Oral Histories of the Nottinghamshire Mental Hospitals: Exploring Memories of Giving and Receiving Care

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Abstract

The closure of the mental hospitals in the UK in the twentieth century has potentially obscured the relevance of psychiatric hospitals as therapeutic environments. The thesis explores the impact of closing the large-scale mental hospitals in the latter part of the twentieth century and the move to care in the community on service users and staff 30 years since their closure. This research has gathered the oral histories of older mental health service users who received care in Nottingham's mental hospitals and those of the staff that provided it in order to understand what has been lost through the modernisation of mental health services, where the relationships between staff and patients are typically short-term and veer towards crisis management. Participatory Action Research has informed the overall research involving participants in all stages of the research project in order to co-construct a history of giving and receiving care with former patients and staff in the now closed psychiatric hospitals in Nottinghamshire. The findings provide new insights into the value of inpatient care within psychiatric institutions and how it has been affected in the shift away from asylum care. Despite elements of social control within the mental hospitals reported by participants, the Nottingham mental hospitals were largely perceived as therapeutic environments, providing rich sources of social, emotional and practical support through the social networks that existed therein, including the social and spatial value of internal and external spaces in the provision of structured rehabilitation for recovery. Participants experienced a sense of dispossession with the advent of care in the community, which did away with the hospital communities that offered valuable occupation, structured social activities, refuge, asylum, and a place of belonging for many.

Contents

List of Figures

List of Tables

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Foreword

After ten years of doing oral history work in partnership with communities, I sought to pursue a PhD in order to critically reflect on my experience of working in the field of oral history through the medium of academic research, while also retaining the community engagement aspects that are central to my vision of oral history. I successfully gained a fully funded PhD position at Nottingham Trent University to undertake this study. The scope of this research project – the geographic focus on mental hospitals in Nottinghamshire and the focus on staff-patient relations – were all pre-established by the department of Social Work at Nottingham Trent University who advertised a fully-funded 3-year PhD scholarship to undertake this research.

Terminology

I am mindful that the terms used to describe a person with mental health problems have changed significantly over time and have been given new meanings reflecting the attitudes of each particular phase in the history and practice of mental health care; similarly the terms used to refer to psychiatric hospitals have changed and have been contested over time. Throughout this thesis, the terms used to identify persons with experience of the psychiatric system similarly reflect the stages in the history and politics of mental health care and the consequent changing understandings of mental ill health.

List of Abbreviations

AEGIS	Aid to the Elderly in Government Institutions
AWU	Asylum Workers Union
ECT	Electroconvulsive therapy Community Mental
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CQC	Care Quality Commission
CTO	Community Treatment Order
DGH	District General Hospital
GDPR	The General Data Protection Regulation
HAS	Hospital Advisory Service
IT	Industrial Therapy
MSRC	Middle Street Community Centre
MIND	National Association for Mental Health
NHA	Nottingham Health Authority
NHS	National Health Service
NSF	National Schizophrenia Fellowship
NSF-MH	National Framework For Mental Health
OT	Occupational Therapy
PAR	Participatory Action Research
PIE	Psychologically Informed Environments
PIPE	Psychologically Informed, Planned Environments
PSW	Psychiatry Social Worker
SPAN	Skills and Practical Activity Network
TAPS	Team for the Assessment of Psychiatric Services
QMC	Queens Medical Centre, Nottingham

Chapter 1: Introduction to the Thesis

Background

The asylums dominated the care and treatment of people with mental ill health for over a century before being replaced towards the end of the twentieth century in the UK, Europe and America by the policy of ‘care in the community’. It has been 211 years since the introduction of the 1808 County Asylum Act that made it compulsory to build asylums in every county in Britain and 30 years since their closure. The rise and fall of the asylums has attracted a constant discourse within mental health policy based on the belief in reform in order to address shortcomings in care. This discourse runs through the debates and reforms to ameliorate care in the nineteenth and twentieth century, and colours the moves to close the mental hospitals and introduce the policies to promote community-based care as mainstream; however, little is known about how the changing institutional context of in-patient care has impacted upon service users and others. This study has aimed to broadly represent and examine the experiences of people who have been inpatients of mental hospitals in Nottinghamshire and the staff who worked there over a period of 50 years of living memory. Autobiographical accounts of mental ill health and treatment are usually treated as peripheral to the official narratives produced by doctors and academic experts (Porter 1985). However, the significance of patient voices in the study of healthcare systems in interdisciplinary contexts offer the potential for more nuanced understandings of the changing meanings of inpatient care from the asylum to community care (Porter 1987, Barham 1997, Gittins 1998, Davies 2001, Wood et al. 2013 and 2015, Calabria et al. in press).

The Study

The focus of this study is the dynamic interplay between people who provided care, both formally and informally, and those who received it, in the Nottinghamshire mental hospitals. It echoes the call made by Roy Porter more than 30 years ago to research the experiences of those who received care to challenge conventional documentary history that tell us very little about the patient’s experience and even less about the interactions between patients and staff (Porter 1985). The study has aimed to understand what has been lost through the modernisation of mental health services, where now the relationships between staff and patients are typically short-term and veer towards crisis management. The research has explored stakeholders’ experiences of care within the mental hospitals, including the institutional environments, treatments, the rehabilitation programmes and the relationships therein; the research took as its starting point the importance of positive relationships for individuals' mental health (Priebe 2006, Middleton et al. 2011) and the role of the therapeutic environment in the provision of inpatient care (Campling 2001, Priebe 2006). This study has drawn from the disciplines of humanities and social sciences by combining two distinct, yet complementary methodologies, namely oral history with participatory action research (PAR). The oral histories, which form the primary source of data in this study, were collaboratively produced with ex-patients and retired staff of the Nottinghamshire mental hospitals who gave or received care between 1948 and 1994, and were collected 30 years since the hospitals' closure. Twenty people with first-hand experience were interviewed multiple times, mostly retired staff and mental health service users who were patients in the local mental hospitals. The study is located within the defined geographical area of Nottinghamshire where there has been a long-established tradition of innovation in mental health services with dramatic changes to care practices such as early community care through the introduction of extra-mural services, open-door policy and therapeutic community principles from the 1940s onwards (Macmillan 1956a and 1956b, W.L.J. 1980, Gittins 1998, Ramon 1991, McCrae and Nolan 2016). The research has focused on care provided at Mapperley and the Coppice hospitals in the City and Saxondale hospital in the County, all built in the Victorian period (Lowe 1988, Parr and Philo 1996), following the 1845 Lunatic Asylum Act, making the provision of public asylums mandatory (Scull 1993).

Justification for Research Methods

The perspectives of former patients and of staff of the now closed mental hospitals in the UK remain marginalised in the history of mental health care (Porter 1985, Gittins 1998). The goal of this thesis was to preserve the legacy of the Nottinghamshire mental hospitals, which is at risk of being lost. The voices of staff and service users are an emergent focus of research across the humanities and social sciences; this is evidenced by recent scholarship that has focused on the role of mental health workers in inpatient care (Long 2011, Borsay and Dale 2015, McCrae and Nolan 2016). In addition, the involvement and co-production of knowledge of people with lived experience of mental health problems and their significant others such as informal carers and their families have become increasingly important to contemporary mental health research and policy

(Department of Health 2005, National Institute for Health Research 2012). Preserving the legacy of the mental hospitals through the experiences of former patients and staff called for the application of the combined use of participatory action research (PAR) with oral history methodology in order to share authority on every aspect of the research process. To explore the experiences of care practices through time and place, the study has made an explicit attempt to co-construct a history of giving and receiving care in the now closed mental hospitals in Nottinghamshire and highlight key lessons for stakeholders engaged in effecting practical change in modern day mental health services.

Structure of the Thesis

The thesis is structured in seven chapters. Chapter two outlines the origins of the mental asylum. The chapter provides a critical analysis of the ideological stance of the anti-institutional literature and its impact and consequences on the demise of hospital care. The negative perception of care provided in institutions was fuelled by a number of influential studies which have been referred to as the 'literature of dysfunction' (Jones and Fowles 1984, Jack 1998). The chapter critically examines Goffman's notion of 'total institutions' (1961) in order to explore the validity of its premise in three main ways. Firstly, it examines the extent to which mental hospitals were 'total institutions' against a review of the impact of mental health policies from the rise of the asylums until their closure. Secondly, it traces the changing patterns and location of the provision of inpatient care from a single institution, the mental hospital, to care in the community, with the consequent fragmentation of social care services and therapeutic relationships, the lack of adequate service provision and the advent of reinstitutionalisation in the community. Thirdly, the chapter examines the extent of institutionalisation within mental hospitals against the themes I identified from existing studies based on published and unpublished oral histories and other qualitative data relating to care practices in the now closed mental hospitals in the UK.

Chapter three details the methodologies employed, namely oral history and participatory action research, including the epistemological stance of this research based on the subjective experiences of former patients and staff, the rationale for the combined use of the methodologies employed, and the ethical and legal considerations taken into account, including the impact of the new General Data Protection Regulation (GDPR). The chapter outlines the iterative cycles of PAR undertaken in this study, the stakeholders' recruitment and sampling strategy. It further outlines the researcher’s positionality and the data analysis strategy employed.

Chapters four, five and six respectively outline the three themes I identified from the data gathered from this collaborative research, namely the experiences of social control in the institutions, the relational care therein and the ambivalent experiences of community care dominated by a sense of loss and dispossession; each chapter includes a discussion of the findings.

Chapter seven examines the impact of participation and the challenges that arose in sharing authority with stakeholders, including the social, emotional and practical implications of this research for all involved. In addition, the chapter outlines directions for future research. The chapter further examines the limitations of this study. It explores the role of nostalgia within the oral histories that were co-produced, and its relationship to the study of memory.

Contributions to Knowledge

The dominant narrative of asylums as ‘total institutions’ perpetuated by the anti-institutional literature has had the effect of erasing the positive therapeutic elements of residential care that existed in the now closed state mental hospitals in the UK and elsewhere. The findings from this study evidence the need for a re-appraisal of the value of care provided therein as articulated in the oral testimonies of people who gave and received care in mental hospitals that bear on current mental health policy and practice. The contested meanings of care that emerged from this study offer the opportunity to redress imbalances in the historiography of psychiatry, where certain accounts of the past are held up as being more valid than others (Gittins, 1998, Davies 2001, Parr et al. 2003). The themes generate new insights about the value of inpatient care that can offer new perspectives for current mental health provision. Participants’ narratives about life in the psychiatric hospitals from the mid-twentieth century onwards reveal these institutions to be much more than just entities of social control, instead also being significant spaces laden with meanings that go beyond their purpose as psychiatric care spaces but as relational healthcare systems (Parr et al. 2003).

Chapter 2: The Demise of the Mental Hospital

Introduction

The image of the psychiatric asylum tends to conjure pejorative connotations and it is usually synonymous with the incarceration of people with mental health problems in poorly run institutional settings, leading to social withdrawal (Poole et al. 2002). The first part of this chapter examines the extent to which mental hospitals in the twentieth century were ‘total institutions’, namely Goffman’s influential theory on the nature of closed institutions with their main purpose resting on the close control of the residents, leading to depersonalisation. I present a thorough critique of the anti-institutional literature from the late 1950s onwards that had the effect of making residential care provided within institutions such as the mental hospitals undesirable. The chapter presents a critical assessment of the impact of mental health reforms in the early to mid-twentieth century in ameliorating institutional care; it encompasses the origins of the asylum, the rising tide of criticism of psychiatric hospitals in the twentieth century; the hospital inquiries, both from within and outside the medical world. The chapter examines the mental health reforms to humanise the mental hospitals, including the ideological impact of the anti-institutional critiques on the eventual replacement of the old large-scale mental hospitals with ‘care in the community’. In contrast, the chapter evidences the development of the social model of psychiatry with the rise of the therapeutic communities, which positively impacted on the provision of care for short and long-stay patients in some hospitals, including the Nottingham mental hospitals from the 1940s onwards. These therapeutic communities gave rise to the traditional recovery model, a development not usually acknowledged in the literature (Winship 2016).

The second part of this chapter provides an evaluation of the internal and external forces that gave rise to the eventual demise of the old large-scale mental hospitals in Britain from the 1980s onwards. This includes a critical analysis of the legacy of deinstitutionalisation, its emergence and how it unfolded; the forces behind it, the libertarianism of the 1960s followed by the influence of the conflicting interests of human rights, safeguarding and public protectionism from 1980s onwards, against a social policy background of commercialisation, pluralism and the internal market in community care. The challenges of implementing the policy of care in the community are analysed, including the impact of neoliberal policies from the 1970s onwards on welfare state provision. The policy of care in the community is critiqued for its inability to produce adequate provision of care for people with long-term needs, alongside the current economic and political challenges that have fragmented mental health services and brought them to crisis point. The chapter further highlights the shift of priorities within the survivor movement and their allies. Their opposition to coercive treatment in the 1980s has shifted towards a move to defend mental health services in the current context of the rapid reduction of social welfare in the age of austerity.

In most hospital histories, based on written archives, the experiences of patients have been widely marginalised (Porter 1985, Gittins 1998). This marginalisation is even more evident in the case of staff such as nurses who tend to be treated as peripheral to the main narrative centred on doctors and administrators. Mental health nurses remain substantially neglected in the history of nursing as the specialism tends to be viewed as its 'poor relation', despite nurses being at the centre of the provision of mental health care (Adams 2009, Nolan 2000, Carpenter 2015, McCrae and Nolan 2016). In the third part of this chapter, the day-to-day roles undertaken by clinical, non-clinical staff and others are explored in the development of care practices and the operation of the hospital. These experiences have often been left out of the record. Evidence from sociological, geographical studies and community-led projects based on oral histories offer often conflicting representations of some hospitals where improvement to care practices were slow and uneven, failing to produce adequate care and within which patients were at risk of abuse; in contrast, other hospitals were remembered as refuges and places of belonging for residents. First-person accounts of giving and receiving care offer a much more nuanced understanding of the hospital environments that go beyond confinement and social control to encompass the value of staff-patient and patient-to-patient relationships and the structured therapeutic environment therein, which has consistently been found to be of paramount importance for service users with long-term mental health needs in their recovery journey (Gilburt 2008 et al., Middleton 2011 et al., Tew et al. 2012, Leach 2015).

Custodial Institutions

Treatment for insanity within the public asylums became the primary course of action in the nineteenth century. The Lunatics Act of 1845 required all counties to build an asylum for pauper lunatics to be admitted via a process of certification. The rise of the psychiatric asylums represented a rejection of what was known as 'the trade in lunacy', namely outmoded practices that saw people with mental illness relegated to the workhouse, private madhouses or prisons (Scull 1993, Busfield 1997). The County asylums were to represent the principles of moral treatment, putting emphasis on both the social and physical environment and the healing power of everyday relationships as key to recovery, achievable within an ordered, secluded and generally rural environment, away from the stresses of emerging industrial society (Digby 1985, Taylor and Taylor 1991, Markus 1982 and 1993, Edginton 1997, Porter 2002). Moral treatment had a significant influence in the architectural design of the new asylums that differed from other institutions that contained the undesirable such as prisons and workhouses (Taylor and Taylor 1991, Edginton 1997). The new asylums were built on open landscapes with extensive grounds to house sports pitches, gardens and farms to influence the wellbeing and restoration to health of the inmates (Digby, 1985, Edginton 1997). Dormitories were preferred as single rooms were associated with prison cells (Hine 1901, Edginton 1997, Alexander 2008). Churches were built on site as the provision of church services was viewed as beneficial to recovery (Hine 1901, Edginton 1997, Richardson 1998, Gittins 1998). The entertainment of inmates was viewed as pivotal for re-socialisation; recreational halls were built with stages to house musical and theatrical events (Hine 1901, Edginton 1997, Gittins 1998). However, although asylums were designed for specific populations in mind, they were used for much greater numbers of people that had originally been intended. The demand for larger scale institutions put a stop to moral treatment and was replaced by the need for containment. Overcrowding overshadowed the nineteenth century ideal of the County asylums as places of refuge and rehabilitation, which reduced them to custodial and prison-like environments (Scull 1979 and 1993, Busfield 1997, Rogers and Pilgrim 2001).

From mid-eighteenth to the early twentieth century, the organisation of the asylum was dominated by the ideas of regimentation, classification and separation as a means to control large populations, designed to induce passivity and dependence, features that the anti-institutional movement claimed were still part of the institutional culture in the second half of the twentieth century (Barton 1959, Goffman 1961, Wing and Brown 1970). The custodial features of the asylum were defined by the legal power of custody over all inmates; the tradition of classifying inmates in asylums followed that of the hospital and prison (Scull 1980). Life in the asylum was defined by strict segregation, classification, routines, and methods of treatments (Hide 2014). The categories were designed in line with poor law principles, namely age, gender, social class and character; the association of the asylum with the poor law system broadened the notion of insanity, the term ‘lunatics’ was to embrace social problems such as epilepsy and chronic incapacity, both mental and physical (Scull 1979, Busfield 1997, Gittins 1998). The asylums were designed to provide institutions of last resort, having the undesirable result of filling the asylums with long-stay chronic cases with little hope for recovery (Busfield 1997, Gittins 1998).

The spatial division of asylums affected the lives of those that lived and worked there and reflected the ideas of the time in terms of gender, class and madness; County asylums were built to segregate the genders, dividing the asylum between male and female sides, effectively running two separate hospitals up until the 1970s when the gender separation was removed. In the nineteenth and twentieth century women were defined and treated as mentally ill more often than men, reflecting the view of women at the time as more socially deviant than men (Showalter 1985, Gittins 1998, Busfield 1997, Appignanesi 2011). The female side was modelled on a Victorian family, the matron holding supreme power, below the medical superintendent, perceived as the absolute patriarch within the asylum hierarchy (Hide 2014). The male side was run on the lines of a military service model. Up to the first half of twentieth century the chief male nurse was originally called the inspector who played the role of 'military commander' (Gittins 1998, Busfield 1997, Hide 2014, Long 2015). The paternalistic asylum-based discipline, the indefinite containment of pauper 'lunatics' and the emphasis on the biological nature of mental illness dominated the late-Victorian period (Prior 1995, Rogers and Pilgrim 2001).

Institutionalisation in the Early 20th Century

The critiques of the asylum in the early part of the twentieth century came from within psychiatry. A well-known example is Lomax, Superintendent at Prestwich Asylum, who exposed the 'total' nature of institutional care, namely the inhumane, ineffective and overcrowded regime of the asylum in *The Experiences of an Asylum Doctor* (1921). His critique of the asylum system paved the way for a Royal Commission on Lunacy and Mental Disorder, emerging out of a new wave of public concern about wrongful detention in County asylums (Busfield 1997, Crossley 2006), which in turn led to the 1930 Mental Treatment Act. The 1926 Macmillan report represented a major review of mental health provision, arguing for a shift in emphasis of psychiatry towards prevention and treatment and a need for the profession to align with other disciplines. The 1930 Mental Health Act that followed introduced voluntary admission and a greater focus on treatment and therapy. The

Act introduced three distinct statuses for psychiatric patients: voluntary, temporary and certified; legal certifications remained the same. Temporary patients were to be hospitalised for a maximum of 6 months without certifications on the grounds that immediate treatment was in their best interest, gaining the right of discharge with only 72 hours' notice (Busfield 1997, Rogers and Pilgrim 2001).

The Act gave rise to the medical model, transforming lunacy into mental illness and 'mad doctors' into psychiatrists, lending legitimacy to their practice; asylums were to be called 'mental hospitals', paupers as rate-aided patients and 'lunatics' as mental patients (Crossley 2006). Late Victorian psychiatry experienced what has been termed a 'clinical turn', moving away from the old prison-like asylums towards the new mental hospitals (Hide 2014). Attendants turned into nurses and their role changed from custodial to clinical and psychiatric outpatient units began to be made available at general hospitals. Formal training for psychiatric nurses was introduced (Busfield 1997; Carpenter 2015, McCrae and Nolan 2016). The 1930 Act signalled the end of segregation but it still emphasised asylum-centred services for people with mental ill health. In 1930 a nationwide network of asylums had developed, 98 asylums were built, housing 120,000 patients; by mid-1930s 90% of patients continued to be detained on a compulsory basis and the number of long-stay elderly patients continued to increase (Rogers and Pilgrim 2001). Although the Act marked the beginning of the creation of therapeutic hospital environments by re-envisaging the asylum as a hospital, no significant changes occurred in the amelioration of institutional care, the mental hospitals remained little different from the Victorian asylums (Ramon 1991, Jones 1993, Busfield 1997).

Post-war Innovations

In post-war Britain, changes in both the perceptions and attitudes relating to mental ill health affected changes in practice. The escalating concerns relating to mental health following the environmental effects of World War One such as shell shock and overcrowding in mental hospitals forced psychiatrists and policy makers to consider alternatives to hospitalisation, such as outpatient clinics (Stone 1986). In addition, these factors gave rise to experiments such as open-door policy, namely the removal of locks on wards as well as hospital gates; the introduction of open-door policy represented a shift away from the biomedical model, questioning the validity of long-term hospitalisation, towards the acceptance of the psychological basis for mental ill health and early discharge (Ramon 1985, Busfield 1997, Fussinger 2011). However, inpatient care remained the main form of treatment of mental illness, as the provision of separate facilities for voluntary patients was slow to develop (Rogers and Pilgrim 2001, Bartlett and Wright 1999, Busfield 1997).

The development of the welfare state with the introduction of the National Health Service (NHS), following the 1944-48 Beveridge reforms, paved the way for a shift in mental health policy and practice and heralded a period of therapeutic optimism (Rose 2001). The establishment of a properly funded and centrally administered NHS in 1948 brought about the general expansion and restructuring of state-funded welfare provision, including the administrative and financial integration of mental health with mainstream health services; psychiatric services were included in the NHS. Psychiatrists sought to align their practice with that of general medicine by the introduction of new controversial 'physical treatments' that were designed to induce somatic change, such as electro-convulsive therapy (ECT) and psychosurgery, dubbed 'physical treatments'. The dominant paradigm in psychiatry rested on mental illness originating in biological causes hence the cure was to be induced through biological changes (Ramon 1991, Busfield 1997, Long 2011).

The advent of the pharmacological age marked by the introduction of the drug Largactil in the mid-1950s was heralded as a revolution in psychiatry for enabling clinical improvements and making early discharge possible. Drug treatment permitted the management of many conditions outside the hospital, including the treatment of people with severe mental illness in the community. It gave impetus to a psychosocial model of psychiatry that encouraged reforms to shorten hospitalisations and the development of community-based care, epitomised by the introduction of day hospitals (Jones 1993, Gittins 1998, Busfield 1997, Fussinger 2011). The reforms were driven by the need to reduce the stigmatising and disabling effects of prolonged hospitalisations (Barton 1959, Goffman 1961); these included the broadening and diversification of occupational and rehabilitation activities and the reduction or suppression of confined practices and the use of constraints (Busfield 1997, Gittins 1998, Crossley 2006, Fussinger 2011); However, the adoption of psycho-social reforms was reported as being largely dependent on the goodwill of those in authority and had little impact on hospital care policies nationally (Ramon 1985, Prior 1991). The continued poor standards of care for long-term patients were confirmed by studies and hospital inquiries of the 1960s and 1970s (Goffman 1961; Wing and Brown 1970, Martin 1984), which eventually paved the way for the replacement of institutional care with care in the community in the 1990s.

Changes in the role and function of psychiatric nurses followed due to new trends such as psychotropic drugs controlling the worst symptoms that allowed for a more therapeutic relationship to be achieved between the nurse and the patient (Nolan 2000, McCrae and Nolan 2016). These new policies emphasised the changing role of mental health nursing towards the provision of psychotherapeutic approaches to nursing care (Ministry of Health 1968, Department of Health 1994). However, these approaches were reported to have developed slowly and unevenly due to the over reliance on the medical model with its narrow focus on the reduction of symptoms, which determined the short-term nature of many nurse-patient interactions. Nurses were reported to act as agents of medical staff such as giving out medication and reporting on patients' moods and behaviour. In contrast, forming relationships with patients was considered to be a limited feature of a nurse's role as their main concerns rested on maintaining their schedule and order on the wards (Altschul 1972, Cormack 1983, Ramon 1985, Higgins et al. 1999).

Early Attempts to Community Care

The Royal Commission of Mental Illness and Mental Deficiency, 1954-1957, marked the turning point in official policy regarding mental health services. It marked the shift from hospital to community-based system of care. It was a result of government inquires investigating accusations of abuse and neglect that had damaged the reputation of mental hospitals, such as *The Plea of the Silent* (Johnson 1957), a collection of testimonies of formally certified patients speaking out against inhumane treatment and wrongful detention which put pressure on reforming the process of certification (Crossley 2001). The Percy Commission recommended treatment in the community and not in large psychiatric institutions whenever possible. It led to the 1959 Mental Health Act that called for a shift towards a community-based system of provision. The policy of closing down the hospitals in England emerged from the then Minister of Health Enoch Powell's famous speech *The Water Towers* (1961), which promised to close all asylums within fifteen years. This pledge made policy in 1962 in the 'New Hospital Plan', which stated the government's decision to devolve responsibility for the creation and delivery of mental health services based in the community to local authorities, putting emphasis on rehabilitation and the reduction of the number of beds in mental hospitals (Ministry of Health 1962). Mental health services were reoriented such that chronic and severely ill patients who would have usually been given care in institutions were offered alternatives such as day hospitals and wards in district general hospitals (DGH), and outpatients with acute and mild mental health difficulties (Busfield 1997). These developments actually had little impact on psychiatric hospital closure until the 1980s, largely due to the lack of financial incentives for local authorities to develop these community-based services that were be essential to genuine community care. The failure to transfer adequate funds for new services has the effect of slowing down the pace of deinstitutionalisation and the closure of the hospitals was not completed until the late 1990s (Rose 1986, Jones 1993, Busfield 1997).

Total Institutions in the mid-20th Century

The closure of the old large state mental hospitals was partly fuelled by the social and ideological climate of 1960s and 1970s. The damning critiques of institutional care that emerged from this period onwards have been dubbed the ‘literature of dysfunction’ for its anti-institutional stance. This literature has been credited for changing public perceptions of residential care, including the care provided in the now closed large state mental hospitals, which in turn led to deinstitutionalisation in the 1980s and the new policy of care in the community in the UK in the 1990s (Jones and Fowles 1984, Scull 1986, Jack 1998, Higham 2006, Johnson et al. 2010). The main premise within the literature of dysfunction rests on the assumption that care provided in the community was superior and preferable to care within institutional settings, such as cares homes for the elderly and the mental hospitals. The undesirable processes of institutional care outlined in the literature of dysfunction are encapsulated within the term ‘institutionalisation’, understood to mean the undesirable outcomes that arise from institutional care, such as social withdrawal, apathy and helplessness, viewed as a result of the loss of identity within these institutions. Depersonalisation was found to be one of the defining features of institutions (Jack 1998). An example is Peter Townsend’s seminal social study of residential homes for elderly people from 1959 to 1975, which concluded that their depersonalising regime involved patients becoming institutionalised after a long stay in a residential institution, recommending the phasing out of this type of residential care (Townsend 1976). Despite some of the theoretical and methodological shortcomings discussed later in this chapter, this literature had considerable influence on encouraging the curtailment of the practices of residential provision and the subsequent development of community care (Jones and Fowles 1984, Jack 1998, Johnson et al. 2010).

Within psychiatry, the main critics of institutional care came from both within and outside of the field. One of the most notable critiques came from Russell Barton, the last superintendent at Severrall's mental hospital, Colchester (1960-1971). Barton coined the term 'institutional neurosis' to describe the disability in social life skills caused by the demands of living in a psychiatric institution. He saw institutions as the only environments that cause such a disability, which he defined as a 'disease' in which the sufferer loses interest and initiative in life and social interactions, becomes submissive and can lose the ability to express emotions. Although Barton was unsure of the cause of institutional neurosis, many factors were associated with the institutional environment in which patients lived, such as limited access to the outside world, loss of personal friends and possessions, imposed idleness, the rigid social structure between patients and staff, the strict routines, staff attitudes, cruelty and malpractice (Barton 1959). Wing and Brown's study (1970) of long-stay male patients in three large hospitals in 1950s in England, viewed institutionalisation as a set of dysfunctional behaviours brought about by the pressures of living in any institutional settings that reflect Russell Barton's critique of psychiatric asylums. Three variables were identified that worsened the effects of institutionalisation, namely the social isolation that arises from living in a closed environment, the length of time being exposed to this environment, and the level of individual predisposition. Individuals in institutions were seen as having a high potential for losing independence and responsibility, to the point of impairing their capacity to cope in everyday life once they return to living in the outside world (Wing and Brown 1970).

Ervin Goffman highlighted how institutionalisation was built into the bricks and mortar of psychiatric institutions in his seminal book *Asylums* (1961), a renowned study of St Elizabeth's hospital, a large mental hospital in Washington DC in the 1950s. Goffman's study has had a profound effect on attitudes towards institutional care in the western world. Through covert participant observation, Goffman attempted to understand how processes and the structures of power in institutions shaped the world and the identity of the patient. Goffman attempted to challenge the conventional wisdom about the purpose of institutions by rejecting the official medical professions' narratives, instead embracing the patients' experiences of institutional care. His work on the pathology of institutional life details the dynamics that shaped relationships between staff and patients through common institutional practices in closed institutions. Goffman saw psychiatric hospitals as 'total institutions', defined by the loss of freedom and the social control of the patient that he likened to prison environments through the barriers to social relations such as locked wards, high walls and the isolated geographical locations. Total institutions reflected most of the old large mental hospitals that were built in the Victorian era in isolated rural settings in the UK. His work recognised the unequal power dynamics in psychiatric hospitals where the relationships between the social groups within, namely patients and staff and between patients, are unequal in terms of social influence. Goffman highlighted the extent of institutionalisation through the paternalism in clinician-patient relationships, identified as a key feature of psychiatry in the nineteenth and twentieth centuries (Scull 1989 and 1993, Busfield 1997, Crossley 2006) and a main characteristic of psychiatric institutionalisation to this day (Chow and Priebe 2013). Goffman saw the dynamics that shaped relationships in mental institutions between patients and staff including the labels and identities that were imposed on the patients as defined by the exercise of control understood to be the essential feature of staff-patient interactions, asserting patients and staff only interact through 'gripes' or requests on the part of the patients which he referred to as 'inmates' (Goffman 1961, p. 85). The common features of total institutions were the forced communal living in contained environments, the regulation of behaviour through strict routines, and role stripping that reduced individual identity to that of inmate. The process of mortification of the self was achieved through rituals such as the removal of personal possessions and the enforcement of communal clothing. Goffman claimed these common features of total institutions existed not only in mental hospitals but also prisons, concentration camps and even monasteries and convents. A theme central to the notion of 'total institutions' was found to be patients' adaptive behaviour to institutionalised care, that is symptoms shown by patients in response to being treated in an institution, such as depersonalisation and the loss of one's identity, consistent with Barton's concept of institutional neurosis and Wing and Brown's process of institutionalisation (Barton 1959, Wing and Brown 1970).

Control was achieved through a system of rewards and punishments. The survival of the inmate was understood to depend on what Goffman referred to as 'secondary adjustments' such as social withdrawal and acceptance of the status quo; the adaptation to the system could occur through forbidden practices such as smuggling and bartering to create illicit power structures, seen as means of self-defence against the destructive forces of the institution. Goffman painted a pessimistic picture of the role of the medical hierarchy whose sole role was based on stripping individuals of their own social identities and replacing them with diagnostic labels; the imposition of the 'career of the mental patient' as a form of social control was viewed as part of the 'cure' from the medico-psychiatric perspective. Examples given are removal of teeth as 'treatment for biting' and forcing hysterectomy on female patients as treatment for sexual promiscuity that served to fulfil the function of the institution as social control (Goffman 1961, p. 76).

Goffman's *Asylums* is an exposition of a theory of organisational discipline and was not intended as a literal explanation of the functions of mental hospitals (Jones and Fowles 1984). His work played a pivotal role in drawing attention to the anti-therapeutic impact of institutional life through an analysis of the form of interactions taking place in closed environments. *Asylums* became associated with the anti-psychiatry movement for opposing the medical model of psychiatry (Prior 1995, Jones 1993, Busfield 1997, Rogers and Pilgrim 2001). However, there are a number of flaws in Goffman's arguments, his work does not consider the mental hospital as part of a health care system which individuals may need access in times of crisis; Although Goffman aimed to redress the record by including the perspectives of the patients, claiming to have based his work on participant observation, there are no direct references to inmates' experiences, instead he relied on highly unusual and selective secondary sources from other institutions to substantiate his views, such as George Orwell's experiences of boarding school (see Goffman 1961, p. 27). In addition, Goffman failed to balance his research by excluding the work of pioneering social psychiatrists that introduced major psychosocial reforms in the mental hospitals from the 1940s onwards. Reformist psychiatrists such as Russell Barton, David Clarke and Duncan Macmillan were making strides to humanise the care provided within the mental hospital from the 1950s onwards in order to break away from the alienating effects of institutionalisation (Ramon 1985, Busfield 1997, Fussinger 2011). Nonetheless, the anti-institutional movement's portrayal of the mental hospitals as closed and totalising environments, based on the dehumanising and depersonalising practices therein through the routinisation and deprivation of meaningful roles, was instrumental in the running down of the mental hospitals, their eventual closure and the introduction of the policy of community care.

Ill-treatment in Mental Hospitals

The effect of the post-war reforms to ameliorate the regime of care practices within large mental hospitals was called into question by a series of scandals in the 1960s and 70s that exposed the abuse of elderly patients in some long-stay hospitals that directly arose from their highly controlling environments. The Aid to the Elderly in Government Institutions pressure group (AEGIS) was instrumental in leading the collection of evidence of harsh treatment of patients that led to a national investigation. Barbara Robb, the founder of AEGIS, published *Sans Everything* in 1967, a collection of her own 'Diary of a Nobody' together with nurses and social workers' accounts exposing the undignified treatment of elderly patients in long-stay wards in seven hospitals. The collection details a number of dehumanising practices that echoed Goffman's concept of total institutions (1961); these included the stripping of personal possessions, the lack of privacy and the strict control of patients' lives through the routinisation of daily living. It revealed significant gaps in the dealing with patients' complaints and called for a procedure to be put in place (Robb 1967, Hilton 2014, Hilton 2017). The independent inquiry that followed dismissed the allegations as inaccurate, partially discrediting *Sans Everything* (NHS 1968).

J. P. Martin documented 15 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. Most scandals occurred in hospitals seen as professional backwaters that had not embraced the post-war therapeutic optimism (Fussinger 2011). The hospitals under investigations lacked the proclivity to embrace the internal reforms to ameliorate the life of patients therein (Martin 1984). The inquiry reports had many elements in common: every inquiry hospital was geographically isolated; isolation occurred at a local level where most of the abuses and the failure of care were attributed to specific 'back' wards where other wards in the hospitals provided good care. For example, the Whittingham hospital inquiry found that maltreatment occurred in 4 wards out of 52 (Payne 1972). Cruelty by staff in specific wards tended to be run by a Charge Nurse with little influence from other medical professions; understaffing was endemic in wards where brutality had taken place; moreover, the wards where abuse occurred lacked in-service training, marked by the lack of innovation and contributed to maltreatment. There was a demonstrable lack of support for long-stay patients who tended to be deprived of caring friends and families, and were therefore most vulnerable to abuse. The discovery and reporting of ill treatment were long-standing; the inquiries found that abuse was not reported by staff or dealt with for staff's fear of breaking ranks and the resulting victimisation, echoing findings from other research on abuse in mental hospitals (Beardshaw 1981). The failure of adequate care was attributed to the closed systems of the mental hospitals, unchecked by external corrective feedback, thus confirming Goffman's notion of 'total institutions'. The chronicity and refractory nature of the long-stay patients made these places unrewarding to work in. The provision of quality care became subordinated to the preservation of order, social control and the status quo (Ham 1982, Martin 1984). The factors that were responsible for the failure of care were found to be organisational. The complacency of policy-makers was evidenced by the termination of monitoring of mental hospitals' activity from 1959 to 1965 (Davidge, et al. 1993).

The inquiries brought about the recognition that the service had been starved of resources, which in turn had become one of the major factors causing the problems faced by all of the hospitals under investigation, which showed a struggle to maintain a service in the face of chronic staff shortage and limited financial resources. A major shortcoming of the inquiries was the lack of any mechanisms for learning the lessons that emerged, due to the local origins, the limited circulation and the difficulties of the Department of Health and Social Security in communicating with the districts (Martin 1984). The inquiries raised public awareness of the issues faced by long-stay patients, but did not achieve as much as it was hoped (Ham 1982, Martin 1984). A systematic follow-up of inquiries did not take place; however four accounts of former inquiry hospitals were published in the Nursing Times; each reported substantial improvements in hospital staffing; rapid staff change and the lack of sufficient staff was dealt with multi-disciplinary management system (Dunn 1981, Dopson 1981a and 1981b, Martin 1981, Slack 1981). In 1969, the government established visiting teams from the Hospital Advisory Service (HAS) to improve the management of patient care in hospitals by conducting inspections, offering advice and promoting good practice. The HAS reports resulted in some improved care but radical change was limited by lack of resources. The reports drew attention to the problem of managing and organising the old mental hospitals and eventually contributed to the argument for their closure (Martin 1984, Rogers and Pilgrim 2001).

The Rise of Social Psychiatry

Despite the biological model dominating psychiatry in the UK in the post-war period, there were significant social and psychological currents at the time, overlooked in the anti-institutional literature. Social psychiatry was highly influential in this period in reforming mental health policy with the aim of improving conditions in the mental hospitals; the belief in mental health stemming from the environment, such as socio-economic factors and social exclusion was also prevalent; the community was seen as the locus for the treatment and prevention (Fussinger 2011, Foot 2015). The anti-institutional literature such as Goffman's *Asylums* (1961) failed to take into account the rise of social psychiatry from 1940s onwards, also known as community psychiatry, influenced by the principles of therapeutic communities. Therapeutic communities originated from reformist psychiatrists working with unprecedented numbers of psychiatric cases of shell shock soldiers that lent a huge stimulus for the development of social psychiatry. The resulting 'social turn' shifted the focus from the medical model based on the reduction of symptoms to the psycho-social model, putting emphasis on prevention, focusing on the effects of environmental stresses on wellbeing (Ramon 1985, Prior 1991, Busfield 1997, Fussinger 2011, Kritsotaki et al. 2016).

The rise of the therapeutic communities was born out of the desire to democratise the relationships between doctors and patients and enhance the therapeutic potential of psychiatric hospitals; the key characteristics were encouraging patients to take an active role in their own recovery and the attempt to break down hierarchies of the medical model in an effort to break away from the alienating effects of the traditional mental asylum. Alternative models of care were introduced from 1950s onwards, notably the open-door policy (Fussinger 2011, Foot 2015) and the development of psychogeriatric care, namely the clinical treatment of mental and physical health in older people (Hilton 2005). The development of the therapeutic community movement included efforts to flatten the hierarchy between doctors and patients and embracing the environmental causes of mental health problems. The movement's ethos had deep repercussions on the conceptualisation, diagnosis and treatment of mental health (Ramon 1985, Fussinger 2011, Foot 2015, Kritsotaki et al. 2016).

The historiography of psychiatry has traced the development of therapeutic communities in Britain as early attempts to rehabilitate patients in 1940s and 50s in the form of separate units within larger hospitals run by reformists, such as Duncan Macmillan at Mapperley hospital, Nottingham, and David Clarke at Fulborn Hospital, Cambridgeshire (Ramon 1985, Busfield 1997, Fussinger 2011). In 1945, Dingleton hospital, Scotland, became the first open-door hospital in the English speaking world under Maxwell Jones (1907-1990), an early reformer of the mental hospital system and founding father of the therapeutic community (Jones 1968). From 1962 a therapeutic community was established at Dingleton, signalling the birth of social psychiatry. Maxwell challenged the specific roles of staff to cultivate genuine relationships, placing a strong focus on emotional problems, crucial in terms of therapeutic relationships (Jones 1968, Ramon 1985, Fussinger 2011, Foot 2015). In therapeutic community hospital settings, staff and patients were encouraged to create active therapeutic environments and attempts were made to break down the traditional hierarchy of authority between staff and patients; the emphasis was placed on democratic, egalitarian social organisation, the importance of meetings to talk through difficulties, seen as a form of group therapy (Fussinger 2011).

The concept of therapeutic community can be seen to encompass all mental health reforms undertaken to humanise the mental hospital from the 1950s onwards. These reforms included the expansion and diversification of both occupational and rehabilitation activities; mixed gender wards; efforts to rebuild links with the outside world; encouraging the public to visit the hospital by building links between the hospital, the surrounding community and patients' families with the introduction of open days, public events and voluntary groups such as the League of Friends to support long-stay patients (Busfield 1997, Gittins 1998, Fussinger 2011). Asylum nurses began to receive formal training and gain recognised qualifications; female nurses were moved into male wards (Hide 2014). However, the introduction of therapeutic community units was reported to have been mainly within the admission wards for short-stay patients (Busfield 1997). The therapeutic community model was not widely introduced as it was considered incompatible with the medical model. The latter was reported as the dominant paradigm and the large size of hospitals and attitudes of staff and management militated against the concept of therapeutic communities (Wing and Brown 1970, Ramon 1985, Busfield 1997). In addition, significant clinical developments took place from 1940s onwards to improve psychiatric care for older patients, brought forward by individual progressive superintendents; these included the development of early multidisciplinary work between psychiatrists, GPs and social workers in order to address the psycho-social and physical needs of older patients living in community. These included day hospitals and emergency services set up at Severall's hospital at Colchester, a geriatric unit at Bethlem Hospital, London as well as at St Francis Hospital in Nottingham. However, these developments were not embraced nationwide due to the government's reluctance to fund these initiatives. Some 20 years later in the 1970s the Government began to support the development of psychogeriatric care as a response to poor care for older long-stay patients evidenced by the hospital inquiries (Hilton 2005).

Community Psychiatry in Nottingham

The Nottingham psychiatric hospitals experienced great changes in the period following the Second World War. Duncan Macmillan, last medical superintendent at Mapperley hospital (1941-1966), was a progressive psychiatrist who began programmes of reform, rehabilitation and deinstitutionalisation in Nottingham ahead of the rest of Britain, introducing the open-door system at Mapperley hospital in 1952, a pioneering move that helped to shape national policies for psychiatric care (W.L.J. 1980, Gittins 1998, Ramon 1991, McCrae and Nolan 2016). The development of support based in the community followed, including both short-term assessment, long-stay care and a geriatric day hospital from the mid-1950s onwards (Macmillan 1956b, Macmillan 1958, Hilton 2016). It was reputed to be the first day hospital opened in the country to cater for long-term patients living in community (Hilton 2005). Macmillan became medical officer for the city of Nottingham in 1945, putting emphasis on prevention and early treatment of mental ill health and developing clinical developments for the care of older people, namely psychogeriatrics. An early form of multi-disciplinary team working was developed through the integration of medical and social services to provide for the psycho-social needs of patients living in community (Macmillan 1956, 1963). Psychiatric nurses began to work alongside psychiatric social workers from 1948 onwards which included pre-admission home visits. The emphasis was on the importance of the social environment by working with the family of people with long-term severe conditions. Early care in the community developed by moving long-stay patients out to the community and thereby reducing the number of beds in the long-stay wards. There was a significant reduction in the proportion of mental health patients who were admitted to hospital: from 73% in 1949 to 57% in 1957; 900 patients were treated in the community during that period. Of the patients receiving inpatient care, half were reported as voluntary patients and half were detained involuntarily (Macmillan 1956a, MacMillan 1963).

The social rehabilitation model of psychiatry was embraced from the 1950s onwards, encouraging a psychotherapeutic atmosphere at the hospital by opening the wards and removing the hospital gates, introducing volunteering, a hairdressing salon and structured rehabilitation through occupational and industrial therapy units and recreational activities such as sports and holidays. Open days were instituted from 1952 onwards in an effort to reduce the stigma associated with the hospital site and to encourage greater cooperation between the patient and their families, evidenced in the 1952 open day hospital booklet for visitors (appendix 1). These were designed to destigmatise the hospital by changing its public perception from a place of containment to a place of rehabilitation (Macmillan 1958, Wing and Brown 1970). Some of the therapeutic developments from 1948 onwards reported at the Nottingham mental hospitals, namely Mapperley, Saxondale and the Coppice, included the emphasis on psychotherapeutic treatment in the form of group and individual therapy sessions designed to encourage patients to function as ‘social beings’ (Nottingham Hospital Management Committee 1970). The scarce literature on the influence of therapeutic community principles on staff-patient relationships suggests that the environment at Mapperley hospital was influenced by the advent of the social model of mental health from the 1950s onwards, and was no longer custodial but more therapeutic in nature. The influence of the therapeutic community principles affected not only the provision of care for patients but also the power relations among staff and patients; therapeutic community principles were reported to have contributed to fostering therapeutic relationships between staff and patients in hospitals that has embraced therapeutic community ideals (Nottingham Hospital Management Committee 1970, Ramon 1985, Busfield 1997).

The Costs of Community Care

The central tenet of twentieth century policy of community care centred on the hospital being no longer viewed as the preferred location for receiving care. The emphasis on care in the community was to provide a new system of care through developing services for every stage of the illness, including prevention as well as treatment through the provision of primary care facilities. This included hospital beds for both acute and chronic patients needing medical or psychiatric care, as well as residential and half-way accommodation, day hospitals, and health and welfare services including social work support services. The new ideal heralded integration rather than separation from the community (Leff 1997, Higgins et al. 1999, Killaspy 2006, Kritsotaki et al. 2016, McCrae and Nolan 2016). Standard institutional critiques such as Goffman’s notion of ‘total institutions’ were called upon in support of the ‘preferable’ care in the family and community alternative (Busfield 1997). In the most exhaustive review of the anti-institutional literature, Jones and Fowles (1984) challenged the anti-institutional rhetoric, referred to as ‘the ideologies of destruction’, which contributed to the closure of residential care and the stripping of public assets in the name of reducing costs.

The advent of the 1970s fiscal crisis in Britain marked the beginning of neo-liberal policies within health and social care by the introduction of the private market within the NHS through marketisation and privatisation; this new phenomenon had the adverse effect of limiting the services provided within the community. As a result, financial constraints hastened rather than delayed the move to community care (Scull 1986, Busfield 1997). In this light, the policy of care in the community can be perceived as a strategy to decrease hospital services without any expansion in community services, a fear expressed by those working in the field, posing a greater risk to access for specialist treatment and losing the opportunities for social connections and networks that the hospital offered. It was the services for those with chronic long-term complaints, including the elderly, which were never properly developed and have been most under attack - day hospitals, residential homes, home visits, district nursing and so forth (Busfield 1997). The 1970s cutbacks in public spending, state fiscal crisis, followed by the ideological transformation of government policies when the Conservative government came in power in 1979 during a recession, resulted in a renewed enthusiasm for care in the community in the new guise of care provided by private individuals in the home, charitable agencies and a subsequent reduction in costs (Scull 1977, Sedgwick 1982, Busfield 1997). The government’s intent was on reducing the mental hospital population through existing networks of health and social care services that would carry the new and heavy burden of services without new initiatives (Jones 1993, Higgins et al. 1999, Rogers and Pilgrim 2001).

The National Health Service and Community Act 1990 based on the Griffiths report (1988), aimed to introduce a new approach to public service management in order to put residential care on an equal footing with community-based options; it documented the cost ineffectiveness of residential care, ensuring its rapid reduction (Audit Commission 1986, 1994). It was the beginning of the demise of public residential provision as a whole through closure and sale of facilities that had the effect of stripping capital assets. Jack (1988) and McCrae and Nolan (2016) reported the process went unchallenged by professionals who wholeheartedly rejected residential care within professional culture in favour of community care alternatives. Evidence from recent research shows that most hospital sites were sold to private investors and redeveloped into luxury flats although a few hospitals retained parts of their buildings for the re-provision of inpatient and outpatient mental health related services (Chaplin and Peters 2003, Moon et al. 2016, Gibbeson 2018). Successive governments continued their commitment to cutting public sector expenditure, which had a drastic effect on mental health care provision. Services for long-term residential care for people unable to manage in the community were never developed, prompting the government to acknowledge the failure of the community care model (Department of Health 1998). It was this willingness to reduce costs that led right-wing governments to support the demands of the libertarian reform movements for closure of the hospitals, without any real commitment to re-provision (Sedgwick 1982, Jones 1993, Rogers and Pilgrim 2001).

Anti-Psychiatry and the Survivors Movement

In the 1960s, anti-psychiatrists appropriated the therapeutic community model and the traditional critiques of asylum put forward by Goffman and others. The movement influenced the closure of the hospitals in the western world. It articulated strong critiques of the mental hospitals that lent further legitimacy to their demise (Fussinger 2011). The term anti-psychiatry denotes a tendency towards radical reform in psychiatry. It has been seen as a political, cultural and social moment in time; a critical approach towards traditional theories and practices of psychiatry including the workings of the asylum, the bio-organic theories of mental illness and the ways in which people with mental ill health were labelled, incarcerated and treated in hospitals; its central tenet was the constitution and removal of institutional power – encompassing the ethos of the larger counter cultural movements of 1960s (Fussinger 2011, Sedgwick 2015, Foot 2015). The movement called into question the traditional definitions and diagnoses of mental illness. In Britain, David Laing and Ronald Cooper advocated equality with the patients by removing barriers as part of the therapy. Their ‘rumpus room’ experiment in the Glasgow asylum for highly disturbed patients underlined the importance of the institutional setting in exacerbating ‘madness’ and the possibilities and limits of experimentation within the institutions (Laing 1960, Cooper 1967). Critiques of the mental hospital came from other camps too, such as the libertarian American psychiatrist Thomas Szasz detailing the failings of psychiatry. He critiqued the concept of ‘mental illness’ and denied its existence. Szasz’s critique challenged the paternalism of coercive psychiatry in favour of liberty and the autonomy of the individual (Szasz 1960).

At the end of the 1980s, Rogers and Pilgrim conducted participatory interviews with members of the London Alliance for Mental Health Action, an association of

London-based mental health campaigning organisations that included representatives from 10 major mental health user groups, including MIND, Survivors Speak Out, and Hearing Voices Network. The research aimed to find out the main objectives of the movement; the central concerns that emerged for the British survivor movement were being disempowered users in the mental health system and that alternatives to the existing system were needed. These included the provision of non-hospital-based sanctuary during mental health crisis and material support such as the provision of housing, which would help counteract homelessness, relapse as well as the negative effects of psychotropic drugs. Overall, deinstitutionalisation was viewed as a welcomed aspect of the new policy of community care, which contrasted with the media's view of the dangers of psychiatric patients in the community. All agreed on the importance of being listened to and being treated with kindness and respect. Some contradictions emerged between the desire for autonomy while the need to rely on professional treatment (Rogers and Pilgrim 1991).

The rise of consumerism in health and social care in the 1980s redefined the role of mental patients as passive to active consumers of services, expressed in some key policy papers such as Working for Patients White Paper (Department of Health 1989) and the Patients' Charter (see Crossley 2001, p. 1488). The new ideology of consumerism that dominated the agenda of shaping public services had the unexpected consequences of strengthening the social movement of disenfranchised service users that posed a challenge to the traditional medical elite and allowed for tipping the balance of power in their favour (Jones 1993, Rogers and Pilgrim 2001, Crossley 2006, Killaspy 2006, Hornstein 2017). The Survivor movement served to propose a social model of mental distress and recommended various reforms from the modernisation to the shutdown of mental hospitals that fuelled the argument to close the institutions down, which gathered momentum in the 1980s (Laing 1960, Szasz 1960, Cooper 1967, Crossley 2006, Long 2014, Foot 2015, Kritsotaki et al. 2016). Significant developments include the Patient Councils in mental hospitals; the first council was introduced at Mapperley hospital, Nottingham, in 1986 (Barnes and Gell 2011). The movement undertook several direct action campaigns to oppose coercive treatment. Notably, the Survivor movement campaigned against the introduction of the Community Treatment Order (CTO) advocated by the Royal College of Psychiatrists, through an amendment of the 1983 Mental Health Act. These CTOs would give the power to medical consultants to treat patients in the community on a compulsory basis; the measure was eventually introduced in the 2007 Mental Health Act (Rogers and Pilgrim 1991).

Unintended Consequences of Consumerism

The validity of the claim that the advent of consumerism had afforded choice and autonomy to service users was undermined by a lack of investment in the provision of community-based services (Barham and Hayward 1995 and 2002, Sedgwick 1982). What was left behind was an acknowledgement of the issue of what would happen to the patients who would no longer have access to the mental hospital (Proctor 2016, Kritsotaki et al. 2016). Sedgwick, in his book *Psychopolitics*, first published in 1982 during deinstitutionalisation, proposed a critique of various thinkers under the umbrella of anti-psychiatry, in an effort to protect social welfare for people with mental ill health. Sedgwick was concerned with how the anti-psychiatry's arguments could be misused to justify the reduction of state provision of mental health services at a time of rapid reduction of state services. The move towards care in the community combined with the powerlessness of those with long-term needs made patients an easy target for public expenditure cuts. In the 1970s, local authority spending on residential facilities for people with long-term mentally ill health was significantly lower than had been for hospital-based services; the large majority of local authorities did not provide residential places for the elderly mentally infirm (Sedgwick 1982, Seager 2006, Proctor 2016). In an effort to address the growing crisis of mental health care provision, Peter Sedgwick critiqued anti-psychiatry's insistence that mental illness is a social construct as a gross form of neglect in their denial for the need of continuous forms of care for individuals who needed more than short-term interventions during deinstitutionalisation (Sedgwick 1982). The anti-psychiatric movement opposed medical power by campaigning to close the mental hospitals and the population of mental hospitals radically decreased, but without consideration for the protection of services; Sedgwick's critique was based on a defence of public mental health services. Sedgwick recognised that the anti-psychiatry movement, in their insistence that mental illness was socially produced, inadvertently fulfilled the right-wing government's agenda to reduce public spending, hence the movement to abolish the mental hospitals contributed towards closing the hospitals without adequate provision in community. Sedgwick identified a strong civil-libertarian interest underlying the pressure for reform of mental health legislation during 1960s and 1970s, which helped to determine the character of the 1983 Mental Health Act. The civil-libertarian ethic views a legalistic framework that secures patients' rights as a means of controlling and limiting medical power. The focus on medical power cast civil libertarians in the role of permanent reforming opposition to the main structures of authority and decision-making at the expense of lobbying for quality of care

(Sedgwick 1982, p. 245). The ethic stops the formulation of new demands for supporting individuals with long-term needs and it ignores the inequalities in the provision and standard of mental health services. Sedgwick's critique shows that mental health services continued to be arranged not by social needs but by the lack of social and political power of service users and their significant others, by the interests of the medical profession and the unwillingness of the state to expand welfare service provision (Sedgwick 1982, pp. 239-245).

Institutionalisation in Community

The dominant perceptions of care provided in institutions as undesirable held by professionals and service users assumed the superiority of the community care paradigm. It became the common sense view that underpinned public policy and professional practice, and a generally accepted self-evident truth by health and social care professionals alike (Jones and Fowles 1984, Jack 1998). What is not usually acknowledged in the anti-institutional literature is that other forms of provision within community care operate under similar institutional processes that can lead to institutionalisation in the community (Busfield 1997, Jack 1998, Chow and Priebe 2013, Kritsokati et al. 2016). The underlining assumption that health and social care has progressed positively as a reaction against outmoded and undesirable care in institutions has coloured official reports and reviews of the literature. The resulting conventional wisdom, namely that all residential care leads to institutionalisation and that the same phenomenon does not happen in the community, is therefore flawed (Jack 1998). This argument in the anti-institutional literature undermines the widely accepted notion of residential care in institutions such as mental hospitals as dominated by social control. The dualistic notion of institutional care neglects to take into account the social processes that affect welfare outside of the institution, perceived as a separate entity from wider social processes rather than its result (Jones and Fowles 1984, Jack 1998). What Townsend, Barton, Goffman and others did not take into account are the wider processes in the provision of welfare, and how community is made up of integrated institutions, including the family, which have the potential to depersonalise; the problems associated with institutional life were highlighted, whereas evidence of older people living in families suffering physical, emotional and financial abuse of similar proportions to the abuse reported in residential homes were ignored (Jones and Fowles 1984).

