient services due to the pernicious effects of the steady cuts in funding.

OT has long been recognised as form of recuperation from mental illness in actively supporting the recovery process.[54] There is strong evidence that having access to meaningful activities has a positive impact on mental and physical health, and promotes a higher quality of life and wellbeing, while access to employment reduces social exclusion and poverty.[55] Csipze and colleagues researched the perceptions of care among 116 inpatients in eight acute wards in London and found that patients in institutional settings spent much less time participating in social activities than fifty years ago. Patients who took part in no activities at all had higher negative symptoms scores than those who took part in regular therapeutic activities.[56] As the oral history extracts above indicate, OT puts a strong emphasis on choice and self-care.[57] The value of meaningful occupation for mental health recovery has implications for improving the provision of care in acute inpatient environments where services are largely fragmented and a growing number of people with long-term mental health conditions experience isolation and exclusion.[58]

Loss of internal and external spaces

An important aspect of care that featured largely in the oral histories was the open-door policy, namely the removal of locks on wards as well as hospital gates, introduced at Nottingham mental hospitals in the early 1950s.[59] The policy enabled patients to move within internal and external hospital spaces once out of crisis point. This option was removed in the new system of community care, which saw the return to confinement in acute inpatient care. Former patients, who still rely on mental health services, correlated having unlimited access to the vast grounds with the ability to freely move within the hospitals' internal and external spaces and lamented the return to locked wards in the current inpatient system as a step backwards in mental health policy. Former patients recounted the pleasure of spending time in the extensive park-like grounds, which aided convalescence and had the effect of fostering a more relaxed treatment environment than the new acute units within the general hospital.

Rodney had fond memories of the hospital grounds and made a close connection with a nurse who he spent time with walking in the grounds:

> It was a really therapeutic place, if you understand nature being something that's better and cheaper than therapy and you can walk out into the grounds and find rest and repose in such an environment […] our nurse took us out for walks around the grounds, she thought we'd benefit from being in the fresh air and she was a kindred spirit because she liked being among trees, flowers and birds.[60]

In a subsequent interview, Rodney recounted his experiences of being an inpatient in the local acute unit of a general hospital in 1991:

> Saxondale was this kind of idyllic rural setting and there were the trees and nature, QMC had nothing of that, I remember being something where if you weren't that ill, you were subjected to an endless stream of games and puzzles, and the outside was non-existent, you didn't go anywhere, there wasn't a beautiful outside to go to.[61]

Kay bemoaned losing the ability to freely move within the hospital spaces as well as the areas adjacent to the hospital:

> You could walk around the grounds and to the nearby shops then but you can't now, we are not allowed out of the ward, now all the wards are locked, which is a prison-like environment.[62]

James felt that access to outdoor spaces was paramount for his rehabilitation:

> As you recover, the therapeutic effects of being able to get out, with staff availability initially and then more on your own terms as you get better, that aids the recovery process.[63]

The original asylums across Britain were set in extensive, park-like grounds away from urbanisation. They encapsulate contemporary arguments about the all-important function of asylum sites as part of a wider therapeutic regime, a hallmark of moral treatment in the nineteenth century, meant to influence the wellbeing of patients and help restore their health.[64] Mental hospitals have often been perceived as isolated spaces excluding patients not only from the outside world but also segregated within these institutions.[65] However, the role played by external natural spaces must be taken into consideration as part of the material experience of giving and receiving care. The grounds held special significance for patients, consistent with what Parr and Philo found about the value of the grounds as a therapeutic landscape in their explorations of the memories of ex-residents of Craig Dunain Hospital.[66] These outdoor spaces offered a setting wherein the illness experience and recovery took place; the concept of therapeutic landscape, coined by Gesler,[67] describes not only the physical and social characteristics but also the symbolic meanings attributed to a space seen as beneficial for one's sense of wellbeing.[68] As the oral history excerpts above attest, patients could exercise some control over how they spent their time within the social spaces available at the hospital, including the grounds. It also reveals how residents embraced the inherent therapeutic qualities of natural environments, which in turn mediated staff-patient relationships, engendering sensitive relationships during times of convalescence.

The most recent Care Quality Commission inspection of specialist mental health services found that too often locked rehabilitation wards are being used as a long-term solution rather than as a step on the road to recovery.[69] Shifting the practice from locked to open wards to allow free movement within and outside the hospital was a major aspect of care within psychiatric hospitals that embraced humanistic approaches to care in the second half of the twentieth century. Recent studies on acute psychiatric units with unlocked wards reported improved relational security, explained by the high level of nursing staff.[70] Understanding mental hospitals as permeable environments offers a more nuanced picture of the reality of everyday life therein. Admission to the hospital could be an opportunity for rest, respite and a source of social support.