Residential care in institutions has been found to be not as debilitating as the literature of dysfunction portrays and alternative forms of community-based care do not necessarily produce different results. Subsequent longitudinal and comparative studies questioned the validity of Townsend and Goffman's arguments, finding that symptoms associated with the negative effects of institutional care existed before residents entered residential care, stemming from breakdown in family relations and other societal factors (Tobin and Lieberman 1976, Johnstone et al. 1981). Research was conducted on the impact of the quality of the interpersonal relationship between persons with a diagnosis of schizophrenia and their family after discharge from mental hospitals; the findings suggested a strong correlation between relapse and family expressed emotions, namely hostile behaviour, critical comments, over-involvement (Brown 1974, Thompson and Doll 1982). Moreover, the levels of dependency of ex-patients living in community continued, hence the problems of institutionalisation were not resolved by closing down the mental hospitals and moving services into the community (Jack 1998). Research contrasting the experiences of patients in mental hospital wards with discharged patients living in residential units in the community revealed similar conclusions; most saw themselves as passive receivers of services over which they had no control. The life style of the patients after discharge did not significantly alter; mental health professionals' interventions in community was found to lead to institutionalisation such as through the outreach intervention programme that reinforced passivity (Hervey 1995, Barham 1997, Leff et al. 2000).

Aspects of total institutions such as loss of freedom and autonomy, the experience of social stigma, and low material standards could be found living in community. Examples of institutionalising practices include service users being dependent on domiciliary care, which tends to reinforce passivity and routinisation of care; it has the potential to replicate the same paternalistic professional relationships within mental hospitals. McCrae and Nolan (2016) refer to long-stay patients moved to residential care as the 'casualties of community care' due to the lack of access to little therapeutic activity. Most residential homes did not have access to the outdoors or occupational therapy; most residential homes were reported to be staffed by untrained workers; the nature of the care approach, whether authoritarian or libertarian, was determined by the home manager's own approach to care. Moreover, institutional practices such as depersonalisation can also be achieved through the excessive administration of drugs (Barham 1997, Jack 1998, Gittins 1998, Chow 2013).

Inadequate Service Provision

The dualistic and negative view of institutions emerging from the literature of dysfunction was ill informed and has sustained a misconceived notion of care in the community, with damaging results for people who require care and those that deliver it. The fall of confidence in social welfare in the second half of the twentieth century was bound up with the idea of welfare as increasingly perceived as contributing to the problem rather than the answer. This paradigm shift in the provision of health and social care was driven by the political ideology of the New Right, resulting in the rejection of residential care as an option (Jones 1993, Rogers and Pilgrim 2001). This phenomenon had the effect of underestimating the number of people needing long-term care in institutions and created stigma associated with care provided in residential settings, which partly influenced social workers to view it as a last resort (Barham 1997, Jack 1998). One of the main flaws with the policy of deinstitutionalisation rested on the assumption that serious long-term mental health problems could be minimised with closure through care provided in community. The majority of long-stay in-patients were successfully relocated in the community (Hervey 1994, Leff 1997 and 2000, Thornicroft et al. 2005). However, acute psychiatric services were overwhelmed by the unexpected and unprepared for consequences of deinstitutionalisation. One of the unforeseen consequences was the emergence of new ‘long stay’ patients, deemed too difficult to care for in community-based homes while requiring asylum in long-term facilities (Mann and Cree 1977, Trieman et al. 1998, Holloway 2005). The new ‘long stay’ patients put into question the previously held view that social impairment associated with certain mental health conditions was caused by institutionalisation, created by the brick and mortar of the old system (Barton 1959, Goffman 1961). The inability to provide appropriate care for these ‘difficult to place’ patients has led to reinstitutionalisation, with service users who would have been long-term hospitalised before deinstitutionalisation now being transferred to different institutional settings such as residential homes, forensic hospitals and mostly prisons (Leff 1997, Chow 2013, Kritsotaki et al. 2016). Similarly, Hutchinson (2016) discussed the current neglect of people with lived experience of mental ill health. Service users no longer have access to a physical refuge during crisis as a result of the closure of the mental hospitals, with many people now being detained in prisons for lack of adequate services.

Ex-mental patients with a diagnosis of schizophrenia living in the community after deinstitutionalisation reported receiving little support from and choice of services in community, which was compounded by social stigma, poverty and exclusion (Barham 1995, Repper 1995). Although service users did not want to return to live in the hospital long-term, most viewed the old mental hospitals' environments as preferable to acute units during crisis. This was because the old mental hospitals were perceived as providing a place away from the chaos of the city, as well as a place of safety. Most felt they were better supported through the care offered in the asylum (Barham and Hayward 1996). The inadequacies in implementing community care policy for people with severe mental problems have been well documented (Thornicroft and Bebbington 1989, Sayce et al. 1991, Marks 1992). Notably, Marjorie Wallace, founder of the mental health charity SANE in 1986, (Schizophrenia, a National Emergency) was critical of community care policy. Wallace wrote a series of articles in the Times in 1987 exposing the neglect of discharged patients in boarding houses, documenting the neglect of patients discharged in community (see Nolan 2000, pp.16-17; McCrae and Nolan 2016, pp. 275-277). Patients and relative associations, such as Mind, were also opposed to closure for fear of safety and neglect of former patients in community; another concern was the loss therapeutic inpatient environments and of respite for carers that the hospital provided (Watch 2004, Ellis 2017).

Since the closure of the mental hospital, there has been a loss of medium-term rehabilitation facilities and the lack of suitable environments in which appropriate treatment and rehabilitation can take place for longer than a year. Current rehabilitation services for people with complex mental health conditions continue to be inadequately resourced (Hollander et al. 1990, Panel 2016, Bailey et al. 2018). Moreover, critiques of the effectiveness of community care led to the re-appraisal of confinement as a model of mental health care, which emerged in two policy papers by two successive governments in the 1990s (Department of Health 1996, 1998). The return to confinement was attributed to the perceived failure of community care to provide adequate care for the emergent new group of 'long-stay' patients since the closure of mental hospitals; this led to the introduction of the need for secure environments. The return to containment was fuelled by the government's response to the moral panic caused by violent crimes committed by mental health service users in community (Moon 2000, Curtis et al. 2009, Moon et al. 2016, McCrae and Nolan 2016).

The conflicts and ambiguities in the project of deinstitutionalisation became apparent in the early 1990s when the pace of closure of the state mental hospitals outstripped the provision of services in community (Barham 1997). The move to community care was assisted by a renewed support for a medical model of psychiatry at the expense of specialised inpatient therapeutic environments. The values and ethos of the social model of psychiatry were eclipsed by the renewed effort of the medical model to control symptoms in order for people to return in community, at the expense of ‘communal relationships’ that existed within the mental hospital environment, signalling the rejection of the social model of psychiatry in support of the medical model through the over reliance on psychotropic drugs in community care (Ramon 1985 and 2005, Jones 1993, National Schizophrenia Fellowship 1989, Barham 1997, Gittins 1998, Taylor 2011 and 2015).

Loss of Services

Mental health service users experienced various forms of loss in relation to their identities and purpose in community through social isolation and exclusion. All experienced precarious relationships with services in the community where medication was perceived to be the primary form of intervention, which diminished people’s efforts to restore dignity to their lives and purpose (Barham 1995, 2002, Repper and Perkins 2003). For Barham, the closure of the old large mental hospitals created ‘old problems in new places’; he likened people with long-term severe mental health problems to pauper lunatics of the asylum 100 years earlier, who faced structurally produced inequalities in the community, resulting in social exclusion and powerlessness, living in but not becoming an integral part of the community (Barham and Haywood 2002). The experiences of service users using community mental health services showed that the significant issues that concerned them became secondary to the services’ imperative to control the symptoms. Medication was found to be the primary form of intervention, devaluing the efforts of people with a severe mental illness to re-establish their personhood, whereas most of the participants wanted purposeful activity in their lives. The lack of service users’ control over community-based services recreated the very dependency that the new system was meant to address. Service users in community were found to be a socially deprived group denied access to full citizen rights, facing multiple exclusions such as from housing, employment and social life, poverty alongside the burden of their psychiatric history often playing a devastating effect on a person’s social networks. Many long-term users of psychiatric services are extremely disadvantaged by poverty and social deprivation, further compounded by self and social stigma (Repper and Perkins 2003, Barham 2005, Corrigan et al. 2012, Clement et al. 2015). In this light, community care can be seen as another form of containment as the ‘mental patient’ discharged from the asylums continue to occupy the position of the ‘other’ within society, often a sense of belonging and social support does not exist for people with long-term and complex mental health needs (Barham 2005). Barbara Taylor (2011), a historian and a former patient of Friern Barnet mental hospital, has argued that the choice and personal autonomy born out of consumerism can be a form of neglect. The recovery model paradigm based on the individual responsibility and self-management (Repper and Perkins 2003, Slade 2009), can be seen to deny the need for inpatient care to those that need it. Taylor eloquently made a case for the value of the mental hospital for a safe place to recover when caring for oneself is no option. For people vulnerable to mental health crisis, the therapeutic environment of the psychiatric hospitals has gone and has been replaced with fragmented services in both hospital and community settings (Taylor 2011, Taylor 2015, Patel 2019). Current mental health services largely lack integration, which in turn negatively impacts on the quality of services available to those in need (Patel 2019). Therapeutic practice has been largely unattainable in acute inpatient settings since the 1980s as a result of rising demands of beds, coupled with the steady reduction of available beds; moreover patients and staff in inpatient wards have reported the lack of therapeutic activities and meaningful interaction due to staff shortage and too many demands placed on the them such as dealing with crisis. The wards have been reported by patients and staff alike to resemble prison-like environments not conducive to recovery due to the shortage of beds and the concentration of people who are most unwell (Curson et al. 1992, Higgins 1999, Moon 2000, Watch 2004, Csipke et al. 2014, Wykes et al. 2018). More than half of NHS hospital beds have been cut in the last 30 years (Ewbank et al. 2017).

There has been a resurgence of interest in Sedgwick’s critique of anti-psychiatry. This is evidenced by a recent national conference entitled *Psychopolitics* (Liverpool University, 2015), the republication of Sedgwick’s seminal book (2015) and a series of articles exploring the legacy of his work and its relevance to the current fragmentation of social welfare (Cresswell and Spandler 2009, Beresford 2016a, Moth et al. 2016, Proctor 2016, Thomas 2016). Notably, the introduction of coercive policies by the Department of Work and Pensions, such as benefit sanctions and the work capability assessment, designed to limit eligibility of access to welfare, has disproportionality affected claimants with mental health conditions (Moth et al. 2016, Beresford 2016b, Thomas 2016). The revival of Sedgwick’s ideas has a direct link to the impact of neo-liberal policies on services and welfare benefits for people with long-term mental health problems, which have dramatically restructured the welfare state. The destructive impact of austerity measures on disability benefits, initiated by the Conservative and Liberal Democrat coalition government in 2010, has meant claimants with mental ill health have been disproportionally affected by cuts in welfare (Morris 2013, Beresford 2016b, O'Hara 2015, Moth et al. 2016, Thomas 2016). Sedgwick's defense of public services for people with mental ill health is of contemporary significance; his call for collective resistance to welfare cuts through alliances between professionals, service users and their significant others has regained popularity in the context of the rapid reduction of welfare and the consequent fragmentation of mental health services. The unintended consequence of the current government's policy of austerity and of neoliberal reorganisation of mental health services has been the formation of new alliances between service users and other interested parties in their collective growing resistance to welfare cuts and the reduction of mental health services (Moth et al. 2015, Moth et al. 2016, Thomas 2016).

A special issue of *Asylum* magazine (2016) was produced by a collective of survivors and their allies from community and academic settings to commemorate 30 years of its existence. The issue reflects on the changes within psychiatric care in the last 30 years from custodial to community care. Helen Spandler referred to some 'inconvenient truths' of the contemporary politics of anti-psychiatry, referring back to Sedgwick's original critique, highlighting how "radicals over-emphasised psychiatric abuse at the expense of psychiatric use" (2016, p. 7). The article reports how service users experience neglect in community; getting a diagnosis no longer entails automatic access to mental health interventions due to the fragmentation of mental health services caused by chronic underfunding. The choice of accessing a bed in an acute mental health unit as a voluntary patient is no longer possible due to the crisis in the availability of beds. The lack of availability of services has given rise to a significant shift in priorities for user groups and their allies now fighting to keep inpatient units open and demand access to services. Spandler claimed professionals are often forced to adopt coercive measures to ensure services are provided. These include using the power to detain individuals under section 1 of the Mental Health Act as well as CTOs. Spandler referred to a new wave of "psychiatric resistance", namely the survivor movement and their allies' shift of focus from resisting psychiatric abuse in the old system to fighting against psychiatric neglect in the current community care settings.

Conflicting Meanings of Care

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 (Rolph and Walmsley 2006) and that fact that they do not easily fit with government policies on deinstitutionalisation. Below I provide a review of the sparse published and unpublished oral histories of life in the mental hospital in the second half of the twentieth century, which reveal often contradictory meanings of care provided therein; mental hospitals could operate as 'total institutions', thus confirming findings from the hospital's inquiries, as well as permeable environments in which patient-staff relationships were much more fluid than reported in the literature of dysfunction. A point not usually highlighted about institutions is their role as places of safety and sanctuary, of residents liking life in hospital and their regrets about its demise.

Prestwich Hospital as a Total Institution

An oral history project was conducted in 1993 at Prestwich Mental Hospital, Lancashire, still open at the time, the same hospital criticised in Lomax's 1921 publication that paved the way for the 1930 Mental Health Act. Twenty-five nurses were interviewed; half had worked at the hospital in the period 1922 and 1975 and half between 1958 and 1975. Despite the emerging critiques of institutional care and the development of clinical innovations in psychiatric asylums from the 1950s onwards, nurses recalled that progress in the amelioration of care practices was slow and uneven. The interviews with staff provided no evidence of progressive change in the provision of care until the mid-1970s despite the recommendations made in contemporary nursing and psychiatric literature that emerged as a result of Lomax's critique of the asylum system and others (Ministry of Health 1968). The evidence include archaic care practices that dehumanised and depersonalised patients such as communal baths and clothes until the early 1970s; nurses reported that the airing courts designed in the nineteenth century asylum to exercise 'inmates' in controlled spaces were still in operation until 1968 and the open-door policy was not adopted until the mid-1970s; although staff recalled instances of compassionate care towards long-stay patients, several interviewed also recalled staff's cruelty to other patients. Although evidence emerged of the hospital management committee taking into account the social needs of residents through recreational activities, occupational therapy was only partially introduced on some wards; the researcher concluded that there was no significant change in the amelioration of care in most parts of the hospital until mid-1970s, providing evidence of Prestwich hospital as a ‘total institution’ (Hopton 1997, 1999).

Hopton (1997, 1999) claimed public social events such as the annual sports day served to promote the community-like environment of the hospital and to simultaneously act as a smoke screen to hide the harsh realities of everyday life in the institution. He concluded that Lomax’s observations of harsh and poor treatment were not very different from those of staff from 1930s to 1970s, suggesting the anti-institutional literature and the subsequent progressive changes occurring in mental health policy had little impact on care practices. The lack of progressive change was attributed to chronic understaffing, the lack of professional education and the propensity of the hospital administration towards a culture of social control at the expense of providing for the psychosocial needs of the residents. For Hopton, what impeded progressive change were the absence of mechanisms to make hospital staff accountable to hospital residents and ongoing supervision and surveillance of ward staff by hospital administrators (Hopton 1997 and 1999), concluding that the official inquiries of 1960s and 1970s into the allegations of ill-treatment of patients were not exceptions to the rule but part of the regime of all mental hospitals in Britain, debunking the myth of the progressive nature of mental health policy.

Hopton’s findings present clear evidence of a hospital that resembled the Victorian asylum in its methods of care and treatment and mirror the findings from the hospital inquiries (Martin 1984). A major shortcoming of his research lies in his assumption that all mental hospitals operated as total institutions. The innovative approaches to mental health treatment and care associated with progressive hospitals such as Fulbourne, Severrals and Maudsley were not taken into account in his critique of mental hospitals as a whole (Fussinger 2011). Hopton attributed substantive changes to nursing practices as a result of a crisis in the legitimacy of psychiatric staff, contrasting with more recent research indicating psychiatric workers were at the forefront of progressive change (Carpenter 2015, McCrae and Nolan 2016); for instance, in the post-war period ‘psychiatric social treatment’ developed, an innovative approach developed by psychiatric social workers (PSWs). The approach was based on a particular type of expertise to fulfill the psychosocial needs of people with enduring mental health problems not only in hospital but also living in community. It sought to improve social functioning by enhancing the sufferer’s social milieu and interpersonal relationships and to thus relieve distress (Long 2013). In addition, Hopton based his arguments on a very small sample that does not include patients and other interested parties’ views of care at Prestwich mental hospital; nonetheless the research evidences a mental hospital whose culture approximated Goffman’s notion of total institutions with little change until the mid-1970s despite the social turn in mental health policy.

Hospitals as Communities

Gittins (1998) collected sixty oral histories of former residents and staff at Severalls Psychiatric Hospital, Essex, England, over 84 years of the hospital's existence. Severrals hospital was widely portrayed as a place of belonging for many, where a sense of community and kinship operated amongst staff and patients and where patients formed strong bonds with other patients and staff. The more positive readings of care provided at Severrals could be attributed to the more liberal regime at the hospital introduced by Russell Barton, the last superintendent at Severrals in 1960 and pioneer of the concept of ‘institutional neurosis’ (Barton 1959). Unlike Goffman’s critique of mental hospitals as ‘total institutions’ which offered no solution to the issues he exposed, Barton made it an explicit aim to improve patients’ conditions by improving contact with the outside world, providing useful occupation and the adoption by staff of encouragement and friendliness to each patient, putting emphasis on the quality of life, the creation of private space for patients and assistance in making links with the community. By the end of 1960, the industrial unit built for male patients was reported to have made a great difference, employment outside the hospital was found and refresher courses for nursing staff were set up. Importantly, 800 patients were de-certified, and a psychogeriatric unit was set up. The open door and unrestricted visiting systems were introduced; the iron railings, synonymous with the Victorian asylum, were taken down in 1960; the removal of the gates went alongside the redefinition of rules, regulations, behaviour, divisions and separations within the mental hospitals (Wing and Brown 1970, Gittins 1998). Gittins (1998) argued that the hospital communities provided a strong sense of belonging for both patients and staff and that the move to care in the community has made interactions between service users limited by the constraints of poverty and the effects of medication.

Craze’s book “From Asylum to Community Care” (2014), based on the oral histories of former residents and staff at Brookwood Psychiatric hospital in Knaphill, Surrey, England, offers more evidence of the complex dimension of care practices within institutions. The oral histories were collected between 2004 and 2006 and spanned the periods before WW2, the hospital closure in 1994 and care in the community. Many of the former residents and staff reported the special significance of the environment of the hospital both as a peaceful place and as a way of life; working at Brookwood fostered a strong sense of pride and value for many. The oral histories excerpts provide a window into the symbolic significance of the asylum for ex-staff and patients narratives, suggesting that entering the institution was like leaving the outside world and entering a blank space where new kinds of identities were possible and could be forged. Many of the staff oral histories evidenced a caring environment and strong links between the residents and staff, albeit within a paternalistic approach to residents, commonly reported in the history of asylums (Prior 1995, Rogers and Pilgrim 2001). Staff reported witnessing a high level of neglect of former residents living in poverty and isolation in the community. Both staff and patients recalled fostering inter-personal relationships that went beyond the boundaries of residents and staff into more familial terms, such as visiting staff's homes. The children of staff played an unexpected role in mediating and blurring the boundaries between staff and residents, creating new kinds of identities beyond those of 'patients' (Calabria 2016).

The therapeutic value of institutional care emerged from reviewing a community publication on life at St Mary's psychiatric hospital produced by former residents and staff at Herefordshire MIND (1995). The dominant perspective that runs through most of the stories is the genuine warmth and the friendships that existed within the institution and St Mary's as a place of safety that felt like home. What emerges from the accounts of life at St Mary's is a sense of the care and companionship not only between residents but also between staff and residents. What stands out most are the themes of human relationships, safety and reciprocity between residents, as well as between residents and staff, including the wider social relations that existed within the institution, many of the residents expressed a sense of feeling understood in ways they did not by their families and extended networks outside the hospital (Calabria 2016).

Hospitals as Therapeutic Environments

The Mental Health Testimony Archive, a project developed in partnership with Mental Health Media in 1999, now part of MIND, holds fifty oral history video interviews with mental health service users, including the full transcripts. All of the oral history interviewers had experience of mental health problems and had first-hand knowledge of the psychiatric system. Interviewees include former long-stay patients who lived in the mental hospitals in the second half of the twentieth century in Britain. The audio-visual collection comprises extensive first-person accounts about everyday life in the large psychiatric institutions, including types of treatments and the experience of living on the wards. For the purpose of this review, I report excerpts from one interview with a former patient of Shenley mental hospital in Hertfordshire that offer a more nuanced understanding of what the mental hospitals could provide. Keith Shires experienced repeated hospitalisations from the 1960s onwards; for Keith ‘‘the old concept of asylum has a valid place”. He remembered the hospital as a stress-free environment partly due to having access to the countryside, which he felt “doesn’t exist in the modern hospital”. Keith expressed the value of structured routine in mental hospitals as helpful for recovery:

> Their philosophy of pushing people into some structure had a practical value, it wasn’t bullying people, and it was gently urging them back into some form of routine, because if you didn’t have the routine then the problems in the mind could take place.

Keith had memories of some staff bullying patients, however he extolled the value of care he received in the mental hospital compared to his experiences of care in acute units. Keith felt more accepted by the community surrounding the hospital than he did back in his hometown: “you could walk to the village, and there was no problems in the pub, you were accepted by the villagers”. He felt that the occupational therapy offered in the new acute units “isn’t quite as sophisticated as it was all those years ago”. A recurring theme in his life story interview is the ability to exert control over his life by choosing the rehabilitation activities and mixing with the local village community while receiving care in the mental hospital, putting emphasis on the local community’s tolerance that he found was lacking when he returned home, where he faced social stigma and exclusion (Mental Health Testimony Archive 1999).

An oral history publication of former staff from Littlemore Mental Hospital, Oxfordshire, provides a complex picture of institutional care practices (Goddard 1996). The hospital regime continued to uphold a strict hierarchy between different occupations throughout the 1960s and the work of the nurses was highly routinized, revolving around strict routines; there was evidence of a humanist philosophy in the care practices from 1920s onwards. T S Good (1906-1936), a progressive superintendent, introduced the reduction of sedative drugs and seclusion and open-door policy. Following the 1959 Act, staff recalled a particular incident in which Mandelbrote, last superintendent (1959-1974), ordered that all patients that had been certified for many years to be reclassified as voluntary and all wards to be unlocked. Although some hospitals carried out the process of desegregation gradually, staff at Littlemore recalled a dramatic reduction of long-stay patients in the 1960s, reporting 600 patients were reorganised and arrangements to move out made in a single day. From then on, staff remembered the hospital as being organised by treatment rather than classification and group therapy being introduced in the admissions wards (Goddard 1996).

Hospitals as Places of Belonging

Research conducted by geographers on the meanings of psychiatric asylum spaces has found mental hospitals to be meaningful social spaces that go beyond the reductionist claims of institutional care solely based on medical interventions and social control. Cornish carried out qualitative interviews with staff and some local residents at St Lawrence mental hospital, Bodmin, Cornwall, in the late 1990s to analyse the effects of deinstitutionalisation during the run down of the hospital in preparation for its eventual closure in 2002. Staff reported the fragmentation of staff relationships due to the extreme apprehension and loss of morale brought about by the uncertainty caused by the lack of clarity and transparency about the closure programme from hospital management. Staff felt the hospital had provided a home-like environment and a place of belonging for many, including a place of refuge and safety. Staff and local residents felt a definite sense of nostalgia about the social life of the hospital that benefited patients and reported the inherent fragmentation or staff-patient relationships as a result of the rundown of the hospital, recalling witnessing neglect and isolation of patients that had been moved out in the community (Cornish 1997). The social fabric of the hospital communities, made up by numerous groups such as staff, patients and residents from nearby villages was bound up with their localities and loaded with significance that goes far beyond the dominant narrative of mental hospitals as psychiatric treatment spaces (Parr and Philo 1996), putting into question the notion of mental hospitals as isolated and closed institutions as portrayed in the literature of dysfunction (Goffman 1961, Scull 1979).

Parr and Philo (2003) reconstructed the meanings attached to Craig Dunain Hospital, Scotland, primarily through interviews with ex-patients and some staff between 2001 and 2002, shortly after the hospital closed in 2000. The narratives reveal a much more complex picture of 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. Gesler described the concept of therapeutic landscape to denote environments that have the capacity to physically, mentally and spiritually heal (Gesler, 1993, p. 171). The remembered significance of the grounds for patients and staff provided a setting where social relations, mental ill health experiences and recovery unfolded and was imbued with discourses of nature as therapy, concluding that psychiatric asylum spaces ought to be seen as complex social geographies, endowed with symbolic and emotional meanings conjured by the everyday experiences of care practices therein. The external spaces of the mental hospital were not only significant in terms of the therapeutic value attached to the idea of having access to the natural environment, but also as a setting for engendering sympathetic staff-to-patient relationships. Ex-patients recounted the extensive grounds would be 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 particular internal and external spaces could be to aid recovery. These spaces, including the spacious grounds, contributed to a perception of a place of recovery and retreat. Interestingly, a report produced by the Highland users group in 1996 as considerations to be taken into account in the design of the new facility that was to replace the hospital as part of the policy of community care included patients and staff's views on the therapeutic value of the hospital's remote location and external spaces in engendering recovery (see Parr and Philo 2003, p. 344). These more positive readings were attributed to the emergence of debates contesting the national policy of deinstitutionalisation undergoing at the time.

The above evidence from first-hand accounts from patients and staff point to a much more fluid and permeable environment within the mental hospital than what the anti-institutional movement presented. Goffman's work marks an important ideological shift in providing a new perspective on institutions at the time of its publication. However, while there was a clear hierarchy of power, which extended throughout the social structure of the institution, social interaction involved much more than discipline and control. These institutions often served as surrogate families, refuges, hospitals and their environments were influenced by the social values and biases of the outside world. Goffman's work has been criticised for being heavily subjective and too much based on the notion of the abuse of power (Hide 2014). *Asylums* was already out of date by the time it was published and mental hospitals were experiencing a 'social turn' that were to challenge their totalitarian features (Weinstein 1994). A widely accepted criticism of his work is that it was based on an atypical asylum in the USA and not on a controlled study. As the evidence from the above review of personal accounts of giving and receiving care show, mental hospitals provided a dual system of care, both medical and social and that these could function both as a 'prisons' and as a sanctuaries (Dwyer 1987). The concept of 'total institutions' emphasises mainly a restrictive notion of institutionalisation as solely taking place in institutions, where patients are seen solely as the passive receivers of the treatment regime and have limited freedom and access to the outside world (Chow and Priebe 2013). More recently, Quirk and Lelliott found the 'permeable institutions' paint a more realistic picture of how care was given and received in modern 'bricks and mortar' psychiatric institutions (Quirk and Lelliott 2001). The review of primary and secondary sources above shows that not all long-stay patients are affected negatively by care provided within psychiatric institutions. Although the experience of being a patient in a mental hospital involved discipline and stigma mirroring being incarcerated in a prison, the admission could also be experienced as a time for rest, a place of respite and sanctuary (Chow and Priebe 2013, Calabria 2016).

Conclusion

One of the key concerns about the old long-stay hospitals was the tendency for patients to become institutionalised. Goffman (1961) highlighted the extent of institutionalisation within primarily psychiatric institutions, which were characterised by the loss of freedom and the social control of the patient that he likened to prison environments. However mental hospitals were not exclusively 'total' but could be more fluid and permeable environments than solely based on the notion of the abuse of power (Weinstein 1994, Gittins 1998, Quirk and Lelliott 2001, Hide 2014). In his study of institutions, Goffman ignored the relevance of state mental hospitals as health care systems (Jones and Fowles 1984, Jack 1998). Significantly, his work ignores the impact of the mental health reform movement including the therapeutic community in Britain on psychiatric institutional care (Hilton 2005, Fussinger 2011, Calabria et al. in press). Deinstitutionalisation was already underway when Goffman's seminal work was published; mental hospitals were experiencing changes that significantly improved their totalising care practices. What is often overlooked in the history of mental healthcare is how the advent of post-war reforms, coupled with the rise of the pharmacological age, gave impetus to the rise of the 'traditional recovery model'. The model was based on a community-oriented psychiatry that adopted a social model of psychiatry. It played an important role in shaping early care in the community policies and the introduction of therapeutic community principles in the inpatient care practices (Jones 1993, Weinstein 1994, Fussinger 2011, Crossley 2006, Winship 2016). This social turn in psychiatry had a significant effect in ameliorating care provided at Mapperley in Nottingham and other hospitals that adopted progressive reforms (Ramon 1985, Busfield 1997, Fussinger 2011).

The literature of dysfunction exposed the totalising features of care in the institutions and helped to influence a turn against hospital care and the eventual closure of the mental hospitals with the move to community-based services. However, closing the mental hospitals was largely based on a mistaken assumption that people with long-term mental health needs could just help themselves. The over emphasis on the total features of hospital environment had the effect of overlooking the support structures within the internal and external spaces within the mental hospital for vulnerable individuals in need of care. It has meant that research on the therapeutic value of the mental hospitals has not been the focus of research. The recent shift of priority within the survivor movement and their allies towards a defence of mental health services and disability benefits in the age of austerity suggests the importance of having access to a place of safety where caring for oneself is no option (Cresswell and Spandler 2009, Taylor 2015, Moth et al. 2015, Beresford 2016, Moth et al. 2016, Thomas 2016, Spandler 2016, Hutchinson 2016).

As the patients and staff oral histories of mental hospital reported in this chapter show, social relations and interactions that pervaded the way of life in the mental hospital played a critical role in the provision of care for residents. The environment of the institution offered a place of refuge and a sense of belonging for many. The peer-to-peer reciprocity and relationships between residents and staff and the extended social networks that existed within contributed to a sense of feeling safe, understood and accepted. These insights into the value of relationships between service users and staff and peer-to-peer friendships and between the extended social networks provide a novel dimension to improving ways of providing mental health care in a post ‘care in the community’ environment.

Jack, Jones and Fowles (1984, 1988) offer a robust explanation for the likely reason for the neglect of research into mental hospitals as therapeutic environments, identified by Moon et al. (2016) to be a consequence of the ‘conventional wisdom’ of the depersonalising and dehumanising effects of institutional care. The oversimplification of the mental hospital environment as places solely designed for the purpose of social control ignores the complex interconnections between the illness experience, the social relations and care practices therein. I would argue that the complex web of social relations within the hospitals could facilitate certain forms of informal sociability among the groups that occupied it. The everyday social interactions within, viewed through the use of internal and external spaces, could act as a therapeutic landscape; it seems that the lunacy reformers' ideal of producing a recovery-like environment through structured rehabilitation and access to nature within the asylum environment held significant value for patients and staff alike throughout the twentieth century. What the narratives of the social groups that occupied the mental hospitals suggest is the hospital to be much more than just a place of containment and medical treatment but also a fluid and permeable environment; it points to the value of patients and staff's experiences in understanding the old mental hospitals as places of health care systems and as communities of belonging (Prior 1995, Goddard 1996, Cornish, 1997, Parr and Philo 2003, Davies 2001, Gittins, 1998, Craze 2014, Calabria 2016, Calabria et al. in press).

Overall, Goffman's theory of 'total institutions' helps to understand how power operates in institutions and tells us little about the everyday care practices beyond social control, such as the material and immaterial care practices that could be helpful in recovery. The assumption that systems take precedence over individuals through the imposition of rigid routines is put into question by evidence of positive aspects of care within psychiatric hospitals from published and unpublished oral histories reported here as well as the efforts made by progressive psychiatrists to ameliorate care practices within psychiatric institutions, such as the introduction of therapeutic community principles in the form of group therapy in admission wards. The hospitals could operate as places of social control as well as therapeutic environments in which formal and informal care practices were significant in aiding recovery for patients. The internal and external spaces must be taken into consideration as part of the spatial experiences of giving and receiving care. The importance of structured occupation and access to the grounds and the outside sporting areas held special significance for both patients and staff in the provision of care and played an important role in recovery. Hence the claim that past models of care have no value is debatable; it provides evidence for supporting the preservation of residential care as an essential aspect of people's rights as citizens to have choice within the provision of mental health care (Jack 1998).

There are limitations with the above review of published and unpublished qualitative data, such as the lack of understanding of the original researchers' positionality and access to the original interviews and transcripts (Thompson 2000, Bornat 2005, Bornat and Wilson 2008, Bornat et al. 2012). Bornat et al. 2012 have made calls for oral historians to revisit existing oral history archives in order to explore how the data may be reconceptualised in light of contemporary concerns. Ultimately, carrying out a national audit and a re-analysis of archived oral histories of life in British mental hospitals would merit consideration for future research to explore ways in which the data may be reconceptualised. The scarcity of first-hand accounts of people that gave and received care coupled with the dominant narrative of mental hospitals as ‘total’ has had the effect of erasing knowledge of the positive therapeutic elements of residential care in the now closed state mental hospitals in the UK and elsewhere. For these reasons, the therapeutic importance of care provided therein has scarcely been documented. Hence, the empirical research undertaken in this study is of timely importance.

Aims and Objectives of the Research

The purpose of this research was to document and preserve the experiences of giving and receiving care in the now closed mental hospitals in Nottinghamshire before these were lost. The main aim of the research was to explore what may have been lost through deinstitutionalisation and the modernisation of mental health services, where the relationships between staff and patients in acute and predominantly community-based services are typically short-term and tend to veer towards crisis management. The research objectives were as follows:

- To investigate the extent to which the mental hospitals were ‘total institutions’.
- To combine participatory action research with oral history for the collaborative construction of historical knowledge.
- To explore the value of relationships for individuals’ mental health (peer-to-peer, medical staff-to-patient and non-medical staff and others to patients).
- To explore the role of the therapeutic environment within inpatient care.

Chapter 3: Methodology

Introduction

This chapter outlines the underpinning epistemology of this study alongside the choice of research design, data collection and analysis strategies that were carried out. It further presents the ethical considerations that were taken into account in this research, the particular ethical issues that have arisen in relation to the methods employed, and the protocols that have been put in place. The main aim of my research was to co-construct a history of giving and receiving care with former patients and staff in the now closed psychiatric hospitals in Nottinghamshire. This historical account reflects their personal testimonies that would otherwise have remained hidden from the public discourse. The literature review I carried out indicated that the most appropriate method for my research was the application of two qualitative research approaches, namely participatory action research (PAR) and oral history, which are interpretative and grounded mainly in the lived experiences of individuals. I have weaved together these two approaches in an attempt to facilitate the active participation of research participants in the planning, the action and reflection of this research project. The objective has been to conduct a collaborative research project that involves working *with* participants instead of doing research *on* them. The choice of mixed methods has been influenced by the desire to reverse the marginalisation of stakeholders in mental health research, namely service users and professionals, whose voices, involvement and co-production have become increasingly important in the design and delivery of services (National Institute for Health Research 2012, Bailey 2012, Slade et al. 2017).

Participatory action research (PAR) was employed as the overall research design in order to foster the co-production of knowledge, between myself as researcher, and the stakeholders as research participants. It is a research approach that emphasises the active participation of research subjects, who usually occupy a passive role in traditional research. PAR methodology seeks to bring about change collaboratively and following iterative reflection; participants become active in all aspects of the research cycle (Kemmis and McTaggart 1982).

As a data collection method, oral history methodology was deemed the most appropriate as it is interpretative and grounded in the lived experiences of individuals; it is particularly suitable to bring to light the experiences of disenfranchised groups whose voices have been excluded from the public discourse and the historical record; oral history can help to uncover how ex-patients and staff experienced the closure of the now closed mental hospitals and the complex meanings of care practices therein. This research deals with an exploration of historical memory that does not rely on the history of psychiatric hospitals written from those in position of authority. The collection of participants' oral histories enabled the evaluation of the lived experiences that would have been otherwise unachievable through traditional documentary evidence, which often fails to uncover alternative forms of knowledge, such as the knowledge held by service users or carers; oral history holds the potential to balance the documentary evidence by giving those who are less socially powerful a central place in the creation of their own histories (Bornat 2010, Thompson 2017). Oral history as a method is intrinsically collaborative, in that 'authority is shared in the dialogical nature of the oral history interview by definition' (Frisch 2003, p. 113). The method allows for the emergence of participants' lives from their perspectives and the collaborative generation of knowledge between the researcher and the research participant (Thomson 2003, Hesse-Biber and Leavy 2010, Thompson 2017).

Underpinning Epistemology

The main interpretative paradigm that has informed the research is social constructivism; reality is viewed as socially constructed by the subjective experience of everyday life, the process by which meanings are created, negotiated, sustained and modified over time in order to understand lived experience from the perspective of those who lived it (Schwandt 2003). This paradigm views knowledge as socially constructed through interaction with others; it is particularly suitable for making sense of knowledge produced in qualitative research that focuses mainly on the lived experiences of individuals where the goal is to uncover the multiple realities based on subjective experiences (Denzin and Lincoln 2011). The experiences of staff and service users of the now closed mental hospital are viewed as socially constructed and influenced by the socio-political debates surrounding mental health care and the policy and practice debates surrounding mental ill health throughout history.

The epistemological assumptions outlined above oppose the positivistic approaches to knowledge production that assumes detachment on the part of researchers and lacks reflexivity. Social constructivism calls into question the notion that researchers are objectively representing an independent reality without bearing any weight on the process or the findings. The main critique of this position rests on too relativist view of the world in which the multiplicity of standpoints produced can each claim legitimacy, hence the relevance of the research may be questioned (Burr 2015). However, by heralding the social processes that produce knowledge and valuing the multiplicity of standpoints, social constructivism challenges conventional research that rests on cause and effect and considers the context that shapes individuals' lives.

Social constructivism is a particularly effective paradigm for making sense of knowledge produced through PAR and oral history, and the interactions between the researcher and the research participants as partners in the research project. Social constructionism aligns with both PAR and oral history as both methods hinge on socially constructed interactions; this PAR-led oral history research brings attention to the socially constructed realities of participants. In doing so, it regains power for participants through the process of becoming actively involved in the research; this in turn produces the conditions that can generate practical change for all involved (Lincoln 2001). The social constructivist approach combined with PAR to produce oral history narratives of life in the mental hospitals make a unique contribution to knowledge; this research approach produces multiple and shared realities about giving and receiving care in the hospital environment as told by those that lived it, discussed in the findings chapters of this thesis.

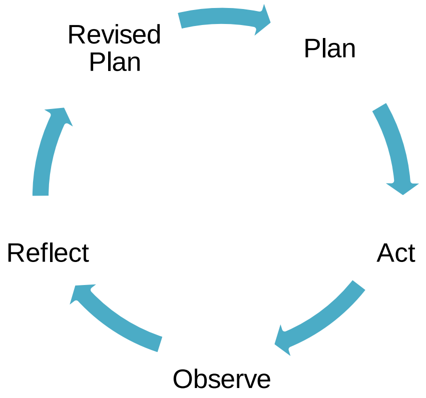
Overall Design

The overall research's theoretical framework has been informed by PAR. The main tenet of PAR is to bring about practical change through iterative and reflexive practice (Reason and Bradbury 2001). The method privileges the views of stakeholders, in the case of this research ex-patients and staff, and it is particularly useful in harnessing their own agency and knowledge by experience; it calls into question the validity of the knowledge produced by researchers as privileged to the knowledge produced by participants. The goal is to uncover different kinds of realities from those limited by conventional inquiry that privileges the knowledge of experts (Kemmis et al. 2014). PAR makes valuable theoretical and practical contributions when undertaking research with mental health service users and staff who have not traditionally been engaged in research and whose voices have been ignored in the history of psychiatry and mental health policy (Porter 1985, Campbell 1996, Nolan 2000, Carpenter 2015, McCrae and Nolan 2016). PAR is oriented towards social action by involving stakeholders who have the most to gain from the outcomes of the research, in order to bring about changes in knowledge, policy, and practice. With its emphasis on grassroots empowerment, it is particularly suitable for conducting research with marginalised communities. PAR differs from other research approaches as it seeks the active involvement of service users with the aim of improving health and social care and to reduce inequalities (Baum et al. 2006, Kemp et al. 2019). It is an applied and cyclical research process that invites all interested stakeholders, who have a vested interest in knowledge constructed about them, to produce action towards social change (Kemmis and McTaggart 1982, 2000). Within the PAR research cycle both researcher and the research participants stay partners throughout the process. This is achieved through stakeholders' authentic involvement and the exercise of personal agency in order to challenge the conventional imbalance of power in research (McTaggart 1991). It is part of a growing trend of action-oriented research in health and social care in the UK for its empowering and inclusive features such as the participatory research on the impact of the modernisation of mental health day services carried out with service users with enduring mental health problems (Bryant 2010, 2011); on self-harm carried out with female prison populations and research in secure estates (Ward and Bailey 2011, Ward et al. 2012, Ward and Bailey 2013).

The application of PAR as an overall framework allows for the experiences of otherwise invisible groups to be shared through active participation. The importance of harnessing the active involvement of mental health service users in research has been well recognised (Hui and Stickley 2007). It has become an important feature of the discussions and planning related to current approaches to prevention, care and treatment in mental health and fits in with the current health policy agendas that calls for the design of services in partnership with service users (Mental Health Taskforce 2016). Research that has actively involved stakeholders to reduce health inequalities has reported a range of positive benefits of participation, including increased confidence and social networks, and improved wellbeing (Bailey 2005, Ward et al. 2012, Bailey and Kerlin 2015).

PAR highlights the power imbalances inherent in traditional social research. Participants take up positions usually occupied by researchers outside of the participants' social realities. In this way PAR can be viewed as an alternative form of research practice that seeks to place participants in a position of influencing research findings and influencing policy (Kemmis et al. 2014). The table below illustrates the PAR research process.

Figure 1 – The Action Research Cycle (Kemmis and McTaggart, 1982)



Data Collection

Oral history methodology was used as a data collection method as it is particularly suitable to investigate how given populations experienced historical events (Hesse-Biber and Leavy 2010). Oral history is the recording of people's memories and past life experiences in the form of an audio or video recording (Thompson 2017). Oral history interviewing entails the researcher and participants spend extended time engaged in the process of storytelling and listening (Hesse-Biber and Leavy 2010). Crucially, oral history produces a unique source of history for future research in which the oral history interview becomes the primary instrument in researching the past (Perks and Thomson 2015, Thompson 2017). One of the main aims of this research is to not only make visible the hidden history of mental health services in Nottingham by collecting oral histories of service users and staff but the preservation of its legacy for posterity is one of the research's imperatives to ensure these testimonies are not lost.

Oral history relies on first person testimony and memory to arrive at a more comprehensive or different understanding of past events, experienced both individually and collectively. Oral history has often been associated with both grassroots and progressive politics, the democratic desire to amplify the voices of marginalised and oppressed groups, and of those forgotten by traditional documentary history (Yow 2014, Thompson 2017). What makes oral history different is that it allows a window into the realm of subjectivity and the emergence of a multiplicity of standpoints about particular experiences. Oral history methodology rests on the subjective meanings of events, the feelings, hopes, fears and metaphors about past experiences (Portelli 2015). Sensitivity to the meanings at different levels of the oral history narratives enables the identification of the significance of silences either as a form of control or agency (Passerini 1987, Freund 2013). Moreover, it can help to unravel the implications of individual and shared misremembering attributed to past events. It helps to identify the way individuals strive to create memories by linking personal experiences to public events in order to add meanings to and make sense of their lives. The unique value of oral history rests not so much in the accuracy of events but in the meanings ascribed to them and the purposes these serve (Portelli 2010, 2015). In the case of this study, oral history methodology allows for an exploration of staff and patients' experiences of care practices at the Nottingham mental hospitals through time and the significance they ascribe to these experiences in shaping their lives.

The use of oral history methodology opens up the possibility of being able to create alternative representations of the past through the collection of lived experiences of marginalised groups. The method has brought about a radical paradigm shift towards constructing knowledge not only from below but also to transform the 'content and purpose of history' making. It opens up new areas of inquiry into the everyday practices of ordinary people that challenge the traditional orthodoxy of knowledge making (Thompson 2017, 3-5). The study of people's narratives calls for interpretative and subjective approaches in that it rests on the view that individuals create meanings that form the basis of their everyday lives and they act according to these meanings to make sense of their social realities (Roberts 2002). Working with people's memories of past experiences puts into question positivist approaches to knowledge production in that the process of the telling enables the teller to be an agent in the making of their own history. The oral history interview is seen as retrospective meaning making in that it communicates the narrator's point of view, feelings and interpretations, and crucially actions are understood in the context of a life told (Plummer 2001, Bornat 2010, Yow 2014, Thompson 2017); the oral history method helps us understand a life in context, how individual agency plays out across societal structures; furthermore, narrators construct their meanings through the process of the telling, and stories, although constrained by social circumstances and resources, are enabled through the patterns that emerge (Hesse-Biber and Leavy 2010).

PAR with Oral History

PAR invites people who are traditionally seen as passive research subjects to actively contribute to the study by working in partnership with the researcher through the iterative research cycle (Kemmis and McTaggart 1982, Rolph 1999); oral history as a method of data collection is inherently participatory as it relies on the active collaboration of the participants in sharing their unique perspectives about a past event or experience in the context of the individual's life (Hesse-Biber and Leavy 2010, Thompson 2017). PAR and oral history are qualitative methods that are both based on subjectivities within which participants' knowledge is privileged; both methods rely on subjects cooperating and giving consent. Both methodologies put emphasis on developing mutual and reciprocal relationships with stakeholders in an attempt to democratise the research process (Hesse-Biber and Leavy 2010, Starecheski and Freund 2013, Kemmis and McTaggart 2014). However some key differences exist, whereas oral history is a collaborative endeavour between the researcher and the narrator through the dual process of recalling and revisiting past experiences (Perks and Thomson 2015, Thompson 2017), at the heart of PAR is a commitment to influence social change (Reason and Bradbury 2001). Oral historians' focus on archiving and open access can benefit PAR practitioners, as well as the critical examination of the complex dimensions of inter-subjectivity (Calabria and Bailey 2018). There are two broad ways of understanding inter-subjectivity in the field of oral history. Firstly, the relationship between the interviewer and the interviewee in the oral history encounter is viewed as a rich source of analysis, such as the effect of the interviewer's positionality on the interview (Chase 2007, Perks and Thomson 2015, Portelli 2015); secondly, oral history demands a critical engagement with the construction of the oral histories, which are not seen as unmediated and a transparent window into the past, but as rhetorical constructs (Portelli 1997, Joan 2013). Oral historians see that oral testimonies comprise both a source of autobiographical memory and a source about the nature of memory. Both autobiographical and social, oral histories are socially framed and embody references to personal and collective meanings of experiences. In this sense, an analysis of the oral histories must take into account how the social structure affects what is told and what is omitted, such as silences, omissions and fabulation; making sense of the constructed nature of memory and the purposes it serves becomes a crucial part of the data analysis (Portelli 2015, Thompson 2017).

Two research projects, combining oral history with participatory methods within health and social care, inspired my approach to this research, reported in a special issue of the Oral History Review on shared authority in oral history (Dunar 2003). Kerr (2003) developed the notion of shared authority in oral history to include collaborative analysis of homelessness in Cleveland, Ohio, USA, in order to impact policy. He cites the failure of academic research on homelessness to bring about any meaningful change for people living on the streets whose own knowledge of the structural causes of homeless are usually ignored in research about them. Kerr wanted to democratise the research project by extending Michael Frisch' notion of shared authority in oral history through the interview encounter, interpretation and presentation; Frisch envisaged the process of sharing authority in oral history to become a platform for movement building by divulging skills and knowledge to the disenfranchised in order to create more representative histories, from below (Frisch 1990). Kerr wanted to engender practical change for homeless people by including not only their own knowledge by experience but also harnessing their own agencies by including their own collective analysis of the persistent structural problems that continued to sustain homelessness in order to address common problems experienced by them. As a response to participants' demands, Kerr changed his research design to include not only participants' life histories but also their own analysis of the issues that perpetuate homelessness. The emergent interrelated themes included the inhumane shelter system and the rise of temporary work contracts, which engendered practical change; the homeless people involved, and other interested stakeholders formed an organising committee that successfully secured a ban on temping agencies entering the city's homeless emergency shelter (Kerr 2003).

Rickard (2003) applied a collaborative approach to her “Oral History of Prostitution” in the UK. The project ran from 1996 to 2000, taking a sex positive perspective on prostitution. Rickard worked as a maid in a sex work flat where she recorded the oral histories. She introduced collaboration in the oral history encounter by encouraging participants to shape the interviews as much as possible, which dictated the length and frequency of the recordings. She also shared the recordings and transcripts with them. Doing oral history in such an unconventional setting was only possible by Rickard's extensive involvement in a professional role with sex workers. She helped to facilitate practical change with the aid of the oral histories for educational and political purposes, her work led to a number of academic and educational outputs.

Situating the Researcher

Reflexivity in qualitative research driven by a social constructionist epistemology demands an understanding of the effects of the researcher’s positionality in the research. It entails an awareness of the way this inter-subjective element influences the process and the outcomes through the researcher’s assumptions and social position (Finlay 2003, Cassell and Symon 2004). There are three major ways in which the researcher’s positionality may affect the research: firstly, by helping to gain access to participants, as they may be more willing to share their life experience with someone who is sympathetic towards their life circumstances; secondly, the nature of the research and the researched is affected by the researcher’s position; thirdly, the researcher’s worldview and background shapes the lens of the research (Berger 2015). This section presents an initial exploration of my own social position in relation to the research, namely how my motivations, assumptions, values, gender, cultural background, personal experiences, biases, and political and ideological stances affect the process of interpretation of qualitative research, which I explored further elsewhere (Calabria 2019a).

I am an immigrant woman from Italy who has lived in the UK for over 20 years. A key aspect that bears on my identity is my involvement in the oral history movement in the UK, with which I have been actively involved through the Oral History Society for the past 12 years, encouraging the collection and preservation of oral histories of marginalised groups (Oral History Society). I identify strongly as an oral history practitioner committed to social justice, seeing myself as someone who helps to foster ‘memory work’ in communities whose stories have not yet become part of the mainstream historical record. I believe my identity as a community-based oral history practitioner enabled me to gain a certain degree of credibility with both mental health service users and staff who took part in this study. The main motivation for participants to take part was a strong desire to preserve the legacy of the local mental hospitals for future generations; I was able to facilitate this through a partnership I set up with a local archive to deposit the oral history collection resulting from this research project.

Another story I seldom told before I started this research project is that I have first-hand experience of mental illness in my immediate family, which in hindsight has had a direct bearing on my choice to undertake this research. Following the birth of my younger brother, my mother suffered from post-natal psychosis that became chronic. I have been a carer and an advocate for my mother by helping to amplify her voice in relation to the care she has been receiving from the mental health services in Italy. However, when I began this study into the memories of people who received and gave care in the Nottinghamshire psychiatric hospitals, I saw myself as an outsider as I have no personal experience of being a mental health service user and had never worked in the field of mental health. In addition, my mother was never hospitalised in the mental asylum. The asylums were abolished in Italy with the introduction of law 180 in 1978, dubbed Basaglia's law, ahead of all of the rest of Europe and the USA; the law prohibited admission to the asylum. The law was passed as a result of the anti-psychiatry movement spearheaded by psychiatrist Franco Basaglia (Foot 2015).

Through the process of establishing rapport and common ground with participants in this research, I found that most of the mental health service users who were interested in the research asked about whether I had experience of mental health services. Talking about my experiences of my mother's mental illness helped to build trust and common ground with research participants, a central aspect of both PAR (Kemmis et al. 2014) and the oral history encounter (Yow 2014, Hesse-Biber and Leavy 2011); both methods rest on building good working relationships to bring about the authentic engagement between researchers and participants. Moreover, through the process of opening up about my experiences of my mother's mental ill health, I experienced a shift in my own positionality within the research from outsider to insider. I critically engage with the impact and implications of my shifting sense of positionality in the final chapter entitled 'Reflections on Methods'.

Ethical Considerations

There were a number of ethical considerations taken into account to conduct this PAR-led oral history research for which relevant protocols were developed. These steps relate not only to the iterative and reflective cycles of PAR, namely the planning, acting, observing, and reflection but also to the initial steps involved in setting up partnerships with individuals in community settings that create both opportunities and challenges, seldom described in the PAR literature. Participation is a major component of PAR, which raises a number of ethical dilemmas, namely the importance of gaining consent, confidentiality and anonymity and protecting individuals from harm (Kemmis et al. 2014). Moreover, a major aspect of the oral history interview is protecting the rights and welfare of the research participants, which poses unique ethical and legal challenges (Yow 1995 and 2014, Thompson 2017), discussed below.

Consent

I undertook a number of steps to address these ethical dilemmas before commencing the fieldwork. I gained ethical approval from the University Ethics committee; as part of the process, I underwent a disclosure and barring service check since the research entails engaging with vulnerable subjects unsupervised. The first step was to gain consent to use the data, informing participants about the purpose of the project, how data would be used, their right to withdraw, and their options to remain anonymous. I prepared a project information leaflet to ensure that participants received adequate information that would enable them to make an informed choice about whether or not to participate (appendix 2). This leaflet explains the purpose of the research; it gives information about myself as the researcher and what participation entailed. Participants were given a range of participation options to share their memories of their time in the mental hospitals, namely through focus groups, one-to-one oral history interviews, group reminiscence, life writing and drawing. It further addressed the future use of data, such as the inclusion of quotations in published material and the right to anonymity. To ensure participants could raise possible concerns without necessarily having to rely on the researcher, details of the main supervisor were given.

Participants were asked to sign a Clearance, Consent Deposit Agreement form to indicate their willingness to participate in the project, even if they opted out of the oral history interview. Participants were asked to confirm that the purpose of the project was explained to them, both verbally and in writing, and that they had the opportunity to ask questions about the research. They were asked for their agreement to take part in the study with the understanding that their participation was voluntary and were informed that they were free to withdraw without giving any reason and without any implications for their legal rights. Participants were asked if they were willing to take part in a one-to-one oral history interview and/or a group reminiscence event to share their memories of giving or receiving care in the mental hospitals (appendix 3). This form required agreement from participants to give their permission for the material to be used for future research, including publication and public display, emphasising that no personal information or memories would be used for research purposes unless consent was gained. All the information was explained face to face and in writing via the leaflet. This two-step process was found to be a good method as it ensured all participants could refer back to the written version of the project’s aims and objectives at any point during the research process and to ask questions of anything that may have been unclear during preliminary meetings. Participants were informed that the oral history interviews would be recorded in digital audio format, and about the uses of the audio recording and of the verbatim transcripts. Moreover, participants were informed that they would receive a copy of their own transcripts for review with the ability to make comments/changes such as additions or omissions.

Preservation and Accessibility

Oral historians view the oral history interview as a historical record and names of participants and biographical information are reported in publications to reflect the truthfulness of the accounts, unless participants request anonymity. Moreover, oral historians insist on the value of preserving the oral histories collected for the benefit of dissemination and future research; this recommendation is made across national and international organisations that promote best practise in oral history work (Oral History Society, International Oral History Association). In the same vein, I wanted to offer participants the option to preserve the legacy of the Nottingham mental hospitals by depositing their oral histories and any memorabilia in a public archive. To this end, I set up a partnership with the Local Studies and Archives in Nottingham to ensure the longevity and accessibility of the data. Very few oral history collections of life in the psychiatric hospitals from the point of view of nurses and patients exist as most psychiatric hospital histories have been written from the point of view of the medical consultants (Porter 1985, Gittins 1998, Borsay and Dale 2015, McCrae and Nolan 2016). The histories of people that worked or lived in the psychiatric hospitals in Nottinghamshire have never been formally recorded. I explained to potential participants that by depositing their oral history interviews and any memorabilia in a public archive, they would help preserve primary sources of history that would otherwise be lost. To date, all participants have opted to have their oral histories deposited in the local archive; the drive to preserve the heritage of the hospital for future generations was one of the main motivators for participants to take part. I designed a memorabilia consent form to enable participants to have their life documents added to the collection (appendix 4).

Confidentiality

To protect participants' confidentiality, information was given on access to data, handled primarily by myself as the researcher and also by my supervisors; reassurance was given as to the adherence of data protection principles (Data Protection Act 1998).

Participants were given the option to withdraw within one month from the start of their involvement. It was made explicit that no reason needed to be given and that no repercussions would occur as a result. Other possible risks in relation to participation were addressed, including maintaining confidentiality if learning about other participants' personal information through a group event. I recognised the possibility of participants experiencing psychological and emotional distress, as recounting past events can bring up painful memories (Yow 1995, 2014). To this end, participants were informed that they would be provided with information about support offered by appropriate organisations; for instance, MSRC offers psychotherapy sessions free of charge for people using mental health services. I identified the possibility that participants might reveal incidents of historical abuse during their time in the hospital or post-care in the community. Participants were informed that should such disclosures occur I would be obliged to pass on such information to the relevant agencies, however the situation did not occur.

General Data Protection Regulation

The General Data Protection Regulation (GDPR) came into effect in the UK on 23 May 2018 (GDPR 2016). It is a new regulation that replaces the UK Data Protection Act 1998 and aims to protect citizens from data and privacy breaches more effectively in order to provide stronger consumer protection. The regulation is particularly important in the context of oral history in that interviewees and any other living persons mentioned in oral history interviews have rights over their personal data, including the right to request access to this information, to modify it, and to request the cessation of its usage, including the right to be forgotten. Oral history interviews are exempt from GDPR requirements when the interviews are being deposited in a public archive in the public interest, which allows for the long-term retention of personal information in the long-term. However the exemption is overridden by 'Special Category Data', that is personal data that identifies living individuals that is likely to cause considerable distress and damage to those individuals; within the ten 'Special Category Data' stated under GDPR regulation, one is particularly relevant to the oral history material collected as part of this research, namely, medical or health related data about a third party discussed in an oral history interview. Under GDPR, it is a requirement to take steps to review potentially sensitive data to avoid breach of the new regulations and ensure duty of care has been taken with regards to participants.

The new regulation came in part way through my research project, after the collection of the oral history interviews was completed. I had to revisit how the data was being utilised in order to ensure compliance. To this end, I identified material within this collection that contain potentially sensitive data about third parties, namely two participants discussing the mental health diagnosis of their children and their experiences of mental health care. Due to the fact that it was not possible to contact the participants' children to gain agreement, I sought advice from Rob Perks, Director of the British Library National Life Stories Collection, (13 November 2018) who recommended embargoing the interviews until the children will be 100 years old. The information shared by the above-mentioned participants about their children's experiences of care in the community is relevant to this research which aimed to explore the impact of the changing dimension of the provision of care. Therefore, I have retained the information about the participants' children in this thesis and anonymised the two participants in order to protect their children's identities. I have sought the advice of Jane Bonnell, Research Data Management Officer at Nottingham Trent University (19 November 2018) who recommended the insertion of a data access statement. The statement is available at the end of this thesis.

Defamation

I recognised the potential to cause harm to the reputation of individuals through the gathering of former employees and patients' memories of their time at the hospital. Participants were informed of the risk of potential libel or defamation, which might result in the permanent removal of the information gathered (Defamation Act 1996). Access restrictions are particularly necessary when interviews reveal personal, confidential or defamatory content; although no specific case of defamation occurred in the interviews, a number of participants mentioned names of former staff and patients in their interviews, which were duly removed in the transcripts. However, it would be painstaking to remove every name mentioned in the audio recording, which would ultimately alter the flow of the interviews; I consulted with

Lynda Naylor, Archivist at the Nottingham Central Library (29 January 2019), who explained the archive does not have the capacity to manage restrictions of access to audio recordings. Therefore, in order to protect the identity of individuals mentioned by participants in the recording, for whom consent was not sought, only the transcripts from this study have been deposited in the archive.

Anonymity

Qualitative research of this kind deals with the most sensitive, intimate and innermost events in people's lives. I offered anonymity to participants, as it could persuade apprehensive potential participants of the safety of any information divulged. Participants were offered the option to remain anonymous in the transcript and likewise in the publication of any information relating to the stories they have shared unless they specifically agreed to share their personal details. They were given the choice of the audio recording, resulting from the one-to-one interview, to be destroyed at the end of the project. Two out of the twenty people who took part in the research requested anonymity and all agreed to have their oral history transcripts deposited. I made changes to the interview transcripts for the two participants in question by changing names, places and dates to ensure participants were not identifiable. As stated under the GDPR section, two more participants have been anonymised in this thesis to protect third parties from potential harm.

Legality and Ethics in Oral History

The ethics surrounding oral history share the same concerns as those relating to PAR. Researchers conducting oral history interviews have a duty of confidentiality, to protect participants from harm, to treat them with respect and courtesy. Moreover, researchers hold responsibility to inform them how the information gathered will be utilised. A major exception exists; oral history entails the recording of people's memories, using digital audio or video equipment, which encompasses the process of legality. In the UK copyright law governs who has the right to access and use the material; when an interview is recorded in either audio or video, two separate copyrights are created, both in the words spoken and in the recording itself (Copyright Designs and Patent Act 1988, Oral History Society). Interviewees own the copyright to their own spoken words, which cannot be used by third parties without their express permission. It is imperative to gain copyright releases from participants otherwise the content of the interview cannot technically be used. For this purpose, at each interview, I asked participants to assign copyright to myself so that I would be able to use the material for research purposes. Participants were asked to tick the appropriate box and to sign the consent form (appendix 3). The purpose of the assignment of copyright was explained to participants face-to-face and in the project information leaflet, namely that it enables the use of the material for research purposes, including parts of the recorded interviews and/or extracts from the transcripts to be used in publication and public presentation, such as academic conferences.

Under the same copyright law (1988), interviewees have the right to request specific exceptions in the use of the material, such as requesting anonymity and opting out of depositing the interview material in a public archive. Interviewees have the right to impose a closed period on the interviews, to limit their use such as refusing to have their interviews broadcast on the radio. In this research, participants were asked for their permission to use the material for research, publication and public presentation purposes only; I ensured that participants were fully aware of the implications of using the material in these ways. Gaining copyright clearance will give authority to the archive where the oral history transcripts have been deposited to make the material available for future research; the restrictions requested by participants have been added to the consent forms to ensure the archive is fully informed of participants' wishes.

Interview Locations

Participants were encouraged to choose the location for preliminary and subsequent meetings and the one-to-one interviews to suit their individual specific needs and preferences, following best practice in the field (Yow 2014, Thompson 2017). Former staff chose to meet in their homes and at times in local cafes, and all chose to be interviewed in their own homes. Former patients tended to prefer meeting and to be interviewed at Middle Street Resource centre (MSRC), a service user-led community centre, where they felt most comfortable, although some interviews were conducted in their homes.

Phases of Participatory Action Research

At the heart of PAR is the commitment to challenge the traditional location of power within research (Lincoln 2001). It is particularly important to involve participants in the decision making process; it is of equal importance to involve participants throughout the stages of the research as much as possible in order to ensure power is shared as equally as much possible between the researcher and the participants (Kemmis et al. 2014). Therefore, establishing collaborative relationships between potential research participants and myself as the principal researcher was crucial. I established a collaborative plan of action that has been iterative and reflective to allow for modifications in the research process as much as possible. Moreover, I set out to create ‘safe spaces’ to encourage stakeholders’ perspectives to emerge including the possibility to express critical opinions of the mental health system, in order to achieve genuine collaboration (Kemmis and McTaggart 2000, Reason and Bradbury 2001, Bergold 2012). I fostered open and inclusive communication and allowed for extensive engagement with individual participants to engage in the phases of the research process through several one-to-one encounters. The process of planning, data collection and analysis has been iterative, evolving through the active participation of participants in shaping the research as much as possible through the planning, action and reflection stages outlined below.

Initial Meetings

The initial iterative phase of PAR, focussing on planning, took place during phone calls and face-to-face meetings, to gauge potential interest in the research and to gather basic information about participants’ memories of their experiences in the hospital. I set up initial contacts with participants to fully explain the purpose and uses of the research. These initial meetings afforded opportunities for participants to ask questions about the research and about the researcher and to raise any possible concerns, including the need for any clarifications and for the researcher to determine the capacity for individuals to give informed consent. Participants were informed of the possibility to become further involved, by reviewing transcripts, contributing to field notes and giving feedback on the interpretation of their interview transcripts. I set out to build trust, rapport and common ground in order to establish equal relationships with participants and to facilitate the co-production of rich data (Kemmis et al. 2014). At this stage, I collected personal artefacts and ephemera; these ‘documents of life’ complemented the process of researching participants’ life experiences, not only as memory probes but also to unravel particular meanings of events and relationships embedded in the artefacts (Plummer 2001). These ‘off the tape’ encounters were particularly crucial in relegating control to stakeholders in that I was able to negotiate what individuals wanted to talk about; explore motivations for taking part and to ask participants to contribute to the research questions and project design. I gathered individuals’ perspectives on key themes and topics that formed their experiences in the hospital. Although participants were given the option of using different methods to participate, such as group reminiscence events, all participants opted for the one-to-one oral history interview. I made careful notes of initial telephone conversations and meetings with participants throughout the research process, including meetings when discussing the transcripts and feedback events. I kept a fieldwork diary to capture my own observations and reflect on the process of my own and participants’ participation.

The success of a PAR project largely depends on building and maintaining trust and commitment by everyone involved in the research project (Tolman and Brydon-Miller 2001). Moreover, preparation is key to producing rich data in any research context (Fujii 2017). To this end, I consciously made a concerted effort to get to know participants by spending extensive time with each individual not only for rapport building and establishing good working relationships but also to get basic information and understand their experiences in the context of their own lives, a crucial aspect of oral history (Yow 2015). I attended several social events run at Middle Street Resource Centre (MSRC) a local user-led community centre where I recruited most of the research participants who were ex-patients; I organised trips to visit former mental hospitals sites with former staff at their request; I attended a reunion of former staff from Mapperley hospital; I visited individual participants at their homes and in public spaces multiple times.

The Interview Negotiations

The second phase of PAR, based on the action element of the research, took place in the interview encounters by incorporating any new topics and themes that emerged from participants, providing a way of balancing the researcher’s power in setting the agenda. I encouraged stakeholders to include any new areas of inquiry and topics that were relevant to them in the context of the research (Yow 2014). For example, new subthemes emerged following the first two interviews with former patients, namely the exploration of the physical spaces and the time in which patients socialised, which helped shed light on how social interactions took place and the exploration of what former patients found helpful when receiving care in the mental hospitals.

Throughout the interviews, participants were encouraged to continuously reflect on the meanings of their experiences, a key technique in oral history interviewing (Yow 2014), by asking open-ended and reflective questions, while probing on the main themes of life in the mental hospitals (appendix 6). The iterative cycles of PAR took place through the dynamic, evolving exchange of questions and responses in the development of the interview (Thomson 2003). The process of adding new lines of inquiry offered by the participants affected the interview protocol and the content of the interviews. The shared endeavour produced in-depth interviews that revealed the subjective meanings of experiences; these included participants' feelings about their experiences of care practices in the mental hospital and their opinions of the care they gave or received in community care settings, and the ramifications of these experiences for mental health care provision. The technique has helped to understand the value of the mental hospital's environment through the context of each individual's life.

Follow-up Interviews

The need for follow-up interviews emerged as a means of engendering the active involvement and genuine collaboration between the research participants and myself as researcher by sharing control over decision making in the research process (McTaggart 1991, Baum et al. 2006). The follow-up interviews reflected the results of the initial PAR cycle of planning, action and reflection that led to revising the planning by taking into account the needs of participants and those of the researcher (Kemmis & McTaggart 1982). The follow-up interviews were agreed with participants on the basis of the following criteria; firstly, if the participant felt there were more memories to share and topics to explore at the natural end of the first interview; secondly, the follow-up interviews became a good opportunity for me to clarify and for research participants to reflect on meanings from memories and topics discussed in the initial interviews. Half of the participants were interviewed more than once, a third of participants were interviewed three times.

Transcript Review

As part of the PAR cycle of action and critical reflection, the individual oral history transcripts were shared with the participants from the outset, following the collaborative process of 'shared authority' in oral history, namely to encourage the collaborative interpretation of the oral history interview (Frisch 1990). The process enabled both myself as researcher and participants to ask questions and clarifications, to sound out my own initial interpretations and establish the need for further interviews, decided in collaboration with participants. At this stage of the research, I was able to gather participants' opinions and concerns and any omissions/additions to the transcript, a necessary step to prepare the material for deposit in a public archive.

Feedback Events

A further phase of action and reflection took place by sharing the results of the thematic analysis of the transcripts with participants. Ex-patients expressed a wish for the meeting to take place at the Middle Street Resource centre (MSRC), a user-led community centre. To this end, I organised two separate feedback events. The feedback meeting took place with retired staff at Nottingham Trent University. Each event lasted about 3 hours and both meetings were structured in exactly the same way. I used a PowerPoint presentation to present the broad themes that emerged from the thematic analysis of the interview transcripts; to ensure that everyone felt they could offer their feedback, I prepared handouts with the broad themes and feedback sheets to gather their views while also noting down individual responses during group discussions. This was followed by gathering participants' views on sharing the impact of their participation that I observed to date and collecting their views on their motivations for taking part and any other impact that emerged as a result of participation. The final activity focused on asking participants about their ideal mental health service by gathering the three most important elements of provision. The findings from the feedback events including the collective plan of dissemination that participants agreed on and the practical outcomes that I observed for stakeholders are discussed in the chapter 7 of this thesis entitled 'Reflections on Methods'. The ways in which participation took place throughout the five stages of the research is mapped out in Table 1 overleaf.

Table 1 – Mapping Participation across the Research Process

Stages of the Research	**Phases of Participation**
Initial meetings	*Planning and Action* Negotiations of level of involvement Contribution to the interview guide in terms of research questions/ topics of discussion Choice of medium in sharing memories Choice of location of fieldwork Negotiating public access to research materials
Initial semi-structured interviews	*Action and Critical Reflection* Negotiation of topics New lines of inquiry incorporated in the interviews
Follow-up interviews	*Action and Critical Reflection* Negotiating topics of discussion Clarifying and reflecting on meanings of experiences shared in the first and subsequent interviews
Transcripts returned to participants	*Individual Critical Reflection and Action* One to one discussion of findings, negotiation of content with participants
Group feedback meetings	*Group Critical Reflection and Planning* Sharing findings with participants Collecting feedback Group plan for dissemination of research findings and further actions

Stakeholders Identification, Selection and Sample

From the outset, I recognised the importance of the selection of a sample for participation. In order to derive a balanced understanding of the experiences of giving and receiving care, it was necessary to obtain a broad spectrum of input. I sought a variety of opinions and levels of allegiance by ensuring the sample included individuals at every level of the institution (Yow 2014, Thompson 2017). I identified three main categories of participants, namely ex-patients, clinical staff such as nurses and psychiatrists and non-clinical staff such as porters and others such as children of staff that lived on site who may have experienced more informal relationships with patients. This method of sampling ensured people across all levels of the mental hospital could share their intimate knowledge of care practices, ensuring those that are usually outside of the sphere of influence with regards to policy could take part.

Recruitment

When preparing a strategy for finding potential participants, I was alert to the issue of gatekeepers within the mental health profession who have struggled to acknowledge the points of view of service users (Rogers and Pilgrim 2001). To deal with the issue, I diversified the recruitment process by promoting the research through online, print and community talks and by adopting a snowballing approach. Firstly, I designed a research poster that I made available via my own website and in print (appendix 5); I promoted the research via existing online groups on social media such as the Nottingham Hospitals History group on Facebook which has just under 2000 followers. Posting online in various local history groups was particularly fruitful in attracting interest amongst former nurses that had worked in the local mental hospitals. Secondly, I distributed the research poster in various local community spaces such as local libraries and cafes.

Community Partnerships

I recognised that it would be difficult to access former patients of the mental hospital without knowing key community informants. To this end, I set up a partnership with the Middle Street Resource centre (MSRC), a service user-led organisation in Nottingham with a long history of co-production with mental health service users. With the help of the centre, I was able to achieve the aim of gaining access to and forming relationships with former patients of the local mental hospitals. The centre's manager kindly offered access to the centre’s meeting rooms free of charge to conduct meetings and record interviews. I further diversified the recruitment strategy by giving talks in the community in partnership with relevant groups and organisations in order to involve as many different individuals as possible. Talks included a special event in Nottingham, open to the public, entitled ‘Oral History and Health’ that I co-organised with the Oral History Society, the East Midlands Oral History Archive and Central Library in Nottingham. I gave a talk at the local Nottingham branch of Rethink Mental Illness, an organisation founded over 40 years ago to voice the needs and concerns of people with severe and enduring mental illness. I also gave a talk at the Nottingham ‘PubhD’, a monthly event where PhD students from any academic discipline explain their work to a non-academic audience in a pub, which attracted much interest from former staff of the local mental hospitals. However, I had to rely on networking and goodwill when recruiting former patients and non-clinical staff. Given the length of time that had elapsed since hospital closure I had to take a pragmatic approach to sampling, relying on a combination of opportunistic and snowball sampling.

Former Staff Sample

Over sixty former staff of the mental hospitals came forward with an interest in participating in the project. These were mostly former psychiatric nurses that started their career in the early 1970s. For participation, I selected former nurses based on length and breadth of experience and different areas of insight that they could offer in relation to the changing landscape of psychiatric nursing through career advancement. Seven nurses were interviewed, one psychiatric social worker, one psychiatrist and four non-clinical staff, the latter had an average of twenty years of service of employment in the mental hospitals. The son of a member of staff was interviewed who lived at the Mapperley hospital site in the 1940s and 50s. Table 2 below lists staff and others’ biographical details.

Table 2 – Details of Staff and Others

Name	Roles	Years of Service	Location
K2 (anonymised)	Nurse, Sister Nurse	1973-1995 1995-present	Mapperley hospital Local CMHT
Louise	Nurse, Sister	1978-1988	Saxondale hospital
Tryphena	Nurse	1958-1961, 1966	The Coppice hospital
Raymond	Nurse, Charge Nurse	1948-1993	Mapperley, San Francis, Highbury hospitals
Sean	Nurse Nurse, Charge Nurse,	1959-1967 1968-1979	Downshire hospital (Northern Ireland) Mapperley hospital
Andrew	Nurse, Charge Nurse, Manager	1968-1979	Mapperley hospital Queens Medical Centre
Mark	Nurse	1980-1984 1985-1990s	Saxondale hospital, Queens Medical Centre, Broomhill House
Richard	Psychiatrist	1978-1984 1985-1990s	Mapperley hospital Queens Medical Centre
Peter	Psychiatric social worker, Manager of the industrial unit	1982 1990s	Saxondale and Mapperley hospitals
Olive	Seamstress, Supervisor	1976-1988	Saxondale hospital
Linda	Hairdresser	1973-1995 1995-present	Mapperley hospital Wells Road centre, Highbury hospital
Craig	Grew up on site Porter Electrician	1959-1977 1977-1988 1988-present	Saxondale hospital Ibid Duncan Macmillan House
Roger	Grew up on site Porter Electrician	1962-1978 1982-1988 1988-present	Saxondale Ibid Duncan Macmillan House
J2 (anonymised)	Child of a former psychiatric doctor	1940s-50s	Mapperley hospital

Former Patients' Sample

Ten former patients were approached through the community partnerships, outlined above; six participated and four declined. Two of the former patients that declined participation had initially agreed to take part but later withdrew. One former patient felt uncomfortable articulating his memories while being formally interviewed with an audio recorder; the participant asked to write his memories instead in the form of a life story but later decided that it was too time consuming and opted out. The second participant that withdrew had spoken at length about her memories of the hospital over a number of telephone conversations, however she declined from being formally interviewed following a relapse. The remaining two participants, former long-stay patients, were approached via their carers who passed the message on saying they did not wish to participate. The overall sample consists of twenty participants, fourteen men and six women; in terms of ethnicity, seventeen participants were British white, one Irish male nurse and two former female nurses from the Caribbean. Despite the relatively small sample, most of the participants have been interviewed multiple times, producing rich data in the form of in-depth and reflective interviews. In total, thirty oral history interviews were conducted with an average length of 1.5 hours for each recording. Participants' memories of the Nottingham mental hospitals span the period from 1948 to 1994. Former patients' biographical details are listed below.

Table 3 – Details of Service Users

Name	Diagnosis	Periods of hospitalisation	Location
K1 (anonymised)	Depression changed to bipolar	1992, 6 months	Mapperley hospital
Karen	Depression	1991, 6 months	Mapperley hospital
Michael	Anxiety disorder	1968, 6 months	Saxondale hospital
J1 (anonymised)	Schizophrenia changed to bipolar	1971, 1976 (6 months) 1991	Saxondale hospital Queens Medical Centre
Rodney	Schizophrenia	1975, 5 months 1979, 3 months 1992, 3 months	Saxondale hospital Ibid Queens Medical Centre
Albert	Anxiety disorder	1971, 6 months 1981, 4 months 1991, 4 months	Mapperley hospital Ibid.; St Francis Queens Medical Centre

Data Gathering

Conducting the interviews

There are two main styles of interviewing in oral history, namely the structured and unstructured interview. The structured interview approach relies on pre-determined questions that are put to the interviewees; this closed-question method makes possible for comparability across other interviews and the data can be easily coded and processed. However, the high degree of standardisation impinges on the flexibility of the interviewer to attend to new areas of inquiry that could reveal essential information about the experiences being researched. In contrast, an unstructured interview does not follow a predetermined set of assumptions and allows for in-depth interviewing, a high level of flexibility and the pursuit of new lines of inquiry that may emerge in the interview. However, using open-ended questions throughout a set of interviews makes data comparison difficult as each narrative can take its own specific shape (Thompson 2017). Following a social constructionist approach, I opted for semi-structured interviews, allowing for open questions to guide the process while having a set of topics guiding the interview. The use of semi-structured interviews allowed to give primacy to the subjects that participants wanted to talk about while also covering a set of topics agreed with participants that related to the research project, without having to follow a particular order, thus ensuring the possibility of comparing data across all interviews (Yow 2014). As interviewer, I aimed to produce in-depth interviews; the method reveals the subjective meanings embodied in the images and symbols narrators use to express feelings about their experiences and simultaneously give them meaning. It is an important interview method to elicit ‘thick narrative descriptions’ that can bring to light the informal, unwritten rules of relating to others (Miller 2000, Yow 2014, Thompson 2017).

My interview style has been influenced by feminist oral history literature that calls for interviewing and interpretative practices to encourage empathy with narrators. This technique helps to examine questions that relate to subjectivity, memory, and emotion in the oral history interview. It calls for a more collaborative and interactive interview process that becomes key to unfolding the subjective elements that shape individuals’ perceptions of the past (Minister 1991, Gluck and Patai 1991). Ultimately, I had to remain flexible to the needs of the participants and follow what each wanted to talk about within the topic under research; this was achieved by subjugating my own agenda to the process of listening ‘in stereo’, namely by subordinating the research agenda to that of listening; this is an established feminist oral history technique that encourages narrators to speak in their own terms; it helps to counteract the power imbalance between interviewers and narrators in the interview encounter (Anderson and Jack 1991). Hence the focus on the interview was not merely on data gathering but also on the interactive, collaborative process during the interview as a key element in shaping individuals' perceptions of the past. I took care to be sensitive to topics initiated by the participants in an effort to encourage them to speak in their own terms and about the topics that felt most appropriate to them, asking follow-up and reflective questions (Hamilton 2008). This technique helped unravel the personal and collective meanings of care in the mental hospital. Like Kerr in his collaborative analysis of the structural and political causes of homelessness undertaken with stakeholders (Kerr 2003), I adopted a two-way process in the interviews. I took account the life history approach as well as the opinions and analysis of participants of the issues that affected them by harnessing their own analysis of the needs and issues that affect the provision of inpatient mental health care. The data produced has been rich and reflective; the average length of each interview is 1.5 hours, where participants narrated their own perspectives and memories in the form of anecdotes that in turn were guided by my probing on set themes or topics. The interview process was complemented with life documents including photographs, used as memory probes and to unravel particular meanings of events (Plummer 2001).

The Interview Guide

I designed a semi-structured interview guide that included the general topics and themes of the life story in the context of the research, an essential process in order to arrive at the social and historical context of the participants' lives (Miller 2000, Yow 2014, Thompson 2017). I identified the key themes of giving and receiving care in the mental hospitals through the review of existing published and unpublished oral history collections cited in my literature review, which informed the initial interview guide. The guide was not fixed but evolved according to what emerged in the initial encounters with participants and during the interviews. I originally intended to organise some focus groups with former patients and staff to explore themes. However, all participants opted for the actual one-to-one oral history interviews, preferring to work one-to-one with the researcher than in a group setting. The guide was used to inform the interview encounter. I designed slightly different interview guides for former patients and for staff, but the guides covered the same topics to ensure the interview material is comparable (appendix 6). The guides contain the following topics/potential lines of inquiry: where and when participants were born, their childhood, education and work if appropriate; life before entering the hospital either as a worker or patient; how, why and when they became involved with the hospitals either as a patient or a member of staff; the social organisation and every day interactions with patients, staff and others, descriptions of ward/hospital life, treatments, community and social activities; memories, feelings and opinions about the closure of the hospitals and experiences of care in the community. The interview guide was intended as ‘guide’ and thus did not limit the possibilities of new areas of inquiry. It developed in an iterative way as the interviews got underway and new lines of inquiry that emerged from participants were added through the process of initial and follow-up encounters.

Data Analysis

Interview Thematic Analysis

The research into the experiences of inpatient care in the mental hospitals is very much an emergent topic of research, which has only a small literature attached to it. This required an inductive approach that enables the development of an understanding of the data being analysed. I chose to carry out an inductive thematic analysis of the interview data, one of the most commonly used methods of analysis in qualitative research (Guest et al. 2011). The thematic analysis has been informed by grounded theory, namely a number of inductive and iterative procedures intended to help identify categories and concepts within the interview transcripts that are then associated with formal theoretical models (Corbin and Strauss 2008). Using inductive thematic analysis is particularly useful when seeking to gather the common meanings of a shared experience across a data set (Bornat 2006, Yow 2014). My approach has been two-fold; firstly, I have read and re-read the transcripts, and identified emergent ideas, patterns and themes and subthemes that emerged as a result of the oral history interviews that were gathered around the theme of experiencing life in the mental hospitals, giving and receiving care both formally and informally; these themes and subthemes were coded using *Nvivo*, a computer assisted qualitative data analysis tool. Secondly, I sounded out the interpretations of the themes with individual participants when discussing the interview transcripts one-to-one and group feedback meetings. I compared and reviewed emerging ideas and categories against the first-person accounts I collected in the contexts of each participant's lives. I searched for confirmations and contradictions relating to care practices in the mental hospital by identifying common occurrences as well as uniquely telling accounts (Miller 2000, Yow 2014, Thompson 2017). The analysis was data driven, namely I coded the data without trying to fit it into my own preconceptions or pre-existing framework while bearing in mind the exploratory research question on care practices (Braun and Clarke 2006). In essence, although I was loosely coding for the research aims, the process of coding and reducing the data into subthemes was data driven and a set of diverse codes emerged as a result.

Transcription

The nature of the research required the preparation of full verbatim transcripts of the interviews. A transcript is an accurate and verbatim rendering of the spoken word into typescript as a way of making the original source material more accessible. The preparation of verbatim transcriptions is extremely time consuming and requires great care and thoroughness (Yow 2014); I faced the daunting task of transcribing verbatim forty hours of recorded audio interviews. I adopted a system of creating partial summaries with time logs for information previously shared in one-to-one meetings, negotiating this process with participants, in order to return to the original location on the audio should the need arise in the future; otherwise the content of the interviews has been transcribed verbatim. This has saved me some time although the process has been time consuming and painstaking, it took around 270 hours to complete. I followed the standard transcription guidelines published by the British Library Life Story Archive (British Library 2011), and academic standards of transcription in the field of oral history (Yow 2014).

Computer Assisted Qualitative Data Analysis (CAQDAS)

I opted for computer assisted qualitative data analysis (CAQDAS) to help organise the large amount of data that the interviews produced. Data includes notes from the one-to-one telephone conversations and face-to-face meetings, oral history interview transcripts, my fieldwork research diary and the data that emerged from the feedback events. CAQDAS is a qualitative research approach used to interpret data through the identification and coding of themes, concepts and processes in order to build a theory; it is particularly suitable when using grounded theory (Wickham et al. 2005, Lewins and Silver 2009). I opted for *Nvivo*, a type of CAQDAS available at Nottingham Trent University to carry out the thematic analysis, retrieve the thematic codes and for the purpose of reducing the data. Its distinguishing features include managing and analysing textual source materials, providing text and coding queries and some conceptual maps to visualise data. There are many benefits for using *Nvivo*. It has reduced the amount of time I would have spent carrying out an inductive thematic analysis using manual steps such as copying and pasting text into tables, reducing the possibility of error. The ability to interrogate the data through software-assisted searches has considerably assisted my own process of reflection and the links between different types of data. I supported the process of coding and developing categories by writing memos in *Nvivo*, notes I kept throughout the process to keep track of developing ideas; a useful process for reflecting not only on the research data and the process of creating and allocating codes to transcript extracts but also to discuss the themes I identified with participants. Digital note taking has enabled to search across the notes and codes to compare concepts as they developed, an integral part of the overall analysis.

Conclusion

The PAR-led oral history approach in this research made it possible to examine the relationship between personal and collective experiences of living and working in the Nottinghamshire mental hospitals while harnessing the knowledge by experience of participants. Crucially, the method allows to problematise the dominant narrative of mental hospitals as outmoded and total institutions that tends to exclude the often-contradictory meanings of the hospitals both as places of social control and as health care systems that functioned as sanctuaries and places of respite, evidenced by existing oral histories (Calabria 2016). The methodological contributions to knowledge that the combined use of PAR and oral history brought to this research are discussed in the ‘reflections on methods’ chapter of this thesis.

Chapter 4: Aspects of Care as Social Control

Introduction

The next three chapters outline the findings from the inductive thematic analysis of the interviews, namely aspects of care perceived as social control by both patients and staff, relational care in the mental hospitals and ambivalent experiences of care in the community, which represent contested meanings of care practices therein. The theme and related subthemes that I identified are outlined at the start of each chapter in flowcharts (figures 2, 3 and 4). Each chapter presents a major theme and related subthemes, followed by a discussion of the findings. The presentation of the themes is organised to reflect the historical developments of inpatient care and policy, illustrating how institutional dynamics in the mental hospitals changed over time. This approach helps to understand the changing context in which participants experienced giving and receiving care from institutional to community care. The interviews cover a period of 50 years, from the post-war period to the closure of Saxondale hospital in 1988 and Mapperley hospital in 1995. The narratives include the experiences of deinstitutionalisation and of giving and receiving care in the early years of community care up to current times. Former staff recalled their experiences of major policy changes, including the reorganisation of the hospital structure, the introduction of social rehabilitation from the 1950s and early care in the community from the 1960s onwards. Staff and patients recalled their experiences of hospital closure, including care practices in community care settings, such as the new acute and inpatient long-term units set up during the development of community care services. Participants filtered their memories of their time at the mental hospital through their experiences of community care and their current concerns, often reflecting on the value of the hospital environment in light of the short-comings of care in the community they experienced or witnessed. Former patients, most of whom are still users of mental health services, framed their narratives around their concerns for their overall health, both their mental wellbeing and physical health in old age; the average age of participants is 65 years old; their narratives were coloured by the structural inequalities they share in common, namely chronic unemployment, abject isolation, and social stigma. Retired nurses framed their narratives around their career development and achievements and the experiences of changes to care practices across time; retired non-clinical staff that worked at Saxondale framed their narratives around the hospitals as their home and around the social networks that existed therein; the son of a former psychiatric doctor from Mapperley hospital who grew up on site framed his narrative around his concerns for his son living in community who suffers from long-term severe mental health problems.

All participants discussed aspects of institutionalisation as a by-product of care within the mental hospitals in Nottinghamshire when recalling memories of their time either working or receiving care. Figure 2 below outlines the main findings in relation to aspects of care in the mental hospitals perceived as forms of social control. Former patients and staff recalled institutional practices by staff as a form of social control of patients. These included the regulation of daily living in the presence of large numbers of people and the consequent enforced lack of privacy, the gender divisions, the strict rules and routines that curtailed freedom, and the experiences of stigma suffered by both patients and staff, all aspects associated with the traditional critique of asylums as ‘total institutions’ (Goffman 1961). Social relations emerged as hierarchical through former staff’s anecdotes but also how these changed through time. All former nurses recalled the administration of psycho-somatic treatment such as electroconvulsive therapy (ECT) as the main form of treatment, which was viewed as generally effective. However, former patients experienced fear and adverse effects of receiving the treatment and the trauma of witnessing the effects on other patients. Some patients recalled being mistreated by staff, such as through the excessive use of force when being restrained. However, what emerged from ex-patients and staff’s oral histories was also the recognition that the institutional environment, with its structured routines and some restrictions of freedom could be helpful in mental health recovery. It calls into question the exclusively totalising effects of institutionalisation; mental hospitals could also provide a place of safety and recovery.

The hierarchical social relations that permeated the mental hospitals could be helpful in protecting Caribbean nurses, who came to work for the NHS as part of the UK Government’s recruitment drive from 1950s onwards, from being discriminated against by other nurses. Another surprising finding emerged from the interviews, namely some of the former nurses who trained as general nurses found the mental hospital hierarchy much more relaxed and preferable to work in than that of the general hospital.

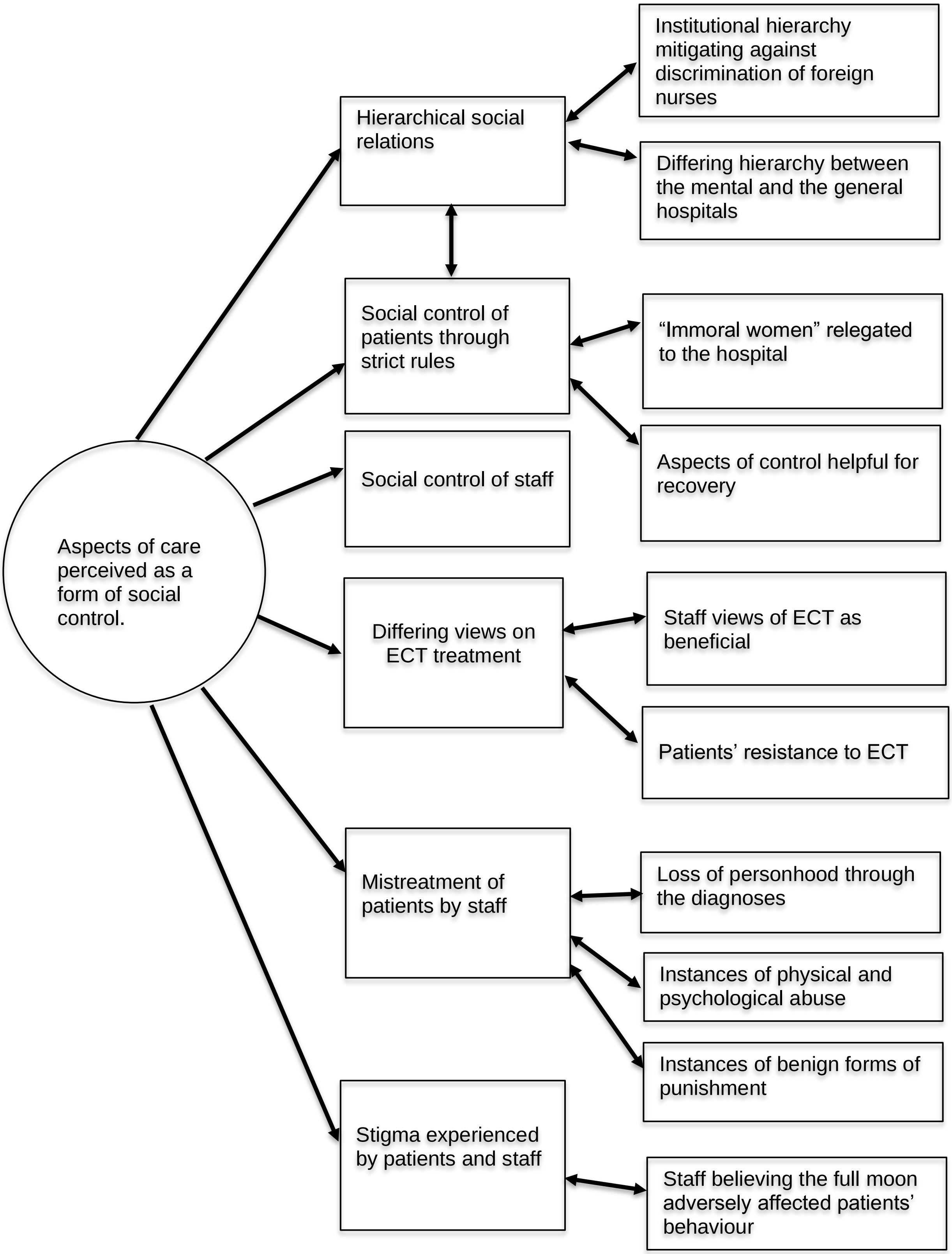


Figure 2 – Flowchart of the main theme and related subthemes of social control

Hierarchical Social Relations

Former staff's oral histories provide rich anecdotes that illustrate the social dynamics between the different groups within the hierarchy of the Nottingham mental hospitals. The hierarchical structure resembled that of other mental hospitals reported in the literature (Ramon 1985, Jones 1993, Busfield 1997). There was a consensus across staff's narratives that a strict hierarchical structure was in place across both the female and male side of the hospitals in Nottinghamshire, the chief male as head nurse on the male side, the matron on the female side who respectively ran all the wards. At the top of the hierarchy was the medical superintendent who was in charge of the hospital, until this role was abolished in 1971 and replaced by hospital management committees. Some authoritarian attitudes recalled in the interviews included doctors' ward rounds up to the end of the 1950s where patients had to stand by their beds, reminiscent to a military camp and the female side run on the lines of a Victorian family with female patients being closely watched to avoid sexual contact with male patients, reported in the literature (Gittins 1998, Busfield 1997, Hide 2014). Craig, former porter (1959-1987), referred to some of these staff attitudes as "a hangover from the old days"; he recalled the matron was authoritative and "used to slap some nurses into shape". Craig remarked on the ways in which the matron exercised authority, such as banning male staff from entering the female staff accommodation on the hospital site. A certain degree of deference was expected towards matrons and Charge nurses, such as porters serving them a cooked breakfast at the start of their shifts and delivering the newspaper to them at the start of each morning shift.

Craig offered clues to psychiatrists' attitudes towards nurses prior to 1960s. He recalled that one of the senior psychiatrists refused to speak to Craig's father, a nurse, as he felt affronted by Craig's father having bought himself a car:

> For a long while he didn't speak to my father because he got a car and "normal people don't have cars, only doctors have cars" and he meant it.

Former staff stressed that although the hierarchy was strict, it relaxed with the advent of social reforms, notably through the introduction of the open-door policy in 1952. Craig further remarked that prior to reforms from 1950s onwards, despite the strict hierarchy, playing sports acted as a means to break down barriers between the different staff groups within the hospital, remarking that 'on the football pitch they were all equal'. Craig was keen to emphasise that the hierarchy relaxed significantly in the 1970s as part of the shift in focus towards the social rehabilitation of patients:

> By the 70s I think things changed fundamentally and it was from patients to staff a lot more laid back as people got older and attitudes changed.

K2, a former nurse at Mapperley in the early 1970s, recalled that when she started her job at the hospital she had to call superiors by their role name instead of first names, a clue to the enforced nature of social relations:

> Unlike now, you call everybody in their first name, they always had to be addressed as “Sister”, and it was always “yes Sister, no Sister”.

K2 referred to the older generation of nurses she worked with in the 1970s as ‘custodial’ in their attitudes to providing care, which she saw as part of the old system:

> I can remember the ward Sister used to have a reputation of being quite scary, but as long as you did your work, you didn’t shy off anything, she was absolutely fine. She ran it like everything had to be right, so you’d conform to that, but she was quite a caring lady in the end, I think there were quite a few ward Sisters and Charge nurses like that when I was training.

Raymond, ex-nurse (1948-1993), remembered the hospital’s hierarchy in the 1950s was fairly accommodating to lower paid staff:

> Everyone was very friendly, although it was hierarchical everyone got on. There was a demarcation between staff and patients; the higher-grade staff was accommodating, there was a strong ethos of care.

The institutional hierarchy between staff was marked by the use of uniforms, which would differ according to ranks; doctors wore white coats, matrons wore black uniforms and caps and regular nurses wore white uniforms and caps. Most of the former nurses interviewed took pride in their uniforms, taking great care for its cleanliness and presentation. Getting free uniforms was seen as one of the perks of the job. Richard, psychiatrist at Mapperley (1978-1984), recalled that staff uniforms were phased out in the 1970s in order to facilitate better relationships with patients. However, he conceded that it was still important to be able to differentiate between staff and patients in the interest of providing care:

> The men wore white coats, it was a bit over the top I always felt, the nurses wore nurse dresses and it was being argued through discussions over time whether it was important that you could tell the nurses from the patients. I think in the end we concluded that it was right that the nurses should be able to be recognised if not by the clothes at least by a badge.

Richard’s reflections on the importance of removing distance between the patients and the medical staff suggest the relaxation of attitudes between staff and patients, signified by the removal of symbols of status; the abandonment of uniforms in psychiatric nursing became a common practice in the 1970s, understood to improve the hospital’s social environment as part of the introduction of the philosophy of normalisation in mental hospitals (McCrae and Nolan 2016). Nurses and psychiatrists have largely been depicted as custodians of psychiatric institutions in the early and mid-twentieth century, often likened to prison guards in the historiography of psychiatry (Goffman 1961, Glouberman 1990, Crossley 2006, Foot 2015). In her social study of life at Severrals mental hospital, Gittins found that the type of uniform reflected the relative power of the individual, likened to military official roles, such as the chief male nurse, played the role of 'military commander' on the male side (Gittins 1998). However, J1, former patient at Saxondale hospital, Nottinghamshire (1971, 1976), found that being able to differentiate staff from patients by uniforms helpful in time of crisis, which was something that was taken away by the time he was admitted to the Queens Medical Centre (QMC) acute unit in the 1990s after the closure of Saxondale:

> I didn't find the uniform at all threatening, I found them quite comforting, you knew who was who, the nurses used to be very recognisable both for female and male, you can't tell the difference between staff and patients these days.

The hospital's institutional hierarchy was reported to have often reflected class divisions, which were further expressed through eating and living arrangements. The superintendent had their own house built adjacent to the main hospital, a common practice in asylum architecture (Alexander 2008). Ranking affected the serving of food up to the 1960s; Raymond, former nurse at Mapperley hospital (1948-1993), remembered the food was served according to seniority:

> We had a dining room for the male staff, you had your half hour break for your lunch, you all had your allocated seat in the dining room, they'd bring in the joint, they'd put it down in front of the senior nurse, he'd carve it and you can imagine what you got if you were the last one in the line, I've seen dinners thrown at the wall from time to time, there were arguments.

The relaxation of hierarchical social relations in the hospital emerged in the oral history interviews with staff that worked at both Mapperley and Saxondale in the mid-1970s. Olive, a sewing room lady and later supervisor at Saxondale (1976-1988), recalled social relations among staff when she first started working were extremely rigid which she recalled easing with time:

> It was very Victorian when I went, you were not allowed to talk to each other. I didn't think I would last a week, you were watched every moment by the supervisor. In the end it was lovely place and I was reluctant to leave.

Former staff from Mapperley hospital who worked in mental hospitals in the early part of the twentieth century recalled social divisions operated not only across the staff hierarchy but also between patients and staff up to the early 1960s. The rigid separation between staff and patients was represented in an anecdote shared by Sean, a former nurse, who did his psychiatric nursing training in Downshire mental hospital, in County Durham Ireland, and subsequently worked there between 1959 and 1964. He recalled mixing with the patients was frowned upon:

> In the early years, because of this rigid setup you weren't allowed to eat or drink with the patients, staff weren't allowed to do that.

Moreover, Tryphena, a former nurse at the Coppice in the 1960s, expressed fear of contamination when mixing with psychiatric patients:

> If you worked in psychiatrics long enough, you become mad, I got out before I got really mad.

Gittins found that fear of contamination was widespread amongst staff at Severrals' hospital and operated through sub-divisions of the organisation of the hospital such as the strict separation of food and washing of clothes between staff and patients (Gittins 1998). Jodelet researched the practices of families in a French village taking in patients from a local mental hospital during deinstitutionalisation. Although the families lived in close proximity with ex-patients, they established similar boundaries to that of the mental hospital, such as the separation of meals, and the use of separate water and washing facilities, suggesting a similar fear of contamination that existed in the mental hospital; she concluded these practices served to deal with the threat of outsiders and to reinforce the families' sense of collective identity (Jodelet 1991). However, the practices of avoiding direct contact between patients and staff appear to have eased with the advent of the social turn in psychiatry in the Nottingham mental hospitals. Sean, former nurse who worked at Mapperley hospital between 1968 and 1979, recalled some of these attitudes, which he helped to change:

> Just after I started, we still had the chief male nurse at that time, we used to do rounds, I was sitting with the patients, the chief male nurse said to me, 'I don't mind you sitting with patients' he said 'But don't drink their tea' and I can remember being so flabbergasted that I couldn't answer him, but that changed.

Institutional Hierarchy Mitigating Against Foreign Staff Discrimination

A surprising aspect that emerged from the interviews with two Caribbean female nurses who took part in the research was the strict hierarchy that operated among staff could be helpful in protecting them from discrimination. The nursing crisis in Britain led to the widespread recruitment of foreign staff from abroad from 1950s onwards, including from the Caribbean islands, former British colonies (Nolan 2000, McCrae and Nolan 2016). Matrons and later nursing officers appeared to have protected Caribbean nurses from racial discrimination; Tryphena and Louise came to England from the Caribbean; they trained and worked as psychiatric nurses in the Nottingham mental hospitals from the 1950s onwards. They recalled being racially discriminated against by their fellow nurses through ridicule, social exclusion, being blamed for theft and being forced to work on undesirable shifts. Tryphena's application to work at Mapperley was rejected on the grounds of her race in 1957:

> The matron didn't accept me because I was black, and she put it down that Macmillan, the Head of the psychiatric hospital, wouldn't like black people to work there because mental patients might call them something, not true, because a year later he had two black men from Nigeria working at that hospital.

Tryphena was later recruited as a nurse at the Coppice hospital, Nottingham. In her interview she reflected on how she became aware of racism when she came to England: "I didn't know that I was black until I really came to England, that's when it sank in". She worried about working at the Coppice, she thought she would raise fears locally that more black people were coming to the area:

> I didn't want to see a black person going there and the white people looking at me and they might put it around that more blacks are coming to work because at that time there was only one black person working there.

She was subjected to unfavourable working conditions; she recalled that her white counterparts blamed black nurses for theft and were often given night, and bank holiday shifts. She recalled a few incidents in which she experienced prejudice and mocking, such as in the following anecdote:

> Another Christmas I went on duty and then you went through a little arch and you went over to the orchard, Sister [name removed] took the golliwogs off the marmalade and strung them up and put them over the kitchen door and that was my Christmas.

Caribbean staff were recruited directly from the Caribbean islands to work at Saxondale hospital as nurses, porters and domestics. Louise, former nurse (1978-1988) from the Caribbean, recalled the hospital's matron would come and meet them off the transport and that she was well liked amongst the Caribbean staff "because she cared for the foreign staff". For Louise, problems began when she was promoted to a management role as Sister of a ward at Saxondale:

> Management at Saxondale was pretty good, personally for myself there were areas that were difficult, because there were incidents. The experiences I had with some nurses and some of the staff is whenever you become part of the managerial structure there seems to suddenly be a problem.

According to Tryphena and Louise's memories, the hospital matrons and later nursing officers played a major role in protecting foreign workers in the workplace by diffusing conflicts and supporting their promotion. Louise published a collection of eleven oral histories of Caribbean women from the Windrush generation who came to work as nurses in Nottingham (Garvey 2010). The oral histories corroborate the experiences of discrimination faced by the Caribbean women that took part in this research project and the role of matrons in defusing the bullying and social exclusion that would arise as a result of racial abuse. Olive, a sewing room supervisor at Saxondale (1976-1988), remarked on societal attitudes towards Caribbean nationals at the time; She explained that making friends with 'coloured nurses' was frowned upon in the 1970s. However, she recalled many positive memories of Caribbean nurses:

> I got on very well with all the nurses, and I shouldn't say this but especially with the coloured nurses, they were really lovely, they did come to see me when I retired, I did private work and they used to come and have their bits and things done, they were very nice people.

All of the white nurses that were interviewed recalled working with nurses from other countries; however, none remembered any tensions based on race and ethnicity. Non-medical staff's memories of foreign nurses were more elaborate. Craig and Roger did not recall any racism at Saxondale and were keen to stress positive relationships with nurses coming from other countries. Roger, former electrician (1982-1988) who grew up on site, recalled:

> They fitted in very well, I don't remember any problems at all, and I certainly don't remember any racist stuff or anything like that.

Some of the young Caribbean nurses that Craig, former porter (1959-1987), knew had trained after the war with his mother; one Caribbean nurse had looked after Craig when he was a baby after his mother passed away. He was keen to emphasize that relationships with nurses from other countries were harmonious:

> Although it was a close-knit community, they just came to be with us and we got on, you'd have a welcoming party for a new bunch of nurses coming through from so and so and then they'd be the nurses who would put on the party and invite all the male staff who wanted to go, in a way they all blended in ok, because as a community, we weren't really that cut off because of that distance and rural settings you made up for it, you talked to people.

Sean, who came from Ireland to work as a psychiatric nurse at Mapperley hospital in 1960s, remembered women coming from Scotland and Ireland to train and work at the hospital. He acknowledged racist attitudes existed towards Irish people in the 1960s, but he personally did not experience discrimination and integrated well into the hospital community:

> I felt that I was welcomed, there wasn't any problems, in the 60s when in certain parts of England, particularly London I think there would have been a lot of anti-Irish feeling because of the Troubles, because of immigration in

> general, but I never experienced any, I quickly got involved in sporting things in the town and I was welcomed.

In her social study of Severrals hospital, Colchester, Gittins (1998) found that a system of differentiation, based on ethnic origins, existed in the nurses' dormitories; moreover, former staff and patients recalled foreign nurses tended to be given unfavorable working shifts such as night duty. However, these divisions began to be challenged from the 1960s onwards as a result of the impact of the major innovations such as the open-door policy, introduced to challenge outmoded practices within the hospital such as the restriction of movement. Hence Craig may not have encountered discriminatory practices prior to the introduction of reforms that were undertaken to improve the social environment at Saxondale hospital, discussed in the next chapter.

Differing Hierarchies between the Mental and the General Hospital

The professional standing of psychiatric nurses in mental hospitals in the latter half of the twentieth century was enhanced through the acquisition of technical skills by becoming a general nurse, which would ensure career progression (Nolan 2000, McCrae and Nolan 2016). Three of the nurses that took part in this research trained as general nurses during their careers as a step towards promotion, which led them all to become Charge nurses. When comparing the general hospital work environment to that of the mental hospital, they remembered that the hierarchy was much more rigid in the general hospitals than the mental hospital environment, and that the latter was a much more preferable place to work. Tryphena, working at the Coppice hospital in the 1950s, recounted:

> At the general hospital we all had different uniforms and different caps, if you went through that door and you saw me behind, black or not, and I was higher rank than you, and you didn't open the door for me, I could go and report you to matron, and that's how it was. At the Coppice if the matron invited me to her office, she would offer me a cup of tea.

K2 left Mapperley to train as a general nurse and returned to work at the hospital afterwards; she reflected on her experiences of the different hierarchies:

> If I thought mental health was hierarchical, general nursing certainly was, I can remember many a time I used to get told off because I used to go and sit on people's bed or on a chair at the side and talk to them and it looked like I was being idle but I wasn't, but you used to get told off, I didn't like lots of the staff there, they weren't as nice people as those from Mapperley.

Sean, former nurse at Mapperley in the 1960s noted that the hierarchy was much more relaxed in the mental hospitals when compared to the general hospital environment:

> Although I enjoyed my time in general nursing, it was still a very rigid set up, it was very much hierarchical, whereas psychiatric nursing was much more relaxed, and much more sharing of information and sharing responsibility and, because it was less rigid, you were able to make more of a contribution and to influence change, which was happening, there was a surge in the 60s, and that's when community psychiatry started coming in.

Sean referred to the impact of the introduction of community psychiatry practices in 1950s and early 1960s on relaxing the hospital hierarchy and improving interpersonal functioning of the patients within the hospital and the wider community that mirror reports in the literature (Macmillan 1956, 1958, 1963). The impact of the introduction of community psychiatry, influenced by therapeutic community principles, is discussed in the next chapter.

Social Control of Patients Through Strict Rules

The institutional practices within the mental hospitals often associated with social control emerged from participants' narratives such as the regimentation and strict regulation of daily activities, which could induce passivity and dependency in patients as reported in the literature of dysfunction (Barton 1959, Goffman 1961, Wing and Brown 1970), which in turn created a challenging environment for staff in providing personalised care. Peter was a social worker and manager of the industrial unit at Mapperley hospital in the 1980s. He documented aspects of institutional life that were still present, designed to control behaviour at the hospital before its closure using photography: the toilet paper rolls were chained to the side; photos from the industrial therapy unit showed the radio, the fridge and the used stamps box had padlocks on them and the doors to the toilet cubicles were designed to be very low to remove privacy. Moreover, some indignities of communal living were recounted in the oral history interviews. Mark trained as a mental health nurse and first worked at Saxondale hospital (1980-1984). He recalled his first impressions:

> It was so institutionalised, people sat at the same seat at the same table and they bolted their food down and then most of them went to bed.

He referred to the environment at Saxondale as "undignified", for the lack of privacy in patients' everyday lives, forced to live with everyone else, without personal space:

> The wards all had a large day room, the dining area and then you'd have your dormitories, and you'd have the bathrooms which were called down the backs, on some of the wards in the mornings, basically 20 men would be washing and shaving so it was pretty rowdy, fairly impersonal, not very humane, like barracks living, 10 sinks along the wall, shaving and washing and shouting.

Mark recalled some of the ways in which nurses would work towards counteracting some of the institutional aspects of care:

> The nurses just got on with it really, you had to, you'd do things properly, you'd do things personally, carefully, you'd chat, it's not just a production line, there was always time for that, I never held that you are too busy to be personal.

One of the institutional practices that emerged from the interviews was the removal of personal clothes for patients; Olive worked at Saxondale hospital sewing rooms (1976-1988), producing clothes for the hospital including name labels and repairs to patients' clothes and staff uniforms. She recalled that only some types of clothing were permitted at the hospital, women were not allowed bras and could only wear dresses. K2, nurse at Mapperley in the 1970s, remembered that patients' clothing would often get mixed up:

> You had communal pyjamas and they would all go off to the laundry and come back and there'd be different pyjamas every time. Everything had to have a label with their name in it, which is a bit institutionalised, sometimes they'd have their own clothes but probably wear other people's as well, things would get muddled up, I can remember on each shift you'd be washing all these pairs of tights out and hanging them up, they never got their own tights, it was just these are tights so everybody gets whatever, that's the way it was.

Another aspect of institutionalisation that emerged from the interviews was the strict routines imposed on the lives of patients that governed every aspect of life in the mental hospital, which could induce passivity and boredom, a hallmark of 'total institutions' (Goffman 1961). Rodney was hospitalised at Saxondale in 1975 following a psychotic breakdown. He remembered alleviating boredom at Saxondale with tobacco; he blames the hospital environment for his ongoing smoking addiction:

> Being involuntarily constrained in a confined environment and fighting boredom and tedium with tobacco which seems to be the normal run of things, they would issue tobacco if you couldn't obtain it yourself.