There are some limitations to the study. There was an obvious over-emphasis on the helpful aspects of institutional care in the oral histories of ex-patients. Life narratives are shaped by the social and political constructs available to narrators and, while acknowledging their subjective nature, these narratives can expose what is at play.[71] Former patients who are still users of the psychiatric system may have emphasised the helpful aspects of care in light of their collective experiences of neglect in current mental health services. In turning to the past to find sources of agency, the negative or contradictory elements of care may have become less relevant to the need for legitimising helpful aspects of care in the face of an uncertain future.[72] During the group feedback events of the study where the main themes that emerged from the research were shared, all were well aware of the imposed public amnesia of the positive aspects of institutional care. Former patients repeatedly referred to those service users who had the loudest voices and were heard during the time of deinstitutionalisation at the expense of those who were concerned about closure and were ignored. It echoes Peter Sedgwick's attempt thirty years ago to defend state provision of mental health services in the face of deinstitutionalisation.[73] The over-emphasis on the positive elements of inpatient care in institutions reveals the social needs of older people with psychiatric disabilities in the present, embodied in individual uses of the oral histories. As a result of this study, former patients initiated communities of dialogue about meaningful care practices

within the now-closed local mental hospitals.[74] An important outcome of this study for ex-patients, staff and their families has been the preservation of their memories for posterity through the production of a discreet public archive. Moreover, through group discussions, a collective consensus emerged about the need to preserve and celebrate the intangible heritage of local mental hospitals.[75]

Conclusion

The experiences of people who received care in the now-closed state mental hospitals have the unique potential to give voice to previously inaccessible knowledge with the power to create new paradigms. The oversimplification of mental hospital environments as places solely designed for the purpose of social control ignores the complex interconnections between illness experience, social relations and care practices therein. The critiques of institutional care overlooked the relevance of residential care for people undergoing crisis and in need of a place of respite; residential provision may be the preferred choice for some who may need time out from environments not conducive to their recovery, as service users in this study and others have pointed out.[76] Crucially, combining PAR with oral history methodology allowed former patients to problematise the prevailing perception of mental hospitals as outmoded and total institutions, which tends to exclude their function as health-care systems. The contested meanings of care within psychiatric institutions offer the opportunity to redress imbalances in the historiography of psychiatry, where only certain accounts are held up as legitimate and authoritative at the expense of others.[77]

These collaboratively produced oral histories about care in psychiatric hospitals in the latter part of the twentieth century reveal these institutions to be meaningful social spaces loaded with significance. The everyday care practices within, viewed through the use of internal and external spaces, could act as a therapeutic landscape. It seems that the nineteenth century lunacy reformers' ideal of producing a recovery-like environment through structured rehabilitation and access to nature held significant value for former patients. Ultimately, the institutional environment afforded unconditional security and social rehabilitation, albeit with custodial and paternalistic aspects of care. The hospitals provided valuable resources for protection and rest during a mental health crisis, which have been lost in community care. The findings can help establish an evidence base for positive change in inpatient mental health provision. These insights are particularly salient in light of the recent review of the Mental Health Act.[78] The review of the Act makes specific recommendations for the need to reduce the prison-like environments within inpatient units by modifying the built environment so that internal and external spaces can engender informal sociability, such as the ability to move between wards and access the outdoors, improving the atmosphere of the wards by making these environments more welcoming. It also recommends increasing meaningful therapeutic activities to aid recovery, all care practices that were embraced by Nottingham mental hospitals in the second part of the twentieth century.

Acknowledgements

Verusca Calabria's doctoral research was possible due to receiving a Vice Chancellor's scholarship from Nottingham Trent University. She would like to thank the participants for taking part in the study.

NOTES

1. Sheena Rolph and Jan Walmsley, 'Oral history and new orthodoxies: narrative accounts in the history of learning disabilities', *Oral History,* vol 34, no 1, 2006, pp 81-91.

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11. House of Commons, The National Health Service and Community Care Act, London: HMSO, 1990.

12. John Martin documented fifteen major scandals in mental and learning disabilities hospitals that led to a series of official inquiries, TV programmes and press campaigns encompassing the period 1968-1979. John Martin, *Hospitals in Trouble*, Oxford: Blackwell, 1984.

13. Barbara Robb published *Sans Everything* in 1967. This collection provided a devastating account of the appalling conditions in long-stay wards and exposed the undignified treatment of elderly patients in seven mental hospitals. The poor care and treatment

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27. Roy Porter, 'The patient's view: doing medical history from below', *Theory and Society*, vol 14, no 2, 1985, pp 175-98.

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32. Interview with James (pseudonym); recorded by Verusca Calabria, 2 August 2016.

33. A mental health unit on the site of the Queen's Medical Centre, a general hospital in Nottingham, which replaced the local mental hospitals.

34. Interview with James (pseudonym); recorded by Verusca Calabria, 6 September 2016.

35. Interview with James (pseudonym); recorded by Verusca Calabria, 6 September 2016.

36. Ramon, 2018, p 190.

37. Interview with Rodney Yates; recorded by Verusca Calabria, 30 September 2016.

38. Interview with Rodney Yates; recorded by Verusca Calabria, 30 September 2016.

39. The term service user in mental health services remains contested and is more typically associated with those who use services today.

40. Interview with Rodney Yates; recorded by Verusca Calabria, 1 November 2018.

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