The autonomy of choosing to eat on your own was removed, which imposed passivity on patients who could only be served by staff off trolleys. K1, a patient at Mapperley in the 1990s, complained about the strict routines in which food was provided. Lunch would always be served at 11.30 am in the ward and patients had to make their food choices a week in advance:

> One thing I objected to was that lunch came out so early, I was just not ready to eat a cooked meal at half past 11 in the morning, you had to select your meals a week before, you had to decide what you would eat each day and it used to irritate me because I'm the sort of person who never plans meals, the staff used to come out and serve the food off the trolley, I hated that.

"Immoral" Women Relegated to the Hospital

Up until the mid-1960s Mapperley and Saxondale were still operating the policy of separating the genders between the male and the female side, which was connected by a long corridor; the only time male and female patients were permitted to mix was at the dances, occupational therapy and outside in the grounds. Most former staff and their children that grew up on site remembered some of the female patients sent to Mapperley and Saxondale hospitals for having had illegitimate children, a practice that continued until the 1950s. Craig, a former porter at Saxondale who grew up on site recalled:

> Some old ladies, way before the war, they had babies out of wedlock or for simple mindedness, when you saw them they were much like any little old lady whether it was the improvement of medicine that cured them or whether they never had a bad problem originally, I don't know.

Peter, a psychiatric social worker at Mapperley in the 1980s, expressed doubt whether the widespread stories of women transferred to live in mental hospitals for life for bearing illegitimate children was in fact a myth as he found no evidence during his time working at the hospital that this had been a widespread practice. When discussing these particular findings with Tryphena, former nurse at the Coppice hospital (1958-1961, 1966), she revealed an interesting memory that counters the above. In the early 1960s she was present at a consultation of a woman with one of the resident psychiatrists who had been sent by her husband to be assessed because she wanted a divorce. Tryphena recalled that the psychiatrist told the woman there was nothing wrong with her, and that she needed to find herself a good lawyer. Ultimately, the oral histories of former staff of the Nottingham hospitals confirm that the spatial division by gender affected the daily lives of people who worked and lived in psychiatric institutions, which reflected the ideas of the time in terms of gender, class and family in the literature (Gittins 1998, Hide 2014). Women could be sectioned by a member of the family or certified by a doctor for bearing illegitimate children. Psychiatrists admitted teenage girls who had illegitimate children until the 1950s. Married women who were suffering from post-natal psychosis were liable to lose their children (Gittins 1998). However, through the process of sounding out my interpretations with participants, I was able to verify that not all psychiatrists in Nottingham followed patriarchal and misogynistic practices against women at the hands of their guardians. It puts into question the validity of Goffman's notion of family members as informal agents of social control, in which he claimed that people close to patients would betray them by forcibly admitting them into hospitals against their will, discredited elsewhere in the literature (Scull 1986).

Aspects of Social Control Helpful for Recovery

Some ex-patients and staff recalled that the structured routine provided within the institutional environment could be helpful to recovery, a stark contrast to the features of total institutions, defined by Goffman by their sole purpose to be the control of patients, denying their function as healthcare systems. Staff and patients at both Saxondale and Mapperley recounted helpful aspects of control in institutional care. The structured routines including getting up at regular times and being served hot meals at regular intervals and restrictions to some freedoms could be helpful during crisis. J1, patient at Saxondale in the 1970s, recalled memories of meal times:

> It was very habitual, always dinner at half 7, 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.

He found the regular provision of food being served at regular intervals beneficial for his care during his recovery, a service no longer available in the new system of acute units in general hospitals as part of the current community care model. He explained the medication used to make him quite hungry, but he was not always able to feed himself, he found being served food at regular intervals helpful:

> There were regular times for the meals, the only time I've been in a more modern hospital at the QMC many years later, about the early 90s, no question of being served, and usually the way I was feeling, I didn't really feel like anything, it helped me being served because it was a little bit more like the sanctuary aspect of it I think, you were looked after then at Saxondale in the 70s.

Moreover, Craig (1959-1987), former porter at Saxondale who grew up on the site of the hospital, also remarked on the abundance of food available at Saxondale:

> Four sets of food per day plus we used to take out sundry items like every ward would have bread, every ward would have milk, tea, sugar, coffee and a couple of tins of biscuits a week and some other items, so if for either medical

> reasons or non-medical reasons they could make tea and toast and coffee and biscuits that was never a problem on the wards.

Similarly, Roger, a former porter and electrician at Saxondale who also grew up on site (1962-1988), recalled:

> We would deliver every meal in heated food trolleys from the kitchen, everything was freshly cooked, and marvellous diet actually and we would take it up to the ward, then left for the staff to serve up, yes so that was breakfast, lunch, dinner and supper, so that's four lots.

Albert, former patient at Mapperley and St Francis mental hospitals (1971, 1981, 1991), reported the food was very good during his hospitalisations and subsequent care he received frequenting the day hospital at Mapperley:

> The meals were fantastic, we had 3 meals per day; when I went to the day centre, I couldn't complain, I used to have breakfast there too, and lunch consisted of a 3-course hot meal and it was very good indeed.

Karen, ex-patient at Mapperley (1991), remarked on the choice of having extra food helpings during her recovery:

> You could get a sandwich or something in between meals if that's what you wanted; you'd get a drink whenever you wanted. I was hardly eating when I went in at all, but I did definitely pick up eating and drinking, if there was any food left you could have seconds.

The institutional nature of the mental hospitals in Nottinghamshire outlined above was one of the key determinants for their closure; psychiatric institutions were increasingly seen as problematic and outmoded as seclusion, regimentation and isolation were no longer considered as an effective mode of care, which in turn encouraged mistreatment (Beardshaw 1981, Martin 1984, Jones 1993). The practice of stripping patients of personal possessions such as clothes was one of the key determinants that started Barbara Robb's campaign to improve the conditions for elderly patients in mental hospitals, which led to official hospital inquiries (Robb 1967, Martin 1984, Hilton 2017). However, participants in this study recalled positive aspects of institutional care practices such as structured routine and access to food at regular intervals aiding recovery, a point not usually discussed in the literature, further explored in the next chapter.

Social Control of Staff

The interviews revealed that social control operated for staff in terms of the regulation of their lives up to the mid-1950s. This included the obligation to live on site and having to gain permission to marry and live off site. Raymond started working at Mapperley in 1948, when Duncan Macmillan, the hospital Superintendent, was still in charge of regulating the living arrangements of nurses:

> The condition of employment was to live in the hospital grounds for the first two years. Staff had to get permission from the medical superintendent to even marry, he had a gate keeper who vetted everybody who came in and out and you had to be in by ten o' clock at night if you were residential.

Social control operated in terms of gender classification on female staff too; women who would get married and have children were not encouraged to return to work in the 1950s; Sean worked as a psychiatric nurse for 55 years, he started his career at Downshire mental hospital, Northern Ireland (1959-1964), and moved to England to do general nursing training in 1964; he worked as a psychiatric nurse at Mapperley hospital (1968-1979) first as deputy charge nurse, then charge nurse and nursing officer. He remembered that they were often short of highly qualified people on female wards in the early years of his career:

> There weren't as many qualified female staff around because they would get married and have children and stay at home to look after families in those days, they didn't get back to work until the families were older.

A marriage bar for psychiatric nurses was in force until 1946 (Gittins 1998); however staff narratives suggest that it still operated in the 1950s although it is likely to have eased due to the psychiatric nursing crisis in the same period (Nolan 2000, McCrae and Nolan 2016). Social control of staff in public institutions was a product of societal values at the time, which was bound up with politics, gender and the long-standing affiliation to trade unionism by asylum attendants and later psychiatric nurses (Carpenter 2015, Long 2015).

Differing Views on ECT Treatment

The interviews with former nurses revealed the extent to which the medical model of psychiatry was part of the regime of the hospital throughout their working lives, which was rooted in the biological approach to mental ill health with its main focus on identifying and the removing symptoms. All former nurses recalled the main forms of treatment available were psychosomatic means of interventions, namely ‘physical treatments’. These included insulin shock treatment and electroconvulsive therapy (ECT); the insulin and ECT treatment units were built in the 1950s at the Nottingham hospitals (Nottingham Hospital Management Committee 1970). Administering psychosomatic treatments was part of psychiatric nurses’ jobs; most of the nurses interviewed gave detailed explanations of the administration of the physical treatments available at both hospitals, such as insulin shock therapy, designed to induce coma, and ECT, designed to trigger an epileptic seizure to relieve the symptoms of severe depression and schizophrenia. Former nurses recalled that patients were asked for their consent to have ECT; most of the staff maintained ECT helped the patients’ recovery and that it was widely administered over a period of forty years. However, patients’ views on receiving ECT were markedly different, fearing the treatment for its long-term adverse effects.

Staff Views of ECT Treatment as Beneficial

Raymond worked as a psychiatric nurse at Mapperley and Highbury Hospitals (1948-1993). He began working at Mapperley in 1948, when the main available treatment was containment. He recalled padded cells and straightjackets were still used to control patients’ behaviour but were phased out in 1950. Raymond remembered administering ECT without any muscle relaxants, which could cause fractures to patients’ bones; he also recalled the adverse effects of administering insulin therapy:

> The doctors were doing straight ECT, it was quite a nasty sort of treatment, it was the kind of last resort at times and deep insulin therapy was another one that was quite severe. I always remember the deep insulin unit, patients were being closely watched because they went into hypoglycaemia reactions and you had to take a wheelbarrow with you every time you went up to the cinema in case somebody collapsed, and you had to wheel them back to the ward.

K2, a nurse at Mapperley hospital in the 1970s, recalled that ECT was performed on the wards directly on patients’ beds. She explained how patients could resist the treatment through the consumption of food or drink:

> You are not supposed to eat and drink after a certain time before ECT, but I guess some people if they didn’t want ECT or they wanted a drink, you’d have

> to be really careful, you were on ECT duty, you had to monitor these people quite closely, so they didn't have a drink.

K2 felt that the ECT treatment was a barbaric practice before the advent of muscle relaxants that would prevent injuries to patients, although she felt the treatment could relieve symptoms for some:

> There were a couple of ladies, they used to call it maintenance ECT, every 6 months they'd have this ECT but they would just be put on a bed, the electrons put on and then the button pressed, they used to have quite a big fit and staff used to have to hold them down to prevent broken bones, that nearly made me leave because "oh my god this is horrible, this is barbaric, how can they do this to people?" But it did seem to sometimes help them, but it was not pleasant.

Sean, a nurse at Mapperley hospital (1968-1979), recalled the administration of ECT could be beneficial to long-stay patients with severe depression, although he acknowledged some of the dangers, mainly the patient becoming well enough to commit suicide:

> ECT worked on lots of cases, it did work particularly for very depressed patients, who had lost not only the will to live but they had become what we called stupor, they'd just sit and almost had to be physically moved, they lost all motivation and we used to do ECT, it gave them back that motivation. There were dangers because sometimes if a patient was very depressed and you make them a little better, they would have enough motivation to commit suicide, that did happen sometimes, it was one of the side effects of ECT.

Richard, psychiatrist at Mapperley (1978-1984), was critical of how ECT was being administered without muscle relaxants in a non-clinical environment:

> It was very basic and perhaps a dangerous way of doing it as we look back now because sometimes there would just be a nurse with a patient on the bed, me giving the anaesthetic and applying the electrodes, giving the fit and that was it. Nowadays you have a qualified anaesthetist who gives the anaesthetic, a doctor who gives the electrodes and several nurses and it is all done in a proper clinical environment, not on someone's bed, that was pretty crude.

Andrew, former nurse (1968-1979), recalled that severely depressed patients at risk of suicide benefited from ECT, although he conceded that it wasn't always the first choice of treatment:

> I think ECT would usually work very well for very severely depressed patients, we would always use a course of antidepressants first and then sometimes another course of a different type of antidepressant, if that didn't work then ECT may well be suggested. Sometimes it wasn't appropriate to give people a course of antidepressants because they were so severally ill that we knew from experience that their lives could be at risk and that it's not right to allow somebody to be so depressed for so long, knowing that there was a treatment that would work fairly quickly and effectively.

Patients' Resistance to ECT

Patients' views on ECT were markedly different from those of the nurses, namely fearing and loathing the treatment and its effects such as prolonged unconsciousness, the inability to breathe and its long-term adverse effects, including brain damage and memory loss. Michael was admitted for depression and paranoia at Saxondale hospital in 1968 when he was 28 years old. He recalled witnessing the effects of ECT on other patients as deeply troubling:

> Quite a lot of the chaps had ECT treatment and they used to be shepherded out to this room where they had it and when they came back, it was awful, they were all shaking and their eyes were red and they were all moaning, they used to come back and sit with us while they were brought back, I remember on one occasion three men came back and they just sat together, their teeth were chattering and they were shaking and it took them quite a few days to get over, that was terrible, so I'm glad I didn't have that.

K1, a patient at Mapperley in the 1990s, remembered being very fearful of the prospect of being given ECT after witnessing people losing consciousness following the treatment:

> When I'd been in there a few weeks and I was still not very well, I developed a fear of ECT and I'd seen people being taken off the wards for ECT and I saw them coming back on trolleys and in particular this friend who'd been in the next bed had a course of ECT, and when they brought her back, she disappeared into a side ward and wouldn't be compos mentis for a while. I was seriously worried about ECT, didn't want it, I had a word with my consultant, and she said "no, you are not having that, we are going to refer you to psychotherapy".

What emerged from the interviews with K1 was the recognition the role played by class in the provision of treatment and care as a marker for differential treatment. K1 built a friendship with one of the female patients on her ward; she felt her friend would have benefited from having access to psychotherapy, which she herself had been offered. However, when discussing the matter with the consultant psychiatrist, she was told that her friend would not respond to talking therapy because of her lack of education. Instead, her friend was prescribed regular ECT treatment. K1 noted people from the lower classes received different kinds of treatment at Mapperley; she strongly believed that her friend would have benefited from talking therapy:

> If ever somebody wanted someone to talk to, it was her, because I knew she came from a family where they didn't look after each other and talking would have been a darn good thing for her.

K1's friend has since developed Alzheimer's disease; K1 believes her friend was given too much ECT as a young woman, which damaged her brain. She concluded that the long-term effects of ECT did not necessarily justify its widespread use to reduce symptoms of mental ill health:

> I know a lot of people say at that time they gave ECT to people because they felt there's no alternative and they are saving a life, but I wonder what sort of life they are saving.

K1 recounted receiving preferential treatment on the basis of her middle class, such as being allowed to go back to the wards during the day, a privilege denied to working-class female patients on her ward:

> I was a southerner, most people were from South Nottinghamshire from a working-class background, my middle class posed a threat to others but also I believe I received preferential treatment as opposed to those that came from a working class background.

Richard, psychiatrist (1978-1984), confirmed that class was a determinant to accessing psychotherapy treatment and that it was generally believed that working class patients would not benefit from this form of treatment. Gittins' social history of life at Severrals' hospital between 1913-1997 (1998) does not discuss whether there was any evidence from the sixty oral history interviews conducted with patients and staff at Severrals hospital that ECT was administrated on the basis of social class. Psychotherapy is mostly absent from her discussion of available treatments. Interestingly a much higher proportion of women than men were administered ECT between 1948 and 1996 at Severrals (Gittins 1998, p. 199). Conversely, McCrae and Nolan reported cases of psychiatric nurses resisting the administration of ECT on patients not only for its suspected damaging long-term effects but also for its disproportionate use on female patients from low social status (McCrae and Nolan 2016).

Former nurses talked about the side effects of ECT in terms of the immediate effects of receiving an electroshock, which is in stark contrast to patients' experiences of receiving and witnessing the administration of ECT. Staff's consensus on ECT's alleged effectiveness of alleviating depression and preventing suicide in severely depressed patients contrasts to the psychological, social and physical damage that could significantly impair a person's quality of life highlighted by ex-patients. Although none of the nurses talked about the side effects and their impact on a person's quality of life, such as memory loss and brain damage, when asked about it after the interviews, most of the nurses were aware of the long-term side effects. It seems to suggest that staff took a medical approach to the administration of ECT; nurses' views of ECT suggest their subordination to consultant psychiatrists in accepting the dominant treatment mode within the mental hospitals, consistent with the literature that portrays psychiatric nurses as agents of psychiatrist doctors (Ramon 1985, Busfield 1997). However, as discussed above, there were cases in which psychiatric nurses resisted the administration of ECT on patients as a reaction against its long-term side effects and when used excessively as a form of social control (Gittins 1998, McCrae and Nolan 2016).

Mistreatment of Patients by Staff

One of the subthemes that I identified from memories of institutional life was instances of mistreatment experienced by patients at the hand of hospital staff. Some patients recalled being mistreated by staff through the loss of their personhood after being given a diagnosis. Some patients and staff recalled instances of physical abuse of patients through the excessive use of force when restraining patients, and some recalled psychological abuse in the form bullying patients by some staff, reflecting the findings from the literature on the hospital inquiries. However, only two participants, namely one patient and one staff, recalled instances of punishment, which were recalled in benign terms.

Loss of Personhood Through the Diagnoses

Two former patients recalled the degree in which patients were excluded from knowledge about decisions taken in relation to their treatments. The power imbalance between staff and patients was revealed in the experiences of two former patients who recounted the absolute authority of psychiatrists in their treatment. A former patient recalled being given the wrong diagnosis and treatment for his condition by a psychiatrist; J1 was hospitalised at Saxondale hospital in 1971 at the age of 17 and was re-admitted in 1976. The psychiatrist prescribed ECT against J1 and his family's will, which resulted in his family transferring him to another mental hospital in Lincoln. He described having ECT was like "waiting for the guillotine", which affected his short-term memory:

> I was tricked into getting ECT, I was given the wrong diagnosis of schizophrenia and I received the wrong treatment, which made me very ill.

He described his early experiences of the psychiatric system through his first encounter with the consultant psychiatrist at Saxondale in which he expressed the sense of betrayal he felt against the doctor who paid no attention to his needs; the psychiatrist told him he would never be able to hold down a job or have a family on the basis his initial diagnosis of schizophrenia. In addition, Rodney was hospitalised at Saxondale in 1975. He recalled that psychiatrists back then were never interested in the life history of the person, saying, "they weren't that bothered about the welfare or the future survival of their patients". He had a difficult relationship with the consultant psychiatrist that gave him his mental health diagnosis at Saxondale, who dismissed Rodney's personal struggles; for Rodney this was an expression of psychiatrists' biases and the absolute power they held in those days. He recalled his initial assessment during his hospitalisation at Saxondale:

> I had a kind of interrogation, "do you hear voices?" A straight answer was not good enough, I tried to elaborate, "yes I hear voices, I hear lots of voices but I don't remember anything they are saying to me" because actually that's what hallucinations are, and from a psychiatrist's point of view, what he's looking for is some tick boxes to indicate and confirm a diagnosis that he wants to make but he hasn't found out who I am, what I am and where I am coming from.

Instances of Physical and Psychological Abuse

Both J1 and Rodney experienced mistreatment by some of the staff in the form of bullying and the misuse of force while at Saxondale; J1 recalled:

> There was one nurse, he was a bit of a bully, he would make pointed comments sometimes like "If you don't behave yourself you'll end up in Rampton, you know what happens there", saying things like that to people, and I thought that was very nasty.

Some ex-staff recalled knowing uncaring staff who were "not good" at their job. Mark, ex-nurse at Saxondale in the 1980s, recounted there was some "bad staff':

> Sometimes attitudes to patients were dreadful, just lack of any warmth, there were definitely people who could talk in a sort of dismissive and condescending way.

Louise, former Saxondale nurse in the 1970s, maintained that management at Saxondale would deal with staff that behaved unkindly:

> You had all grades of staff that sometimes weren't as kind to the clients as they should have been but if any of that was observed, it was always reported, and it was sorted, they did not tolerate cruelty to patients.

J1 and Rodney remembered being manhandled with force. K2, a former psychiatric nurse at Mapperley and current mental health nurse, recalled there was no training on how to restrain patients in the 1970s, which could result in excessive use of force:

> There were difficult times if somebody was quite aggressive and wanted to hit people, harm themselves or harm others and obviously they had to be restrained, there are ways you have to do it now, there is a training called 'break away' that every staff member is supposed to go through every year, in those days you didn't get formal training.

Instances of Benign Forms of Punishment

None of the former staff and patients from Mapperley hospital recalled any forms of reward or punishment system. Instead, the subject of reward and punishment emerged in some of the interviews with staff and patients that had worked or received care at Saxondale hospital. This is concordant with Goffman's notion that discipline was attained through a system of rewards and punishments which led to social withdrawal and acceptance of the status quo within the institution (1961). However, patients and staff alike felt the forms of punishment used on unruly patients were fairly benign. Former staff were keen to stress they did not witness any ill treatment towards patients, in stark contrast with the experiences of some patients that took part in this research and the findings from the literature review on the hospital inquiries (Johnson 1957, Robb 1967, Beardshaw 1981, Martin 1984). Michael, a patient at Saxondale in 1968, recalled the greatest form of punishment was being sent to bed early "if you were playing up", stressing the hospital was a friendly place where he formed good relationships with staff. Craig grew up on site; both his parents worked at Saxondale as nurses. He worked as a porter at the hospital (1959-1987) and later as an electrician at Mapperley (1988-1995); he corroborated what Michael said regarding forms of punishment; He further described a system of punishment based on reducing access to monetary and food and drink allowances, reminiscent of the rituals of rewards and punishments outlined in Goffman's theory of total institutions (1961):

> The only punishment in them days was called dressing gown and pyjamas, if someone did something wrong on the male ward, I think it was restricted with how many cigarette allowance or money or cups of teas, that's above and beyond the normal meals they could have and gradually they'd earn it back.

Stigma experienced by Patients and Staff

The topic of stigma emerged across all interviews with reference to both patients and staff. Ex-patients recalled their experiences of stigma around becoming a mental patient, being hospitalised in a mental hospital and the stigma linked to a diagnosis. Despite being told that he would never get a job or have a family, J1 found a job in a local gym and subsequently married and has two children. He recalled being discriminated against by the hospital doctor that had originally assessed him at Saxondale after J1 secured a job in his local community:

> The same psychiatrist that had administered the ECT told the post office where I worked that I could not hold down a job, so I lost my position. He also

> told me that I wouldn't be able to hold down a relationship, but I have been happily married for 35 years and I have two children.

K1 recalled making the realisation on her first night at Mapperley hospital that "I had become one of them". Rodney was keen to stress that he is still has the diagnosis he was given in the 1970s, schizophrenia. He felt that "there's no escaping it, no way in and no way out" and that he was told there was no point in helping him because of his diagnosis of schizophrenia which was seen as non-treatable:

> There was a kind of unofficial policy where they did stand off from people with my condition and I knew nothing about my condition, I knew nothing about where they got this word schizophrenia from and when I look back, that is the most disgusting thing to happen to me.

The stigma was compounded by Rodney's family's response to his diagnosis, they were 'shocked and ashamed' that he had been admitted to the mental hospital:

> The stigma was very strong, no one ever asked how you found it there [Saxondale], it was taboo.

Rodney talked about how being a mental patient was linked to the loss of personhood:

> It was very rare that anybody would come back and actually say hello unless they were obligated to visit the ward, you could be further devalued by the length of time you stayed there, and it had a kind of abrasive effect on your spirit.

Michael felt deeply ashamed of his mental health breakdown:

> I didn't really want to know about it, I was ashamed of it really, I saw it as a weakness in my life, I let everybody down, I felt it was a failure, giving into the pressures.

Moreover, staff and their family members living on site shared the stigma with patients. Roger grew up and worked as an electrician on Saxondale hospital estate, his father was a nurse; they were given a tied house on site; he experienced stigma as a child:

> We were a small village, completely isolated, and of course slightly taboo because I remember friends at my school that weren't allowed to come to my house because we were at the nut house, as other people would call it.

Moreover, staff's attitudes to mental ill health could contribute to stigmatising patients. A recurring theme throughout the interviews conducted with former staff was a consensus that the full moon increased patients' 'madness'. Roger, a former porter turned electrician at Saxondale, remembered that during full moon, patients would regularly act out:

> When it was a full moon, it was crazy! You could set your watch by it, honestly you knew when there was a full moon, they'd be screaming and shouting and running up and down the corridors, there's something in it.

Craig recalled that his father, a former nurse, attributed patients' sudden burst of violence to the full moon:

> There is a lot to be said for the lunacy as in when there was a full moon, a lot of them would go off on one, you just knew they'd be mad as a hatter for two days.

Staff Believing the Full Moon Adversely Affected Patients

Tryphena, a nurse at the Coppice Hospital in the 1950s and 60s, recalled that staff would often attribute patients' bursts of violent behaviour to the full moon. However, she also believed that patients were not as mentally ill as patients in other hospitals due to the fact that the Coppice was a private institution, signifying the belief that 'madness' was linked to class:

> Because a lot of the patients that came to the Coppice, they had money, there wasn't so much madness.

Critical literature review of studies conducted in the US on the effects of the lunar cycle on people's moods concluded that there is no significant relationship between the cycles of the moon and human behaviour (Rotton and Kelly 1985, Kelly et al. 1996). This view was nonetheless prevalent in the eighteen century, linked to the theory that 'madness' was the result of an imbalance of the bodily humours, which were influenced by astrological events, including the lunar cycle (Porter 2002, McCrae 2011). It is surprising this collective belief remained widespread until the hospitals' closures. Staff who subsequently worked in acute units after the introduction of community care reported that the belief that the full moon adversely affects mental health service users to be widespread to this day among mental health staff (McCrae 2011).

The extracts above corroborate the research that has evidenced how mental health care workers have historically shared in the stigma of their patients; in her historical study of the role of mental healthcare workers in de-stigmatising mental illness in Britain in the period between 1870 and 1970, Long argued mental healthcare staff unintentionally reinforced the stigma associated with severe and long-term mental ill health (Long 2014). Long makes a compelling argument on how the representation of mental illness by mental health professionals was a by-product of professional aspirations, socio-economic motivations and the political context at the time. Together, these factors helped to generate discourses that perpetuated the stigma of mental ill health (Calabria 2017). Moreover, the oral history extracts above confirm the key role psychiatric doctors played in perpetuating negative and devaluing attitudes towards patients, discrimination and exclusion through their own practices, still a major issue facing psychiatric practice today (Stuart et al. 2011). The anecdotes relating to experiencing stigma that emerged in the oral histories illustrate the dominance of the medical model in psychiatric practice and impact on mental health patients, supporting the traditional critique of asylums as 'total institutions', in which the patients are seen as suffering from contingencies instead of mental ill health, where the imbalance of power between staff and patients leads to the mortification of the self, and a consequent loss of individuals' identity. In this context, the labelling process leads to the loss of self-identity, which is understood to create the illness (Barton 1959, Goffman 1961). Ex-patients' experiences of stigma from the label of the mental patient in relation his/her geographical surroundings is consistent with Goffman's theory of depersonalisation, leading to the loss of status and social distancing and the literature on the negative effects of psychiatric labelling on patients (Barton 1959, Brown 1985, Jones 1993). However, the experience of becoming a mental patient could also hold surprisingly positive connotations, discussed in the next chapter entitled 'Relational Care in the Mental Hospital'.

Conclusion

The themes outlined above resemble the general characteristics and common features of Goffman's total institutions (1961): the breakdown of barriers that exist in normal everyday life in terms of all life taking place not only in the same location but also under the same authority; daily activity carried out in the company of others and all were required to act alike and to follow the rules and tight schedules and regimentation, imposed from above. Goffman likened mental hospitals to prison environments; authority was exercised through the regulation of behaviour through clothes, food and routines. Goffman suggested that a privilege system operated in total institutions which provides a framework for personal reorganisation i.e. house rules, admission procedures etc.; the system of rewards and privileges in total institutions reflected in a world built around minor privileges that can lead to belonging. Goffman saw patients' adapting to the institutional environment by accepting the institution's privilege system as a way of making a home. For Goffman, breaking the rules would equal the suspension of privileges as a form of punishment, which is concordant with the oral histories of both staff and patients who gave and received care at Saxondale hospital in terms of patients being punished by removing some privileges due to misconduct. The dehumanising aspects of institutionalisation, such as communal clothing and the regimentation of daily activities that emerged from the oral history interviews, reflect the concerns of the anti-psychiatric and survivor movement around coercive psychiatric practices. They opposed the expert medical knowledge and that of labelling in favour of experts by experience (Rogers and Pilgrim 2001, Crossley 2006, Fussinger 2011). The misuse of power by doctors through forcing treatment and dismissal of patients' own views has been a common feature in the literature on psychiatric institutions (Johnson 1957, Robb 1967, Martin 1984, Ramon 1991). In addition, stigma affected both patients and staff, and staff's attitudes could further stigmatise patients, born out of the biopolitical context of the time, furthering the stigma of mental illness (Long 2014). Staff held a collective belief in the full moon adversely affecting mental patients, which contributed to stigmatising patients, even though studies have shown there is no correlation between the moon's cycles and psychiatric hospital admissions (McCrae 2011). Interestingly, most participants recalled the hierarchy within the hospital relaxed over time and the nurses who trained in general hospitals found the mental hospital a much more relaxed atmosphere that the former to work in; moreover, nurses who came to work from abroad recalled matrons and nursing officers would use their authority to protect them from being discriminated against and supported their promotion. In terms of the treatment regime, nurses held that ECT treatment was an effective treatment whereas ex-patients unanimously viewed it as a form of abuse for its long-term debilitating effects such as memory loss; some former patients remembered mistreatment and dehumanising attitudes of staff perceived to have been fuelled by their diagnosis, whereas most staff did not remember any specific abuse. The Caribbean nurses who took part in the study experienced racism at the Nottingham mental hospitals. However, their white counterparts did not recall witnessing any forms of personal, cultural or institutional racism.

The themes I identified reported in this chapter evidence how some of the institutional characteristics of the mental hospitals such the regimentation of everyday life that survived the rehabilitation turn were still present in the Nottingham mental hospitals up to their closure. The oral history excerpts on the dominance of the biological modes of treatment illustrate that the removal of symptoms was still dominant model in the provision of inpatient care up to the hospital's closures; it exposes the widespread criticisms of mental health system by service users and their allies for focusing too much on the medical model based on the removal of symptoms rather than the person as a whole (Repper and Perkins 2003). Participants' memories portray diverse but also convergent meanings about their experiences of changing care practices through time. The divergent meanings rest on the hospitals being remembered by some as enclosed spaces, removed from normal life, within which discipline and order permeated the way of life for all. However, participants in this study perceived some aspects of control within the mental hospitals as helpful for recovery; these included regular daily routines for patients, such as help with getting out of bed and being served food at regular times. Restricting some freedoms could be helpful in protecting patients from harm during crisis such as limiting access to their own expenditure. Moreover, the system of punishment and reward was painted as fairly benign and not to have led to depersonalisation and social withdrawal as asserted by Goffman and others. The findings provide a more complex picture of the intersectionality of class, gender and ethnicity that Goffman postulated, which would merit further investigation. Crucially, Goffman's concept of 'total institutions', embraced by the anti-institutional movement, is inadequate to conceptualise what most of the participants in this research felt about living and working at the Nottingham mental hospitals. The next chapter outlines the theme of relational care in the Nottingham mental hospitals that I identified. The theme of relational care provides a novel dimension to understanding care practices from within that is in stark contrast to the emergent theme of institutional practices outlined above.

Chapter 5: Relational Care in the Hospitals

Introduction

The theme of relational care I identified within retired staff and ex-patients' interviews portrays the changing dimension of the social relations between those who provided care and those who received it, mediated not only through the strict hierarchy and norms within the institution but also the social reforms that came into place over the course of 50 years. Staff recalled being deeply influenced by the 'social turn' in psychiatry, reporting its significant impact on the provision of care with a definite change of focus from custodial care to social rehabilitation. Nurses in particular were keen to stress their active role in ameliorating institutional care practices. Participants' oral history interviews reflect the main developments in the improvements of inpatient care within the hospital, influenced by the introduction of the social model of psychiatry with its emphasis on therapeutic relationships and social rehabilitation, alongside the introduction of extra-mural services, such as day hospitals and the provision of residential care for long-stay patients in the community from the 1950s onwards. The interviews show the importance of communal relationships and social networks that existed within the hospitals for patients' increased sense of wellbeing; in addition, staff emphasised the high level of mutual support between the different professions that contributed to job satisfaction and a genuine sense of staff belonging.

All ex-patients and most of the staff interviewed viewed social rehabilitation within the hospital environment through the provision of structured activities to be a key factor towards recovery. These included meaningful occupation and recreation such as sports and access to the outdoors. Spending time outside in nature was unanimously perceived as a therapeutic activity that aided convalescence. Access to outside spaces was reported to foster sensitive staff-patient relationships. In addition, ex-patients, who were all short-term residents of the Nottinghamshire mental hospitals, expressed a strong sense of identification with the hospital community. The hospital was remembered as a place of belonging within which patients could make sense of their mental health condition, while occupying valued roles within the hospital community, which in turn contributed to increased sense of wellbeing. Similarly, staff attributed long-stay patients' strong sense of belonging to the hospital environment to the family-like relationships that were formed and fostered through the provision of meaningful social roles, discussed below. Figure 3 below outlines the main themes and subthemes.

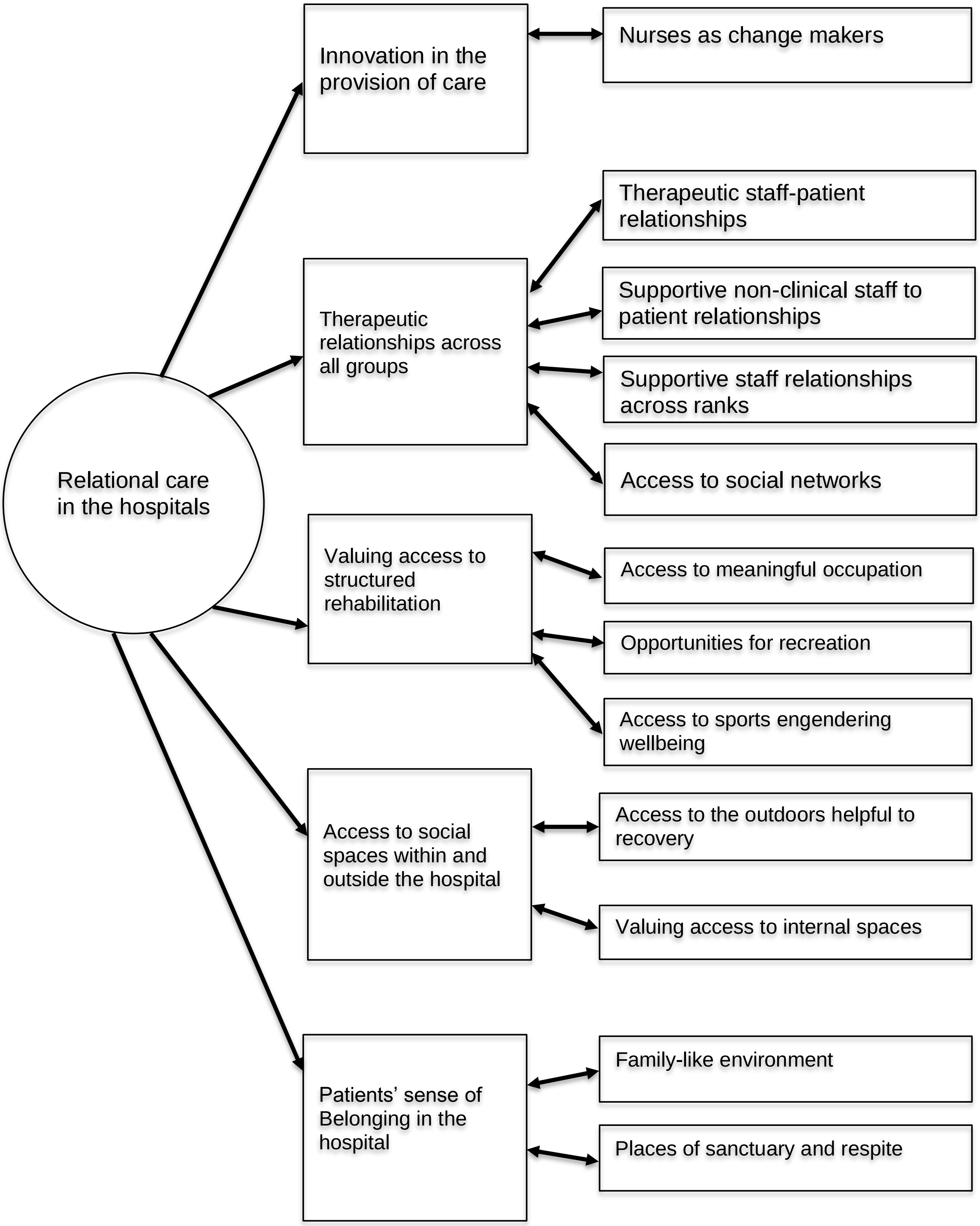


Figure 3 – Flowchart of the main theme and subthemes of relational care

Innovation in the Provision of Care

In contrast to the features of Goffman's 'total' institutional care, I identified elements of innovation to engender social rehabilitation in inpatient care across all interviews with ex-staff across a period of fifty years of service, reflecting the changing dimensions of the provision of inpatient care reported in the literature (Jones 1993, Rogers and Pilgrim 2001). The nurses that began their career in the 1940s and 50s recognised the shift towards a psychosocial model of care that was partly enabled by the introduction of psychotropic drugs, which occurred at Mapperley and Saxondale hospitals in the early 1950s (Smith 1980, Nottingham Health Authority 1985). Nurses remembered the introduction of positive changes that reflected the shift to the social model of psychiatry such as the open-door policy at Mapperley in 1952, followed by Saxondale (Nottingham Hospital Management Committee 1970). All participants remembered both hospitals being open, without locks on doors and no entrance gates. Staff recalled the major changes that followed the open-door policy including the establishment of rehabilitation wards, patients' clubs, industrial and occupational therapy units, a day hospital, group therapy on the lines of therapeutic communities and links to the community via open days and the introduction of volunteers.

Interestingly, nurses working at Mapperley in the 1960s recalled that the status of all patients changed from compulsory to voluntary with the advent of the 1959 Mental Health Act. Following the change, Sean, nurse, recalled, "the patients had some sort of say in how long they were staying". Richard, psychiatrist, recalled how the influence of social psychiatry at Mapperley hospital had originated in Macmillan's reforms, and affected the quality of inpatient care. Changes included the introduction of short-stay admission wards, run as rehabilitation wards with the idea of moving people back into the community once they had recovered; Richard recalled the efforts made towards improving the care for patients including the development of individual bed spaces and moving long-stay wards to the ground floor to improve access to the grounds for geriatric patients:

> The rehabilitation ward was something a bit newer in that patients came in and there was an effort to try and do something more than just sit and look after them and then the day ward, patients came in each day and there was an effort to try and integrate them into the community. The ones in the rehabilitation wards were moved on and eventually got out.

J2, son of a psychiatric doctor, grew up on the Mapperley hospital site in the 1940s and 1950s. He remembered that psychiatrists would come from all over the world to visit Mapperley as they did not believe it was possible to run an open-door institution. He remembered hospital doctors visiting patients in their own homes in the 1950s to avoid hospitalisation and staff making links with the local community in an effort to destigmatise the hospital through the introduction of open days. All Mapperley hospital's former staff recounted similar memories of the impact of community psychiatry introduced by superintendent Duncan Macmillan from 1950s. This was collectively remembered as a revolutionary legacy that improved psychiatric care in Nottingham before all other hospitals in Britain. The oral histories corroborate the literature on Macmillan's efforts to ameliorate care practices at the hospital by taking into consideration social and environmental factors in supporting recovery (Macmillan 1956a and 1956 b and 1958, Wing and Brown 1970, Ramon 1985, Busfield 1997, Fussinger 2011).

Across the interviews with former staff there was recognition that the traditional hierarchy within the hospitals relaxed over time and became much more fluid with the advent of social reforms. Craig, porter from Saxondale who grew up on site (1959-1987), felt he lived at the hospital during "the heyday period":

> My heyday there, it was a lot more relaxed with the doctors, but you would still give them a certain amount of respect.

Richard, psychiatrist (1978-1984) recalled the changing organisation of Mapperley hospital:

> By the time I got there the governing of the hospital was in the hands of a consultant elected by the consultants, the nursing officer managed the nurses and the doctors managed the doctors, and together gave advice to the administrator about treatment.

Andrew, Charge nurse (1968-1979) explained the innovative practices that were introduced at Mapperley hospital included a move towards community-based mental health services, mixed wards, the introduction of advanced anti-depressants and major tranquillisers which helped to reduce the length of stay:

> Mental health services were changing, the emphasis was more on the community and keeping people in hospital for as little time as possible and the role of nursing changed as well, the older days of nurses being a sort of figures of authority changed considerably.

Richard recalled specialisation was introduced in the late 1970s to bring about a more patient focused form of recovery by introducing three levels of wards, namely acute, rehabilitation and longer-stay wards, which he felt significantly improved inpatient care:

> You would have the acute admission wards, the mother and baby unit for mothers and their children, the rehabilitation wards where people could go and be there a bit longer and be helped to look towards leaving and the longer-stay wards, the patients had a greater control of what was happening, it became more focused on the particular needs of those patients.

Prior to the 1959 Act medical superintendents were generally seen as holding complete authority within mental hospitals; the role of the superintendent was abolished in 1971 (Busfield 1997). Gittins claimed that this signalled the increasing split between the bio-medical model of psychiatry that relied on drugs and somatic treatments and a social model that saw mental illness as primarily related to social problems. From 1970s social workers and community psychiatric nurses became increasingly important in mental health services, impacting on the provision of the social model of care (Gittins 1998). Nottingham, Worthing and Bolton were some of the areas where mental hospitals began to develop early services such as domiciliary services organised through GPs (Ramon 1985). Within this backdrop, the role of psychiatric nurses in the provision of care began to significantly change.

Nurses as Change Makers

Within the theme of innovation, I identified a subtheme in relation to the role of nurses as agents of change in actively improving care practices. Nurses recounted being able to exercise their own agency by influencing positive changes in the everyday care of patients and their treatment, challenging the traditional role of consultant psychiatrists as holding absolute power within the hospital hierarchy and nurses only acting in the interests of asylum doctors. Nurses felt they played a pivotal role in the assessments of patients, and were best placed to do this as they developed therapeutic relationships and knowledge of patients' needs. Nurses pointed to the nature of relationships between themselves and the doctors as much more fluid and permeable than Goffman's notion of staff relations within psychiatric institutions (Goffman 1961).

Sean, former nurse (1968-1979), remembered nurses being the main policymakers within the hospital, able to effect change in the provision of care following the social reforms from 1960s onwards:

> My memory is that the nursing staff were the main sort of policy makers, medical staff didn't get involved much in policy making. They would look after the medical side, the physical side of patients but the nursing staff were the people who sort of ran the hospital, they had a strong voice, and in those days, we had strong unions, everybody was in the nursing union.

Andrew recounted making changes to improve patients' care as a Charge nurse on the Trent ward at Mapperley (1968-1979):

> Doctors would come in at various times and they'd all want to know how patients were, I remember starting a system called a Cardex review, I said if you want to know what's going on with the patients, you come here at 9 o' clock and I'll go through the whole list but I'm only going to do it once and so

> eventually everybody came, the consultants, the psychologists, the OT people, and then we would have half an hour review of every patient.

He stressed the active role of nurses in contributing towards the amelioration of care for patients:

> The nursing staff were with the patients all the time, so the consultant would have to rely on those observations of the nursing staff so nursing involvement was very important, it would be those discussions at ward rounds that you would base future treatment on.

Sean trained as a general nurse when he first moved to England from Ireland in 1968. The fact that Mapperley hospital had embraced social reforms to improve the care for patients was one of the main motivations to return to work in psychiatry:

> I kept in touch with lots of people and the development of psychiatry, that was the time that open hospitals were being developed and the concept of that kind of interested me, being involved in the sort of decision-making with open hospitals and with care in the community and having patients involved in decision-making as well and that was the sort of thing that attracted me back.

In his new role as Charge nurse, Sean was keen to counteract the rigid set up by encouraging staff to interact with patients during meal times:

> I started people having staff sit downs at the breakfast table with the clients, even if it was only a cup of tea and a bit of talking, and that sort of helped cement and develop relationships and get this trust going and I found that a big help, that was actually implemented in all the wards because we used to share developments.

More evidence of nurses as change makers in improving the everyday lives of patients emerged in the interview with K2, ex-nurse at Mapperley (1973-1995):

> If the ladies wanted clothes they'd order it from this hospital shop and I can remember there was a time when we were going, these clothes are horrible, they were crumpled and you'd see somebody else in them as well, so we set up a Marks and Spencer's account and we used to take them out into Marks and Spencer's, in wheelchairs often, to pick their own clothes and then go for a meal, so that was quite a nice time.

Olive, a seamstress and later supervisor of the sewing rooms at Saxondale (1976-1988), recalled effecting change to improve patient's everyday living:

> The patients' dresses came from Mapperley, I wouldn't put my mother in them, I was asked to pick clothes for the patients eventually. It didn't suit me to be a Victorian; I encouraged patients to do what they wanted to do with their own clothing. I organised for the patients to go into town and buy their own clothes.

After training as a general nurse, K2 became Sister on the medical ward at Mapperley in the late 70s. She was able to influence positive changes to care practices through fostering good working relationships with other nurses:

> I got the ward Sister's post, staffing never changed. I knew all the staff, it probably gave me a bit more authority to try and change things on the ward, you had a bit more power to say, let's try this way or let's try that, and I guess

> if anything went wrong it was back to you then, as a staff nurse you could think there's a ward sister there, she can deal with it.

K2 recalled the introduction of the 'cardex' system on all wards, namely individual care plans for patients, an improvement she took pride in:

> We used to have individual care plans, you'd write in every shift about every patient on the ward and everybody was in it and you went through and wrote about everybody, you could put down exactly what needed doing, so it was quite clear when you weren't there, people used to just follow the care plan.

Andrew, nurse at Mapperley (1968-1979), was promoted to Charge nurse at the age of twenty-one, only eight months after he started working as a psychiatric nurse. Andrew put the promotion down to a general trend within the hospital management to break away from the old system:

> It was really unheard of then, completely broke the mould, at the time there were older men in their 40s who still hadn't got their first Charge nurse job and there was someone of my age who had got a charge nurse's job.

Andrew recalled that soon after his promotion the District Nursing Officer, in charge of all the mental health services, began to appoint younger people into positions of authority. This provides a clue to the changing power relations within the mental hospital in the 1970s; Andrew recalled that "he [the District Nursing officer] was looking for change and that he wanted younger people in the driving seat, more and more young people were appointed".

The role of nurses remains marginalised in the history of mental health care and in the present multidisciplinary system. The small research available suggests psychiatric nurses occupied a lower status than general nurses (Carpenter 2015, McCrae and Nolan 2016). With the advent of social reforms in psychiatry, the role and function of psychiatric nurses changed due to new trends such as psychotropic drugs controlling the worst symptoms and allowing for more therapeutic staff-patient relationships to be achieved (Higgins et al. 1999). The literature suggests this change was slow to be implemented and only practiced to a limited extent; the medical model with its narrow focus on symptoms determined the short-term nature of many nurse-patient interactions; forming relationships with patients was found to be a limited feature of a nurse's role (Cormack 1983, Nolan 2000). However, the findings from this research challenge the traditional portrayal of nurses as merely acting as the agents of medical staff such as giving out medications and reporting on patients' moods and behaviour (Ramon 1985), further contesting the notion that nurses were exclusively concerned in maintaining their schedule and order on the wards (Goffman 1961, Busfield 1997). The above transcript excerpts illustrate the role of nurses in decision-making regarding the care of patients and their active role in taking their own initiative to improve patient care in the hospital's environment. It provides evidence that institutional care was predominantly nurse-led and it challenges the traditional hierarchy so often associated with the historiography of psychiatric institutions (Goffman 1961, Scull 1980, Ramon 1985). Historically, psychiatric nurses gained a strong voice within the asylums and paved the way to better working conditions ahead of all other health workers with the creation of the Asylum Workers' Union (AWU) in 1895, which eventually contributed to improved conditions for all other health workers (Carpenter 2005). One notable instance of direct action organised by the Asylum Union occurred in 1922. Nurses at Saxondale, who were all AWU members, barricaded themselves with their patients at the hospital to resist a proposed wage decrease (Gittins 1998).

Therapeutic Relationships Across All Groups

The influence of the therapeutic community movement on the provision of care at the Mapperley hospital emerged from the interviews with ex-staff. Nurses recalled therapeutic community principles (TC) that were part of the care provided at the hospital in the form of group therapy, putting patients in decision-making positions and the emphasis placed by nurses on fostering therapeutic staff-patient relationships. All of the former nurses described developing relationships with patients through building rapport and trust, forming and maintaining genuine, respectful and authentic relationships that would aid recovery. Nurses would encourage choice for patients within what was available; some nurses viewed the patients like family members whilst recalling that other staff that were unkind and dismissive with patients.

Raymond, nurse (1948-1993), remembered there was a basic form of group therapy at Mapperley in 1950s in which staff and patients would discuss the running of the ward in open meetings. Andrew, nurse (1968-1979) was in charge of a mixed admission ward that ran on TC principles. He maintained that psychiatric care at the hospital had been influenced by Dingleton hospital, Scotland, the first hospital in Britain to be run on TC principles (Jones 1968), referring to the open-door policy as a symbol of Mapperley hospital as "an early adopter of modern treatments". Andrew recalled the efforts placed on encouraging patients' active involvement in their own care:

> We ran on therapeutic community lines, the ward ran as a community and we encouraged patients to make decisions about how the ward ran, the staff and the patients became a team together in a way and we spent an awful lot of time with the patients, sat chatting and we'd have group therapy, which

> consisted of what we called community meetings where all the doctors, the nurses and the patients sat in a big group and we'd discuss how the ward ran, nobody's contributions was any more or less valuable.

Andrew described how group therapy worked:

> The main idea was to talk about the running and the treatments of the ward and what was available, it would sometimes stray into personal issues and the staff would try and direct it a bit but we'd try not to interfere too much, they were fairly free for all, and usually patients, most would contribute, sometimes you would see a patient who, from the body language, you could say they wanted to contribute but didn't feel able and you would try gently to coax people to talk.

The nurses involved in providing group therapy recalled patients were actively encouraged to openly talk about their needs and to offer support to one another through group therapy. Andrew stressed the importance of involving patients in decision-making:

> A lot of the interactions would be between nurses and patients on a day-to-day basis and that's the therapeutic community, everything was aimed towards therapy and helping the patients improve to make decisions for themselves and to get better. Patients were generally supportive of one another and that's one of the things we encouraged and this whole therapeutic community thing was about caring for one another and so patients derived a lot of support from other patients as well as nurses and doctors.

Hi time working at Mapperley had a profound effect on Andrew's subsequent career. Working as a manager in the NHS, he was able to develop a democratic approach to working with his fellow colleagues and with patients:

> I was always fairly inclusive and democratic and I think that was because of my time at Mapperley, because that's how I would have involved staff in decision-making like we would involve patients in decision-making, I think it was working in that set up that really shaped how I continued as a manager, taking into account everybody's opinion.

Albert, ex-patient, had experience of taking part in group therapy at Mapperley hospital during his hospitalisation in the 1990s. He described the group therapy sessions as helpful in his recovery, such as learning coping techniques from other patients. He set up his own anxiety self-help group as a result of being inspired by the therapy group run at Mapperley hospital:

> I found there that similar people had similar mental experiences and we did different things, we had groups like the group that I formed, because really and truly this is the reason why I formed my own group in later life.

The evidence of the implementation of therapeutic community principles at Mapperley hospital that I identified from the oral histories portrays efforts made to embrace the social model of psychiatry. The findings suggest that although routine and medication controlled the rhythm of everyday life, from 1950s onwards a more enlightened and humanitarian pattern or care emerged, influenced by the wider social psychiatry movement introduced by Duncan Macmillan. This change contributed to the shift from custodial to therapeutic care (Macmillan 1956a and 156b, 1958, MacMillan 1963, Nottingham Hospital Management Committee 1970). The extracts above suggest the therapeutic community principles embraced at Mapperley hospital influenced the power relations among staff and patients, encouraging more equal relationships that fostered recovery. Participants' oral histories also corroborate Gittins' findings about the dual system of care available at Severrals hospital, both medical and social, under reformer psychiatrist Russell Barton (Barton 1959, Gittins 1998).

Therapeutic community principles were first embraced by the Royal College of Psychiatrists as a means to develop humanistic driven approaches to social psychiatry and community based care in the early part of the twentieth century. In 2002, the Royal College of Psychiatrists Centre for Quality Improvement worked in partnership with the Association of Therapeutic Communities to develop community-based approaches, known as psychologically informed environments (PIE); the PIE approach was introduced in homeless resettlement but has not been widely applied to all health and social sector due to the lack of evidence-based practice (Haigh et al. 2012). A study was conducted on the impact of psychologically informed and planned environments (PIPE) across 3 sites within prisons, which reported a number of emerging impacts, including improved relationships between prisoners and staff and improved prisoners' behaviour (Turley et al. 2013).

The above findings from staff's narratives help shed light on the impact of therapeutic community principles on mental health recovery, a subject that remains under-researched (Veale, et al. 2015). Gaining a better understanding of the impact of these humanistic principles in the provision of inpatient mental health care could significantly improve the inpatient care in current mental health settings. Although the system of care in acute units differs significantly to that within mental hospitals in terms of length of stay and the focus on medication rather than interpersonal relationships, the introduction of therapeutic community elements as a form of care in acute units has been found to be successful in improving patient autonomy. It has direct positive effects in improving personal recovery in the areas of involvement in personal treatment and planning for discharge (Hansen and Slevin 1996). Ultimately the hallmarks of therapeutic community, namely the emphasis on the healing power of everyday relationships based on kindness, empathy and mutuality, are powerful forces in helping individuals to recover their mental health (Borthwick 2001).

Therapeutic Staff-Patient Relationships

The interviews with former staff provide evidence of the extent to which TC principles influenced the role of nurses in fostering and maintaining therapeutic relationships for patient recovery. Sean began working at Mapperley hospital in 1968, first as deputy Charge nurse, then Charge nurse and Nursing officer. He recalled the importance of forming and maintaining close relationships with patients, an essential part of the role even when he worked in a mental hospital in Ireland at the end of the 1950s:

> You worked towards building close relationships with patients, where they trusted you and actually helped you with other patients.

Sean explained the value of fostering therapeutic relationships with patients in diffusing patients' aggressive behaviours. Building trust and rapport was key in reducing incidents of violence:

> At that time we did have a high instance of violent patients and we would have physical assaults quite often, patient to patient and patient to staff, sometimes that was because of the approach of staff who didn't do it in a sort of controlled, non-aggressive way, in all my time there I was only attacked once and I would like to think that was because I learnt the proper way to approach clients, so they trusted and formed a relationship so they trusted you, they wouldn't attack you, in fact they would protect you from being attacked from other clients.

Andrew, nurse (1968-1979), remembered fostering therapeutic relationships in the admission wards in the 1970s:

> The relationship with patients was very different, much more therapeutic, we sat with the patients, watched telly and made cups of tea and lived like a community.

Tryphena, nurse in the 1960s, reflected on the kinds of support she offered residents:

> It was your job to engage with the patients, and to be aware of individual needs. I found the people that needed to play cards, they always tried to get to play cards or games, if somebody had run out of material to work they'd come and ask for it, some people would say, I wish we would have more of those meetings where we can talk about how we feel, whenever I could I would try.

K2, nurse in the 1970s and 80s, recalled her main job was to spend time talking to the patients, partaking in rehabilitation activities. She stressed that treating patients with respect and dignity was a central part of her duties as a nurse; She shared a copy of her job description from 1975, which specified that psychiatric nurses were to treat patients with respect and dignity as a core purpose of her role; she recalled “we were looking at everybody as an individual, they hopefully realised that we valued them”. She remembered forming long-lasting relationships with returning patients:

> You got to know your patients, some of them quite well. I think it brought them some comfort that they knew you when they came back.

Louise, nurse, also formed long-lasting relationships with long-stay patients at Saxondale in the 1970s and 80s:

> Strong links were formed with the people I was caring for, most of the patients were long-stay patients so you knew the patients inside out and they knew you inside out.

When asked about the qualities of a good psychiatric nurse, Andrew gave some examples:

> A good nurse would be somebody a patient felt comfortable with and the nurse felt comfortable with patients who allowed patients to learn for themselves without being overly interfering, you’d guide patients, but you wouldn’t make decisions for them.

Mark was part of the cohort of nurses that transitioned from institutional to community care, moving from Saxondale to work in the acute unit as part of the general hospital at the Queens Medical Centre (QMC) during the period 1984-1995. He recalled relationships between staff and patients were generally therapeutic at Saxondale; for Mark, at the heart of his psychiatric nursing training was the value of building relationships with patients and their carers; “it’s about getting people to trust you”, maintaining that authenticity and genuineness were essential attributes for a nurse in order to aid recovery, “there’s nothing more helpful than thinking somebody does care about you during your recovery”. Mark reflected on the importance of building genuine relationships with patients to aid their recovery:

> It was like a sort of genuine friendships, so even though you have your professional boundary you always have to maintain, people see through you if you are not genuine, you have to sort of invest in the relationship for them to get something out of it, some improvement, some relief.

For Mark forming genuine relationships with patients was at the core of supporting patients’ recovery:

> I remember somebody said “it’s drugs and ECT that get you better” but it’s not, it’s people, it’s relationships, I’ve had some fantastic relationships, I’ve lost count of them, they are friendships, people thank you, I still see people occasionally in the street that thank me for things that happened 20, 30 years ago.

For Mark, the main challenges of working as a psychiatric nurse was dealing with the unequal position of power:

> It's difficult because as a nurse you are in a position of power, but it doesn't have to be skewed because most nurses are capable of neutralising it as best they can, so that would be beneficial to the patient within the confines of the environment.

Despite some experiences of bullying and excessive use of force by staff reported in the previous chapter, ex-patients' memories of relating to staff during their hospitalisation tended to be mostly positive. Patients recalled experiencing supportive and helpful relationships with staff, helped by having continuity with the same nurse, making an effort to form positive and long-lasting relationships with them; involving them in their care, encouraging them to develop new interests. Some patients referred to the matrons as 'motherly figures' and male nurses as 'pals'. J1 formed a good relationship with a male nurse while at Saxondale, who supported him and his family in his fight against receiving ECT. This nurse bought J1 his first long-playing record to encourage him to listen to music as part of his recovery. Similarly, K1 was encouraged by the psychiatrist at Mapperley to talk to the nurses to help with her recovery, "because they can be very helpful, and they were very helpful". She recounted positive experiences of receiving support from a nurse during her hospitalisation:

> I remember this staff nurse, she would come and pull up a chair beside me, and she'd say "well, we can talk or not talk, it's up to you, and if you don't want my company you tell me", it was very sensitive of her and her just sitting there sometimes in silence was enough to be helpful and if I needed to talk about why I was crying I could do that, what I was thinking about, she was there, so she was excellent, didn't impose herself on me.

K1 learnt some coping techniques from the nurses that cared for her, which she used to support the friend she made on her ward when her friend experienced a panic attack during a day trip out of the hospital:

> She had a panic attack, I thought distraction was a good thing because I can remember talking to her and trying to get her to look around, I think I did this because that's what the nurses did for me, I'd say "Oh look at that interesting ceiling, look this is what they used to do in those days", because I knew she was really in a bad place and luckily after a while a nurse came over and she took over and looked after her. I just knew the nurses had done that for me so I did that for her so that was nice.

K1 recalled being encouraged by 'her nurse' in the 1990s to exercise her own agency to help smoking cessation in some of the communal areas:

> They were smoking everywhere in the hospital, including the TV room. If there was something I wanted to watch I had to sit there and other people would just be mindlessly smoking, I got so fed up with this and I spoke to my lovely nurse and she said "you can take it into your own hands to say that you want some non-smoking places here", I had to gather a petition together to

> get a non-smoking area, a lot of the staff were quite encouraging. We got the TV room made non-smoking.

Similarly, Karen, patient in the 1990s, felt she received very good care and was able to exercise her own agency in improving the care therein:

> The staff was extremely helpful. They had a representative for each ward, they'd have like a board meeting every so often and I used to be the representative for that, if you got anything that you wanted, such as what you discussed as a ward, what would make things better, then it was all brought up at these meetings.

The type of support J1 received when at Saxondale was bound up with what he has found to be helpful in managing his mental health condition, in his own words "emotional support and chatting through what you'd been going through". He explained that although the Sister on the ward he was on was quite officious, she was motherly towards him, which helped him through his crisis. He compared the type of emotional support he could access at Saxondale hospital with the support provided at the day centre in Beeston (Nottingham), set up on the same site of the day hospital in the mid-1970s (now MSRC):

> The woodwork chap there was a volunteer, but he had a good listening ear and if I was in here he could do that, there was always some members of staff that you were more keen to talk to than others but then eventually they made it official that you had to have a key worker.

The interview extracts above reflect on how nurses would take an active role in forming positive relationships with patients to encourage recovery across a period of 50 years of service. Similarly, ex-patients recounted instances of receiving good care that helped them through their mental health crisis.

Positive relationships are central in helping people facing mental health difficulties through achieving a successful therapeutic alliance (Priebe 2006, Huxley et al. 2009). The inter-subjective qualities of the relationship between client and professional play a pivotal role in determining outcomes (Middleton, et al. 2011). The core features of a helping relationship for service users when engaging in services is feeling safe, accepted and understood, and that the quality of the relationship with staff, their availability, consistency and unconditional respect are effective indicators in supporting personal recovery. The excerpts from the oral histories above point to elements of the therapeutic alliance being practiced within the now closed mental hospitals; staff recalled forming positive relationships with patients to aid their recovery. Despite its effectiveness in mental health recovery, therapeutic practice has largely been unattainable in acute units since the 1980s with over 100% bed occupancy, putting too much pressure on ward staff as a result of rising demands of beds (Higgins et al. 1999).

Supportive Non-clinical Staff to Patient Relationships

Long-serving non-clinical staff recalled forming deep bonds and genuine and long-lasting friendships with patients, perceived to be closer than the relationships formed with nurses. Staff recalled patients tended to open up more easily with the general staff, such as porters and domestic staff, than medical staff as they were not directly involved in the provision of care, such as the administration of medication. Craig, porter at Saxondale, felt that the relationships that were formed between the general staff and the patients were genuine friendships that had been fostered through living on the site of the hospital as part of a community:

> The patients accepted me as part of the community because they knew me as a child, they would be quite open with me, they would come to see us the porters, sit down and gossip.

Linda, hairdresser at Mapperley (1973-1995), referred to the familiar atmosphere of the hospital as a key factor in forming good relationships with patients:

> Everybody had a good relationship with the patients, it was such a relaxed, easy place to work in, that's how I remember it, it was amazing, proper family.

She reflected on the differences in forming relationships with male and female patients:

> Men are not as good at talking to you and opening up as women, but some of them did, and yet they'd say "oh you've made me feel human again" or "I feel better now, especially now that you've washed my hair" that sort of thing, but you would never get as close to a male patient as you would to a female patient because they don't open up the same. I treated them the same as I did the women, some men used to come in and chat, they'd sit for hours with me, because they'd talk but they were not very good at opening up like a female patient would be. I met some great patients, great characters, certainly happy times, happy memories, and happy past.

Linda felt the most important quality for a hairdresser working in a mental hospital was not to betray patients' confidence:

> You don't betray their confidence because they are not going to tell you anything, not that you prompt them or anything like, they tell you things because they want to tell you, they feel safe, secure and that's lovely.

Former staff understood the continuity of staff and patients' relationships to be determined by the availability of staff, the level of time available to be with patients and the long-term nature of employment the mental hospital afforded most staff. In the case of Saxondale hospital, most staff lived on site, which helped foster long-lasting staff-to-patients relationships. Roger as an electrician and Craig as a porter knew all the staff as they dealt with every ward as part of their jobs maintaining the Saxondale site. Roger recalled “there was a huge amount of domestic staff in those days”:

> They were terrific with the patients, they’d make tea and do lots of other little things that perhaps you wouldn’t have to do, alter clothes, all manner of stuff, some of the more touching things I saw, people that were in their last days being nursed.

Richard, ex-psychiatrist, shared an anecdote about the value of social connections between the telephonists and patients:

> An important person at Mapperley was the telephonist at the front door, they would answer the phones and people of course would come in including patients and that and these telephonists would know as much about anything as anybody in the hospital.

Olive, seamstress at Saxondale, bonded with the patients who volunteered in the sewing rooms:

> It was lovely, I bonded with the patients that used to volunteer in the sewing room, when I took over I was supervisor for the last few years, everything was more relaxed, I really enjoyed having the patients with us.

Supportive Staff Relationships Across Ranks

Relationships between staff were remembered as being characterised by mutual support and defined by collaboration. Great emphasis was placed on the value of learning skills from more experienced staff; nurses recalled that senior staff had time for trainee nurses and used to know everyone by first name; long-serving staff remembered senior nurses would inspire younger ones by passing on knowledge on to newer nurses. Staff relationships were marked by continuity, working on the same shifts, in long-term employment, the ratio of staff to patients was remembered as high. Long-lasting staff relationships were formed, fostering a sense of belonging marked by mutual trust and friendship and work satisfaction. Social support between staff ranged from feeling part of a community, the comradeship and the sense of being valued. What Raymond was most fond of remembering about his time as a nurse (1948-1993), was the camaraderie between staff:

> The comradeship, the staff, you felt you were doing something useful, you could see the improvement over the years and the way that the patients were treated, and the way things were moving on rather than just containing them.

Sean, nurse at Mapperley hospital (1968-1979), reflected on how skilled his co-workers were, giving examples of learning observation skills from senior nurses:

> I can still remember the Charge nurse was terrific in teaching for the signs and symptoms to watch for. It was his experience and intuition and little signs

> which were passed on to me and I passed on to people down the line. I can still remember back then how vital the support was from colleagues, I didn't think of it then as maybe being skillful, but it's a very skillful job really, these people were skilled operators, skilled carers.

Similarly, Louise, nurse, reflected on the importance of the knowledge passed down by people that worked at Saxondale for generations:

> They had the awareness and training to know how to deal and how to involve or not involve, and they also knew if there was a crisis who to get in touch with, what they can and can't do, so they were training a lot, it was like a big family structure, the admin staff and all that, they knew the clients, most of them knew them by name.

Andrew formed such strong bonds during his working time at Mapperley hospital that the friendships passed the test of time:

> There's certainly quite a special relationship between people who worked in those institutions in those days and you know most people I think remember them quite fondly and warmly.

Mark, nurse, had fond memories of senior nurses he worked with, "there were some absolutely brilliant staff there, very inspiring and I never forgot them". He felt the level of support from senior staff was invaluable in the early days of his nursing career:

> These people would test you, they would question you all the time and they had time for you even when you were a student, so you felt valued and as a student you were included in the numbers on the shift, so when a nursing officer, who is several grades above you pays some attention to you, it was invaluable.

Similarly, K2 commented on the senior staff acting as role models for trainee nurses:

> I'm a great believer that the best way to learn is via experience, doing the practicalities and learning from the other staff. As a student, qualified staff were role models.

Richard, psychiatrist, recalled the relationships between consultant psychiatrists were convivial within the hospital settings. It reflects how the current system of care has fragmented staff relationships due to staff's dispersal across different sites:

> The doctors used to meet at lunchtime with coffee in the library, it is not possible in the way things are structured presently, people are everywhere. It was a good professional community, I hope that rubbed off on a lot of the patients, because if the staff can be community minded and can be content in themselves, it's likely what they do for the patients would be good.

The repeated mention of camaraderie among staff related to the sense of the close-knit communities that existed therein, a recurrent theme across other staff and others' narratives of life in the mental hospital (Calabria 2016). There still remain a strong bond among staff that worked at Mapperley from the 1970s onwards;

Andrew has helped organise staff reunions every year since the hospital's closure in 1995.

A topic from staff's narratives that I identified relates to the role of non-clinical staff, such as porters, domestics, hairdressers and electricians, in providing informal support not only to patients but also to clinical staff. Non-clinical staff remembered performing the dual function of carrying out their respective jobs as well as offering practical informal support to the nurses and doctors, while providing practical and emotional support to patients. Non-clinical staff recalled offering extra support to clinical staff in the delivery of care during breaks and outside of their working hours. Practical support offered included feeding patients or taking them on outings in their spare time. The types of emotional support recalled included companionship for patients, extra care at difficult times, helping to relieve the nurses during busy periods/staff shortages and some material help such as buying gifts for patients without family or friends.

Craig described the kinds of help offered to support the nurses and the volunteer groups at the hospital including attending day trips to help nurses care for patients, putting chairs out for cinema nights, and setting up the sports facilities. Craig, porter at Saxondale, recalled porters were "an extra pair of hands":

> You'd be a volunteer on the wards, while you were hanging around in your spare time you would make a cup of tea, help a nurse make a bed, shift some stuff, put your feet up and watch a film with a patient who you were chatting to.

Linda, hairdresser at Mapperley (1973-1995), remembered the porters were readily available to offer practical help when needed. She recounted ways in which she offered informal support to nurses in her spare time:

> I can remember if I wasn't busy, I would go to the ward and if anybody needed say their toileting, many of times I've taken a patient to the toilet, left them at the toilet for the nursing staff to see to them, I looked at it as helping the nursing staff, everybody at Mapperley helped one other.

Linda remembered the relationships between staff across all grades was convivial, and that everyone was willing to help, providing clues to how relationships operated across the hierarchy, "no matter what you did as a job, if you could help somebody, you would help them". Similarly, Roger, ex-porter and electrician, remembered relationships were harmonious across staff hierarchies within the hospital community:

> Right from us down at the bottom, the workmen, right the way through the domestic and nursing staff, everybody seemed to get on, the jobs were done, and I must say that everybody to me seemed very happy.

He commented on the continuity of staff relationships that existed at Saxondale:

> As a porter you get to know all the staff because you are dealing with everybody on your shift.

The theme of helping relationships that runs across the experiences of providing care is evidence of the social capital that existed within the hospital environment, staff helping each other out of their own sense of duty, in the form of non-clinical staff offering practical support to other staff and emotional and practical support to patients. The continuity of relationships emerged as a key factor in fostering camaraderie and practical staff-to-staff and staff-to-patients support and the loss of it through staff's changing patterns and location of work. Former patients, who continue to use mental health services, perceived the continuity of care to have been deeply affected in community care where services are often fragmented; they explained feeling isolated and stressed upon discharge from acute impatient settings, consistent with other studies (Barham 2006, Newman, et al. 2015).

Access to Social Networks

Another important aspect of care I identified from staff's interviews was access to informal rehabilitation available for patients through the extended networks within the hospital community that lent its unique form of social support from relatives of staff, such as the children who grew up on site, and volunteers. Staff recalled how the children on site played an unexpected role in mediating and blurring the boundaries between staff and patients, creating new kinds of identities beyond those of 'patients'. The estate's children were encouraged to engage with the patients as part of the patients' recovery; two long-term staff that grew up on the site of Saxondale hospital, discussed forming positive relationships with patients, providing companionship and developing close friendships. Roger remembered making genuine friendships with patients as a child:

> We were the kids on site, our relationship with the patients was such that we did get to know them quite well, and I can reel off quite a few names of some of the older chaps.

He felt the hospital environment offered him "a mainstay of really good friends", in terms of bonding with the patients:

> We made great friends with some of the patients, we'd see them every day. You'd go out around the grounds and there was a young chap, he played football with us, he was there for as long as I remember, and we'd have a totally normal relationship, I remember dad saying "treat them with respect, it is their home, you are in their home", and we did.

Roger's memories of relating to patients was bound up with access to the extensive grounds and the children being allowed to roam around the hospital grounds and wards, "as a child you could walk around everywhere, patients were never a threat". Roger's memories of bonfire nights reveal the extent to which friendships were formed among children of staff and younger patients:

> The hospital wouldn't have a formal bonfire, but we as the kids on the estate did, the patients that were able would come over and watched the fireworks, we would build this enormous bonfire right outside our house on the field opposite, we would put on soup and jacket potatoes and buy fireworks, a lot of the younger patients came over and had bonfire night with us.

Craig who grew up on site recalled the matron at Saxondale started encouraging the children on the estate to spend time with patients from the 1960s onwards:

> She was one of the early ones who encouraged the estate kids to wander around the hospital and go where they want so the patients themselves would mix with children which was a sign of normality to them and some would have children themselves at home that they were probably missing them and some would just come up for a chat, especially the old ladies they used to love to stroke your hair and give you kisses.

Louise, nurse (1978-1988), remembered the reaction of long-stay patients when staff's children visited the wards:

> There were two staff there that had their children, every so often they used to bring the girls onto the ward and the reaction of the patients was absolutely fantastic, it was as if they were in awe, and they would sit and talk, you could just see the love in their eyes.

In addition, volunteers were recruited to help run the social activities in the hospital. Louise recalled that "they were really good, because it was normalising, it wasn't the workers and the older people that they were seeing", pointing to the extended network of individuals that would come onto the wards to provide a link with the community outside the hospital. Louise encouraged her son to work at Saxondale during the holidays:

> He worked as a domestic and he really formed links with some of the patients just the same that most of the staff did, they were just extended family, you cared for them according to the individual.

Albert, former patient (1971, 1981, 1991), had such a positive experience of care that he returned to the hospital as a volunteer; he remained incapacitated by his mental health condition and was unable to work for most of his life. A staff member at Mapperley hospital encouraged him to take on some volunteering at the hospital; Albert took on the voluntary role of minibus driver for eight years. He shared some fond memories:

> Lovely memories, the best one is when we went to the Granada studios at Manchester, I had a full bus, lovely day, the driver who would normally bring in the people to the event gets a free meal, so I had a free meal while the rest

> had a walk around the Coronation Street set and then I joined them, really enjoyed it, came back and everybody was happy.

A recurring theme across the interviews was the importance of social support and social networks fostered therein. Although none of the long-stay patients took part in this research, what emerged from some of the short-term patients and the long-serving staff were memories of genuine friendships, mutual support in the form of emotional, practical and material help: helping other patients during crisis, providing companionship, giving money/gifts; sustaining friendships outside the hospital. Michael recalled a strong sense of reciprocity existed between patients during his hospitalisation in the 1970s at Saxondale:

> We got some money together to help a chap to go and give him some money and clothes together because he got nothing, and he didn't want to leave, because he got nowhere to go.

He associated Saxondale as a friendly place due to the wide range of activities available to patients, "it was a friendly place, they had a library, snooker table, pond with newts, a tennis court and a church, even ballroom dancing". Albert, former patient, felt making friends with others at Mapperley helped him overcome his own mental health issues:

> I know Mapperley hospital did wonders for me, I made a lot of friends, which was very beneficial.

Karen, ex-patient, felt she received "tremendous help" at Mapperley and she was "really glad that I went in and to me it is such a shame that the hospitals have been closed down". She described socialising took place during and in between the activities:

> If we'd got any spare time in between, we could sit in like an alcove with tables and chairs and look out on to the grounds, you could sit there and a have a chat amongst yourselves.

Understanding the context in which social networks that existed in the hospital fostered social support can help improve the provision of mental health care; the qualities of these networks such as support and trust can be utilised in the provision of care for vulnerable client groups in community settings. Several studies have shown the importance of social support and social networks for people with long-term mental health problems to aid recovery and maintain wellbeing (Loat 2011, Kogstad et al. 2013, Leach 2015). Social Networks were a prominent theme of life in the mental hospitals for staff that lived on site for decades, offering some insight into the everyday life within. The narratives reveal a level of fluidity of roles and relationships; for instance, the friendships between non-clinical staff and patients appeared genuine and long-lasting. Crucially, relationships were formed and fostered through every day rituals such as cups of tea, the significance of which emerged through anecdotal evidence. For example, Linda, hairdresser (1973-1995), recalled:

> No matter who you were, when you turned up at any of the wards the first thing you would be offered was a cup of tea.

According to non-clinical staff, long-stay patients were able to exercise some degree of agency in how they lived their lives, forming long lasting relationships with others at the hospital, visiting staff in their home, exercising choice of psychosocial treatment and through access to spaces including trips outside the hospital. Relationships among nurses and patients and among general staff and patients were generally reported to be of a helping nature. For instance, Linda recalled a patient living in the community who volunteered at Mapperley hospital's hairdresser's salon for many years. She offered support to her through including her in social activities and ensuring she felt comfortable with the work:

> We'd sit and talk before the patients came in, and because she was quiet and timid, I would say "if you don't want to do anything, or you are not comfortable with anything, tell me and I will do it", I didn't ever want to make her think that she got to do it, I think I helped her and she stayed with me for years.

Craig remembered patients forming romantic relationships at Saxondale, some married while at the hospital. Despite the lack of accommodation for patient couples, they spent daytime together in the shared spaces; Linda recalled keeping in touch with long-stay patients who moved out in the community for years after closure. When describing his day job around the wards, Craig talked about small acts of kindness towards the residents:

> You'd see a lot of the patients getting up and they'd say "morning" to you or "nice day", the trick on the old girls' wards would be to whistle a war time song like "A long way to Tipperary", by the time you left the ward they'd all be singing it, all this would be before 7 o'clock.

As the oral histories of former patients and staff above show, social interactions that pervaded the way of life in the asylum played a crucial role in the provision of care for residents. The peer-to-peer reciprocity and relationships between patients and staff and the extended social networks that existed in the institutions contributed to a sense of feeling safe, understood and accepted. These insights into the value of relationships between staff-to-patient and peer-to-peer friendships provide a novel dimension to improving ways of providing mental health care in a post 'care in the community' environment.

The excerpts above offer important insights into the relational environment that existed in the mental hospital, which offered a broad spectrum of helping factors that indicate that peer-to-peer, staff-to-patient relationships could be permeable and fluid (Quirk, Lelliott and Seale 2006). The findings suggest that fostering practices that develop supportive relationships that extend to service users' families, neighbours and wider social networks would provide a vital source of support for people experiencing mental health difficulties. Patients' memories of what they gained indicate the relationships fostered with nurses were not only helpful to support their recovery through being listened to but also in terms of learning new coping skills. Ultimately the kinds of relationships that existed in the mental hospitals across all groups evidence the long-standing communities that existed within the hospital. These communities offered both formal and informal care for patients, discussed below, which contributed to the environment of the institution being perceived as place of refuge, recovery and belonging for many. These relationships were of a different quality to staff-patient relationships today. The staff-patient relationships described by participants in this study resemble Ramon's call for a type of professionalism that reflects emotional closeness, and emotional availability of staff for service users to become an essential for the provision of current mental health services, particularly in inpatient settings (Ramon 2005, p. 15). However, the obstacles to cultivating close staff-patient relationships in modern day services has been impeded by the crisis in staff recruitment and retention, which mitigates against continuity of relationships. Moreover, cases of historic abuse in secure hospitals such as Rampton that emerged in the 1980s have fuelled preoccupation with risk, which further mitigates against close relationships (Martin 1984).

Valuing Access to Structured Rehabilitation

Social rehabilitation emerged as a major form of beneficial care across the interviews with former staff and patients from 1950s onwards. All recalled a wide range of activities available at the hospital, including structured occupation, recreational and social activities, including access to sports and the extensive grounds and other social spaces where social networks were fostered. Staff and patients agreed on the value of having access to purposeful and meaningful occupational opportunities that provided structure to patients' lives during a time of convalescence, as well as recreational spaces and activities and access to designated spaces where patients could spend their leisure time. Staff and patients recalled that the hospital communities creating a family-life environment that encouraged a relaxed atmosphere, fostered through not only structured rehabilitation but also a sense of belonging.

Access to Meaningful Occupation

Former staff recalled social rehabilitation at Mapperley, the Coppice and Saxondale played a major role in patients' psychosocial treatment, which contrast starkly to memories of the widespread use of medical treatments such as ECT on long-stay patients. Staff who began their career in the 1950s remembered the introduction of occupational and industrial therapy departments (OT and IT) at the Nottingham mental hospitals, which represented the pinnacle of community psychiatry at the time as reported in the literature (Nottingham Management Committee 1970, Fussinger 2011, Long 2013). The type of work that was carried out was gendered; women would mainly do housework and knitting, men physical work such as gardening and woodwork. Although these gendered divisions would be questioned today, at the time they were considered appropriate. The IT department was designed to support long-stay patients regain skills to re-enter the world of work in community and foster independence. Roger, porter (1962-1988), recalled Saxondale was an early provider of the "industrial therapy care". His father was in charge of the IT unit and secured contracts with local companies; the hospital received an income and the patients a nominal fee for carrying out menial work. Raymond, nurse, recounted the importance of IT in the rehabilitation of long-term patients:

> The start of the industrial therapy unit was very good, particularly for people that had been in for some time, it got them equipped for life, they had to clock in like they do in most factories, simple things like polishing pencils, that got them all back into the work routine.

There was a consensus among former staff that the purpose of occupation was to rehabilitate patients by providing a structured routine for when they would be returning to the outside world. This was seen as a way to increase mental stability for patients unable to cope in the community who needed long-term care for the rest of their lives. Sean, nurse (1968-1979), remembered that it was often the patients who came forward requesting some form of occupation and the staff would also be aware of the patients' histories and tried to match occupations according to patients' skills. The attitude towards patients as workers in the IT units was generally remembered as being fairly relaxed. Andrew, nurse (1968-1979), recalled the printing department at Mapperley was partly run by patients:

> They used to do the printing for all the hospitals in the psychiatric group and a few patients worked there and set the machines up.

Richard, psychiatrist (1978-1984), recalled:

> There was a fair amount of choice, we tried to keep every patient with some sort of weekly plan, so they might go to the industrial therapy one day and do gardening on the next, and that was decided with them.

Linda, hairdresser (1978-1995), remembered male patients feeling proud of the work they carried out, which gave them a sense of purpose and helped with their recovery:

> The patients on the wards would go down to industrial therapy and work, the lads used to go and work in the gardens, they'd got up and went to work, they'd come back and make things and they were chaffed that they could do things, they started to get a little bit better.

The service users that took part in this research were all short-term patients of the mental hospital and did not take on specific jobs during their hospitalisations; instead they took part in occupational therapy (OT); all asserted that structured rehabilitation in the form of meaningful occupation at the Nottingham mental hospitals was helpful in their recovery, namely access to creative activities in a supportive environment. A sense of connectedness is one of the key dimensions of the recovery journey and the processes relevant to clinical research and practice; a central aspect of the recovery journey is to connect an individual's life context to environmental factors such as opportunities for employment and community integration (Leamy et al. 2011). All of the service users that took part expressed a sense of dispossession due to the inability to gain meaningful employment and social roles within society as a result of social stigma due to their mental health diagnosis. Access to meaningful voluntary and paid work is an essential aspect in fostering sense of belonging and social capital for people with long-term mental health issues (Tew et al. 2012). Four participants are active members of MSRC, where they occupy important roles as advocates in the mental health community. They described MSRC as a community of belonging, which has provided a strong sense of identification with place. It has in part replaced the social function of the hospital according to some of the service users that took part in this research.

Rodney, patient (1975, 1979), spent most of his time at OT, he enjoyed socialising with other patients during quizzes and other social events organised by the hospital, including an outing to Alton Towers. As part of OT, he went swimming with a group at a nearby pool regularly. J1, patient (1971, 1976), remembered different rehabilitation projects were available at Saxondale during his hospitalisation. He didn't want to do menial work in IT, instead he chose to attend

OT, which he found beneficial, describing the atmosphere at OT as relaxing; he could bring and play his own records. He chose to spend most of his time in the OT department:

> I showed an interest in the occupational therapy and the occupational therapists were creative people but also quite caring, I felt comfortable in that environment, we did more artistic things there.

Subsequent to his hospitalisation, he attended OT as a form of day care in the 1970s at Saxondale. The art-based activities inspired him to become an artist; staff encouraged him to explore his creative skills:

> 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 and that's where I got my first inklings that I was good with using my hands with in terms of weaving and basketry.

Karen, patient in the 1990s, recalled the value of structured occupation for her own recovery:

> We did art, pottery making, we did play reading which I found was very good, you didn't have to do all the activities, for the occupational therapy, but I found it very useful and I did like doing those activities.

She recalled the initial outings to help her rehabilitation into the community, which she found beneficial:

> I play darts my local team, they let me out twice just before I came out when I was getting towards getting on, which was gradually getting you back into things, when they feel as though you are ready, you know yourself when you feel a bit better.

K1, patient in the 1990s, learnt to make art as a coping strategy in OT at Mapperley, which she resorts to when she relapses into depression:

> They had an excellent occupational therapy and I hadn't done anything like art since I was a child at school, I can remember resisting doing art, but finally, I went along to OT and 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 that, I remember the woman at OT was just lovely.

Structured rehabilitation at the hospitals was augmented by the provision of extensive occupational activities, namely through volunteering to help run the hospital. Both Mapperley and Saxondale had their own operating farms until the mid-1980s. Patients worked on the farm and the vegetable gardens, Former staff recalled long-term patients would help maintain the hospital site, including the extensive grounds. Roger, electrician (1982-1988), remembered the extensive grounds were "pristine, it was better than a park"; the patients worked alongside staff to carry out repairs of staff's houses and the roads on site. Craig, porter, recalled maintenance staff were incentivised to take patients to work alongside the maintenance crew for an extra fee, equivalent to the price of a pint. Patients would get "extra tea and biscuits" and became part of the social network of staff that maintained the hospital:

> In them days you got something like 10 pence extra if a patient worked with you which was about enough for one pint, so it wasn't bad, the patients who worked in the workshop with us, they were invited to our work dos and Christmas parties, they would sit in the mess room with you and have a pint.

Olive, seamstress, recounted some patients helped out in the sewing room as a form of rehabilitation:

> We had four patients, they were all right, they were a happy bunch, it was something for them to do, I suggested some of the patients, if they were capable, to come down and bring their own sewing, and we bonded with them, very nice people.

Former staff associated patients' jobs on site with support for the running of the hospital, which engendered a strong sense of identification with place, fostering a sense of belonging to the hospital community. Louise, nurse, explained that having a specific duty within the hospital helped to foster a sense of purpose and self-validation for long-stay patients:

> I remember a lady who went in when she was 20, she was about 80 when she was transferred from here and I can see her now, for years and years, her job was to clean the toilet, she didn't just clean the toilet, it was something that she had an obsession with, it was a good obsession because the staff knew it was something she wanted to do and she really did a thorough job, and it gave her a lot of satisfaction.

Similarly, Craig recalled some long-stay patients helped run the wards:

> On the old lags' wards certain patients, it was their job to do the washing up, and they did it religiously "that's my job Craig" and they would collect everything.

Craig associated the social roles of long-stay patients working on site as a way of making the hospital their home:

> For some it was their home, they were happy, they could hold down a little job within the hospital sphere because it was their community.

He recounted an anecdote about one of the patients who derived a strong sense of belonging to the hospital community through occupation:

> Another patient worked in the canteen, [name removed] used to wash up all the pots, collect the tables, a bit like a barman but poured pots of the tea and on the tables and that lot, they put him out a couple of times and he would always come back "no I like it here Craig" he said "these are my friends, this is my job".

Craig remembered some long-stay patients had jobs in the local community, which he believed gave them some independence while retaining a base at the hospital:

> The bit of extra money gave them the independence they needed, they could go to the shop, they could go to town if they wanted, they felt at home in the hospital.

The Nottingham mental hospitals embraced the post-war social turn in psychiatry by introducing the social rehabilitation model with a focus on patients' occupational and social functioning after discharge. Traditional critics of the mental hospitals argue this approach did not promote social inclusion or the opportunity for individuals to reclaim a sense of self after being labelled a mental patient (Goffman 1961, Ramon 1985). Goffman viewed the then newly developed idea of industrial therapy as a form of tyranny, as a means of reorganising the life of 'inmates', in which a system of punishment and reward operated to regulate behaviour (Goffman 1961). However, the above excerpts highlight the value of occupation within the now closed mental hospitals from the point of view of both staff and patients, perceived as a means of regaining a sense of self, and to develop self-care strategies. The introduction of OT and IT in the British mental hospitals as a form of inpatient and outpatient care from the 1950s onwards represented the shift from institutional to extra mural services in British psychiatry. These practices were developed to facilitate the rehabilitation of long-stay patients in the form of industrial subcontracted work in an environment designed to resemble a factory floor (Long 2013). The philosophy influencing the move to help people with mental ill health to re-enter the world of paid work was part of the inter-war discourses of work and mental health that went to inform the emerging field of occupational therapy; the intention was to re-equip individuals with the skills needed to return to work (Jones 1993, Rogers and Pilgrim 2001); occupation was generally perceived as both therapeutically and economically beneficial (Gittins 1998).

The movement towards reforms in British mental hospitals developed towards the emphasis on rehabilitation and resettlement through the provision of meaningful domestic and industrial roles within an open hospital setting, leading to transitional communities of various kinds to full participation in community life for a certain proportion of patients (Busfield 1997). Wing and Brown, in their social psychiatric study of the relationship between institutionalisation and schizophrenia, observed long-term patients over a period of five years at Mapperley, Nether and Severrals hospitals and concluded that both occupational and industrial therapies were helpful in improving outcomes and reducing mental disturbance for individuals with long-term mental health conditions within and outside institutions (Wing and Brown 1970). OT has long been recognised as form of recuperation from mental illness in actively supporting the recovery of individuals (Long 2013). Ex-patients' views on the impact of having access to structured occupation highlight the benefit of occupational therapy and its applicability to psychiatric hospital environments. There is strong evidence that having access to meaningful occupational activities has a positive impact on mental and physical health, and promotes higher quality of life and wellbeing, while access to employment has the impact of reducing social exclusion and poverty (Waddell and Burton 2006, Black 2012, Tew et al. 2012). Researching how service users experience occupational therapy in inpatient settings is critical to provide an evidence base for the development of creative activities for recovery (Rani and Mulholland 2014). However, research into the impact of occupational therapy for the promotion of social inclusion and connectedness remains underdeveloped (Hitch et al. 2016). The provision of high quality, effective mental health care is enhanced by the provision of occupational therapy. Occupational therapy is a form of values-based health and social care practice centred around mutual respect between clients and professionals, with a strong emphasis on choice and self-management. It supports good decision-making by acknowledging differing values and outcomes (McMorris 2017). The findings have important implications for the current provision of mental health care since the advent of care in the community where services are often fragmented and a growing number of people experience isolation and exclusion (Repper and Perkins 2003, Newman, et al. 2015). The importance of developing interventions such as the promotion of wellbeing through occupation would help individuals develop practical strategies that could be transferred to the context of their lives (Nolan et al. 2011). The value of creative activities and structured occupation for mental health recovery has implications for improving the provision of care in secure environments, namely prisons, and high, medium and low secure forensic services.

Opportunities for Recreation

Former staff recalled that the ‘Soc and Rec’ departments functioned to organise social and recreational activities at the Nottingham mental hospitals, recalling positive memories of the recreation and celebrations during a period of 50 years of service. K2, nurse, recalled “it was probably the first bit of social inclusion as you may call it nowadays”. The Soc and Rec offered a wide range of group activities, including singing, dancing and evening entertainment, holidays and sports. Sean recalled that a lot of emphasis was put on recreation:

> Keeping patients occupied was an important task and made them feel better and made them feel part of the community based in the hospital.

Raymond was part of the first cohort of staff taking patients on holidays in the 1950s as part of the amelioration of care at Mapperley hospital:

> We'd be under canvas for a couple of weeks, self-sufficient, just pick up milk and bread and the rest of the time you'd have barbecues and make your own entertainment, games in the fields or walks along the canals, it was quite good fun.

Mark, nurse, remembered the extensive range of activities organised on the wards:

> They'd come around the wards with quizzes, darts, and in the summer holidays, most wards had some kind of rotas for going away to places like Skegness and Blackpool. There was the big hall where they'd have concerts and plays.

He referred to the hospital community as rooted in the legacy of social club activities, common among large-scale employment contexts in the mid-twentieth century:

> Society was different then, there was still this sort of legacy of social clubs that you had in the coal industry, Boots, they all had their own big social and recreational departments, holidays out, bowling club, football teams, there was a lot of that still evident, the patients liked it, they expected entertainment and activities, because everybody knows that helps with symptoms, boredom, institutionalisation, so there was a purpose behind it.

Social celebrations featured largely across all interviews with staff, bound up with the sense of community and the extended social networks within the hospital. These celebrations typify community life, such as Christmas parties and the hospitals' open days, and were linked to memories of designated social spaces, such as the recreational halls, the lawns and the patients' canteen. Mark, nurse in the 1980s at Saxondale hospital, recalled that "we'd celebrate anything, and there would be lots of individual stuff as well, like one-to-one activity". Tryphena, nurse in the 1950s and 60s at the Coppice hospital, recalled that "the patients had special high tea and cake" for birthday celebrations. K2, nurse at Mapperley hospital from the 1970s to the 1990s, enjoyed organising Christmas parties so much that she worked 30 consecutive Christmases at Mapperley, dressing up as Santa; she explained the effort made by staff in trying to make the celebrations family-like:

> I can remember a couple of us going into town with a list of what we thought our patients would like and getting whatever we could and wrapping it up, then on Christmas morning we did use to put little Santa hats on and go around and give the presents out. I used to love it and then helping set the tables up ready for a nice communal Christmas dinner, we used to try and keep it like you would at home, you'd have a big family gathering with your crackers and all your little extra bits.

Non-clinical staff working at Saxondale recalled celebrations in extremely positive terms, repeatedly using words such as 'terrific', 'phenomenal' and 'magical', with reference to the collective effort employed to make the hospital festive. Celebrations were open to the community from nearby villages, such as the annual flower show; Roger recalled that “anyone worth their salt” would bring their vegetables at the show, which made Saxondale “feel like a traditional village”, revealing the importance of these events for the hospital community. Figure 3 below is a reproduction of an original cover for one of a flower show at Mapperley Hospital.

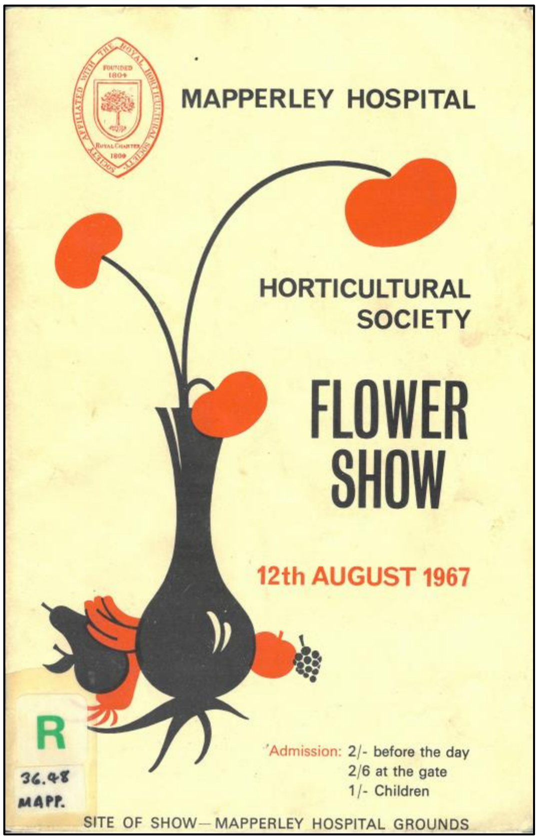


Figure 4 – Mapperley Hospital Horticultural Show 1967
Courtesy of Nottingham Library Local Studies.

What made celebrations important for the hospital staff was the communal effort to organise parties for all; these included the hospital children’s party and parties for staff and patients. Craig, porter, remembered:

> All the wards at Christmas had two parties, one staff party and one for the patients, for the patients’ party anyone that had anything to do with the ward, whether you were a child or worked there would go to the patients’ party, for the staff party on the ward actually it was really a glass of sherry and a mince pie in the side room but for the patients’ party, they had music, cakes, sandwiches, beer, sherry.

Craig, porter (1977-1988), was keen to stress the level of permissiveness around the patients' consumption of alcohol and cigarettes during festivities, for which patients were allowed extra allowances:

> Some would have a barrel of beer for the patients, one ward as long as February they were still having a pint of beer each night for those who wanted it, the little old ladies' wards there was more like a sherry in them days.

Craig remembered the matron on the geriatric wards "wanted to make a fuss of them because they had been forgotten":

> She used to do a little bar room and made it look like an artificial pub in one of the verandas, but they all had their beer.

Olive, seamstress (1976-1988), remembered Christmas parties at Saxondale fondly:

> Several of the patients would be able to come down, the nurses would see that they were all nicely dressed, and they just came for a cup of tea and some cakes and the staff as well and the amount of cups of tea we made, and all the patients loved it, they thought it was lovely, they'd come down and they wanted to hug you.

Roger, electrician (1982-1988), recalled the importance of the recreation halls in bringing together the hospital community and people from the local area, built in the Victorian period as part of moral architecture to encourage the re-socialisation of the patients:

> The involvement with the community was so much so that Saxondale and Mapperley had what we called a main recreation hall, which was pretty spectacular place.

Olive revealed the extent to which staff-patient relationships were fostered through social celebrations:

> If we had any parties or anything going on we would say to a nurse "If you want to send any of the patients down to have a cup of tea with us", they used to come in, and it was a nice relaxed atmosphere.

Raymond, nurse (1948-1993), recalled the efforts made to break down the physical and social barriers between the hospital and the world outside through the introduction of open days, sports events, annual fetes open to the public:

> They did have open days, but also they had what they called flower shows on the field there, they were open to the public, they had a sports day that was open to the public as well, all these sorts of things were good for compatibility with patients, it all helped bringing it more into the open.

Former staff remembered groups of volunteers providing social and material support to patients who were isolated, and they organised social activities. Staff viewed volunteer activities as a link between the hospital and the community, contributing to the social rehabilitation aspect of care, through the organisation of film nights, bingo etc. Former staff recounted some of the material support from the League of Friends; at Mapperley, they fundraised for a minibus for the hospital to take patients on outings, and donated money towards essentials for those that struggled financially. At Saxondale, the League of Friends bought equipment for hobbies and games. Both Roger and Craig, non-clinical staff, remembered volunteers offered additional practical help such as staffing the patients' canteen and companionship for long-stay patients. Louise, nurse, recounted the role of the League of Friends in organising an extensive programme of events, published through the Saxondale hospital patients' magazine:

> Patients used to be taken out, they used to go for drinks, out to eat in places, the hospital had a theatre of its own, and things used to be provided there and people used to come from all over the place for entertainment of all forms.

Staff recalled the League of Friends' practice of 'adopting a patient'; it was commonly assumed that befriending isolated long-stay patients could bring about greater cooperation of the patient and lead to recovery (Macmillan 1958). The policy was widely practiced in mental hospitals from 1950s onwards by volunteer groups to act as surrogate families, widely criticised in the literature for its paternalistic attitudes towards patients (Jones 1993, Busfield 1997, Gittins 1998). Former staff that took part in this research acknowledged the practice of adopting a patient was paternalistic, but most felt that the help was offered in good faith. Overall, they believed the most isolated residents of the mental hospitals benefited from the emotional, social and material support.

Access to Sports Engendering Wellbeing

All participants remembered engaging in sports as a vital form of rehabilitation and a means of breaking down barriers and social differences between patients and staff, which fostered a strong sense of identification with the mental hospital sites. Patients had their own football and cricket teams and more able patients could join the staff teams at both Mapperley and Saxondale hospitals. Richard, psychiatrist, recalled Mapperley was famous for its cricket team, "they used to have Sunday cricket, I remember people being enthusiastic about it". When Raymond, nurse, started working at Mapperley at the end of the 1940s, it was considered important for staff to be good at sports, "it was one of the major factors of relaxing the patients". Raymond remembered staff and patients played alongside each other, which he felt was good for building good relationships with patients:

> We mixed together in the sporting team, we had a good cricket team and patients were in the cricket team with the staff.

Craig, porter, maintained the facilities at Saxondale were “second to none”, sharing an anecdote about the importance of their football team for engendering a sense of pride within the hospital community, which comprised of staff and patients. He referred to long-stay patients as ‘lags’ throughout the interview:

> In my father’s day, one of the things they were proud of was the staff won cups because it shone some glory on the hospital, the patients’ teams were mainly for fun although the football team was for the old lags.

Craig offered a scanned copy of a photograph of Saxondale football team from 1950 for the archives, in which his father played.

Figure 5 – Saxondale Football team 1950
Courtesy of Craig Hopkinson

J1 developed a life-long passion for cricket from his time as an inpatient at Saxondale through the relationship fostered with the physical training instructor:

> He saw that I was interested in my cricket and he encouraged me, you were gently encouraged to get involved.

After his discharge from a mental hospital in Lincoln, where he was transferred due to his refusal to continue ECT treatment, J1 returned to Saxondale to play in the staff cricket team as he developed good relationships with staff:

> I joined the staff cricket team and played with them long after I stopped receiving treatment at Saxondale. Some of the nurses who were on the ward with me, one or two were good cricketers, they knew that I was interested in cricket and they probably saw I scored quite a few runs, I did play quite a few games for the staff team so there was no problem about that, as an ex-patient I could play and it was nice for me to play there, I’d been doing something positive and achieving something there.

J1 further developed a keen interest in football, he attended a day hospital in Beeston from 1970s onwards where patients and staff formed a football team and played against other hospital teams, providing opportunities for increasing social capital:

> Anybody who was interested would play football, we arranged quite a few games against Mapperley, Saxondale and one or two of the day centres, and some of the patients would come when there was a cricket match on.

Other organised sports included bowls, tennis and snooker. Both Mapperley and Saxondale had tennis courts and bowling greens, and each ward had a snooker table at Saxondale; patients recalled playing sports alongside staff was part of the care they received. Michael recalled:

> I used to enjoy playing cards and snooker with other patients and the staff, we played tennis and football with them.

Rodney, ex-patient, remembered the sporting facilities at Saxondale contributed to a sense of feeling part of a supportive environment to which patients could belong:

> There was life there and there were facilities there that were second to none, they had a wonderful cricket pitch, I suppose they didn’t play very good cricket but that wasn’t important, the things were all there and these were made available to patients.

Staff viewed sports as a means to facilitate staff-patient relationships, which played a key role in motivating patients to engage in physical activities. Male staff got actively involved in the promotion of group physical activities for male patients, often playing alongside them in sports teams, which contributed to the social fabric of the hospital community for the male population of the hospitals; some female staff referred to playing table tennis with female patients but generally women were not engaged in sports. The findings suggest nurses played an important role in addressing the physical and psychosocial needs of patients through forming supportive relationships; in particular, all expressed the perceived benefit of staff playing football alongside patients in developing a new sense of self and providing the opportunity to enhance the therapeutic alliance, and a sense of belonging to the hospital community; the gender specific context of sports in the mental hospitals could be attributed to the long tradition of separating the genders up until the 1970s including the norm that nurses could only work on wards with patients of the same gender, a rule that relaxed in the 1970s. J1’s experiences of joining the hospital football team suggest that team identity can override the usual staff-patient distinctions, serving to break down divisions between professionals and service users, developing more equal relationships outside of the traditional roles assigned by the hospital hierarchy, which fostered a sense of wellbeing. The findings corroborate recent research on the benefits of physical group activity to improve the physical, psychological and social wellbeing of people with serious mental ill health (Happell, et al. 2012, Cullen and McCann 2015).

Moreover, former patients in this research collectively expressed worries about their overall health, including their physical health and the lack of organised physical exercise available through services. Research has found that comorbidity exists between long-term serious mental health conditions and physical health issues; hence the need to create support in achieving better physical health, which can improve service users' quality of life. Research into the correlation between regular physical exercise in leisure time and the amelioration of mild to moderate mental health problems has evidenced reduced mortality and the improvement of mental wellbeing; for example, physical activity can play a pivotal role as an effective way to counter depression and anxiety (Paluska and Schwenk 2000).

Social inclusion and meaningful roles the person with psychiatric disabilities is able to occupy are at the heart of the recovery process, alongside the need to create communities that are inclusive and tolerant (Slade 2009, Slade et al. 2017). The findings from this research point to the role of the hospital environment as an inclusive social space, through the formal and informal care practices that existed therein; recovery partly depends on finding and pursuing meaningful and purposeful occupations. This ability is derived not only through a person's drive but also through interactions with others, as well as access to support networks, both formal and informal that helped create opportunities, such as joining football and cricket teams at the hospitals.

Until recently, exercise has been a neglected area of intervention for mental health recovery, despite its proven beneficial effects on wellbeing (Callaghan 2004). Sports has been found to be an excellent mental health recovery strategy for its capacity to encourage supportive social relations, thereby enhancing the relationships between staff and service users through sharing common interests and experiences (McKeown et al. 2015). In a recent participatory study of the role of sports for mental health recovery, similar findings emerged. The relational, personal as well as the physical aspects associated with playing sports were found to be key aspects in the recovery journey. Moreover competition and collaboration were found to be key elements in engendering interest in and commitment to the groups. The longstanding nature of some groups were a key factor in their success in offering a stable base for building and maintaining relationships through competition and collaboration inherent in football (Lamont, et al. 2017). Collaborative activities such as sport are a key part of the current dominant paradigm in mental health policy, working *with* rather than doing *to* as best practice for personal recovery (Slade et al. 2017). The introduction of sports in mental health services would ultimately reduce health inequalities of people with serious mental ill health.

Access to Social Spaces Within and Outside the Hospital

A subtheme across the interviews with ex-staff and patients that I identified was the value of having access to designated spaces within and outside of the hospitals, which fostered social relations with staff and others that lived on site and in the vicinity. These included the patients' canteen, the library, the hairdresser's salon, access to the extensive grounds, the hospital shop as well access to the local shops on the adjacent Mapperley Plains, a local area reachable by foot from Mapperley hospital and the local village of Bingham, the closest one to Saxondale.

The importance of having access to the grounds emerged as a major theme across the interviews. Access to the park-like grounds at Mapperley, Saxondale and the Coppice, including the outdoor sporting areas was perceived as playing a pivotal role in personal recovery by ex-patients and staff alike; yet, the impact of open spaces on the care provided within the now closed mental hospitals has not generally been researched.

Access to the Outdoors Helpful to Recovery

Staff and patients associated having access to the grounds with the freedom of movement within the hospital and an important aspect of the care available within the hospitals. Linda, hairdresser at Mapperley, recalled:

> The patients could walk around the grounds freely, which was nice, they could have a wonder around, you could walk around everywhere.

Louise, nurse, commented on the freedom patients enjoyed to roam around:

> We had patients that had a lot of freedom to roam around the extended property and grounds, they could go about where they wanted around the hospital grounds.

Tryphena, nurse, described the extensive natural environment at the Coppice as pleasant, “you had rose beds, greenhouses, flower beds, there was rolling countryside for miles”. Richard, psychiatrist, described the grounds at Mapperley as “a very good place” in which patients “could get out into the countryside fairly quickly from the hospital”. Richard viewed the general environment of the hospital, including the natural environment as places in which patients could be free to be themselves:

> The general environment and the gardens would certainly have been much better, and of course people could wonder around and not cause offence to anybody and nobody would be too upset about them wondering around.

K2, nurse, described the extensive grounds at Mapperley as “a beautiful place”. She reflected on the therapeutic value of accessing the grounds for mental health recovery:

> Mapperley used to have beautiful gardens, and the patients used to go and work in the gardens as well, I love gardening now, so I can imagine how therapeutic that must have been.

Roger, electrician, recalled patients were “free to roam, they’d come to our house and have a cup of tea, it was good for the patients mixing with staff”. Rodney, ex-patient, recalled the therapeutic value of having access to the extensive grounds for mental health recovery. He described Saxondale as “a kind of idyllic rural setting”:

> Saxondale 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 enjoy seeing birds and find rest and repose in such an environment.

He made a close connection with a nurse at Saxondale who he spent time walking with in the grounds:

> She 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 walking the grounds and being among trees, flowers and birds.

Albert, ex-patient, loved going for walks in the grounds:

> Mapperley hospital was fantastic, the whole of the grounds was really lovely, you could come in one end and come out on the other and know that you walked.

Karen, ex-patient, remembered enjoying having access to the grounds at Mapperley, “it was lovely, you could see for miles because it is up a hilltop”.

The original asylums across Britain were usually set in extensive, park-like grounds away from urbanisation to encapsulate the contemporary arguments about the all-important function of the asylum site as part of a wider therapeutic regime, meant to influence the wellbeing of patients and help restore their health (Hine 1901, Edginton 1997). Gathering patients in extensive open spaces using moral architecture that opposed prison like built environments were the hallmarks of moral therapy (Du Plessis 2012). Access to the extensive grounds was thought to bring physiological benefits to patients able to enjoy extended walks beyond the boundaries of the hospital and restore ‘sanity’ (Woddis 1964, Markus 1993, Edginton 1997, Moon and Kearns 2016).

Mental hospitals have often been perceived as isolated spaces excluding patients not only from the outside world but also segregated within the institutions (Goffman 1961, Scull 1979). However, the role played by the external natural spaces must be taken into consideration as part of the material experience of giving and receiving care. The grounds and the outside sporting areas held special significance for both staff and patients. These outdoor spaces offered a setting wherein social interactions among patients and between patients and staff as well as experience of illness and recovery took place. In remembering these places, both staff and patients recounted the importance of the outside spaces as a symbol of freedom as patients were allowed to roam freely, which was perceived as therapeutic, consistent with findings from other qualitative research about the therapeutic value of access to extensive grounds in mental hospitals (Parr and Philo 2003). The concept of therapeutic landscape, first coined by Gesler, (Gesler 1993 p. 171), 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 (Curtis, et al. 2009, Wood et al. 2013 and 2015). As the excerpts above attest, spending time in the extensive grounds could engender social interactions perceived to aid recovery by both staff and patients alike. Staff and patients recalled the importance of nurses in encouraging patients to go for walks as part of their recovery, whether the patients chose to be accompanied or not. It hints to how patients could exercise some control over how they spent their time within the social spaces available at the hospital, including the grounds. It reveals how patients and staff embraced the inherent therapeutic qualities of natural environments, which in turn mediated staff-patients relationships, engendering sensitive relationships during times of convalescence.

Valuing Access to Internal Social Spaces

Other internal social spaces that engendered social interactions outside of wards were the hairdressing salon, the hospital shops and the patients’ canteen. K2 remembered patients having regular access to the hairdresser’s salon, “the women used to have a wash and set in those days as it was called and that was quite well equipped”. Linda, hairdresser, described the salon was in the middle of one of the wards at Mapperley, “staff and patients going in and out all the time, which was nice". She used to set up the salon as a social space to support social interactions with the patients:

> Chairs all around because people wanted to come in, sit and talk so we had to have plenty of chairs for that, it was small, but it was cosy and I tried to make it as friendly and as cosy for them as I possibly could.

Linda recalled the salon acted as a social space for patients who needed a break from their ward through the emotional and social support she offered:

> A lot of them would say "we are fed up on the ward, can we just come and sit and talk to you?" If I wasn't busy they'd come in and sit and talk and I always gave them the time, because they needed it, that's what they wanted, they wanted you to sit and just talk about anything and everything.

She stressed her role encompassed offering emotional support to patients through listening and being sympathetic:

> I was helping them in a little roundabout way and it was nice to have them trust you, no greater compliment than somebody trusting you with their inner most thoughts and fears, there's nothing nicer, you don't betray their confidence because they are not going to tell you anything, they tell you things because they want to tell you, they feel safe, secure and that's lovely.

Access to hairdressing on site was considered an integral part of the therapeutic developments to improve patients' care, instituted at Mapperley and Saxondale and the Coppice hospitals from 1950s onwards as part of the psychosocial treatment of the patients (Barton 1959, Nottingham Management Committee 1970, W.L.J. 1980, Nottingham Health Authority 1985); the hairdressers seem to have played an important role in offering social support to patients, in particular helpful emotional transactions such as the opportunity to offload unpleasant feelings. Hairdressers are a well-established source of social support when dealing with significant mental health issues and use important supportive strategies to try and help their clients to cope (Milne 1999). Social support provided by hairdressers on the high street was found to engender high levels of informal support within the community; research has found clients mostly use their hair stylists for the purpose of social support, which appears to alleviate their distress (Milne et al. 1992). A paper written by individuals with lived experience of mental ill health and of the psychiatric system, based on focus groups with service users within inpatient settings, reported that service users actively seek out recreational opportunities while in inpatient care, including the opportunity to access hairdressing facilities (Walsh and Boyle 2009). The service has now been reintroduced at Wells Road low secure hospital in Nottingham.

The shop on the site of the Nottingham mental hospitals was another social space that fostered informal sociability. For K2, ex-nurse, the shop at Mapperley provided choice as well as social opportunities:

> In the hospital there were lots of social opportunities, the hospital shop was one of these places, the patients used to put in an order every week of what they wanted from the shop and chat to the women working there.

Linda, hairdresser, stressed having access to a shop onsite gave patients access to personal care items:

> My mum worked in the shop, she loved it and the patients loved it because they could buy anything, there was always lovely stuff, you could buy anything in that shop, for the patients it was brilliant, anything, sweets, chocolates, toiletries, papers, cigarettes, it was a brilliant shop, it was lovely.

Staff remembered the patients' canteen at the Nottingham mental hospitals as pleasant and convivial environments. Tryphena recalled a small building was erected on the grounds of the Coppice hospital called the 'Gateway' in 1961 where patients could meet their visitors without having to bring them inside the hospital; staff could not go to the Gateway unless invited by the patients:

> They could take their visitors there, they didn't have to come into the hospital and we couldn't go there, we had to be invited by the patients.

Non-clinical staff described the patients' canteen at Saxondale as a very pleasant social space, set in the grounds of the hospital; Craig remembered the importance of this designated space for long-stay patients to socialise, which he referred to as 'old lags':

> For the old lags the best chatting up place was the patients' canteen because it was like a traditional pub, each one had their own chair round the corner and their own set of mates and their own tricks of the trade.

There was consensus among former patients that access to the library was therapeutic during the period of hospitalisation. Michael, ex-patient, used to borrow books from the library at Saxondale, "that was really good, I enjoyed that, I used to read a lot". What K1 enjoyed most during her hospitalisation was spending time in the library and doing research about the history of Mapperley. Having access to the library helped her make sense of her experience through reading self-help books. Most participants who either worked or received care at Saxondale recalled fond memories of the librarian at Saxondale who used to organise music appreciation sections for patients who could listen to their favourite music.

Contrary to the traditional notion of mental hospitals as isolated and removed from the community, ex-patients and staff recalled that a connection to the outside world was well established at both Mapperley and Saxondale hospitals and patients' access to the outside world was part of their recovery. Sean, nurse, recalled “a lot of the patients went out on their own”. Most participants that worked at Mapperley recalled the hospital had a special connection to the community at Mapperley Top, a local area reachable by foot from Mapperley hospital, where patients built social connections with local people. Linda remembered “if you spoke to anybody in the shops, the Blue Parrot café, the chip shop, the patients would walk in, staff knew that they were Mapperley hospital patients”.

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 sanctuary and a source of social support both from within and from the adjacent local community, recurrent themes in published and unpublished oral histories of residents of the now closed mental hospitals (Calabria 2016). Amongst the former patients there was consensus of the value of the psychiatric hospitals in providing safe and calm environment; these factors were recounted in relation to experiencing supportive relationships with staff and peers; of feeling at home and of belonging and in having space and peace around them, including the option to access amenities in the vicinity of the hospital.

Patients’ Sense of Belonging in the Mental Hospital

Former patients reflected on their personal meanings of receiving care at the Nottingham mental hospitals. What emerged was a strong sense of identification with place, in terms of a shared sense of belonging and a general sense of the good care patients received, bound up with a shifting sense of identity during moments of crisis. K1 felt that her experience of hospitalisation at Mapperley helped her make sense of her mental health condition:

> It was the first time that I came to terms with the fact that I had a mental illness, I was in my late 30s by then and I hadn’t had any sort of diagnosis before, I was able to develop an understanding of my behaviour without blaming myself all the time.

K1 began to develop mental health problems while at university; the stigma she experienced impeded her from receiving support:

> My family didn’t believe I had a mental illness, they believed that I was just wilfully bad rather than mad, it’s one of the problems in those days, a lot of people believed that you had to be stupid to have a mental illness, if you were at university, you wouldn’t get depression or mental illness, at Mapperley it was the first time I’d heard someone tell me that it wasn’t all my fault, my responsibility, my behaviour was dictated a lot by the illness rather than I wanted to do daft things and upset everyone and everything.

Michael first developed mental health problems while working at the Electricity Board in Nottingham. His time as an inpatient at Saxondale helped him “feel better”, he described he could ‘fit in’ and felt ‘at home’ in a way he had not experienced in the community:

> I just fitted in with the men, I felt at home at last, I felt that I could be myself, I felt free and in some ways, it lifted me, instead of low self-esteem, I felt cleverer and better, that lifted my self-esteem which has always been very low, being there I felt better.

He felt he belonged at Saxondale, as he formed strong connections with other patients:

> I fitted in there, they were more my type of people and I was doing well, I got to know people, I got on and it was friendly, and it was quite a good spell.

While at Saxondale, Michael volunteered to help less fortunate patients with practical and material support, which gave him a sense of purpose and improve his self-esteem:

> I like talking to people and I felt I could help them with filling in forms, they couldn’t read and in some ways it made me feel a lot more useful in helping people and I felt quite a lot better and with having a job I was still being paid, I got cigarettes, I was better off than they were so I helped them with that, a lot of them didn’t work.

He compared the feeling of belonging in Saxondale to that of the Middle Street Centre (MSRC), a mental health service user-led organisation, where he volunteers, both places in which he could be himself within a safe environment:

> What helps me is a feeling of being at home, of feeling myself, of being part of it and peaceful, and it can feel like being worth-while here, I feel I can help people, the people that run the centre asked me to get to know the people here to talk about the problems and help them and get to know them, so I do that, I like helping people, I think it’s a sense of belonging and I got that sense of belonging when I went to Saxondale, I belonged there with the right kind of people, what I like about here, especially when I first came here, you could be entirely yourself, you could cry and shout and nobody bothered, and that’s what it was like at Saxondale, it was all right.

J1, ex-patient, despite his negative experiences of care, described the hospital environment at Saxondale as comforting:

> It was a happy sort of environment for me and I am sure for most of the other people who were there, it was a comforting thing going there and looking forward to get off the ward and I could express my creativity within what they got to offer.

J1 also volunteers at MSRC on a regular basis; the centre was formally a day hospital he used to frequent in the 1970s and again in the 1980s as day centre run by social services. He was pleased he was able to pick up the occupational therapy’s activities he had started at Saxondale once he began to attend the day hospital from the mid-1970s. The day hospital was turned into a mental health centre run by social services in the 1990s with the advent of community care.

Despite the stigma attached to the hospital sites, the emerging evidence points to the value of the mental hospital communities as a rich source of social capital in fostering ample opportunities for belonging, social support and validation. A crucial aspect that I identified from service users’ narratives is the need for valued social roles in the community, evidenced in the literature (Barham 2006, Repper and Perkins 2003, Slade 2009, Slade, et al. 2014, Leach 2015). This evidence from participants’ experiences correlates with other research based on the memories of ex-patients and staff who felt a definite sense of belonging to a community, which operated within spatial boundaries and distinct rules, laws and regulations, reinforced by the densely entwined network of kinship connections (Gittins 1998, Parr and Philo 2003, Calabria 2016).

The concept of fostering a sense of belonging has important implications for mental health interventions. It plays a crucial role in the process of recovery and a low sense of belonging is an indication for the need for interpersonal interventions (Fisher, et al. 2015). The process of recovery is inextricably linked with the role that community plays in providing resources and opportunities to begin the recovery journey. The process necessarily entails interactions and transactions between the person and community and the wider society (Slade 2009, Slade, et al. 2014). Service users suggested strategies for increasing a sense of belonging and community connectedness to reduce self-stigma and increase their sense of wellbeing during the group feedback; there was a consensus for the need to access communities of choice as places to belong. Service users that took part in this research explained they were able to achieve a positive sense of self through their active involvement of the running of MSRC, a service user-led centre, in spite of the stigma associated with their psychiatric disabilities and continuing symptoms. Service users felt that they were able to surmount the social impact of their psychiatric disabilities through fostering a strong sense of belonging at the centre. However, what emerged from individual service users’ interviews were some problems with regard to being able to support oneself, which is not always possible due to potential relapse. Crucially, recovery entails the individual’s active involvement in social roles. This can be achieved either by returning to roles lost through illness, or through the making of new social roles as stigma may have caused the loss of social roles within work, family and friends (Repper 2003, Slade 2009). None of the service users that took part in this research returned to the social roles they previously occupied. Society remains largely hostile to people with long-term mental ill health. The oral histories point to the recognition for the need to provide long-term support in designated environments. Michael, K1, J1 and Rodney possess a heightened awareness of oppression in connection with their mental health label, which has encouraged them to challenge the status quo by viewing their new identity as mental patients as a strength rather than a position of weakness. They all occupy positive social roles at MSRC, suggesting they have been able to find a new sense of personhood through positive social roles acquired through a community of choice. The correlation between participants' expression of the value of the relational care within the mental hospitals through formal and informal social support alongside the structured rehabilitation programme, point to the paramount importance of taking into consideration the environment for positive recovery.

A key concern for policy makers is the reduction of the prevalence of stigmatisation that impedes personal recovery for individuals with mental health problems. Interventions that consider sense of belonging as a prevention mechanism or supporting existing interventions could help moderate the damaging effects of self-stigma (Cook, et al. 2014). The findings in this chapter suggest that improving community belonging for people with long-term mental health issues could bring considerable benefits to their lives. I identified a key recommendation from the relational narratives of care in the mental hospitals, namely to develop inclusive communities that enable access not only to peer support but also to designated places of belonging.

Family-like Environment

A recurrent theme that I identified from former staff's memories centred on Mapperley and Saxondale hospitals as family-like environments, bound up with a sense of belonging not only for staff but also for long-term patients. Long-serving staff repeatedly referred to the hospital as the patients' home and the efforts that staff made to foster a welcoming and comfortable environment. Louise, nurse, saw herself as "a mother figure" to long-stay patients for whom the hospital was their home, "I was ward Sister for two female wards at Saxondale; it was like a family". She experienced grief when patients were moved out of the hospital as part of the closure, "I started crying, they were like my family". She repeatedly referred to Saxondale as a family unit, seeing the female patients she cared for as part of her extended family:

> Saxondale was a lovely place to work, it was like a family unit, it was a really well set out place, it was a family-oriented place, so not only with the patients and staff and all grades of staff, it was home.

Raymond, nurse, described Mapperley as “a big family”:

> Everyone was in the same position, staff and the patients, it was like a big family home, and I think there was a lot of trust and compassion shown to them.

Linda, hairdresser, repeatedly described Mapperley hospital as having “a family atmosphere”, for the willingness of everyone to help one another regardless of their job status. For her, at Mapperley “we were all like family”:

> I keep going back to family because that’s how it felt, everybody was willing and able to help each other if we could, whether you were just the hairdresser or the domestic on the ward and the patients used to sit and talk to the domestics too, the porters coming and going, it was a proper family atmosphere.

Former staff felt that the village life within Saxondale contributed to the sense of home and belonging; the hospital was located on an isolated site in the countryside and operated as a self-sufficient community to an extent, with its own bakery, farm, even its own mortuary. In particular, the remote location was perceived as having played a role in the creation of a close-knit community and active social networks. The close-knit communities that were formed at both Mapperley and Saxondale constituted the underlining sense of family-environment. Former staff referred to the hospital as the patients’ home and that relationships between patients and staff were generally convivial. Craig, porter, reflected on the importance of Saxondale as a place of belonging for many former patients:

> It was such community that you did seem to know everyone’s name, at least the names you went by, I can’t remember anyone where I am now but there people you knew each other by name.

What further contributed to a feeling of home was the expression of permissiveness in terms of patients’ ability to freely move around the hospital and visit staff in their homes on site. Craig remembered the matron at Saxondale associating the freedom of patients to roam around the hospital with fostering a sense of home:

> She used to say it’s the patients’ homes, if the patient wasn’t under close watch they were free to roam wherever they wanted to, in the staff quarters, around the grounds and in the billiard rooms, anywhere, it was their home and they had a right to wander.

He recalled how some patients would visit his father for a chat in their home:

> Any patient could just walk into any of the houses and regularly as a small child I’d get up in the morning and there’d be one of the patients sitting on the sofa, because we never locked the door in those days and they’d see my dad

> and have a cup of tea. They would often call by just for a chat, one patient used to come down just for a game of chess which my father thought was very educational and used to say “you can go and play with my son anytime you want to” but he was far too good for me.

J1, ex-patient, recalled the hospital environment as being fairly relaxed:

> We walked through the streets, we were quite free to roam about, we were voluntary patients.

Furthermore, he recounted that “people even then could do their own thing within”:

> There was a chap who used to regimentally, quite early in the evening get his dressing gown on, get his own coffee and make a whole ritual about getting his coffee, having other little sort of treats for himself, so people even then could still do their own thing within.

Similarly, Michael also remembered the atmosphere at the hospital as relaxed as a patient as Saxondale; a friend visited him regularly and took him out on day trips:

> That was all right, they let me do that, no fuss, no bother, I just went and told them and I went out for a drive around, they let you go home for the weekends.

Michael recalled going to the local village unaccompanied:

> We could go down the street to the pub in Radcliffe by ourselves, sometimes we went down the village café.

Roger, porter who grew up on site, repeatedly referred to Saxondale as village like, he felt proud of the community that existed on site:

> There was a big community, we had our own factory, our own farm, a shop, for a lot of people it was like a self-contained village. It was just like a little village, you had carpenters, electricians, the hospital grew its own produce.

Mark, nurse, also described the hospital as a big village, with plenty of social activities due to the high number of patients and staff living on site:

> There was always something going on, Saxondale was like a big village, there was 800 patients there, there was probably about the same number of staff, there were always people around, new people all the time, I had just left home and it was quite exciting, making new mates, the work was interesting.

Louise, nurse, recalled the strong bonds formed across patients and staff contributed to the family-like environment:

> Most patients were friends and family to one another, they formed closed friendships, and there are groups of patients that stuck together no matter what happened.

For Louise, what contributed to a sense of community and village and family-like atmosphere was the kinship that existed among generations of staff that worked on site:

> We were a big institution, all areas were covered, within that we had electricians, potters, gardeners, carpenters, domestic staff, you name it. Most of these workers had worked there for a long time, one of the things that used

> to happen at Saxondale, it used to be a family structure, one set of a family bringing another set of the family so there was a lot of that so you had three generations of porters and that went right through the structures.

For K2, nurse, what constituted the family-like environment was the familiarity and reciprocity that existed between staff and patients:

> It was like an extended family, quite a lovely community, because we cared about each other and would help each other, so you'd have the ward sister, then you would have the staff nurses, the nursing assistants, so there wasn't actually that many tiers that you'd see, everybody knew everybody.

She recalled a strong sense of kinship among staff across the hierarchy, which she feels is no longer the case in current mental health care settings:

> The nursing officer would come around, the duty officer would often walk around all the wards, they'd know everybody by name, which was quite good, nowadays I would think my senior manager know me but above that they wouldn't have a clue who we are.

For Tryphena, ex-nurse, what made the Coppice hospital a home were the everyday rituals and the care taken to make the hospital feel like a home:

> The table was set at all times, the vases of flowers, it was like a restaurant, the food, I could go to work and have anticipation, look what's for lunch tomorrow and really enjoy it because the food was cooked just down the hall, nice big kitchen, everything was spotless.

J1, ex-patient, described the ward he was on as "quite homely, with only a small dormitory", which he found comfortable for his needs.

Roger, porter, had a very strong sense of identification with Saxondale, having grown up on the site:

> I loved it, it was a great way of working, and of course I was on foot walking around all the wards, all the places I remember as a kid, it was phenomenal, and people, I knew everybody, everybody knew me so it was wonderful.

Staff recalled the hospital functioned as a home for a number of long-term elderly patients that had no social ties outside of the hospital, and relied on the community therein for social support. For Craig, former porter who grew up on the hospital estate, Saxondale "was not just a community, it was a way of life", recounting that "it was home to them" and he felt that "they were looked after". The oral histories extracts above point to the efforts made by staff to create a family-like environment; it resembles the philosophy of moral treatment with its focus on making the physical as well the social environment pleasant to encourage for recovery (Borthwick 2001). These arguments are supported by the therapeutic community movement in terms of creating family-like environments based on mutual support, shared values and solidarity (Fussinger 2011).

Places of Sanctuary and Respite

Both staff and patients were keen to stress the value of the mental hospitals as places of safety and sanctuary and of refuge, a point not usually highlighted in the literature about psychiatric institutions (Rolph and Walmsley 2006). Olive, seamstress at Saxondale, felt the hospital environment provided safety for long-term patients and recounted the fear experienced by some when the hospital was due to close. Olive shared the views of one of the patients on closure:

> One lady we spoke to, she wasn't going to go, but of course she had no choice, she had to go, whether it was a good thing or not I don't know but Saxondale was really a wonderful place for them, I do feel that it was the safest place for them up there, it was a shame that was closed.

For Louise, ex-nurse, Saxondale was a "heaven" for both the patients and the staff:

> Some patients had lived there from when they were very young so it was home for them and although they used to get a lot of visitors from their families, only some because a lot of them were just forgotten, what staff would ensure is that they were treated like family.

Similarly, former patients viewed the hospital as a place of respite; they expressed a sense of feeling safe within the hospital environment. For K1 the mental hospitals provided security during times of crisis:

> The emphasis in the psychiatric hospital was on keeping me safe. I had very warm feelings about it, it was a refuge at a time I needed one and I felt connected, I think it made me feel I had a place, my story is one of feeling alienated from society and I think that that gave me a sense of connection.

For Albert, "Mapperley hospital did wonders for me, all in all I can't complain that I as an individual at 80 years of age, that I've not had the attention". He reflected on the importance of accessing a place of refuge during his recurrent mental health crises:

> When you lose the sense of who you are, the importance of feeling safe and protected is more important than anything else.

Karen felt she received good care during her hospitalisation and felt she could not have recovered without her time as an inpatient at Mapperley hospital:

> It was helpful, I know going into Mapperley hospital was very good, it's what you need and the help they provide, I ended up a different person, I'm still on anti-depressants but they keep me very good on the dose that I'm on.

Andrew, nurse, recalled that a large proportion of the patients were not able to live independently in the community:

> A lot of patients that suffered from chronic schizophrenia, who really couldn't live outside of an institution, they were on medication, they lived there, it was board and lodging for them and they had a lot of support from the staff.

Former staff recalled that long-stay patients lived their lives out at the hospitals until death, many without relatives. Roger, electrician, recalled that “you would see it all the way through”:

> They were looked after, even when they passed away they were looked after, they went to the mortuary and were laid out by me and the Head porter, always done with respect.

K2, nurse, recounted efforts made to care for long-stay dying patients, who were completely isolated, with kindness and respect to individual needs:

> On the sick ward lots of the elderly came to die, which was quite sad as quite often they had no relatives. They’d been at Mapperley for many years, you could tell if somebody had probably 24 hours to live so we used to put them in the side room because it was a bit more private and then we used to try and get a member of staff to sit with them all the time, I am not religious but I can remember holding somebody’s hand because I knew they were religious and reading them bits of the bible, we used to all do different things, you’d do their hair, or put some makeup on so they didn’t die alone.

The excerpts above provide substantive evidence of the hospital community acting as pseudo-family members. The sense of belonging through the social connections that were formed and fostered within the context of the hospital communities seemed to have positively impacted not only patients but also staff wellbeing.

Through the PAR phases of planning, action and reflection, stakeholders were encouraged to reflect on their personal values and norms, their cultural identifications, and community affiliations. Four of the service users that took part in this project are actively involved in the running of the Middle Street Resource Centre (MSRC), a service user-led organisation. During the group feedback meeting with service users in which I shared my findings, all made a strong correlation between the communities of belonging that existed in the mental hospitals to the sense of community affiliation they derive from MSRC. Four participants recommended having “more Middle Street centres” to help foster a sense of belonging for people with serious mental health problems who are marginalised within society. One participant expressed a strong sense of identification with the centre, he “would not know what to do without it”; all stressed the importance of finding a place to belong for their recovery journey. What the service users that took part in this research have in common is few community ties outside of MSRC, largely relaying on the activities run at the centre as their main source of social support. It points to the importance of having access to communities of choice for service users who feel isolated living in community in order to increase their social connections.

The correlation between belonging and mental health is an emergent area of research in the western world. A sense of belonging is widely associated with mental wellbeing (Tew, et al. 2012, Fisher, et al. 2015). A strong correlation exists between a sense of belonging and self-stigma, namely the process in which individuals with a mental health diagnosis internalise public attitudes of prejudice and discrimination and suffer several negative consequences such as loss of self-worth that can lead to isolation and ostracism (Corrigan 2005, 2012); the effects of self-stigma in people with severe mental ill health include low self-esteem and self-efficacy, lower coping skills and treatment engagement as well as hopelessness (Drapalski, et al. 2013). Feeling a strong sense of belonging has been found to help protect against self-stigma for individuals with mental health issues (Treichler and Lucksted 2017).

Baumeister and Leary (1995, 2017) argue the need for belongingness amounts to more than the basic need for social contact and this need is satisfied by an interpersonal connection marked by stable and continuous relationships. The context in which social interactions with other people takes place is essential for satisfying the need to belong. Loneliness is implicated in negative aspects of mental health; the unmet need to belong has been found to be a major risk factor for loneliness, and the consequent reduced wellbeing (Hagerty, et al. 1996, Mellor, et al. 2008). The lack of community spaces for service users has been compounded by the closure of most mental health day centres in the UK as a result of cuts to public services and the government's introduction of austerity measures (Moth et al. 2015). Belonging to a community is generally characterised not only by the level of social engagement and participation in a given group but also by the social and environmental factors linked to a given place; feeling connected increases wellbeing through feelings of mutual respect and self-esteem (Palis et al. 2018). The theme of belonging that I identified from the oral history interviews point to the importance of incorporating social and community factors in mental health interventions as the social fabric of the hospitals' communities was done away with their closure.

Conclusion

The overall theme of relational care attests to the changing dimensions of the provision of care that had a significant impact on the mental hospital environments, moving away from the totalising features of institutional care towards more therapeutic approaches. Despite depersonalising institutional practices that remained until their closure, the hospitals benefited from the social reforms in the form of the introduction of advanced care practices such as therapeutic community principles and psychosocial approaches to care. These innovative care practices, introduced by pioneering psychiatrists from the 1940s onwards under the umbrella of ‘community psychiatry’, had a dramatic impact on promoting positive attitudes towards patients and social rehabilitation, demonstrating the social model of mental health policy operated alongside the medical model.

The findings evidence a humanistic culture of caring within the Nottingham mental hospital, albeit with aspects of institutionalisation, which contrasts significantly with the evidence portrayed in the literature on mental hospitals as ‘total institutions’ (Goffman 1961, Robb 1967, Martin 1984, Hopton 1999). Participants’ oral histories challenge the idea that staff and patients’ relations were purely dictated by social control. The Nottingham mental hospitals were perceived as a safe haven, providing a community of belonging for both staff and patients, within which relational care practices took place, perceived to be helpful to recovery. The hospital acted as a thriving community that provided much more than just social control. The oral histories show that social life was at the heart of the hospital through the cafe, access to the extensive grounds and the surrounding local community, the shop, the hairdresser’s salon. Structured occupation and recreation were recognised as an important source of dignity and purposefulness to promote wellbeing for both patients and staff, activities over which patients could exert some control over their lives. The findings point to the importance of sports such as football and cricket in fostering recovery; one of the main recommendations from stakeholders that took part in this research is access to sports should be included in mental health policy as a means to personal recovery. Stakeholders recognised the value of having access to the extensive grounds as a form of therapy, which was lost with the hospitals’ closures. Participants correlated having unlimited access to the grounds with the freedom of movement within the hospital’s internal and external spaces that all enjoyed in the old system of care and lamented the return to locked wards in the current system as a step backwards in mental health policy.

What cuts across all of the interviews is the relative power between staff and patients, which could be fluid and permeable. Ex-staff and patients' oral histories point to the Nottingham mental hospitals as therapeutic environments within which therapeutic staff-patient relationships were formed and fostered. Participants' oral histories reveal a complex web of helping relationships across clinical, non-clinical and others that made up the communities therein and the surrounding villages and urban areas. Former staff and patients alike recognised the value of availability of staff who fostered therapeutic alliance, offering practical advice such as coping strategies and social, emotional and at times material support. Ex-patients reported to have benefited from the social connections to peers and others that provided informal support by helping to give meaning to distressing experiences. The hospitals could provide a degree of both formal and informal social support through the structured rehabilitation programmes and the social networks that existed on site, which former patients and staff viewed as key factors in personal recovery. Patients were encouraged to rehabilitate by taking on social roles within the hospital, thus the roles that both short-term and long-stay patients occupied could be a source of validation as some patients developed a strong identification with the hospital's community. Moreover, volunteers provided a bridge between the hospitals and the local community, contributing to the social rehabilitation aspect of care through a varied programme of social and recreational events, helping to foster informal social connections within and in the proximity of the hospital site. Furthermore, the material practices of everyday care, such as making or being offered a cup of tea, were an integral part of the caring culture within the mental hospitals, reported by participants as engendering close interactions between the different groups that occupied the hospital.

For ex-patients who still rely on mental health services, sense of belonging was inextricably linked to being connected to a group of people in a particular place, feeling valued and accepted by others in a designated social environment, which in turn was perceived to improve wellbeing, an experience not readily available in community. The sense of belonging to the hospital communities provide a useful analytical lens to understand the wider structural forces that continue to socially exclude individuals with serious mental health problems. The service users that took part in this research continue to feel excluded in community and have created social bonds through communities of interest that are peer-led within designated spaces wherein they feel able to be themselves. Ultimately, the hospital environment afforded unconditional security, structure, availability of both formal and informal social support, and a sense of belonging and community for many, albeit custodial and paternalistic aspects of care. The findings from this study conducted 30 years since the closure of the mental hospitals, concur with what Parr and Philo found about the definite sense of belonging and the value of the grounds as a therapeutic landscape in their explorations of memories of ex-residents and staff at Craig Dunain hospital (2003). The social relations and the interactions, including the communal relationships that formed across the staff hierarchies within the hospitals, have gone. Psychiatric institutions as a treatment model have been cast as anti-therapeutic, yet this study demonstrates that not all patients were negatively affected. All of the former patients in this study found the treatment on some level to be beneficial. Overall, the experience of being an inpatient held positive therapeutic meanings despite some negative experiences of care, concurring with the experiences of other patients reported in the literature in which the old mental hospitals were remembered as places of health care systems and as communities of belonging (Prior 1995, Goddard 1996, Cornish, 1997, Parr and Philo 2003, Davis, 2001, Gittins, 1998, Craze 2014, Calabria 2016, Calabria, et al. in press).

These collaboratively produced oral histories offer a novel interpretation of the relational care provided therein. The experiences of people that worked and lived in institutions have the unique potential of giving voice to previously inaccessible knowledge that has the power to create new paradigms. They have the power to disrupt the dominant public discourse of mental hospital as custodial institutions solely dominated by discipline and punishment. The concept of total institutions provides a false dichotomy between the care within psychiatric institutions and life in the community, which are neither necessarily separate nor irreconcilable; seeing residential care as a form of last resort is likely to reinforce a notion of inevitability of institutionalisation rather than underfunding, poor staff training and low staff-to-patient ratio (Jones and Fowles 1984, Jack 1998, Higham 2006, Johnson et al. 2009). 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 (Barham 1992, 1995, Taylor 2015).

The significance of social capital amongst residents and between residents and staff within the institution must be recognised for the part it plays in the recovery of people with mental health problems. Fostering practices that develop relational geographies in terms of supportive relationships that extend to service users' families, neighbours and wider social networks would provide a vital source of support for people experiencing mental health difficulties. The findings help establish an evidence base for positive change in mental health provision by providing novel insights into the value of relational care through inter-personal, and therapeutic relationships that existed therein and how these have been affected in the shift away from institutional care.

The next chapter outlines the main findings that I identified in relation to participants' experiences of community care.

Chapter 6: Mixed Experiences of Care in the Community

Introduction

Despite participants expressing positive experiences of community care, such as increased patients' independence and well-funded services in the early years of the new system, most participants had misgivings about the quality and availability of services since the hospital closures. This chapter discusses the main themes and subthemes that I identified from the oral histories in relation to community care, namely improved care in the early days of community care in Nottingham, adversely affected by subsequent funding cuts and the restructuring of services under the UK government's austerity programme; the ambivalence of both staff and patients about the quality of inpatient care provided in acute units as opposed to the care provided in the mental hospitals such as the loss of a homely atmosphere of the wards and access to internal and external spaces; the sense of dispossession for both service users and staff in terms of the loss of adequate rehabilitation services; the perceived lack of a community of belonging; the experiences of neglect as a result of the loss of the hospital community and the consequent fragmentation of staff-to-patient, patient-to-patient and staff-to-staff relationships; some participants discussed the loss of skilled staff within mental health provision. Participants associated their feelings of what has been lost with the closure of the hospitals and the advent of community care with a strong sense of dispossession for servicer users and, to a lesser extent for staff. In addition, retired staff who lived on the site of Saxondale hospital expressed a deep sense of loss from the removal of the physical signs of the hospital. Figure 6, below, outlines the main findings in relation to participants' experiences of community care.

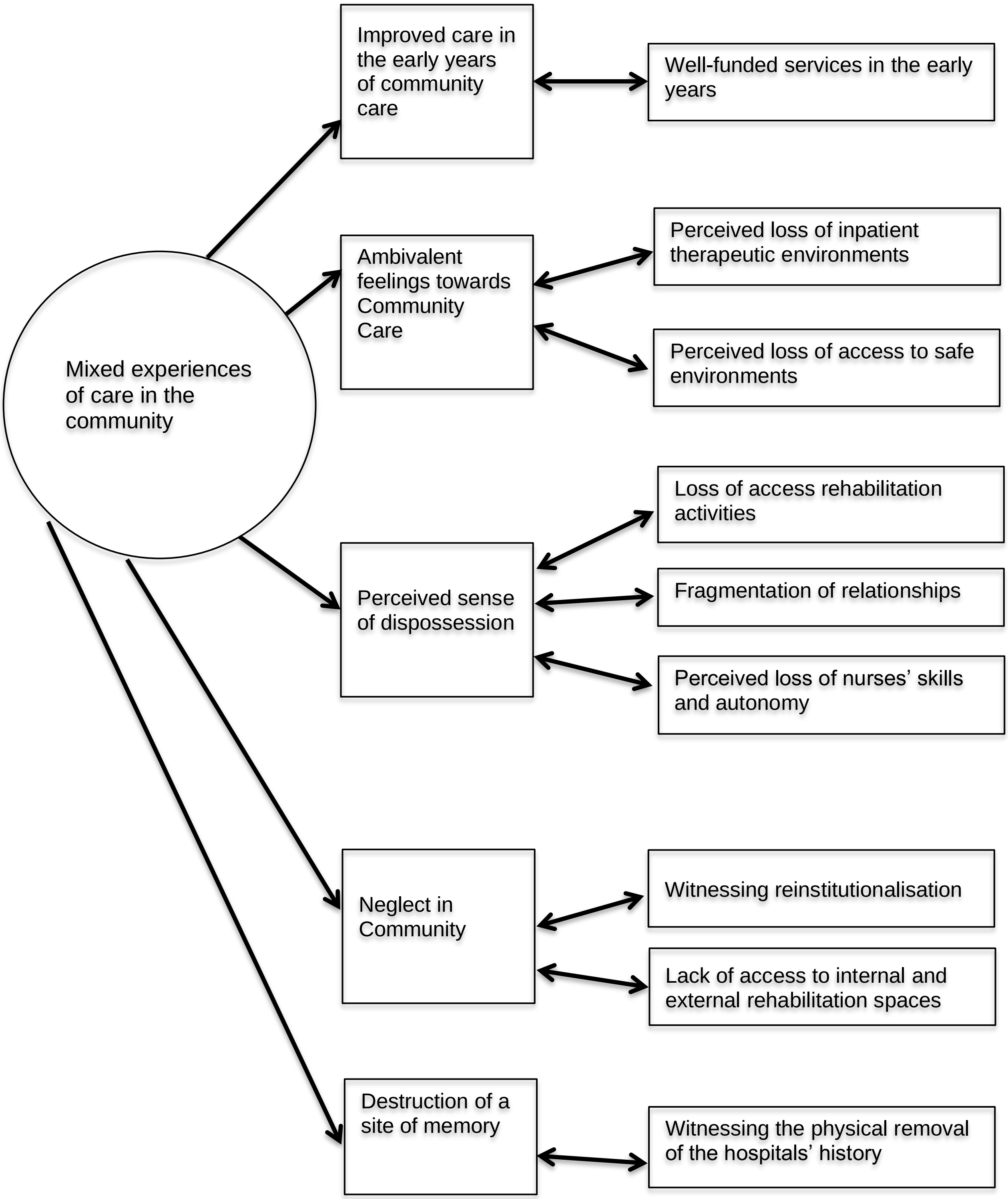


Figure 6 – Flowchart of the main theme and subthemes of community care

Improved Care in the Early Years of Community Care

Three former staff involved with the set-up of community care stressed the importance of independent living for people with long-term mental health problems; moreover, there was a consensus that the introduction of inter-disciplinary teamwork provided a more holistic approach to recovery, which contemporary researchers such as Carpenter (1999), Perkins and Repper (1998) identified as important in providing adequate care in the new care system. All three staff that were directly involved in the implementation of care in the community in Nottingham agreed that with the passing of time, gradually most services were reduced or removed due to cuts to mental health budgets.

Normalisation of people with mental health problems was the main philosophy driving the implementation of community care (Wolfensberger et al. 1972, see Owen 2004). During the 1970s, staff recalled efforts were made to de-stigmatise mental illness to see it like any other illness, without the need for separation and containment, epitomised by Goffman's notion of 'total institutions'. The new focus in mental health policy was to encourage people with long-term mental health problems to have a 'normal' life as much as possible, explicitly endorsed in the 1989 Caring for People paper that paved the way for the NHS and Community Care Act 1990 (Department of Health 1989, 1990). The philosophy of normalisation was largely based on removing the totalising features of institutional life postulated by Goffman (Scull 1986). Some of the nurses described positive aspects of community care, namely clients gaining independence by living in community with the ability to make their own decisions. K2 remarked that "people did not have to be condemned to be in hospital for life" and benefited from community care as "there was no one to tell them what to do". Richard, psychiatrist, explained what the philosophy of normalisation meant in practice, moving from custodial to community care services:

> The idea was that people should be able to go to the general hospital to be treated like any other illness.

Richard was in charge of developing the first community-based mental health team in Nottingham in the mid-1980s. Six mental health teams operated across specific geographical areas of Nottingham; some rehabilitation day services were set up to provide re-skilling for long-term service users. He recalled the substantial expansion of social workers in mental health services, working with psychiatric nurses to create multidisciplinary teams. Richard felt that "on the whole things have improved very pleasingly" due to the much broader mental health practitioners' specialisations such as specialist forensic services. Richard explained the staff were mostly supportive of the new system of community care:

> The majority were enthusiastic about something new, providing that clients went to the right place and that they had the right bridge between being out and yet having some sort of contact.

Mark worked as a nurse in the first mental health team established at the Queens Medical Centre (QMC). He recalled how mental health practitioners embraced the humanist approach that characterised the new community care model:

> It wasn't a particularly strong medical model, we were nurse-led. In the first couple of years we would do follow-up, outreach and there was counselling sessions set aside by nursing staff, individual one-to-one work with inpatients.

Well-funded Services in the Early Years

Two former staff recalled the 1990s being a 'generous' time in terms of the finances available for mental health services. Richard reflected on the initial gains as a result of deinstitutionalisation, "We were given a lot of extra finances to empty the mental hospitals". The National Service Framework (1999) supported the process of hospital closures and resettlement of long-stay patients in community. Mark described the level of support available when he worked as an acute nurse at QMC in the 1990s:

> All of that decade, coincidentally a Labour government, I went from working nearly always on my own as a staff nurse to nearly always working with another staff nurse and that was a massive improvement in every way, especially for my stress levels, if there was just you all the time, that gets to you.

Peter, psychiatric social worker, was adamant that closing the hospitals was the right thing to do, providing that the same level of inpatient support continued to be provided in smaller units delivered by interdisciplinary teams. Peter was involved in the dismantling of the institution; he found that some people were able to adjust to the change and that some struggled. It was an exciting time for him professionally as there was huge potential for change through the implementation of innovative initiatives to support living in the community. Peter recounted that the rehabilitation service set up to transition long-term patients into care in the community at Mapperley supported 500 patients. The rehabilitation system consisted of two long-stay wards, day centres, a community team, residential care facilities and the short-term rehabilitation unit at Mapperley Hospital. Peter managed the industrial therapy unit at Mapperley (1985-1988), which he renamed as Skills and Practical Activity Network (SPAN). The ethos of SPAN changed from the way in which industrial therapy had been run previously so that workshop groups were set up as cooperatives. He explained that the income generated belonged to service users who could choose to share it out or reinvest it in the cooperative, therefore gaining democratic control of the business. Peter was able to access European Union funding to create a new purpose-built workshop and to acquire and modernise another building. He recalled that the principle behind these workshops was for service users to take control and gain a voice:

> If you ask people their opinion about things, sometimes for people that have been in services for a long time, their eyes gloss over, but if you put £100 on the table that the group have generated and say what are we going to do? Everyone wakes up and joins in and there was a real engagement with those decisions, and even some of the most institutionalised people woke up to the fact that they had a voice in that situation.

Peter explained that the complex bureaucracy involved made the service unsustainable in the long-term. The service ran for about 15 years before it closed down; about 120 people took part in the initiative, which tended to cater for service users that had been part of the service for a long time. Rodney, ex-patient, took part in the activities of SPAN, which helped him find a job in community:

> The skills and practical activities network was so central to helping people back into the community, it was the stepping stone that laid between hospital and being back at home for me.

Rodney lamented the closure of the service; he felt "the whole dream of social and therapeutic activity in the community was knocked on the head" when SPAN closed down, which he put down to cutbacks in mental health services in the late 1990s. For Rodney, closing SPAN was "short-sighted and insensitive to the needs of people that were within the service". In addition, Richard, psychiatrist, recalled that some aspects of social rehabilitation of institutional care such as group therapy groups were retained through recreational activities in the early years of care in the community, which eventually closed down:

> The Stone Bridge centre in Carlton had a games hall in it so they could have football, netball, whatever games. They were able to have community meetings in the hall like the old days.

One exception was the Beeston day centre, a social services day centre, now MSRC since 2012; Richard recalled, "It was akin to the industrial therapy that they used to have at Mapperley, the only centre that remained opened".

Ambivalent Feelings of Community Care

There were mixed opinions of the care received in the new acute mental health unit set up at the QMC in Nottingham. Staff were generally enthusiastic about the change, although they conceded that the new wards were not designed for long-term admissions and service users had negative memories of the care they received. Mark was part of the first cohort of nurses working at the unit; he remembered the latter part of the 1980s as a progressive era in mental health provision, where staff had "a bit of a blank canvas, at QMC we used to set it up how we wanted it, it was new, exciting, dynamic, forward thinking". Richard, psychiatrist, recounted that the QMC would only serve those with very short-term needs but it would not necessarily aid recovery:

> The problem was that the wards were not designed for relaxing living, they were designed for acute medical wards, we did a bit of pulling down walls but there was a limit to what one could do, and of course there weren't the gardens or the space that there was at Mapperley, I don't think it was ideal in the end.

He explained plans were made to build small acute inpatient units, which never materialised, as "there was never the money to build inpatient facilities and staff them". For Richard, the main challenges facing mental health provision have centred on the lack of availability of inpatient services and the finances to cover for the cost of staff to provide appropriate rehabilitation:

> A number of inpatient beds across Nottingham were reduced considerably over time so we couldn't afford for people to be in hospitals too long, so there isn't the luxury of having people in hospital for longer periods, which sometimes was necessary, that certainly is something that has been lost.

Perceived Loss of Inpatient Therapeutic Environments

Andrew, ex-nurse, felt that the setting up of psychiatric wards within district general hospitals was misjudged. He worked at the QMC when the acute mental health unit was first opened and felt the ideals of 'normalisation' were not fulfilled as the therapeutic atmosphere of the old mental hospital was not reproduced:

> It was probably a mistake to put mental health services on general hospital sites, when the mental health services came to QMC they took over one floor of the block but you got no access to gardens or nice surroundings, it was part of a modern unit, it just didn't have the warmth or the space, mental health patients weren't particularly welcomed at QMC, the idea was that patients with mental health problems were no different to patients with physical problems and they should all be treated in the same environment, of course it didn't work and that's all closed now.

All of the service users that took part in this researcher, who received care at the QMC acute mental health unit, recalled negative experiences. Albert recounted being left to wait for a disproportionate amount of time and injured himself at the hospital during a mental health crisis:

> I was admitted to the QMC very quickly, I was waiting in the mental health department 7 hours before a doctor came to find out why I was admitted, I was then put on a ward, quite honestly it was not a psychiatric ward, it was nothing like the treatment I'd received at Mapperley hospital, I didn't know whether I was coming or going so I fell down in the ward, smashed my head and in doing that I ended up on the floor and they stitched me up in a fashion.

For Albert the acute wards at the QMC were not suitable to care for people with mental ill health:

> I'm glad for everybody's sake that they closed the psychiatric wards there [QMC] because they were not wards in my opinion suitable for mental patients.

He felt that Mapperley was a much more caring and supportive environment than the QMC acute unit and regretted that younger service users are not able to gain access to the care provided in the old system:

> The younger people that were in for like depression or anxiety, they would keep coming back, I think they would have found that a bit difficult, because they knew that if they were feeling poorly again and then they needed to come into hospital, they knew that they were coming back to Mapperley and then all of a sudden it was taken away from them, I would imagine it would make them feel secure and safe knowing that they were coming back to Mapperley hospital and then all of a sudden it was gone.

Similarly, J1 complained about the lack of a therapeutic environment at the QMC acute unit, comparing his experiences of good care he received at Saxondale:

> It was much more dismissive at the QMC. At Saxondale in the 70s you knew what was happening, it was a structured day, including being served regular food, and I think that helped.

J1's daughter has a diagnosis of bipolar disorder. He recounted a time when she was hospitalised at QMC and was allowed to have access to her own bankcards. She spent a large amount on takeaway food, resulting in her accruing debts, which she regretted once discharged. J1 and his wife felt it was inappropriate to allow their daughter access to money during a mental health crisis and that she would have benefited from being hospitalised under the old system at Saxondale where personal possessions such as money would have been removed during a period of crisis. He reflected on his daughter's experiences in acute units:

> My daughter hasn't had that opportunity going to a place like Saxondale, there were more staff, and they were more recognisable and I think probably the training was better, I just go in there now and I can't relate at all to seeing

> my daughter in hospital, I feel threatened myself because it is only people who are more or less sectionable who go there.

He compared his daughter's experiences of inpatient units within the system of community care to the inpatient care he received at Saxondale:

> I can't imagine being in such a relaxing atmosphere like that in hospital, when I visit my daughter and just because there are not so many voluntary patients, it seems to me to be more stressful and certainly it was for me much later on when I went into the psychiatric ward at the QMC, it wasn't conducive to that sort of thing, Saxondale was pretty good for that.

Perceived Loss of Access to Safe Environments

J1 complained about the lack of bed availability in acute units. His daughter experienced a mental health crisis recently and was offered a bed in an acute unit in London. Although too far for the family to support her during her crisis, she had no choice but to accept. Similarly, Andrew, ex-nurse, felt that "the pendulum had just swung too far now'" with reference to the lack of available beds for people experiencing a mental health crisis making people vulnerable in community:

> The run-down of acute beds is just dreadful and I know of community nurses who spend a whole day scouring the country looking for beds for patients who need inpatient care because there aren't any locally, patients who need acute inpatient care often end up being treated miles away from their family. Patients that do need to get inpatient care don't have access to those facilities nowadays.

Mark, former nurse, felt that the policy of community care was the right solution to improve the provision for short-term mental health care interventions. However, he pointed out the care was still needed for service users who struggle to cope in community. He worked in one of the new inpatient rehabilitation units set up as part of community care in Nottingham, Broomhill House, which has since closed:

> Care in the community doesn't take into account a certain group of patients who we had at Broomhill who can't always make it, there's a number of patients in every city that are just very difficult to treat properly, very chaotic, very heavy users of services, they go to A&E all the time, they jump off bridges, needing ambulances and police resources and these people need somewhere like Broomhill.

Both former patients and retired staff felt that the environment of the now closed local hospitals were more welcoming and provided a more relaxing atmosphere than the acute unit in the general hospital. They attributed this to the availability of rehabilitation activities within the internal and external spaces available in the old mental hospitals, including access to the outdoors. Moreover service users felt safer in the environment of the old mental hospital and recalled a high level of staff numbers, which in turn allowed for a higher level of interaction with staff. Crucially, all agreed there were sufficient beds locally to cope with demand in Nottinghamshire in the old system. Service users of adult acute inpatient care have consistently reported the care provided in acute mental health units to be anti-therapeutic as a result of the lack of safety, privacy, comfort and meaningful activity to foster recovery (Rooney 2002). Other studies have found acute units are difficult places to work and to recover due to the concentration of people who are most unwell who cannot be treated in community (Killaspy 2006, Caldas and Killaspy 2011). Acute units are characterised by often-inadequate staffing levels and overreliance on medication as the preferred mode of treatment at the expense of psychosocial interventions (Haigh 2002, Bowers, et al. 2005). Moreover, one of the unforeseen problems with the provision of acute inpatient care in general hospitals has been the blocking of beds by what has been termed as the new 'long-stay patients' (Moon 2000). This has been compounded by the steady reduction of hospital beds. The current crisis in availability of beds in acute units is increasingly leading to long-distance placements; this crisis, coupled with the scarcity of rehabilitation services, increases the likelihood of suicide for people in crisis, removed from family and friends (Gilburt 2015, Bailey et al. 2018).

Perceived Sense of Dispossession

Former patients, all of whom are still dealing with long-term mental health problems, expressed a strong sense of dispossession in terms of the removal of and the inability to access adequate rehabilitation services, with the associated loss of formal social support and a community of belonging. Former staff and patients expressed their sense of loss in terms of the fragmentation of relationships amongst staff and the effect this has had on care practices, recalling instances of neglect in community and reinstitutionalisation. Long-serving staff had an emotional investment in the hospital sites, reflecting the findings from the scarce literature on the subject (Gittins 1998, Craze 2014, Calabria 2016). They expressed a strong sense of grief resulting from the dissolution of the hospital communities and the suppression of the public memory of the hospital site by the forced removal of physical signs of its history.

Loss of Access to Rehabilitation Activities

The sense of dispossession and neglect amongst participants was palpable. Both former patients and staff expressed a sense of loss of a place of safety, belonging in terms of the availability of staff's time, the social support therein and the availability of structured rehabilitation. Participants' sense of loss was contextualised in their accounts of the perceived neglect of service users with long-term needs in community since the advent of community care. The loss of the hospital communities and access to rehabilitation was bound up with the loss of the physical sites of the mental hospitals, which emerged as a major motivator for participants to take part in this research. Nurses discussed their memories of some patients expressing misgivings about the closure of the hospitals. K2 currently works as a nurse in a local mental health team and stayed in touch with some former long-stay residents. She recalled that "some patients missed the activities, Saxondale was a community". K2 compared the rehabilitation available under the old system to current services:

> The rehabilitation in the old days was good, you could give a lot of time to people and got to know the patients very well, now there is so much paperwork and no time to talk to the patients.

For K2, the sense of belonging for people with long-term mental health conditions was bound up with the regular social recreational activities:

> Some of the patients that had been in Mapperley years and years, when it closed and they were dispersed all over, they lost their sense of identity, they were so used to doing things and meeting people and all of sudden they were all put out, they lost their little family, they felt safe and secure because they were all there.

Mark, nurse, felt the closure of the hospitals overlooked the importance of the close-knit communities and social networks:

> The hospitals were closing, and the communities were breaking up, people perhaps just didn't value it enough, low level socialising is undervalued, it's like watching telly with your kids, you might not want to do it but it means a lot to them.

Mark stressed that community care was a much better option than having long-stay psychiatric hospitals. However, he conceded that the hospital was a strong source of social support for long-term service users who tended to be isolated:

> I think it meant a hell of a lot to patients, I think it was community, and identity, friendships, company if you wanted it.

Mark felt that the social aspect of hospital life was lost in the process of modernising services in the 1990s, "because the hospitals closed and staff weren't bothered about doing that side of things". Sean, nurse, recalled that many of the long-stay patients lost a sense of belonging to a place:

> They've lost what was their community, many of the people that were pushed out became socially isolated, I don't think there were enough community services to compensate.

Similarly, Craig, former porter, recalled that a lot of the patients missed Saxondale "because of the community, they always had a Christmas party, a holiday once per year". Linda, former hairdresser, felt that the current inpatient settings such as Wells Road hospital, which is a low secure unit, are much less permissive than the mental hospital where patients had access to social and recreational spaces:

> They'd call in at the library, they'd call in to me and then they'd go and have a cup of tea or coffee because they were free to walk around, whereas they are not now, because it is secure now.

Linda remarked that access to the library has been reduced to two days per week at the Wells Road centre, a medium secure hospital, whereas at Mapperley was open daily. She felt service users in current settings have lost the therapeutic environment of the mental hospital that provided them with a sense of purpose and belonging:

> The patients on the wards would go down to industrial therapy and work, the lads used to work in the gardens, they'd got up and went to work, whereas they don't do that now, that's all been stopped, they don't get up and go out to work like they did when I was there, it was lovely, the lads were chaffed that they could do things, they started to get a little bit better, and they'd look forward to it and that stopped, when you look back, that was a shame.

Roger felt "Saxondale was a fantastic place to be", referring to memories of residents being happy at the hospital and he felt that they lost the community they belonged to:

> I remember seeing some very happy people at Saxondale, people with a purpose who perhaps couldn't look after themselves very well, people who needed that support and who most definitely at Saxondale got that support, with the additional bit thrown in like employment, the industrial unit, the patients would help out, the loss of that community is a tragedy.

Despite the custodial nature of the mental hospital environments, Roger felt that the hospital community provided care for people with long-term needs who struggled to cope in community; Roger was adamant that the care at Saxondale was significantly more adequate than what is available in the new system:

> The hospital clothed them, gave them work, medication, fed them, buried them, whether that's better than being in the community, and being supported but I have my doubts about the long-term view for somebody who's very poorly because you can slip under the net, can't you, and be missed and suffer.

Rodney felt grateful to have had access to occupational therapy during his hospitalisation at Saxondale; he recounted how “it was part of our treatment to go everyday down to the occupational therapy”, reflecting on the value of structured rehabilitation:

> 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.

He explained the importance of investing in meaningful occupation for mental health recovery:

> We were encouraged to do the creative things because that’s where our strengths lay from within the hospital; skills and practical activities networks had a whole range of things that they brought out of the hospital.

Rodney expressed a strong feeling of loss with the hospital’s closure; he felt that the ideals of community care never materialised, “Saxondale hospital was taken away from us and nothing put in its place”. For Rodney, the legacy of the mental hospitals was the economy of scale that could provide regular, large-scale access to rehabilitation facilities and the availability of staff that aided the recovery process:

> They could convene more people into a more diverse range of groups in a way that community cannot, because clients are dispersed, the hospitals were available on a large scale and inevitably if you can have a diverse range of facilities and opportunities to have meaningful activity, this on its own is so significant for the patients, because there is a greater possibility and potential for those clients to convene in topics that they have an aptitude or an interest and it is more important that they keep themselves meaningfully occupied in the intervening times that they are confined in hospital, 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.

For Rodney, 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 were all there and made available to patients are gone”:

> It was daylight robbery or another way of putting it is stealing the common from off the goose rather than the goose off the common, because simply the common was no longer available to people who had psychiatric disorders anymore and that was a real loss because not only was the space and the sites where these big hospitals stood removed but the whole capacity to deal with the large scale mental ill health that we have in our society.

Rodney 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 are inadequate to support people with long-term needs. Rodney was critical of the Recovery College in Nottingham; Recovery Colleges are a new educational form of intervention based on the reintegration of people with psychiatric disabilities into society that supports self-management through education (Slade et al. 2014). Rodney sees the service, located on the part of the same site as the now closed Mapperley hospital, as a form of neglect due to the short nature of the intervention, based on self-help, highlighting the gaps to services for people with the need for continuing care:

> We all yearn to actually have a part in society, you don’t get this by claiming that educating us in a recovery college will be the answer to everybody’s problems.

For Rodney, the need for longer-term rehabilitation, namely adequate support between the hospital and returning to the community, is key to personal recovery:

> What you swept away by putting a recovery college at the site of the old mental hospital 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.

Similarly, K1, service user, felt the closure of the hospital was misjudged, also associating the hospitals’ closure with a form of robbery:

> 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, it might have been true that they were difficult economically to match modern building and facilities 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, mentally ill people were being robbed of the facilities that they had.

She explained the importance of having access to a safe environment that Mapperley hospital provided during her mental health crisis:

> 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.

J1 reflected on the loss of the hospital in terms of the absence of a place of sanctuary 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.

As a service user J1 felt he lost the choice to be a voluntary patient due to the lack of resources:

> 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.

Albert, service user, felt the legacy of Mapperley was the provision of care for every aspect of a person's needs, "everything about Mapperley hospital was good".

The excerpts above point to the value of structured care and rehabilitation provided in the now closed mental hospitals. These included taking care of basic needs such as clothing, food and emotional needs, companionship; importantly, the loss of structured meals and routines in the current inpatient care was perceived as anti-therapeutic. Moreover, service users and staff alike pointed to the lack of rehabilitative services as a stepping stone between crisis and recovery; there was a consensus that the environment of the mental hospitals provided a more welcoming and relaxing atmosphere conducive to recovery which is perceived as lacking in current inpatient settings. Crucially, service users felt they have lost the choice to access a place of safety and sanctuary, no longer the case under the current crisis in the provision of mental health inpatient services due to the pernicious effects of the steady cuts in funding. A recurring theme in staff and patients' oral histories which re-emerged in the group discussions during the feedback events was the lack of investment in community care services. Participants wanted to know what happened to the funds raised from the real estate from the sale of the old Victorian hospital buildings. J2, son of a psychiatric doctor and carer for a son with a mental health diagnosis, was upset that funds from the sale of the hospital sites were not ring-fenced; similarly, K1, service user felt that:

> They had beady eyes on the huge revenue that could be generated for other projects in the health service, not to do in mental health.

For Rodney "the problem has not gone away in terms of the need in mental health". Reflecting on community care's failure to provide appropriate support, "it is a very sick legacy of actually aspiration without delivery of mental health services":

> The big dream was care in the community, and I don't think they ever reached the stage, they were determined that the money should go elsewhere.

Fragmentation of Relationships

Service users' main assertion in relation to care in the community was the absence of long-standing relationships with staff and others and a lack of appropriate support in the provision of current mental health services. Both staff and service users felt that the social fabric of the mental hospital has been lost in community care, resulting in the fragmentation of social networks. Louise, nurse, felt that people with long-term mental health problems living in community lack social connections, which was a key aspect of the relational care available at Saxondale hospital:

> What has been lost with the closure of Saxondale is a sense of community and a sanctuary for patients, and what is left now is just horrible concrete in acute units.

For Louise the community that existed therein provided a rich source of social support for residents, "the patients formed relationships and friendships and these friendships were not considered when moving them out". For K2, nurse, the loss of a sense of community caused social isolation for people with enduring mental ill health:

> Things are different now, they've lost what was their community, many of the people that were pushed out became socially isolated, there were not enough community services to compensate.

Reflecting on caring practices, Roger, former electrician, felt that older people with long-term mental health problems would have likely received better care in the old hospitals, as they would have benefited from the long-term staff-patient relationships:

> Wouldn't it be better to be looked after by someone who wants to look after you from the community who knows you rather than someone who is being paid to look after you?

He recalled seeing a former long-stay patient living in supported housing in the community who "was a shadow of his former self" as "there was nobody around for him to hang out with". All the service users that took part in this research rely on voluntary sector services and self-help groups for social support. All expressed a strong sense of the absence of a place of belonging within services bound up with the provision of inappropriate care. Rodney bemoaned the loss of the hospital community:

> It was a community that was there and available for us, it has never been replaced, we were promised wonderful care, claiming we needed our freedom but they never gave it to us.

J1 attributed the loss of support and continuity of relationships with staff over the years due to gradual cuts in services; reflecting on the level of support available at Saxondale hospital, J1 felt that “we didn’t know that we had it so well staffed and well-funded in those days”. For J1, the deep social connections formed at the hospital were lost, “you knew people around you, you trusted them, they trusted you, it’s all gone now”. He lamented the effects of cuts to services, which reduced the number of staff available that had previously helped him regain independence:

> They could take me out away from my house and probably have a coffee somewhere in an environment like a pub where I wanted to try and latch on to things I’d enjoy before, it was a way of doing it.

The services he had access to in the community have also closed down over time. J1 felt that his mental health issues were exacerbated as a direct result of the dwindling mental health support in the age of austerity; since he took part in this study, he has experienced another relapse, brought on after having been found fit for work by the Department of Work and Pensions, despite being incapacitated by his long-term mental health condition. During the frequent meetings and the interviews recorded as part of this study, J1 made repeated references to the threat of closure of the Beeston day centre run by social services from the local council in 2011 and 2012 due to continuing cuts to funding; the threat of the centre’s closure caused him a lot of anxiety. From 2005 to 2012, J1 suffered from a severe bout of depression and relied on staff at the day centre for vital social support provided by staff at the centre. A campaign ensued by service users in collaboration with mental health practitioners to fight the centre’s closure, which was won. An unintended consequence of the campaign was the centre was to be run as a service user-led organisation (MSRC). J1 often feels under pressure to help sustain the everyday activities at MSRC while having to manage his condition:

> I’m getting more edgy and my stress is showing at the moment so that support we had then isn’t there now so it’s all right saying this is a brave new world, peer support and do it yourself, anybody with any sort of thought would think that, I know there were bad things about the old days but, having a bit of the old system with more support workers available for people would be desirable.

For J1, the expectation for service users to run the social centre is a form of neglect:

> We are a community centre, we are not called a psychiatric day centre now, but we’ve got nowhere else to go and we keep being reminded that we are valued and that we are the heart of the place but it gets very stressful like today when people always ask me to do things and I am not well enough to do them.

J1 felt the key element of care that was lost with the hospitals' closure was formal social support available from staff:

> We haven't really got that listening ear support really now, which we would have done in the old days, that's the big difference to me.

The social networks and sense of community that existed within the hospital provided the context of building and maintaining long-lasting friendships. Michael, former patient, felt the hospital offered access to a community of people going through similar challenges that could offer mutual support to one another; he also felt that staff back then had time to talk to patients whereas now they don't:

> The staff were quite pleasant and would talk to you, nowadays they are too busy with the paperwork and you get to speak with healthcare assistants, lots is going wrong, back then they had time.

Similarly, Rodney, ex-patient, felt that staff in the current system are not easy to relate to as they are "too busy with the paperwork and not enough time to get to know you and support creative activities". Such comments effectively signal the loss of the professional specialised interpersonal knowledge in the old system. J2, son of a psychiatrist who lived on the Mapperley hospital site, has a son with serious mental health problems living in community. He felt the therapeutic relationships that his son could form with staff in the old system have been furthered fragmented by the imperative of the current mental health recovery model to rely on peer support:

> There are no peer-support workers in the community, they are trying to get people to do it voluntarily now and in a way 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. For people with mental health problems that is the problem, that hasn't been happening so the hospital was helping people out that way.

The excerpts above testify to the loss of therapeutic relationships for people using mental health services in terms of the reduced access to trained staff with limited time available to offer support. In turn, the limited availability of staff and their time spent with service users has negatively affected the quality of relationships in the current services when compared to the relationships in the mental hospital. This is concerning given the quality of relationships in mental health is a strong predictor of recovery (Gilburt 2008, Middleton et al. 2011, Tew et al. 2012).

A significant loss for staff that emerged during the fieldwork was the social connections between staff. A direct consequence of community care was the loss of and security of employment and demotion. For some this has had the adverse effect of fragmenting staff relationships. Staff recounted the loss of friendships and camaraderie, signified by memories of reduced collaboration and peer support from each other as staff were less likely to show mutuality to staff they had no connection to. Linda worked as a hairdresser at Mapperley hospital for 22 years. She was made redundant and re-employed as a freelance contractor for local inpatient services; she remarked that “it felt like a bit of a kick in the teeth”. For Linda, the biggest loss was the mutual, informal support that staff provided to one another as staff relationships have been difficult to foster in the new system:

> We all had to adjust, not just the patients, we’ve gone from this big old massive Victorian beautiful building to a square box, that’s what it felt like, it wasn’t the memories, the companionship between staff as a whole changed over the years, it wasn’t as nice or as friendly, people tended to keeping themselves to themselves.

Linda felt the essence of caring through a sense of belonging to a community has gone with the new system of inpatient care:

> People don’t seem to be bothered about it now, there’s definitely a huge difference from when I was at Mapperley in the 70s, 80s and 90s to now, people that had been there before me, we made long and lasting friendships and that doesn’t seem to happen today, which is quite sad.

Linda is no longer able to build long-term connections with staff at the Wells Road centre, a low secure unit built on the grounds of the old Mapperley hospital, and on the inpatient units at Highbury hospital, where she still works as a hairdresser. She explained that this is because “I am never in the same place for long enough, before I worked at Mapperley Monday to Friday and got to know everyone”. For Linda, the fragmentation of relationships with patients since the advent of community care has been bound up with the changing nature of her employment and the location of care:

> I don’t go often enough to Wells Road to get to know them like I did, and that’s the difference, you lose that, we’ve all gone our separate ways because of Mapperley closing, you don’t form the same sort of friendships and attachment to people because you are in one place for any length of time, you are not gonna form the same sort of lasting friendships as we did.

Similarly, for Roger the impact of closing the hospitals resulted in the loss of kinship between staff and between staff and patients:

> You don’t automatically back someone up, patient or staff, because he’s not one of yours, you don’t automatically do someone a favour unless they are mate because, well you don’t really know them whereas the big thing at Saxondale was from the patients to the staff you knew their sons, you knew their daughters, you knew their mothers, we use to know a lot of the patients’ mothers, fathers or sons.

He felt that the social fabric of the hospital was done away with by its closure:

> The inner external community like the canteen, the shops, just walking around the estate with people, you all had that common link, you knew each other, people in them days knew each other, they don’t now.

The consensus among most of the staff was that closure of the hospitals meant the loss of friendships and social networks, through the lack of social capital that existed therein, which fostered reciprocity and kinship among the different groups. Louise, nurse, felt that although she was able to retain her status and salary, she lost the connection with patients that who become family-like members, signifying the importance of long-lasting relationships with patients in making long-serving staff's jobs more satisfying:

> It affected people's lives in many ways, it affected the work, their payments, their living, losing clients that you'd seen as friends and family, they were like friends and family, it really was drastic for me.

For Roger, the personal loss was the community and the possibility of steady employment:

> A big loss for me personally, because I grew up and worked in a place where you knew people, it was familiar and in those days, if you needed a job there was always a post going, it carried on, people's children went back and things like that, so a great loss.

The above oral history excerpts point to two key elements affecting professional relationships in mental health policy in the context of community care. Firstly, the changing nature of employment, working on short-term contracts has adversely fragmented staff relationships, impacting on the quality and longevity of staff relationships that were formed and fostered in the mental hospital, which in turn engendered high levels of informal support and camaraderie among the staff discussed in the previous chapter. Secondly, lacking continuity of working patterns and locations has affected the relationships staff are able to form and foster with service users, crucial for the provision of therapeutic relationships that has been found to be a strong indicator of recovery; the evidence from participants' oral histories suggests staff in the mental hospitals were able to foster therapeutic relationships with patients through extended time spent interacting with them, providing emotional support by mainly listening, a form of relational care that has been found to be crucial to recovery within inpatient and outpatient services (Gilburt 2008, Middleton et al. 2011, Tew et al. 2012, Chester et al. 2017). The oral histories point to the level of social isolation experienced by service users living in community, who reported feeling uncared for and neglected in the community, due to the short-term nature of interventions available within the policy of community care.

Little is known about what social support means in practice for people with mental health difficulties. The decline in kinship and social contact in the twenty-first century has had a particularly significant impact on people affected by mental health problems, who are likely to experience isolation, exclusion and loneliness as a result of their condition coupled with self and social stigma (Leach 2015). People with mental health difficulties tend to have access to smaller social networks and most of the people within their networks tend to be other mental health service users; these networks tend to be less powerful in providing access to more mainstream opportunities, often denied to people that have experienced mental health problems (Forrester-Jones et al. 2012). The concept of social capital is useful to understand mental health recovery as a process (Putman 1995, 2000). Putman defines social capital to be the existence of networks, norms of reciprocity and social trust that enable people to collaborate for their own mutual benefit. The main aspects of social support interactions are the need for human contact, which in turn helps to reduce feelings of uncertainty and to gain a greater sense of control over one’s life (Leach 2015). Research on the value of social support carried out in the UK points to the paramount importance of friendship and kinship; although the term is difficult to define, an appreciation of the social factors that help form and maintain friendships can help inform what helps or hinders social support during periods of crisis and distress (Allan 1989, 2008). The availability and continuity of staff-client relationships coupled with access to structured social rehabilitation within the context of the kinship that existed within the hospital environment appear to have been key to fostering social support in the now closed mental hospitals.

The destructive impact of austerity measures on mental health services has given rise to a growing resistance to the cuts and transformation of mental health services by both service users and other interested parties, such as carers and practitioners, against the government’s policy of austerity and neoliberal restructuring of mental health services in England (Moth et al. 2015, Moth et al. 2016, Thomas 2016). The campaign to save MSRC has not been documented, however it provides evidence of the impact of the current unprecedented unfolding crisis in mental health services. The cuts, restructuring of services and welfare reform are leading to increasing levels of inequality, which has a direct correlation to increasing levels of mental distress in the general population (Moth, Greener and Stoll 2015).

Perceived Loss of Nurses Skills and Autonomy

Some staff discussed the loss of skill and autonomy as a result of the move to community care. Andrew became a nursing officer in an acute unit built on the site of Walsgrave hospital (Coventry) in the 1990s; he felt the autonomy nurses had in decision-making concerning patients' care was replaced by consultants' authority. He felt the therapeutic relationships between nurses and patients were disrupted as a result of the new rigid system of observation put in place:

> It was almost a backward step in terms of treatment and involvement of the nursing staff I'd come from at Mapperley, it was very much led by the consultants, it was very hard to come to terms with the fact that the nursing staff on the wards were very limited in terms of decisions that they could make on care and observation of patients, it was very much dictated by the medical staff, at Mapperley the nursing staff used their skill, expertise and judgment to decide how the patients would be treated and observed.

Andrew bemoaned the loss of nurses' autonomy in the provision of inpatient care that he had at Mapperley hospital, he felt that "the nurses should have the opportunity to decide how they cared for their patients but that was all taken away". For Sean, ex-nurse, nurses' observation skills were the most important aspect of care; in his opinion these skills have been lost under the new system of care: "very disturbed clients are dealt with now in secure wards with locks". He felt the skills acquired by nurses through the knowledge passed down by senior staff have been lost: "there were lots of experienced people around then". Sean remembered that "their powers of observation were exceptional, they almost had second sense":

> It was exceptional observation, very skillful, almost an inner feeling as well, awareness. I can remember sitting in the office of the ward that I worked on and just feeling I hadn't seen this guy for a while, and I would go out into the main area and he's missing, you developed that almost a second sense really, you don't see it nowadays, people don't have it.

Experiencing Neglect in Community

Both clinical and non-clinical staff expressed concern for the lack of care of former patients after they were moved out of the hospitals following their closure. Long-serving staff that had formed and maintained long-term relationships with former patients recounted instances of neglect of former residents living in community. Peter, psychiatric social worker, recalled how long-stay patients were first moved to half way houses "without money for furniture, many had mattresses on the floor", a situation that occurred to ex-patients elsewhere (Craze 2014). Craig, porter, remembered conversations with former residents in which they expressed misgivings about the new system and missing some aspects of life in the mental hospital. Craig was critical of the policy of deinstitutionalisation and community care; firstly, he felt that some doctors used the new policy as a means to make a profit by opening their own nursing homes to house former patients. Secondly, he emphasised the care offered to former long-stay patients in private lodgings lacked the structured rehabilitation and regular routines available in the old system:

> I used to stop at a lot of greasy spoon cafes around town, I would often see some of the old patients, because they had nowhere else to go in the day, the landlords used to turn them out in these semi-private things, they'd say "Oh it was all right at Saxondale, all I can get is toast or porridge, no butter on my toast the other day". One day I was having a chat with a former patient and he went into a place, and he says "I miss the old place" he says "It's all right doing what you want and lay around all day, but you get fed up" which was this modern political correct thing, in the old days they used to make you get out of bed, have a wash, do this and that, now they could sit around all day.

Craig recalled some former residents faced difficulties in their new lodgings in community and sought support from the old staff when possible:

> I saw some of the old lags and they always asked about my dad, he was popular with some of the old lags, he used to help them out, there were always phoning him off duty or coming around for a cup of tea.

K2 worked at Mapperley during the time when care in the community was integrated within health and social work in the early 1980s and felt that "it was difficult to function in the community although some people did flourish". Andrew, nurse, felt that the standard of care deteriorated:

> They were in these hostels, they were turfed out at weekends so they couldn't sit and watch the telly and do what they wanted, most weekends you would see patients who you looked after at Mapperley, wandering around town, sitting in the Victoria Centre, around the market square, it was good that they were out, but it wasn't really care in the community as I'd imagine it.

Similarly, Roger, electrician, stated "with care in the community everything goes", recalling memories of neglect of former residents living in community:

> Into the very early 90s I would see familiar faces wondering around the city, which I found really upsetting, I'd see people who were safe and secure at Saxondale, I saw them in the Victoria centre sat there with nothing to do, I saw them wondering through St. Ann's looking very lost, quite shabby.

For Roger, Saxondale provided a strong sense of belonging for isolated individuals with long-term mental health needs who struggled to cope on their own:

> The thing is they belonged, and I think they knew they belonged; the surroundings, I can't think of a better place to be if you needed psychiatric support, to see people wondering through the Victoria centre, I dread to think what happened to them.

Albert, former patient who is now in his 80s, runs an anxiety self-help group which provides a vital source of social support for many in the community; he struggles with keeping the group going, particularly around fundraising for the group's activities, explaining the challenges he faces:

> Care in the community is stretched, they can only do so much under the circumstances, the cutbacks and everything else. I had three nurses coming to see me when I was doing the in-betweens at the QMC and the mental hospital, these nurses were concerned about following things up, but now unfortunately they don't do it because of the cutbacks.

Witnessing Reinstitutionalisation

Former staff witnessed reinstitutionalisation in community care, namely patients who would have been hospitalised long-term now living in other institutions such as residential homes, forensic hospitals and prisons or high security hospitals as a result of closing the mental hospitals, reflecting the literature on long-term service users inevitably entering other institutions for the lack of adequate services (Priebe et al. 2005, Chow 2013). Richard, psychiatrist, recalled that in the early days of community care in Nottingham, six residential rehabilitation units were set up, which are now all closed. He explained the provision for inpatient care was inadequate even then to cover the demand, viewing reinstitutionalisation of service users was a direct result of the policy of bed reduction:

> There was more provision then than there is now, but even with 6 places to move people on to, there were no beds, and there would be arguments between clinicians about where somebody would be.

Mark worked as a nurse at Broomhill House, a small inpatient rehabilitation unit set up in Nottingham during deinstitutionalisation. He concurred with Richard's appraisal in the 1990s inpatient services often failed to move people out within the target time due to lack of appropriate resources:

> People sat on acute wards for years sometimes, some people would be back too because they would fall between services. Hospitalisation was supposed to be 6 months to a year but then changed, we tried 3 months for some people, but it was quite often more than a year, because that depends on having somewhere suitable to move on to, there was nowhere to go.

Similarly, Andrew, former nurse, was critical of the policy of deinstitutionalisation as he felt "they were really only moving from one institution to another". Moreover, J2 is a carer for his son who has a diagnosis of schizophrenia and struggles to cope in community. In the 1990s, his son was kept in an acute unit at QMC for 2 years due to the lack of adequate inpatient services:

> That length of time means that people are going to find it very hard to have a normal life. The acute ward was not being used as an acute ward, they didn't have a separate ward for the patients who had got better.

J2, who is now is in 80s, is concerned about his son's long-term welfare living in community without appropriate support:

> The problem is there's always going to be people who need to have continual care and the other groups of patients, I'm not entirely happy with my son's position, he's in a flat and he's had to adapt to living in community.

The lack of adequate services was a recurring theme in both staff and service users' oral histories. All agreed on the perceived failure of community care policy to sustain the provision of appropriate rehabilitation in the long-term due successive governments' cuts to services in mental health; the group feedback meeting organised with service users revealed a significant disconnect between the decision of closing the hospitals made by policymakers to improve care and how service users who experienced receiving care in the local mental hospitals felt about closure. The consensus was that policymakers made the decision on what was best for service users without taking into account their views, a recurrent experience among service users when engaging with services (Slade, et al. 2014). Former staff and patients agreed the hospital environment provided significantly more choice in terms of structured rehabilitation. The re-appraisal of confinement with the introduction of secure environments as a model of mental health care the 1990s (Department of Health 1996, 1998) was attributed to the perceived failure of community care to provide adequate care for the emergent new group of 'long-stay' patients coupled with the perceived danger these individuals posed in community since deinstitutionalisation (Moon 2000).

Lack of Access to Internal and External Spaces

A critical aspect of care that has been lost with the advent of community care, which featured largely in participants' oral histories, was the removal of free movement within internal and external spaces, with the return to confinement in the current system of inpatient care. When asked about her opinion of community care, Louise, nurse, felt "care in the community is awful" as the patients have lost the ability to walk around and out of the hospital on their own and have lost access to outdoor spaces; she stressed the return to institutional practices pre-open-door policy limited choice for clients; she felt that it would have been preferable to improve the old system at Saxondale hospital than start a completely new provision of care:

> Quite frankly I am not keen with care in the community, if the improvement in the new places could have been done in the large psychiatric hospitals with all that was there, I think that would have been better. Where people used to have really severe mental health problems, you used to have space to explore, now they are locked into a limited space in psychiatric units in general hospitals, that sense of freedom and that sense of healing environment and atmosphere isn't out there.

J2, son of a psychiatric doctor at Mapperley hospital, grew up on the site of the hospital during the time the open-door system was introduced. He reflected on the impact of removing the open-door system in the current inpatient mental health provision:

> People were able to get out of the wards, I think that's a tragedy that we are back to the state of what it was before, unfortunately I think it was a mistake, they haven't got the grounds that the patients used to walk and used to be therapeutic, that has been taken away.

Linda, hairdresser, reflected on how care changed in the current provision of inpatient care. She recalled that "they [the patients] could walk around then but they can't now, they are not allowed out of the ward". It is important to acknowledge that mental health service users in the current care system receive acute care, such as those currently subject to constraint. The majority of service users who might once have been free to roam the old hospital grounds are now in their own accommodation and can exercise their own freedom. However, Linda was making reference to the patients for whom the hospital was their home as well as a place of rehabilitation for voluntary patients at the time of institutional care. In addition, Rodney, service user, felt that the biggest scandal in community care lies in funding being spent to keep people locked up rather than providing the choice of rehabilitation that was made available in the old system, which allowed patients to move freely in the hospital once the crisis point had passed.

The therapeutic value of having access to vast grounds featured largely across the oral histories of service users, staff and others. Former staff recounted the pleasure of spending time in the extensive mental hospital grounds, which had the effect of fostering a more relaxed treatment environment than the new acute units within the general hospital. Access to the grounds was associated with aspects of permissiveness bound up with the mental hospital environment; J2, son of a psychiatric doctor, bemoaned the loss of access to outside green spaces that were available in the old system, comparing the new system of locked wards in acute units and secure environments to a total institution:

> Mapperley hospital was one of the first hospitals to have open wards, now all the wards are locked, which is a pity, a prison-like environment.

He reflected on the loss of the therapeutic landscape in the form of the extensive grounds that the hospital provided coupled with the freedom to walk around the hospital without locks on the wards:

> The beauty of Mapperley hospital was that they had these large grounds that they could walk around and that was therapeutic so there is a lot to be done in mental health and it's a tragedy that 50 years ago the position was much better in Nottingham.

For J1, access to outdoor spaces was essential for his recovery journey:

> 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.

Rodney was an in-patient at the QMC in 1991 for one month; there was no open space within and outside of the unit available to service users:

> Saxondale was this kind of idyllic rural setting and there were the trees and the nature and the birds, Queen's [QMC] had nothing of that, I remember Queen's 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.

The most recent Care Quality Commission inspection of specialist mental health services found that too often locked rehabilitation wards were being used as long-term solutions rather than a step on the road to recovery (CQC 2017). Shifting the practice from locked to open wards to allow free movement within and outside the hospital was a major aspect of permeable models of care within psychiatric units in general hospitals that Quirk et al. (2006) recommended in order to foster relational care, hinting to the return of open-door policy practiced by the old state mental hospitals that embraced humanistic approaches to care in the second half of the twentieth century. The findings from this PAR-led oral history study concur with more recent research on the therapeutic value of open wards that could help influence change in mental health inpatient practice. Recent studies on acute psychiatric units that unlocked wards reported high rates of unauthorised absences (Beaglehole et al. 2017, Smith 2018); although Beaglehole reported an increased rate of violence amongst service users, Smith's study contradicts those of Beaglehole's in that a decrease of such occurrences was reported, explained by the high level of nursing staff, which improved relational security.

Destruction of a Site of Memory

Three former staff that lived on the Saxondale hospital site not only felt grief from the dissolution of the hospital community, but also a deep sense of loss from the removal of physical signs that represented the history of the hospital, expressed through highly emotive language such as the forced destruction of their own village.

Witnessing the Physical Removal of the Hospitals' History

Craig felt insulted by the developers of the Saxondale estate who changed the names of the streets to erase the memory of the hospital. He explained local residents tried to resist the changes and were able to retain the name 'Saxondale' for the main drive leading up to the estate while dropping the word 'hospital'; for Craig, the government and the developers "eradicated the history of the hospital":

> It's like a war destroyed my village because the village is gone, it's been ethnically cleansed, the signs have gone, and everything is called something different now.

Craig compared the closure and subsequent erasure of the memory of the hospitals to the destruction of a village during war times:

> When they closed it the way they did it, it was the same as some of these films where, in war when they destroy a village and a few survive, well they destroyed my village, they destroyed some of them patients' villages, they didn't kill their friends but when you take them far away, when you split everyone up, you might as well have lost them so the people you grew up with are gone, the people you work with are gone, the patients you talked to are gone, the people you played with are gone, the memories.

Roger recalled visiting the Saxondale hospital site after closure, which was not redeveloped for a number of years:

> I remember walking around those wards in those corridors and it was all the leaves blowing in and the floors coming up and that beautiful oak floor in the recreational hall, people had been in and stolen things so it was like watching your village being destroyed, it was awful.

He expressed sadness for the lack of care of the then abandoned site:

> I watched that little village going from being immaculately presented and looked after, people were proud, by the time it closed, no one cared.

Louise, nurse who lived on the Saxondale hospital site, described the place feeling like a "ghost hospital" during closure:

> It was a sad time, the wards were closing one at a time, the hospital was dying, that's the word I can use for that, it was the death of that community.

Since the 1960s asylums have been stigmatised as a site of patient abuse. Former asylum sites are containers of memory for those that lived and worked in them; real estate developers have been operating a form of ‘strategic forgetting’ of the old asylum buildings. Most of the redevelopment brochures and planning documents have removed its history, thus operating a form of selective remembrance to remove the stigma attached to their bricks and mortar (Kearns et al. 2010). The main issue with memorialising the old Victorian asylum buildings rests on their contested histories (Moon and Kearns 2016, Gibbeson 2018). Long-serving staff that worked at Saxondale until closure recounted how historical documentation was thrown into skips while the hospital was emptied; Louise, nurse, and Craig, porter, rescued some of the documents in an effort to retain the memory of the hospital; they offered these documents to be deposited alongside their testimonies at the Nottingham Central Library.

Conclusion

The theme of improved care in in the early years of community care I identified points to the clear benefits of community care policies, such as redefining persons with a psychiatric disability from patients to clients. The closure of the hospitals also meant the end of living in institutions for life for people with severe long-term mental health problems. However the ideal of community care was perceived to have failed for the lack of appropriate services to replace what the hospital provided. Deinstitutionalisation had the effect of doing away with the hospital communities, which offered meaningful occupation, refuge, asylum and a sense of belonging. The oral histories in this study reveal the importance of having access to a supportive therapeutic environment for mental health recovery. Participants' experiences of community care are in stark contrast to their experiences of care in the local hospitals, which were remembered as safe heavens that could foster recovery during a mental health crisis and for those with continuing support needs. Crucially, the hospital environment fostered therapeutic relationships for patients as well as a web of networks and relationships for many. Participants' oral histories point to the overall sense of neglect and dispossession in community care. Long-term care of people with severe mental ill health was perceived as fragmented and subject to under-funding in the new system of care. Service users expressed a sense of neglect since closure, referring to the loss of care and the structured environment available in the mental hospitals. In addition, staff expressed concern for the lack of care of former patients after they were moved out of the hospitals, signalling the potential neglect for service users with long-term needs lacking access to supportive environments. The findings concur with the themes of neglect and isolation in recent literature, where the lack of appropriate care has been associated with neglect for people with long-term mental health problems (Taylor 2011 and 2015, Spandler 2016, Hutchinson 2016).

Mental health provision in acute settings was reported as inadequate and reduced to the point of crisis. The lack of availability of local inpatient beds was reported to adversely affect the support available to people during a mental health crisis. Instead, the environment of the old mental hospitals was remembered as welcoming and preferable to the new system. In addition, participants reported the adverse effects of isolation often leading to mental health distress and relapses coupled with the perceived lack of therapeutic relationships within current mental health services. Similarly, staff experienced the fragmentation of relationships, which was perceived to have negatively impacted on the relational care provided in current settings where staff time was mostly taken up by clerical and administrative tasks at the expense of building and maintaining interpersonal bonds with service users. Stakeholders felt that the project of care in the community failed them by the degrees of oversight and neglect in the current system. The experiences of loss of the hospital environment as a place of rehabilitation and the subsequent neglect in community reported in this research echo similar findings in the literature on the experiences of rehousing of former asylum residents in the community in the UK and New Zealand who were forgotten 'in landscapes of despair' (Joseph and Kearns 1996).

The continued isolation of service users and consequent risk of loneliness in community point to the need to consider the effect of stigma for people experiencing mental health problems; it calls for a consideration of creating opportunities to build networks of social support in safe environments. The service users that took part in this research explicitly expressed the need for designated places of belonging in which to feel accepted. All felt that the removal of the open door policy that had been instituted in mental hospitals as part of the social turn in psychiatry from the 1950s onwards was a return to the prison-like environment that the anti-institutional movement had wanted to do away with the hospitals' closure. Closed wards and the lack of access to green spaces were perceived to worsen outcomes for service users in need of inpatient care. Importantly, the service users that took part in this study brought to light the fact that voluntary admission is no longer an option in the current system, contributing to their current sense of neglect. The claims made by participants in this study are corroborated by the findings in the 2017 Care Quality Commission report entitled 'The State of Care in Health Services 2014-2017'. The report found that too often locked rehabilitation wards were being used as long-term solutions rather than a short-term solution to aid recovery during crisis.

The beneficial social and spatial aspects of the mental hospitals highlighted by participants have important implications for the current policy of social inclusion in mental health, driven by the modernisation agenda since the 2004 Social Exclusion Unit report (Social Exclusion Unit 2004). The policy centres around encouraging people with mental ill health to take part in mainstream society in order to counter the experiences of exclusion, marginalisation and discrimination in many spheres of life such as employment and community life (Repper and Perkins 2003, Rankin 2005). The imperative of social inclusion in the policy landscape has been adopted to redesign mental health services as a means to encourage independence from services (Spandler 2009). Initiatives have emphasised the use of mainstream facilities instead of day services, which been claimed to inhibit social inclusion and to run counter to the recovery agenda (Spencer 2004, Lingwood, 2005); in contrast, service users have sought to safeguard opportunities for peer support in safe places (Bryant 2010). The policy of social inclusion does not necessarily reflect the views and concerns of people using services by failing to take into account the difficulties individuals with long-term mental health conditions face in accessing volunteering and employment opportunities in the wider society such as social stigma (Repper and Perkins 2003, Spandler 2009).

This collaborative research demonstrates that accessing internal and external social spaces for informal social contact between service users and between service users and staff are paramount for recovery, which runs counter to the assumption implicit in the policy of social inclusion that these spaces are socially exclusive. Participants in this research, who live with long-term mental health conditions, find it difficult to partake in mainstream social activities and prefer having access to designated safe spaces for their social interactions. As the participants from this research have shown, social networks within services offer an important source of social capital for people who experience fluctuations in their mental health; it evidences what day service users with enduring mental health problems find helpful, including spaces for refuge and belonging. Ultimately statutory day services have played an important part in providing psycho-social rehabilitation in mental health since the 1940s as part of community psychiatry and early care in the community (Winship 2016).

The NHS social prescribing takes a psychosocial approach to improving health and wellbeing outcomes (Halder et al. 2018). It has aimed to fulfil this purpose by connecting individuals to community groups and statutory services for practical and emotional support with the aim of increasing social contacts, improve access to services and social networks within communities (South et al. 2008). Social prescribing has been found to reduce the use of primary care services through increasing social connectedness and reduce loneliness (Kellezi et al. 2019). Taking into account the social and spatial needs of people with long-term mental health conditions could inform future social prescribing initiatives aimed at improving this population’s wellbeing by encouraging group membership and a sense of community belonging.

The dramatic reduction of residential care for mental health service users and others, on the basis of the premises made within the literature of dysfunction and successive governments intent on reducing spending, has led to less choice and a virtual asylum through poverty and destitution in community (Killaspy 2006, Moon et al. 2016); it exposes the inherent contradictions of the policy of community care as bringing about more choice and quality of life, while simultaneously reconstituting aspects of institutionalisation in community as a direct result of reducing services. In addition, these oral histories provide a lens to assess the impact of the culture of consumerism, based on choice and personal autonomy, that emerged in the 1980s as a consequence of privatisation, marketisation and managerialism (Rogers and Pilgrim 2001); the recovery model's insistence on self-help can be perceived as a form of neglect for those whose self-reliance is not an option (Taylor 2015).

The contested nature of the care practices within mental hospitals challenge the dominant narrative of asylums as closed system within which social control dominated care practices, remembering the hospital environments as places of belonging and sanctuary. The literature on mental hospitals tends to portray these environments as dominated by oppressive and inhumane practices based on the abuse of power. However, as this research attests, the hospitals were remembered both as places of social control as well as therapeutic environments by former patients and staff alike in which relationships were much more fluid and permeable than reported in the literature. The positive aspect of the care provided within the now closed psychiatric institutions tend to remain excluded in the dominant narrative about inpatient care which in turn serves to justify the current policy of care in the community with its emphasis on the recovery model based on self-help and the reduction of services.

The perspectives of not only the staff but also the patients and others who came in regular contact with the mental hospital offer the prospect to rectify disparities within the historiography of psychiatry whereby only certain accounts are held up as legitimate and at the expense of others (Davis 2000). This collaborative study produced contested realities that allow for alternative representations to emerge through the multiplicity of conflicting standpoints that resulted from the genuine by-product of the active collaboration between the researcher and the research participants through the iterative phases of the research (table 1).

The findings suggest the need to rethink the notion of asylum as a place of sanctuary, safety, and recovery; the experiences of community care in this study requires a consideration of the social and cultural costs associated with the closure of the hospitals in terms of the loss of symbolic identity linked to the hospital location and the communities therein; these include a re-valorisation of hospital-based structured rehabilitative practices such as occupational therapy, access to the internal and external spaces such as the outdoors and the hairdressing salon, and open-door policy that offered meaningful care. The findings point to the need to examine environments that could fulfil this function, a call to re-evaluate the paramount importance of the structured social rehabilitation aspects of care available through the internal and external spaces within the now closed mental hospitals. The relational security fostered through the hospital communities, such as the long-lasting staff-patients relationships and others, was perceived as a key factor in recovery.

The prevailing narrative of the culture of psychiatric institutions as mainly based on punishment and discipline has obscured the relevance of the asylums as relational environments. This study has revealed often contradictory meanings of care provided therein; mental hospitals could operate as ‘total institutions’, thus confirming findings from the hospital’s inquiries and other studies, as well as permeable environments in which patient-staff relationships were much more fluid than reported in the anti-institutional literature. The findings problematise the prevailing wisdom on past models of mental health care as outmoded and dehumanising by making unique theoretical contributions to knowledge that reveal important aspects of care helpful to recovery therein, which have been lost with the move to community care practices. These substantive findings evidence the potential significance of psychiatric hospitals in the provision of stability, safety and social connectedness against a backdrop of perceived isolation and neglect through the perceived lack of psychosocial support from statutory services for people with long-term mental health issues in the context of (post) community care provision.

Chapter 7: Further Analysis and Reflections

Introduction

This chapter is structured in two parts. Firstly, the chapter discusses the process of doing this research. It reflects upon the extent to which it was possible to relegate control of the research process within this PAR-driven oral history study; I account for the unfolding process of collaboration through the planning, the collection of the oral histories, the analysis and the presentation of findings. In addition, the chapter explores the outcomes of participation for all involved, and the ethical, practical, social and emotional tensions that arose. I include a discussion of the disconnect between the theory/ideal of involving service users and others in research and the practice/reality of stakeholders' situated knowledge often being considered an invalid form of knowledge by academics/practitioners. In the second part of this chapter, I critically reflect on the theoretical and methodological implications of this exploratory oral history study driven by PAR, highlighting the limitations of this study. In this part of the chapter I explore the interconnection between memory and nostalgia within the oral histories and its implications for the heritage of psychiatry. I outline the unique contributions to knowledge that the combined use of oral history with PAR makes, including directions for future research.

Evolving Agendas within Safe Spaces

This collaborative research relied on a mix of one-to-one and group meetings. These were intended to build a shared understanding of how the research process would take place, the kind of data that would be produced and how meanings would be derived from the data and used. At the heart of both oral history and PAR research is the concept of shared authority, which allows for the democratising of the research process and demands the participants shape the design of the research as much as possible (Frisch 1990 and 2003, Kemmis and McTaggart 2005, Hesse-Biber and Leavy 2010). Creating shared authority required my willingness to commit time and energy to building trust with stakeholders to develop closeness and establish common ground. This is especially important in the case of persons with experience of the psychiatric system who have traditionally been excluded in research about them (Cook 2012). I set out to create 'safe spaces' to facilitate inclusive and open communication, so that participants' differences of opinions and conflicts could emerge in relation to their experiences of mental health care and the research itself, a key technique in PAR-led research (Kemmis 2000, Reason and Bradbury 2001, Bergold 2012). In these face-to-face spaces I was able to build trust, rapport and common ground and to sound out individuals' current concerns, and interest in their level of involvement in the research. I offered them different methods for sharing their memories and sought out questions and topics that were most relevant to their experiences of care over time. I gave them the choice of locations for my fieldwork and I encouraged them to voice any concerns in relation to the research. I further negotiated public access to stakeholders' oral histories by agreeing whether or not participants wished to deposit their oral histories in a local public archive.

Although all agreed to take part in some group discussions to discuss the findings across all interviews, one of the main obstacles to active collaboration rested on participants wanting to work individually with me as the main researcher. This process required numerous encounters with stakeholders beyond what I had anticipated. It demanded frequent communication to keep up momentum, which was impended by structural inequalities and mental illness relapses. For instance, some service users did not have access to a computer and could not receive emails; others were not able to travel to the chosen location of the fieldwork due to financial, practical or health reasons; I diversified forms of communication to keep all participants informed of the project's progress, sending transcripts by post, sounding out interpretations and negotiating follow-up interviews via frequent letters, phone calls and face to face visits to participants' homes or other spaces deemed suitable by them. In order to foster good working relationships, I found myself becoming involved in the lives of service-users through the process of getting to know them outside of the research, such as attending social events at their local community centre, which most of the participants rely on for their social contact and support. I became deeply aware of their isolation and poverty through the process of getting to know stakeholders' life histories and current life challenges, which led me to practice mutuality by offering some practical support. For instance, I gave lifts to participants who live in geographically isolated areas of Nottingham before and after our meetings, I bought drinks when meeting service-users and retired staff in social environments, sent Christmas cards, travelled to their homes if they were unwilling to get public transport to the community centre. These acts of mutuality engendered closeness with participants, which in turn helped service users to speak frankly and openly about their experiences of receiving care over time. I also benefited from forming genuine social connections with the research participants. In particular, I was moved by the reciprocity demonstrated by retired staff and ex-patients alike, who showed great concern about my right to remain in the UK as a

European national after the 2016 EU membership referendum, in which the UK voted to leave the EU, thereby casting doubt over my continued right to reside in the UK.

During the initial and follow-up semi-structured interviews, I facilitated the process of sharing decision-making through subjugating my own agenda to the process of listening to individual participants in order to balance the inherent unequal power I held as researcher; this technique allowed for new areas of inquiries to emerge; I observed participants were able to steer the focus of the interviews towards what mattered most to them and to engage in critical reflection about the issues that they saw as important in providing appropriate care in time of crisis and convalescence. The research started out with an initial focus on the value of relationships within the care provided therein but developed in significant new directions such as the inclusion of their experiences and opinions of community care, which would have not been a focus of this research had this been a traditional oral history project.

During feedback group events, multiple perspectives were retained in the presentation of the results and ex-staff and service users alike learnt with interest about the aspects of care available and the differing views on care practices at the Nottingham mental hospitals across time. Overall participants' responses were consistent across the feedback events where a general consensus emerged with regards to the themes I identified across all interviews. This evidences the extent to which stakeholders were able to steer the research's agenda to include themes and topics that were relevant to them. These group events served as key 'communicative spaces' that encouraged open dialogue amongst people with similar experiences. I observed that group feedback afforded an opportunity for mutual validation of each other's accounts. By sharing their testimonies with others, participants fostered strong peer identification and sense of solidarity among the different groups that took part in this study. The data produced in these events was qualitatively different from the one-to-one oral history interviews in that individual actors expressed their own opinions and hopes for dissemination in a much more assertive way. Many stakeholders recognised each other from past grassroots campaigns to save services; within the group settings, participants formulated a collective plan for dissemination of the findings through talks with key decision makers in community and the co-production of an exhibition. Russo suggests survivor-controlled research by its very nature sets off a collective process that instigates ownership of the research (Russo 2012); even though this was intended as a collaborative research project initiated by the researcher and not survivor-led research, the group events encouraged ownership and collective action for both service users and former staff, some of which are carers, who expressed an interest in co-presenting the research findings to local mental health service commissioners. Hence even though participants in this research preferred one-to-one interactions to group work, the group feedback events encouraged the appropriation of the research outputs for future use. In addition, bringing stakeholder groups together has been found to facilitate the discussion of difficult or taboo topics (Bergold 2012); retired staff seemed more comfortable to express their misgivings in a group rather than one-to-one settings about not wanting to appear too optimistic about the hospital environment in view of the dominant discourse of the mental hospitals as outmoded and custodial institutions. One of the main concerns that I identified during the group feedback session with staff was that they did not want to be perceived as being overly enthusiastic about the care practices in the old system as they all agreed there were aspects of institutional life that were undesirable. These included the strict routines, the confinement of people for life and communal washing and clothing. In addition, some former staff emphasised that they did not feel completely comfortable with criticising current community care policies as all are retired apart from one nurse; hence they have not kept up with current developments.

In summary, although I initially controlled the research project, this changed and evolved over time as the participants shaped the project's agenda and steered the topics of research. I initiated the research with an initial interest in exploring staff-to-patient relationships within the mental hospital; the research's agenda shifted towards what mattered most to participants as the iterative phases of PAR got underway, in this sense power was shared between myself as researcher and individual participants throughout the phases of the research process. The research participants had the opportunity to steer the agenda by bringing a significant focus to their individual experiences of inpatient care coupled with their opinions on aspects of care that they found meaningful and helpful for recovery. My agenda differed from theirs in significant ways; although we shared the common goal of wanting to record and preserve their testimonies for future generations, my main goal was to identify common and divergent themes in order to write up my thesis and produce academic outputs. Besides the creation of an archive, what mattered most to service users and ex-staff alike was the actual creation of their testimonies in a transcript format and its use to engender dialogue and raise awareness in the wider community of the care needs of people with mental health problems through community and heritage activities; it was at times difficult for some participants to comprehend the length of the research process, such as the time it took to prepare transcripts and for the researcher to provide an overview of all the themes I identified.

Interpretative Conflicts

A key aspect of the practice of PAR-led research is an examination of the different ways researchers versus participants interpret the findings (Baum et al. 2006). Equally, oral history methodology calls for an examination of possible interpretative conflicts through the imposition of researcher's concepts as opposed to the participants' meanings attached to experiences. One of the most cited pieces of research on the subject of interpretive conflict in oral history is one of Katherine Borland's publications, based on the oral history of her grandmother (1991). Borland examined the exchange that took place when her grandmother disagreed with Borland's interpretation of one anecdote her grandmother shared in her oral history interview; the conflict that ensued was due to their differing understandings of what a particular event in her grandmother's life. Borland had mistakenly believed that her grandmother shared her feminist mindset, which coloured her interpretation of her grandmother's life story. This shows the failure to engage in dialogue with the person whose story is being interpreted. As a result, Borland called for the process of interpretation to become a collaborative endeavour and to consider oral history interviewees as an important first audience for research outputs (Borland 1991). Through the process of 'active listening' during the iterative phases of PAR, I observed two main instances in which disagreements emerged in the research; firstly during the preparatory meetings and interview encounters, ex-patients and staff alike were confused about questions that related to the relationships formed and fostered in the mental hospitals. Most of the participants misinterpreted my questions as wanting to find out about romantic and sexual relationships rather than social connections and friendships; an example is given below:

> *Researcher:* What about instances of, you know, reciprocity and friendships between staff and patients?
>
> *Participant:* Formal or informal? It was highly frowned upon to have a sexual relationship with a patient or take them out… a male staff and a female patient or a female patient and a male staff, having said that there was a couple who got, did get married who I believe were… once the person was… dismissed, not dismissed themselves, the patient was released and they'd been out and about, that was if I can think of two, again out of the entire time there that would be it.

In response to this recurrent misunderstanding, I changed my line of inquiry to ask open-ended questions about the staff/patients they met and how they got on, moving away from what I realised was a fairly academic and impractical way of framing my questions. Moreover, I became aware that asking direct questions about the nature of friendships between staff and patients could be perceived as if I did not understand the meanings of the anecdotes participants shared. For instance, during a one-to-one meeting to discuss the transcript with a former nurse, I asked if she felt she had made genuine friendships with any of the patients in her care, she responded that she told me so in her interview, although this had not been clearly stated but discussed through lengthy anecdotes.

Another interpretative conflict that emerged occurred during the group feedback meeting with two former staff who were puzzled by my imposition of the terms ‘clinical’ and ‘non-clinical’ staff, stating they did not recognise staff divisions according to rank between nurses and other staff such as porters or electricians when working in the mental hospitals. These participants resisted my interpretation of the hierarchical nature of work in the psychiatric institutions evidenced in the literature, instead collectively remembering the hospital as a communal space in which staff worked along each other on an equal footing. In hindsight, former staff may have felt uncomfortable to be categorised according to rank, preferring to remember everyone as part of the hospital team.

Research Dynamics

While it is not possible to discuss at length all of the complex dynamics that emerged in this project, the interviews with two service-users offer some clues to the relationship formed between myself as researcher and service users as active participants in shaping this research and its impact on collaboration and on de-centring the traditional power of the researcher. Although the initial interviews with two stakeholders with experience of the psychiatric system presented narrative coherence, I was struck by the lack of coherence in subsequent interviews. Both participants asked for follow-up interviews to further explore their experiences of care. I agreed with each participant the topics they wanted to discuss prior to the interviews being recorded; however, during the recordings both participants veered from the mutually established set agenda to talk about their current existential struggles and needs. I was conscious that researchers must be flexible and responsive to individuals in order to withstand the lack of certainty and the ambiguity that ensues from collaborative projects with marginalised groups (Shopes

2003); equally, I was acutely aware that people with mental health problems are seldom listened to and whose stories tend to be disregarded as lacking coherence; I felt I was being tested for proof of my commitment to their cause. I was willing to endure the uncertainty to stay true to the project of sharing control and encourage genuine collaboration; eventually these participants did open up about their experiences and opinions of mental health care practices; allowing for time in the form of multiple encounters and flexibility in the research encounter to deal with ambiguities was crucial in fostering trust; my willingness to sit with the uncertainty provided the space for these individuals to eventually feel comfortable to open up about their own personal critiques of the system and evaluation of the care received through time.

Editing Transcripts

I shared transcripts with participants for their approval and input, including sounding out my initial interpretations on the themes I identified. Some challenges emerged from this process, which called into question the extent to which authority can be shared and the degree of influence participants had on the editing of their interview transcripts. Most participants resisted making any substantial changes to the transcripts, thus declining collaboration in the management of data about their lives, an experience mirrored in Rickard's collaborative 'Oral History of Prostitution' project (Rickard 2003). However, some ethical dilemmas emerged as a result of negotiating authority in the iterative phase of the research. I met several times with a service user, resulting in three interviews being recorded. During an interview, this participant shared explicit details of issues he faces with close members of his family. Following good practice in oral history, I took into consideration the effects of making this part of his life story public. I considered that if I reported verbatim what he shared about his struggles with some members of his family, this could create harm for the participant and significant others (Yow 1995, Rickard 1998). I discussed and negotiated with the participant to redact these sections from the transcript, agreeing to deposit the edited versions in the local archive. In addition, some tensions emerged in the editing process with two former staff, which requested detailed changes to improve the grammar and presentation of the transcript into a publishable account of their oral histories, a common occurrence when sharing oral history transcripts with narrators (Borland 1991, Hesse-Biber and Leavy 2010, Sheftel and Zembrzycki, 2013). For instance, a participant whose English is not her first language often used verbs in the present tense instead of past tense when describing events; both participants wanted to remove the excessive use of prepositions and conversation fillers such as ‘you know’ as the preservation of their narratives in a coherent form in a public archive was paramount. I remained open to modifications while balancing the research’s integrity in terms of treating the oral history interview as a primary source of history. For example I corrected grammatical mistakes of verb tenses in the transcript, as it does not affect the content of the record. However I resisted making substantial changes to the content of the transcripts, explaining to participants the importance of producing a reliable account of the spoken word as it occurred during the interview, which is not the same product as an edited publication, to which participants agreed. Instead I negotiated with participants to add separate notes in the transcripts for clarifications and additions.

Barriers to Participation

I identified two main barriers to participation. Firstly, this oral history study required participants to demonstrate a high level of articulacy in order to take part, which is often expected as part of oral history based research (Plummer 2001, Thompson 2017) but necessarily precludes people who feel less confident to speak or have limited verbal communication for whom a more visual approach to data collection and representation would have been more appropriate. Although I offered stakeholders alternative methods to share their memories of giving and receiving care, all but one person opted to have their oral history recorded. This is likely to have been influenced by my sense of identity as an oral history practitioner inadvertently influencing the methods of research at the expense of more inclusive methodologies. With hindsight, I recognised I could have employed photovoice, a community-based PAR strategy using photography to help communities to record and reflect on their concerns and produce critical knowledge and dialogue that can impact change (Wang et al. 1997, Wang 1999). This method may have attracted participation from stakeholders that felt less confident to speak about their experiences and/or people with different communication styles.

Secondly, some tensions emerged with two participants, namely a service user and a former member of staff, who resisted becoming involved in the group data analysis and reflections, viewing their individual testimonies as valid on their own terms to represent the value of care practices within the local mental hospitals. Their main motivation for attending the group feedback events was to reminisce about life in the old state mental hospitals but saw no value in taking part in interpreting the overall findings. Their responses raise the question of whether it is always possible or even desirable to involve research participants in the collective process of interpretation whose vested interests in taking part may be at odds with the overall research agenda (Shopes 2003). Shopes poses the important question of whether sharing authority is always desirable, especially in the case when we may not share the same social and intellectual goals as the group under research. Shopes points to the need to be clear about how we go about putting ourselves as researchers into the frame so to retain our own critical stance, which necessarily impedes shared authority (Shopes, 2003:109).

Community and Politics of Research

Although I embraced collaboration as a key aspect of the research, there have been certain constraints I faced when attempting to share power with participants. Participation and action are the central tenets of PAR in order to bring about practical change (Ward et al. 2012). At the heart of PAR in health and social care is the imperative of working with service users and other interested parties to balance the knowledge by expertise with knowledge by experience, thus co-constructing research outcomes that are relevant to the communities that researchers commit to support. This process demands going beyond collaboration in the analysis and interpretation of data to create practical outcomes for stakeholders (Pollard and Evans 2013). However, there is no guarantee that the findings produced from collaborative projects with service users and the public will effect change (Khan 2010). Researchers doing PAR-driven qualitative research need to balance the relationship between the demands of research and the practice of doing it. This awareness necessitates managing participants' expectations in the context of what can be achieved within projects that often lack adequate resources, which can lead service users to experience their involvement as tokenistic (Ward et al 2009, Pollard and Evans 2013). As a result of the cycles of planning, action and critical reflection, participants suggested actions to improve their situation by expressing some preferences for dissemination of the research findings. Participants asked me to facilitate the co-production of an exhibition to showcase the personal and collective experiences of care practices in the now closed mental hospitals. Participants also wanted to share findings with the Nottingham Mental Health Trust and local commissioners of mental health services. Although my drive to create a public archive of the legacy of the mental hospitals matched participants' expectations, my priority as a PhD student wanting to publish the research for policy impact were not necessarily a shared goal. Participants on the whole thought practical change could be achieved through public engagement in the form of an exhibition and talks given to decision makers in mental health service design and delivery. In collaborative research, the researcher's commitment to share authority in scholarship and theory development is affected by the bias of the researcher and the doing advocacy work which mediate participants' narratives; hence, the research necessitates the need to balance the researcher's own ideas with those of the participants (Rickard 2003). Projects that combine oral history work with participatory methodologies should take into account the need for multiple outputs to suit all stakeholders, including the researcher's commitment to scholarly work (Shopes 2003, Sheftel and Zembrzycki 2013). Importantly, PAR-driven qualitative projects tend to have no end date, which needs to be made explicit. In this respect, researchers have a moral obligation to be involved in the longer-term to help develop community-driven outputs. Kerr (2003) developed his PAR-driven oral history project on homelessness years after initially starting a traditional oral history project. Similarly, Rickard (2003) invested several years of involvement to help facilitate practical change in her collaborative 'Oral History of Prostitution' project through a number of outputs, including a health education project based on the oral histories and an educational resource for health professionals. I am in the process of applying for funding to facilitate the co-production of an exhibition and I am researching avenues to share findings with local commissioners of mental health services. Fundamentally, the research is likely to extend beyond the given milestones set out at the start of the project, reflecting that political and social changes that can be traced back to the application of PAR take time to be realised.

Implications for Research Practice

Researchers involved in user and public involvement in research need to confront what Ward et al. (2009) have termed 'epistemological dissonance', namely the lack of recognition that these groups can offer valid forms of knowledge that can effect social change and influence policy. When presenting findings from this study at events and conferences, I have encountered negative attitudes towards presenting a more complex view of the old state mental hospitals as permeable environments and communities of belonging, which I was unprepared for. This situated knowledge born out of participants’ knowledge by experience that portrays alternative representations of the mental hospitals in the form of positive narratives of institutional care have routinely been discounted as lacking validity on the basis that ex-patients and staff are institutionalised, despite having lived in the community for 30 years since the closure of the hospitals. I observed this resistance from proponents of the new recovery model, which can partly be explained by their lack of acceptance that humanistic approaches to care have a much longer history than is usually acknowledged, such as the impact of the therapeutic communities on inpatient care practices and the development of early community care from the 1940s onwards (Rolph 1999, Walmsley and Rolph 2001, Fussinger 2011, Winship 2016). Furthermore, this resistance was expressed by some researchers in the field of medical humanities who critiqued the validity of service users and staff’s knowledge on the basis it could be instrumentalised to return to asylum practices. This criticism suggests a lack of understanding of current mental health policy in which asylum has been reconfigured in the new guise of community care (Moon 2000, Quirk et al. 2006, Curtis et al. 2009).

I faced other constraints in my attempt to implement genuine collaboration with participants, which forced me to confront my position of privilege. A service user asked to co-present at an academic conference, which I welcomed and felt pleased about the person’s active interest in the research. However, the request was not granted, which upset the research participant; I felt unsettled and experienced guilt by the inability of relegating power and to have inadvertently caused this individual to experience rejection. I understood the significance of his upset over the rejection to attend the conference as a form of social exclusion commonly experienced by people with long-term mental health problems, which inevitably raised questions about the level of impact this study could make, further discussed below. Fundamentally, the epistemological dissonance I encountered affects the validity of different forms of knowledge, eclipsed by the inherently unequal power dynamics and decision-making that largely remains in the hands of academics and practitioners. This authority on knowledge-production remains unchallenged by the policy of user and public involvement in mental health (Hutchinson 2016). A solution to breaking down the ‘corridors of power’ that continue to exist albeit the closure of asylums rests on balancing the politics of community with those of academia and health and social care practice, requiring multiple outputs to meet all of the stakeholders’ needs in order to relinquish genuine control.

Impact of Participation

What follows is an exploration of the impact of participation for all involved through a discussion of the opportunities, challenges and tensions that arose as a result of the iterative stages of this PAR-led oral history research, including the social, emotional and practical implications of doing this PAR-led study. I discuss the implications of the conceptual shift in my own positionality within the research from outsider to insider and the bearing this has had on the research.

Effects of Participation on Stakeholders

The potential benefits of collaborative oral history is many-fold for participants, for social change and for bringing about novel dimensions of social and historical understanding of the past and the present (Thomson 2003); within PAR, change is viewed as a necessary outcome (Bergold 2012); a key element of PAR is the emphasis on mutual learning where the boundaries dissolve between what Lincoln refers as the ‘knowledge producing’ and the ‘knowledge consuming’ elites and the community under study; this process has the potential of producing practical change in the stakeholders who are traditionally disenfranchised from traditional research. It can encourage capacity and knowledge development on a personal and collective level (Lincoln 2001). The collaborative and iterative process of storytelling, reviewing, interpreting and disseminating the knowledge produced through the combined oral history and PAR processes generated new understandings for all involved. Overall, service users felt this project to be the start of some real change in terms of rediscovering aspects of care that they found meaningful in the previous system of care. In addition, service users reported increased self-confidence and awareness of what they found useful in their care through the process of remembering and reflection during interviews and frequent ‘off the tape’ interactions and subsequent discussions of the transcripts and the research findings. A service user felt empowered through the process of the interview in which he felt able to coherently reflect on his experiences of mental ill health and the care he received across time and place; this individual gained confidence in speaking about his experiences to help others in similar situations and used his interview transcript to give talks to other service users about his recovery journey. Another service user felt confident to speak publicly about her experiences, and shared her transcripts with others to increase awareness of the importance of having access to a welcoming environment during crisis**;** two retired nurses have used the transcripts to write their own life histories; they reported initiating intergenerational dialogue with their extended families. As a result of participation, four service users set up a group to research the history of MSRC, a former psychiatric day hospital. Similarly one retired nurse set up a closed online group, ‘Mapperley hospital staff 1880 – 1993’, to share memories and historical artefacts about the hospital among former colleagues. The group has 81 members and serves a range of purposes, from sharing information about the passing of former colleagues and organising reunions among staff, to sharing memories of the hospital and historical documents and photos. An important outcome of this study for stakeholders has been the preservation of their memories through the production of a discreet public archive, containing interview transcripts, photographs and other memorabilia. Overall, stakeholders were positively affected by participation and the burgeoning of activity in community demonstrates how stakeholders effected change at the local level through initiating communities of dialogue about meaningful care practices and the legacy of the local mental hospitals of which little is known in the public discourse.

Emotions in Sensitive Research

Participation in oral history, through the process of telling of one’s story, is generally reported as empowering; the process gives value back to a person’s life through the act of remembering (Perks and Thomson 2015; Thompson 2017). The mother of one of the children at the Columbine High school shooting conducted oral history interviews with the aim of helping those affected deal with the trauma that ensued. An unintended consequence of the research was that participants gained comfort through the process of reflecting on their own experiences in the oral history encounter (Mears 2008). Similarly, service users in this study often commented that they found comfort in the process of reflecting back on their experiences of receiving care in the local mental hospitals. All felt silenced by the inability to talk about their time at the hospital due to the stigma attached to the site as well as having been a patient in the asylum. In this sense, the oral history method had the inherent capacity to empower participants through the process of the telling (Thomson 2003, Hesse-Biber and Leavy 2010, Thompson 2017). The process of revisiting one’s life story through the oral history interview can both act to affirm as well as destabilise one’s own life story for both the researcher and the research participant, especially when recalling traumatic experiences (Rickard 1998). This is particularly salient in the case of mental health service users who have experienced the trauma associated with losing their identity by the imposition of the label of 'mental patient' (Rath 2012). One participant, K1, reported finding the process of revisiting the transcripts from the three interviews recorded with her difficult; she reported feeling unsettled by the process of being reminded of her breakdown and initial journey through the mental health system with her first hospitalisation. In addition, K1 felt guilty about the level of stream of consciousness in her interview. When discussing the themes that I identified from her interview, she divulged that she felt she used me to offload about her life's vicissitudes. In my attempt to share power with her by my willingness to listen 'in stereo' (Anderson and Jack 1991), K1 had inadvertently treated it like a therapy session.

Researcher's Shift in Positionality

While I had taken into account the possibility of participants experiencing distressing emotions as a result of taking part in this study, I had not expected the research to affect me on an emotional level. I experienced counter-transference during an interview with a service user who spoke candidly about her experiences of her mental health breakdown. The content of her oral history triggered painful emotions about my past, the result of which is discussed elsewhere (Calabria 2019a). As I progressed into the fieldwork, the inevitability of dealing with painful emotions and the past resurfacing became apparent. Engaging in sensitive research may generate researcher distress as a consequence of being exposed to the suffering experienced by research participants (Crowther and Mari Lloyd-Williams 2012). Moreover, when the research mirrors the personal experiences of the researcher, it can lead to liminality that researchers can enter when engaged in sensitive topic research. Liminality can bring about a significant disruption in a person's sense of self within the social structure (Janzen 2016). Through the process of listening to the life stories of people who have received or given care in psychiatric hospitals, my own repressed memories of the social stigma I was exposed to as the child of a woman with a mental health diagnosis began to emerge. As a result, I found myself in a temporary liminal space, occupying a third position in the research. I no longer saw myself as an outsider, but rather by virtue of the knowledge by experience that I possess I began to feel closer to being an insider within the communities I was researching.

My shifting sense of positionality has certain implications for my research. My newly discovered position of being a researcher with knowledge by experience became a conscious political act. I developed an intense feeling of solidarity with participants who not only have the difficult task of managing long-term mental health problems in their everyday lives but also coping with the social exclusion they face due to their diagnosis, issues that mirror my mother's experiences. Reflexivity in research involves self-scrutiny and some form of change to the self (Bourke, 2014) Incorporating my own reflexive practice helped restore my own agency in the process of re-inserting myself back into the research writing; through becoming aware of my closeness to the subject of the research, I am now a stakeholder in this study. I am no longer an outsider by virtue of the knowledge by experience that I possess, the distance between participants and myself has been reduced. However, I have not directly experienced the kinds of exclusions and social discrimination that people with a psychiatric label have often had to face. This brings to light the realisation that I occupy a third position in the research, a liminal space of in-between-ness; crucially, I have the privilege of entering and leaving this third space at my own choosing. As a result, I now see myself as insider with outsider agency. The research has unexpectedly given me a voice to talk about the experiences of mental health in my family in the context of the research, therefore sharing my own interpretative authority with participants. My basic assumptions and values been challenged, and I was forced to confront my pre-existing value judgments, my own kind of resistance, and thus examine the impact of the privileged position I occupy as researcher when engaging in sensitive fieldwork. It has forced me to re-evaluate my own past, and has brought about new kinds of conversations and ways of interpreting the research at hand; in so doing it has given me the opportunity to not only to reclaim some personal agency but also the possibility of personal healing (Calabria 2019a).

PAR researchers must prepare for their views to change as a result of participation and influences of stakeholders (Kemp et al. 2019); this study has had a long-lasting impact on myself; the dialogue that developed about the experiences of care practices through prolonged interactions with service users and retired staff and carers was instrumental in fostering new understandings and readjust my views on the care my mother received with respect to the value of the relationships she formed and fostered with staff and others in her own recovery. As a result of carrying out this research, I started volunteering for a local carers group, recognising my need to better understand the challenges I have been facing as a carer while also wanting to effect change among the local community of stakeholders that I have formed relationships with.

Social Implications

There have been other ethical issues that have arisen from the fieldwork in terms of social impact. To enable democratic action and greater social equality, practitioners of PAR and oral history are invited to build mutual and reciprocal relationships (Benmayor 1991, Minister, 1991, Lincoln 2001, Kemmis et al. 2014). PAR and oral history work characteristically require the building of long-term relationships with participants with the aim of fostering good rapport and closeness in order to produce rich data (Hesse-Biber and Leavy 2010, Kemmis et al. 2014); in this case in-depth oral histories were collaborative produced. Relationships that are formed in oral history and PAR research tend to be intense due to the long periods of the engagement and the nature of sharing personal memories and building mutual relationships, which often turn into friendships or helping relationships. However, fostering closeness can bring about unwanted consequences when engaging with individuals and groups that experience loneliness and isolation, such as mental health service users (Perkins and Slade 2012).

Co-researching oral history/life stories resembles some aspects of social work because in facilitating the process of telling participants' stories, the researcher becomes involved in participants' lives through close contact with individuals and groups and inevitably relationships are formed. Building close research relationships, researchers tend to acquire some of the characteristics of social work professionals, such as warmth, empathy and genuineness, and the research may resemble some aspects of social work itself; Atkinson found that some research can come to look and feel like social work, such as her experience doing PAR-led life history research in the field of learning disability where long-term research relationships are more in evidence (Atkinson 1993 and 2005). There are definite links between social work and research when doing sensitive research, which requires good listening skills, warmth and empathy, central to the tenets of oral history and PAR (Plummer 2001, Kemmis and McTaggart 2005). Reflecting on my research practice in terms of building good working relationships, this has meant getting to know research participants, facilitating the process of participants talking about their experiences of care practices in their own terms, and building mutual trust through fostering authentic relationships. This research demanded a strong commitment to reciprocity, which has been a core element of my oral history work as a community-based practitioner; through carrying out acts of mutuality, I discovered their need for human contact was greater than I had anticipated, and became painfully aware of participants' isolation and loneliness, more evident in the case of service-users but not exclusive to them. Two main risks arose; firstly, being friendly and open and interested in participants' lives fostered emotional bonds which can cause feelings of rejection when the research ends (Plummer 2001); PAR calls for strategies to relate to research participants such as fostering mutual concern and caring, which inevitably creates friendships and the difficulty of ending these once the research is complete; friendships are hard to maintain when researchers move on to new research projects (Atkinson 2005). The second risk lies in being seen as a potential helper in every day matters. Researchers can learn from social work practice in terms of mitigating some of the issues inherent with developing close relationships with research participants that inevitably come to an end. Atkinson (2005) suggests safeguards are required to explain roles and promote openness in research relationships; strategies include self-awareness, research logs, supervision and encouraging a reflexive approach on the part of the researcher that help foster authenticity in research relationships. The similarities are even more evident in the reflexivity skills used in both practitioners and researchers in narrative-based research where the process of individual construction of participants' memories becomes an integral part of the research in order to make sense of the events and to bring about change (Plummer 2001, Atkinson 2005). A distinctive lack of practical guidance exists in dealing with these particular social and emotional issues that arise in collaborative oral history research in health and social care which would merit further research. The production of a toolkit would provide direction to researchers using applied oral history to effect change including safeguards and ways to balance the need for the researcher's empathy with the need for protection and privacy of the researcher (Calabria and Bailey 2018).

Practical Implications

The time consuming nature of PAR and oral history research goes with the territory, as the validity of knowledge produced in PAR research rests on the quality of the interactions between participants (Kemmis 2000, Reason and Bradbury 2001); similarly, the quality of the rich data produced in oral history rests on the level of rapport and common ground between the researcher and the narrator (Yow 2014, Thompson 2017). This process demands time and effort on the part of researchers wanting to engage with participatory methods in order to build a 'safe space' in which stakeholders feel able to express critical views as a form of experiential knowledge. Both PAR and oral history research demands that researchers commit themselves to extended periods of time engaging with individuals and groups in the community. It raises the issue of academic researchers managing the level of commitment required against other institutional pressures such as the increasing priority imposed by the Research Excellence Framework (2014) on the impact agenda in academic research outputs with outcomes linked to funding; these pressures may prevent long-term dedication to a community group to bring about change. Moreover, this project demonstrated the need for material resources to be available for co-researchers, such as travel expenses, and material support, such as funds to cover for the cost of food, to be included when planning for PAR projects (Bergold 2012, Cook 2012). Relying on the goodwill and the charity of the researcher without proper resourcing for participatory led-research can lead to replicating the structural exclusions that have marked the lives of people with psychiatric disabilities (Cook 2012).

Limitations of the Study

In this part of the chapter, I examine the limitations of the study. Moreover, I provide an analysis of the inter-subjective elements within the oral histories, namely the role of nostalgia that emerged across the oral histories and the silences/omissions and the occurrences of misremembering that I observed.

I recognise that there are some limitations to the methodological and sampling approaches adopted in this exploratory research that could be considered as potential weaknesses of the study. Firstly, the small sample of participants has been largely self-selective. This may reflect involvement of service-users and staff with more positive experiences of giving and receiving care in the closed hospitals. Indeed 18 out of 20 participants felt that the hospitals should not have closed and their main motivation to take part has been to preserve the hospitals' heritage. In addition, the study is based on the experiences of care within the specified geographical location of Nottinghamshire, which makes it difficult to generalise. Moreover, I had originally anticipated that some former long-term patients would take part in the research project. However, the service users who took part were all short-term patients in the mental hospital with stays of no longer than 6 months. Some had been sectioned and others were voluntary patients, and some had repeated hospitalisations. However, all are long-term users of mental health services, with an average of 36 years' experience of the psychiatric system, thus all were able to compare the nature of the care they received in the mental hospitals with care in the community.

Interdisciplinary research that relies on people’s memories throws up the obvious critique of validity and reliability. Overcoming these issues include procedures such as triangulation, thick description, prolonged engagement with participants and their checks on data interpretation through debriefing (Creswell, et al. 2007, Thompson 2017). The content of the interviews was triangulated with notes from prior meetings with participants and through the rich and reflective oral histories that emerged during the research phases outlined above. PAR has its own ‘in-built safeguards’ (Winter and Munn-Giddings 2001) with regard to validity, namely the collaborative negotiation and evaluation of practices under research can reveal significant aspects of the situation, such as different power relations and possible conflicts of value. However, oral history rests on memory and demands a critical engagement with the process of inter-subjectivity in terms of the interplay between individual and collective memory. Participants were able to provide further checks for validity of the data through the iterative cycles of PAR, namely one-to-one meetings and phone calls throughout the research process including when they received and discussed the transcripts with the main researcher, and the feedback from group events, previously discussed.

The oral history testimonies reported in this study must be understood as culturally mediated constructs, as a narrative product of the interplay between past experience and present recollection, which are necessarily filtered, constructed and a selective product of memory, discussed below.

Oral History as Memory

The contested realities that emerged from the combined use of PAR and oral history methodologies throws up some unique challenges in interpreting the data. The fundamental tension between the two methods rests on how validity is measured. PAR’s measure of validity rests on the extent to which authentic and genuine research relationships were formed and fostered during the research process. However, the validity of oral history rests on deconstructing the individual and collective meanings therein, which demands critical engagement. Oral history as a primary source of knowledge can inform our understanding of the past by revealing the meanings given to lived experiences and events, where knowledge and 'being' are defined in terms of consciousness and revealed in the processes of perception (Thompson 2017). The specificity of oral history rests on inter-subjectivity which is bound up with memory, viewed as ‘an active process of creation of meanings’ (Portelli 1997, p. 23), which allows for the interpretation of the meanings produced therein both in terms of the interplay between private and the public spheres that the life narratives can reveal (Thomson 2007, Thompson 2017). The inter-subjectivities at play in oral history narratives offer rich sources of interpretation in understanding knowledge produced through time and place and the influence of personal agency and the social structure in what is revealed and omitted through content and form (Tumblety 2013). The former staff and patients’ oral histories portray an overwhelming sense of nostalgia for the old mental hospitals, which demand an examination of the complex relationships between the time of the telling and the time of the event, and the nature of memory.

Nostalgia

Ex-patients and staff’s narratives of care practices in the Nottingham mental hospitals reported in this study are clearly laced in nostalgia. Nostalgia was present both in the recollections of what life was like in the mental hospitals and when recounting experiences of neglect in community. Feelings of nostalgia were expressed through the perceived sense of loss of hospital-based care and it was bound up with the perception of the hospital environment as therapeutic for mental health recovery. Feelings of nostalgia were also attached to both the built environment in terms of the internal and external spaces, and the social landscape in terms of the formal and informal care provided by the communities that existed therein. Both staff and patients attributed symbolic meanings of home and belonging to their time in the hospital, such as a homely and family-like environment, a place of safety and sanctuary.

Nostalgia plays a significant role in the construction of collective identity; it is commonly viewed as a form of selective memory that typically functions to foster a sense of collective belonging for lost communities. The presence of nostalgic feelings in the oral histories of participants in this study is reminiscent of other collective memories of lost communities such as ex-mining communities (Bennett 2009). Nostalgia for the now closed mental hospitals has been found to be a reoccurring feature in social studies on the impact of deinstitutionalisation (Cornish 1997, Parr and Philo 2003, Wood et al. 2013 and 2015). As recent scholarship claims, these nostalgic narratives must be understood in the context of conflicting moral claims to place and belonging. Savage (2008) sees nostalgia as a key tool for those whose belonging is defined by local rootedness to repudiate the moral claims to belong for new, middle-class mobile incomers for whom attachment to place is a choice rather than through kinship connections or long residence. The presence of nostalgia in life histories help to unravel how communities have experienced collective loss and signifies the strategies used to foster a sense of continuity in the face of uncertainty (Bennett 2009). Making reference to Fred Davis' seminal study on nostalgia (1979), Bennett states that the peculiarities of nostalgia rest on its relationship to the present concerns that provide clues to the role it plays in reconstructing identity. Moreover, narratives of community decline can serve as a means of registering and understanding dramatic change, helping to preserve a sense of place at a time when collective memories are threatened by the destruction and remaking of urban environments (Ramsden 2016); in the case of old the county asylums in the UK, most have either been raised to the ground or turned into luxury flats, thus materially effacing the memories of place held by those who lived and worked in them. The presence of nostalgia in asylum narratives reported here seems to serve as a testament to former residents' sense of belonging. These memories act to simultaneously preserve a hidden and forgotten past within public memory and to create an alternative site of memory for those who considered the institution their homes and their community of belonging. The motif of loss in the participants' oral histories serves as a testament to former patients and staff's emotional attachment to the hospitals, in evidence when sharing photographs and memorabilia during group events. Participants asked the researcher to facilitate the production of an exhibition about the legacy of the local mental hospitals; this may help to explain the reason for the collective consensus for the need to preserve, celebrate and share the intangible heritage of the hospital with wider audiences. Long-serving staff compared the closure of Saxondale to the destruction of their village, thus providing evidence of the forced amnesia of the memory of mental hospitals as deeply stigmatised sites (Kearns et al. 2010). Crucially, nostalgia in these narratives could be viewed as a form of resistance to strategic forgetting. It serves to legitimise a particular version of the past that has been denied to both residents and staff alike through the dominant public discourse of hospitals as custodial and outmoded institutions that institutionalised residents and staff alike. It provides evidence that the process of individual and collective remembering and remembrance are not exclusively based on the stigmatised memories of asylums as argued by Kearns et al. (2010). The feelings of nostalgia that emerged from participants' oral histories simultaneously serve to create and sustain alternative representations of the hospital that is otherwise denied within the public discourse, which tend to exclude experiences that diverge from the collective dominant representation of institutional care practices as solely dehumanising. The emergence of nostalgia and emotional attachment to the asylums sites and the communities therein has implications for the preservation of their material and immaterial heritage. It calls for a reconceptualisation of the heritage of asylum and a revaluation of the formal and informal care practices that existed therein that impinge on wellbeing (Calabria 2019b).

Misremembering and Silences

A unique quality of oral history rests on the study of collective misremembering and the purposes these serve; the often cited example that illustrates the significance of misremembering in oral history narratives is the oral history research of Alessandro Portelli that linked individual to collective memory; for instance, the causes of the death of an Italian steel worker was collectively misremembered by his peers; Portelli identified strategies individuals employ to create memories by linking personal experiences to public events in order to add meanings to and make sense of their lives. Shared misremembering made the death of the steel worker more meaningful, arguing that the value of oral history is not so much about the accuracy of events but about the meanings ascribed to them whether real or imagined (Portelli 2015). I observed one consistent misremembering in former nurses' oral histories with regards to how Duncan Macmillan, the last superintendent of Mapperley hospital, was remembered. The nurses who worked at Mapperley hospital had fond memories of Macmillan, recounting anecdotes on his efforts to modernise care practices in familiar terms, despite never having met him; nurses' oral histories were framed around their professional identities during a period of great changes in mental health policy. These secondary memories of Macmillan's efforts to ameliorate care are likely to have been passed down through generations of nurses, may serve not only to give meaning but also to provide legitimacy to their lives as defined by their constructed selves as change makers in the mental health system. It could be interpreted as a strategy for seeking validation for their life long efforts to ameliorate institutional care; furthermore, misremembering their close connection to Duncan Macmillan may have served retired practitioners as a strategy against the vilification of the psychiatric nursing profession, a historically undervalued and stigmatised occupation that continues to be negatively perceived (Ross and Goldner 2009, Long 2014).

Silences about specific areas of experience in oral history narratives are not only effects of oppression and control as Passerini found in her research into the lives of working class Italians during fascism who had collectively suppressed memories of the regime (Passerini 1987). Silence can also be a form of agency that can transpire through the multiple negotiations between the participant and the researcher before, during and after the oral history encounter (Passerini 1987, Freund 2013). There was an obvious lack of reference in staff's oral histories to instances where staff had mistreated patients, a phenomenon often reported in the literature (Martin 1984, Busfield 1997, Moon et al. 2016). Life narratives are shaped by the social and political constructs available to narrators, while acknowledging their subjective nature, these narratives can expose what is at play (Portelli 2015). Both the need to preserve a past that has been largely denied in the public domain and the effect of an imagined audience in the form of future researchers accessing former staff and patients' oral histories may have affected what they said and omitted to say. Moreover, retired staff were conscious that they may have presented an overly optimistic view of their time working in the local mental hospitals; this conscious over-emphasis of what was helpful in the provision of care in the old system may have been a collective strategy to counter the imposed amnesia about hospitals as healthcare systems, amplified by the removal of the signs of its history. Similarly, service users may have emphasised the helpful aspects of care in light of the perceived collective sense of dispossession and neglect in the current provision of mental health care. However, service users were more open to discuss instances of mistreatment and abuse of power within institutional care. In addition, the service users that took part in this research were well aware of the imposed public amnesia on the positive aspects of institutional care within the mental hospitals and repeatedly referred to those service users with the loudest voice who got heard during the time of deinstitutionalisation at the expense of those concerned about closure who got ignored. This points to a perceived hierarchy within the service user movement which for them continues to determine whose issues are taken into account in the planning and delivery of services, echoing the concerns of Sedgwick (1982) 30 years ago in his attempt to defend state provision of mental health services in the face of deinstitutionalisation.

Conclusion and Directions for Future Research

This research set out to problematise the prevailing account of mental hospitals in the twentieth century as total institutions in order to explore what may have been lost with their closure and the transition to the community care model. In doing so, this research makes unique theoretical contributions to knowledge by revealing important social and spatial aspects of care that participants found helpful for their recovery. This experiential knowledge can influence both the design and the provision of inpatient and outpatient mental health services to improve the quality of care.

This study aimed at combining participatory action research (PAR) with oral history to co-construct oral histories about care practices, in the now closed mental hospitals, in order to harness the active involvement of service users who have the most to gain from the research and those of former staff who have usually been marginalised in the history of mental health care. As a result, I facilitated the mutual generation of the findings with participants in the context of this sensitive research in order to formulate collective analysis of the changing care practices from the old mental hospitals to care in the community policy. This was achieved through the interview process by the combination of the oral history approach based on life history experiences, and introducing collaboration throughout the stages of the research, encouraging participants to shape the research as much as possible; this in turn dictated the content in terms of what participants wanted to talk about, the length and frequency of the recordings and the extensive periods of times I spent with participants through the cycles of planning, action and reflections. The involvement of research participants in the interpretation ensured participation became embedded in the production of meanings. The co-constructed histories have now been deposited at the Nottingham Local Studies for posterity.

In summary, this research has required multiple encounters with service users and former staff alike to actively work with them to forge meanings through critical discussion at every stage of the research process. This required dealing with uncertainty and being flexible and committed to investing considerable time in order to produce ‘good’ results and outcomes; participants were able to actively shape and steer the research design process, determining areas of inquiry, constructing their own meanings as well as taking ownership of the outputs and expressing their views on future outcomes. The advantages of actively involving stakeholders in this study rest on the creation of experiential knowledge from first hand experiences of stakeholders as service users and former practitioners. Both ex-patients and former staff of the mental hospitals in Nottinghamshire that took part in this study were able to challenge the overall dominant perceptions of the mental hospitals as undesirable and outmoded institutions, by providing their own alternative interpretations of aspects of care they found meaningful and helpful in their recovery, while also being able to criticise some aspects of care that they found unhelpful and depersonalising. The experiential knowledge derived from this study provides a new dimension to understand the paramount importance of relational care and structured rehabilitation within inpatient care practices that can influence policy makers in service planning and provision. In this sense, this research has met the stakeholders' wish not only to preserve and make available their experiences of care in the mental hospital for posterity but also to influence change to current services, a common motivator for service users to get involved in research (Cook 2012). Through an analysis of the research process and the evaluation of impact on all stakeholders, including myself as the main researcher, this project has created genuine participation through mutual reciprocity, personal and collective gains and empowerment. In addition, PAR and oral history researchers ought to allow for the process of change and to adapt to multiple levels of reflexivity in the process of scrutinising the connections between the self in relation to the object of the research, the methodology and the inter-subjectivities at play. Thinking reflexively about the voice of the researcher within qualitative research offers an additional interpretative lens to research practice by engaging with the notion of liminality. It can enhance research rigor by monitoring the tension between involvement and detachment of the researcher. The continuous process of reflexivity can help to go beyond questioning the truth of others and our own; it is not just a tool but also a moral and ethical project (Calabria 2019a).

The co-constructed oral histories that form this research project represent the vantage points of those that gave and received care in the now closed mental hospitals. Their perspectives help to understand experiences that have not been widely researched, and to bring to the fore a novel dimension to aspects of care practices within the old state mental hospitals that engendered therapeutic benefit. The substantive findings provide valuable knowledge produced by people who have traditionally been marginalised within the history of mental health care and do not usually get an opportunity to influence the historical record or mental health policy. The active collaboration between the stakeholders and myself as researcher helped to generate unique insights into meaningful aspects of care helpful to recovery that can influence the design and provision of current care practices. Valuable knowledge that bears on current policy emerged from the collaborative enterprise with participants, who helped shaped the areas of research within this study. Staff and service users alike provide a clear and consistent critique of the ‘new’ recovery model from 1990s onwards for service-users for whom self-help is not always an option. The implicit assumption within the recovery model that service-users need to self-help compounds moments of relapse, which exposes the inherent contradiction within the policy, on the one hand service-users are expected to seek self-improvement to foster a sense of purpose, on the other this imperative can adversely affect service users’ wellbeing who may not always be able cope with the responsibilities and demands this entails. The collective critique that emerged from participants’ situated knowledge would not have been possible through a traditional oral history research focused on care practices within the mental hospital.

The combined use of PAR and oral history can improve practice, social outcomes, and reduce inequalities. The choice and combination of methods makes a unique contribution to the methodological literature concerning participatory action research and oral history; it highlights how these two distinct, but complimentary methodologies are particularly suitable in engaging and giving a voice to marginalised communities and in producing knowledge by experience that can help reduce social inequalities. Oral history is essentially a form of PAR when it goes beyond sharing authority in the interview encounter to extend the process to the analysis, presentation and dissemination to engender practical change. Qualitative research that engages both oral history and participatory action research methodologies produces rich reflections and a multitude of outcomes for stakeholders through the iterative collaborative research process as outlined in this study. Researchers engaging in oral history work that has collaboration at its centre need to balance their personal commitment to scholarly work with advocacy and change in the communities that have a primary stake in the work. By including the iterative PAR cycles of planning, observation and reflection, oral history based research can significantly reduce the unequal power dynamics in the encounter and produce practical outcomes for participants. Moreover, it can create opportunities to draw research methods from across disciplines. Importantly, the combined use of PAR with oral history raises the question of whether academics are prepared to work in ways that go beyond traditional academic projects and calls for the need to balance advocacy with the research’s integrity, which necessarily required long-term commitment beyond the scope of this PhD research while maintaining the requirements of scholarship.

Although I committed to create spaces in which participants could develop their authority over the research material, the study was constrained by the lack of material resources to develop meaningful actions proposed by stakeholders. This in turn requires the researcher's time, capacity and commitment and the inherent need to manage stakeholders' expectations on what can realistically be achieved. Crucially, there are undeniable barriers to sharing authority with participants from disenfranchised positions to effect change at the macro level when there is a disconnect between the ideal and the practice of user-involvement and their knowledge by experience in health and social care in which academic and practitioners' knowledge by expertise continues to retain authority. Moreover, adopting a more inclusive data collection methodology may have attracted participants who feel less confident to record their experiences or may have different communication styles. Various aspects of this study would merit further research, including the development of socially engaged outputs that could potentially bring about change at both the micro and the macro levels, listed in table 4 overleaf. Ultimately the stakeholders in this project, namely service users and retired staff and carers alike, developed a sense of ownership of the research outputs and the outcome of the research was relevant and valued by them.

Table 4 – Directions for Future Research

Outputs	**Aims and objectives**
An exhibition on the heritage of the Nottingham mental hospitals	Showcase the multiplicity of experiences of participants about the legacy of the local mental hospitals and raise awareness of their therapeutic value.
A national audit and re-analysis of existing oral history collections	Consider ways in which the data may be reconceptualised, taking into account the ethical issues in the project of reuse.
A report to local commissioners of inpatient mental health services	Provide a summary of the research findings to raise awareness of what has been lost with the closure of the local hospitals.
A methodological paper on the combined use of PAR with oral history methodology	Evidence how the application of oral history as a tool in participatory action research can improve practices and social outcomes and reduce inequalities in health and social care.
A paper in a medical humanities edited collection	Demonstrate how patients and staff's perspectives from this study can usefully contribute and challenge aspects of the conventional history of mental health care.
Article in Asylum Magazine	A magazine article based on the influence of therapeutic community on care practices in the Nottinghamshire mental hospitals in *Asylum Magazine,* which provides a forum for debate about mainstream services and radical, critical or alternative perspectives on mental health.
A book chapter relating to the heritage of psychiatry	A book chapter that explores the material and immaterial heritage of the old state mental hospitals.
A funding application to the Heritage Lottery Fund	Work in partnership with community groups and community-based arts organisations to explore the early experiences of community care using participatory methods.

Data Access Statement

Due to ethical restrictions detailed in the methods' section of this thesis, some interview transcripts produced by this research have been anonymised. All of the interview transcripts from participants, who consented to data sharing, plus the photographs and other documents of life, are available to bona fide researchers from Local Studies, Nottingham Central Library, Angel Row, Nottingham, NG1 6HP, Email: enquiryline@nottinghamcity.gov.uk. Due to the sensitive nature of the research, two interview transcripts from this collection have been embargoed for one hundred years from the date of deposit. The catalogue number of this collection is L36.48.

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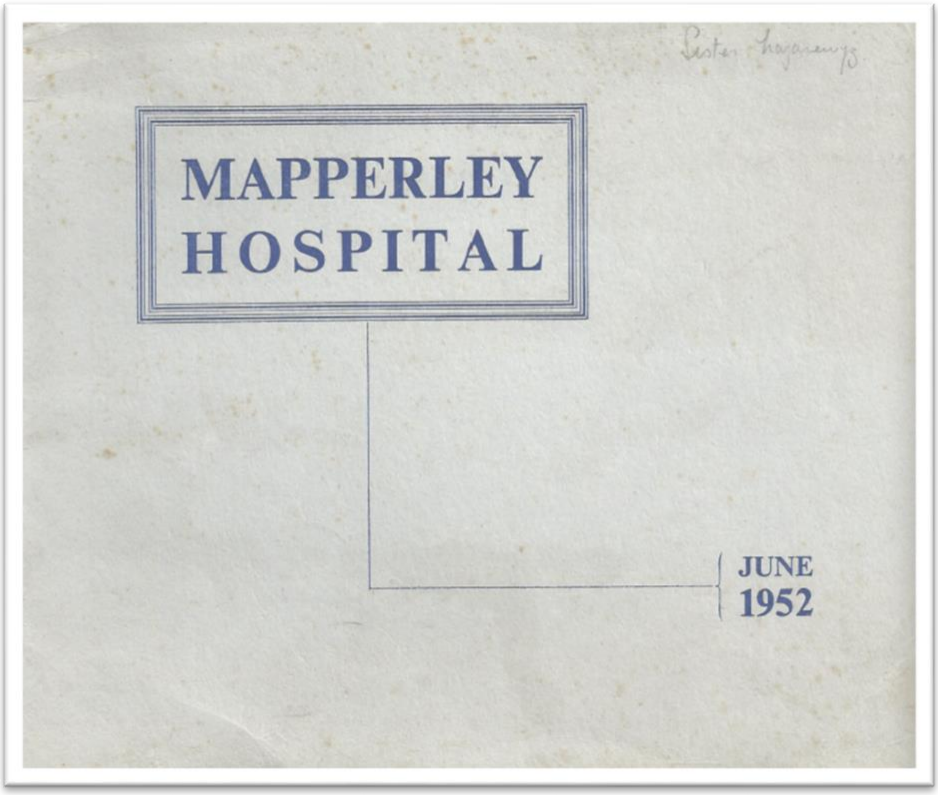
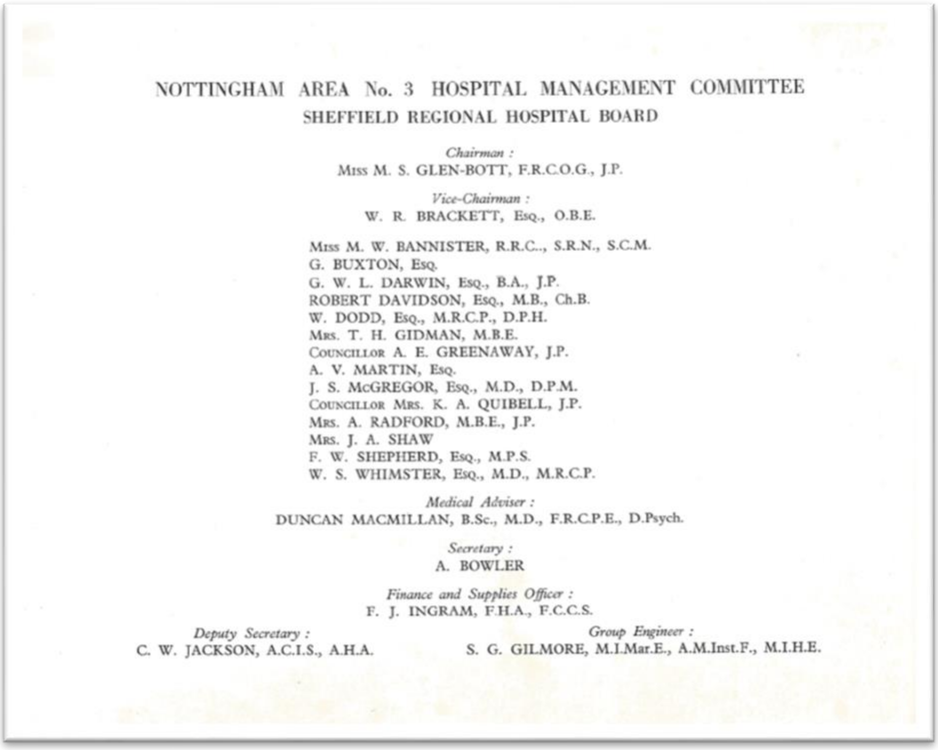
Appendix 1: Mapperley Hospital Open Day Brochure



Sister Lazarewyz

MAPPERLEY HOSPITAL

JUNE 1952



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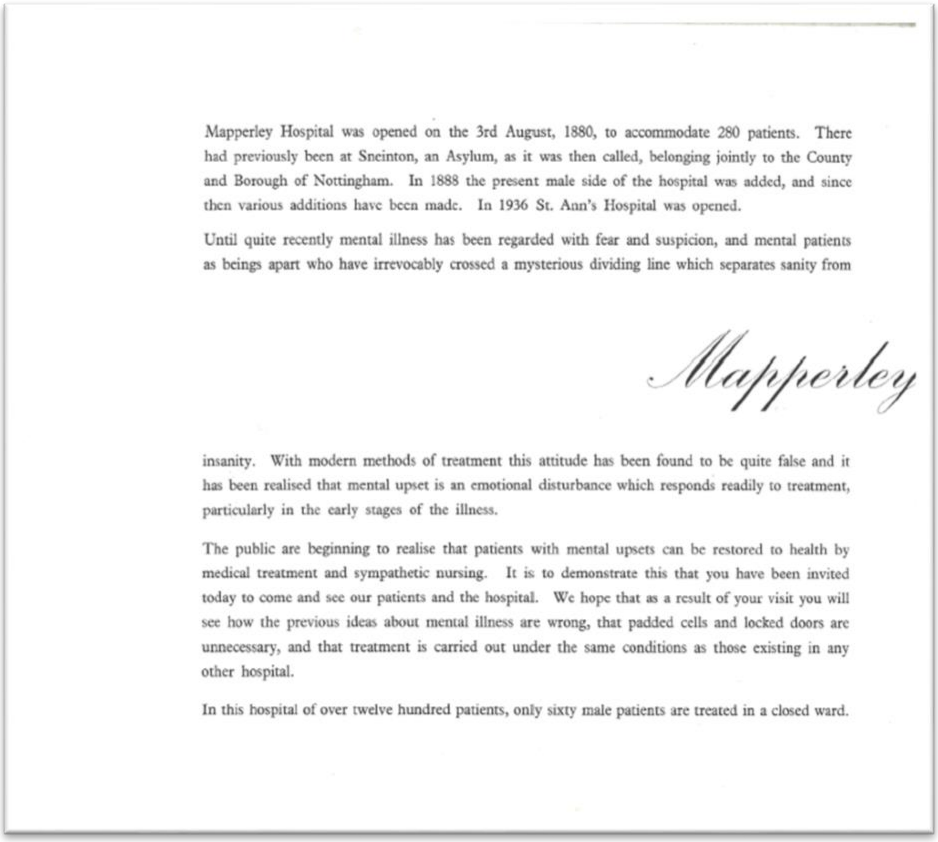

Mapperley Hospital was opened on the 3rd August, 1880, to accommodate 280 patients. There had previously been at Sneinton, an Asylum, as it was then called, belonging jointly to the County and Borough of Nottingham. In 1888 the present male side of the hospital was added, and since then various additions have been made. In 1936 St. Ann's Hospital was opened.

Until quite recently mental illness has been regarded with fear and suspicion, and mental patients as beings apart who have irrevocably crossed a mysterious dividing line which separates sanity from

Mapperley

insanity. With modern methods of treatment this attitude has been found to be quite false and it has been realised that mental upset is an emotional disturbance which responds readily to treatment, particularly in the early stages of the illness.

The public are beginning to realise that patients with mental upsets can be restored to health by medical treatment and sympathetic nursing. It is to demonstrate this that you have been invited today to come and see our patients and the hospital. We hope that as a result of your visit you will see how the previous ideas about mental illness are wrong, that padded cells and locked doors are unnecessary, and that treatment is carried out under the same conditions as those existing in any other hospital.

In this hospital of over twelve hundred patients, only sixty male patients are treated in a closed ward.

This is probably unique in this country and deputations from other hospitals visit to study the methods by which this new approach to treatment developed.

During 1951 out of 945 admissions only nine were certified, the others being either voluntary or temporary. 839 patients were discharged during the year.

It must be realised that the mental hospital forms only one part of a modern mental health service.

Hospital . .

Equally important are the out-patient clinics and the department of social work and community care.

Out-patient departments are established in all the hospitals of the city, and more than half the time of the consultants attached to this hospital is spent in this work. The opportunity is thus given to patients to have treatment in the early stages of their illness when it is most effective.

The social workers carry out invaluable work in the homes of the patient, both in helping to correct social factors contributing to the breakdown in health, and in re-establishing the patient in the outside community after having been in hospital.

Work in the mental health service as a nurse, social worker, or voluntary worker offers a great opportunity for valuable and interesting service.

Courtesy of University of Nottingham Manuscripts and Special Collections.

Appendix 2: Information Leaflet

The Oral History of the Nottingham Psychiatric Hospitals

This sheet provides some background information about the project and what will be involved if you decide to take part.

What is this project about?

The history of mental health services in Nottingham has not been fully documented. The voices of former residents and staff in the psychiatric hospitals need to be preserved before their important memories are lost. The research will focus on the importance of friendships between residents and the relationships between staff and residents. The findings will help to get a better understanding of what has been lost with the closure of the psychiatric hospitals and the experiences of moving to care in the community.

Who will carry out the work?

The work will be carried out by Verusca Calabria, a PhD researcher at Nottingham Trent University as part of her research fieldwork. Verusca is also an oral historian with 10 years' experience of supporting communities to tell their stories.

What will be done?

The researcher hopes to collect around 25 or 30 personal testimonies of life in the psychiatric hospital. The researcher would like to collect personal memorabilia and/or photographs of life in the Nottingham psychiatric hospitals.

What does taking part mean?

If you decide to take part, you can contribute in various ways:

- You can participate in a focus group to determine the research questions and talk about any memorabilia or photographs that you may have.
- You can share your memories in one-to-one **oral history interviews**.
- You may prefer to share your memories in a group with other former residents or staff.
- You may wish to recount your memories by writing these down or through drawing. You have the option of giving copies of your personal photographs or other memorabilia to be used for research purposes and to be deposited at the Local Studies Library in Nottingham for future use (a separate consent form is available).

- You have the option of contributing to the research findings, which will be shared with you for your comments.

How will participants be recruited?

Participants will be recruited through a variety of means including word of mouth with existing contacts, articles in the local press, community centres, and sheltered housing. The researcher will not disclose any information relating to your participation or refusal to participate to any related body or personnel.

What is an oral history interview?

An oral history interview aims to capture people's memories and feelings about past events and everyday life experiences. An interview can last anywhere between one to two hours. Verusca Calabria, the researcher, will invite you to talk about your background, how you moved into or started work at the psychiatric hospital and what life was like at the hospital, including any connections you made with residents or staff, daily activities and social events. If you decide to be interviewed, the interview will be conducted at a place and time that is most convenient to you. You will also have a chance to shape the research questions by participating in a focus group to discuss about what life was like in the hospital.

Gaining Consent

You will be given a *Consent*, *Clearance Note and Deposit Agreement* form to sign before the interview to ensure you have been given sufficient information and that your permission has been obtained. You will also be asked to give permission to use the material for future research, education, publication and display purposes. No names or material will be published or provided to researcher without your consent.

Will I be quoted?

It is important to be aware that Verusca Calabria, the researcher, may wish to include quotations from your interview in reports, and publications and presentations, including audio clips of your interview. The primary purpose of collecting information via focus groups, interviews and group reminiscence is for research purposes. In your consent form you will be asked to confirm that you are happy with this. You will have the choice to determine how the material is used in the future.

How will you protect my confidentiality and anonymity?

The recorded material will be handled only by the principal researcher and her supervisors, in line with data protection principles and the University's approved research protocol. Hard copies of research notes will be kept in locked filing cabinets, and electronic files kept on password-protected computers that are not accessible to anyone else.

You will have the option to remain anonymous. If you choose this option, you will not be named or otherwise identified in any publication arising from this research and no unpublished opinions or information will be attributed to you, either by name or position unless you specifically agree to.

What are the potential benefits of taking part?

Your individual memories will help preserve the history of the Nottingham psychiatric hospitals, which are at risk of being lost. Your contribution will help to shed light on the importance of connections between residents and staff that could bring about important knowledge, which could influence change in mental health provision today. You will have the option to have your oral history recorded and deposited in a public archive for the benefit of researchers in the future. We hope that you will find participation an enjoyable experience.

If I take part, can I subsequently withdraw?

Having agreed to take part you are still free to withdraw from any aspects of the study up to one month from the date start date of your participation. You do not need to give a reason and there will be no repercussions as a result. If you wish to withdraw any of your data please contact Verusca Calabria via email: verusca.calabria2015@my.ntu.ac.uk or telephone: [number removed].

What are the possible risks of taking part?

The interviews are strictly confidential, and we will ensure all agreements regarding access are adhered to in strict accordance with your wishes.

You are free to withdraw from the project at any point. As a result of your involvement in the study, you may have access to information of a confidential nature, for instance through participation in a focus group. This could be as simple as having access to other participants' personal information. You will be asked to agree not to disclose the identity of other participants or anything discussed in focus groups, group reminiscences etc., unless otherwise agreed by the group.

What happens if I disclose information that relates to harm and/or is defamatory?

If you disclose information regarding harm to yourself or others, for example relating to cases of historical abuse, the researcher will be obliged to pass the information on to the relevant agencies, such as the police. If you disclose information that may damage the reputation of a person/organisation, we may remove the information from the records of the research, including the interviews and/or transcripts.

What happens if I become upset as a result of remembering life in the hospital?

The researcher will pass on to you information about relevant organisations and/or individuals who can provide the support that you may require.

What happens after the interview?

After the interview the contents of the audio recording will be transcribed verbatim in a word document. You will receive a copy of this. Notes from group discussions and reminiscences will also be typed up and shared with you. The digital recording will be stored securely at Nottingham Trent University and you will have the option of agreeing that the recording and/or transcript can be deposited at the Local Studies and Archives in Nottingham (Angel Row, Nottingham NG1 6HP). Local Studies Library in Nottingham has a policy to collect and conserve materials on a permanent basis; hard copy masters are stored in a reserve store and digital master copies are stored on an external hard drive stored in a separate safe location. In line with the requirements of the Data Protection Act 1998, personal information such as names and addresses will be stored separately to prevent unauthorised access.

What happens to the memorabilia?

If you choose to donate any form of memorabilia to the Local Studies Library in Nottingham, please note that the Local Studies Library has a policy of collecting published material and photographs relating to local history; if you would like to deposit unpublished material e.g. letters, diaries, the Local Studies Library has a policy of transferring this material to Nottinghamshire Archives. Please note that if the memorabilia are deemed to be of sensitive nature, Local Studies Library may decide to limit access to the materials for a certain period of time.

What happens if I decide to withdraw memorabilia from Local Studies Library?

You are free to withdraw your memorabilia up to one month from the date of donation. Thereafter the ownership of the memorabilia will transfer to the Local Studies library and cannot be withdrawn.

Who is responsible if anything goes wrong?

Verusca Calabria, the researcher conducting this project, reports to Di Bailey, Director of Studies, School of Social Sciences at Nottingham Trent University. If you have any concerns with any aspects of the research, please contact Di Bailey on 44 (0)115 848 6079, email: di.bailey@ntu.ac.uk; Burton St, Nottingham NG1 4BU.

Appendix 3: Consent, Clearance and Deposit Agreement

The Oral History of the Nottingham Psychiatric Hospitals

Please read and confirm your consent to take part in this project by ticking the appropriate box(es) and signing and dating this form

1. I confirm that the purpose of the project has been explained to me, that I have been given information about it in writing, and that I have had the opportunity to ask questions about the research.

☐

2. I agree to take part in this project with the understanding that my participation is voluntary, and that I am free to withdraw without giving any reason and without any implications for my legal rights up to one month from the date of my participation.

☐

3. I agree to take part in a reminiscence event to recount what life was like in the psychiatric hospital, such as daily routines and events during my time there, the connections I made, and what happened when the hospital closed.

☐

4. I do not wish to be named or otherwise identified in any publication arising from this project.

☐

If you would like to take part in a one-to-one oral history interview, please indicate your choices below. If you do not wish to be interviewed, please go to section 10.

5. I give permission for the interview to be audio-recorded and I hereby assign the copyright in my contribution to Verusca Calabria, the project researcher, with the understanding that the interview recording, and transcript will be used solely for research, publication, and presentation purposes only.

☐

You have the option to have your audio recording and/or transcript deposited at the Local Studies Library Nottingham. Please indicate your preferences below:

6. I agree for the audio recording and the transcript to be added to the oral history collection of the Local Studies **Library**, Angel Row, Nottingham I agree that all material will be preserved as a permanent public reference resource for use in research, public display, publication, broadcasting, the Internet. The material will be used for educational purposes only.

☐

7. I wish to remain anonymous and I agree that only the transcript of my interview, provided it is anonymised (all names of people, places and dates will be removed), is deposited at the Local Studies Library, Angel Row, Nottingham in strict accordance with my wishes. I agree that the transcript will be preserved as a permanent public reference resource for use in research, public display, publication, broadcasting, the Internet. The material will be used for educational purposes only.
☐

8. I do not wish to deposit the interview in a public archive and request that the digital audio file be destroyed at the end of the project.
☐

9. Please sign to confirm that you have read through this document and check that you have selected the correct options.

Name of respondent	Date	Signature

Name of researcher	Date	Signature

You will be given a copy of this consent form to keep.

You can contact the researcher as follows:

Verusca Calabria, PhD researcher, tel. [number removed], email verusca.calabria2015@my.ntu.ac.uk, Graduate School, School of Social Sciences, Nottingham Trent University, Burton Street, Nottingham.

Appendix 4: Memorabilia Deposit Agreement

This sheet is for recording information about objects that you may be willing to loan or donate to aid the research into the history of the Nottinghamshire Psychiatric hospital. You may choose to deposit the original or a copy of the item at the Nottingham Local Studies, Angel Row, Nottingham. The material will be preserved as a permanent public reference resource for use in research, public display, publication, broadcasting, the Internet. The material will be used for educational purposes only.

Form completed by:

____

Date form completed:

____

Nature of the object (e.g. old photograph, letter or other):

____

Object name:

____

Owner of the object:

____

Signature:

____

Description: (including personal significance)

____

____

____

____

Dimensions (mm) (if applicable):

Height___________________Width________________Depth____________

I offer this item **on loan** for the purpose of the research to be used for research, publication, and presentation purposes only.

☐

I offer that **a copy of this item is deposited** at the Local Studies Library in Nottingham with the understanding that it will be preserved as a permanent public reference resource for use in research, public display, publication, broadcasting, the Internet. The material will be used for educational purposes only.

☐

I offer the item as **a donation** to the Local Studies Library in Nottingham with the understanding that Local Studies Library will preserve the material as a permanent public reference resource for use in research, public display, publication, broadcasting, the Internet. The material will be used for educational purposes only.

☐

The Local Studies Library collects oral history recordings and photographs relating to local history; if you would like to deposit unpublished material e.g. letters, diaries, is the Local Studies Library free to pass the item on to Nottingham Archives?

☐

Agreed date of return (if applicable): ……………………………………………………

Please note you are free to withdraw your memorabilia up to one month from the date of donation. Thereafter the ownership of the memorabilia will transfer to the Local Studies library and cannot be withdrawn.

You will be given a copy of this consent form to keep.

You can contact the researcher as follows:

Verusca Calabria, PhD researcher, tel. [number removed], email verusca.calabria2015@my.ntu.ac.uk, Graduate School, School of Social Sciences

Nottingham Trent University, Burton Street, Nottingham, NG1 4BU

For use by the researcher only:

Date of return:……………………………Return by (Full name): ………………………

Signature:…………………………………Item catalogue number:……………………

Appendix 5: Research Poster

Mapperley Hospital Staff

The coach
Mapperley Hospital

Saxondale
Hospital

Exercise yard
Mapperley
hospital

Images courtesy of Paul Swift, Nottingham University Hospitals N.H.S. Trust

Do you have memories of Nottinghamshire psychiatric hospitals?

A PhD researcher at Nottingham Trent University would like to capture the memories of your time living or working in the Nottinghamshire Psychiatric hospitals.

What is the research about?
The history of mental health services in Nottinghamshire has not been fully documented. The voices of former residents and staff in the psychiatric hospitals need to preserved before these important memories are lost. The research will focus on the importance of friendships between residents and the relationships between staff and residents.

What is involved?
Participants will have a choice to decide what to talk about and how the information is captured, for example stories of life in the institution could be told in a group or in one-to-one interviews. If you decide to take part, you will be given detailed information about the process including how to help shape the research.

Who can take part?
Anyone who has either lived or worked in any of the psychiatric hospitals in Nottinghamshire, including Mapperley, Saxondale and St Anne's.

How to take part?
Contact Verusca Calabria, PhD researcher, Nottingham Trent University, email: verusca.calabria2015@my.ntu.ac.uk, tel. 0779 1092850.

NOTTINGHAM
TRENT UNIVERSITY

Appendix 6: Stakeholders' Interview Guides

EX STAFF BROAD THEMES	INTERVIEW GUIDE MORE DETAILED AREAS OF INQUIRY
Life before the hospital	Time & Place of Birth Education, training Work history – explore if relevant What led them to work at the hospital If moved from abroad – ask why he/she chose Nottingham If continued to work in the field – explore further later in the interview
Arrival	What happened first? First impressions of the environment/ward/school of nursing Physical description of the hospital/ward(s) Accommodation Support – did they already know anyone? What they felt about starting to work there; Hopes, fears, expectations
Work	Professional structure and whether it changed over time Explore relationships and interactions between staff from doctors to porters Typical day at work, regular tasks; conditions of work: hours, shifts, pay etc. Any job perks? i.e. overtime, pensions, free uniforms; clothing regulations Ask about his/her work ethos and whether these have changed over time?
The patients	Types of diagnoses/conditions/needs etc. Types of treatment available/patients involvement if at all in their treatment.
Life in the hospital	Physical description of the hospital/ the ward(s): sleeping, eating, rest area(s) Daily routines: regular activities on the ward (medication rounds, etc.) Daily activities: OT, sports, other activities such as using the library Visits from friends and family, other types of occupation? Food, clothing regulation, access to washing facilities Weekend activities/holidays/leave from the hospital? Interactions with other patients. Any instances of reciprocity between patients? Memory of the wards. Cigarette and/or tea breaks? Time outside in the grounds
Social networks and support	Relationships at work: did they make any friends? Camaraderie? Ask about contact with patients, how relationships were formed. Ask about groups that may have supported the patients i.e. League of Friends, other voluntary groups etc. what they did, any memories? Ask about patterns, type and significance of contact with other staff and others such as volunteers.
Staff Entertainment	Ask about regular events Ask about the staff club if there was one or other places where staff socialised
Staff entry & exits	Procedure for entering/leaving the hospital if any. How about the patients?
Social Networks and support	Everyday interactions in the hospital. Relationships with other patients: did they make friends? Stayed in touch after? Did they witness/experience any violence? Ask about patterns and significance of contact with family, friends, community organisations, others. Ask about volunteers
Closure of the hospital	How did they find out? Where they involved in any of the decisions/practical arrangements? Explore. What they felt about closure; how closure affected their professional career Their memories of 'care in the community': how did it affect the patients? Explore memories of what happened. Did they stay in touch with former patients? How about former staff? And what about former workers?
Mental health services since closure	Explore changes relating to care in the community during and/or after the hospital closed. How their work changed over time. If still involved, what's their job like now? Any challenges?
Looking back	Explore what the interviewee feels about the closure of the hospital. Ask about feelings about their time working in the hospital. How did their time working in the hospital compare with community care?

EX PATIENTS BROAD THEMES	INTERVIEW GUIDE MORE DETAILED AREAS OF INQUIRY
Life before the hospital	Time & Place of Birth Education, training Work history – explore if related; career choices and decisions if willing What circumstances led them to the hospital If moved from abroad – ask why he/she came to Nottingham If stayed in the hospital more than once/stayed in other hospitals, ask for details
Arrival	Experience(s) of admission to the hospital How he/she felt about being admitted to a mental hospital First impressions of the environment/ward(s)/grounds etc. First impressions of the people he/she met (staff and patients) Support – did they have support from someone/people from the outside/inside?
Life in the hospital	Physical description of the hospital/ the ward(s): sleeping, eating, rest area(s) Daily routines: regular activities on the ward (medication rounds, ward rounds etc.) Daily activities: occupational therapy, sports, other activities such as using the library, visits from friends and family, other types of work? Who made decisions on activities? Food, clothing regulation, access to washing facilities Weekend activities/holidays/leave from the hospital? Interactions with other patients. Any instances of reciprocity between patients? Memory of the wards. Cigarette and/or tea breaks? Time outside in the grounds
Staff	Interaction with staff: which staff and what context did the interaction take place? Where did most of the interactions take place? Ask about interaction with the outside world if any.
Entry & exit	Could he/she leave the hospital? Explore circumstances. Procedures for leaving/returning.
Treatment	What kind of treatment did he/she receive if any? Did he/she have any choice on type of treatment received? How negotiated the relationship with the consultant psychiatrist. Choice in attending the rehabilitation centre? Any other the activities? Did treatment changed over time?
Social networks and support	Everyday interactions in the hospital. Relationships with other patients: did they make friends? Stayed in touch after? Did they witness/experience any violence? Ask about patterns and significance of contact with family, friends, community organisations, others. Ask about any groups that support them/other patients i.e. League of Friends etc.
Leaving the hospital	Explore decisions about leaving the hospital, who made it, how it was organised. What happened when they were left. How leaving affected them personally. Did they stay in touch with people they met in the hospital as patients and/or staff?
Connections with the outside world	Did they ever leave the hospital during their stay? If so in what capacity i.e. home visits, work in the community, outings with staff/other patients alone etc. Did they participate in any public activities in the hospitals? If so ask to describe.
Closure of the hospital (if applicable)	What he/she found out about closure. What he/she felt about closure. How the move into the community was organised/what happened. Their memories of moving out and into ‘care in the community’. How closure affected them personally. Did they stay in touch with people they met in the hospital (both patients and staff)?
Mental health services after the hospital	Experience of mental health services since leaving the hospital Social support received – where from? Network of social relationships – inside the mental health system/outside. How do these compare?
Looking back	How becoming a mental patient has affected them Explore what the interviewee feels about the significance if at all of the mental hospitals for patients. Overall how do they feel about their time as patients in the hospital?